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Susanne R. Young, Secretary

MEMORANDUM

TO: Vermont General Assembly; Government Accountability Committee and Joint Fiscal Committee
CC: Susanne Young, Kristin L. Clouser and Doug Farnham
FROM: Justin Kenney, Interim Chief Performance Officer
RE: Annual Outcomes Report – 3 VSA §2311 (c)
DATE: September 30, 2021

Attached please find the 2021 Outcomes Report. As in the past, this report is being provided in two formats: as an online Clear Impact scorecard and as a PDF (attached below). For the best viewing experience, it is recommended to view the online version which can be accessed at <https://app.resultsscorecard.com/Scorecard/Embed/71055>. To view a short tutorial on how to utilize a Clear Impact scorecard, I suggest viewing the following short video which was developed for the Agency of Human Services: <https://vimeo.com/198406616>.

Specific to this year’s report, I would like to call attention to three specific items noted below:

- Many of the indicators have been impacted by the COVID-19 pandemic and the unavailability of 2020 Census data. As such, some indicators may show an unusual trend or not be as current as expected.
- In a few cases the names of indicators in the report have been updated slightly to better describe the values being provided. The values themselves have not changed.
- The Gross State Product per Capita indicator was inadvertently reported in the wrong way for the past few years. The values have been updated accordingly.

Not included in the report, but as additional information associated with current efforts to expand the scope and breadth of the current slate of indicators, is a list of current indicators that staff reported could be disaggregated by race and ethnicity. It should be noted however that in some cases data would be suppressed due to small sample size.

Population Outcome	Indicator
Vermont has a prosperous economy	(A)(iii) rate or percent of unemployment per 1,000
Vermonters are healthy	(A) percent of adults 20 years of age or older who are obese

Vermonters are healthy	(B) percent of adults smoking cigarettes
Vermonters are healthy	(C) percent of adolescents in grades 9-12 who used marijuana in the past 30 days
Vermonters are healthy	(E) Rate of suicide over 100,000 Vermonters
Vermont's communities are safe and supportive	(D) recidivism rate
Vermont's communities are safe and supportive	(F) number of first-time entrants into the corrections system
Vermont's children and young people achieve their potential	(B) percent of children ready for school in all four domains of healthy development
Vermont's children and young people achieve their potential	(C) children below the basic level of fourth grade reading achievement under State standards
Vermont's children and young people achieve their potential	(E) percent of adolescents in grades 9-12 using marijuana within the last 30 days
Vermont's children and young people achieve their potential	(F) percent of adolescents in grades 9-12 who had a suicide plan
Vermonters with disabilities live with dignity and independence	(A) estimated employment rate of Vermonters age 21-64 with all disabilities

If you have any questions about this report, please don't hesitate to reach out by email (Justin.Kenney@vermont.gov) or phone (802-461-6259).

Justin Kenney

OUTCOMES REPORT ("Act 186")

THE STATEWIDE OUTCOMES REPORT WAS ESTABLISHED UNDER 3 V.S.A. SEC. 2311 (2014 ACT 186).

[Note: Slide the blue scroll bar to the right to display all content.]

OUTCOME 1

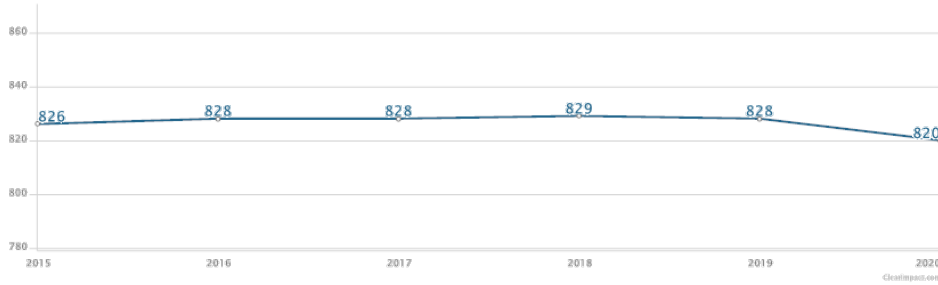
O Act186 VERMONT HAS A PROSPEROUS ECONOMY

Most Recent Period Current Actual Value Current Trend

I VDOL % or rate per 1,000 jobs of non-public sector employment

2020	820	↘ 2
2019	828	↘ 1
2018	829	↗ 1
2017	828	→ 1
2016	828	↗ 1
2015	826	→ 0

Data Source: US Bureau of Labor Statistics, online at <http://www.vtmi.info/indareanaics.cfm?areatype=01>



Story Behind the Curve

2020 data captures the start of the COVID recession. 2019 will be considered peak of last economic expansion.

Yr	State	Chittenden	Non-Chittenden
2020	820	830	815
2019	828	839	823
2018	829	838	824
2017	829	839	824
2016	828	837	823
2015	828	833	825
2014	826	832	823

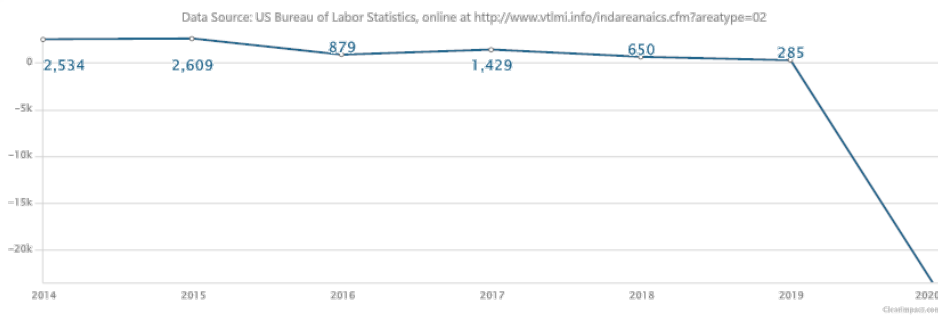
Partners

What Works

Strategy

I VDOL Net change in nonpublic sector employment

2020 -24,779 ↘ 3



2019	285	↘ 2
2018	650	↘ 1
2017	1,429	↗ 1
2016	879	↘ 1
2015	2,609	↗ 1
2014	2,534	→ 0

Story Behind the Curve

2020 data captures the start of the COVID recession. 2019 will be considered peak of last economic expansion.

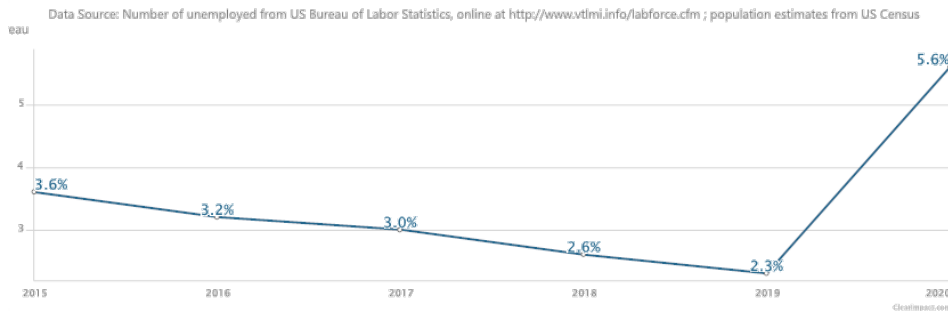
Yr	State	Chittenden	Non-Chittenden
2020	-24779	-7709	-17070
2019	285	206	79
2018	650	285	365
2017	1429	585	844
2016	879	719	163
2015	2609	1308	1301
2014	2534	523	2011

Partners

What Works

Strategy

VDOL Unemployment Rate (per 1000/labor force)



2020	5.6%	↗ 1
2019	2.3%	↘ 4
2018	2.6%	↘ 3
2017	3.0%	↘ 2
2016	3.2%	↘ 1
2015	3.6%	→ 0

Story Behind the Curve

2020 data captures the start of the COVID recession. A long period of economic expansion continued through 2019.

Year	State	Chitt	non_Chitt
2020	5.6%	4.8%	5.9%

2019	2.4%	1.8%	2.6%
2018	2.5%	2.0%	2.8%
2017	3.0%	2.2%	3.2%
2016	3.2%	2.5%	3.5%
2015	3.6%	2.7%	3.9%

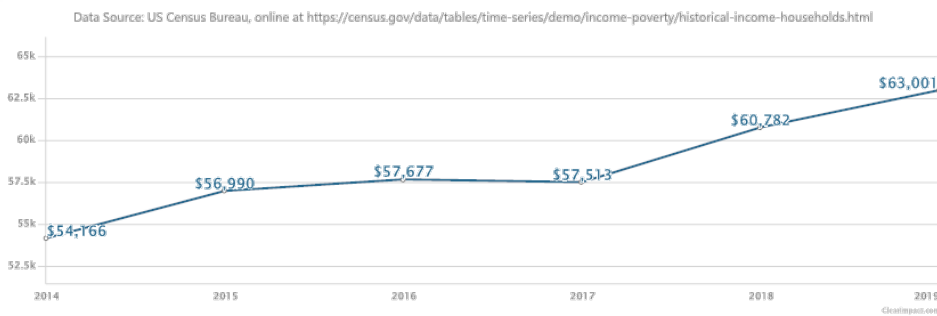
Partners

What Works

Strategy

ACCD Median household income

2019	\$63,001	↗	2
2018	\$60,782	↗	1
2017	\$57,513	↘	1
2016	\$57,677	↗	2
2015	\$56,990	↗	1
2014	\$54,166	→	0



Story Behind the Curve

The most recent data available is from 2019.

	State	Chittenden	Non- Chittenden
2019	63001	68516	n/a
2018	60782	66906	n/a
2017	57513	64444	n/a
2016	57677	68843	n/a
2015	56990	67997	n/a
2014	54166	62004	n/a

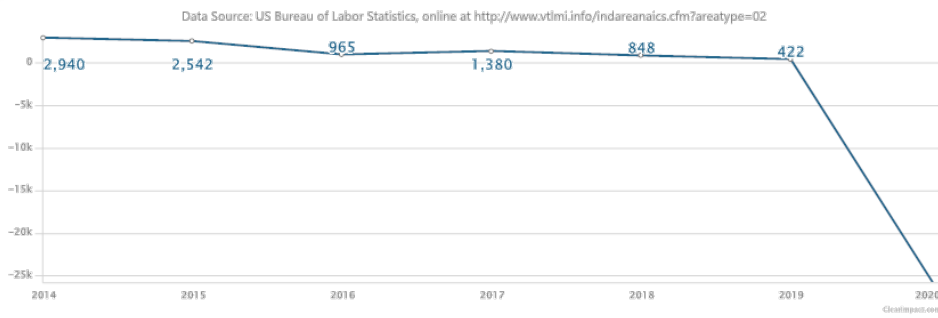
Partners

What Works

Strategy

VDOL Net change in jobs (New Jobs)

2020	-27,155	↘	3
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2019	422	↘ 2
2018	848	↘ 1
2017	1,380	↗ 1
2016	965	↘ 2
2015	2,542	↘ 1
2014	2,940	→ 0

Story Behind the Curve

2020 data captures the start of the COVID recession.

Yr	State	Chittenden	Non-Chittenden
2020	-27155	-8249	-18906
2019	422	221	221
2018	848	359	489
2017	1380	500	880
2016	965	365	600
2015	2542	1492	1050
2014	2940	601	2339

Partners

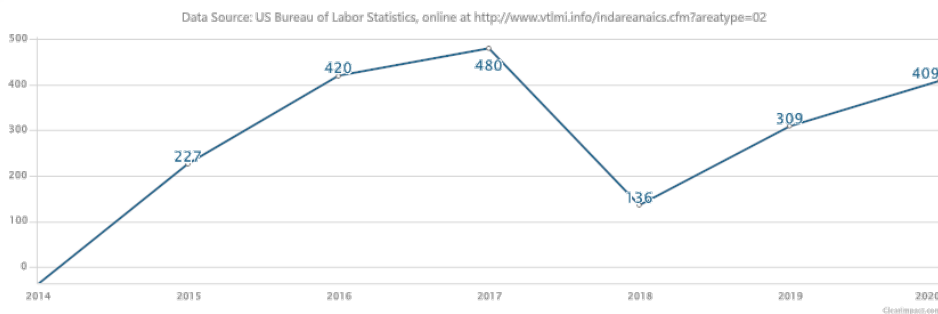
What Works

Strategy



VDOL Net change in business establishments

2020	409	↗ 2
2019	309	↗ 1
2018	136	↘ 1
2017	480	↗ 3
2016	420	↗ 2
2015	227	↗ 1
2014	-38	→ 0



Story Behind the Curve

2020 data captures the start of the COVID recession. 2019 will be considered peak of last economic expansion.

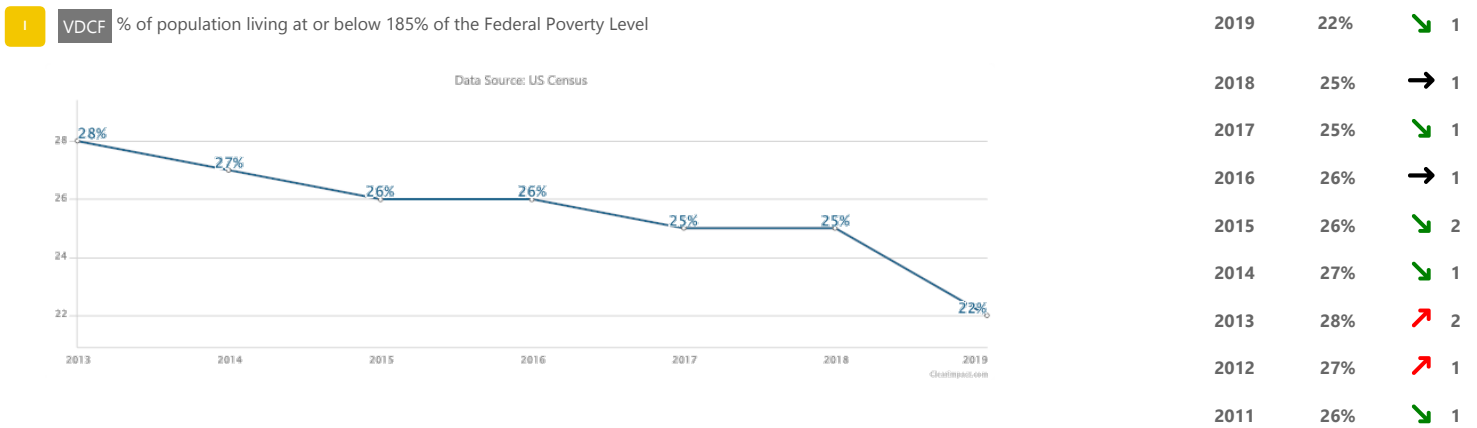
	State	Chittenden	Non-Chittenden
2020	409	227	182
2019	309	131	178

2018	136	119	17
2017	480	178	302
2016	420	180	240
2015	277	162	65
2014	-38	99	-137

Partners

What Works

Strategy

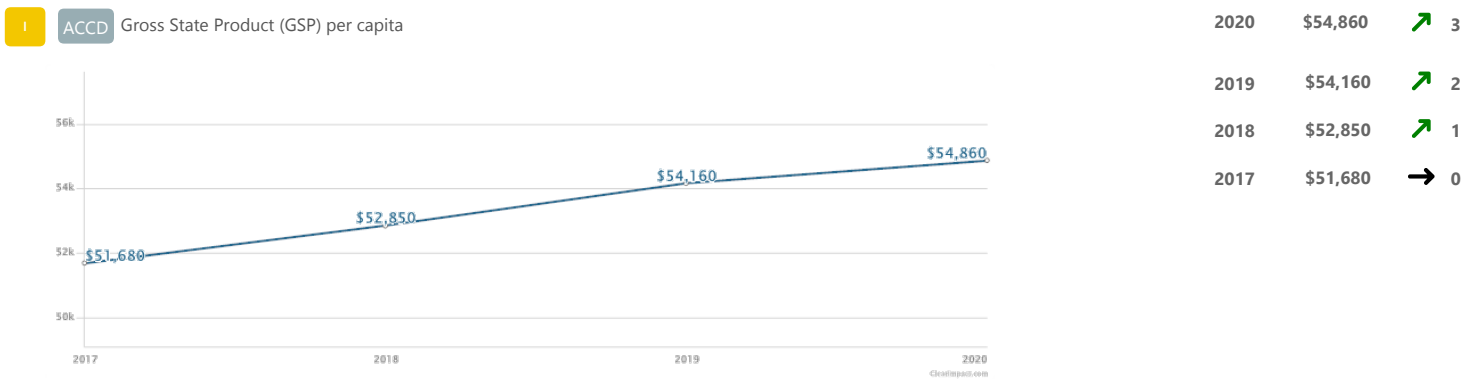


Story Behind the Curve

Partners

What Works

Strategy



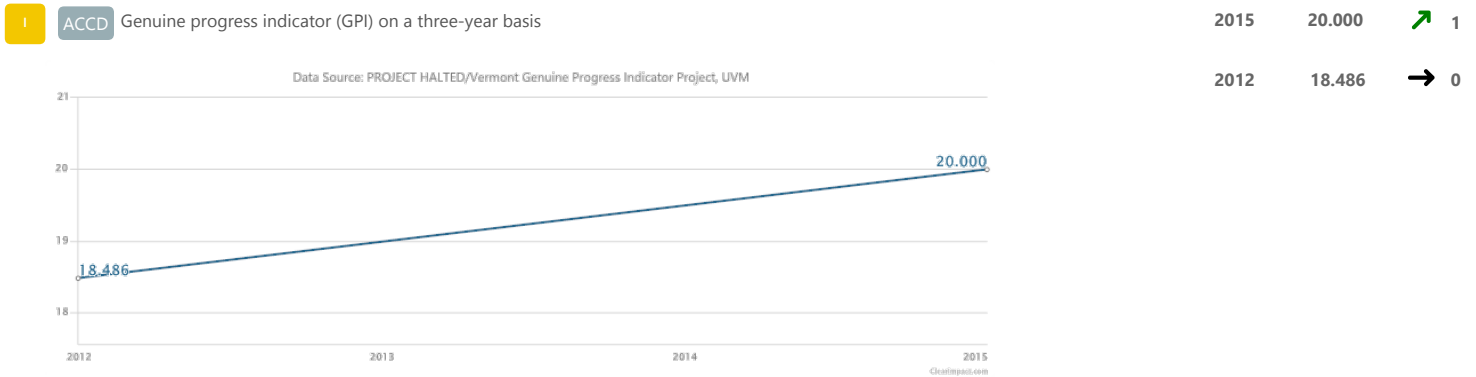
Story Behind the Curve

Billions of dollars (nominal); Gross State Product is a measurement of a state's output; it is the sum of value added from all industries in the state. ... GDP is the market value of goods and services produced by labor and property in the United States, regardless of nationality.

Partners

What Works

Strategy



Story Behind the Curve

NOTE: The individual responsible for coordinating this work (Eric Zencey) has passed away. We have not been able to learn the future of the project, at this time.

In 2012, Vermont became the first state in the nation to legislate the compilation and policy use of an alternative indicator of macroeconomic performance known as the Genuine Progress Indicator (GPI). (Maryland was the first to do so through Executive Order.) While Gross State Product estimates the dollar value of the gross receipts of the economy, the GPI estimates the dollar value of the net economic benefit produced by economic activity in the state. GPI achieves this net figure by taking a basic measure of economic welfare--Personal Consumption Expenditure--and adjusting it in light of various kinds of costs and benefits that GSP ignores. To accomplish this, GPI compilations assign dollar values to otherwise uncounted costs like degradation of natural resources and to otherwise uncounted benefits like volunteer work and the domestic production (cooking, childcare, and the like) that Vermonters do for themselves.

- **The GPI stands at about 66% of the state's Gross State Product (GSP) of \$30.355 billion.** 1 Some gap between the two figures is to be expected, as gross receipts usually exceed net benefits. 2 The size of the gap can be meaningful. Generally, the largest contributor to the GPI-GSP gap is the uncounted environmental costs imposed by economic activity on citizens of the state. Vermont's experience here compares favorably to that of other states. A fifty-state GPI study done in 2014, using data current to 2012, found that Vermont had the 16th smallest gap between the two figures.3 Within New England, though, Vermont lagged behind four of its six regional neighbors, edging out New York (22nd) and Connecticut (18th) but standing behind Massachusetts, Rhode Island, New Hampshire and Maine.
- **The GPI trend for the years 2013-2015 is positive.** The 2015 GPI increase of 7.0% over the 2014 figure is more than triple the growth in GSP. In 2014, GPI grew by 3.6% over 2013, a percentage point higher than GSP growth of 2.6%.
- **The results for a longer time period are less salutary.** Over the past decade GPI declined slightly, 0.9%, from \$19.94 to \$19.77 billion. In contrast GSP grew by 8.7% in those years. Among the indicators exerting a downward pressure on GPI over the decade were the Cost of Non-Renewable Energy Resource Depletion (up by \$1.1 billion) and the adjustment for income inequality, which rose by \$1.8 billion.
- **Increasing income inequality is the largest single drag on the GPI.** Increases in the total income of Vermonters can't promote the general welfare if they aren't generally shared. GPI includes a deduction for increasing concentration of income. In 2015, the income adjustment charge was \$6.48 billion, up 5.42% over the year before. In the ten years since 2005 the charge has increased 40%. In keeping with national trends, well-to-do Vermonters are seeing their incomes increase while Vermonters at the lower and middle parts of the income scale are not.

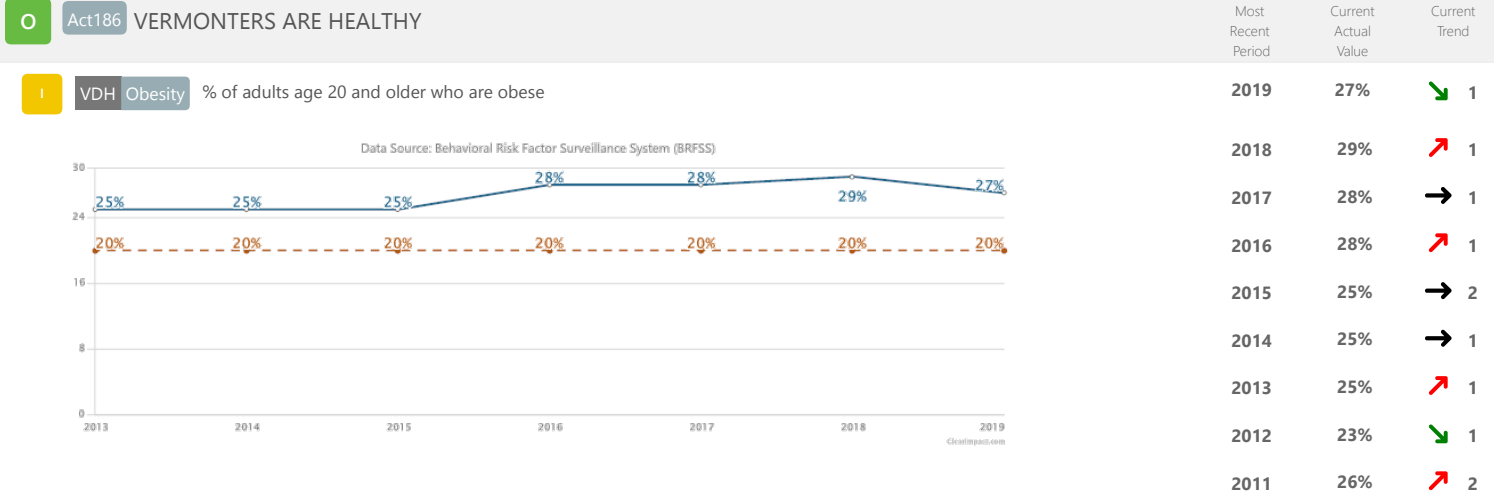
Partners

University of Vermont, Gund Institute for the Environment

What Works

Strategy

OUTCOME 2



Story Behind the Curve

Last Updated: November 2020

Author: Physical Activity & Nutrition Program, Vermont Department of Health

In 2018, the Behavioral Risk Factor Surveillance System (BRFSS) data showed that 29% of Vermont adults age 20 and older are obese. This is higher than in 2017, when the prevalence was 28%, however the difference is not statistically significant. We know that obesity prevalence rises with age, and that adults with a high school education or less and a lower income are more likely to be obese.

While we do not know specific causes of this recent rise, we know that the rate for adults with no leisure time activity was 18% in 2018 or almost one in five Vermont adults get no physical activity outside of the workplace. Additionally, of concern is that the rate of fruit consumption among adults with 40% of adults eating two or more fruits a day in 2017. 22% of adults reported eating three or more vegetables a day in 2017. While these two measures have shown an increase between 2015 and 2017, they are still quite low.

Obesity is a major health concern due to its connection to many chronic diseases. Heart disease, diabetes and many forms of cancer are linked to obesity. In Vermont, we see high rates of these diseases and see the linkage between health behaviors such as getting the recommended amount of physical activity and eating a healthy diet (as well as tobacco use). Together with lung disease, these chronic diseases were the cause of 53% of deaths in Vermont in 2016. This has led us to organizing our work to highlight these preventable diseases through [3-4-50](#) (see Strategies below for more information).

We now also know that those with obesity and chronic diseases are at higher risk for COVID-19 complications. It is more important than ever to work to reduce obesity rates in Vermont.

Partners

- [3-4-50 partners](#): The organizations listed on this page have signed on to help change the three modifiable behaviors that lead to chronic disease, including obesity.
- [Office of Local Health District Offices](#), Vermont Department of Health: The Offices of Local Health work in communities to prevent obesity and other health concerns.
- [Division of Maternal & Child Health](#), Vermont Department of Health: Maternal and Child Health programs such as [WIC](#) promote obesity prevention.
- Division of Economic Services [Three Squares](#) program, Vermont Department of Children & Families: [SNAP-Ed](#), a program for people eligible for SNAP/Three Squares provides nutrition education in five regions of Vermont.
- [American Heart Association](#): Promotes healthy eating and physical activity to prevent heart disease.
- [American Cancer Society](#): Promotes healthy eating and physical activity to prevent cancer.

What Works

There are several [evidence-based strategies](#) that can be used to improve the prevalence of obesity that change the environment or policies to make the healthy choice the easy choice. These include, [Electronic Balance Transfer \(EBT\) for farmers markets and other food access programs](#), [healthy community design](#), and [worksite wellness programs](#). [More information is available from the Centers for Disease Control and Prevention](#).

Strategy

Three health behaviors: poor diet, lack of physical activity and tobacco use; lead to four chronic diseases: heart disease, lung disease, some cancers and diabetes; which cause over 50% of deaths in Vermont. [3-4-50](#) is a framework that helps shine a light on preventable chronic disease to both start a conversation about how to encourage Vermonters to make healthier choices and provide concrete, no/low cost strategies for partners to implement. We are working with communities, schools, worksites and child care programs, providing tips on working with people in their organization or under their care to help them with healthy choices. These organizations can also “sign on” to 3-4-50, by making a commitment to continue this work. Examples include municipalities committing to healthy community design plans, and worksites, schools and child care programs developing policies to support healthy eating and physical activity during the work and school day.

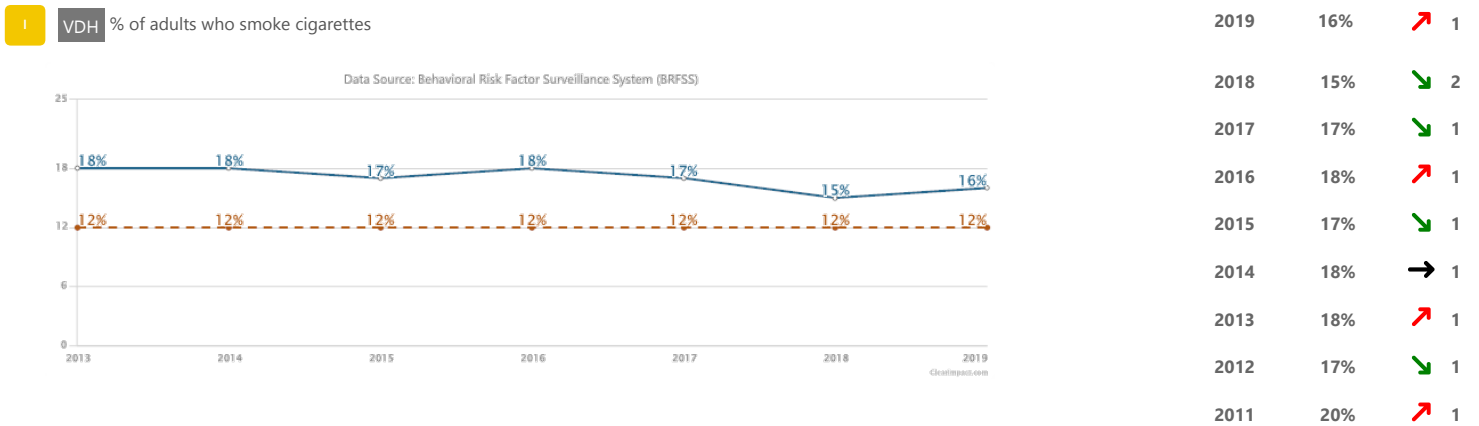
Why Is This Important?

The [American Medical Association declared obesity a disease](#) in 2013. [Healthy Vermonters 2020](#) includes a goal of lowering adult obesity rates in Vermont to 20% by 2020. We monitor obesity rates because of obesity’s impact on many chronic diseases. Understanding the rates of obesity in Vermont provides context for what strategies are needed to lower the rates.

Notes on Methodology

This indicator is age-adjusted to the 2000 U.S. standard population. In U.S. data, age adjustment is used for comparison of regions with varying age breakdowns. In cases where age adjustment was noted as being part of the statistical analysis, the estimates were adjusted based on the proportional age breakdowns of the U.S. population in 2000. For more detailed information on age adjustment read the CDC's Statistical Notes. These data are limited to adults 20 years of age and older as those younger than 20 are generally not yet fully developed and tend to have more weight variability than older adults and are therefore excluded from this measure, following the guidelines of Healthy People 2020.

Due to BRFSS weighting methodology changes beginning in 2011, comparisons between data collected in 2011 and later and that from 2010 and earlier should be made with caution. Differences between data from 2011 forward and earlier years may be due to methodological changes, rather than changes in opinion or behavior.



Story Behind the Curve

Last Updated: March 3, 2020

Author: Tobacco Control Program, Vermont Department of Health

Adult smoking prevalence in Vermont was 17% in 2015, which had been a significant reduction from 2011. In 2018 the prevalence dropped further to 15%, putting Vermont at slightly lower than the national rate of 16%. According to the Campaign for Tobacco Free Kids, among all states Vermont ranks 10th lowest in adult smoking prevalence.

In the last 20 years in Vermont, there has been a gradual decline in smoking from a high of 24% in 1996. Compared to national rates, Vermont shows a significantly higher smoking rate among racial/ethnic minorities; Vermonters who make less than \$25,000 in annual income; and those who have less than a high school degree (Tobacco Use Among Adults and Youth in Vermont and United States). Vermont is one of the most rural states in the nation; research shows that tobacco use is higher among rural populations, adult, youth and pregnant women.

Vermont has a robust and long history in tobacco control and prevention. In 1987 Vermont was the first state to implement a Smoke-free workplace law, and in 1995 Vermont public schools became smoke-free. In 2001 Vermont established a comprehensive Tobacco Control Program and the Vermont Tobacco Evaluation and Review Board, both funded by the Master Settlement Agreement dollars. The State also began offering an evidence-based state Quitline that is accessible and staffed by trained counselors. The program also implemented counter marketing to raise awareness about the dangers of tobacco and resources to quit. The comprehensive approach of the program expanded to include collaboration with Medicaid and the Blueprint for Health, Quit Online and text services, and mass reach media to provide motivation to quit.

Vermont has made significant progress in passing policies that protect from hazardous secondhand smoke, reduce youth access and contribute to people quitting. In 2012 the Vermont Tobacco Evaluation and Review Board and others worked on establishing price parity among cigarettes and other tobacco products which helps to prevent consumers switching to another harmful product when the price of cigarettes is increased, and updated to include tobacco substitutes now considered tobacco products and taxed at 92% wholesale price as of July 1, 2019. Other protective policies passed in the past several years include restricting smoking in cars when children under the age of 8 are present; restricting use of e-cigarettes where lit tobacco products are not allowed; requiring all tobacco products be safely stored behind the counter or in a locked case, and increasing the legal age to purchase tobacco products to 21 in addition to restricting online purchase of vaping products to only those with a wholesale license.

Partners

- - National Jewish Health: The program's contractor which provides the Quitline and Quit Online in English, Spanish and other languages per translation services, an incentive-based pregnancy protocol, and text messaging support.
 - Department Vermont Health Access: The Vermont Medicaid office collaborates with the program on expanding and promoting the tobacco treatment benefits. The Medicaid tobacco benefit includes brief or intermediate one-on-one and group counseling and approved nicotine replacement therapies that when combined with counseling doubles the likelihood of a successful quit.
 - Blueprint for Health Quit Partner Program: A network of regional coordinators and tobacco treatment specialists that are supported by the Blueprint and the Health Department's Tobacco Control and Prevention Program. In every health service area of the state are tobacco treatment specialists serving in hospital, clinical and community settings. Quit Partners use the Fresh Start program, a 4 session format which provides peer support, skill based learning and tips for managing stress.
 - Substance Misuse Prevention Council (SMPC): A Governor appointed board dedicated to a statewide comprehensive and coordinated approach to prevention of all substances to improve the health and well-being of Vermonters.
 - Coalition for Tobacco-free Vermont: A statewide coalition comprised of members of health voluntary organizations (Lung, Cancer, Heart) and community tobacco coalitions. The Coalition works to advance strong tobacco control and prevention policies to create a Tobacco-free Vermont.

What Works

Population-wide interventions that change societal environments and norms related to tobacco use - including increases in the unit price of tobacco products, comprehensive smoke-free policies, and hard-hitting media campaigns - increase tobacco cessation by motivating tobacco users to quit and making it easier for them to do so. CDC Best Practices for Comprehensive Tobacco Control Programs gives four specific recommendations for promoting quitting, addressing tobacco use among adults and shifting to tobacco-free social norms:

- promote health systems change,
- expand insurance coverage and utilization of insurance coverage,
- support state Quitline capacity, and,
- state and local policies that influence and support behavior change.

Vermont's Tobacco Control Program implements these strategies within the current funding granted by the CDC and the State of Vermont. The program is seeking to expand its efforts and efficacy in its health systems engagement with other insurers to complement the accomplishments it has realized for expanding and promoting tobacco benefits in Medicaid. In working with Medicaid, CPT codes were turned on in January 2014 allowing medical practitioners and other providers to bill for reimbursement of cessation counseling services. In 2014 and 2015 mailings were sent to Medicaid beneficiaries and providers alike, which promoted the free tobacco cessation resources available to Vermont's smokers. This mailing resulted in a surge of Quit Tool Kit orders and an increase in the use of the CPT codes for reimbursing tobacco treatment counseling.

The Tobacco Program also advocated for including tobacco as a reporting measure in the Accountable Care Organizations operating in Vermont. The Program has been working on supporting more accessible and mobile-friendly cessation resources including text to better reach and support Vermonters seeking to use 802Quits. The program is also implementing a pregnancy protocol through the Quitline (1-800-Quit-Now) that offers \$5 and \$10 gift cards for each counseling session. Airing mass reach media is also an important component of the comprehensive program that effectively reaches smokers and encourages them to contemplate and/or take action steps towards quitting.

Strategy

The Tobacco Control Program is implementing new initiatives and methodologies to reach, treat, and assess our progress in reducing tobacco use among adults, including those with smoking prevalence:

- A multi-year initiative to create a Culture of Health in behavioral health centers that receive state funding. Many of the state's designated agencies have become or are in the process of becoming tobacco-free campuses and incorporating tobacco into treatment strategies. The Tobacco Control Program partners with the Department of Mental Health and the Division of Alcohol and Substance Abuse Prevention to supply technical assistance, training, webinars and tobacco-free signage.
- The Program is in year 4 of a four-year CDC Quitline Enhancement grant to ensure cessation benefits are free and accessible to all Vermonters and to maintain our Quitline capacity in serving smokers in Vermont; federal funding ends in 2018.
- Implementation of legislation passed in Act 135 that strengthens social norms around tobacco and establishes more smoke-free environments, including cars and around state buildings, creating healthier environments for children and for adults trying to quit smoking.
- Funding of community grantees who work to educate on tobacco to youth, stakeholders and decisionmakers on why it is important to restrict access to tobacco by children and to increase the number and type of tobacco and smoke free environments. Successes include smoke and tobacco-free college and hospital campuses, parks, beaches, and community gathering spots across Vermont.

Similar to statewide efforts, local partners are using data to drive local strategy. For regional data on Tobacco indicators, check out our Public Health Data Explorer.

Why Is This Important?

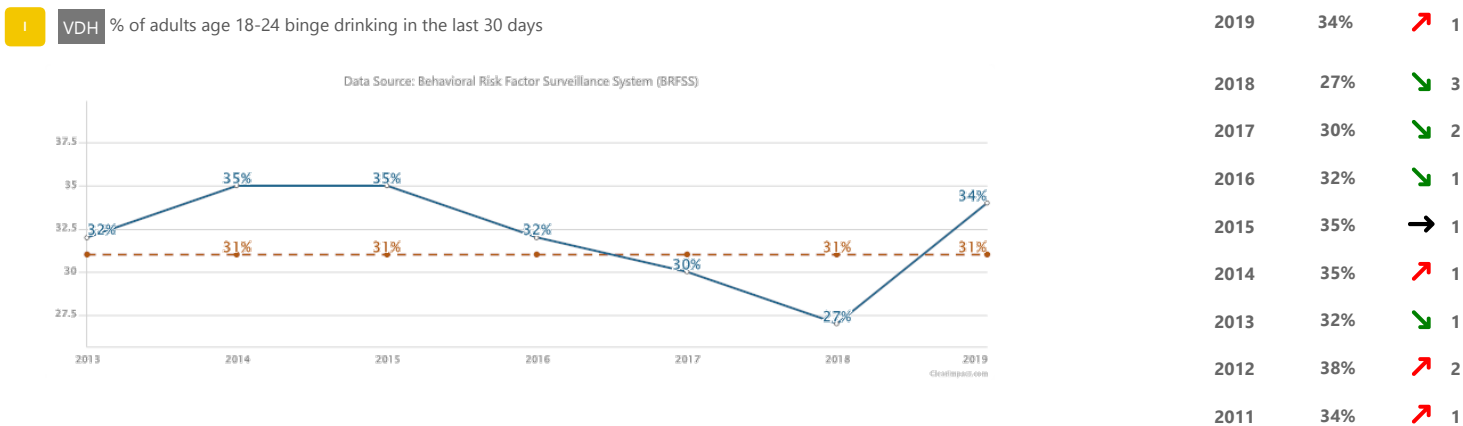
Tobacco use is the #1 preventable cause of death. In Vermont, smoking costs approximately \$348 million in medical expenses and results in an estimated 1,000 smoking-related deaths each year. 10,000 kids now under 18 and alive in Vermont will ultimately die prematurely from smoking. Countless other lives, including those of friends and family members, are impacted by the negative effects of tobacco use and secondhand smoke exposure. Reducing tobacco use and the chronic disease and mortality it causes is one of CDC's Winnable Battles.

Notes on Methodology

Data is updated as it becomes available and timing may vary by data source. For more information about this indicator, click [here](#).

This indicator is age-adjusted to the 2000 U.S. standard population. In U.S. data, age adjustment is used for comparison of regions with varying age breakdowns. In order to remain consistent with the methods of comparison at a national level, some statistics in Vermont were age adjusted. In cases where age adjustment was noted as being part of the statistical analysis, the estimates were adjusted based on the proportional age breakdowns of the U.S. population in 2000. For more detailed information on age adjustment visit [/www.cdc.gov/nchs/data/statnt/statnt20.pdf](http://www.cdc.gov/nchs/data/statnt/statnt20.pdf).

Due to BRFSS weighting methodology changes beginning in 2011, comparisons between data collected in 2011 and later and that from 2010 and earlier should be made with caution. Differences between data from 2011 forward and earlier years may be due to methodological changes, rather than changes in opinion or behavior.



Story Behind the Curve

Updated: Jan 2020

According to the 2019 Behavioral Risk Factor Surveillance System (BRFSS), 27% of young adults 18-24 engaged in an episode of binge drinking, defined as five or more drinks in one occasion for men and four or more for woman. Alcohol use among Vermont adults (18+) is statistically higher than the US. While we don't have comparable national information from the BRFSS, according to the 2017/18 National Survey on Drug Use and Health (NSDUH) results, Vermonters aged 18-25 have amongst the highest rates of binge drinking of any US state.

In addition to the NSDUH results, the 2018 Young Adult Survey (YAS) was conducted in Vermont by the Pacific Institute for Research and Evaluation (PIRE) as part of a statewide evaluation of a federally funded grant, called the Regional Prevention Partnerships (RPP). The target population for this online survey was Vermont residents aged 18 to 25. State estimates for key measures align closely with those obtained from NSDUH.

The 2018 YAS results reported the rate of prevalence of any binge drinking in the past 30-days for youth ages 18-20 was 44%, and 56% for young adults ages 21-25. While the rate of binge drinking 20 or more days in a 30-day period is at a low of 3%, the rates of those who binge drank 6-10 days in a 30-day period is 13% for people aged 18-20 and 16% for those aged 21-25. College students are more likely to binge drink in the past 30 days than young adults who do not attend college (61% vs 37%). However, the rates of binge drinking 20 or more days in the 30-days is at 1% for full-time college students and 6% for all other youth adults.

The Vermont Department of Health supports college age youth through community-based, environmental and individual prevention programs aimed at reduction of binge drinking, marijuana and substance use, early intervention and prevention through our work with the colleges across the state through the College Symposium. Participation from colleges across the state around common concerns and challenges many colleges are experiencing. Every other month, we are meeting with colleges across the state to talk about their substance use interventions and assessments to coordinate a better system of care and institute best practices for assessing substance use. In addition to our work with colleges, VDH also supports environmental and individual prevention strategies and programs through our Regional Prevention Partnerships (RPP) statewide grants, ADAP's Prevention Consultant program and statewide media campaigns.

Partners

What Works

A comprehensive approach using multiple evidence-based programs, practices, and policies such as those listed in the National Registry of Evidence-based Programs and Practices (NREPP) or recommended by The Community Guide. These include programs serving individuals, as well as community-wide strategies such as media advocacy and community education.

There is research that indicates policy changes, such as increased taxes on alcohol products, decreases use.

Strategy

Why Is This Important?

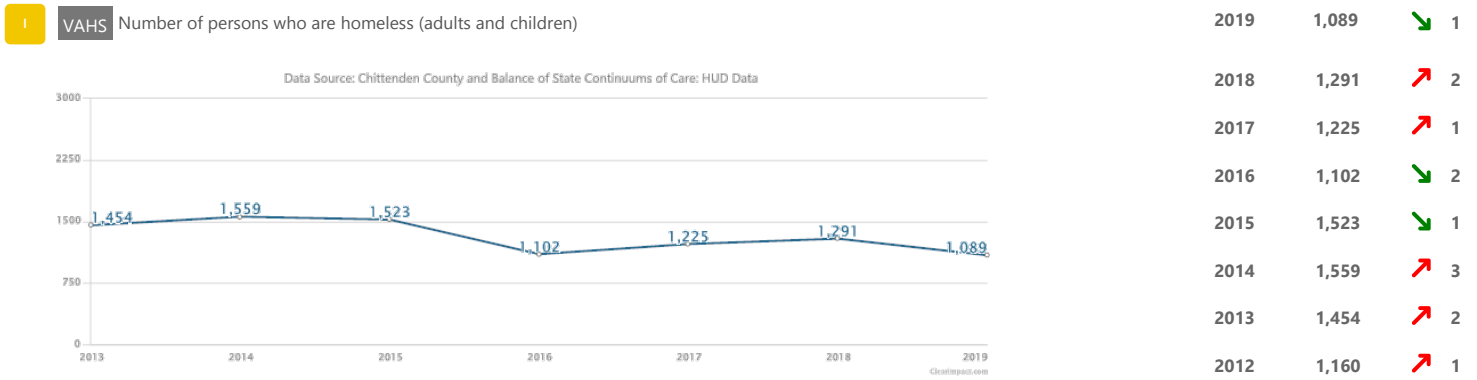
Notes on Methodology

Binge Drinking is defined differently for males and females:

- Males: 5 or more drinks on one occasion
- Females: 4 or more drinks on one occasion

This indicator is age-adjusted to the 2000 U.S. standard population. In U.S. data, age adjustment is used for comparison of regions with varying age breakdowns. In order to remain consistent with the methods of comparison at a national level, some statistics in Vermont were age adjusted. In cases where age adjustment was noted as being part of the statistical analysis, the estimates were adjusted based on the proportional age breakdowns of the U.S. population in 2000. For more detailed information on age adjustment visit www.cdc.gov/nchs/data/statnt/statnt20.pdf.

Due to BRFSS weighting methodology changes beginning in 2011, comparisons between data collected in 2011 and later and that from 2010 and earlier should be made with caution. Differences between data from 2011 forward and earlier years may be due to methodological changes, rather than changes in opinion or behavior.



Story Behind the Curve

Following multiple years of increases in the number of Vermonters reported homeless; data from the 2015 Point-In-Time count showed a small but welcome 2% decrease suggesting the trend may be plateauing. The statewide trend may mask regional differences. Chittenden County witnessed the most significant decrease in homelessness while most other Vermont counties saw modest increases. While no single measure of homelessness purports 100% accuracy, the Point-In-Time count uses standard definitions developed by HUD and constitutes Vermont's best proxy measure at this time. (Note that count methodology evolved in 2013 and it is likely that the true extent of homelessness in Vermont was higher than officially reported prior to that time.)

Homelessness remains a challenging problem in Vermont as families and individuals with extremely low incomes encounter a three-fold problem of an extremely tight rental market, increased competition for rental subsidies, and histories or behaviors that often warrant additional customized services for a housing placement to be successful.

According to a 2015–2020 Housing Needs Assessment, Vermont's statewide rental vacancy rate is hovering close to 1%. A Housing market is considered balanced and healthy when vacancy remains between 4% and 6%. **The extreme scarcity of available rental units drives up prices as it drives down opportunity for people in emergency shelter.** This leads to longer shelter stays which fills shelters to capacity and pushes people in crisis to motels or warming shelters.

Sequestration of federal funding in 2013 reduced Vermont's share of HUD Section 8 rental assistance by over \$6 million dollars. This represented the equivalent of critical rental subsidy assistance for over 900 Vermont households. The Agency of Human Services has used state funds to address some of this shortage through innovative programs such as the Vermont Rental Subsidy Program but cannot completely offset such a significant reduction in rental assistance for struggling Vermonters.

Partners

Homelessness in Vermont is a population-level problem. While the Agency of Human Services (AHS) and its Departments are working to reduce homelessness and increase housing stability in Vermont, AHS recognizes that housing stability is something many other specific partners are accountable for improving. Each of the partners below was identified as having a contributing role to play in improving this population-level indicator for the state of Vermont.

- All AHS Departments
- Community Action Agencies
- Designated Agencies
- Domestic Violence Shelters
- Emergency Shelter Network
- Governor's Council on Homelessness
- Governor's Housing Council
- Health Care Providers
- Housing First Organizations
- Local Faith Community
- Local Housing Authorities
- Local Land Trusts
- PATH Providers
- Private Landlords
- Supportive Housing Providers
- Transitional Housing Providers
- U.S. Department of Agriculture – Rural Development
- U.S. Department of Homeland Security – FEMA – Emergency Food & Shelter Program
- U.S. Department of Housing and Urban Development
- U.S. Interagency Council on Homelessness
- U.S. SAMHSA
- U.S. Veteran's Administration
- Vermont Affordable Housing Coalition
- Vermont Agency of Education – McKinney-Vento Coordinators
- Vermont Center for Independent Living
- Vermont's Continuum of Care
- Vermont Department of Housing and Community Development
- Vermont Community Development Board
- Vermont Housing and Conservation Board
- Vermont Housing Finance Agency
- Vermont State Housing Authority
- VT Coalition of Runaway and Homeless Youth Programs
- Warming Shelters and Drop-In Centers

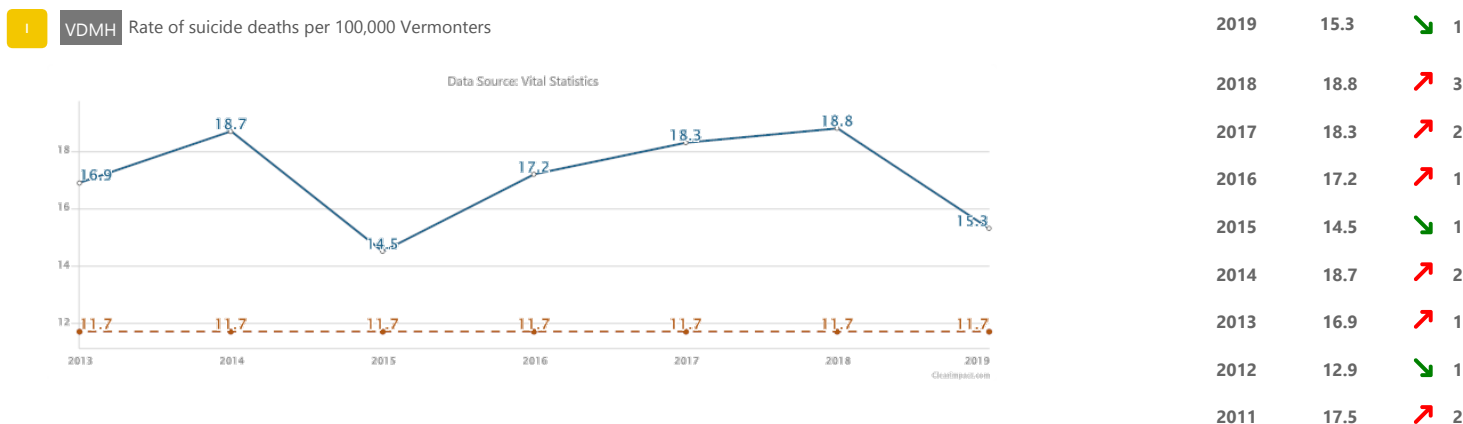
- And most importantly, Vermonters experiencing homelessness and the neighbors, friends, families and communities who help them find a place to call home.

What Works

Lowering the rate of homelessness in Vermont will require the sustained work of our many partners, an honest assessment of the complex challenges faced by low and extremely low income Vermonters, and the collective will to address these challenges in a coordinated way. Quality jobs, transportation, education and health are all key factors for housing stability, and, as such, many programs in AHS and beyond are contributing to this effort.

A few components of a successful strategy to end homelessness in Vermont include:

- **Significant development of more rental housing** which is affordable and accessible to Vermont households earning less than 30% of area median income. Once built, this housing must be available to the homeless. A culture change may be required to move us from a position of “who is eligible for housing?” to “what blend of supportive services or subsidy assistance will each family need to be a responsible tenant and good neighbor?”
- **A more intentional approach to targeting and braiding of rental assistance** (federal and state) with the supportive services or case management people who have experienced homelessness may need to be successful.
- **Strengthening of local Continuum of Care groups and Housing Review Teams** through systems approaches such as coordinated intake, common assessment tools, and rapid referrals to the most appropriate housing, program or assistance to reduce the amount of time a family is homeless.
- **Implementing best practices** in emerging areas such as Rapid Rehousing.



Story Behind the Curve

We want the trend of suicide deaths in Vermont to go down.

This is a Vermont Department of Health Healthy Vermonters 2020 objective and county level data is available.

Author: Vermont Department of Mental Health

Suicide is a major public health challenge, but it is often preventable. In 2016, Suicide was the 8th leading cause of death for all Vermonters.¹ Over the past two decades, trends in death by suicide have increased in Vermont and the United States. Since 2000, this rate in death by suicide has increased by 49%, which is the second largest percent increase in the United State (13.2 per 100,000 persons 1999-2001 to 19.7 per 100,000 persons 2014-2016).²

In recent years, more than 100 Vermonters have died by suicide each year. Vermont's rates of suicide, calculated as the number of deaths by suicide per 100,000 people, are higher than the national averages.¹ Deaths by suicide in Vermont appear to follow national patterns in terms of age and gender breakdowns. More men die by suicide than women. Firearms are the method used for nearly two-thirds of the deaths by suicide.¹

Only about a third of people who took their own life had a reported history of mental health treatment.³ Suicide is not just a mental health problem, it is community problem. Suicide touches every socioeconomic status, race, identity, and community... and everyone can help.

The Vermont Departments of Health and Mental Health are collaborating with community partners to reduce these rates. One Agency cannot turn the curve alone; there are many partners who have a role to play making a difference.

Sources

1 Vermont Vital Statistics. For more data on suicide mortality and self-harm morbidity, please visit our [website](#).

2 Vital Signs: Trends in Suicide Rates and Circumstances Contributing to Suicide — United States, 1999–2016 and 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67(22):617-624.

<http://www.healthvermont.gov/health-statistics-vital-records/surveillance-reporting-topic/injuries>

Suicide is a major public health challenge, but it is often preventable. If you or someone you know needs help call the National Suicide Prevention Lifeline is 1-800-273 TALK -- A crisis intervention and suicide prevention phone service available 24/7 at 1-866-488-7386

The Agency of Human Services is currently using the scorecard to assess our agency contribution to reducing the rate of suicide in Vermont, and to keep track of key data elements to guide our efforts. One Agency cannot turn the curve alone; there are many partners who have a role to play making a difference.

Updated in July 2019

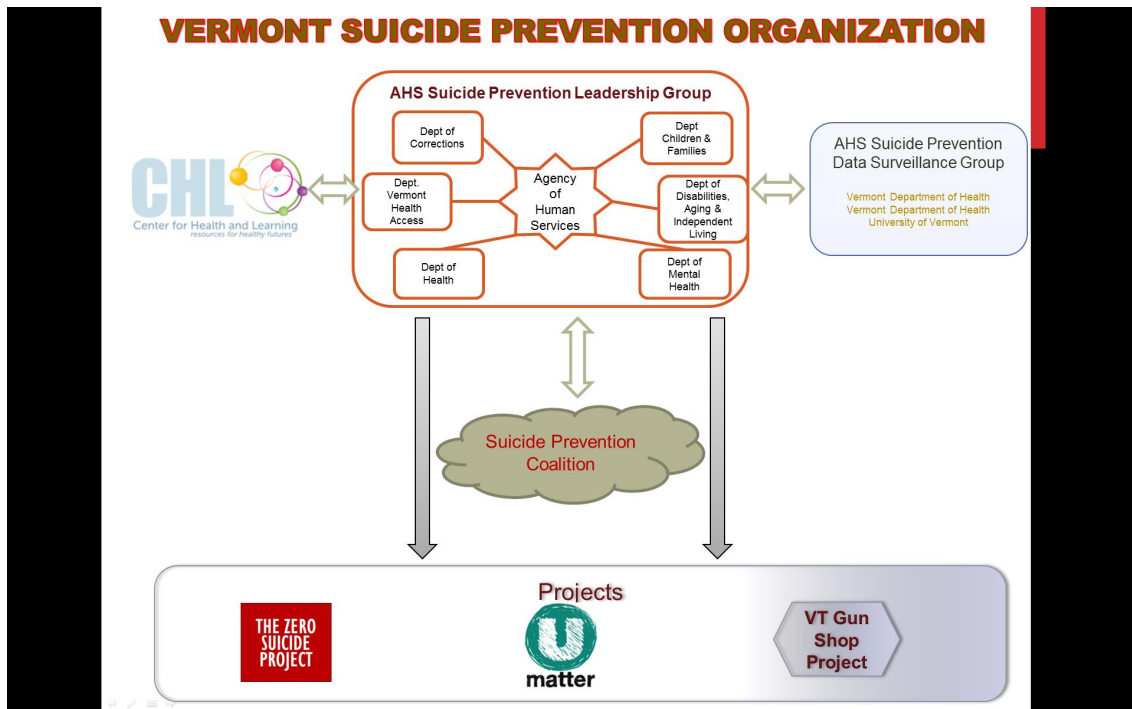
Partners

Suicide in Vermont is a population health problem. More importantly, with a comprehensive approach, it's a preventable problem.

The Agency of Human Services (AHS) and its Departments are working to reduce the rate of suicide in Vermont. AHS recognizes that preventing suicide is a community wide effort along with strong collaboration with healthcare providers. As such, Agency Of Human Services has created a AHS Suicide Prevention Leadership Group with representation from AHS central office as well as the Departments of Mental Health (DMH), Health (VDH), Disabilities Aging and Independent Living (DAIL), Children and Families (DCF), Corrections (DOC) and Vermont Health Access (DVHA). In addition there is a public-private-academic partnership at the Suicide Prevention Surveillance Workgroup headed by the Vermont Department of Health with participation from DMH, University of Vermont (UVM) and Vermont Suicide Prevention Center.

Vermont's suicide prevention plan aligns closely with the World Health Organization's (WHO) suggested strategy. The plan categorizes actions into three broad categories; Universal Prevention, Selective Prevention and Indicated Strategies essentially signifying primary, secondary and tertiary prevention strategies. These are broad and take a population health approach to this problem.

The Leadership Group in alliance with the Vermont Suicide Prevention Center (VtSPC) has created a broader group entitled the Vermont Suicide Prevention Coalition where there is representation from provider groups (inpatient and outpatient) suicide attempt survivors, family members, Agency of Human Services, Agency of Education, schools and higher educational institutions, Veterans Affairs, legislators as well as the Centers for Health and Learning. The coalition guides and informs the statewide prevention efforts.



Strategy

The Vermont Department of Mental Health (DMH) will work in partnership with the Agency of Human Services Leadership Group as well as the Center for Health and Learning (CHL) will promote interventions in all three categories i.e. Universal, Selective and Indicated.

Universal Strategies

1. Increase access to healthcare
2. Promote positive mental health
3. U Matter campaign plans to accomplish the following:
 - a. Promote the message that suicide is preventable
 - b. Equip gatekeepers with the knowledge and skills to respond effectively to those in distress
 - c. Increase public awareness of the importance of addressing mental health issues
 - d. Establish a broad-based suicide prevention and intervention strategy throughout Vermont
 - e. Sponsor a media campaign to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
 - f. Promote positive youth development
 - g. Put into place long-term, sustainable approaches to prevention and early intervention
4. Vermont Gun Shop Project:

Since nearly two-thirds of all deaths by suicide in Vermont use firearms as the means, Department of Mental Health has partnered with the Center for Health & Learning, Vermont Sportsmen's club, GunSense Vermont along with Suicide prevention coalition to increase the knowledge and awareness of gun shop owners in Vermont about the use of guns for suicide. In addition resources and helpline information will be made available to gun shops to post in their shops to give those who may go to a gun shop the information they need to get timely help

Selective Prevention

1. Targeted services for people at higher risk: This will include gatekeeper training as well as Mental Health First Aid training for those in key positions to identify people at higher risk. These gate keepers will be trained in screening for depression as well as trained in screening for suicidality.
2. Helplines:
 - a. DA crisis services
 - b. 211 - National Suicide Prevention hotline
 - c. Peer run warm line
 - d. Domestic violence hotline
 - e. Sexual violence hotline

Indicated Strategies:

Vermont has adopted the Nation Action Alliance for Suicide Prevention's platform called Zero Suicide. Zero Suicide project is a collection of intervention designed to improve care for those identified with needing help with suicidal thoughts and other related problems. The alliance defines Zero Suicide as "a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice."

The four areas of intervention under this project are as follows:

1. **Screening:** Embed widespread screening of depression and suicidality in healthcare settings including primary care practices. The Blueprint for Health Medical Home practices to enhance their screening regarding suicidality by using Patient Health Questionnaire (PHQ) questions about depression and suicidal thoughts in Primary care settings.

2. **Assessment:** For those patients who screen positive to then do an enhanced screening/severity assessments regarding severity of suicidality e.g. Columbia Suicide Severity Rating Scale (CSSRS). Support Blueprint's community health teams to help patients access appropriate treatment with the local DAs for individuals who screen as needing an intervention
3. **Suicide focused/ competent treatment:** Support Designated Agency (DA) pilot sites to access training in modalities specifically about care for the suicidal person:
 - a. Counselling about Access to Lethal Means (CALM)
 - b. Assist DA pilot sites to train clinicians in using Collaborative Assessment and Management of Suicide (CAMS) which includes an online initial training followed by a learning collaborative style continuous education on CAMS. Build capacity for ongoing training in Vermont by developing a Train the Trainer model
 - c. Reinforce use of Cognitive Behavioral Therapy and Dialectical Behavioral Therapy as the best treatment practices for problems commonly associated with suicidality such as depressive disorders, anxiety disorders and personality disorders. The CAMS methodology is complimentary to these treatments methods.
 - d. Roll training out to providers outside of the DAs: Community Health Teams, therapists embedded in Medical Homes, etc.
4. **Follow-up:** Partner with the inpatient psychiatric units as well as emergency rooms at hospitals to develop and send caring letters after a person who had suicidal thoughts is discharged from their facility. Designated Agency Crisis Centers to develop and send caring letters after a person who had suicidal thoughts is discharged from the hospital.

Similar to statewide efforts, local partners are using data to drive local strategy. For regional data on mental health indicators, check out our Public Health Data Explorer.

Why Is This Important?

This indicator is part of Healthy Vermonters 2020 (the State Health Assessment) that documents the health status of Vermonters at the start of the decade and the population health indicators and goals that will guide the work of public health through 2020. Click here for more information.

This indicator is also part of the State Health Improvement Plan (SHIP), a five-year plan that prioritizes broad Healthy Vermonters 2020 goals: reducing prevalence of chronic disease, reducing prevalence of substance abuse and mental illness, and improving childhood immunizations. The SHIP is a subset of HV2020 and details strategies and planned interventions. Click here for more information.

Act 186 was passed by the Vermont Legislature in 2014 to quantify how well State government is working to achieve the population-level outcomes the Legislature sets for Vermont's quality of life. It will assist the Legislature in determining how best to invest taxpayer dollars. The Vermont Department of Health and the Agency of Human Services report this information annually. Click here for more information.

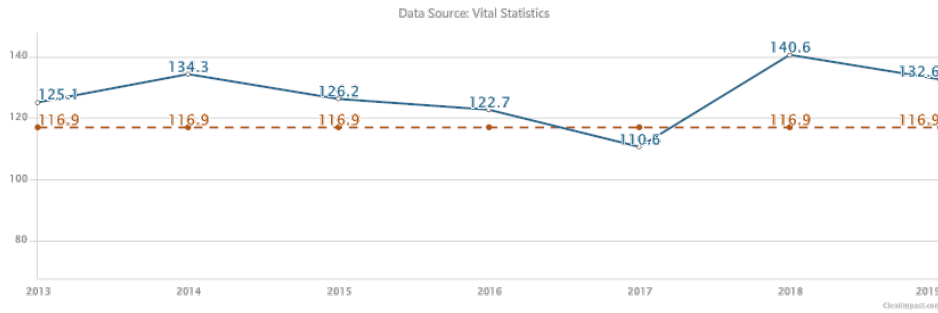
The Agency of Human Services (AHS) operates in support of the Governor's overall agenda for the state and his seven statewide priorities. Additionally, AHS' mission and the work of its six Departments are targeted to achieve results in four strategic areas: the reduction of the lasting impacts of poverty; promotion of the health, well being and safety of communities; enhancement of program effectiveness and accountability; reform of the health system. Click here for more information.

Notes on Methodology

Suicide is determined using the International Classification of Disease version 10 (ICD-10) codes for underlying cause of death (X60-X84,Y87.0, U03). Suicide rates are age-adjusted to the 2000 U.S. standard population. Age adjustment helps take into account the different age structures of populations that die by suicide, so Vermont's rates can be compared to the U.S. and other jurisdictions. For more detailed information on age adjustment visit <http://www.cdc.gov/nchs/data/statnt/statnt20.pdf>.

This indicator is updated with final data from Vermont Vital Statistics.

2019	132.6	↓	1
2018	140.6	↑	1
2017	110.6	↓	3
2016	122.7	↓	2
2015	126.2	↓	1
2014	134.3	↑	1
2013	125.1	↓	1
2012	126.2	↑	1
2011	96.1	↓	1



Story Behind the Curve

Last Updated: September 2020

Author: Injury Prevention Program Team, Vermont Department of Health

- Over the time period between 2002 and 2019, the number and rate of fall-related deaths have increased. The 2019 Vermont death rate of 132.6 per 100,000 adults age 65 and older is significantly higher than that in 2002, as well as higher than the national rate of 63.3.

Partners

- Vermont Department of Health
- Vermont Department of Disabilities, Aging and Independent Living (DAIL)
- Department of Vermont Health Access including the Blueprint for Health and the Support and Services at Home (SASH)
- Vermont Falls Free Coalition
- Area Agencies on Aging (AAA)
- Home Health Agencies
- Hospitals

What Works

Risk of falls increases with age but falls should not be considered an inevitable part of the aging process. Because there are many reasons an individual might fall, and these can act synergistically, falls prevention must be multifactorial and comprehensive.

Traditionally, the evidence base supports programming that includes early assessment, exercise, medication management, and safety within environmental design. Often those individuals at risk of falling (in this instance, defined as those Vermonters age 65 and older) experience: a fear of falling, limiting mobility which affects strength and stability, and medication which may cause drowsiness or impair balance. There has been a wealth of research on elderly falls prevention interventions that has been incorporated into a variety of evidenced based programming and strategies. We are working to more fully incorporate these strategies into Vermont's community services and statewide systems.

Studies show that a combination of behavior changes can significantly reduce falls among older adults. Experts recommend:

- Participating in a physical activity regimen with balance, strength training, and flexibility components
- Consulting with a health professional about getting a fall risk assessment
- Having medications reviewed periodically
- Getting eyes and ears checked annually
- Making sure the home environment is safe and supportive

Strategy

- The Vermont Department of Health received grant funding to run a state falls prevention program from 2014-2017. The falls prevention program goals are to reduce falls related injury and deaths in older adults in Vermont.
- Strategy
 - Coordinate with Falls Free Coalition and local Area Agencies on Aging (AAA) on a statewide Falls Prevention Awareness Day media messaging.
 - Coordinate with Falls Free Coalition to enhance activities statewide to increase fall prevention programs in communities.
 - Assess number and type of falls prevention programs currently being offered throughout the state through a comprehensive program-directed survey.
 - Assess the numbers/types of stakeholders engaged in efforts to reduce falls among adults over age 60.
 - Create a statewide, searchable database accessible to older adults, community organizations and providers to offer information on falls prevention programming and assessment.
 - Work with hospital service areas (HSAs) to establish systems for screening of falls risk and referral to appropriate services
- Similar to statewide efforts, local partners are using data to drive local strategy. For regional data on injury indicators, check out our Public Health Data Explorer.

What We Do

The Vermont Department of Health (VDH) Falls Prevention Program helps older adults to improve their health, receive education and training, and find resources to prevent falls-related injuries and death. This program is housed within the Division of Emergency Preparedness, Response, and Injury Prevention. Through partnerships with community organizations, such as Area Agencies on Aging (AAAs), Emergency Medical Service (EMS) agencies, and community hospitals and health care providers, VDH coordinates referrals for and trainings on evidenced-based falls prevention programs. VDH continues to build a multifactorial infrastructure focusing on screening and assessment, exercise and strength building, medication management and reconciliation, and home safety. Additionally, VDH is involved in Vermont's state falls prevention coalition, Falls Free Vermont, which is a collaboration of key stakeholders and health care professionals committed to reducing preventable falls through building capacities related to networking, referral systems, and resources.

Who We Serve

Falls prevention programs are available to Vermont older adults who:

- Are at risk for falling.
- Have had previous falls.
- Worry about falling.

Additionally, VDH serves community partners engaged in falls prevention work through offering resources, data, trainings, and facilitated discussions to staff.

How We Impact

Falls Prevention Screening and Assessment

Falls are preventable and not a normal part of aging. In the U.S., 1 in 4 older adults reported experiencing a fall and an older adult falls every second of every day throughout the country. While the risk of falls increases with age, less than half of older adults talk to their doctor about their fall. In Vermont, 1 in 3 adults ages 65 and older reported having a fall in the past year and falls are the leading cause of accidental deaths in the state.

VDH promotes the use of the Centers for Disease Control and Prevention’s (CDC) *Stopping Elderly Accidents, Deaths, and Injuries (STEADI)* toolkit, which was created to help patients and health care providers with simple, evidenced-based tools through effective education materials, screening and assessment tools, and interventions that prevent falls-related injuries and deaths. Through collaborative partnerships and coordinated activities, VDH is working to build a sustainable statewide falls prevention program that promotes healthy aging and mitigates costly injuries for both older Vermonters and health care systems.

Indications of Progress through Data Collection

VDH uses various databases and data sources to track progress of the state’s falls prevention program. Through review and analysis of data on falls-related injuries and deaths, as well as the number of individuals screened, assessed, and referred to falls prevention programs, VDH continually evaluates this program to ensure there is improvement in health outcomes. The falls prevention program consistently seeks feedback from community members, health care providers, and partnering organizations to continue building a robust statewide falls prevention program.

Why Is This Important?

This indicator is part of Healthy Vermonters 2020 (the State Health Assessment) that documents the health status of Vermonters at the start of the decade and the population health indicators and goals that will guide the work of public health through 2020. Click here for more information.

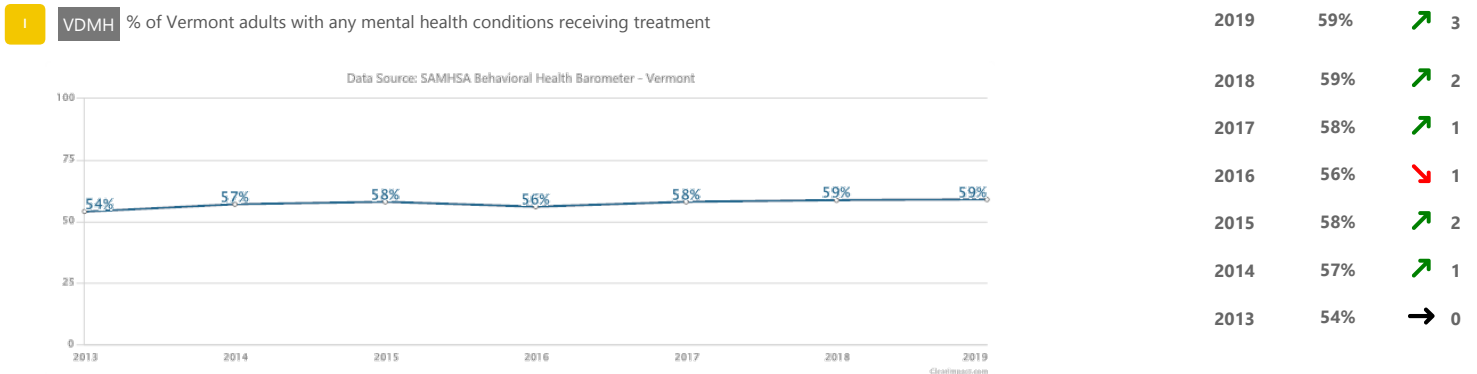
Falls are the leading cause of injury among older adults. In fact, 1 in every 3 adults ages 65 and older fall each year. Some falls are minor, but others can result in serious injury, such as a broken hip or a head injury, as well as a loss of independence and mobility.

The population of Vermonters age 60 and older numbers 101,827 or about 1 in 6 Vermonters (Vermont Population Data). As the baby boomer generation ages, interest grows in living independently and staying active longer. An injury resulting from a fall, such as hip fracture or traumatic brain injury (TBI) can permanently disable or kill an otherwise healthy individual. Furthermore, the average cost of a hip fracture is \$35,000 dollars for the hospital stay alone (Centers for Disease Control and Prevention). The use of EMS personnel to deliver interventions presents a novel opportunity to target individuals at risk who may not otherwise interact with the healthcare system, especially as many older adults are reluctant to discuss falls with providers or family.

Notes on Methodology

Data is updated as it becomes available and timing may vary by data source. For more information about this indicator, click here.

This indicator is age-adjusted to the 2000 U.S. standard population. In U.S. data, age adjustment is used for comparison of regions with varying age breakdowns. In order to remain consistent with the methods of comparison at a national level, some statistics in Vermont were age adjusted. In cases where age adjustment was noted as being part of the statistical analysis, the estimates were adjusted based on the proportional age breakdowns of the U.S. population in 2000. For more detailed information on age adjustment visit /www.cdc.gov/nchs/data/statnt/statnt20.pdf.



Story Behind the Curve

We want the percent of adults receiving treatment when it's needed to go up.

The percentage of Vermont adults with any mental health condition is generally higher than the percentage of adults in the United States and higher than the percentage of adults in the Northeast. However, more Vermont adults are getting treatment than the national average (58% vs 43% in 2015). Other data sources--such as data reported to SAMHSA's Uniform Reporting System (URS)--show that Vermont's use of community mental health services is much higher than national averages (39 per 1,000 people vs 23 per 1,000 people in 2015).

The Agency of Human Services is currently using the scorecard to assess our agency contribution to increasing the rate of treatment in Vermont, and to keep track of key data elements to guide our efforts. One Agency cannot turn the curve alone; there are many partners who have a role to play making a difference.

Vermont's percentage of mental health treatment among adults with AMI was higher than the national percentage in both the 2013 and 2014 barometer reports.

Updated January 2017.

Partners

There are many partners in Vermont who contribute to this effort. Designated Agencies, Specialized Services Agencies, private mental health providers, primary care providers all provide services to Vermont adults with any mental health condition. Families, friends, and communities who support and empathize with those with mental health conditions reduce stigma, which is a barrier to treatment. Peer support work through wellness cooperatives and advocacy groups help those in need of treatment navigate a system with support.

Strategy

Similar to statewide efforts, local partners are using data to drive local strategy. For regional data on mental health indicators, check out our Public Health Data Explorer.

Notes on Methodology

Percentages are from the SAMHSA Behavioral Health Barometer report for Vermont, available online at for each state at http://www.samhsa.gov/data/us_map.

Any mental illness (AMI) among adults aged 18 or older is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having any mental illness.

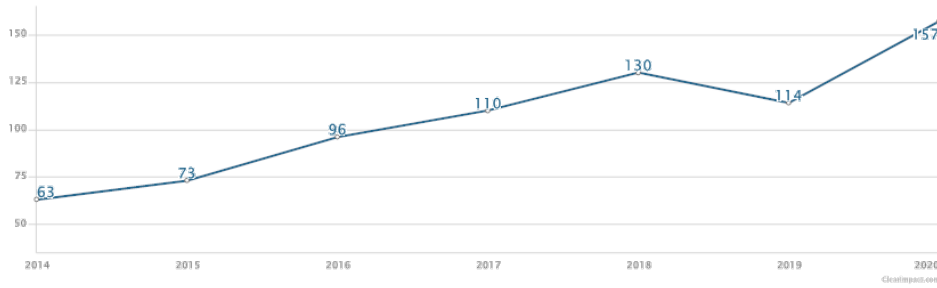
Percent getting treatment is defined as adults who received mental health treatment or counseling within the year prior to being surveyed

Data are based on five years of NSDUH survey data. For example, data point 2014 represents data from NSDUH surveys for 2009-2013. NSDUH first included questions regarding any mental illness in 2008.

Updated January 2016.

2020	157	↗	1
2019	114	↘	1
2018	130	↗	4
2017	110	↗	3
2016	96	↗	2
2015	73	↗	1
2014	63	↘	1
2013	69	↗	1
2012	50	↘	1

Data Source: Office of the Chief Medical Examiner



Story Behind the Curve

August 2021

Please note data for the most recent two years are considered preliminary and are subject to change.

In Vermont, like other states, the use of heroin and misuse of other opioids (e.g. prescription narcotics) is a major public health challenge. Such disorders increase pressure on our health care, child protection, and criminal justice systems, and has far-reaching effects on families and communities. Vermont is taking a multi-faceted approach to addressing opioid addiction that involves multiple community partners. The Health Department has a leading role in the State’s comprehensive strategy. The interventions for which the Health Department has responsibility, with public information, social marketing and messaging; pain management and prescribing practices; prevention and community mobilization; drug disposal; early intervention; overdose prevention and harm reduction; expanded access to treatment and recovery services; and recent legislation enacted. Additional information is available at <http://www.healthvermont.gov/response/alcohol-drugs>.

For more information, please search “Fatalities” in the [Data and Reports](#) section of the Health Department’s website. In particular, the data briefs include information at the county level. Please note that in 2017, both the current and history were updated. Monthly information by county is also available in the data and reports section – search on “preliminary” to find the most recent information.

As indicated in the data brief, fatalities increasingly involve illicit fentanyl. Fentanyl is 50 to 100 times stronger than heroin.

NOTE: Vermont, as with the rest of the United States, saw a large increase in overdose fatalities that coincided with the COVID-19 pandemic. COVID-19 first began to be diagnosed in Vermont in March 2020. Some of Vermont's actions taken in response to overdose deaths are outlined in a document Opioid Overdose Response Initiatives An overview of opioid overdose response strategies on our website.

Partners

What Works

Strategy

Why Is This Important?

Notes on Methodology

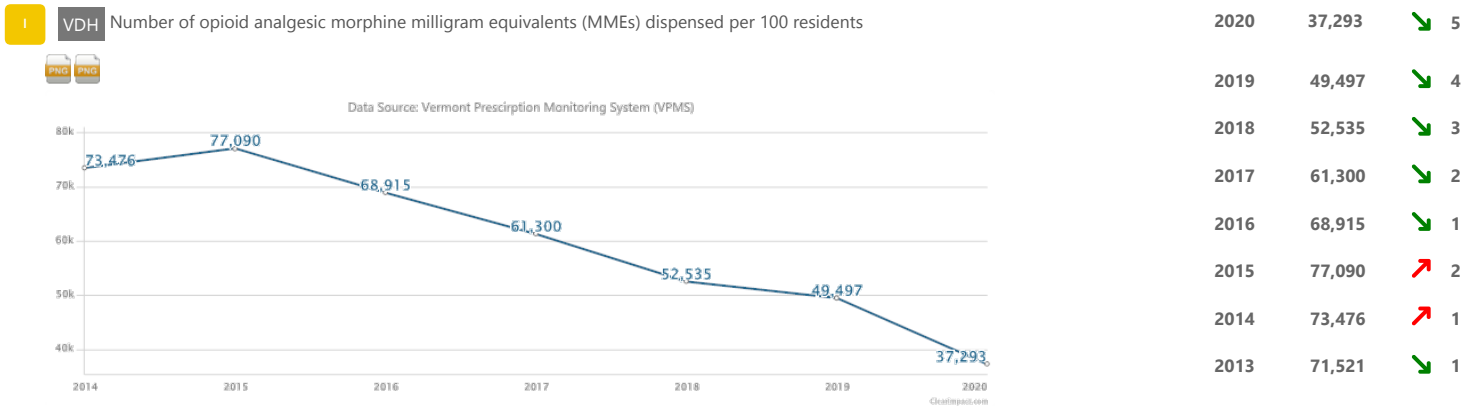
Vermont drug-related fatalities data come from the Vermont Department of Health Vital Statistics System and are based on deaths of Vermonters.

The drug-related fatalities reported here include accidents, suicides, homicides and fatalities with undetermined intent. All deaths involved at least one legal or illicit opioid including: heroin or prescription drugs.

This report does *not* include deaths due to chronic substance use (such as HIV, liver disease, or infection); death due to injury related to substance use (i.e., car accident or falls) or deaths due to medical professional error.

It is important to note that most drug-related fatalities are due to combinations of substances (e.g., a prescription opioid and cocaine), not a single drug. Additionally, the circumstances under which each of these fatalities occurred are unique, and cannot all be attributed to addiction and/or dependence.

Beginning in 2017, the Drug- and Opioid- Related Fatality Briefs present data differently than in the past to be consistent with the methods used by the Center for Disease Control. The revised report has data on the total numbers of Vermont residents who died, regardless of where that death occurs (i.e. in Vermont or in another state). Previously, the Brief reported on the total number of deaths that occurred in Vermont, regardless of the decedent's state of residence. For a more comprehensive explanation of the changes, see the methodology notes at the end of the Brief. All historic information has also been updated to be consistent with the 2017 data.



Story Behind the Curve

August 2021

Many Americans suffer from chronic pain and deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, there is limited information about the benefits of opioids long term, and there are serious risks of opioid use disorder and overdose.

Prescription opioids provide a point of initiation of future opioid abuse or dependence. Pooling data from 2002 to 2012, the incidence of heroin initiation was 19 times higher among those who reported prior nonmedical pain reliever use than among those who did not (0.39 vs. 0.02 percent) (Muhuri et al., 2013). A study of young, urban injection drug users interviewed in 2008 and 2009 found that 86 percent had used opioid pain relievers nonmedically prior to using heroin, and their initiation into nonmedical use was characterized by three main sources of opioids: family, friends, or personal prescriptions (Lankenau et al., 2012). This rate represents a shift from historical trends. Of people entering treatment for heroin addiction who began abusing opioids in the 1960s, more than 80 percent started with heroin. Of those who began abusing opioids in the 2000s, 75 percent reported that their first opioid was a prescription drug (Cicero et al., 2014). Examining national-level general population heroin data (including those in and not in treatment), nearly 80 percent of heroin users reported using prescription opioids prior to heroin (Jones, 2013; Muhuri et al., 2013).

Vermont encourages prescribers to only prescribe opioids when essential, and instead use other means for controlling pain.

A single opioid prescription can be prescribed with a different number of doses, in differing strengths, or in different formulations. This can make comparisons across prescriptions challenging. Morphine milligram equivalents (MMEs) are a way to standardize and compare prescriptions across these variations. Many research experts, federal agencies (e.g., CDC, BJA, SAMHSA) and VPMS use MMEs in order to better understand the abuse and overdose potential of opioid analgesics.

Total MME is a good indication of the total amount of opioids dispensed in the state. Reducing the amount of opioids dispensed is an important part of the statewide strategy to reduce opioid overdose and dependence. Total MME is reported as a rate per 100 people in Vermont to allow comparisons between counties of different sizes.

Note: The 2014-2015 increase in MME is attributable in part to the August 14, 2014 rescheduling of tramadol from a Schedule V to a Schedule IV drug. VPMS only collects data on Schedule II-IV controlled substances; therefore prior to rescheduling, tramadol was not reported to VPMS and is not included in the calculations. The total MME of dispensed opioids has consistently decreased after 2015.

The 2020 decrease is partially due to the use of the 2020 VT census data which showed a reported a higher estimate than the Vermont population estimates that were previously used. Also, the COVID-19 pandemic, starting in March 2020, has disrupted the provision of healthcare in Vermont which can impact this number.

Partners

- Patients
 - Prescribers
 - Pharmacists
 - Treatment Providers
 - Insurers
 - Community coalitions
 - Harm reduction agencies
 - Center for Disease Control
 - Substance Abuse and Mental Health Administration
-

What Works

Vermont is taking a multi-faceted approach to addressing opioid addiction that involves multiple community partners. The Health Department has a leading role in the State's comprehensive strategy which is outlined here:

https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Strategic_Plan.pdf

Notes on Methodology

Data are from the Vermont's prescription drug monitoring program, known as the Vermont Prescription Monitoring System (VPMS). VPMS is a statewide electronic database of Schedule II – IV controlled substance prescriptions dispensed from Vermont-licensed pharmacies. It does not include all prescriptions.

VPMS is a clinical tool that exists to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse, and diversion of controlled substances.

- Individuals can, and do, fill prescriptions at pharmacies that are not Vermont-licensed. For example, some residents fill prescriptions in New Hampshire. These prescriptions are not included in the VPMS data.
- VPMS does not currently collect data on controlled substances dispensed from emergency rooms, veterinarian offices or opioid treatment programs (OTPs) that dispense methadone and buprenorphine for opioid addiction, such as those treated in a "hub". It DOES contain data from office-based opioid treatment at a physician's office, such as those treated in a "spoke".
- Data submitted to VPMS by pharmacies can contain errors. Each data upload from a pharmacy is screened for errors and sent back to the pharmacy to be corrected if errors are discovered. However, not all errors are found or corrected.
- Finally, the VPMS data is for prescriptions dispensed. The VPMS does not contain information regarding when, or if, a prescription was picked up or how a prescribed medication is used.

Routine reporting on the VPMS is available on the website: <https://www.healthvermont.gov/alcohol-drugs/reports/data-and-reports>

References

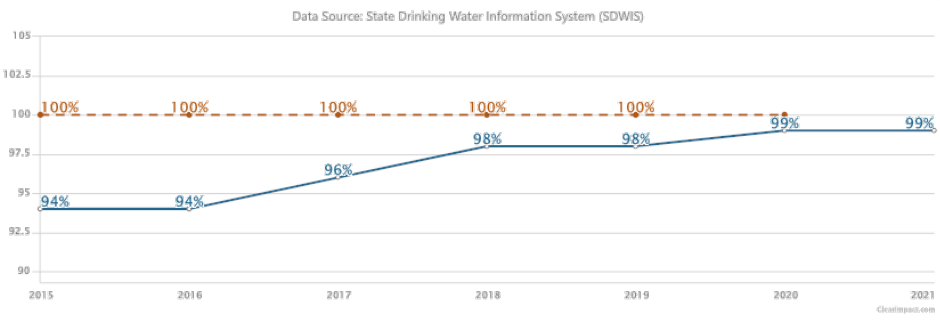
Information included on this page drew from research and the established literature. For more information, please see:

CDC Fact Sheet: https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf

National Institute on Drug Abuse: <https://www.drugabuse.gov/publications/finder/t/142/Opioids>

I DEC % of public drinking water supplies in compliance with health-based standards

2021	99%	→ 1
2020	99%	↗ 1
2019	98%	→ 1
2018	98%	↗ 2
2017	96%	↗ 1
2016	94%	→ 1
2015	94%	→ 0



Story Behind the Curve

Compliance rates have consistently increased in the last several years as more water systems have come into compliance with standards.

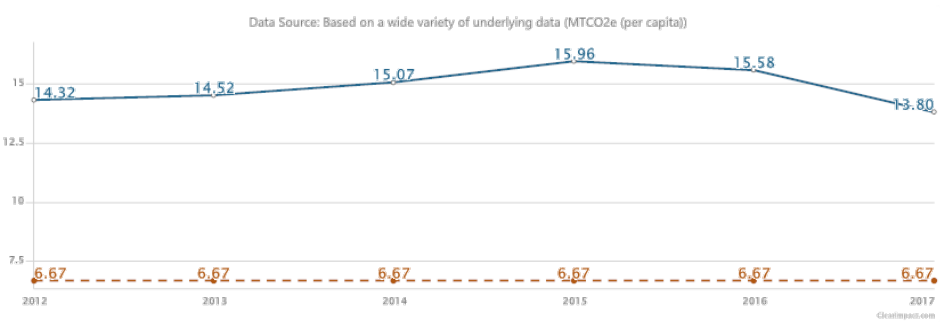
Partners

What Works

Strategy

I DEC Total greenhouse gas emissions per capita, in units of annual metric tons of equivalent carbon dioxide per capita

2017	13.80	↘ 2
2016	15.58	↘ 1
2015	15.96	↗ 3
2014	15.07	↗ 2
2013	14.52	↗ 1
2012	14.32	→ 0



Story Behind the Curve

The Global Warming Solutions Act established mandatory greenhouse gas levels as opposed to aspirational targets for 2025, 2030, and 2050. The 2025 requirement is based on the Paris goals and is 26% below 2005 levels. The 2030 and 2050 goals are 40% and 80% below the 1990 baseline respectively. Population values for per capita greenhouse gas emissions estimates are an average value from two economic growth scenarios in a study from ACCD for 2010. The "Current" year metric is from the latest VT GHG Emissions Update issued May 2021. The data are for calendar year 2017, and are the most current complete data that has been published. Per capita emissions have been trending down from 2015 - 2017 mainly due to emissions reductions seen in the electricity sector. Year to year variability is common due to the multitude of factors that influence the calculations. Units MTCO2e is thousand tons of carbon dioxide equivalents; MMTCO2e == Million tons of CO2e.

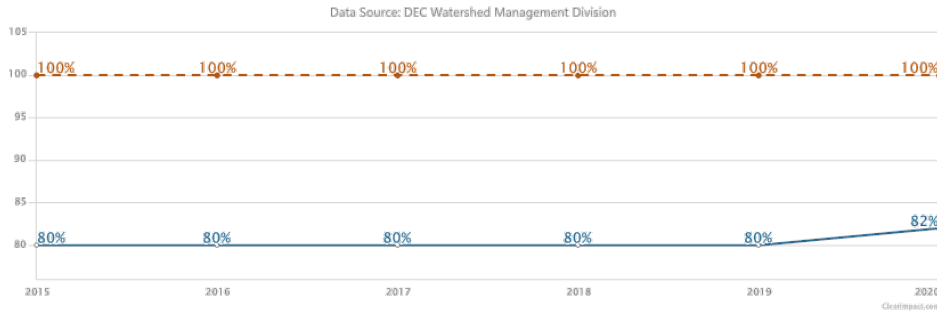
Partners

What Works

Strategy

DEC % of Vermont's rivers and lakes (excluding Lake Champlain) that meet State water quality standards for fishing

2020	82%	↗ 1
2019	80%	→ 4
2018	80%	→ 3
2017	80%	→ 2
2016	80%	→ 1
2015	80%	→ 0



Story Behind the Curve

Story Behind the Curve

This data is compiled and analyzed every two-years/bi-annually. The percentage of rivers and streams fully supporting aquatic life has increased slightly (2%) from the last reporting period. In 82% of Vermont's rivers and streams, the aquatic organisms are considered healthy and support fishing uses. The remaining 18% are either impaired (due to pollution or altered flow/hydro dams that don't currently meet water quality standards) or the health of the aquatic biota is unknown. Over time, updated assessment data shows areas where we have been successful in river and stream restoration as well as areas where we have identified new impairments or alterations, making overall progress slow. Implementation of regulatory and voluntary measures is expected to help improve the water quality of our rivers and streams and their uses for fishing; however, it is expected to take many years to show substantial progress. The source of CY2020 data is the 2020 assessment conducted and submitted to EPA in early 2020. The net improvements of full support waters during this assessment period were due to the removal of impairments such as a large stretch of Ball Mountain Brook, and shorter reaches of Tributary #23 to Stevens Branch, North Branch of the Deerfield River. The net increase is also due to improved flow conditions in Seaver Brook, Lower Flint Brook, Mollys Falls Brook, Sucker Brook, and Mendon Brook.

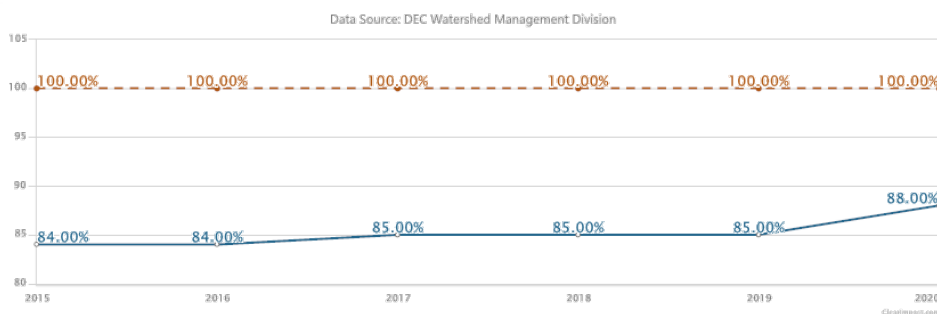
Partners

What Works

Strategy

DEC % of Vermont's rivers and lakes (excluding Lake Champlain) that meet State water quality standards for swimming

2020	88.00%	↗ 1
2019	85.00%	→ 2
2018	85.00%	→ 1
2017	85.00%	↗ 1
2016	84.00%	→ 1
2015	84.00%	→ 0



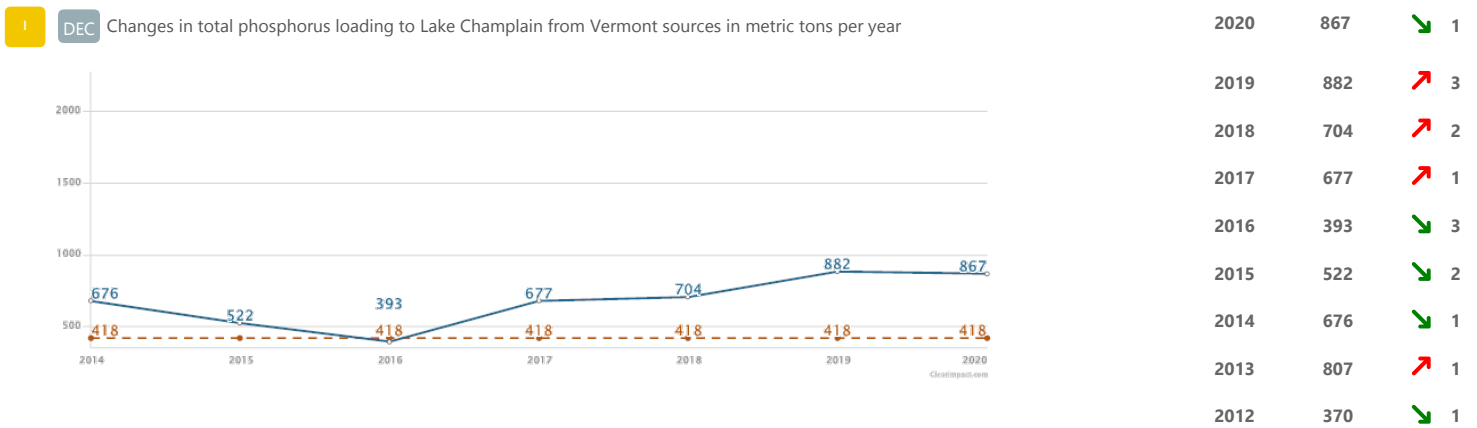
Story Behind the Curve

This data is compiled and analyzed every two-years/bi-annually; annual fluctuations are expected due to updated assessment data reflecting the current conditions on our waters. There are over 55,000 acres of lakes in the state of Vermont; of these acres 88% support swimming/recreational uses (78% consistently, and 10% where they are occasionally limited due to conditions that make swimming less desirable at times). The remaining 12% are consistently limited due to aquatic invasive species, and/or cyanobacteria (blue-green algae) blooms. A slight improvement (3%) was reported in the overall condition of the health of Vermont lakes during this most recent reporting period. The net increase in the full support waters was due to improvements in Ticklenaked Pond water quality and flow restorations in Ball Mountain Reservoir, Mollys Falls Pond, Peacham Pond, and Molly Falls Reservoir.

Partners

What Works

Strategy



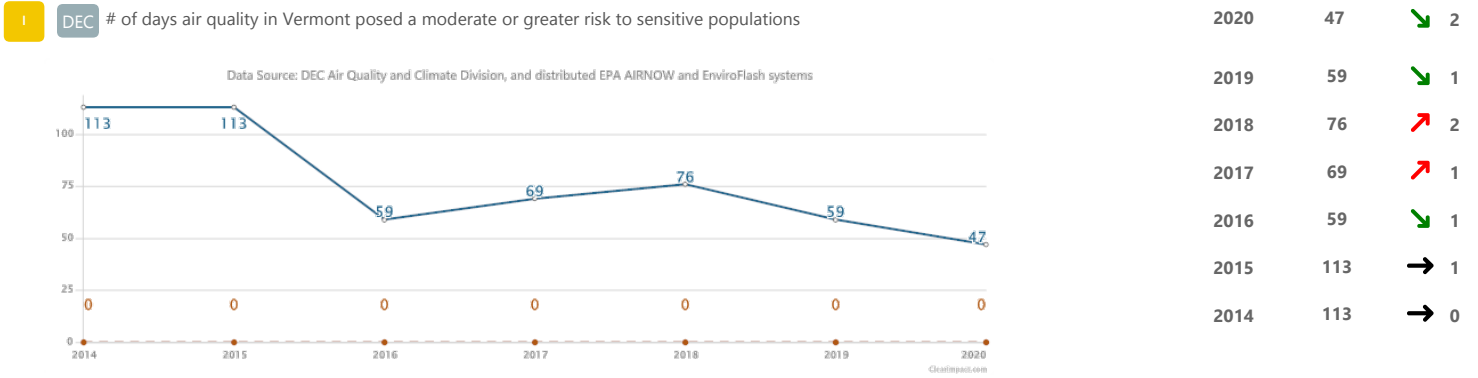
Story Behind the Curve

The phosphorus data shown here represents an estimate of total Vermont loads of phosphorus, based on estimated loads from major Vermont tributaries to Lake Champlain. Total gaged areas for tributaries located primarily in VT are adjusted by the proportion of gaged area relative to total VT watershed area in the Lake Champlain drainage to estimate total VT loads. This number is an approximation, as gaged areas may not be a perfect analogue to un-gaged areas, particularly in the direct Champlain drainage area. Higher amounts of precipitation, particularly heavy rainfall, move more phosphorus from the land to flowing waters and on downstream to the lake. As a result, annual phosphorus loading patterns closely follow annual stream flow patterns. The target load of 418 metric tons total phosphorus represents the maximum amount of phosphorus the lake can receive each year, as specified by the Phosphorus Total Maximum Daily Loads (TMDLs) for Vermont Segments of Lake Champlain, and continue to meet water quality standards. With the passage of the Vermont Clean Water Act (Act 64) in 2015, we now have additional permitting and funding tools to further reduce phosphorus loads to our rivers, streams, and lakes. Decreased loading should be measurable at a local level (individual smaller rivers and streams) as implementation progresses, however it is likely to take many years to show substantial progress in the larger Champlain tributaries and the lake itself. The DEC utilizes additional metrics to evaluate load reductions over time (see our annual RBA report for more information). Loads are calculated and reported for Water Year (year 2020 starts Oct. 1, 2019 and ends Sept. 30, 2020). Water year is the same as Federal Fiscal Year (FFY). NOTE: We have adopted a new approach for calculating total estimated loads that represents our "best available/improved understanding" method and have updated the table for current and past years to represent this improved methodology.

Partners

What Works

Strategy



Story Behind the Curve

This metric is the number of days per year that the “air quality index” (AQI) was categorized as “Moderate” or “Unsafe for Sensitive Groups” (USG) for at least one pollutant at one monitoring site based on the National Ambient Air Quality Standards (NAAQS) for ozone and fine particulate matter (PM2.5). Each calendar day with poor air quality is counted once regardless of how many sites or pollutants meet the criteria on that day. Monitors for ozone are located in Bennington, Rutland, and Underhill; monitors for PM2.5 are located at these sites as well as in Burlington. Air quality in the USG range exceeds the federal air quality standards (is worse than the standard); Moderate air quality still poses some risk to sensitive populations and can have additional environmental and visibility impacts. Current year is calendar year 2020. The target number of days with poor air quality is zero, even though air quality is affected by natural phenomenon (such as wildfire smoke) and emissions from upwind of Vermont's borders. These factors, in addition to changes in meteorology from year to year, result in great year-to-year variability, but there is a significant improvement in air quality on a decadal scale.

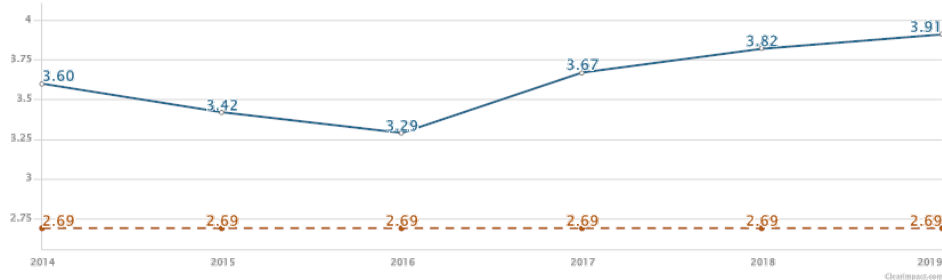
Partners

What Works

Strategy



Data Source: DEC Solid Waste Management Program



2018	3.82	↗ 2
2017	3.67	↗ 1
2016	3.29	↘ 2
2015	3.42	↘ 1
2014	3.60	→ 0

Story Behind the Curve

In 2019, Vermont continued the previous three year's trend of increasing waste production with a 2% increase in annually generated waste in 2019. Of the waste generated, Vermonter's continued to dispose 66% of that waste and to divert (recycle, compost etc.) 34%. These rates of disposal and diversion have held steady despite the increased generation. Data for calendar year 2020 will be available by the end of 2021 and will show the impact of two significant changes within the waste management system; 1) the response to the Covid-19 pandemic and 2) the successful implementation of the Universal Recycling law ban on landfilling food scraps in July 2020.

Partners

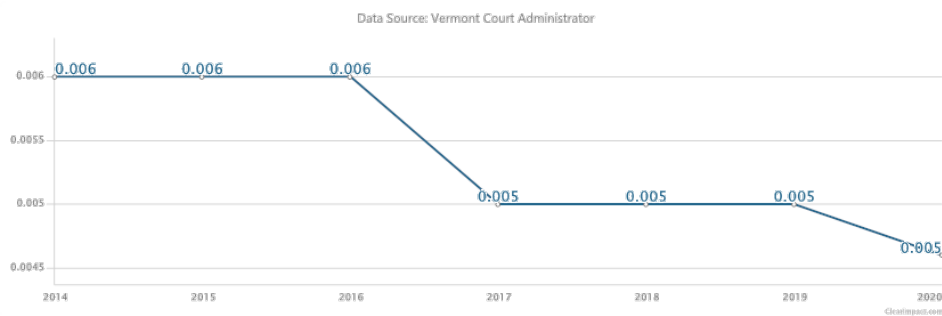
What Works

Strategy

OUTCOME 4

O Act186	VERMONT IS A SAFE PLACE TO LIVE	Most Recent Period	Current Actual Value	Current Trend
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I DPS Rate of petitions granted for relief from domestic abuse per 1,000 residents



2020	0.005	↘ 1
2019	0.005	→ 2
2018	0.005	→ 1
2017	0.005	↘ 1
2016	0.006	→ 2
2015	0.006	→ 1
2014	0.006	→ 0

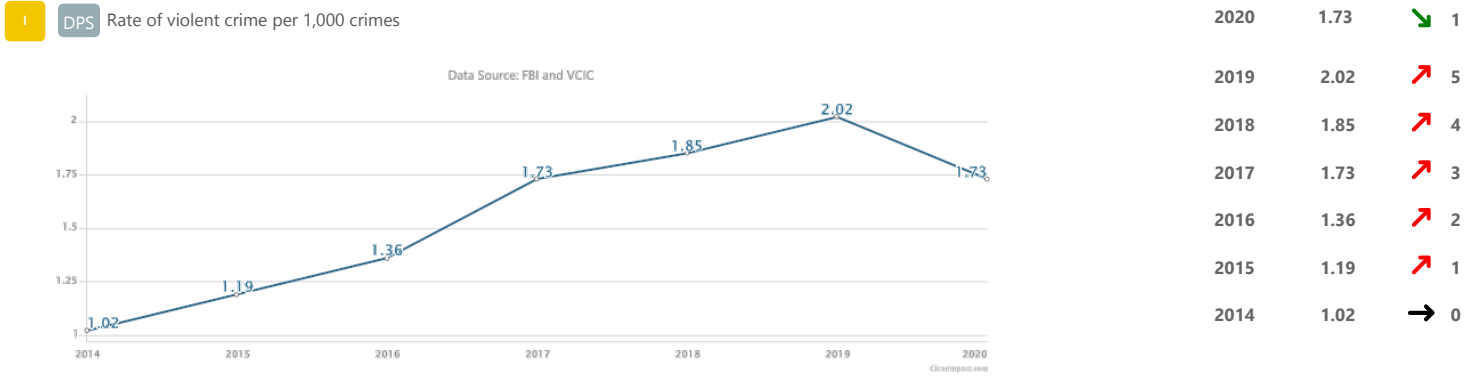
Story Behind the Curve

This indicator remains relatively constant. This information is provided by the Vermont Judiciary and is considered a reliable data source. Population for analysis taken from 2020 US Census data. An analysis would need to be undertaken of the Vermont, Maine and New Hampshire court systems to determine a Northern New England benchmark for this measure to ensure an accurate comparison.

Partners

What Works

Strategy



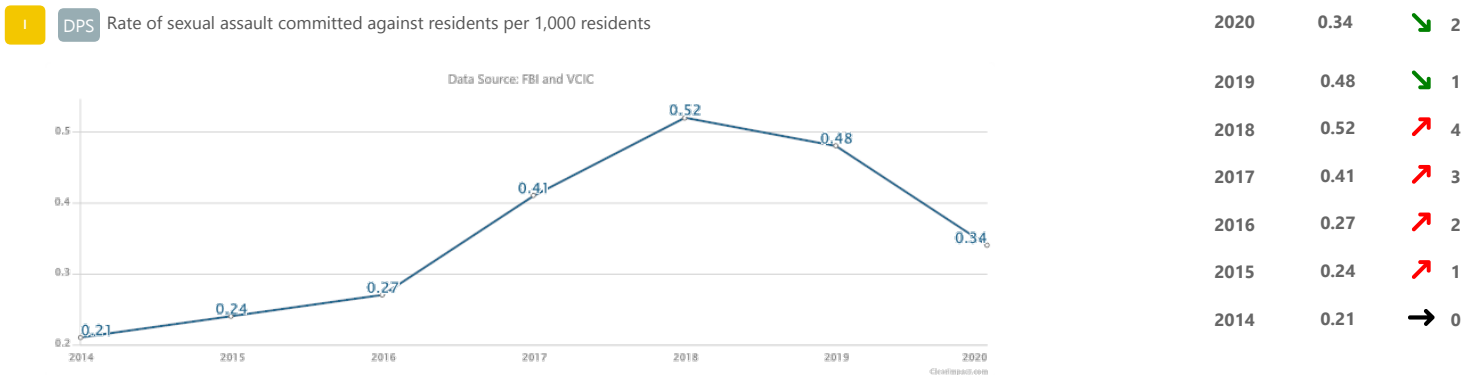
Story Behind the Curve

The indicator showed a decrease in 2020. However, DPS is aware this may be due to disruptions in reporting due to COVID rather than direct changes in crime rate. Additionally, DPS began an initiative during late 2015 to work with law enforcement agencies to improve the quality of data being collected. We expect that there may be a rise in the violent crime data submitted to the state over time which may be indicative of better reporting (as opposed to increases in criminal activity). Prior data updated to reflect information provided through the FBI Crime in the United States Report.

Partners

What Works

Strategy



Story Behind the Curve

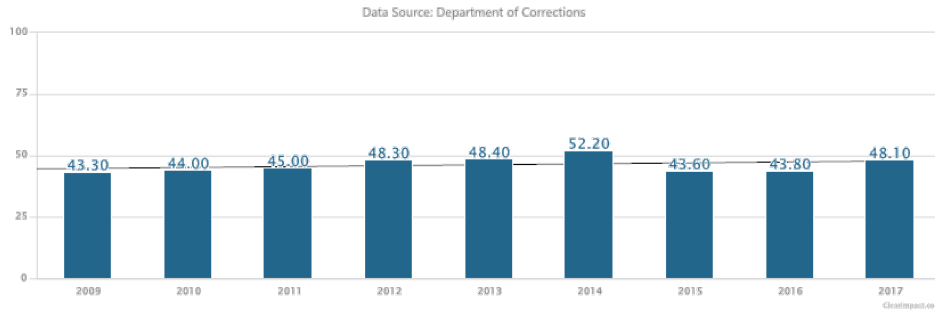
The indicator showed an decrease in 2021. However, DPS is aware this may be due to disruptions in reporting due to COVID rather than direct changes in crime rate. Additionally, DPS began an initiative during late 2015 to work with law enforcement agencies to improve the quality of data being collected. We expect that there may be a rise in the assault data submitted to the state over time which may be indicative of better reporting (as opposed to increases in criminal activity). Prior data updated to reflect information provided through the FBI Crime in the United States Report.

Partners

What Works

Strategy

VDOC Recidivism Rate



Year	Rate	Trend	Change
2017	48.10	↗	2
2016	43.80	↗	1
2015	43.60	↘	1
2014	52.20	↗	5
2013	48.40	↗	4
2012	48.30	↗	3
2011	45.00	↗	2
2010	44.00	↗	1
2009	43.30	↘	1

Story Behind the Curve

We want the trend of recidivism rates in Vermont to go down.

Recidivism is defined per statute as follows:

Citation-2011 Act 41 Section 5: "The Department shall calculate the rate of recidivism based upon offenders who are sentenced to more than one year of incarceration who, after release from incarceration, return to prison within three years for a conviction for a new offense or a violation of supervision resulting, and the new incarceration sentence or time served on the violation is at least 90 days."

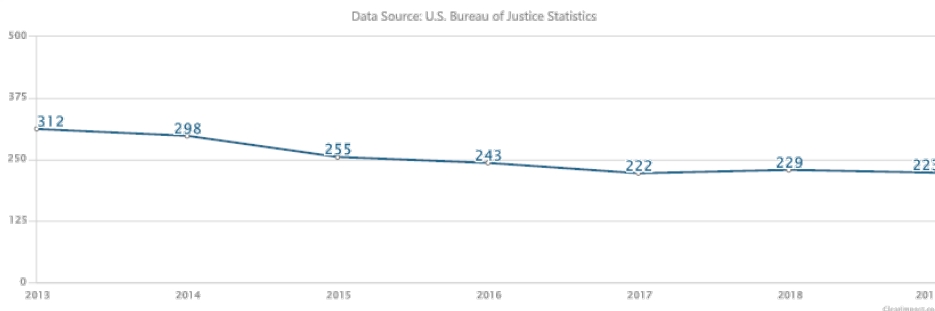
The yearly rates show an increase leading to the highest rate in 2014. However, the 2014 rate has reliability issues due to changes in software that stored the data needed to calculate the measure. The trend indicate that the rate has remained stable.

Partners

What Works

Strategy

VDOC Incarceration Rate Per 100,000 Adult Residents



Year	Rate	Trend	Change
2019	223	↘	1
2018	229	↗	1
2017	222	↘	4
2016	243	↘	3
2015	255	↘	2
2014	298	↘	1
2013	312	↗	2
2012	302	↗	1
2011	255	↘	1

Story Behind the Curve

The Vermont Corrections system integrates services for long term sentenced prisoners (those sentenced to a maximum of greater than one year) and shorter-termed jail inmates (those sentenced to a maximum of under one year).

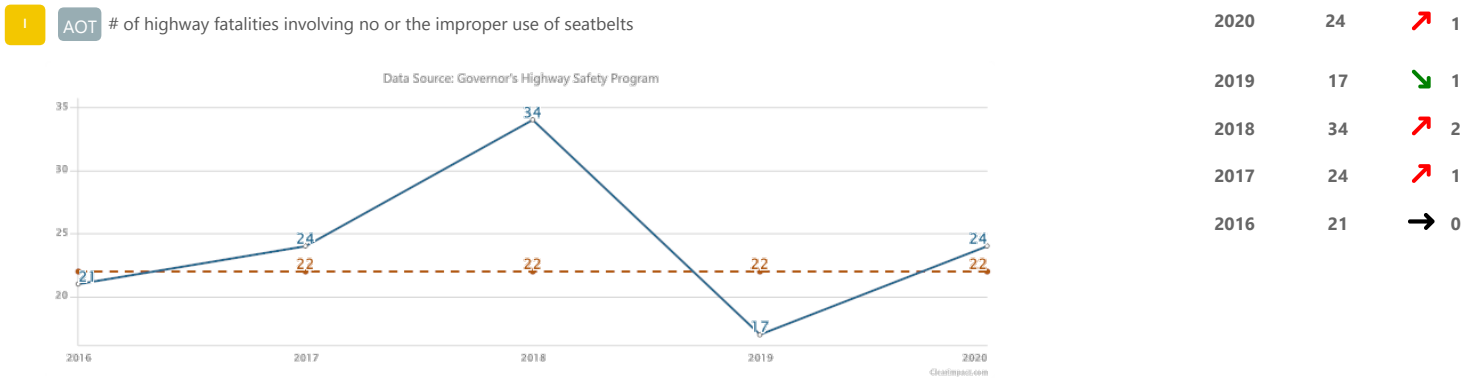
At year-end 2019, **Vermont** had one of the the lowest imprisonment rates in the U.S. compared to the nationwide average (539 per 100,000 Adult).

Source: <https://bjs.ojp.gov/content/pub/pdf/p19.pdf>

Partners

What Works

Strategy



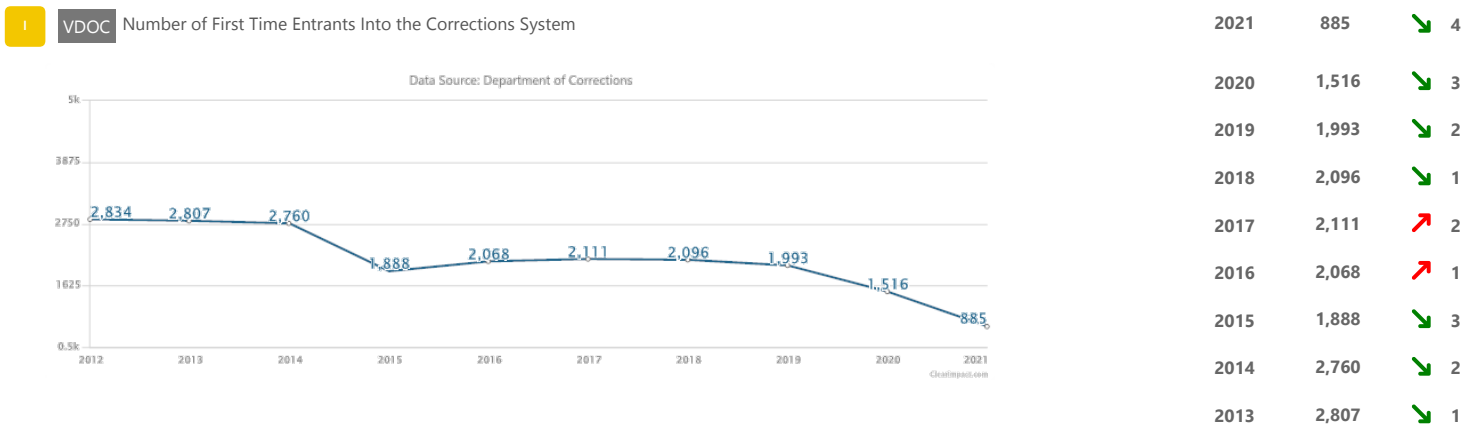
Story Behind the Curve

As identified in the Highway Safety Plan, the goal is to decrease unrestrained passenger vehicle occupant fatalities 4% from the five-year average of 23.0 in 2011 - 2015 to a five-year average of 22.08 by December 31, 2018.

Partners

What Works

Strategy



Story Behind the Curve

These data show a decrease number of first-time entrants into the corrections system. The Vermont criminal justice system has engaged in multiple initiatives to divert individuals to appropriate services and reduced the use of the correctional system. Some examples include pre-trial, diversion, and community and restorative justice programs.

In 2021, 78.7% of the first time entrants identified as White, 11.9% as Black, and 9.4% as other Indigenous or people of color.

Partners

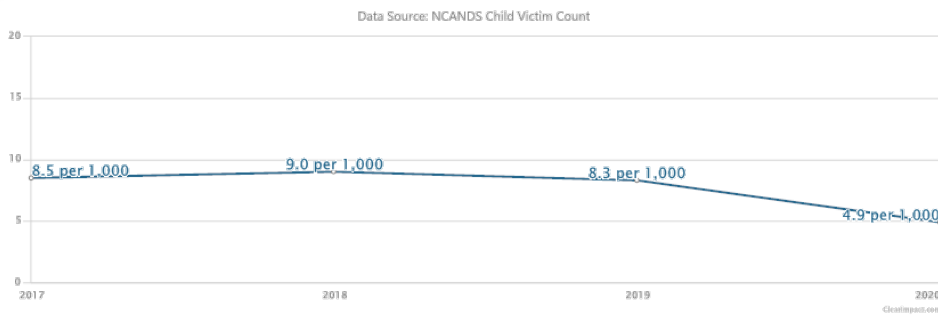
What Works

Strategy

OUTCOME 5

O	Act186 VERMONT'S FAMILIES ARE SAFE, NURTURING, STABLE, AND SUPPORTED	Most Recent Period	Current Actual Value	Current Trend
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I	VDCF Rate per 1,000 Vermont children found to be a substantiated child victim of abuse and neglect.	2020	4.9 per 1,000	↘ 2
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2019	8.3 per 1,000	↘ 1
2018	9.0 per 1,000	↗ 1
2017	8.5 per 1,000	→ 0

Notes on Methodology

NCANDS Child Victim Count (duplicate value). Vermont child population estimates, by year, used to calculate rate per 1,000. Current reporting period uses VDH 2019 population estimates (latest available).

Last updated: September 2021

Updated by: Department for Children and Families

Story Behind the Curve

We want to reduce the incidence of child abuse and neglect as part of our efforts to ensure that all Vermonters are healthy and safe.

In Vermont, the rate of substantiated child abuse and neglect per 1,000 children has decreased from 9.0 in 2018 to 4.9 in 2020. This is due to several factors including Vermont's sustained efforts to treat the opioid epidemic, increases to Family Services staffing and the work of our community partners. Our community partners have made key investments in child abuse prevention, early childhood services, and comprehensive family supports which is also having an impact.

AHS is currently using this tool to assess our agency contribution to reducing the rate of child abuse and neglect in Vermont. One Agency cannot turn the curve alone; there are many partners who have a role to play making a difference.

Partners

Child abuse and neglect in Vermont is a population-level problem. While the Agency of Human Services (AHS) and its Departments are responsible for intervening in, and working to reduce the rate of child abuse and neglect in Vermont, AHS recognizes that preventing abuse and neglect is something many other partners contribute to.

In the Agency strategic planning process for reviewing our strategic plan population-level results and indicators, each of the partners below was identified as having a contributing role to play in improving this population-level indicator for the state of Vermont.

- Vermonters
- Vermont families
- Communities
- Agency of Human Services
 - Department for Children and Families
 - Protective Services Child Care
 - Children's Integrated Services
 - Disability Determination (do SSI determinations for kids in custody)
 - Family Services Division
 - Family Supportive Housing
 - Medicaid
 - Reach Up
 - Strengthening Families Demonstration Project
 - Strengthening Families Child Care
 - Vermont Rental Subsidy
 - Integrated Family Services
 - Department of Mental Health
 - Vermont Department of Health
- Local law enforcement and Special Investigation Units
- Vermont Judiciary, attorneys, and other court personnel
- Prevent Child Abuse Vermont
- Parent Child Centers
- Health Care Professionals
- Educators and other school personnel
- Agency of Education
- Designated Agencies
- Mandated reporters
- VT-FACTS
- VTFUTRES
- UVM Child Welfare Training Partnership
- Casey Family Programs
- VFAPA
- KIN-KAN
- VT KIN AS PARENTS

What Works

Strengthening Families™ is a research-informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs and communities in building five protective factors:

- Increase parental resilience
- Strengthen social connections
- Improve knowledge of parenting and child development
- Provide concrete support in times of need
- Promote social and emotional competence of children

Child abuse prevention initiatives across the Department for Children and Families and the Agency of Human Services draw on this evidence-informed approach.

Strategy

The deaths of Dezirae Sheldon and Peighton Geraw in 2014 caused the entire child protection system to question what could have been done to prevent these tragedies. Vermont's Child Protection System has undergone an unprecedented number of reviews and inquiries in an attempt to answer this question.

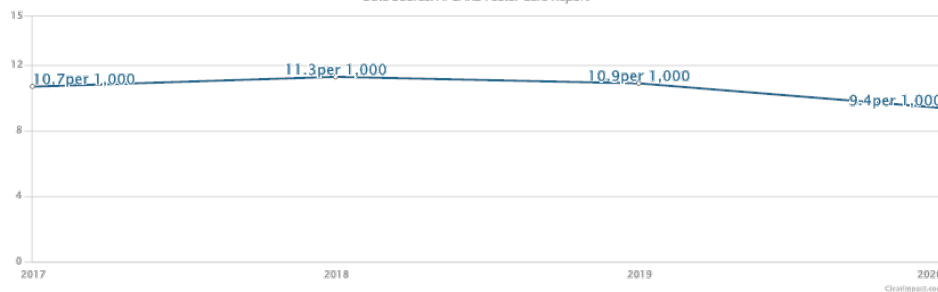
DCF has implemented significant improvements based on reviews conducted by Casey Family Programs and the Vermont Citizen's Advisory Board. DCF also sought feedback from its staff, community partners, and the public to develop a plan to improve our policies and support our workforce. Implemented changes include:

- Increased staffing capacity in the districts and in the DCF Central Office, with support from AHS, the Governor's Office and Legislature;
- Contracted with community partners to provide the services of six substance abuse specialists who will help social workers with investigations in which substance abuse is alleged to be a contributing factor to child abuse or neglect
- Renewed the emphasis on child safety in the Family Services Division mission;
- Implemented new policies requiring management consultation in cases of serious physical abuse;
- Held a statewide conference in March 2015 for staff and partners focusing on the needs of young children and how to improve our focus on the safety and wellbeing of these young children;
- Updated training on child safety and risk assessment in partnership with Casey Family Programs and the Children's Research Center;
- Introduced a comprehensive coaching program to support continual skill development for staff; and
- Improved the DCF website to provide better information to the public about FSD policies and practices.

Act 60 went into effect on July 1, 2015. This legislation makes several key changes possible:

- Information sharing among professionals across the child protection system
- Closer collaboration between DCF and Vermont's Special Investigation Units
- Adoption of a mandatory six-month supervisory period for children reunified to a home in which they were abused or neglected
- Creation of a Joint Legislative Child Protection Oversight Committee

For more information about ongoing efforts to strengthen Vermont's child protection system, please [click here](#).



2019	10.9per 1,000	↓ 1
2018	11.3per 1,000	↑ 1
2017	10.7per 1,000	→ 0

Notes on Methodology

Out of home care includes foster care, kinship care, therapeutic foster care, and residential and group care. A judge may order a child be taken into the custody of the Department for Children and Families (DCF) if the child has been abused or neglected; is beyond or without parental control; or has been adjudicated delinquent.

Data source: National Adoptions and Foster Care Reporting System (AFCARS).

Last updated: September, 2021

Updated by: Department for Children and Families

Story Behind the Curve

We want to reduce the rate of children and youth in out of home care as part of our efforts to ensure that all Vermonters are healthy and safe and families are safe, nurturing, stable, and supported.

The rate of Vermont children coming into state custody due to abuse and neglect has slowly decrease from 11.3/1,000 children in 2018 to 9.4/1,000 in 2020.

There is more work to be done to assure child safety and support vulnerable families. However, it is anticipated that the rate of children and youth in out of home care will continue to slowly decrease based on findings from the 2019 Report on Child Protection in Vermont.

Partners

Child abuse and neglect in Vermont is a population-level problem. While the Agency of Human Services (AHS) and its Departments are responsible for intervening in, and working to reduce the rate of child abuse and neglect in Vermont, AHS recognizes that preventing abuse and neglect is something many other partners contribute to.

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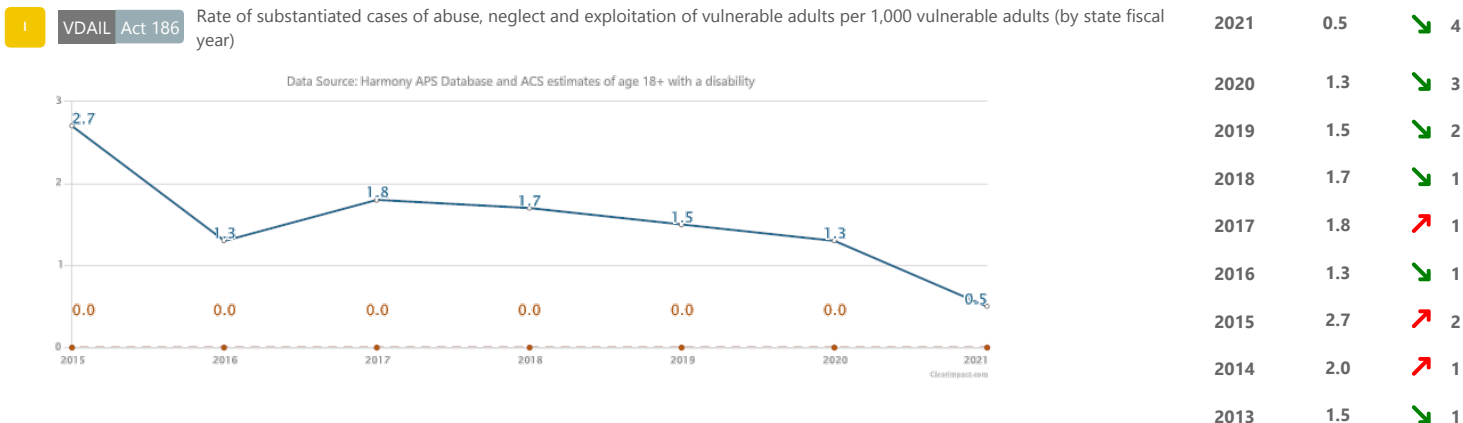
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- Implemented new policies requiring management consultation in cases of serious physical abuse;
- Held a statewide conference in March 2015 for staff and partners focusing on the needs of young children and how to improve our focus on the safety and wellbeing of these young children;
- Updated training on child safety and risk assessment in partnership with Casey Family Programs and the Children’s Research Center;
- Introduced a comprehensive coaching program to support continual skill development for staff;
- Implemented a qualitative case review system to help inform our progress on achieving outcomes for children and families; and
- Improved the DCF website to provide better information to the public about FSD policies and practices.

Act 60 went into effect on July 1, 2015. This legislation makes several key changes possible:

- Information sharing among professionals across the child protection system
- Closer collaboration between DCF and Vermont’s Special Investigation Units
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For more information about ongoing efforts to strengthen Vermont's child protection system, please click [here](#).



Story Behind the Curve

This population indicator shows the estimated rate of abuse, neglect, and exploitation of vulnerable adults. This rate is related to both motive and opportunity of perpetrators; the vulnerability of victims; the state of the Vermont economy; education of the public and stakeholders; challenges within families including stresses on caregivers and caregiver support services; individual support of vulnerable adults; effective screening, training, and oversight of paid caregivers; effective practices at financial institutions to prevent or identify financial exploitation; effective reporting, investigation, and substantiation/prosecution at Adult Protective Services.

Partners

People who report suspected abuse, neglect, and exploitation, including both mandatory and non-mandatory reporters. This includes vulnerable adults, family members, friends, neighbors, volunteers, staff of local health and human service agencies, and staff of banks and financial institutions.

What Works

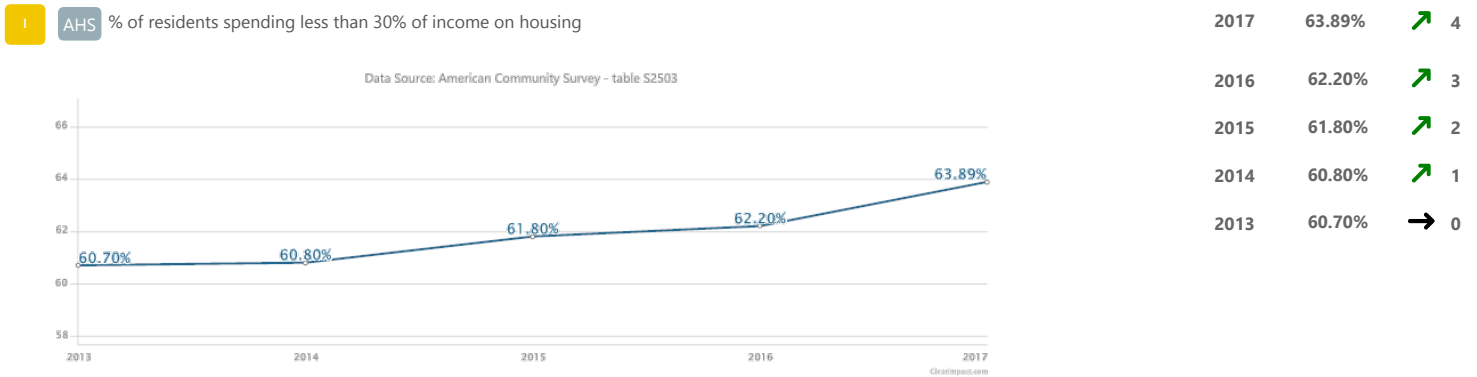
Education and training of the public on identifying and reporting helps to encourage both prevention and early reporting of suspected abuse, neglect and exploitation of vulnerable adults.

Strategy

Notes on Methodology

Updated August 2021.

Numbers of substantiations are from DAIL DLP Adult Protective Services, by state fiscal year. DAIL DLP produces a current estimated rate using the total estimated number of vulnerable adults (with disabilities) in Vermont from the US Census American Community Survey Table S1810 ACS 1-year estimates.



Story Behind the Curve

Monthly housing costs as a percentage of household income for the past 12 months.

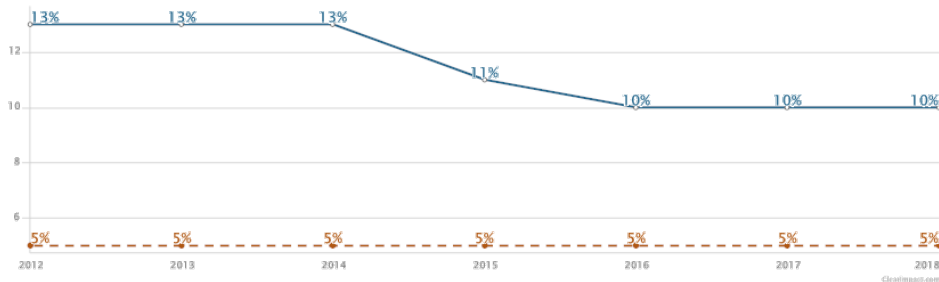
Partners

What Works

Strategy

2018	10%	→ 2
2017	10%	→ 1
2016	10%	↘ 2
2015	11%	↘ 1
2014	13%	→ 3
2013	13%	→ 2
2012	13%	→ 1
2011	13%	→ 0

Data Source: Current Population Survey (CPS), Food Security Supplement (FSS)



Story Behind the Curve

Updated January 2020

Author: Physical Activity and Nutrition Program, Vermont Department of Health

Food insecurity is defined as the lack of access to enough food to fully meet basic needs at all times due to lack of financial resources. Households that are classified as food insecure with hunger are those in which adults have decreased the quality and quantity of food they consume because of lack of money. The adults are quite likely to be hungry on a frequent basis or are at a point where their children's intake has been reduced due to lack of family financial resources. These children are likely to be hungry on a regular basis and the adults' food intake is also likely to be severely reduced.

Using the Current Population Survey, Food Security Supplement, Vermont's rate of food insecure households (for 2015-2017) is 9.8%; the Healthy Vermonters 2020 goal is to have less than 5% of households living with food insecurity. . Nationally, [food insecurity rates](#) range from 7.4% in North Dakota to 20.1% in Mississippi^[1]. According to a review by the U.S. Department of Agriculture, food insecurity in states varies by, and depends on, household factors, such as income, employment and household structure (i.e. single parents), as well as state-level characteristics, such as average wages, cost of housing, levels of participation in food assistance programs (including summer meal programs for children) and tax policies^[2]

[1] The State of Obesity, Better Policies for a Healthier America. Robert Wood Johnson Foundation. 2004-2018.

[2] Bartfeld J, Dunifon R, Nord M, et al. [What Factors Account for State-to-State Differences in Food Security?](#) Economic Information Bulletin No. 20. Washington, D.C.: U.S. Department of Agriculture, Economic Research Service, 2006 (accessed May 2016).

Partners

- Office of Local Health District Offices, Vermont Department of Health: Works with communities to increase access to healthy foods; runs [Women Infants and Children \(WIC\)](#) program that provides food and nutrition education to families in need.
- Division of Economic Services (3SquaresVT, Farm to Family), Vermont Department for Children & Families: Administers and promotes 3SquaresVT and Farm to Family coupons.
- Agency of Education Child Nutrition Programs: Administers and promotes nutrition programs for children in childcare programs and schools, such as the School Lunch and Breakfast program.
- [Vermont Nutrition Education Committee \(VNEC\)](#): brings state and non-profit food access organization leaders together to coordinate on food access services and issues.
- Vermont Food Bank: Provides healthy food to Vermonters in need, as well as cooking classes, taste tests and other services to help people have better access to food.
- Hunger Free Vermont: Promotes nutrition programs for children and adults in Vermont and coordinates Hunger Councils throughout the state.
- Agency of Agriculture: Promotes local food through farmer's markets, community supported agriculture, and farm to school programs.
- Vermont Farm to Plate: Promotes use of local food in institutions, retail establishments, restaurants and other establishments in Vermont.

What Works

In order to impact food insecurity and improve health, we need to increase access to affordable, high quality food, especially for low income populations and assure people are taking advantage of federal food benefit programs, as appropriate. These programs include 3SquaresVT (formerly Food Stamps), WIC, in school and out-of-school time meals, and child care meal programs.

The United State Department of Agriculture (USDA) and Centers for Disease Control and Prevention's Recommended Community Strategies and Measurements to Prevent Obesity in the United States note that farmers markets, community-supported agriculture programs, farm-to-school initiatives, and SNAP (Supplemental Nutrition Assistance Program) outreach programs are all effective ways to increase access to nutritional food. Focusing on availability and affordability, as well as sustainability and economic viability, is crucial to the success of any initiative aiming to reduce food insecurity.

Strategy

The United States Department of Agriculture (USDA) Food and Nutrition Services (FNS) Supplemental Nutrition Assistance Program (SNAP) provides nutrition benefits to eligible low-income households so they can purchase food from authorized food retailers. The goal of SNAP-Ed, a program under SNAP, is to improve the likelihood that people eligible for SNAP will make healthy food choices within a limited budget and choose physically active lifestyles consistent with the 2010 Dietary Guidelines for Americans and the USDA food guidance, MyPlate. The Vermont Department of Health manages SNAP-Ed funding through a Memorandum of Understanding with the Department for Children and Families. With this funding, a multilevel food access project is being implemented that includes grants to community-based organizations to provide education and help food shelves, childcare centers, and schools make policy and environmental changes to increase access to, and consumption of, healthy food, and increase physical activity among SNAP eligible Vermonters.

Since 2008, the Vermont Department of Health has provided grants and training to community coalitions who were required to build partnerships with local health advocates, residents, and town leaders to work toward improving access to healthy food within municipalities, focused on low income communities. This has resulted in established or expanding community gardens, farmers markets, and local food hubs in order to aggregate and distribute healthy food to food pantries, schools and other local institutions serving high need populations, see page 10 of [the Vermont Healthy Community Design Resources, Examples for Creating Healthy Communities: Physical Activity, Healthy Eating, Tobacco, Alcohol & Drug Abuse Prevention](#).

Offices of Local Health staff participated in the trainings and participate as partners in this work. Beginning in state FY2016, funding for all of the community coalitions ended. Many of the Office of Local Health staff continue this work, as appropriate.

Finally, the Vermont Department of Health staff lead the Vermont Nutrition Education Committee (VNEC), a group of professionals who meet regularly to discuss, plan, and improve coordination of food access efforts across the state, and are active participants on the Farm to Plate Food Access Cross Cutting Team and Farm to School Network, groups that are working to improve state policy and programs to increase access to local and healthy food among those Vermonters most in need.

Why Is This Important?

The effects of hunger on children can be detrimental to their health, well-being, and lifelong success. Children living in food insecure homes are at greater risk for poor health, nutritional deficiencies and obesity/overweight, as well as developmental delays, poor academic achievement, depression, and increased aggressive or hyperactive behavior^[1].

This indicator is part of Healthy Vermonters 2020 (the State Health Assessment) that documents the health status of Vermonters at the start of the decade and the population health indicators and goals that will guide the work of public health through 2020.

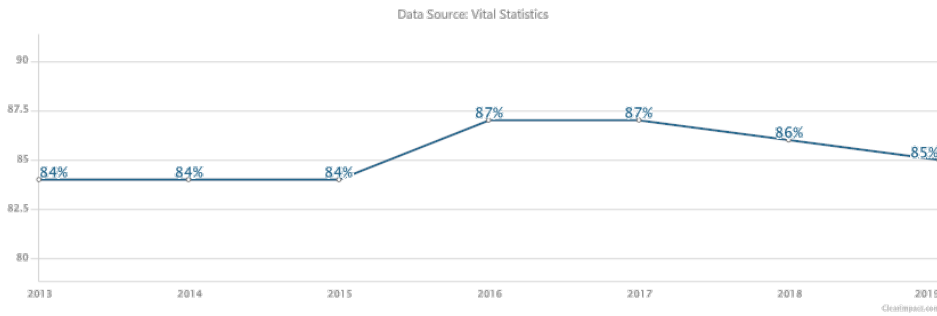
^[1] Food Research and Action Center. The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being White Paper, <http://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf>. December 2017.

Notes on Methodology

The data for this measure are from the Current Population Survey (CPS), Food Security Supplement (FSS). This survey is conducted by the U.S. Census Bureau for the Bureau of Labor Statistics among the civilian non-institutionalized U.S. population 16 and older. The CPS is a labor force survey that contacts about 50,000 U.S. households a month. Then once each year, respondents from the CPS are asked a series of questions about food security, food expenditures, and use of food and nutrition assistance programs, the FSS. Over the course of the FSS survey period, about 1 in every 250 Vermont households are surveyed. To provide individual state measurements, the CPS FSS combines 3-years of data to ensure statistically meaningful results.

I VDH % of women who receive first trimester prenatal care

2019	85%	↘ 2
2018	86%	↘ 1
2017	87%	→ 1
2016	87%	↗ 1
2015	84%	→ 3
2014	84%	→ 2
2013	84%	→ 1
2012	84%	↗ 1
2011	83%	→ 3



Story Behind the Curve

Last Updated: November 2020

Author: Vermont Department of Health

The proportion of women reporting first trimester prenatal care remains steady at 85% as measured on the birth certificate. Pregnancy is a critical time for laying the groundwork for a healthy life. Starting prenatal care and getting regular checkups with a health care provider as soon as possible is vital to ensuring a healthy pregnancy and baby. If a pregnant person needs help finding a health care provider, the Local Health Office and the WIC Program can provide assistance.

This can also be a critical time to prevent problems, such as premature birth, and address certain risk factors, such as tobacco, alcohol, and cannabis use, as well as other substances, identify possible signs of depression and anxiety, and connect families to important resources during pregnancy and for new parents. This is also a time to start thinking about how to feed your baby. For most babies, breastfeeding is the healthiest choice. In addition, breastfed babies are healthier and are less likely to have allergies, colds, ear infections, diarrhea, and some other sicknesses. Talking to a health care provider or a WIC nutritionist about breastfeeding can happen during this prenatal period. Many resources are available during pregnancy.

Partners

- Local Health Office
- WIC Program
- Strong Families Vermont home visiting
- Perinatal Mood and Anxiety Disorders (PMADS) Resources
- Vermont Child Health Improvement Program (VCHIP)

What Works

Prenatal care is a key component of a healthy pregnancy. Regular prenatal care helps to identify and treat complications and promote healthy behaviors. Outcome data suggest that babies born to mothers who do not receive prenatal care are 3 times more likely to be of low birth weight, and 5 times more likely to die, compared with babies born to mothers who receive prenatal care. In addition to medical care, prenatal care includes counseling and education.

The Vermont Department of Health and the Vermont Child Health Improvement Program (VCHIP) has been working for over 20 years to strengthen and expand a network of obstetric providers and nurses at Medicaid participating hospitals throughout Vermont and New Hampshire that serve Vermont births, and collaborate to improve the quality of care provided to women and infants enrolled in Medicaid. The goal of the work is to improve access, coordination, and quality of care, as well as to establish prenatal care standards and recommendations by standardizing quality assessment, benchmarking, and reporting.

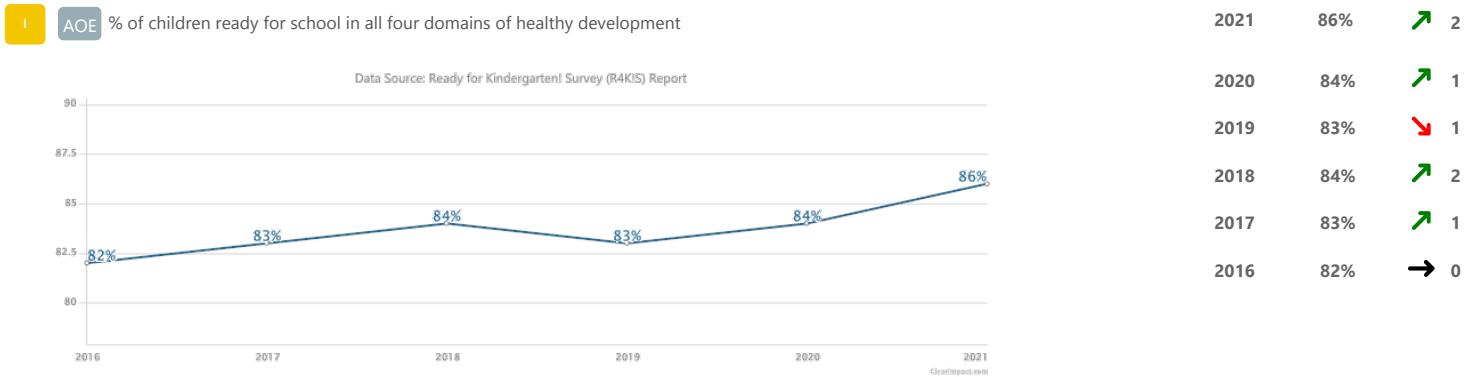
Strategy

The U.S Department of Health and Human Services provides a fact sheet that outlines key components of prenatal care. This includes why prenatal care is important, what happens during prenatal care visits, and what types of screenings and tests are recommended.

Why Is This Important?

Act 186 was passed by the Vermont Legislature in 2014 to quantify how well State government is working to achieve the population-level outcomes the Legislature sets for Vermont's quality of life. It will assist the Legislature in determining how best to invest taxpayer dollars. The Vermont Department of Health and the Agency of Human Services report this information annually. Click here for more information.

Notes on Methodology



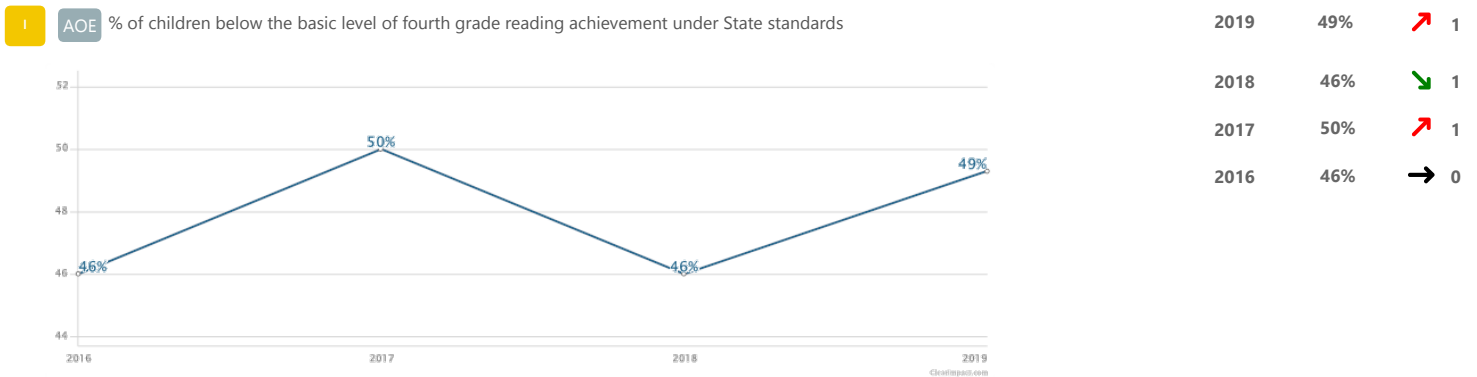
Story Behind the Curve

Kindergarten Readiness Survey (R4KIS)

Partners

What Works

Strategy



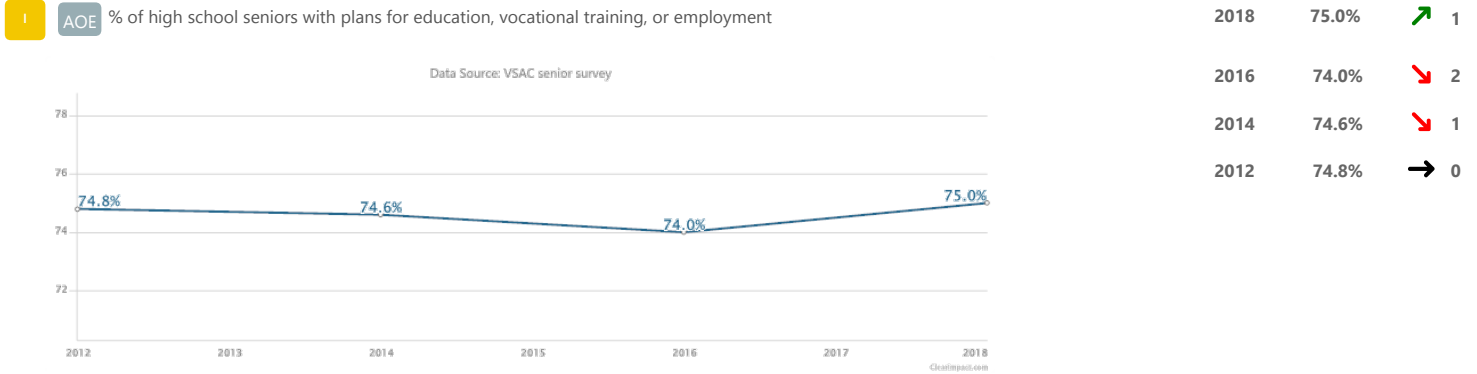
Story Behind the Curve

No statewide summative testing occurred during SY20 due to the pandemic.

Partners

What Works

Strategy



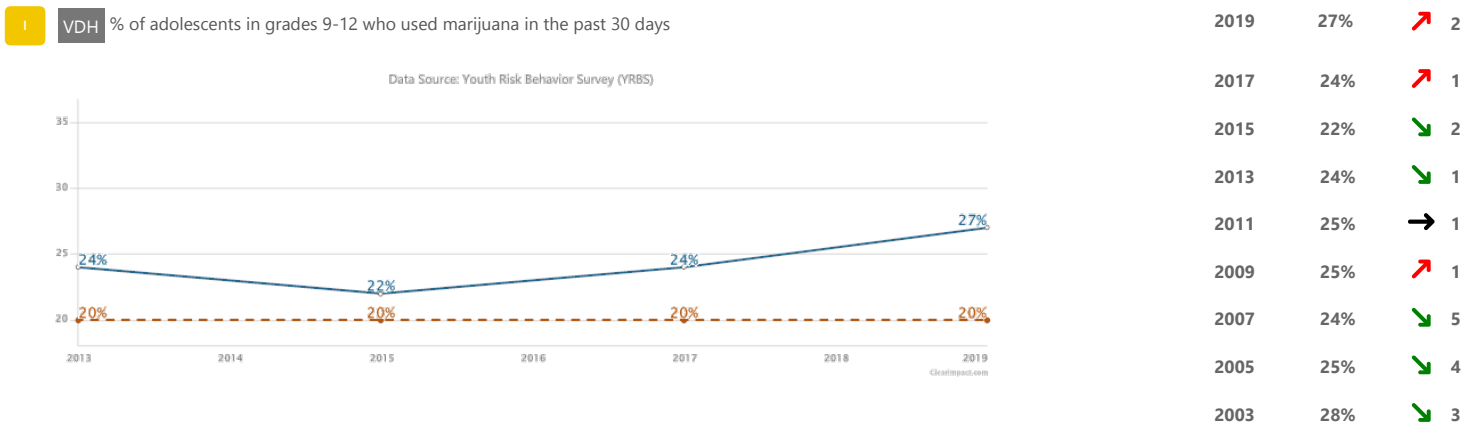
Story Behind the Curve

Data are collected by VSAC. This collection only runs every other year. They were not collected during SFY20.

Partners

What Works

Strategy



Story Behind the Curve

Last Updated: Jan 2020

Author: State Epidemiological Outcomes Workgroup, Vermont Department of Health

According to the Youth Risk Behavior Survey (YRBS), past 30-day marijuana use among high school students increased significantly between 2015 and 2017 and again between 2017 and 2019 as discussions of legal adult use has been debated by the Vermont legislature. In 2019, more than a quarter of high school students used marijuana during the past 30 days and six percent of students reported using marijuana before age 13. While all demographic groups are at risk for using substance such as marijuana, some groups report higher use than others. LGBT high school students (35%) are significantly more likely than their heterosexual peers (26%) to report using during the past 30 days.

Research has shown that early (i.e. adolescent) and persistent use of marijuana can have several adverse effects on thinking, judgment, and physical and mental health. Early and persistent use of marijuana has been associated with chronic bronchitis, increased risks of several cancers, attention and memory impairment, and significant reduction in IQ, as well as increased risk of serious mental illness. There is an association between early marijuana use and subsequent abuse of other illegal drugs and excessive alcohol consumption. Other recent research has demonstrated that marijuana use in adolescence has a negative impact on college degree attainment, adult income, and measures at age 25 of relationship and life satisfaction. In Vermont more adolescents are in treatment for marijuana disorders than any other substance including alcohol. Reduced perception of risk among youth is likely influenced by many communitywide factors such as changes in marijuana policy and norms.

ADAP works with public and private colleges across the state to plan and host an annual College Symposium that for the last two years has been focused on marijuana use and its impact on health and academics. In addition, reduction of 30-day marijuana use among youth and young adults is the goal for both our statewide Regional Prevention Partnerships (RPP) and School-based Substance Abuse Services (SBSAS) grants to 20 supervisory unions across the state. Prevention strategies include education, local policy education and enhancements, assessment and planning, screening, family education, capacity building and youth and young adult focused activities. In addition to the evidence-based strategies being implemented by the grantees, VDH maintains the Parent UP website featuring a section on marijuana education for parents.

Partners

Schools, Pediatricians, Department of Mental Health, Substance Abuse Prevention Coalitions, Parents.

What Works

Screening, Brief Intervention and Referral to Treatment (SBIRT) for adolescent marijuana users identified by pediatricians or school authorities; parental monitoring of behavior and peer affiliations; school-based prevention curricula focused on marijuana; continued legal sanctions on possession and use of marijuana.

Strategy

Continue work of school-based prevention curricula; engage parents in prevention activities, develop a plan to increase awareness of pediatricians of the dangers of early use of marijuana.

Why Is This Important?

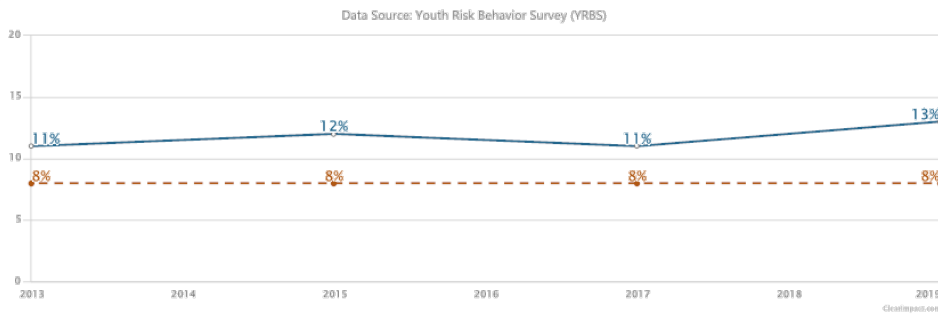
This indicator is part of Healthy Vermonters 2020 (the State Health Assessment) that documents the health status of Vermonters at the start of the decade and the population health indicators and goals that will guide the work of public health through 2020. [Click here for more information.](#)

Act 186 was passed by the Vermont Legislature in 2014 to quantify how well State government is working to achieve the population-level outcomes the Legislature sets for Vermont's quality of life. It will assist the Legislature in determining how best to invest taxpayer dollars. The Vermont Department of Health and the Agency of Human Services report this information annually. [Click here for more information.](#)

Notes on Methodology

Data is updated as it becomes available and timing may vary by data source. For more information about this indicator, [click here.](#)

Note that prior to 2013, statewide estimates were generated by weighting responses from a representative sample of schools. In 2013, the methodology was changed and all student responses were used in creating statewide estimates, allowing for more accurate reporting. 2011 data were recalculated in the same way as 2013 data in order to improve comparisons. As a result, 2011 YRBS estimates that were published online after 02/04/2015 may be slightly different compared to those published previously.



2017	11%	↓ 1
2015	12%	↑ 2
2013	11%	↑ 1
2011	9%	→ 0

Story Behind the Curve

We want this trend to go down.

In 2019, the percentage of adolescents that had made a suicide plan in the past year (YRBS) was 13%.

The act of making a suicide plan can be an impulsive reaction to a life challenge that may be mitigated by short term supports, or an indication of a more serious mental illness requiring longer treatment. Either way the indicator of suicide planning identifies youth who were at high risk of suicidal action and therefore in need of immediate mental health support to remain safe at some point during the year. Untreated mental health issues can result in serious negative outcomes for the health and development of adolescents. Mental health is measured in the YRBS (Youth Risk Behavior Survey) with one question addressing persistent feelings of sadness or hopelessness and four questions on suicidal ideation or action. Suicidal ideation or action questions assess consideration of and planning for suicide, attempting suicide, and being medically treated for suicide attempts.

The data is collected from the Youth Risk Behavior Survey. For more data on suicide mortality and self-harm morbidity, please visit <http://www.healthvermont.gov/health-statistics-vital-records/surveillance-reporting-topic/injuries>

The Vermont Departments of Health and Mental Health are collaborating with community partners to reduce these rates. One Agency cannot turn the curve alone; there are many partners who have a role to play making a difference.

Suicide is often preventable. If you or someone you know needs help call the National Suicide Prevention Lifeline is 1-800-273 TALK — A crisis intervention and suicide prevention phone service available 24/7

Partners

- Vermont Department of Health
- Vermont Department of Mental Health
- Vermont Suicide Prevention Center
- University of Vermont/Vermont Child Health Improvement Program (VCHIP)
- School health and mental health professionals
- Community faith leaders
- Community primary clinical care providers

What Works

Systems using evidence based programs covering prevention, screening and identification of youth at risk and subsequent treatment and follow up are being developed in Vermont. Key strategies include the following: Zero Suicide, Lifelines curriculum, U_Matter for Schools, Mental Health First Aid (MHFA), the Columbia-Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) toolkit, and the Collaborative Assessment and Management of Suicidality (CAMS.) Vermont has been building its prevention programming and mental health services to respond to the increase in youth, who engage in suicide related behavior.

Strategy

Vermont is focus is on increasing its capacity to offer a specific set of evidenced based practices and programs designed to address the key elements influencing the rise in youth suicide rates and other measures such as youth considering suicide. These strategies include increasing training and capacity for mental health counselors to use the Zero Suicide/CAMS framework in identifying and treating suicidality, supporting “upstream” programs such as U_Matter, and increasing youth afterschool quality programming. Many early childhood and school age programs address mental health and wellness and key concepts such as “connectedness.”

Why Is This Important?

This indicator, coupled with Vermont's numbers of youth suicide deaths, will inform our knowledge of population-based suicide related behaviors and also the special issues of identified subpopulations. These data can inform practitioners who work in health and mental health and public health planners as to how to plan interventions that are designed for both the individual practitioners and also community based prevention. There are several measures that describe risk behaviors related to suicide and VT MCH is using these measures to fully understand the scope of the issue of teen suicide and suicidal behavior, and how to address related factors such as bullying, mental health, substance abuse, etc. to promote effective prevention actions.

Notes on Methodology

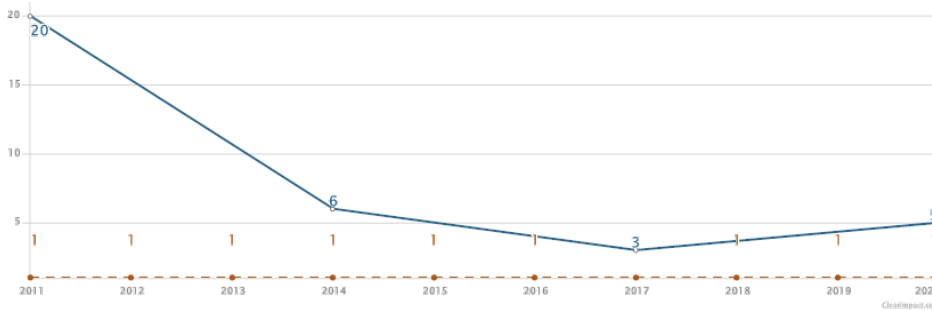
The Youth Risk Behavior Surveillance System (YRBSS) is a national program funded by the Centers for Disease Control and Prevention. It is major source of information about youth health related behaviors that may contribute to leading causes of death and disability as adults. The VT YRBSS asks youth about concerning behaviors such as "feeling sad or hopeless" and suicide plans and attempts. Detailed analyses of Vermont data also informs on special subpopulations.

OUTCOME 7

Act186 VERMONT'S ELDERLY LIVE WITH DIGNITY AND IN SETTINGS THEY PREFER

I VDAIL State Ranking on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers (AARP, Scan Foundation, Commonwealth Fund)

Most Recent Period	Current Actual Value	Current Trend
2020	5	↗ 1
2017	3	↘ 2
2014	6	↘ 1
2011	20	→ 0



Story Behind the Curve

This scorecard ranks states and DC in order from 1 to 51 on a wide range of issues pertaining to older adults and people with disabilities. The LTSS scorecard has five domains that states are ranked within, and each of those domains has multiple indicators that are used to derive the overall score. The domains include:

- Affordability and Access
- Choice of Setting and Provider
- Quality of Life and Quality of Care
- Support for Family Caregivers
- Effective Transitions

AARP and ADvancing States recognize that the report can be challenging when solely viewed as a numerical ranking; however, it also can provide states with opportunities to highlight areas of success while simultaneously identifying areas for improvement. ADvancing States believes that all states have unique attributes and strengths and we are encouraged with the progress all states have made since AARP initiated this project in 2011. ADvancing States encourages each state to look beyond the total tabulations and state rankings and spend time understanding the individual components within each of the domains and how your state may improve as well as areas of success that you can highlight.

A few important things to consider about this report:

Some of the factors that impact the indicators are within Aging and Disability or Medicaid agencies' spheres of influence, but many are not. (i.e. the poverty rate in your state, Medicare policy, housing affordability, and Federal funding allocations for several programs)

Some of the data-sources used, including those from the Federal government, (especially CMS) may not be current enough to reflect improvements made in state systems since the information was first collected.

Many state-specific innovations may also not be captured because the report relies on sources of data that can draw all-state comparisons.

Many of the indicators and data sources shifted since the most recent (2017) release of the scorecard, so we do not believe it is useful to compare results across the different reports; however, we caution that there is likely to be press attention paid both to the individual state rankings as well as to any change in positioning that occurred between the releases.

The ranking of the top five states is as follows (note: some states are tied in this ranking system)

1. Minnesota
2. Washington
3. Wisconsin
4. Oregon
5. Vermont

Partners

A wide variety of public and private entities contribute to each state's ranking including:

- the federal government
- state government
- local government
- HCBS service providers
- LTSS facilities
- Housing agencies and providers
- Transportation agencies and providers

What Works

Strategy

Notes on Methodology

Data source: national reports (as of August 2021):

<http://www.longtermscorecard.org/~media/Microsite/Files/2020/LTSS%202020%20Short%20Report%20PDF%20923.pdf>

<http://www.longtermscorecard.org/2017-scorecard>

<http://www.longtermscorecard.org/2014-scorecard>

<http://www.longtermscorecard.org/2011-scorecard>



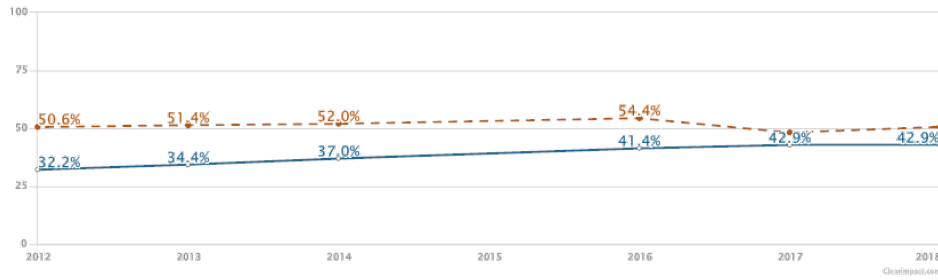
VDAIL

Hospice enrollment: Percentage of chronically ill Medicare decedents age 65 and older who were enrolled in hospice during the last 6 months of life

2018

42.9%





2017	42.9%	↗ 6
2016	41.4%	↗ 5
2014	37.0%	↗ 4
2013	34.4%	↗ 3
2012	32.2%	↗ 2
2011	28.5%	↗ 1
2010	23.5%	→ 0

Story Behind the Curve

Vermont ranked 43rd among US states in 2018. Target values are US values, i.e. across all states.

While Vermont has low enrollment in hospice for this cohort, Vermont also has a high rate of deaths in hospital. Efforts by hospice providers and physician practices to enroll more people in hospice could support people dying in settings that are often more personal and satisfying than the hospital, while also deducing the costs of end of life care.

Partners

Hospice focuses on caring, not curing. In most cases care is provided in the patient's home. Hospice care also is provided in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. Hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

What Works

Strategy

Notes on Methodology

Hospice Care is the percentage of Medicare decedents aged 65 years and older enrolled in hospice care in the last six months of life after a diagnosis of one of nine chronic conditions with a high probability of death. The senior ranks are based on data from The Dartmouth Atlas of Health Care. The percentage of Medicare decedents aged 65 and older enrolled in hospice care in the last six months of life varies by state. Nationally, in 2015 54.4% of Medicare decedents were enrolled in hospice care in the last six months of life.

Source: America's Health Rankings analysis of The Dartmouth Atlas of Health Care, United Health Foundation, AmericasHealthRankings.org

https://www.americashealthrankings.org/explore/senior/measure/hospice_care_sr/state/VT

As of August 2021 this is the most current report/data available.

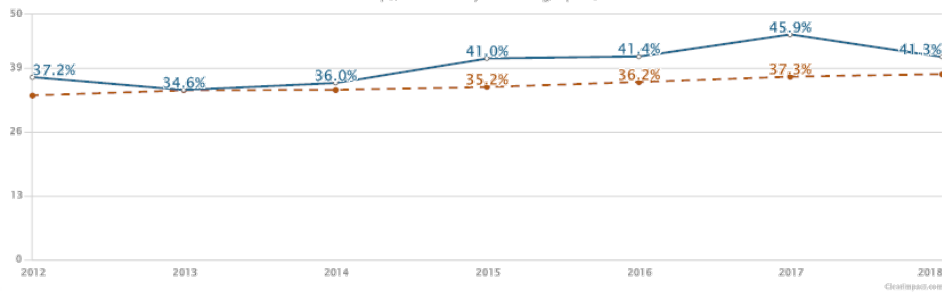
OUTCOME 8

O Act186 VERMONTERS WITH DISABILITIES LIVE WITH DIGNITY AND IN SETTINGS THEY PREFER

Most Recent Period Current Actual Value Current Trend

I VDAIL Estimated employment rate of Vermonters age 21-64 with all disabilities

2018 41.3% ↘ 1



2017	45.9%	↗ 4
2016	41.4%	↗ 3
2015	41.0%	↗ 2
2014	36.0%	↗ 1
2013	34.6%	↘ 5
2012	37.2%	↘ 4
2011	39.8%	↘ 3
2010	40.7%	↘ 2

Story Behind the Curve

This population indicator shows the estimated employment rate of all Vermonters with disabilities who are age 18-64. Employment is one way that Vermonters with disabilities contribute to their communities and the Vermont economy. Employment income is also directly related to economic status and independence.

Note that the employment rate is higher in Vermont, but related earned wages are lower in Vermont. There is also evidence that some people with disabilities want a job but do not have one, and that some people with disabilities who have a job would like to work more hours and/or earn higher wages.

As reported by Joyce Manchester of the Joint Fiscal Office, an unusually high number of Vermonters of working age are eligible for SSDI. This tends to remove them from the active workforce.

Partners

This employment rate is related to the state of the Vermont economy and labor force; work incentives and disincentives within public benefit programs; and the efforts of employment programs including the Division of Vocational Rehabilitation, the Division for the Blind and Visually Impaired, the Department of Labor, the Department of Mental Health, and the Division of Developmental Disabilities Services. Individual employment is directly supported by the efforts of local partners including VABIR, designated agencies, and specialized service agencies.

What Works

Strategy

Notes on Methodology

(2018 is the most recent data available as of August 2021)

<http://www.disabilitystatistics.org/reports/acs.cf...>

Erickson, W., Lee, C., von Schrader, S. (2017). Disability Statistics from the American Community Survey (ACS). Ithaca, NY: Cornell University Yang-Tan Institute (YTI). Retrieved from Cornell University Disability Statistics website: www.disabilitystatistics.org

A person is considered employed if he or she is either

1. "at work": those who did any work at all during the reference week as a paid employee (worked in his or her own business or profession, worked on his or her own farm, or worked 15 or more hours as an unpaid worker on a family farm or business) or
2. were "with a job but not at work," : had a job but temporarily did not work at that job during the reference week due to illness, bad weather, industrial dispute, vacation or other personal reasons. The reference week is defined as the week preceding the date the questionnaire was completed.

'Target' value is the national rate. Note high margins of error for estimated state rate. Caution should be used when interpreting a statistic based on small sample sizes or when the Margin Of Error (MOE) is large relative to the estimate. The MOE is a measurement of the accuracy of the statistic. We highly recommend that you indicate the sample size and MOE when reporting a statistic.

The ACS definition of disability is based on six questions. A person is coded as having a disability if he or she or a proxy respondent answers affirmatively for one or more of these six categories.

Hearing Disability (asked of all ages): Is this person deaf or does he/she have serious difficulty hearing?

Visual Disability (asked of all ages): Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?

Cognitive Disability (asked of persons ages 5 or older): Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?

Ambulatory Disability (asked of persons ages 5 or older): Does this person have serious difficulty walking or climbing stairs?

Self-care Disability (asked of persons ages 5 or older): Does this person have difficulty dressing or bathing?

Independent Living Disability (asked of persons ages 15 or older): Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

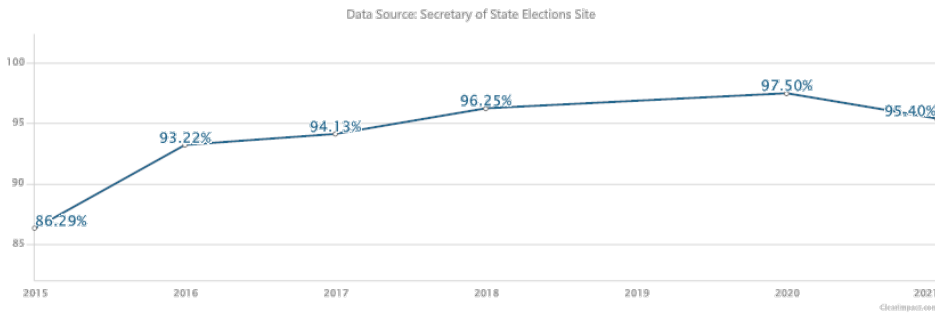
OUTCOME 9

O Act186 VERMONT HAS OPEN, EFFECTIVE, AND INCLUSIVE GOVERNMENT

Most Recent Period Current Actual Value Current Trend

I SOS % of people who are eligible to register to vote and who have registered

Year	Current Actual Value	Current Trend	Count
2021	95.40%	↓	1
2020	97.50%	↑	4
2018	96.25%	↑	3
2017	94.13%	↑	2
2016	93.22%	↑	1
2015	86.29%	→	0



Story Behind the Curve

Data as of 9/29/21. There are currently 491,887 registered voters. The recent census figures indicated there are 461,304 people over the age of 18 in VT. This results in a percentage of 106% of the eligible population being registered. This is the result of the fact that the registered voter number includes our "challenged" voters, who are voters that the local election officials believe have moved, but have not yet responded to the notice sent. We cite this figure for consistency because the percentage of voters who voted in the election (the next measure) is measured against this total number of registered voters, because a challenged voter may still cast a ballot in the election if they first confirm their residence. A more accurate reflection of how many eligible Vermonters are currently registered would compare our number of active voters (those not challenged) against the eligible population. Our current number of active voters is 440,413. As a percentage of the eligible population, this is 95.4% (440,413 / 461,304).

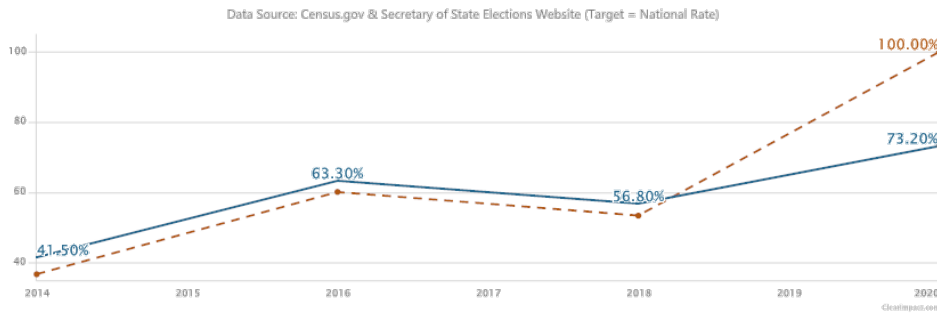
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What Works

Strategy

SOS % of registered voters voting in the general election

2020	73.20%	↗ 1
2018	56.80%	↘ 1
2016	63.30%	↗ 1
2014	41.50%	↘ 1
2012	60.50%	→ 0



Story Behind the Curve

This was the highest voter turnout in a statewide election in Vermont history. Of these 73.2% of voters who participated, 74% of those did so by returning their ballot early.

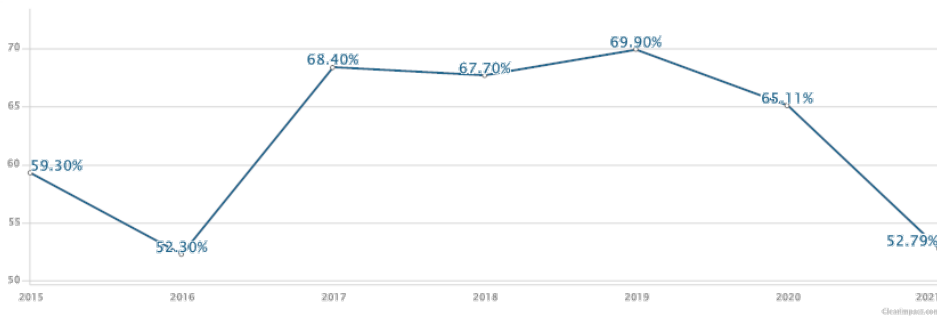
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Strategy

AOA % of State grants awarded that include performance measures

2021	52.79%	↘ 2
2020	65.11%	↘ 1
2019	69.90%	↗ 1
2018	67.70%	↘ 1
2017	68.40%	↗ 1
2016	52.30%	↘ 2
2015	59.30%	↘ 1
2014	69.10%	↗ 2
2013	68.30%	↗ 1



Story Behind the Curve

Grants with performance measures dropped in SFY 2021 as a result of the large number of grants that were provided for COVID relief. It should be noted that appropriations for pass through non-state entities, such as UVM, Tax Lister Education, GF transfers to Capital Funds, and others, are processed and reported as "grants" but do not have performance measures attached, nor standard grant agreements. Other such situations include federal grants where performance measures are part of federal reporting and audit requirements and are therefore not included in the grant document.

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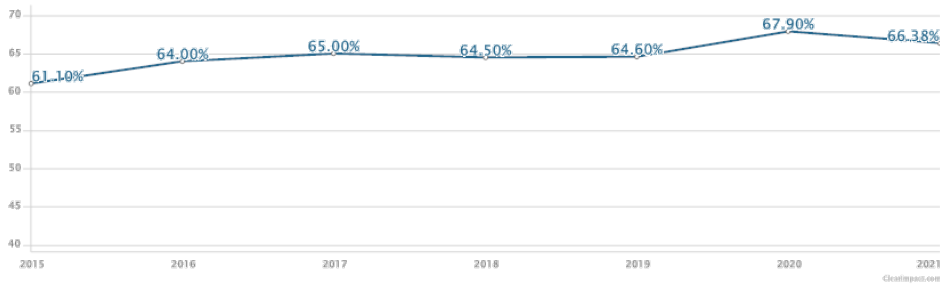
What Works

Strategy

AOA % of State contracts awarded that include performance measures

2021	66.38%	↘ 1
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Data Source: VISION System queries



2020	67.90%	↗	2
2019	64.60%	↗	1
2018	64.50%	↘	1
2017	65.00%	↗	3
2016	64.00%	↗	2
2015	61.10%	↗	1
2014	41.20%	↘	1
2013	58.20%	↗	1

Story Behind the Curve

After some inconsistency in the initial years, % of contract awarded which contain performance measures has stabilized around 65%.

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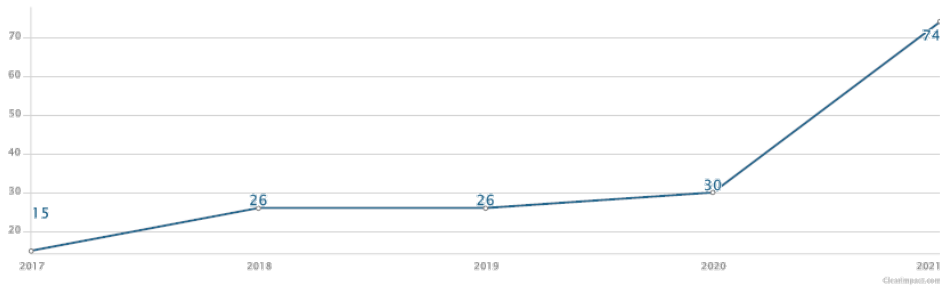
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ADS # of departments that are able to accept online payments

Data Source: Vermont.gov Web Portal (individual units of State Government)



2021	74	↗	2
2020	30	↗	1
2019	26	→	1
2018	26	↗	1
2017	15	→	0

Story Behind the Curve

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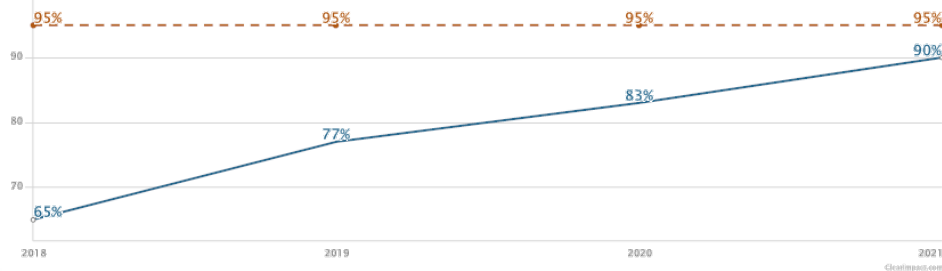
Strategy



ADS % of departments using up-to-date website template

2021	90%	↗	3
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Data Source: Agency of Digital Services/VIC



2020	83%	↗ 2
2019	77%	↗ 1
2018	65%	→ 0

Story Behind the Curve

Target was missed due to redirection of resources to COVID response.

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OUTCOME 10

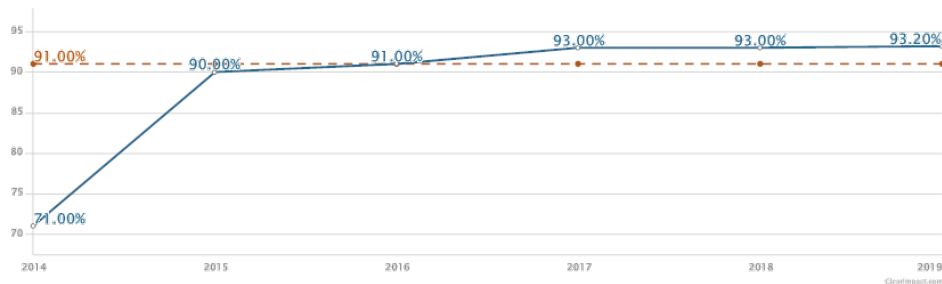
O Act186 VERMONT'S STATE INFRASTRUCTURE MEETS THE NEEDS OF VERMONTERS, THE ECONOMY, AND THE ENVIRONMENT

Most Recent Period	Current Actual Value	Current Trend
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I PSD % of Vermont covered by state-of-the-art telecommunications infrastructure

2019	93.20%	↗ 1
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Data Source: Public Service Department



2018	93.00%	→ 1
2017	93.00%	↗ 3
2016	91.00%	↗ 2
2015	90.00%	↗ 1
2014	71.00%	→ 0

Story Behind the Curve

Data was not updated in 2020 due to complications from COVID. The PSD is currently processing data from service providers and will update the data later in 2021.

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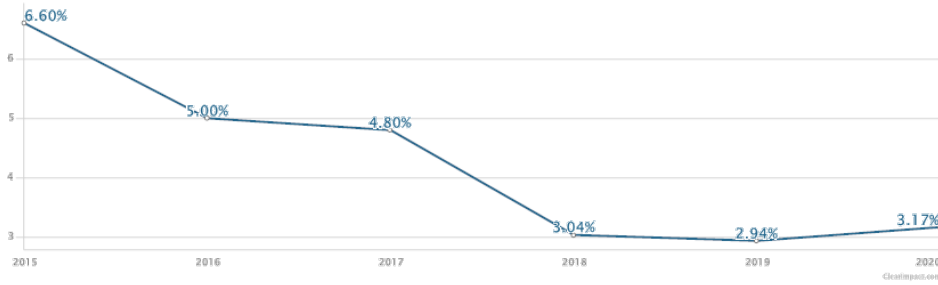
What Works

Strategy

I AOT % of structurally-deficient bridges, as defined by the Agency of Transportation

2020	3.17%	↗ 1
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Data Source: Annual inventory and inspections by VTrans (Target less than 10%)



2019	2.94%	↘	4
2018	3.04%	↘	3
2017	4.80%	↘	2
2016	5.00%	↘	1
2015	6.60%	→	0

Story Behind the Curve

Annual inventory and inspections by VTrans of bridges with spans > 20 ft on state and town highways, and short structures with spans between 6 and 20 ft on the state highway system.

Bridge condition performance continues to be responsibly managed in accordance with established asset management principles and guidelines.

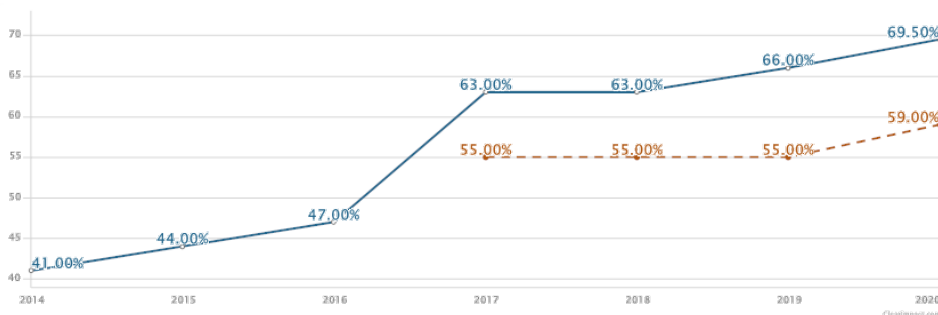
There was a change in the definition of Structurally Deficient (SD) structures. This term was previously defined in <https://www.fhwa.dot.gov/bridge/0650dsup.cfm> as having a condition rating of 4 or less for Item 58 (Deck), Item 59 (Superstructure), Item 60 (Substructure), or Item 62 (Culvert), OR having an appraisal rating of 2 or less for Item 67 (Structural Condition) or Item 71 (Waterway Adequacy) Beginning with the 2018 data archive, this term will be defined in accordance with the Pavement and Bridge Condition Performance Measures final rule, published in January of 2017, as a classification given to a bridge which has any component [Item 58, 59, 60, or 62] in Poor or worse condition [code of 4 or less].

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Strategy

PSD % of Vermont retail electric sales from renewable energy



2020	69.50%	↗	2
2019	66.00%	↗	1
2018	63.00%	→	1
2017	63.00%	↗	3
2016	47.00%	↗	2
2015	44.00%	↗	1
2014	41.00%	→	0

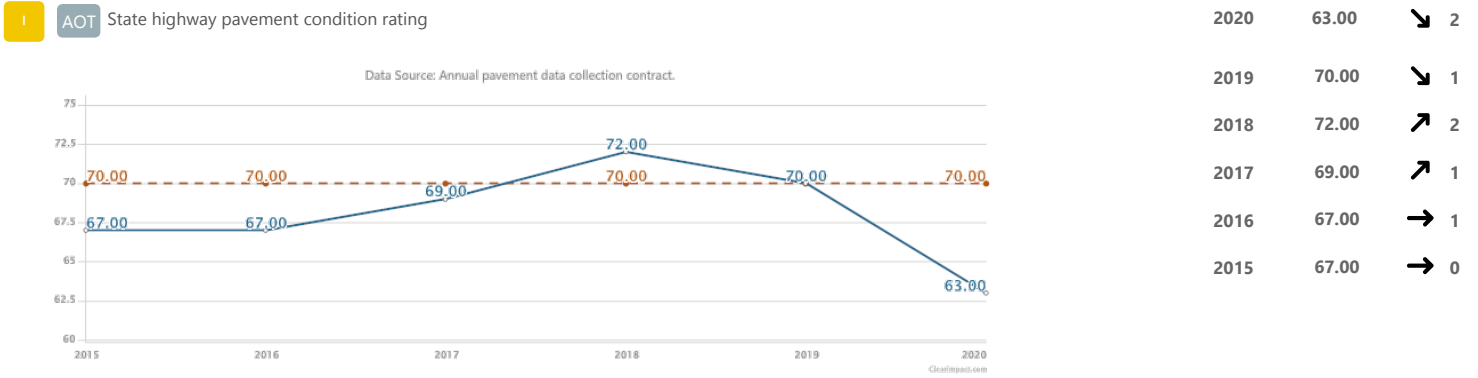
Story Behind the Curve

The percentage of power supplied to customers for which utilities held a corresponding amount of Renewable Energy Certificates, required by law to be 55% in 2017, rising to 75% by 2032.

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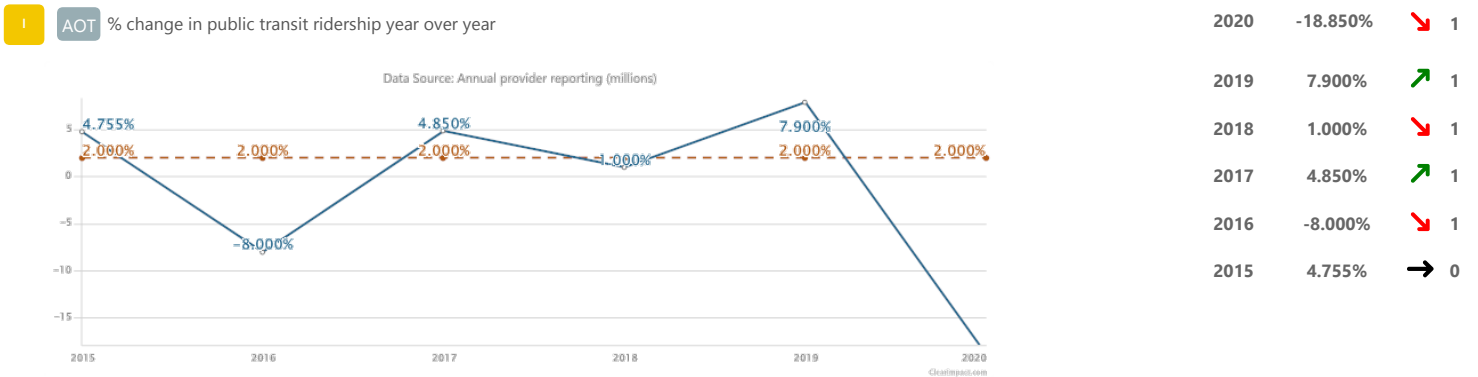
Story Behind the Curve

Pavement Condition (PC) is a measure of a driver's experience while traveling down the road and is rated on a scale of 0 to 100 based on measured pavement distresses. The scale is called the composite pavement condition index. Pavement condition is tracked using two different performance measures, Travel Weighted Average Condition and the Percent of Pavement Mileage in Very Poor Condition. Two measures are used to ensure a balance between good condition roads for the majority of travelers and a reasonable minimum condition for less-traveled roads.

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Story Behind the Curve

Public Transit ridership in SFY20 significantly impacted by the COVID-19 pandemic. We saw a drop in ridership in excess of 965,000 rides taken.

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