Delaware Valley Hospital, Inc.
2019-2022 Community Service Plan
2021 Update

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 each Objective.

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

2021 Executive Summary

The COVID pandemic continued to affect the nation in many areas but one that truly suffered was the follow up with patients for routine and chronic care. The public's unwillingness to come to health care facilities, for fear of catching COVID continued. In the summer months this improved, only to regress in the fall, when the prevalence of COVID once again spiked. The hospital continued virtual visits, social distancing and staggered appointments but the results regarding the following priorities still suffered.

For the most part, the planned interventions took place. Patients were called through UHS' Population Health program staff. Reminders were sent to patients through the mail, and through the patient portal:*My Chart*, for those patients who elected to sign up. Phone calls were also completed through the automated service. Unfortunately, the added influence providers can bring to the message was often lost as they were not seeing their patients, face-to-face, as often.

As time goes on, the numbers of patients (numerator) who fall within the time frame of any given objective, increases. If the numbers of patients meeting the objective does not increase, the percentage of compliance will automatically decrease, due to the numerator becoming steadily larger.

Because the COVID-19 pandemic has continued much longer than anyone could have imagined, we will be making a concerted effort to re-focus on disease control and wellness strategies in 2022, despite COVID-19 conditions. We will be transitioning to a more "business as usual" emphasis so that we can help patients refocus on their general health and well-being.

Community Service Plan Metrics- 2019-2021

	Goal %	Actual %	Improvement Strategies
Goal 4.1 Increase Cancer Screening rates **4.1.1 Objective:** DVH patients, who had an interaction with DVH within the last two years, and are between the ages of 50-75 have had appropriate colorectal screening.			Because COVID-19 pandemic has continued much longer than anyone could have imagined, we will be making a concerted effort to re-focus on disease control in 2022, despite COVID-19 conditions.
2019	70	64.4	
2020	68	47	
2021	47	41	
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:** DVH patients, between the ages of 50-85 have had an annual well care visit.			Because COVID-19 pandemic has continued much longer than anyone could have imagined, we will be making a concerted effort to re-focus on wellness strategies in 2022, despite COVID-19 conditions.
2019	50	36.5	
2020	50	25.5	
2021	50	26	
4.3.2 Objective: DVH patients, between the ages of 18-85 who have been diagnosed with hypertension, have had their blood pressure adequately controlled (<140/90).			Although the metric was met for 2021, we will continue to focus on blood pressure control in 2022.
2019	71	71.7	
2020	72.5	76	
2021	66	72	
4.3.3 Objective: DVH patients, 18-75 years of age, with diabetes, will have had HbA1c testing within a year and the result will be <8.0%.			Because COVID-19 pandemic has continued much longer than anyone could have imagined, we will be making a concerted effort to re-focus on wellness strategies in 2022, despite COVID-19 conditions.
2019	67.2	69.9	
2020	67.2	24	
2021	71	23	
4.3.4 Objective: 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.			This metric has consistently been either met or very nearly met throughout the UHS system. Therefore, the UHS system is dropping this metric in 2022.
2019	72	72.6	
2020	72	70.7	
2021	72	74	

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

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

2021 Executive Summary

The continued COVID pandemic wreaked havoc across the nation in many areas but one that greatly suffered was in our ability to deliver wellness programming. Due to social distancing constraints, in-person classes were not feasible, or even prudent. Many in our area either do not have access to a computer and/or the internet or find the service too costly or are not computer literate. This is especially true of our older residents who are generally the patients who benefit from this intervention, so virtual classes were also unrealistic. We lost a certified trainer in 2020 and another in 2021. This left the hospital with just one trainer. It had been a struggle to find enough participants to make this a valuable program already – (supposed to have at least 8-10) and the COVID pandemic just added to these struggles. The decision was made to no longer offer these classes. We consistently had too few attendees for the amount of resources it took to give these workshops. However, the Rural Health Network of South Central NY still offers these classes and we forward this information along to our providers, social worker and patient care coordinator to share with patients who may benefit from the program.

In 2020, the decision was made to focus our efforts on moving our community toward becoming an Age Friendly community, which should be much more impactful in improving the health and well-being for residents of all ages.

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

2021 Update: Although the pandemic cut into much of what we wanted to do, working with the Walton Chamber of Commerce, the community's Veterans' Plaza was better utilized for a variety of activities. These included open-air concerts, farmer's market, and the Walk for Hunger. The Plaza is part of the community's flood mitigation project. In addition, the hospital's Community Relations Director wrote a grant for the Chamber to commission a street scape plan that would benefit merchants and the public by making an attractive and walkable main street. That project was funded and the plan is being developed by the county's landscape architect. The Director also spearheaded the project to purchase and plant appropriate evergreens in decorative barrels along the main street and near other businesses that can be used to make the street more inviting all year and especially during the holidays. These activities are small steps toward creating opportunities for residents to socialize, and walk in an attractive, inviting environment.

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

2021 Update: The county planning department did write several grants to begin the development of the Water Street flood mitigation project to include a riverside walk and picnic areas. The picnic areas were put in place but construction of the river walk has not yet been funded.

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

Intervention: Survey community members

2021 Update: The grants sought to fund the survey were not received so in late 2021 Delaware Valley Hospital did make the commitment to fund the cost of the survey itself. The decision was made after the hospital felt it was on financially solid ground despite the lower than expected volumes caused by the pandemic. Discussions with the Rural Health Network of South Central NY took place regarding development, distribution and tabulation of the survey results. A contract was drafted and sent to the legal department for review. Work has begun on the questions for the survey. Discussion with the Walton School District also secured their support to help formulate and distribute a survey for the middle and high school age students.

DVH also continued to sponsor activities that provided socialization opportunities to the public to help offset the additional isolation and depression that some may have felt due to the restrictions COVID brought to bear. These included a 5K Run in Downsville, the Hunger Walk in Walton, the Music on the Delaware group that help several virtual concerts and the local Little League and prom night.

Because of the pandemic, much effort centered around the distribution of the vaccine to area residents. The hospital's Community Relations Department took the calls from those wanting to be vaccinated. The department also worked closely with the Delaware County Public Health and Office for the Aging Departments to coordinate clinics and communicate to the public. The hospital held ongoing clinics, which continue to this day. The hospital's Delaware County Fair booth space was utilized by the NYS Department of Health to give vaccines on site. Hospital staff traveled to Sidney, Hancock and Masonville to offer vaccinations.

Delaware Valley Hospital also provided water bottles to the Hancock, Downsville, Livingston Manor, Roscoe and Franklin Central Schools for their kids as they transitioned to water dispensers rather than water fountains in their schools.