Community Health Improvement Plan
2024 Annual Report

THE
University of Vermont
HEALTH NETWORK

Champlain Valley Physicians Hospital

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A Message From Leadership

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President & Chief Operating Officer
Champlain Valley Physicians Hospital

The University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) is committed to improving the health and well-being of the people of our North Country communities. Every three years, UVM Health Network's six health care partners conduct a Community Health Needs Assessment (CHNA). The CHNA is built upon the foundation of New York State's Prevention Agenda — its health improvement plan and blueprint for state and local action to improve the overall health and well-being of all of our citizens. CHNAs help us reflect on our work to date as a critical healthcare partner in this region and consider the challenges and opportunities involved in creating healthier communities. This process informs how we respond to the changing needs of patients across our region and how we work in collaboration with our diverse community partners. This will be the last annual report for this Community Health Improvement Plan cycle focused on addressing the priority areas of Promote Well-Being and Prevent Mental and Substance Use Disorders and Prevent Chronic Diseases.

CVPH's Calendar Year 2024 Community Health Improvement Plan (CHIP) annual report serves as a year-over-year demonstration of our upstanding commitment, accountability and effectiveness strengthening the health of our region. This report highlights successes with our key partners as well as opportunities for carrying the work forward in the year ahead. We will continue to center the needs of those in our community most impacted by the social, economic and environmental factors influencing health outcomes. Work is ongoing to ensure that all individuals have fair access to the care and services that meet their needs.

I hope this report offers you a snapshot of how our dedicated, skilled, and compassionate team members are taking action each day to improve the health and well-being of our community served. We look forward to building on this work and identifying new opportunities for collaborating with our patients, friends, families, and neighbors on responsive local solutions. Thank you for taking time to learn about our investment in community health.

In partnership,

Introduction

Annual Report Overview

Adopting an 'Implementation Strategy' and evaluating the impact of our Community Benefit programs is a requirement of our health system's tax-exempt status. This demonstrates our commitment, accountability and effectiveness in addressing our communities' identified health priorities. An annual progress report is best practice for Community Benefit. This report spotlights programmatic highlights, investments made, and collaboration with our key partners to improve the health of our community in 2024.

ABOUT US

The University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) is part of a six-hospital network serving patients and their families in northern New York and Vermont. We're not just caregivers and staff - we're your friends and neighbors, offering expertise and compassionate care as close to home as possible. That's what we call the heart and science of medicine.

Prioritization

The Clinton County 2022-2024 Community Health Assessment priorities were informed by rigorous, year-long assessment activities carried out and facilitated by CVPH and Clinton County Health Department (CCHD). This included the Community Health Priority Setting Session, which improved outreach to 25% more stakeholders this cycle. The Community Health Priority Session included partners representing 18 sectors. Priorities selected reflect a commitment from partners to continue addressing the priorities from the previous two health assessment cycles. The two priority areas and goals being addressed collaboratively for the next three years are:

Promote Well-Being and Prevent Mental Health and Substance Use Disorders
Focus Areas:

- *Promote Well-Being*
- *Prevent Mental and Substance Use Disorders*

Prevent Chronic Diseases
Focus Areas:

- *Healthy Eating and Food Security*
- *Physical Activity*
- *Chronic Disease Preventive Care and Management*
- *Tobacco Prevention*

Summary of Accomplishments

This annual report for calendar year 2024 details key actions taken to advance population health initiatives and community health priorities.

Highlights of 2024

- Our organization is proud of the strides University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) has made in improving the health and well-being of our community. The year was marked by significant milestones, impactful partnerships, and a steadfast commitment to addressing critical social and health needs
- In 2024, we also saw the release of the New York State Department of Health's Prevention Agenda for 2025–2030, emphasizing social needs. This aligns with our writing year for the next Community Health Needs Assessment (CHNA). As a partner with the Clinton County Health Department, CVPH is actively collaborating to create a comprehensive CHNA, which will guide future initiatives.
- Our foundation's funding initiatives continued to focus on resilience and community health across the lifespan. Some of these efforts included:
    - Supporting walking groups and distributing bicycle helmets to promote physical activity.
    - Providing funding to Sweethearts and Heroes, which offers training and education to educators and school-aged children, emphasizing social-emotional learning.
- Internally, CVPH prioritized employee wellness and engagement through the work of the Wellness Committee. Efforts included:
    - Introducing the Cart of Connection and Well-Being , a mobile resource providing support and care to employees at their workstations. Leaders have utilized the cart on approximately 15 occasions this year.
    - Organizing activities such as walking challenges and movie nights to promote team building and well-being.
    - Expanding access to mental health resources through Lyra Health, enhancing support for our staff.
- In the area of mental health and substance use prevention, CVPH supported a care coordinator in the Emergency Department (ED) through Champlain Valley Family Centers.
    - This addition has helped streamline transitions for patients with substance use needs back into the community.
    - Efforts also included implementing social determinants of health screenings in the ED to better address patients' social challenges .
    - Anti-Stigma training was provided to approximately 100 CVPH staff in 2024.

Highlights of 2024 CONT.

- Our focus on chronic disease prevention and management has expanded through partnerships with the Heart Network and inclusion in the Chronic Disease Care Coordination Network. Highlights included:
    - Introducing programs related to SNAP benefits and vegetable prescription programs.
    - Redesigning the Chronic Disease Self-Management Program in collaboration with Get Healthy North Country providers.

Key Community Partnerships

- Behavioral Health Services North
- Champlain Valley Family Center
- United Way of Northeastern New York
- National Alliance on Mental Illness
- NYS Office of New Americans

Investments

United Way of Northeastern New York

$20,000

Funds supported ALICE families (Asset Limited, Income Constrained, Employed), those facing severe poverty, homelessness and other essential services. These funds will assist North Country residents in times of need and are distributed across multiple agencies in Clinton County through United Way. Most often, they are focused on homelessness prevention, food insecurity, transportation, access to medical care, mental health, youth development and general wellness.

Town of Plattsburgh Parks

$5,000

This marks the second year of this funding. These funds are being used to upgrade town parks, ensuring they are accessible to all, including individuals with developmental disabilities.

TOTAL: $25,000

Work Underway/Anticipated for 2025

- We are excited about the development of our new Community Health Needs Assessment and the opportunity to further strengthen relationships with community partners. Together, we aim to create a healthier, safer, and more supportive environment for our CVPH family and the communities we serve.
- The Initiation of the Population Health Service Organization (PHSO) Diabetic Care Mgt Pathway will aim to coordinate and improve the care of individuals with diabetes. This will be established by the care manager assessing the need for resources and linking individuals with resources. This could include any or all of the following: Pharmacist, Resource Coordinator, Health and Wellness Coach and/or Clinical Diabetes Care and Education Specialist.
- In the pilot we are also partnering with NY Quits for smoking cessation and will be educating patients about CDSMP (chronic disease self-management program).
- CVPH will host a virtual chronic disease self-management program in January of 2025.
- Establish workflows to facilitate timely admission to Champlain Valley Family Center (CVFC) Intensive Crisis Stabilization Center (ICSC), (Opening July 2025). This site will establish a separate location for those in the community facing a crisis, not requiring ED or hospital level care.
- Our Wellness team is continuing work on establishing Wellness ambassadors.

Thank you to our team, partners and stakeholders for making 2024 such a great year. We look forward to continued collaboration and success in the year ahead.

Calendar Year 2024: Work to Date

Chronic Disease Preventive Care and Management

IN ALIGNMENT WITH NYS PREVENTION AGENDA GOALS: Prevent Chronic Diseases

1. **Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.**
   Measures:
   - **Increase the percentage of adults who had a test for high blood sugar or diabetes within the past three years, aged 45+ years.**
   - **Reduce rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 population.**
2. **In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.**
   Measures:
   - **Increase the percentage of adults with chronic conditions who have taken a course or class to learn how to manage their condition**
   - **Reduce the percentage of adult Clinton County resident with self-perceived poor or extremely poor physical health.**

Objective: Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone.

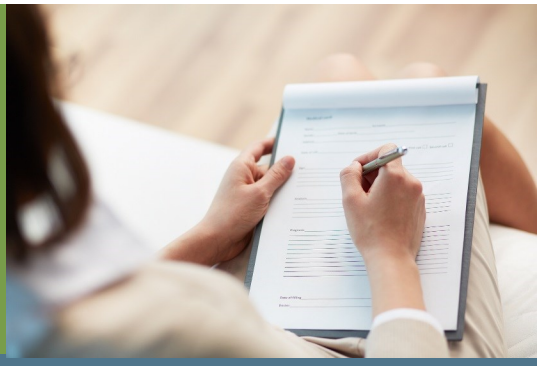
Calendar Year 2024: Work to Date

- A1C control QI project: included calling patients overdue for their A1C testing to get them scheduled to see their provider. Ended the year about the same as we started - 19.5% of our diabetic patients have an A1C over nine (slightly down from 19.7% at the start of the year. Our target is <10%.
- Launched partnerships with the Heart Network and Adirondack Health Institute (AHI) to be part of the Chronic Disease Care Coordination Network. Providers are referring patients to:
  - SNAP-Ed Fruit and Vegetable Prescription program: Any patient at risk of or diagnosed with a diet-related chronic disease and has food insecurity qualifies. Partnered with Cornell Cooperative for this program in mid-2024. As part of the program, patients attend classes that teach them about eating healthy and how to cook healthy. For each class they attend, they receive a $25 voucher for fruits and vegetables.

- SNAP-Ed Fruit and Vegetable Prescription program cont.
    - There are a total of six classes for each session. These classes are free of charge.
- Chronic Disease Self-Management program through Get Healthy North Country: Providers refer patients via gethealthynoco.org. Participants attend classes on a variety of topics related to chronic disease: diabetes management, pain management and chronic disease. These classes are free of charge. Chronic disease courses are scheduled for 2025.
- CVPH is a pilot site for the Chronic Disease Care Coordination Network.
- The PHSO has initiated the Diabetic Care Management Pathway:
    - Any patient with a A1C <9% qualifies for the DM Care Management Pathway.

Progress on measures: No outcome measurement data reported at time of report.

Prevent Mental and Substance Use Disorders



IN ALIGNMENT WITH NYS PREVENTION AGENDA GOALS: Promote Well-Being and Prevent Mental and Substance Use Disorders

1. **Prevent opioid and other substance misuse and deaths.**

Measures:

- **Reduce Drug Overdose Mortality by three points.**
- **Reduce Opioid Overdose Mortality by three points.**

2. **Prevent and address adverse childhood experiences.**

Measures:

- **Decrease the percentage of Clinton County adults who have experienced two or more adverse childhood experiences (ACEs).**

Objective: Build support systems to care for opioid users or at risk of an overdose.

Calendar Year 2024: Work to Date

- As of 2024, CVFC provides a targeted case manager primarily in the Emergency Department (ED) focused on:
  - Screen individuals for health-related social needs.
  - Engage in SUD services for those in need among any of the service providers.
  - Provide Narcan to patients and families upon request.
  - Follow-up with individuals until connected with intake agency.
- CVPH Emergency Department is part of a research project with UVM Start treatment and Recovery (STAR). Buprenorphine Emergency Department Quick Start Algorithm created and in use in ED.
  - Anti-Stigma training was provided to approximately 100 CVPH staff in 2024.
- In 2024, Behavioral Health Services North (BHSN) opened an Adult and Child residential respite facility.
  - BHSN and CVPH have collaborated in facilitating individuals from ED or Inpatient to these less restrictive beds and continue their treatment.

Populations of focus: Adults across the lifespan

Key community partnerships:

- CVFC
- NAMI

Progress on measures:

- By end of the year, case manager engaged with 17 patients to provide or connect them to services addressing an identified social need, including enrollment in a substance use disorder program. Additionally, two individuals were helped to get to an inpatient rehab from the ED.

Promote Well-Being

IN ALIGNMENT WITH NYS PREVENTION AGENDA GOALS[1]: Promote Well-Being and Prevent Mental and Substance Use Disorders

1. **Strengthen opportunities to build well-being and resilience across the lifespan.**
2. **Facilitate supportive environments that promote respect and dignity for people of all ages.**

Measures:

- **Reduce the percentage of adult Clinton County residents with self-perceived poor or extremely poor mental health.**
- **Increase Clinton County's Opportunity Index Score by 5%.**

Objectives:

1. **Create and sustain inclusive, healthy public spaces.**
2. **Increase access to health and wellness programs for North Country residents .**
3. **Establish a working committee focusing on wellness and well-being.**
4. **Engage employees in wellness and well-being activities.**
5. **Provide education on resources available to CVPH employee's that would support/ enhance their own wellness and well-being.**

Strategies:

1. **Support programming within local townships and schools.**
2. **Create a cart of Connection and Well-being .**
3. **Identify minimum of three activities for engaging wellness and well-being for employees.**
4. **Consistent attendance and participation in committee events.**
5. **Build an ambassador program for engagement in wellness and well-being activities.**

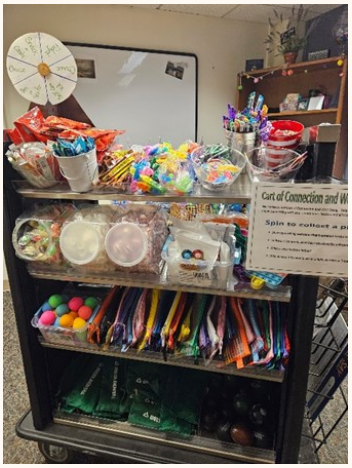
Calendar Year 2024: Work to Date

- The Foundation of CVPH sponsored several wellness programs and increased access to fitness activities through its community grant program and strategic partnerships.
    - Sponsored a walking group in Champlain, NY.
    - Supported improvements to the community hockey rink in Champlain, NY.
    - Purchased an adaptive wheelchair for local pickleball courts.

    - Sponsored an adaptive cycling clinic.
    - Purchased 400 bicycle helmets for children in Essex County.
    - Partnered with four townships in Clinton County to sponsor free summer activities.
    - Partnered with Shine On! and Sweethearts & Heroes programming to encourage social and emotional wellness for students throughout the region.
- Plan to invest in current partnerships in 2025 to ensure access to programming remains.
- The mission of CVPH's standing Wellness and Well-Being committee is to work together to foster well-being by encouraging balance, awareness of personal strengths and resources by creating a workplace where wellness is a priority.
- **Goal:** to increase and maintain involvement and engagement for all CVPH employees including hospital-based employee's as well as offsite clinical and support locations.
    - The wellness and well-being committee is responsible for identifying goals, providing resources/information/activities related to the betterment of CVPH employee's wellness and wellbeing using the standard focus of the NIH's eight dimensions of wellness.
    - Committee members will focus on best practice, education as well as performance improvement. Key indicators selected based on OKR's of the UVM Health Network and CVPH hospital and offering forums for feedback from employees. Quality data will be obtained from results of surveys and feedback given during educational sessions and activities.
    - Committee highlights in 2024:
        - Presentation at Explore Conference " Wellness and Well-Being."
        - Implemented "Cart of Connection and Well-Being."
        - Organizational Wellness/Gratitude Board and Wellness Cards
        - Promoted Organizational "Healthy Recipes" over holidays and Walking Challenge over the summer.
        - Partner with OCC Health and Wellness for community engagement (Movie Night, YMCA night).
        - Wellness Wednesday (one time monthly) for education and engagement.
        - Dedicated Staff wellness spaces added to the Emergency Department and Adult Psychiatry.

- CISM team continues to be activated more frequently to support staff post traumatic internal events, in addition to providing ongoing support to staff for evolving complex cases presenting challenges to staff.

- CVPH launched Lyra Health in 2024: Increased access to an array of counseling services, both in-person and virtual options.



Populations of focus:

- School-aged children
- Seniors
- Differently-abled individuals
- All CVPH Employees

Key community partnerships:

- Local townships and schools
- Town of Plattsburgh
- YMCA
- Lyra Health
- CVPH Occupational Health and Wellness

Progress on measures:

- Cart of Connection and Well-Being has been utilized: on 15 different occasions supporting APP/NPP's, Nursing Students, Clinical floor staff on R3, R4, R5, inpatient and outpatient rehab, Nutrition Services, EVS and Leadership (clinical and non-clinical) for a total over 200 individuals impacted.
- Wellness Challenge (walking): 17 unique individuals participated.

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