Nathan Littauer Hospital & Nursing Home
Implementation Strategy for Needs Identified in the
2019 Community Health Needs Assessment

Introduction

Nathan Littauer Hospital & Nursing Home (NLH) has prepared a Community Service Plan (CSP) to support the New York State Commissioner of Health's mission to improve the health of all New Yorkers and to participate in public health initiatives as related to the New York Prevention Agenda. This initiative seeks to integrate traditional medical services with public health interventions that stimulate positive behavioral changes to improve health status. We now are presenting our Implementation Strategy for the needs identified in our 2019 Community Health Needs Assessment.

By participating in this public health effort, Nathan Littauer Hospital supports the overall goals of the New York State Health Department which are to focus on primary/secondary disease prevention, promote access to quality health care services and eliminate health care disparities where they exist.

Nathan Littauer is a proud member of the Adirondack Regional Health Network (ARHN) which creates a synergy that allows all of the members to move towards common goals in a way that is both efficient and effective. ARHN provides a much needed forum for the various community partners to share resources and to collaborate on the development of each county's Community Health Assessment and each hospital's Community Service Plan. To plan for the next 3 years, in 2019 ARHN prepared a comprehensive collection and analysis of data regarding the health issues and needs in Essex, Fulton, Hamilton, Saratoga, Warren and Washington counties. Throughout this process we have been meeting with Fulton County Public Health and in some cases, Hamilton County Public Health to coordinate efforts.

Nathan Littauer Hospital and Nursing Home, founded in 1894, is the only hospital in Fulton County. Located in Gloversville, New York in the foothills of the Adirondack Mountains, NLH is a fully-licensed and accredited health care facility. We provide an array of services ranging from critical care to routine outpatient procedures on our 34 acre campus. We have a 74-bed acute care hospital, an 84-bed residential Nursing Home, a Medical Arts Building, state-of-the-art Surgical Center, a Dialysis Center, and a Primary/Specialty Care Center. Additional Primary/Specialty Care

Centers are located in Mayfield, Speculator, and Caroga Lake, three in Johnstown, Fonda, Perth, and Broadalbin. Currently we have a new Medical Arts building under construction which is slated to be open in June of 2020. We continue our trend to expand and deliver preventive and primary care in our local communities.

We are governed by a **Board of Directors** consisting of fifteen members who serve a three-year term in office. The Board is comprised of physicians and members of the community who represent various professional designations. No compensation is provided for these positions.

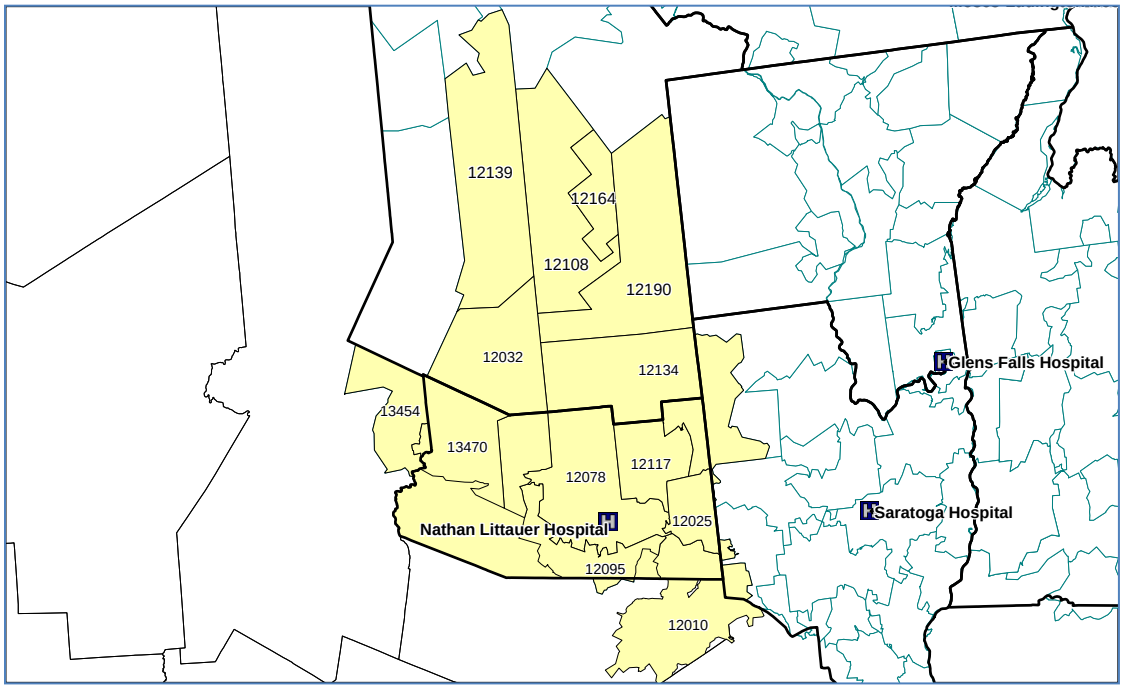
Mission Statement for Nathan Littauer Hospital

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. (This mission statement is reviewed annually by the Board of Directors.)

Nathan Littauer Hospital Service Area

The service area for Nathan Littauer Hospital is composed of thirteen ZIP codes in Fulton County, Southern Hamilton County and bordering areas of Montgomery County. Historically, about 88% of Nathan Littauer Hospital's in-patients reside within this geography.

Nathan Littauer Hospital's Service Area



New York State Prevention Agenda and the Department of Health

The next cycle of the Prevention Agenda is 2019-2024. The new vision of the Prevention Agenda 2019-2024 is to "*be the healthiest state for people across all ages"*. The focus areas, goals and recommended evidence-based interventions and actions have been updated based on a current assessment of the populations' health status and health changes as well as input from stake holders across the state according to the New York State Department of Health.

As in previous years, the NYS Department of Health asked that each local health department (LHD) and all partner hospitals/hospital systems in the county work together along with other community partners to identify and address local health priorities associated with the NYS Prevention Agenda.

LHDs and hospitals are strongly encouraged to develop one Community Health Needs Assessment (CHNA) and one plan per county by working together with other partners including the Population Health Improvement Programs (PHIPs) in their region. This collaborative approach will leverage the efforts and resources of all health organizations in a community toward shared community health goals. And improve effectiveness and reduce duplication in the assessment and planning effort.

As in previous years, hospitals are also asked to reflect their Prevention Agenda efforts in their community benefit programs when completing the Internal Revenue Service Form 990 Schedule H. Hospitals are expected to continue to increase their investments in the Community Benefit categories of Community Health Improvement and Community Building, whose definitions include the kinds of activities needed to improve the health of communities. The goal is that each hospital will align and increase its investments in evidence based interventions related to the

Prevention Agenda.

Figure 6: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

Priority Area: Prevent Chronic Diseases	**Focus Area 1: Healthy Eating and Food Security**
	Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 1.1: Increase access to healthy and affordable foods and beverages
	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
	Goal 1.3: Increase food security
	Focus Area 2: Physical Activity
	Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
	Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
	Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
	Focus Area 3: Tobacco Prevention
	Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
	Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
	Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
	Focus Area 4: Preventive Care and Management
	Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
	Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
	Goal 4.3: Promote the use of evidence-based care to manage chronic diseases
	Goal 4.4: Improve self-management skills for individuals with chronic conditions
Priority Area: Promote a Healthy and Safe Environment	**Focus Area 1: Injuries, Violence and Occupational Health**
	Goal 1.1: Reduce falls among vulnerable populations
	Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
	Goal 1.3: Reduce occupational injuries and illness
	Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
	Focus Area 2: Outdoor Air Quality
	Goal 2.1: Reduce exposure to outdoor air pollutants
	Focus Area 3: Built and Indoor Environments
	Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
	Goal 3.2: Promote healthy home and school environments
	Focus Area 4: Water Quality
	Goal 4.1: Protect water sources and ensure quality drinking water
	Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
	Focus Area 5: Food and Consumer Products
	Goal 5.1: Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
	Goal 5.2: Improve food safety management

Figure 6 Continued: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

Priority Area: Promote Healthy Women, Infants and Children	**Focus Area 1: Maternal & Women's Health**
	Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
	Goal 1.2: Reduce maternal mortality and morbidity
	Focus Area 2: Perinatal & Infant Health
	Goal 2.1: Reduce infant mortality and morbidity
	Goal 2.2: Increase breastfeeding
	Focus Area 3: Child & Adolescent Health
	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships
	Goal 3.2: Increase supports for children and youth with special health care needs
	Goal 3.3: Reduce dental caries among children
	Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders	**Focus Area 1: Promote Well Being**
	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages
	Focus Area 2: Prevent Mental and Substance Use Disorders
	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults
	Goal 2.2: Prevent opioid and other substance misuse and deaths
	Goal 2.3: Prevent and address adverse childhood experiences (ACEs)
	Goal 2.4: Reduce the prevalence of major depressive disorders
	Goal 2.5: Prevent suicides
	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population
Priority Area: Prevent Communicable Diseases	**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 (STIs)
	Goal 3.1: Reduce the annual rate of growth for STIs
	Focus Area 4: Hepatitis C Virus (HCV)
	Goal 4.1: Increase the number of persons treated for HCV
	Goal 4.2: Reduce the number of new HCV cases among people who inject drugs
	Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections
	Goal 5.1: Improve infection control in healthcare facilities
	Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile
	Goal 5.3: Reduce inappropriate antibiotic use

New York State Prevention Agenda Priorities

The Mohawk Velley Population Health Improvement Program (MVPHIP) partnered with Nathan Littauer and Fulton County Public Health Department to complete their 2019-2021 Community

Health Needs Assessment and Community Service Plan. Key informant survey data was compiled by Adirondack Rural Health Network. Key informants represent a broad range of sectors, community interests, and include organizations that represent the medically underserved, low-income, and minority populations. In addition to the key informant responses the assessment included quantitative data sources collected and published by New York State, as well as health indicators included on the MVPHIP website compiled by Healthy Communities Institute. Nathan Littauer Hospital & Nursing Home and Fulton County Public Health also collected a small sample of the community members' views of the health of the community. Community members were asked to select their top three biggest health issues. Sixty-five percent felt substance use was the biggest priority, followed by chronic diseases at fifty-seven percent, and mental health issues at forty-six percent. Based on the key informant priority rankings and our ability to effect the chosen priorities, Nathan Littauer Hospital and Fulton County Public Health Department will collaborate on the following New York State Prevention Agenda priorities:

Prevent Chronic Disease and Prevent Communicable Diseases.

Implementation Strategy

A hospital facility's implementation strategy must be a written plan that for each significant health need identified, either:

- Describes how the hospital facility plans to address the health need, or
- Identifies the health need as one the hospital facility does not intend to address and explains why it does not intend to address the health need.

Although an implementation strategy must consider all of the significant health needs identified through our CHNA, it is not limited to considering only those health needs and may describe activities to address health needs that the hospital facility identifies in other ways. In order to address a significant health need Nathan Littauer Hospital & Nursing Home has included in the implementation strategy:

- A description of the actions we intend to take to address the health need and the anticipated impact of these actions,
- Identify the resources the hospital facility plans to commit to address the health need, and
- Describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

Priority Choice #1

Prevent Chronic Diseases

Focus Area 4: Preventive Care and Management

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

Disparity Focus: Rural residents have limited access to care due to less options for public transportation, socioeconomic conditions, access to mass media and emerging technologies, built environment, and some physical barriers

Intervention: Expand access to evidence-based self-management interventions for individuals with arthritis, asthma, cardiovascular disease, and diabetes

Process Measures: Number of workshops delivered. Number of participants who complete 4 out of 6 sessions, and the number of sites and or counties where workshops are delivered

The percentages of adults (35.9%) and children who are obese (17.6%) in Fulton County is higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. The burden of obesity may contribute to higher rates of death and hospitalization due to diabetes (and other chronic conditions) in Fulton County (24.1 and 291.5 respectively) in in upstate New York (15.4 and 237.2).

Smoking and smoking-related diseases seems to pose a significant challenge for Fulton County, with seven indicators listing as worse than the comparison benchmarks. The percentage of adults who smoke in Fulton County (19.1%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Bench mark of 12.3%. Chronic lower respiratory deaths and hospitalizations are significantly higher in Fulton County (83.4 and 33.4, respectively) than in Upstate New York (45.4 and 28.0) and the state as a whole (34.1 and 30.6). The percentage of adults with asthma in Fulton County (13.2%) is slightly higher, in comparison to upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are higher in Fulton County (124.2) than in Upstate New York (84.3), and New York State (69.7), and lung and bronchus cancer deaths in Fulton County are (67.6), are higher than Upstate New York (53.0) and New York State (43.5). On a positive note, the percentage of colorectal screenings for those 50-75 years of age in Fulton County is 76.11% which is higher than Upstate New York (68.5%) and New York State (69.7%). Colorectal screening was a focus of Nathan Littauer Hospital & Nursing Home during the period of 2016-2019.

One of the ways Nathan Littauer Hospital & Nursing Home intends plan to continue to address Chronic Disease in our community is to offer evidence-based self-management programs. These programs address the significant health conditions identified through the CHNA. It is anticipated the impact of these actions will:

- Increase self-efficacy in managing one's health
- Increase or maintain independence, positive health behaviors, or mobility
- Reduce disability (fewer falls, later onset or fewer years of disability, etc.)
- Reduce pain
- Improve mental health (including delays in loss of cognitive function and positive effects on depressive symptoms)
- Improve quality of life

In addition to the benefits that these evidence-based programs will provide to our community members, there are also benefits to Community-Based and Health Care Organizations such as:

- More efficient use of available resources
- Facilitation of partnership development and community /clinical linkages
- Better health outcomes and a more positive health care experience
- Fewer hospital and doctor visits and lower health care costs
- Ease of replicating and spreading programs
- Greater opportunity for varied funding sources and programs get proven results

Currently Nathan Littauer Hospital has staff trained to lead the following evidence-based programs:

- Chronic Disease Self-Management Program (CDSMP)
- Diabetes Self-Management Program (DSMP)
- National Diabetes Prevention Program (NDPP)
- Chronic Pain Self-Management Program (CPSMP)
- The Butt Stops Here (TBSH)
- Active Living Every Day (ALED)
- Healthy Eating Every Day (HEED)
- Tai Chi for Arthritis and Fall Prevention

Nathan Littauer Hospital & Nursing Home provides certified peer leaders for CDSMP, DSMP, CPSMP along with other specially trained personnel for the other programs. In addition to providing the staff needed to facilitate these programs Nathan Littauer Hospital & Nursing Home covers fees associated with trainings, travel and wages of peer leaders, space to hold workshops in the hospital, at our HealthLink office and also in our primary care centers. Transportation to the workshops can often be a challenge. However, we do offer cab vouchers for people who do not have access to public transportation or other transportation including partnering with our local Office for the Aging. All printed materials, books, equipment, advertising for recruitment of participants, and required licenses needed to lead some of the above programs are provided by Nathan Littauer Hospital & Nursing Home. Data entry and the tracking of outcomes from these evidence-based programs is also provided by Nathan Littauer Hospital & Nursing Home.

Collaboration within the organization involves our primary care offices; inpatient nursing staff, our physical and occupational therapy departments, nutritional services, and discharge planning. We will focus the next three years on this intradepartmental collaboration with a goal to increase our referrals and medical notes utilizing the electronic medical record. The goal is to develop a seamless integration of provider referral, self-management class attendance complete with medical notes into our EMR system.

Fulton County Public Health will also refer participants to our programs well as advertise our workshops via social media and distribute packets given out by their staff in the community. They will purchase the books needed for another evidence-based program called *Walk with Ease* which we hope to begin facilitating in 2020.

Our local Senior Centers in Gloversville and Johnstown, the Housing Authority in Amsterdam, Creative Connections Club House and private businesses such as Willow Tree Wisdom have offered space in their facilities to run programs at no cost to us. They will also assist in educating the public on our programs and informing them of when they will take place.

Lexington Center has two programs that work closely with us and have offered several of the evidence-based programs in the past and are interested in future programing. Lexington Center, Family Counseling Center, Mental Health Association and HFM Prevention Council, and multiple other businesses, agencies and the faith-based community centers including and St. John’s church have offered space in-kind in an effort to globally educate the community about the programs. This will help us meet the required number of participants to maintain the fidelity of the programs. Our plan is to offer these programs in different locations and at different times of day to make them more accessible to our community.

We will continue to partner with Adirondack Rural Health Network (ARHN) and Mohawk Valley Population Health Improvement (MVPHIP) who assist with suppling grant funds to support our programs. The MVPHIP also assists with the organization of a HUB that Nathan Littauer Hospital & Nursing Home participates in to work towards a plan make sure the programs are sustainable and work towards gathering data and information to ultimately make them reimbursable via insurance companies.

Priority Choice #2

Prevent Communicable Diseases

Focus area 5: Antimicrobial Resistance and Healthcare-Associated Infections

Goal: To reduce inappropriate antibiotic use
Disparity Focus: Low socioeconomic conditions, availability of resources to meet daily needs, access to health care services, quality of education, transportation options, social norms and attitudes
Interventions: (1) Conduct an educational campaign for the public on antimicrobial resistance and appropriate antibiotic use (2) Healthcare clinician education
Process Measures: Number of community members encountered, number of health care clinicians encountered, social media impact, number of printed materials and multimedia products produced and distributed and number of classes offered in the community on antibiotic stewardship

According to the CDC, antibiotic resistance is one of the biggest public health challenges of our time. Each year in the U.S., at least 2.8 million people get an antibiotic-resistant infection, resulting in 35,000 annual deaths. Certain disparities increase the risk of antibiotic-resistance such as: increased age, people residing in a health care setting, living in a rural area and lower socioeconomic status.

Therefore, data suggests that Fulton County would be at an increased risk with 18% of the population being 65 years of age and older- much higher than Upstate New York at 16.37%. The household income in Fulton County averages $61,941, with per capita income of $26,298, which is much lower than that of New York State, at $93,443 and $35,752 respectively. The percentage of individuals in Fulton County living below the Federal Poverty Level is 16.0%, which is higher than Upstate New York at 11.7%.

Nathan Littauer Hospital & Nursing Home plans to build a team of clinicians and support personal that will collaborate with Fulton County Public Health to decide on educational material that will be consistently disseminated into the community. Visiting nursing agencies along with local pharmacies will also be invited to participate. Once a cohesive messaging plan is developed the hospital's graphic designers will consult with our team. Once the Marketing Team develops the final material they will then utilize our in-house print shop to produce the materials.

HealthLink Littauer, the hospital's community education department and Fulton County Public Health will print educational materials to be dispersed at work sites, community events, health fairs, and wellness days. Nathan Littauer Hospital & Nursing Home Primary Care Centers will also display the information. When speaker requests come to either Nathan Littauer Hospital or Fulton County Public Health, we will encourage the topic of Antibiotic Resistance be presented if appropriate. A VIP luncheon, a gathering a healthcare users, will be held at Nathan Littauer Hospital & Nursing Home on the subject of Antibiotic Resistance.

Social Media campaigns from both Nathan Littauer Hospital & Nursing Home and Fulton County Public Health will relay educational information about antibiotic-resistance. Newspaper articles such as the *Wellness Words* published in the Leader Harold and will be published and packets produced by Fulton County Public Health part of direct mail campaigns. Nathan Littauer Hospital & Nursing Home also will discuss this priority with local pharmacies during the *"Let food be thy medicine event*" slated to happen in December 2020.

As we leverage our existing relationships with businesses, the faith-based community, school districts and other agencies, we believe we will make significant strides toward educating the community. Nathan Littauer Hospital & Nursing Home and Fulton County Public Health will also offer healthcare provider education to prescribers in our service area.

Adirondack Rural Health Network

The Adirondack Rural Health Network (ARHN) is a program of the Adirondack Health Institute, Inc. (AHI). AHI is a 501c3 not-for-profit organization licensed as an Article 28 Central Service Facility. AHI is a joint venture of Adirondack Health (Adirondack Medical Center), University of Vermont Health Network- Champlain Valley Physicians Hospital, Glens Falls Hospital and Hudson Headwaters Health Network. The mission of AHI is to promote, sponsor, and coordinate initiatives and programs that improve health care quality, access, and service delivery in the Adirondack region. Established in 1992 through a New York State Department of Health, Rural Health Development Grant, the Adirondack Rural Health Network (ARHN) provides a forum for local public health services, community health centers, hospitals, and community mental health programs, emergency medical services, and other community-based organizations to address rural health care delivery barriers, identify regional health needs and support the NYS Prevention Agenda to improve health care in the region. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning in the region. The Community Health Assessment (CHA) Committee, facilitated by

ARHN, is comprised of hospitals and county health departments working together utilizing a systematic approach to community health planning. The CHA Committee is made up of members from Adirondack Health, Alice Hyde Medical Center, Elizabethtown Hospital, Hamilton County Public Health Services, Moses Ludington Hospital & Inter-Lakes Health, Nathan Littauer Hospital and Nursing Home, UVM Health Network-CVPH, Warren County Health Services, and Washington County Public Health Services.

Priorities not chosen

Nathan Littauer Hospital & Nursing Home does not have the clinical infrastructure to address mental health issues at the hospital level for on-going treatment. We do refer to appropriate providers and hospitals in the area. Additionally, our clinicians are trained to meet the needs of a patient with a mental health issue in a medical setting. We have cooperative relationships with the Family Counseling Center, even offering them office space in exchange for quick mental health referrals for our patients in crisis. We refer to a neighboring hospital's mental health treatment facilities available. On the Primary Care level, we are able to provide situational mental health assistance; providing medication as indicated and/or referral to appropriate local and regional resources. Nathan Littauer Hospital and Nursing Home and Fulton County Department of Public Health are members of the Mohawk Valley Population Health Improvement Program (MVPHIP). MVPHIP identified behavioral health as a priority and has a workgroup to address stigma and provide mental health resources to the region.

Regional Priority

Because of the limitations listed above Nathan Littauer Hospital & Nursing Home did not choose to focus on the Prevention Agenda Priority Promote Well-Being and Prevent Mental and Substance Use Disorders. This focus area was identified by stakeholders as their second largest need in our area. The ARHN CHA voted unanimously to address this as our regional priority. To avoid replication of services, NLH will not address this priority in our hospital implementation plan. Therefore, Nathan Littauer Hospital & Nursing Home will work in conjunction with ARNH to implement meaningful NY Prevention Agenda interventions to the best of our abilities.

Approval

This report was prepared for the December 17, 2019 meeting of the Nathan Littauer Hospital & Nursing Home Board of Directors. The Board will be asked to approve the Implementation Plan for the Needs Identified in the 2019 Community Health Needs Assessment for Nathan Littauer Hospital & Nursing Home.