Community Health Improvement Plan

Chittenden & Grand Isle Counties

2026–2028

University of Vermont Health

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Overview of the Community Health Improvement Plan

Overview of the Community Health Improvement Plan

The 2026–2028 Chittenden & Grand Isle Community Health Improvement Plan (CHIP) outlines a shared, community-driven approach to improving health and well-being across the region. Adopted by the UVM Medical Center Board of Trustees, the CHIP builds directly on findings from the 2025 Community Health Needs Assessment (CHNA) and focuses on strategies that reflect community priorities, reduce inequities, and strengthen partnerships over the next three years. Based on community input and mixed-methods data analysis, three priority areas emerged as the focus of this plan.

- Building Community Connectedness
- Engaging on Mental Health
- Increasing Health Care Access

2025 CHNA: Community Health Themes Shaping the CHIP

Community input from the 2025 CHNA revealed consistent themes across surveys, focus groups, and community conversations. These findings reflect both the challenges community members experience and the assets and strengths they identified as foundations for improvement. These themes are drawn directly from the analysis presented in the 2025 CHNA, which informed the selection of CHIP priority areas.

Community-identified challenges included:

- **Difficulty accessing care:** Long wait times, challenges navigating the healthcare system, transportation barriers and limited availability of services
- **Mental health access and engagement challenges:** Unmet mental health needs, difficulty accessing timely services, and challenges navigating available supports, particularly for populations facing cultural, linguistic, or system-level barriers
- **Social isolation:** Feelings of disconnection, loneliness, and limited opportunities for belonging, particularly among older adults, youth, and rural community members
- **Structural stressors:** Housing instability, financial pressure, and transportation challenges affecting overall health and well-being
- **Need for culturally responsive services:** Desire for care and community spaces that feel welcoming, inclusive, and respectful of language, culture, and identity

At the same time, community members identified important strengths and assets, including:

- **Strong community organizations and service providers:** Many participants praised organizations with “passionate workers who want to help,” particularly those offering human-centered, relationship-based support
- **Schools as trusted community hubs:** Schools were consistently identified as safe, accessible spaces for connection, services, and support for children and families

- **Informal community networks:** Neighbors, family members, and peer networks often help address transportation, caregiving, and access gaps, especially in rural areas
- **High levels of insurance coverage:** Overall insurance coverage rates remain high compared to national averages, providing a foundation for addressing affordability and access barriers
- **Community willingness to engage:** Community members expressed a strong desire to participate in solutions, emphasizing collaboration, shared responsibility, and community-driven approaches

Together, the challenges and assets identified through the CHNA underscore the need for equity-centered, community-driven strategies that address access, connection, and mental well-being in integrated ways.

For more detail on key findings, data sources and engagement methods, please see the full **2025 CHNA report**.

CHNA Priorities Not Selected at This Time

The 2025 Community Health Needs Assessment identified additional priority health needs that were considered, including cost of living, cultural humility and inclusive health care, and improving community safety.

The CHIP focuses on areas where coordinated, cross-sector action will be most effective within the scope of this plan. The CHNA Steering Committee and community participants of the prioritization process deemed:

- Cost of living challenges are driven largely by broader economic and policy factors.
- Community safety efforts are more appropriately led by public safety agencies and community partners.
- Cultural humility and inclusive care, though not addressed as a standalone priority, are embedded throughout all CHIP strategies and are reflected in ongoing organizational practices.
- While cost of living is not addressed as a standalone priority, financial barriers to health care access, including insurance affordability, out-of-pocket costs, and transportation expenses are explicitly addressed through strategies within the Increasing Health Care Access priority area.

To learn more about the CHNA prioritization process, please see Page 40 in the **2025 CHNA report**.

CHIP Development Process

Following completion of the 2025 CHNA, University of Vermont Health Community Health Improvement facilitated the development of the Community Health Improvement Plan on behalf of University of Vermont Medical Center. CHNA data, partner feedback, and existing community initiatives informed selection and refinement of CHIP goals, objectives, and strategies.

The Chittenden Accountable Community for Health (CACH) Core Team was charged with final review of the CHIP to ensure strategies are realistic, aligned with community capacity, and appropriate for shared implementation.

The UVM Medical Center Board of Trustees approved and adopted the CHIP on February 6, 2026.

Engagement Tactics

- 8 presentations
- 2 webinars
- 12 engagements with community and cross-sector partners to solicit feedback
- Administration of a follow-up survey to gather input on implementation readiness and potential areas of focus

Governance, Oversight and Resources

UVM Medical Center supports community health improvement through funding, staff capacity, leadership engagement, data support, and cross-sector partnerships aligned with Community Health Needs Assessment (CHNA) priorities. It has also formally adopted this Community Health Improvement Plan (CHIP) as its implementation roadmap.

How community health improvement is governed and supported:

Community Health Investment Fund (CHIF):

- Provides over $1 million annually to support community-based initiatives aligned with CHNA priority areas.

Housing-related investments:

- UVM Medical Center supports initiatives that advance stable housing and housing-related support. Recent investments include Community and Street Outreach ($200,000), Harbor Place ($191,625), and Beacon Apartments ($148,764).

In-kind resources:

- Staff time for planning, coordination, grant review, and evaluation; leadership participation; and population health expertise and data support.

CHIP implementation coordination:

- Coordinated through the Chittenden Accountable Community for Health (CACH) with backbone support from UVM Health.

Oversight and accountability:

- Strategy-level performance measures reviewed at least annually and summarized in publicly available reports on the **UVM Health Community Benefit website**.
- Progress is monitored by UVM Medical Center's community benefit governance structure and the Local and System Boards.

Alignment with broader priorities:

- Grounded in the 2025 CHNA and informed by statewide priorities, including the 2025–2030 State Health Improvement Plan (SHIP).
- UVMH Strategic Planning Committee assures system alignment between the objectives and goals of network and partner strategic plans and the CHIP.

CACH Core Team

- Adrienne Lueders-Dumont – Senior Communications Director – United Way of Northwest Vermont
- Alicia Schwartz – Director of Nursing – Community Health Centers
- Amy Rex – Superintendent – Milton School District
- Beth Reilly – Community Care Manager – WRAP Program – UVM Health
- Cara Gleason Krebs – Director of School Services – Howard Center
- Jackie Reno – Executive Director – The Family Room
- Katie Wells – Physician Emergency Medicine – UVM Medical Center
- Kristen Pierce – Physician Infectious Diseases – UVM Medical Center
- Lacey Smith – Bridges Recovery Shelter Director – CVOEO
- Matt MacNeil – Director of Evaluation – Howard Center
- Penrose Jackson – Executive Director – Vermont Public Health Institute
- Sonali Samarasinghe – Field Office Director – U.S. Committee for Refugees and Immigrants
- Stephen Hayes – Public Health Supervisor – Vermont Department of Health- Burlington District Office

Priority Area:
Building Community Connectedness

GOAL: Strengthen social connection and a sense of belonging by supporting conditions that enable community members across the lifespan to engage in safe, inclusive, and supportive community environments.

Populations of Focus

- Youth
- Young adults
- Older adults
- LGBTQ+ individuals
- New American, immigrant, and refugee communities
- BIPOC community members
- Rural community members
- People with disabilities, including those who are neurodivergent
- Families with limited access to community supports
- Individuals experiencing social isolation
- Individuals experiencing marginalization

Objective 1: Increase access to youth environments that promote belonging, safety, and positive connections with peers and trusted adults.

Community Indicators

- % of students in grades 9-12 who feel like they matter to people in their community (Source: Vermont Youth Risk Behavior Survey / Healthy Vermonters 2030)
- % of students who are chronically absent from school (Source: Healthy Vermonters 2030)
- % of middle school students who experienced bullying on school property in the past 12 months (Source: Vermont Youth Risk Behavior Survey)
- % of high school students who experienced bullying on school property in the past 12 months (Source: Vermont Youth Risk Behavior Survey)
- % of students in grades 9-12 who felt sad or hopeless almost every day for two weeks or more in a row in the past 12 months (Source: Vermont Youth Risk Behavior Survey / Healthy Vermonters 2030)

Proposed Health System Measures

- **Screening: Developmental Screening in the First Three Years of Life** - Increase early developmental screening (Source: UVM Medical Center Internal Data; OHSU DEV-CH)
- **Well-Care Visits: Child and Adolescent Well-Care Visits (age 3-21)** - Increase well-care visits for children and adolescents (Source: UVM Medical Center Internal Data; NCQA/HEDIS WCV)
- **Patient Experience: HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Overall Rating of Hospital** - Improve overall patient experience (Source: UVM Medical Center; CMS HCAHPS)

Strategy 1.1

Enhance the capacity of schools and youth-serving organizations to foster inclusion, expand mentoring, and strengthen youth-adult connections through mentoring, career exploration, and job shadowing partnerships.

Proposed Performance Measures

- Number of partner schools and youth-serving organizations engaged in CHIP-aligned initiatives
- Number of youth connected to inclusion, mentoring, and/or job shadowing opportunities through CHIP partnerships
- Percentage of youth remaining engaged in programs for 6+ months
- Percentage of partner organizations reporting improved capacity to connect diverse youth with caring adults and developmental supports

Objective 2: Strengthen conditions that enable older adults to build and sustain social connections and engage in community life through accessible programs, spaces, and events.

Community Indicators

- % of adults age 65 and older living alone (Source: U.S. Census American Community Survey)
- % of adults age 65 and older who report rarely or never receiving social and emotional support (Source: Vermont Behavioral Risk Factor Surveillance System)

Proposed Health System Measures

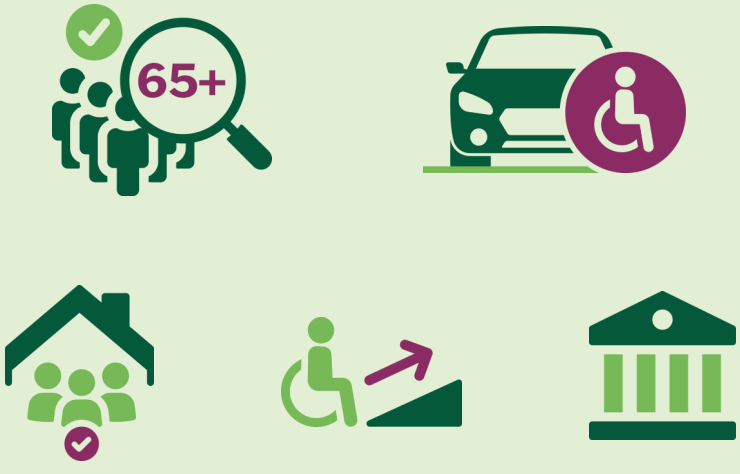
- **Screening: Care for Older Adults—Functional Status -** Increase functional status assessment for older adults (Source: UVM Medical Center; NCQA/HEDIS COA—data not currently available)

Strategy 2.1

Activate partnerships with aging services, transportation providers, community centers, municipalities, and other organizations to increase access to programs, transportation, accessible spaces, and social gatherings that foster social connection for older adults.

Proposed Performance Measures

- Number of aging services organizations, transportation providers, or municipalities engaged as partners through CHIP coordination
- Number of older adults reached through social connection programs, transportation options or community spaces supported by CHIP partnerships
- Percentage of participating organizations reporting strengthened capacity to reach or engage isolated older adults



46.1%

of adults 65+ live alone in Chittenden County

SOURCE: Community Survey / 2025 CHNA

Priority Area:
Engaging on Mental Health

GOAL: Strengthen community capacity to support mental health and prevent substance-related harm through coordinated approaches that expand access to care, promote well-being across the lifespan, and reduce stigma.

Populations of Focus

- Black, Indigenous, and People of Color (BIPOC) communities
- New American communities, including immigrants and refugees
- LGBTQ+ individuals
- Youth and young adults
- Older adults
- People with disabilities, including those who are neurodivergent
- Individuals experiencing substance use challenges
- Rural community members
- People with limited English proficiency or limited digital access
- Individuals facing economic instability, housing insecurity, or social isolation

Objective 1: Strengthen access to mental health services and support for adults through partnerships that expand reach, coordination, and culturally responsive care.

Community Indicators

- % of adults age 18 and older with any mental health condition receiving treatment (Source: Healthy Vermonters 2030)
- Average number of mentally unhealthy days reported by adults in the past 30 days (Source: Vermont Behavioral Risk Factor Surveillance System)
- Mental health provider density (number of mental health providers per population) (Source: Health Care Workforce Census)

Proposed Health System Measures

- **Care Coordination: Follow-Up After ED Visit for Mental Illness** - Increase timely connection to outpatient mental health care after an ED visit for mental health concerns (Source: UVM Medical Center; NCQA/HEDIS FUM – data not currently available)
- **Care Coordination: Follow-Up After Hospitalization for Mental Illness** - Increase timely follow-up care after psychiatric hospitalization (Source: UVM Medical Center; NCQA/HEDIS FUH – data not currently available)
- **Screening: Depression Screening and Follow-Up Plan** - Increase systematic screening for depression in primary care with documented follow-up plans (Source: UVM Medical Center; NCQA/HEDIS DSF)

Strategy 1.1

Drive collaboration among primary care, behavioral health, and social services to improve service navigation, expand delivery options, and increase awareness of available support.

Proposed Performance Measures

- Number of coordination activities or initiatives supported that expand mental health awareness, service delivery options and/or cross-sector coordination
- Number of adults reached through mental health services, information or supports facilitated by CHIP partnerships
- Percentage of participating organizations reporting strengthened coordination or improved capacity to serve adults seeking mental health support

Objective 2: Optimize youth mental health through school and community environments that promote well-being, connection, and access to care.

Community Indicators

- % of students in grades 9—12 who made a suicide plan in the past year (Source: Youth Risk Behavior Survey / Healthy Vermonters 2030)
- % of children ages 3—17 with any mental health condition receiving treatment (Source: Healthy Vermonters 2030)

Proposed Health System Measures

Screening: Developmental Screening in the First Three Years of Life - Increase early identification of developmental concerns in young children (Source: UVM Medical Center; OHSU DEV-CH)

Strategy 2.1

Enhance the capacity of schools, prevention coalitions, and youth-serving organizations to implement evidence-informed youth mental health approaches and strengthen early-intervention pathways.

Proposed Performance Measures

- Number of schools, prevention coalitions, or youth-serving organizations engaged in youth mental health promotion through CHIP coordination
- Percentage of participating organizations reporting strengthened capacity to identify youth needs and connect them to mental health support

Objective 3: Strengthen community capacity to prevent substance-related harm and strengthen connection to treatment.

Community Indicators

- Rate of opioid-involved accidental or undetermined drug overdose deaths per 100,000 people (Source: Vermont Department of Health / Healthy Vermonters 2030)
- % of students in grades 9-12 who used cannabis (marijuana) in the past month (Source: Youth Risk Behavior Survey / Healthy Vermonters 2030)
- % of people age 12 to 20 who reported binge drinking in the past month (Source: National Survey on Drug Use and Health / Healthy Vermonters 2030)
- % of adults age 21 and older who reported binge drinking in the past month (Source: Healthy Vermonters 2030)

Proposed Health System Measures

- **Care Coordination: Follow-Up After ED Visit for Substance Use** - Increase timely connection to treatment or support services after an ED visit for alcohol or substance use (Source: UVM Medical Center; NCQA/HEDIS FUA – data not currently available)
- **Care Coordination: Initiation and Engagement of Substance Use Disorder Treatment** - Increase the number of individuals who initiate and remain engaged in substance use treatment (Source: UVM Medical Center; NCQA/HEDIS IET – data not currently available)

Strategy 3.1

Partner with harm reduction, treatment, and prevention organizations to enhance pathways to care, strengthen community-based prevention efforts, and reduce stigma associated with substance use.

Proposed Performance Measures

- Number of harm reduction, treatment, or prevention organizations engaged as CHIP partners through coordination or joint activities
- Number of community members reached through substance use prevention, treatment pathways, or stigma reduction activities supported by CHIP partnerships
- Documentation of strengthened connections between community settings and substance use treatment services

Priority Area:
Increasing Health Care Access

GOAL: Improve access to affordable, timely, and appropriate health care services by supporting equitable coverage, strengthening provider capacity and addressing barriers to care.

Populations of Focus

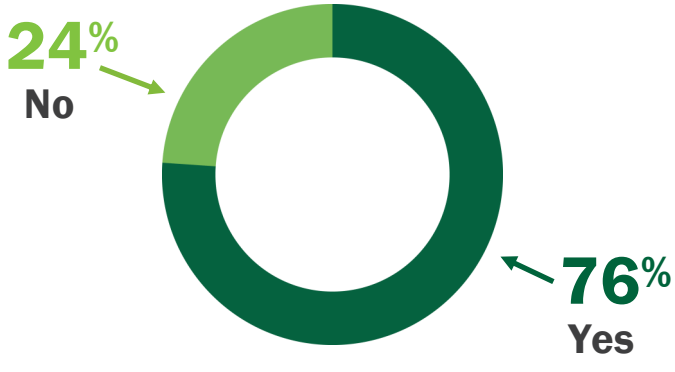
- Uninsured and underinsured community members
- Low-income individuals and families
- New American, immigrant, and refugee communities
- Black, Indigenous, and People of Color (BIPOC) community members
- LGBTQ+ individuals
- Rural community members
- Older adults
- People with disabilities, including those who are neurodivergent
- People experiencing homelessness
- Individuals with limited English proficiency
- People with chronic health conditions
- Individuals navigating complex or unfamiliar health care systems

Objective 1: Improve access to affordable, timely health care by strengthening insurance coverage, reducing financial and administrative barriers, and supporting connections to preventive and ongoing care.

Community Indicators

- % uninsured by race and ethnicity (Source: American Community Survey)
- % of adults experiencing transportation insecurity (Source: Healthy Vermonters 2030, BRFSS)
- % uninsured, total population (Source: American Community Survey)
- % of adults who did not take prescribed medication in the past year due to cost (Source: Vermont Behavioral Risk Factor Surveillance System)

"I can access health care services that meet my needs."



SOURCE: Community Survey / 2025 CHNA

Proposed Health System Measures

- **Well-Care Visits: Annual Wellness Visit (AWV Medicare)** - Increase preventive care utilization among Medicare beneficiaries (Source: UVM Medical Center; CMS AWV)
- **Well-Care Visits: Child and Adolescent Well-Care Visits (age 3-21)** - Increase well-care visits for children and adolescents (Source: UVM Medical Center; NCQA/HEDIS WCV)
- **Well-Care Visits: Annual Preventive Visit (age 22-64 non-Medicare)** - Increase preventive care utilization among working-age adults (Source: UVM Medical Center; Custom measure - data not currently available)
- **ED: Left Without Being Seen** - Reduce the number of patients who leave the ED before being seen (Source: UVM Medical Center; CMS OP-22)
- **Care Coordination: Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions** - Increase timely follow-up for patients with complex health needs after an ED visit (Source: UVM Medical Center; NCQA/HEDIS FMC)

Strategy 1.1

Enhance coordination among enrollment navigators, community health workers, and community partners to reduce financial, administrative, and logistical barriers to care and improve access to preventive and ongoing health services.

Proposed Performance Measures

- Number of community-based organizations, enrollment navigators, or community health workers engaged in insurance enrollment outreach through CHIP coordination
- Number of community members reached and connected to coverage or financial assistance through community-based outreach
- Number of individuals enrolled in insurance via CHIP coordination
- Number of outreach events convened and/or attended
- Percentage of participating organizations reporting improved capacity to reduce access barriers or connect individuals to needed health care services

Objective 2: Increase the availability of primary care and mental health services to meet community needs.

Community Indicators

- Primary care physician density (people per provider) (Source: County Health Rankings)
- Mental health provider density (people per provider) (Source: County Health Rankings)
- % of adults age 18 and older who did not see a doctor when they needed to because they could not afford it in the past 12 months (Source: BRFSS / Healthy Vermonters 2030)
- % of people who delayed dental care due to cost in the past 12 months (Source: Healthy Vermonters 2030)

Proposed Health System Measures

- **Readmission: Hospital-Wide, 30-day, All-Cause Unplanned Readmission** - Reduce unplanned hospital readmissions (Source: UVM Medical Center; CMS HWR)
- **Patient Experience: HCAHPS Responsiveness of Hospital Staff** - Improve staff responsiveness to patient needs (Source: UVM Medical Center; CMS HCAHPS)

Strategy 2.1

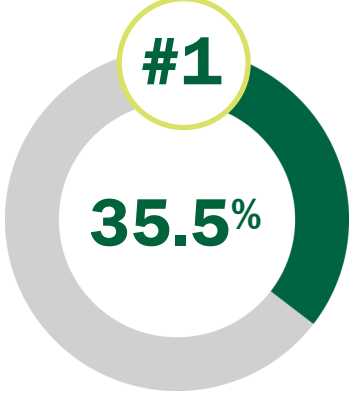
Expand flexible service delivery options, including telehealth and community-based settings, that extend the reach of available providers.

Proposed Performance Measures

- Number of initiatives supported that expand telehealth, community-based service delivery or healthcare career pathways
- Number of community members reached through expanded service delivery options supported by CHIP partnerships
- Percentage of participating organizations reporting expanded service capacity or strengthened ability to reach underserved community members

Top Choice for Improving Health Care Access from Survey—35.5% said:

"...More appointments outside typical business hours"



SOURCE: Community Survey / 2025 CHNA

For More Information

To learn more about the Community Health Improvement Plan or to get involved, please contact:

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Culture, Experience, and Community Health

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