2019-2021 Community Service Plan
Delaware County Service Area

1 Titus Place
Walton, NY 13856
607-865-2100

Area Covered in Service Plan: UHS Delaware Valley Hospital's (DVH) Community Service Plan covers the hospital's service area, most of which is located in Delaware County, NY.

The plan was developed through collaboration with our local Delaware County Health Department, and other hospitals, located in Delaware County, which includes O'Connor Hospital, Delhi, NY and Margaretville Community Hospital in Margaretville, NY.

Contact Information of Collaborating Partners

UHS Delaware Valley Hospital
Dotti Kruppo, Community Relations Director
1 Titus Place
Walton, NY 13856
607-865-2409
Dotti.Kruppo@nyuhs.org

Delaware County Public Health Department
Amanda Walsh, MPH, Public Health Director
99 Main Street
Delhi, NY 13753
607-832-5200
Mandy.walsh@co.delaware.ny.us

Delaware County Public Health Department
Heather Warner, Public Health Programs Manager
99 Main Street
Delhi, NY 13753
607-832-5200
Heather.warner@co.delaware.ny.us

O'Connor Hospital
Amy Beveridge, Director of Operational Support
460 Andes Road
Delhi, NY 13753
607-746-0331
Amy.beveridge@oconnorhosp.org

Margaretville Memorial Hospital
Marilyn Donnelly, RN
42084 NY Route 28, Margaretville, NY 12455
845-338-2500 x-4061
Marilyn.donnelly@hahv.org

Community Health Assessment update completed with the assistance of the Southern Tier Regional Population Health Improvement Program (PHIP). Support provided by Mary Maruscak, Evan Heaney, and Stephanie Wright.

Over the course of 2019, UHS Delaware Valley Hospital, has worked with its partners, Delaware County Public Health, O'Connor Hospital, and Margaretville Hospital to complete a needs assessment and develop our respective Community Service Plans. Population Health Coordinators with the Southern Tier Regional Population Health Improvement Program (PHIP) also assisted in updating the assessment. Updates to the needs assessment used a variety of national and state sources to obtain local-level data. In addition, a review of the Delaware County Office for the Aging's and Community Services Department's Annual Assessments and Plans informed some needs as well as potential opportunities to work together to address identified needs. In order to solicit community input from a range of stakeholders, two surveys were developed. The first was sent electronically to fellow health and human service providers throughout the county to gain their perspective regarding the prevention agenda and associated priorities. The second survey was developed for the public. It too, was sent electronically and provided the team with the community's thoughts about the needs and challenges facing the community in terms of health and accessing services. Additionally, a group roundtable event was held in May of 2019 with a wide variety of health and human service providers in attendance. Breakout sessions provided attendees with an opportunity to share their thoughts in which priority areas were most important. After review of the data, the group decided to continue to focus on the priority areas of *Prevent Chronic Diseases* and *Promote Well-Being* and *Prevent Mental and Substance Use Disorders.* The disparate population all three hospitals and Delaware County Public Health will focus on is *low-income residents living in rural areas of Delaware County*; however, our focus will not be solely limited to residents who meet these criteria. This decision is based on the notable health disparities among rural residents in this socioeconomic group.

Prevent Chronic Diseases

Diseases of the heart, cancer, and lung conditions are, in that order, the biggest killers of our neighbors. The Delaware Valley Hospital's primary care providers will focus on measures dealing with proper management of chronic disease. The focus will be: seeing more patients for an annual wellness exam; patients diagnosed with high blood pressure will have their pressure controlled; diabetic patients will have had an annual Hga1b test, with a reading of less than 8; patients will receive colorectal screening; prescriptions for medications used to manage chronic disease will be written for 90 days in order to foster better compliance. The effectiveness of each objective will be measured by the percentage of the appropriate patient population that either had the recommended screening, and/or had their condition adequately controlled. The intervention that will be used to achieve the above objectives will be to work with primary care providers and staff to put in place systems that will provide both providers and patients with screening reminders through EHR alerts, mail, phone calls, email, and/or e-chart notifications. For the prescription objective, EHR alerts will be used and the percentage of chronic disease prescriptions that have been written for 90 days will be measured. Because it is equally important to give patients the opportunity to learn basic tools to help them self-manage their condition(s) there are two objectives that address this issue.

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: *A healthcare provider or human service agency will have referred more participants to the Chronic Disease Self- Management Workshop. DVH will continue to offer opportunities for those with chronic disease to learn self-management skills.* The intervention that will be used to increase referrals will be to work with marketing staff, primary care provider offices and local human service agencies to put systems in place to assure awareness of the availability of the chronic disease self-management program. The measures for these objectives will be the percentage of participants referred by a healthcare provider or human service agency and the number of workshops held.

Promote Well-Being and Prevent Mental and Substance Use Disorders

Delaware Valley Hospital has chosen to focus much of its work over the next few years in the Walton community. The high percentage of aging, disabled, and those living in poverty or the low-income employed necessitates intervention. The Walton community has suffered through two major and two moderate floods since 1996. These events led to a sense of victimization throughout the community and its residents. All of these factors had led DVH to believe that to really make an impact on the health of its own community, it needs to better address social determinants of health. However, not much headway can be made without the cooperation of the community's organizations, school, government, and residents. Some new initiatives to beautify the community by several local groups; new-to-area and/or younger residents in both school board, government, and other leadership positions; and a new foundation that was created from the estate of a couple who were long-standing members of the community have all coalesced into a force of positivity. Based on the renewed sense of community and positivity among Walton residents, DVH discussed the presentation of a series of workshops (for the entire county) based on the AARP Age-Friendly Communities Program, which includes 8 Domains of Livability: 1) Outdoor Spaces and Buildings; 2) Transportation; 3) Housing; 4) Social Participation; 5) Respect and Social Inclusion; 6) Civic Participation and Employment; 7) Communication and Information; and 8) Community and Health Services. Care Compass Network (CCN) has agreed to fund the series. The county's Mental Health Department is collaborating with DVH to present the programs. We believe that progress in the areas of communication and information, social participation, and respect and social inclusion, we will be able to make strides, over time, in reducing the feelings of anxiety, fear, depression, sadness or the feeling of hopelessness or helplessness. Discussions with others included Delaware County Rural Healthcare Alliance members; Walton Central School Community Committee, town and village officials, Walton Ministerium, Board of Education, Chamber of Commerce resulted in unanimous enthusiasm and support. Further discussion took place with the program coordinator for stream program. The stream program of the county's soil and water conservation department is working on flood mitigation and the plan includes development of an area of Walton adjoining the Delaware River, called Water Street. The ultimate plan can include places for socialization, physical activity and events. Some of the work is funded and a grant application is pending to build a trail. It was agreed this was the perfect time to work together to ensure the best possible use of the area. The first workshop of the series will be held January 30 and will feature Esther Greenhouse, nationally renowned expert on built environments. Organizations, from across Delaware County, will be invited to all the workshops. However, DVH and its local partners intend to focus our efforts on the Walton community and any countywide efforts, such as transportation that may come out of the series. Based on this our efforts will be as follows:

Focus Area 1: Promote Well-Being

Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan

Objective 1.1.1: ***By December 31, 2020, at least one community within the DVH service area will be actively working to become an age-friendly community*** **Interventions:** Build community wealth by serving as the catalyst to create inclusive, healthy public spaces and Inter-generational socialization opportunities

Measures: Improvement in accessibility, socialization, and well-being measures. In 2020, we will hold series of workshops based AARP's *Road to Livability* program, then follow-up meetings between interested parties from Walton area to create a coalition of community members. This committee will prioritize initiatives; identify next steps and potential committee members to address each initiative. Members will recruit and form subcommittee(s) of residents, focused on at least two priorities identified. Subcommittees will formulate their respective objectives, develop work plans and create timelines to achieve the objectives and choose a representative to sit on the community coalition. Working with the subcommittees the coalition will reach consensus on best practice interventions, core measures and roles of stakeholders

Objective 1.1.2 ***Increase accessibility of physical environment by 5% (baseline to be set in 2020)***

Interventions: Develop consensus on development of Water Street through flood mitigation project and other funding.

Measures: Accessibility of physical environment. In 2020, the coalition will review previous walk audit done by Rural Health group. It will complete a walk audit of both Walton's Water Street and Delaware Street to assess the accessibility from one to the other, as Delaware Street is the main business district of the community, and the streets run parallel to each other. Survey and complete discussions of suggested use of Water Street property.

Finally, Objective 1.1.4: ***By December 31, 2021, increase the percentage of adults who report ongoing participation in at least one socialization opportunity other than work. (baseline to be set in 2020)***

Interventions: Survey community members through social media, events, print media, workplace, being mindful be inclusive of new-to-area residents.

Measures: Number of people participating at socialization opportunities. In 2020, focus coalition and committee work on identifying socialization opportunities and identify and implement ways to disseminate the information to help foster feelings of well-being through inclusion and participation.

Ongoing Participation

Delaware Valley Hospital staff (Community Relations Director) will play an integral role, with Care Compass Network staff to ensure appropriate stakeholders from across the county are invited to the various Age-Friendly workshops and that the Walton coalition is developed and functioning. Delaware Valley staff will be the catalyst to ensure Walton community stakeholders hold follow-up meetings and formulate subcommittees to focus on specific interventions, based on the consensus of the group. DVH will maintain representation on the coalition and other sub-committee(s) as appropriate; work to ensure walk audits are completed and results reviewed and follow-up decisions made. Working with Delaware County Mental Health Department, the survey of socialization opportunities and participation will be formulated and DVH will tabulate and report results to the coalition and subcommittee members. If necessary, DVH will assist in providing support in writing any grant requests.

DVH is a non-profit, Article 28 General Hospital and has been designated as a Critical Access Hospital. DVH is affiliated with United Health Services (UHS) of Binghamton. United Health Services, Inc. is the sole corporate member and parent corporation of Delaware Valley Hospital, Inc.

Mission Statement

As a trusted partner, we listen, educate, value and inspire our patients as we deliver the high quality care and services needed most often. Delaware Valley Hospital also serves as the gateway for patients to access the specialists and state-of-the-art technology available within the UHS system.

This Mission Statement was adopted on December 17, 2019 by the Delaware Valley Hospital Board of Directors.

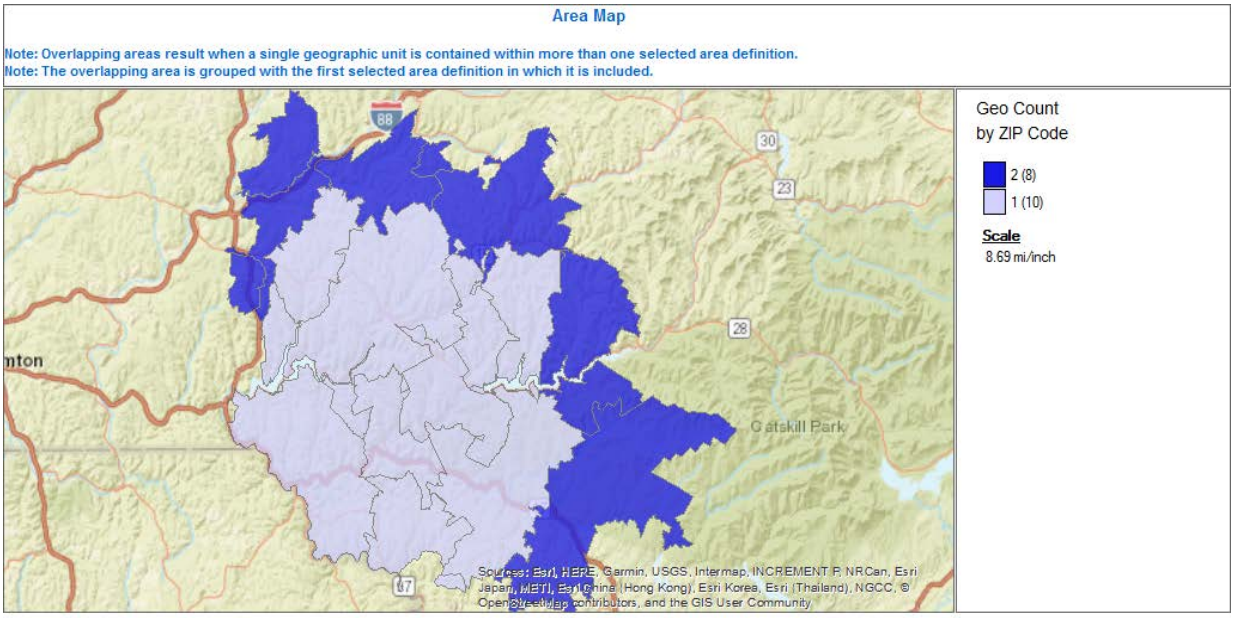
Description of Service Area

The local healthcare environment in Delaware County is greatly influenced by specific aspects of the physical, legal, social, and economic environment within the county. It is located on the eastern border of upstate New York's Southern Tier Region covering 1,467 square miles, of which 1,442 miles are land and 25 miles are water.

The county is characterized by a mountainous terrain and winding, twisting, two lane roads, making travel difficult and even hazardous during the winter months. The county has no public transportation system, making access to care challenging. Although a few private transport services have become available in the area, regular use is cost prohibitive.

Geographically, Delaware County is the fourth largest of New York's 62 counties and is the fifth most rural. The population density is only 31.56 persons per square mile. The large size of the county is reflected in the fact that it borders seven counties (Broome, Chenango, Greene, Otsego, Schoharie, Sullivan, and Ulster) as well as the State of Pennsylvania.

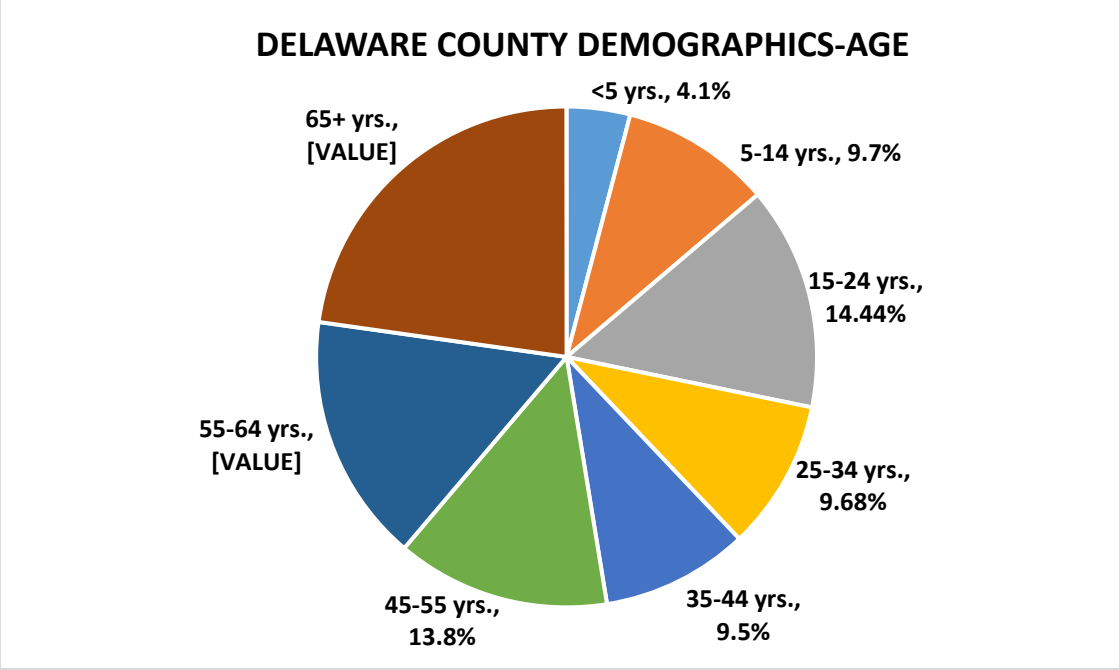
UHS Delaware Valley Hospital serves the residents of southwestern Delaware County and northwestern Sullivan County. It encompasses approximately a 30 miles radius with approximately 33,000 residents. More specifically, for 2018, the primary service area, (the area where 80% of discharges originated, include the following locations: Walton, Roscoe, Hamden, Delancey, Hancock, Long Eddy, Downsville, Sidney Center, Fremont Center and East Branch. The secondary service area includes Unadilla, Delhi, Franklin and Masonville, Livingston Manor, White Sulphur Springs, Andes, Treadwell,



Population

According to https://factfinder.census.gov Delaware County has a population of 45,951, which is a 1.7% decrease since 2013. Seven Delaware County towns and villages fall into the top 20 fastest shrinking communities in the state. Factors that may contribute to this are related to the fact that Delaware County, like many other upstate counties, is aging at a rapid rate while young professionals continue to leave. On a subjective note, the hospital's service area has long attracted tourists, sportsmen and women from the downstate or NJ area. This increases the population during the spring through fall seasons. In addition, many of these visitors purchase or build homes planning to eventually retire to this area. Once they do, they often have left their children and many friends behind and have little support system in place. Without those supports, as they age, they often become isolated and have limited access to transportation and therefore socialization and shopping opportunities. Because many do not qualify for Medicaid, they also lack access to medical care if they cannot drive themselves or find an alternate means of transportation.

Age: Almost 23% of the population is age 65 and over, making the age group the largest within Delaware County. This is nearly a 15% increase from the last report, which cited the 2010 census figures. The median age for both men at 46.5 and women at 47.6 are well above that of NYS at 38.4. Walton's median age is slightly lower than that of the county at 43.7: men at 42.8 and women at 44.6. However, according to the Census Bureau, 2013-2017 American Community Survey 5-Year Estimates 31.3% of Walton's population is 65 or older, substantially higher than the 23% for the county.



Source: https://factfinder.census.gov

Gender:
The population is almost evenly divided between male and female: 24,096 male and 23,884 female

Race/Ethnicity:
Based on the US Census, 96.3% of the Delaware County population is White. This is significantly higher than the NYS (66.1%) and U.S. (75.7%) averages.

Disability:

Percentage of the Population Living with a Disability, 2016

	Delaware County	NY State
Disability	25.80%	22.90%
Cognitive Disability	10.70%	8.70%
Hearing Disability	4%	3.90%
Vision Disability	3.50%	3.70%
Self-Care Disability	5.90%	3.50%
Mobility Disability	13.30%	13.90%
Independent Living Disability	9.40%	3.90%

Source: Behavioral Risk Factor Surveillance System (BRFSS)

Delaware County has a higher percentage of persons with a disability among each category, except for vision disability and mobility disability. Persons with a disability are a distinct demographic group experiencing health disparities that can be addressed by tailored policy interventions. Most likely, because of the many housing and support resources for the disabled population are available in the Walton community, 15% of men and 11.1% of the women are estimated to be disabled according to https://factfinder.census.gov

Education:

Comparison of Delaware County and NYS
Education Attainment 2013-2017, for persons over 25

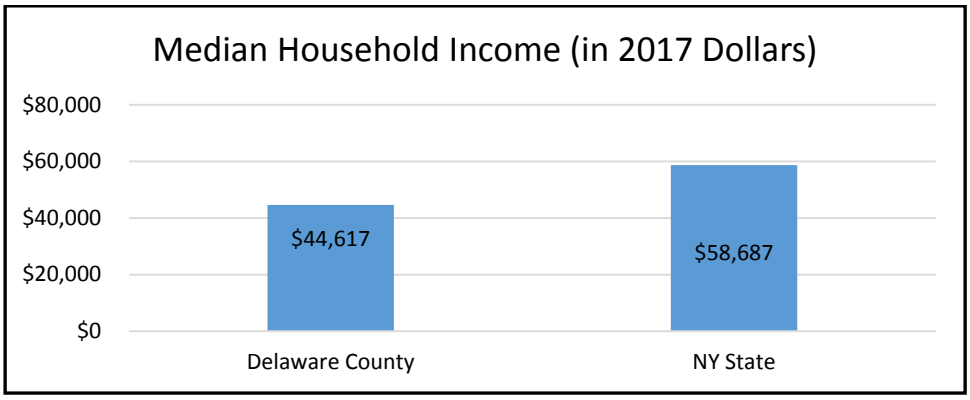
	Delaware County	NYS
High School graduate or higher	87.7%	86.1%
College 4 or more years, graduate	21.6%	35.3%

Source: https://www.census.gov/quickfacts/table/PST045215/36,36025

The above table shows that Delaware County has a 1.6% higher percentage of people over the age of 25 who are high school graduates than NY State. However, the percentage of people who have attained a Bachelor's Degree or higher is 13.7% lower the NY State percentage.

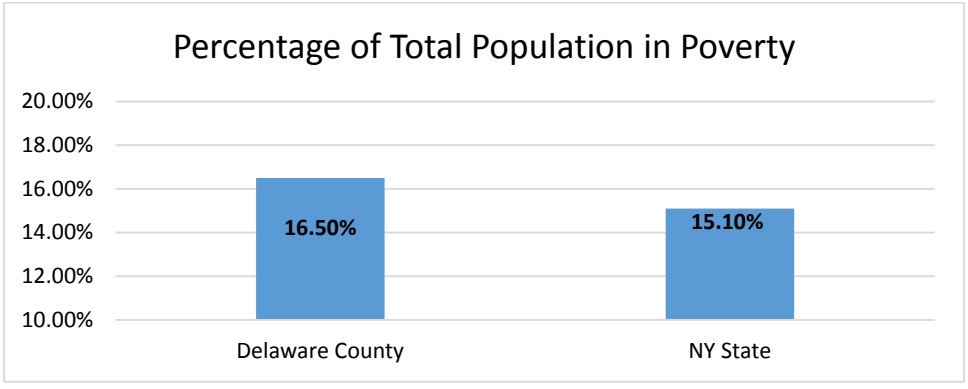
In Walton, 13.4% of residents 25 years of age and older do not have a high school diploma, however in those age 18-24, 100% have graduated from high school (or equivalency) and almost 14% of them have a bachelor's degree or higher.

Socio-economic:
The unemployment rate in Delaware County as of October 2019 is 4.0%



Source: US Census Bureau QuickFacts, 2018

The graph shows that the median household income in Delaware County is less than that of New York State by about $14,000. Lower wages create a need for dual family incomes and hinder attempts to employ and retain young people, but makes it extremely difficult to attract professionals from out of the area with new expertise. Financial well-being is a social determinant of health that can shape quality of life, including access to care, housing, and ability to afford a personal vehicle.



Source: NYS Poverty Report, March 2018; US Census Bureau QuickFacts

Delaware County's 2013 CHA reported that the poverty rate was 17.1%, and we saw a decrease in that rate to 16.4% in the 2016 update. For this report, we can see that the percentage of total population in poverty has remained mostly consistent, with a slight increase to 16.5% The New York State rate has decreased from 15.9% in the 2016 update to 15.1% now. The Delaware County rate remains higher.

The poverty rate of related children, under 5 years of age, living in female head of household with no husband has decreased since the 2016-2018 report, from 59.8% to 32.3% However, children between the ages of 5-17 has increased to 54% from 41.2%.

Although the median income for Walton is higher than that of Delaware County at $48,300, the U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates the income of 25.8% of all households in Walton have, in the past 12 months, been below the poverty level.

When looking at the socio-economic demographics of the employed vs. the unemployed, 7.9% of employed individuals live in poverty, while 12.4% of the unemployed do. This led us to research the United Way's ALICE (Asset Limited, Income Constrained, Employed) data to better understand the full scope of the challenges that families in Delaware County face when it comes to poverty and related factors.

The ALICE Project was initiated by United Way of Northern New Jersey several years ago to bring focus to the families and individuals who work but whose salaries do not provide sufficient resources to meet basic needs. The Project developed a methodology using publicly available census, employment, wage, cost of living, and other data to help to understand the extent of ALICE in our communities, those who are above the federal poverty level, but below a sustainable wage. The ALICE Project is now implemented in 18 states, with New York joining in 2016. The chart below was developed with information taken directly from: www.unitedforalice.org/newyork County Pages for Delaware, Otsego and Sullivan Counties.

As you will see, of the 10 communities that fall within the hospital's service area, only Franklin, Tompkins and Masonville have less than 40% of their households considered to be an ALICE household or in poverty, the rest are all over 40% and Walton and Rockland are well over 50%. Walton and Rockland are two communities where Delaware Valley Hospital has a physical presence.

ALICE Data – 2016 Delaware, Otsego and Sullivan County Data – Delaware Valley Hospital Primary & Secondary Service Area

Town (by County Subdivision)	Households	Percent ALICE & Poverty
Delhi (includes Delancey)	1402	44%
Colchester (includes Downsville)	864	45%
Franklin	902	35%
Tompkins	398	38%
Unadilla (Otsego County)	1723	42%
Walton	2366	59%
Rockland (Sullivan County- includes Roscoe and Livingston Manor)	1451	56%
Andes	502	44%
Hancock (includes East Branch)	1251	49%
Masonville	527	39%

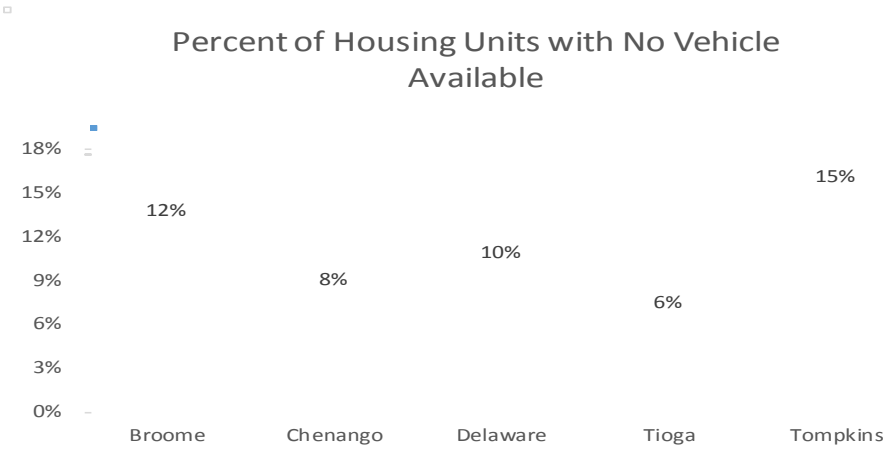
ALICE Data- 2016 Delaware County

Housing Occupancy	Housing Units	Percent of Total
Total Housing Units	31,222	100

Occupied Housing Units	19,898	63.7
Vacant Housing Units	11,324	36.3
For Rent	565	1.8
Rented, not occupied	36	0.1
For sale only	446	1.4
Sold, not occupied	117	0.4
For seasonal. recreational or occasional use	9,276	29.7
All other vacant	884	2.8

According to U.S. Census Bureau, 2010 Census there are 3,106 housing units in Walton. Almost 77% are occupied and 23% or 705 are unoccupied. Of the unoccupied units, 449 or 63.7% are for seasonal, recreational or occasional use. Most likely demonstrating the large number of part-time residents.

Housing



Source: https://factfinder.census.gov

The graph shows the percent of housing units with no vehicle available by county. 10% of households in Delaware County do not have a vehicle available to them. In a largely rural county with a low population density and no public transit system, this can pose a significant challenge to maintaining employment, accessing care, and reducing social isolation. Transportation is an important social determinant of health, and lack of access to consistent and reliable transportation can have repercussions for health and well-being. Another subjective observation: although many senior citizens may have a vehicle available, they no longer use the vehicle or use it very limitedly.

Employment:

2013-2017 Delaware County Employment by Industry

Numbers are based on civilian employed population 21,434 people aged 16 and over

Industry	Persons employed	Percent of labor force
Agriculture, forestry, fishing, and hunting, mining	739	3.7%
Construction	1,715	8.6%
Manufacturing	2,766	13.9%
Wholesale trade	427	2.1%
Retail trade	2,172	10.9%
Transportation and warehousing, and utilities	759	3.8%
Information	334	1.7%
Finance and insurance, and real estate and rental and leasing	700	3.5%
Professional, scientific, and management, and administrative and waste management services	1,241	6.2%
Educational services, and health care and social assistance	5,221	26.2%
Arts and entertainment, and recreation, accommodation, and food services	1,912	9.6%
Other services, except public administration	916	4.6%
Public administration	1017	5.1%

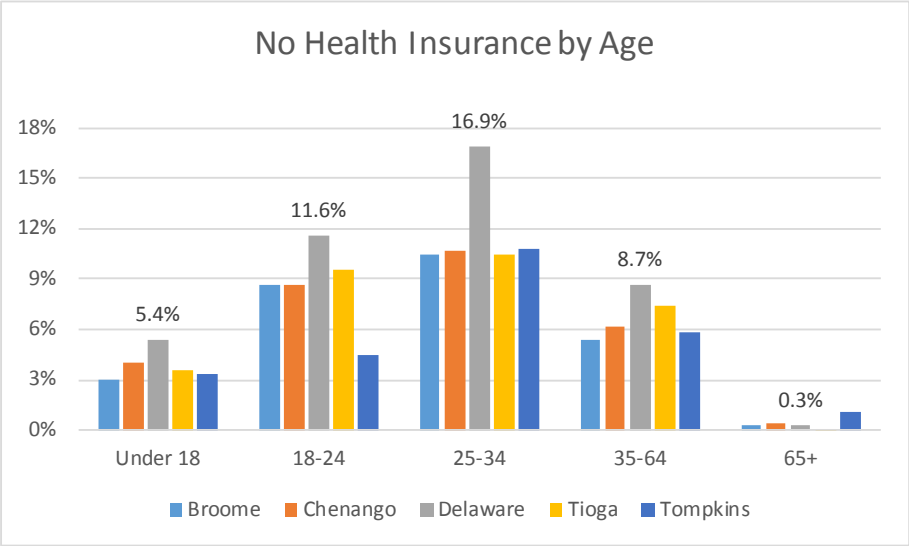
Source: U.S. Census Bureau, 2013-2017 American Community Survey,

In Delaware County, the estimated population from 2013-2017 aged 16 years and over was 39,157 with 21,434 in the civilian labor force. Of those in the labor force, there were 19,919 people employed and 1,515 people unemployed. There were 17,715 (42.25%) not in the labor force, which includes children less than age 16, retired individuals, and disabled individuals.

Table shows that the top five fields in which persons 16 and over were employed: Educational services, health care and social assistance; Manufacturing; Retail trade; and Arts and entertainment recreation, accommodation, and food services and Construction. With 45.2% of the population NOT in the labor force and nearly 6% of the county unemployed, this puts a strain on the remaining labor force of 49.7% to generate income in Delaware County. While the percentage of unemployment has declined, the percentage NOT in the labor force has increased.

In Walton, there are 4,080 age 16 and over. 1,803 (44.19%) not in the labor force and 2,277 in the labor force. Of those 2,102 are employed and 175 are not. Educational services and health care and social assistance is the field in which most of the residents are employed (431); followed by 419 in manufacturing: arts, entertainment, and recreation and accommodation and food services employ 186; 139 work in Other services, except public administration; 112 work in the field of professional, scientific and management and administrative and waste management services. All other categories have less than 100 employed in those fields.

Insurance Status



In Walton 93.3% have health insurance coverage but 45.3% have public coverage (49%) and 6.7% have no coverage. Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

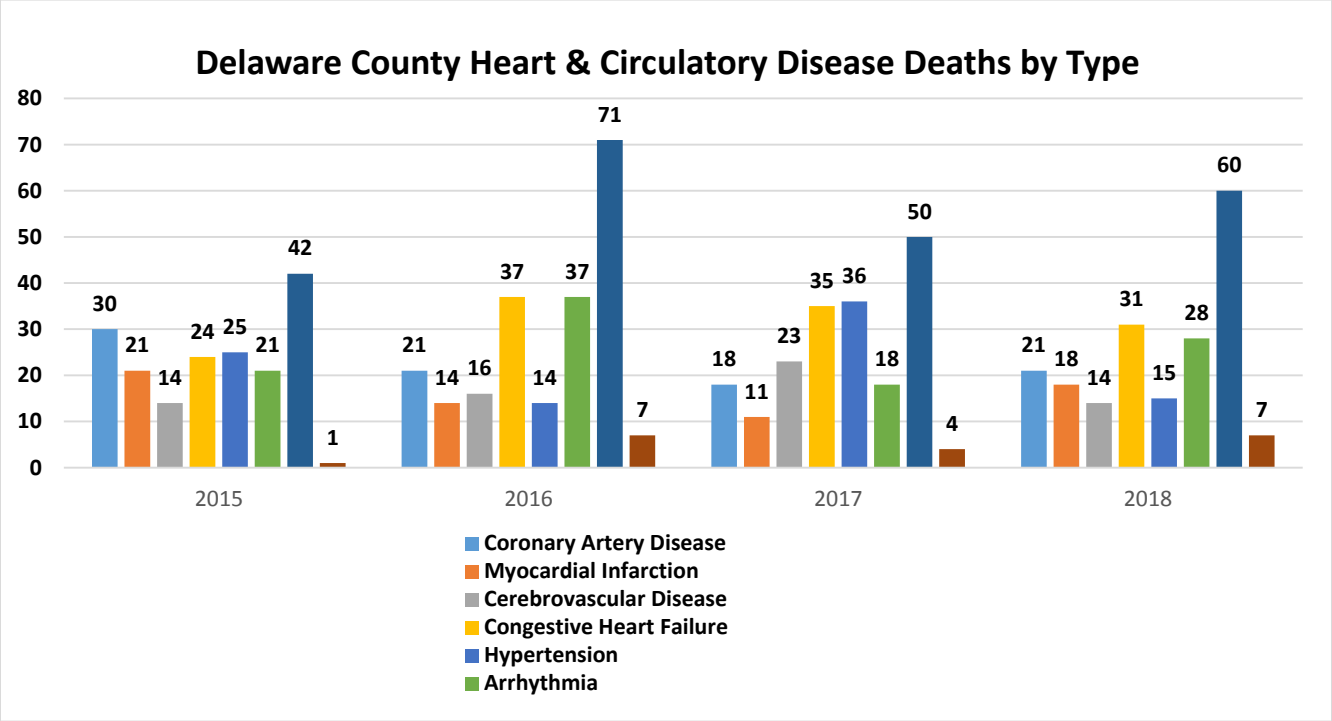
Health Status:

Delaware County Causes of Death

Cause of Death	2014	2015	2016	2017	2018
Accidents	14	8	7	11	17
AIDS Related Illness	0	0	0	0	1
Alzheimer's	0	0	0	0	0
Cancer	**105**	**105**	**119**	**77**	**92**
Chronic Obstructive Pulmonary Disease (COPD)	**40**	**42**	**26**	**16**	**41**
Cirrhosis of the Liver	5	5	9	5	0
Congenital Anomalies	1	3	0	0	0
Dementia	36	26	18	18	26
Diabetes Mellitus	1	4	1	4	0
Drug Overdose	2	5	10	6	10
Gastritis, Enteritis, Colitis, Diverticulitis	1	2	3	1	4
Heart & Circulatory Diseases	**155**	**135**	**210**	**160**	**163**
Homicide & Legal Intervention	0	0	0	0	1
Multiple Organ Failure	5	5	7	5	8
Neurologic Disease	3	6	4	4	1
Pending Investigation (Sent for Autopsy)	1	4	0	2	1
Pneumonia/Diseases Pulmonary Circulation	**41**	**67**	**16**	**55**	**46**
Renal Failure	18	18	13	11	17
Septicemia	19	8	16	9	22
Suicide	9	5	13	7	7
Tuberculosis	0	0	0	0	0
All Other Causes	13	10	16	5	11
TOTAL DEATHS *Deaths are reported to the county in which a person resides.	469	458	488	396	468

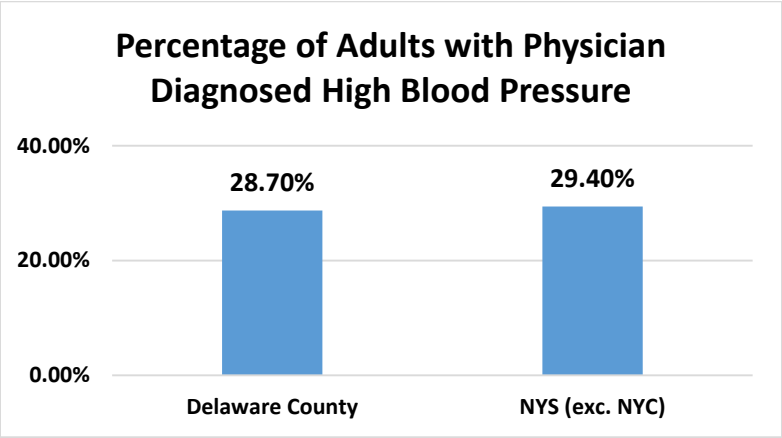
Source: DCPHS Annual Reports: 2014, 2015, 2016, 2017, 2018

The leading causes of death in Delaware County include heart and circulatory disease, followed by cancer and then lung conditions. Chronic disease prevention and care strategies remain necessary activities needed by the Delaware County population.



Source: DCPHS Annual Reports: 2015, 2016, 2017, 2018

Graph shows cardiopulmonary disease due to aging as the leading cause of heart-related deaths in Delaware County from 2015 through 2018. Other leading causes of death from heart and circulatory disease include congestive heart failure, hypertension, and arrhythmia. Heart and circulatory disease deaths accounts for a high number of mortalities in Delaware County.

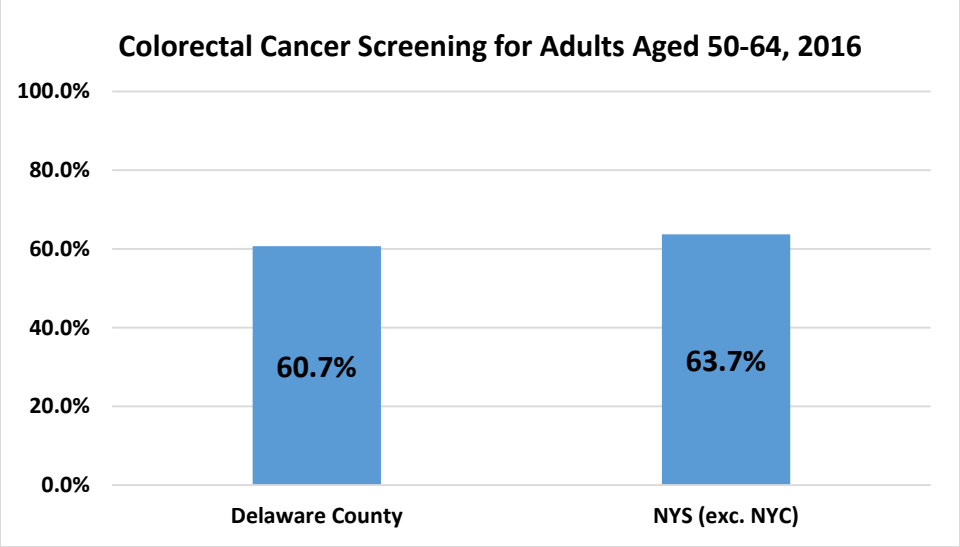


Delaware County Cancer Incidence by Gender, 2012-2016

Site of cancer	Incidence			
	Males		Females	
	Avg. Annual Cases	**Rate per 100,000**	**Avg Ann Case**	**Rate per 100,000**
All Invasive Malignant Tumors	173.6	490.3	164.4	469.8
Oral cavity and pharynx	8.6	23.8	3	10.6
Esophagus	3.6	9.4	.4	.9
Stomach	2.2	5.6	1	2.7
Colorectal	17.6	50.8	14.6	37.9
Colon excluding	11.4	34.9	10.4	26.5
Rectum & rectosigmoid	6.2	15.9	4.2	11.4
Liver/intrahepatic bile duct	4.0	10.2	0.6	2.5
Pancreas	4.0	10.6	4.0	10.5
Larynx	2.8	7.5	.4	1.3
Lung and bronchus	28.8	78.6	23.4	62.1
Melanoma of the skin	8.2	25.3	6.0	18.9
Female breast			38.6	108.0
Cervix uteri			1.0	3.3
Corpus uterus and NOS			13.4	39.5
Ovary			5.6	15.9
Prostate	31.8	82.3		
Testis	1.8	9.6		
Urinary bladder (incl. in situ)	16.2	45.5	5.4	13.3
Kidney and renal pelvis	6.2	19.4	5.0	14.3
Brain and other nervous system	1.4	4.4	2.2	8.0
Thyroid	2.0	8.0	5.8	25.2
Hodgkin lymphoma	0.4	1.4	1.2	5.2
Non-Hodgkin lymphomas	6.6	17.9	6.8	17.5
Multiple myeloma	3.2	8.8	3.2	7.5
Leukemias	6.6	21.5	5.4	15.6

Source: NYSDOH, New York State Cancer Registry, 2012-2016

According to table, breast cancer in females and prostate cancer in males account for the types of cancer most frequently affecting the population. Males and females share lung as the second most common types of cancer. The third is uterine for women colorectal for men. The fourth leading incidence for males is urinary bladder and colorectal for females. There is much higher incidence of various types of cancer among males than females: males have more than double the oral cancer; 10 times the rate of esophageal; double the stomach cancer; almost 7 times the larynx; almost 5 times the melanoma; almost 4 times the bladder; and 16.5 times higher rate of lung cancer and 6 times higher rate for leukemia. Females, on the other hand, have almost double the brain cancer rate and 17 times a higher rate of thyroid cancer.



Source: eBRFSS, 2016

*Blood stool test within 1 year, or sigmoidoscopy within 5 years with blood stool test within 3 years, or colonoscopy within 10 years.

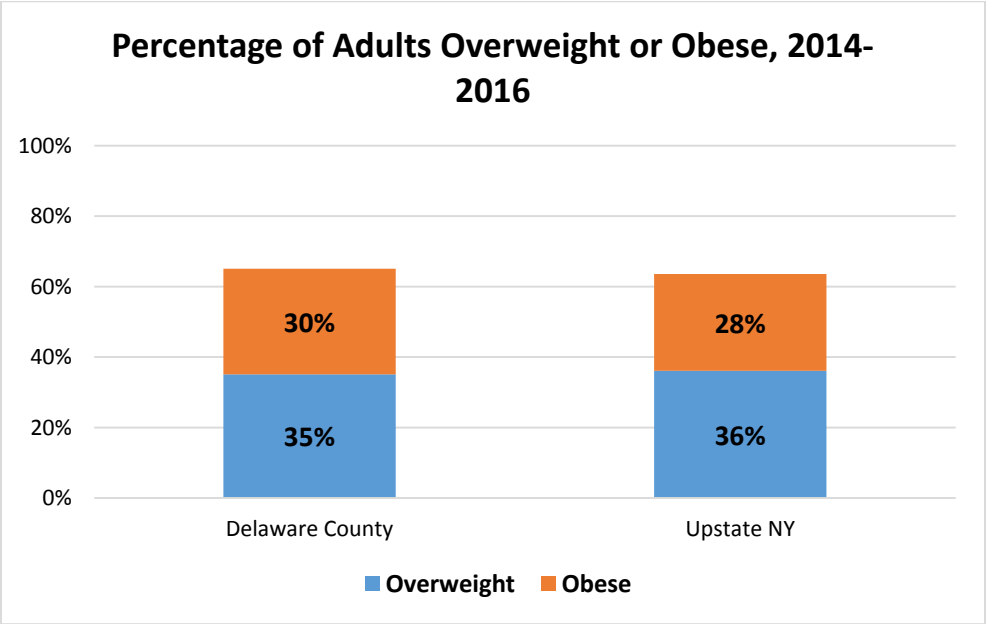
Colorectal screening rates are slightly lower in Delaware NYS excluding NYC. Neither are achieving the NYS Prevention Agenda 2018 goal of 80% of adults aged 50-75 receiving colorectal cancer screening based on the most recent guidelines.

Delaware County Diabetes Indicators, 2014-2016

Indicator	DIABETES		
	Hospitalization per 10,000 Diabetes mentioned in dx (age-adjusted)	Hospitalization per 10,000 Primary dx: Diabetes (age-adjusted)	Mortality per 100,000 (age-
County Rate	176.3	13.9	21.6
NYS Rate – exc. NYC	209.9	15.9	17
Sig Dif	Yes	Yes	Yes

Source: http://www.health.ny.gov/statistics/chac/chai/docs/dia_12.htm

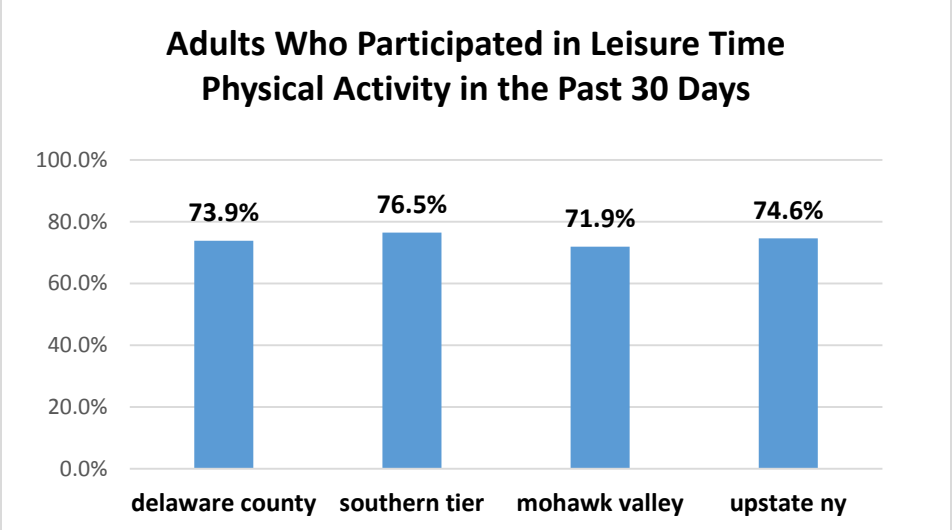
Delaware County's diabetes hospitalization rates are significantly lower than Upstate NY, but mortality rates are significantly higher. This decrease in hospitalization rates marks an improvement from the previous Community Health Assessment when Delaware County hospitalization rates were higher than the state.



School District Code	School District Name	Percentage Obese
120102	Andes Central School District	0.0*
120401	Charlotte Valley Central School District	29.1
120501	Delhi Central School District	13.3
120301	Downsville Central School District	21.2
120701	Franklin Central School District	0.0*
120906	Hancock Central School District	30.4
121401	Margaretville Central School District	0.0*
121502	Roxbury Central School District	23.5
121601	Sidney Central School District	21.8
121702	South Kortright Central School District	15.9
121701	Stamford Central School District	22.8
121901	Walton Central School District	15.2

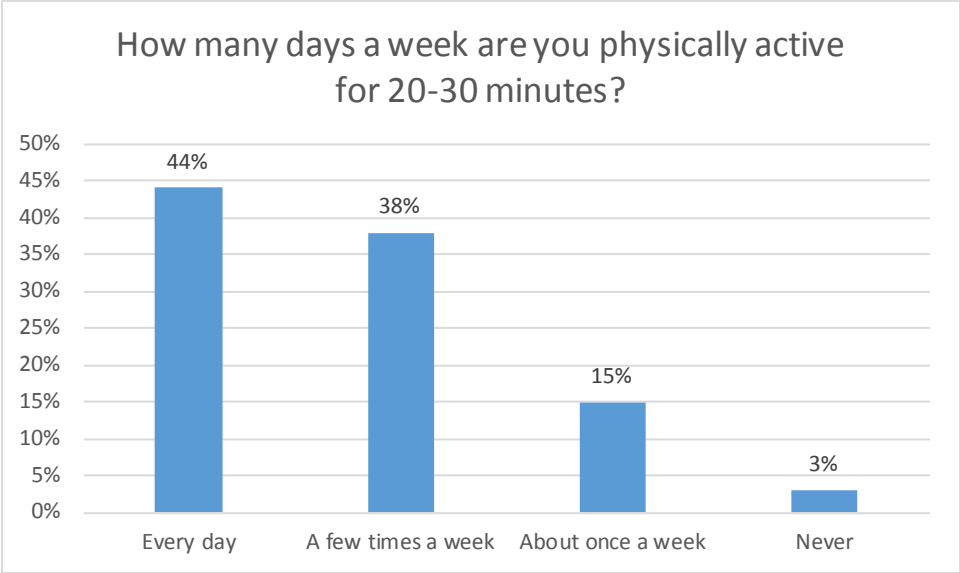
*Fewer than 10 events in the numerator, therefore the rate/percentage is unstable.
Source: NYS Prevention Agenda Dashboard, 2012-2014

Highlighted schools are located within the hospital's service area. Hancock school has the highest percentage of obese children out of the 12 schools in the county. Within the service area, Downsville has the next highest, followed by Walton, Delhi and Franklin.



Source: eBRFSS, 2016

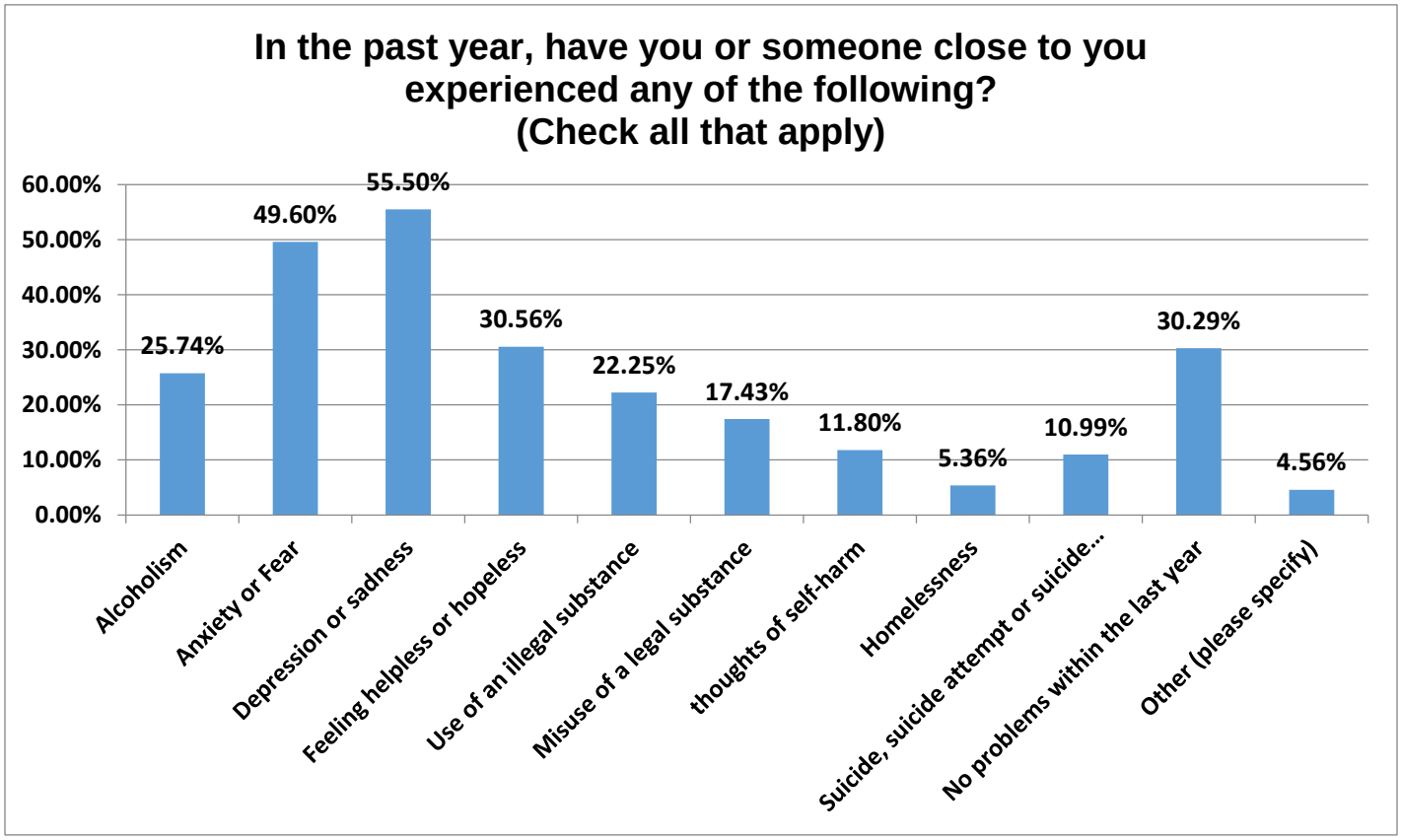
Graph shows that a greater percentage of Delaware County survey respondents participate in physical activity than the Mohawk Valley region, but less than the Southern Tier and Upstate NY.



Source: Delaware County Community Survey

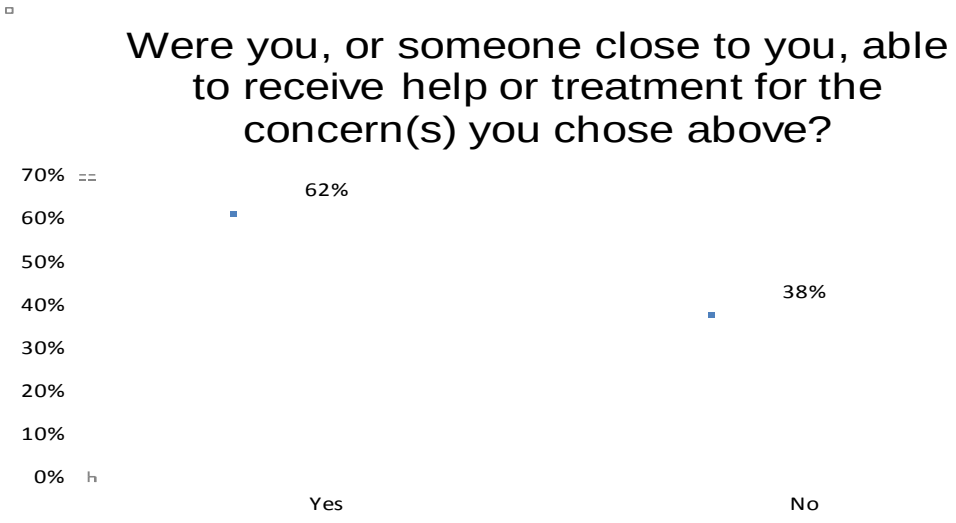
Graph shows that the vast majority of survey respondents are active at least once a week, and about 45% are active every day. This question considered physical activity to be both voluntary exercise and work-related physical activity.

Mental Health Status



Source: Delaware County Community Survey, 2019

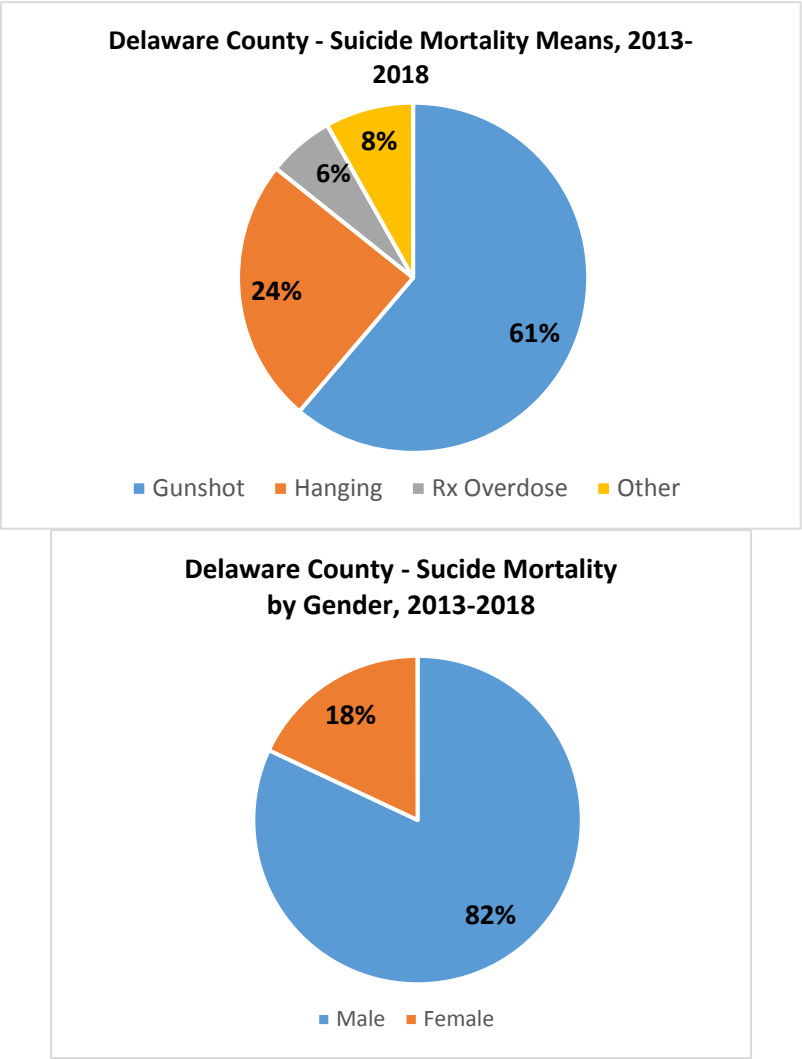
Graph illustrates 70% of survey respondents reported mental health issues with either themselves or someone close to them in the past year. This need contrasts with the limited availability of mental health services throughout the county.



Source: Delaware County Community Survey, 2019

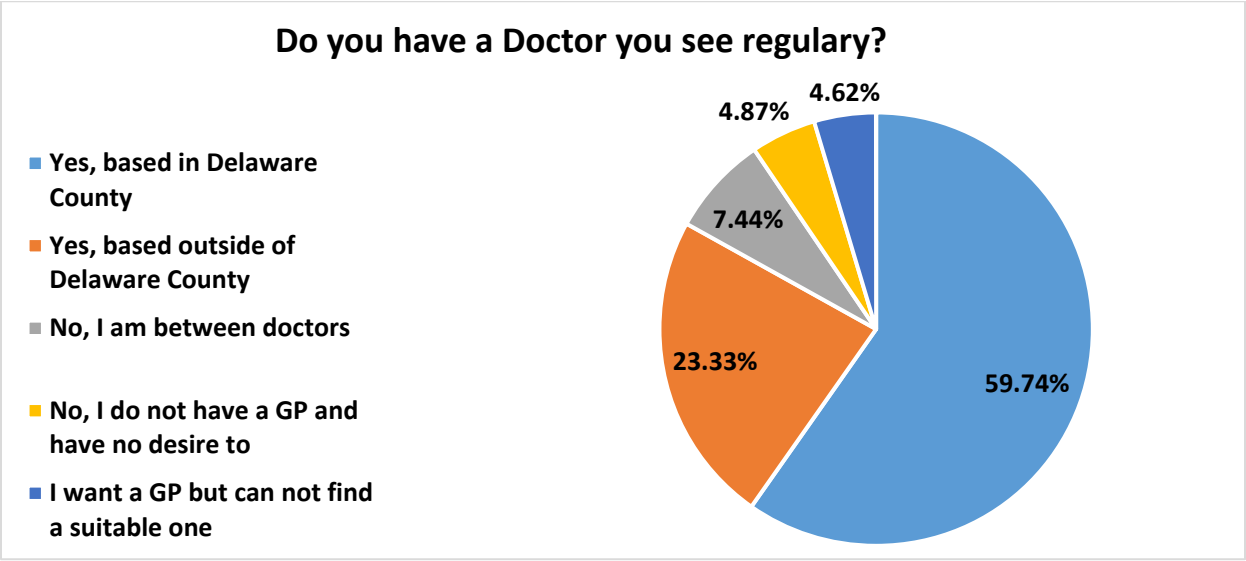
Although 70% of survey respondents reported a mental health issue, almost 40% were unable to receive treatment. Survey respondents reported barriers to accessing treatment as including stigma, embarrassment, and denial, transportation, and lack of mental health providers.

Delaware County's suicide death rate is much higher than Upstate NY and the NYS 2018 Prevention Agenda objectives 2.5.1 and 2.5.2. In 2014, the data states the age-adjusted rate was as high as 18.5 suicide deaths per 100,000.



Source: Delaware County Public Health Annual Reports, 2013-2018

Graphs indicate that over three quarters of the suicide deaths in Delaware County are among men, and the most common means is gunshot, followed by hanging and prescription overdose. Suicide prevention and intervention should be considered when addressing important health issues as a County.



Source: Delaware County Community Survey, 2019

The 2019 Community Survey had similar results to the BRFSS. About 83% of respondents to the survey have a general practitioner either in county or out of county that they see on a regular basis. The survey also revealed cost to be more of a factor than demonstrated by the BRFSS: 18% of respondents said they needed medical care that they did not receive in the past year, and 32% of those attributed it to cost.

County Health Rankings

The County Health Rankings is a measurement of the health of all counties in the nation and each county is ranked within its state. The County Health Rankings data is provided through collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The rankings are developed using a variety of national data sources such as vital statistics, sexually transmitted infections data and Behavioral Risk Factor Surveillance System (BRFSS) survey data. The goal of the Rankings is to raise awareness about factors that influence health and that health varies from place to place. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g. 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state. The rank is calculated from scores in the categories listed in the following chart. The chart does not include all measures used in determining ranking.

Delaware County Health Rankings – Key Measures – Higher the rank the worse the measures

	Delaware County	**NYS**	**Note**
Overall Health Outcomes Rank	**25/62**		
Length of Life	**25/62**		
Quality of Life	**21/62**		
Poor or fair health	15%	16%	2016 BRFSS – Self -reported
Poor physical health	3.6 days/30	3.6	2016 BRFSS – Self -reported
Poor mental health	3.8/30	3.6	2016 BRFSS – Self-reported
Low birth weight	7%	8%	
Not included in overall Quality of life rank			
Frequent physical distress	12%	11%	2016 BRFSS – Self-reported
Frequent mental distress	12%	11%	2016 BRFSS – Self reported
Diabetes prevalence	10%	10%	
Health Factors	**48/62**		
Health Behaviors	**33/62**		

Adult Smoking	19%	14%	
Adult Obesity	30%	26%	20 yrs and over with BMI over 30
Physical Inactivity	26%	25%	20 yrs and over no leisure time activity
Access to exercise opportunities	61%	93%	
Not included in overall Health Behaviors Rank			
Food insecurity	12%	12%	Lack of adequate access to food
Limited access to healthy food	1%	2%	Low income & don't live near grocery store
Insufficient sleep	32%	37%	< 7 hrs of sleep on average
Clinical Care	**43/62**		See below for information on HPSA scores
Uninsured	7%	7%	
Primary Care Physicians	2850:1	1200:1	
Mental Health Professionals	870:1	370:1	
Not included in overall Clinical Care Rank			
Other Primary Care Providers	1184:1	944:1	
Social & Economic Factors	**54/62**		
Children in Poverty	30%	20%	
% Children Living in Single-Parent Households	41%	34%	
Not included in overall Social & Econ Factors			
Disconnected Youth	6%	7%	Age 16-19 neither working or in school
Median Household Income	$45,400	$64,800	
Children eligible for free or reduced lunch prices	58%	53%	
Physical Environment	**35/62**		
Severe housing problem	18%	24%	Having 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen and/or plumbing facilities
Long commute (>30 mins)- drive alone	32%	38%	
Not included in overall Physical Environment			
# households with severe cost burden	2,704= 15%	20%	Spend > 50% of household income on housing

Note: Clinical Care

The Health Professional Shortage Area (HPSA) scores range from 0-26—the higher the score the higher the priority. In Delaware County, the following HPSA designation and scores exist:

Primary Care-

- East Delaware County is a geographic designated HPSA and scores 9
- Walton Service area is designated low income and scores 17
- Dental- Medicaid eligible in Delaware County scores 18
- Mental Health – Medicaid Eligible in Del Co scores 17

Comparative Data

Delaware County ranked 25 for overall health outcomes out of 62 counties in New York State, where a higher number signifies worse outcomes. For the purposes of this report, Delaware County will be compared with 5 counties: Chenango, Essex, Livingston, Otsego, and Sullivan. Counties for comparison were chosen based on similarities with Delaware County in location, size, rank status, and population similarities. Additional data is provided in the Needs Assessment.

Comparison Chart (rank out of 62)	Delaware	Chenango	Livingston	Essex	Otsego	Sullivan
Overall Health Outcomes	25 (3rd)	46	12	10	32	61
Length of Life	25 (3rd)	58	12	10	39	60
Quality of Life	21 (3rd)	25	12	20	23	60
Health Factors	48 (5th)	30	16	13	23	50
Health Behaviors	33 (4th)	40	21	14	24	34
Clinical Care	43 (5th)	32	23	16	12	52
Social & Economic Factors	54 (5th)	30	16	21	44	51
Physical Environment	35 (4th)	5	43	9	29	51

Challenges

The sheer size, topography and parochial nature of the communities within Delaware County pose huge challenges in the delivery of health care. There are many challenges but for Delaware Valley's plan, the key findings are below:

Key Findings from the Assessment

- **Lack of Transportation**
- **Aging Population**
- **Poverty**
- **Prevalence of Chronic Disease**
- **Prevalence of Mental Health Needs**

Access

DVH has begun to address many of these issues in a variety of ways. The hospital has expanded the hours that its primary care offices are open. Both the Downsville and Roscoe offices are now open 5 days per week. The Walton office is open until 7 PM, Mondays through Thursdays and until 5 PM on Friday. Recently Saturday morning hours have been added. The hospital's retail pharmacy is open 7 days a week. The imaging and lab departments offer evening and weekend appointments. The hospital's outpatient rehabilitation department offers early morning and evening appointments. By extending hours, patients have the opportunity to receive care without having to take time off from work. Many aging parents rely on their children or neighbors/friends for transportation to health care appointments. This allows the caregivers the ability to schedule those appointments at a more convenient time.

Delaware Valley also has a representative on the county's transportation committee.

The hospital also created an office for two representatives from the Rural Health Network of South Central NY. The organization serves Delaware County, yet had no physical presence in the area. Their office was based approximately 1

hour away: central to their coverage area but challenging when trying to reach the far corners of their territory. Because they have no budget for a second office, DVH provides the space, phone, supplies at no charge to the organization. This helps them provide Delaware County residents with many referral, navigation, and social service-type supports.

Prevalence of Chronic Disease
Three DVH staff members are certified leaders of the Stanford University evidence-based Chronic Disease Self-Management Program. The program is offered at least twice per year and also is offered both during the day and in the evening for convenience.

DVH has also hired a Care Coordinator RN who works closely with the primary care providers to help patients who are high risk for admission to the hospital due to their chronic disease. She offers 1:1 guidance and support based on their needs. She also works very closely with the certified dietitian/nutritionist who also offers individualized guidance. The dietitian also works with approximately 20 SNAP recipients each year in conjunction with the Rural Health Network of South Central NY's Fruit and Vegetable Rx program.

The providers began to track, and will continue to track various metrics regarding chronic disease throughout this three-year plan. As DVH is in the process, with the entire UHS system, in preparing to implement the Epic electronic health record in April 2020, it is believed that the program's features will enhance the providers' efforts to serve as the patients' medical home and guide their care.

Tele-endocrinology
Working with UHS, DVH offers videoconferencing appointments with a UHS nurse practitioner specializing in diabetes care. This not only provides further care for its diabetic patients but also eases the access to care.

Prevalence of Mental Health Needs

Tele-mental Health

Working closely with the Delaware County Mental Health Department over several years, Delaware Valley instituted a tele-mental health program to help increase access to mental health professionals. The hospital contracts with a vendor who supplies a psychiatric nurse practitioner and two licensed clinical social workers. Patients see providers through videoconferencing at the hospital's primary care office in Walton. DVH is currently in the process of requesting an additional LCSW, as there is still unmet need. The stigma that some patients feel can be reduced because they are coming to a primary care facility as opposed to a mental health facility.

CPEP in ED
Working with UHS' Comprehensive Psychiatric Emergency Program (CPEP) DVH was able to institute videoconferencing in its ER so that UHS' mental health professionals can actually see the patients prior to them being sent to UHS (1 hour away) only to find they actually don't need hospitalization. This will reduce the unnecessary use of resources: ambulance and crew; a second ER visit and the need to find the patient a ride back home after the assessment has taken place at UHS.

Assets and Resources

Delaware Valley Hospital has chosen to focus much of its work over the next few years to the Walton community. Walton's population consists of 31.3% of residents age 65 and over, compared to the county's 23%. 26% of the population is disabled. Over the past 12 months, 25.8% of all households have been below the poverty level. 59% of the households fit the definition of poverty or of ALICE (Asset Limited, Income Constrained, Employed). 45.3% of the population has public insurance coverage and 6.7% have no coverage at all.

The Walton community has suffered through two major floods. One in 1996 and the second in 2006. Two smaller events, considered moderate flooding, took place in 2010 and 2011. These events led to a sense of victimization throughout the community and its residents. All of these factors had led DVH to believe that to really make an impact on the health of its own community, it needs to address many of the social determinants of health. However, it could not make much headway without the cooperation of the community's organizations, school and government and residents.

Some new initiatives from a local 4H club to beautify the community; the formation of a new art group that sponsored an art walk with activities and a created community mural entitled, *Walton Rising*; new younger residents in both government and chamber of commerce leadership positions; and a new foundation that was created from the estate of a couple, who were long-standing members of the community have all coalesced into a force of positivity. The school administration is also comprised of younger residents who have grown up in Walton and want to see it thrive.

The hospital is an active member of the chamber and the community committee of the school. It has also actively participated in many of the activities that have been taking place.

Over the past several years, DVH has also been an active participant in Care Compass Network with its Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider System (PPS). Through this participation, both new and existing relationships with area organizations has been strengthened.

Based on all of the activity and renewed sense of community and positivity among the residents, DVH discussed the possibility of presenting a series of workshops (for the entire county) based on the AARP Age-Friendly Communities Program, which is based on the World Health Organization's 8 Domains of Livability. They include:

- Outdoor Spaces and Buildings
- Transportation Options
- Housing- appropriately designed or modified and affordable
- Social Participation
- Respect and Social Inclusion
- Civic Participation and Employment
- Communication and Information
- Community and Health Services

Discussion was held with the Care Compass Network East Regional Performing Unit, which is comprised of hospitals and organizations and agencies from both Delaware and Chenango County. The series had been presented in Binghamton area, but while it was of great interest to many in Delaware and Chenango counties, they were unable to make time in their schedule to attend, as attending would involve 2 hours of travel time in addition to the time needed to attend the workshops. The idea was well received and Care Compass agreed to fund the series.

DVH staff has spoken with many county agencies and the county's Community Services Department is serving as a partner to present the programs. The consensus is that if we can make progress in any of the areas, but especially in communication and social participation, respect and inclusion, we will be able to make strides, over time in reducing the feelings of anxiety, fear, depression, sadness or the feeling of hopelessness or helplessness.

Further discussion took place with the county's Delaware County Rural Healthcare Alliance members. They also were enthusiastic about the initiative. At a Community Committee meeting of the Walton Central School, the initiative was discussed and received overwhelming enthusiasm from the school administration and board members, both town and village officials (supervisor and mayor, respectively), the fire department, and the Walton Ministerium. Further discussion took place with the mayor, supervisor, chamber president and the program coordinator for stream program. The stream program of the county soil and water conservation department is actively working on flood mitigation and the plan includes development of an area of Walton adjoining the Delaware River, called Water Street. The ultimate plan can include places for socialization, physical activity and events. Some of the work is funded; a grant application is pending to build a trail. It was agreed this was the perfect time to work together to ensure the best possible use of the area.

The first workshop has been scheduled for January 30 in Walton and will be presented by Esther Greenhouse, nationally renowned expert on built environments. Organizations, agencies and healthcare providers from across Delaware County, or those that serve Delaware County will be invited to all the workshops. However, DVH and its local partners intend to focus our efforts to the Walton community and possibly the neighboring communities of Downsville and Hamden, if the community has interest. Both of these communities have very few resources in their own towns and their residents travel to Walton for some of these like grocery shopping for instance.

Community Service Plan

Prevent Chronic Disease

Focus Area 4: Preventive Care and Management

Disparity: Unless otherwise noted the disparity for all of the following will be: DVH Primary Care patients fitting demographics as described in Objectives.

Interventions: Unless otherwise noted the interventions will be as follows for all of the following: *Work with primary care providers and staff to put systems in place to provide both providers and patients reminders through EHR alerts, mail, phone calls, email and/or e-chart notifications*

Measures: Unless otherwise noted the measure will be as follows for all of the following: Percentage of DVH patients, as described, who comply screening guidelines.

Goal 4.1 Increase Cancer Screening rates

4.1.1 Objective: By December 31, 2021, the percentage of adults, age 50-75 years old, receiving a colorectal screening will increase.

Interventions *Work with primary care providers and staff to put systems in place to provide both providers and patients reminders through Electronic Health Record (EHR) alerts, mail, phone calls, email and/or e-chart notifications*

> **Year 1** Projected (or completed) Intervention**:** As of September 2019 64.4% of DVH patients, who had an interaction with DVH within the last two years, and are between the ages of 50-75 had appropriate colorectal screening. 70% is the goal for 2019.
>
> **Year 2** This will be determined by the UHS system members based on performance in 2019.
>
> **Year 3** This will be determined by the UHS system members based on performance in 2020.

Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.

4.3.1 Objective: By December 31, 2021 the percentage of adults, age 50-85 years old, having an annual well care visit will increase.

> **Year 1** Projected (or completed) Intervention**:** As of September 2019 36.5% of DVH patients, between the ages of 50-85 had an annual well care visit. 50% is the goal for 2019.
>
> **Year 2** This will be determined by the UHS system members based on performance in 2019.

Year 3 This will be determined by the UHS system members based on performance in 2020.

4.3.2 Objective: By December 31, 2021 the percentage of adults, age 18-85 years old, diagnosed with hypertension who have their condition adequately controlled will increase.

Year 1 Projected (or completed) Intervention**:** As of September 2019 71.7% of DVH patients, between the ages of 18-85 who have been diagnosed with hypertension, had their blood pressure adequately controlled (<140/90). The target for 2019 is 71%.

Year 2 This will be determined by the UHS system members based on performance in 2019.

Year 3 This will be determined by the UHS system members based on performance in 2020.

4.3.3 Objective: By December 31, 2021 the percentage of adults, age 18-75, with diabetes, who have had HbA1c testing within a year with a result of <8.0% will increase.

Year 1 As of September 2019 at least 69.5% of patients age 18-75 years of age, with diabetes, will have had HbA1c testing within a year and the result will be <8.0%. Goal is 67.2% for 2019.

Year 2 This will be determined by the UHS system members based on performance in 2019.

Year 3 This will be determined by the UHS system members based on performance in 2020.

4.3.4 Objective: By December 31, 2021 most prescriptions for chronic disease management will be written for 90 days in order to foster better patient compliance and convenience

Year 1 As of September 2019, 72.6% of prescriptions, written for the chronic conditions of patients who have had any interaction with DVH within the last 2 years, will be written for a 90 day supply. Medication types included in the measure: ACE inhibitor/ARB medications, diabetes, beta-blocker, high and moderate and low intensity statin medications. Goal is 72% for 2019.

Year 2 This will be determined by the UHS system members based on performance in 2019.

Year 3 This will be determined by the UHS system members based on performance in 2020.

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.

4.4.1 Objective: A healthcare provider or human service agency will have referred more participants to the Chronic Disease Self- Management Workshop.

Disparity: Community members with chronic disease

Measures: The percentage of participants referred by primary care providers or human service agencies

Interventions: Work with marketing staff, primary care provider offices and local human service agencies to put systems in place to assure awareness of the availability of the chronic disease self-management program.

Year 1 Recognized that most participants are learning of the program through one sole provider or through advertising. There is a need to create more widely-based knowledge of the program.

Year 2 Systems will be in place and utilized by the fall of 2020.

Year 3 At least 25% of the participants will have been referred from an agency or provider.

4.4.2 Objective: Access to Chronic Disease Self-Management Workshops will continue.

Disparity: Community members with chronic disease

Measure: Number of series of workshops offered

Interventions: Hold chronic disease self-management workshops

Year 1 During 2019, 2 series of workshops were held in the spring. A fall series was offered but there were not enough participants to actually hold the program.

Year 2 During 2020, at least two workshops will be held

Year 3 During 2021, at least two workshops will be held.

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

1.1.1 Objective: By December 31, 2020 at least one community within the DVH service area will be actively working to become an age-friendly community.

Interventions: Build community wealth by serving as the catalyst to create inclusive, healthy public spaces and inter-generational socialization opportunities

Measures: Improvement in accessibility, socialization, and well-being measures

Year 1: Researched building Age Friendly communities through AARP - discussed concept with potential stakeholders including local officials, organizations, agencies, schools, potential community partners and garnered support to move project forward.

Requested and secured funding from Care Compass Network to hold series of workshops regarding Age Friendly communities - set dates, secured venue, caterers and developed invite list

Year 2: Hold series of workshops based on a blend of AARP's *Road to Livability* program and NY State's *Livable NY* program which incorporates the importance of the social determinants of health

Hold follow-up meetings with appropriate interested parties from Walton area to create a coalition of community members to prioritize potential Age Friendly Community initiatives; identify next steps and identify potential committee members to address each initiative.

Measures: Two committees will be formed or existing committees, integrated into addressing at least two components of the Age Friendly Community

Recruit and form committee(s) of community residents, which is representative of the population and also includes appropriate community based organizations, agencies and government entities to develop an action plan and timeline to address at least two components of becoming an Age Friendly Community.

Measures: Committee objectives and timelines will be developed

Committees will formulate their respective objectives, based on Age Friendly series and develop a workplan and create a timeline to achieve those objectives and choose a representative to sit on the community coalition.

Measures: Best practice, core measures and stakeholder roles will be determined

Committees will reach consensus on best practice interventions, core measures and roles of stakeholders

Year 3: To be determined based on 2020 results/decisions.

Objective 1.1.2 Increase accessibility of physical environment by 5% (baseline to be set in 2020)

Intervention: Develop consensus on development of Water Street through flood mitigation project and other funding

Measures: Accessibility of physical environment

Year 1: Held discussion with Town Supervisor, Village Mayor, Project Manager for Water Street project, and Chamber of Commerce President to assess feasibility of having an impact on Water Street use and development.

Year 2: Review previous walk audit done by Rural Health group

Complete walk audit of Water Street and Delaware Street in Walton NY

Year 3: To be determined based on 2020 results/decisions.

Objective 1.1.3: By December 31, 2021 decrease the % of adults who report feeling anxiety or fear, depression or sadness, helpless or hopeless

Interventions: Survey community members

Year 1: Delaware County Community Survey completed. Question- In the past year, have you or someone close to you experienced any of the following: Results of these measures included: Anxiety or fear 49.6% - Depression or sadness 55.5% - Feeling helpless or hopeless 30.56%

Year 2: Focus committee work on socialization opportunities to help foster feelings of well-being

Year 3: To be determined based on 2020 results/decisions.

Objective 1.1.4 By December 31, 2021 increase the % of adults who report ongoing participation in at least one socialization opportunity other than work. (baseline to be set in 2020)

Interventions: Survey community members

Measures: Number of people participating at socialization opportunities.

Year 1: Discussions centered around correlation of isolation and feelings

Year 2: Develop a survey to get sense of socialization activities and participation throughout the community. Focus committee work on socialization opportunities to help foster feelings of well-being

Year 3: To be determined based on 2020 results/decisions

Delaware Valley Hospital staff will play an integral role, with Care Compass Network staff to ensure appropriate stakeholders from across the county are invited to the various Age-Friendly workshops. DVH staff will also secure the venue and caterer for each workshop.

Delaware Valley staff will be the catalyst and champion to ensure Walton community stakeholders hold follow-up meetings and formulate committees to focus on specific interventions, based on the consensus of the group. DVH will maintain representation on the steering committee and any other sub-committee that is appropriate.

DVH will work with Delaware County Mental Health to create survey of socialization activities.

If necessary, DVH will assist in providing support in writing any grant applications.

In addition, DVH will continue to meet regularly with Delaware County Public Health staff and staff from both O'Connor Hospital and Margaretville Hospital to continue dialogue regarding our activities so we can identify opportunities to work together.

Dissemination of Report

The report was provided to the hospital's Board of Directors for review and approval on December 16, 2019. It will be disseminated to the staff of DVH through email; hard copies will be provided to the hospital's senior management team. An overview will be presented to the hospital managers and volunteers. It will be located on the UHS website and a news release will direct the public to the site at https://www.nyuhs.org/about-us/community-service-reports/.