

# OUTCOMES REPORT ("Act 186")

THE STATEWIDE POPULATION-LEVEL 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

### Act186 VERMONT HAS A PROSPEROUS ECONOMY

Time Period Actual Value Current Trend

#### Act186 % or rate per 1,000 jobs of non-public sector employment

2018	829	↗ 1
2017	828	→ 1
2016	828	↗ 1
2015	826	→ 0



#### Story Behind the Curve

This long period of economic expansion continued through CY2017. Private sector jobs grew faster than government sector jobs.

	State	Chittenden	Non-Chittenden
2017	829	839	824
2016	828	837	823
2015	828	833	825
2014	826	832	823

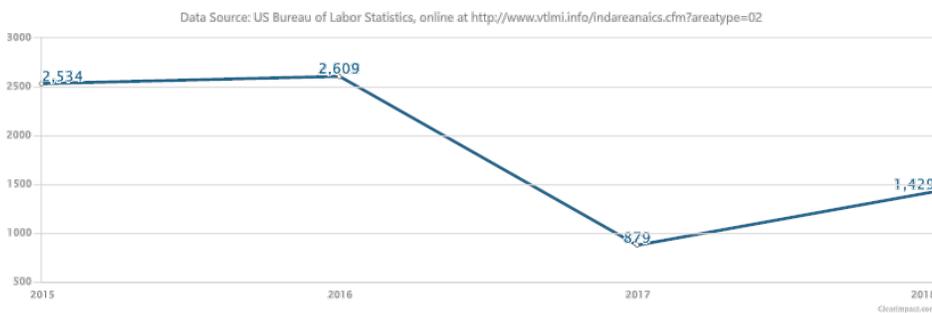
#### Partners

#### What Works

#### Strategy

#### Act186 Net change in nonpublic sector employment

2018	1,429	↗ 1
2017	879	↘ 1
2016	2,609	↗ 1
2015	2,534	→ 0



#### Story Behind the Curve

This long period of economic expansion continued through CY2017. Private sector jobs continue to be added.

	State	Chittenden	Non-

	State	Chittenden	Non-Chittenden
2018	1429	585	844
2017	879	716	163
2016	2609	1308	1301
2015	2534	523	2011

Partners

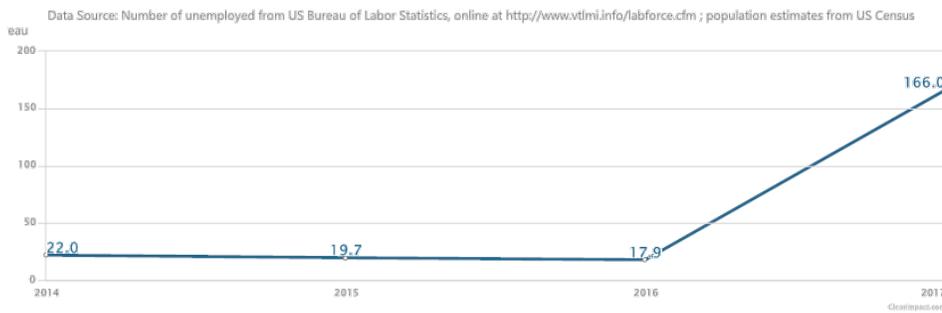
What Works

Strategy



Act186 % or rate of resident unemployment per 1,000 residents

2017	166.0	↗	1
2016	17.9	↘	2
2015	19.7	↘	1
2014	22.0	→	0



#### Story Behind the Curve

This long period of economic expansion continued through CY2017. The number of unemployed persons continues to fall.

	State	Chittenden	Non-Chittenden
2017	16.6	13.4	17.8
2016	17.9	14.8	19.0
2015	19.7	16.0	21.0
2014	22.0	23.3	23.3

Partners

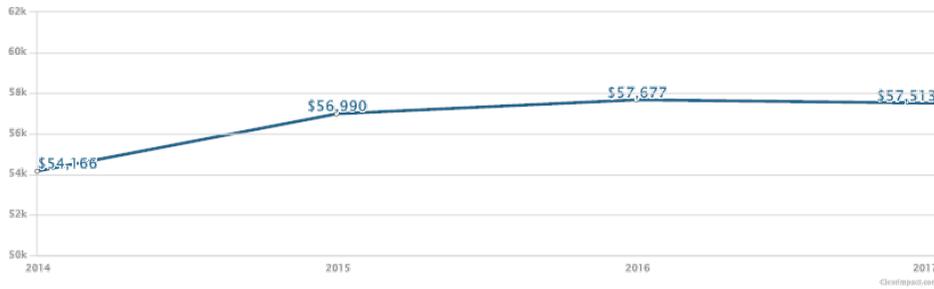
What Works

Strategy

**Act186** Median household income

2017	\$57,513	↓	1
2016	\$57,677	↑	2
2015	\$56,990	↑	1
2014	\$54,166	→	0

Data Source: US Census Bureau, online at <https://census.gov/data/tables/time-series/demo/income-poverty/historical-income-households.html>



**Story Behind the Curve**

This long period of economic expansion continued through CY2017. This 1-yr measure of income is volatile.

	State	Chittenden	Non- Chittenden
2017	57513	64444	n/a
2016	57677	68843	n/a
2015	56990	67997	n/a
2014	54166	62004	n/a

**Partners**

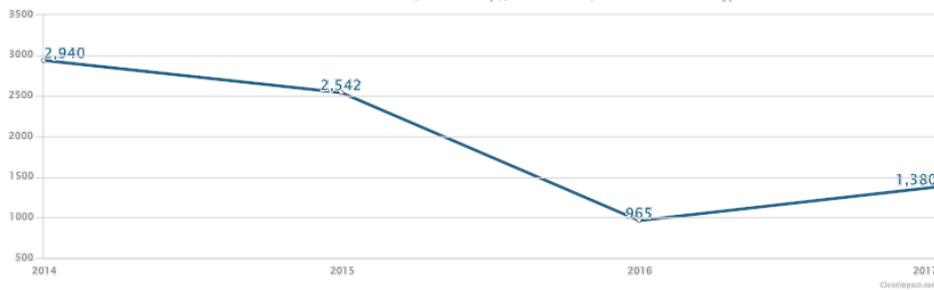
**What Works**

**Strategy**

**Act186** Net change in jobs

2017	1,380	↑	1
2016	965	↓	2
2015	2,542	↓	1
2014	2,940	→	0

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



**Story Behind the Curve**

This long period of economic expansion continued through CY2017. Jobs continue to be added.

	State	Chittenden	Non- Chittenden
2017	1380	500	880
2016	965	365	600
2015	2542	1492	1050
2014	2940	601	2339

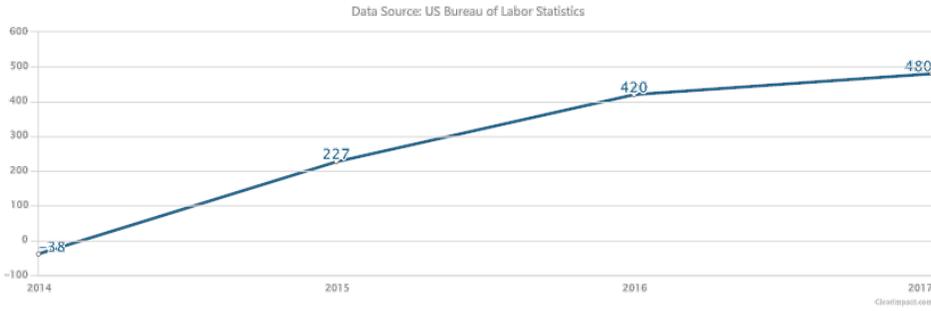
**Partners**

What Works

Strategy

**Act186** Net change in business establishments

2017	480	↗	3
2016	420	↗	2
2015	227	↗	1
2014	-38	→	0



Story Behind the Curve

This long period of economic expansion continued through CY2017. Business establishments continue to be added.

	State	Chittenden	Non-Chittenden
2017	480	178	302
2016	420	180	240
2015	227	162	65
2014	-38	99	-137

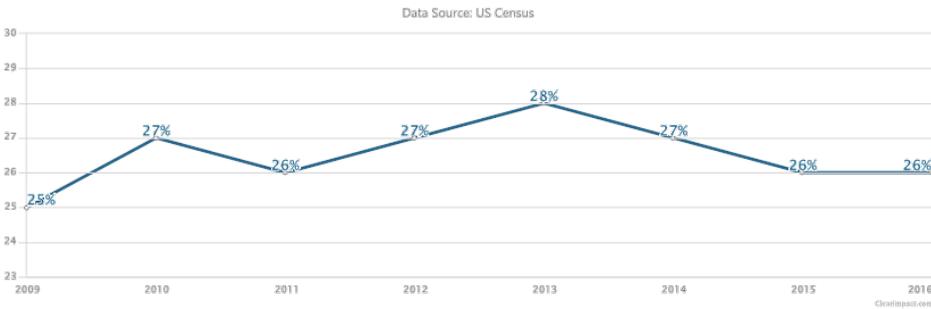
Partners

What Works

Strategy

**Act 186** % of population living at or below 185% of the Federal Poverty Level

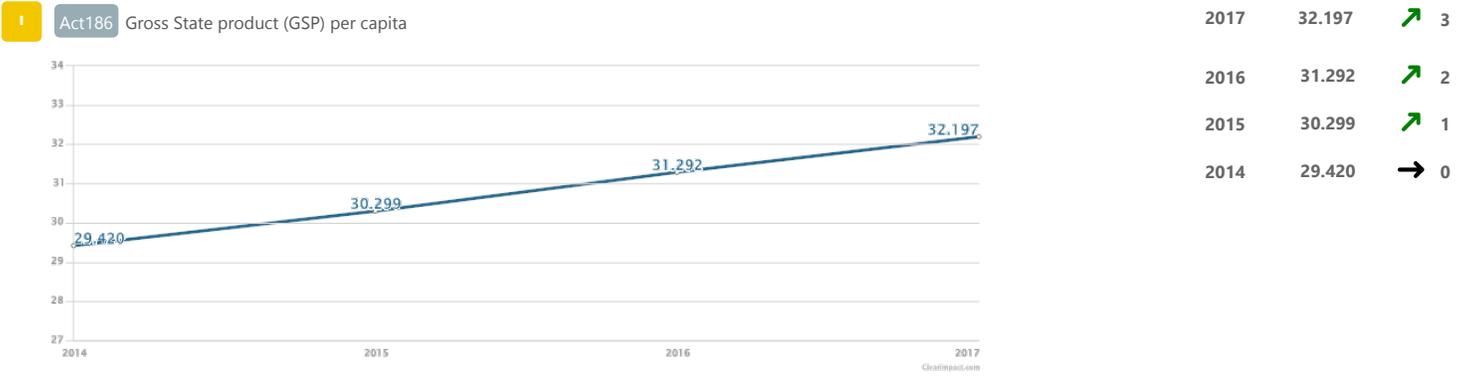
2016	26%	→	1
2015	26%	↘	2
2014	27%	↘	1
2013	28%	↗	2
2012	27%	↗	1
2011	26%	↘	1
2010	27%	↗	1
2009	25%	→	0



Story Behind the Curve

Partners

What Works



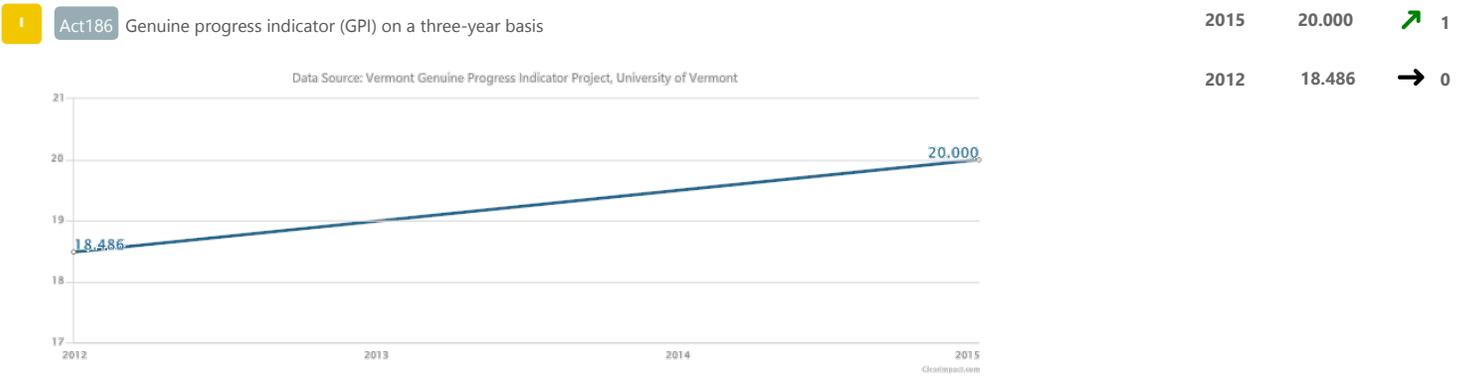
**Story Behind the Curve**

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**

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.

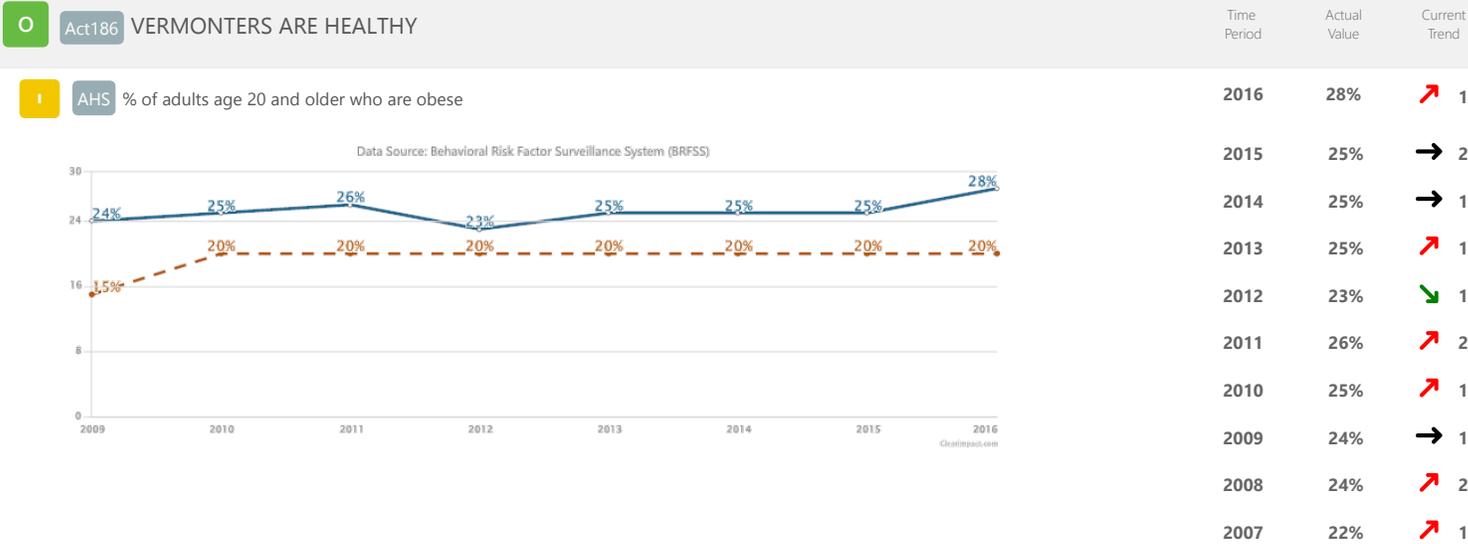
- **The GPI stands at about 66% of the state's Gross State Product (GSP) of \$30.355 billion.** 1 Some gap between the two figures is to be expected, as gross receipts usually exceed net benefits. 2 The size of the gap can be meaningful. Generally, the largest contributor to the GPI-GSP gap is the uncounted 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

Partners

What Works

Strategy

## OUTCOME 2



Story Behind the Curve

Last Updated: December 2017

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

In 2016, the Behavioral Risk Factor Surveillance System (BRFSS) data showed that 28% of Vermont adults age 20 and older are obese. This is higher than in 2015, when the prevalence was 23%, 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 have seen the rate for adults meeting physical activity guidelines stagnate in recent years, at 59%. Additionally, of concern is that the rate of fruit consumption among adults has been on the decline, with 32% of adults eating two or more fruits a day in 2015, down from 35% in 2013. On a positive note, 20% of adults reported eating three or more vegetables a day in 2015, up from 18% in 2013.

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 are the cause of 57% of deaths in Vermont. This has led us to organizing our work to highlight these preventable diseases through [3-4-50](#) (see Strategies below for more information).

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#### 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.

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#### 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](#), [healthy community design](#), and [worksites wellness](#) programs. [More information is available from the Centers for Disease Control and Prevention.](#)

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#### 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.

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#### 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.

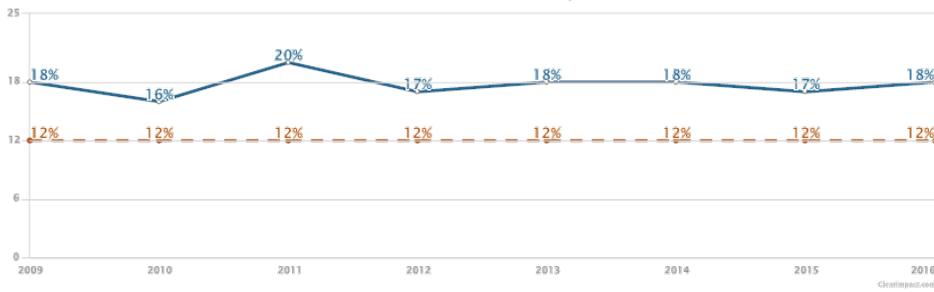
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#### Notes on Methodology

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.

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)



2015	17%	↘	1
2014	18%	→	1
2013	18%	↗	1
2012	17%	↘	1
2011	20%	↗	1
2010	16%	↘	1
2009	18%	↗	1
2008	17%	↘	1
2007	18%	→	1

### Story Behind the Curve

Last Updated: September 20, 2017

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 2016 the smoking rate rose slightly to 18%. According to the [Campaign for Tobacco Free Kids](#), Vermont ranks 18th lowest in adult prevalence and in recent years has been the same as the national rate. 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.

Over the past five years, 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. 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; and requiring all tobacco products be safely stored behind the counter in a locked case.

### 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.
- Tobacco Evaluation and Review Board (VTERB): An independent state board dedicated to a statewide Comprehensive Tobacco Control Program that continually and effectively reduces tobacco use prevalence 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.

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#### 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.

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#### 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](#).

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#### Why Is This Important?

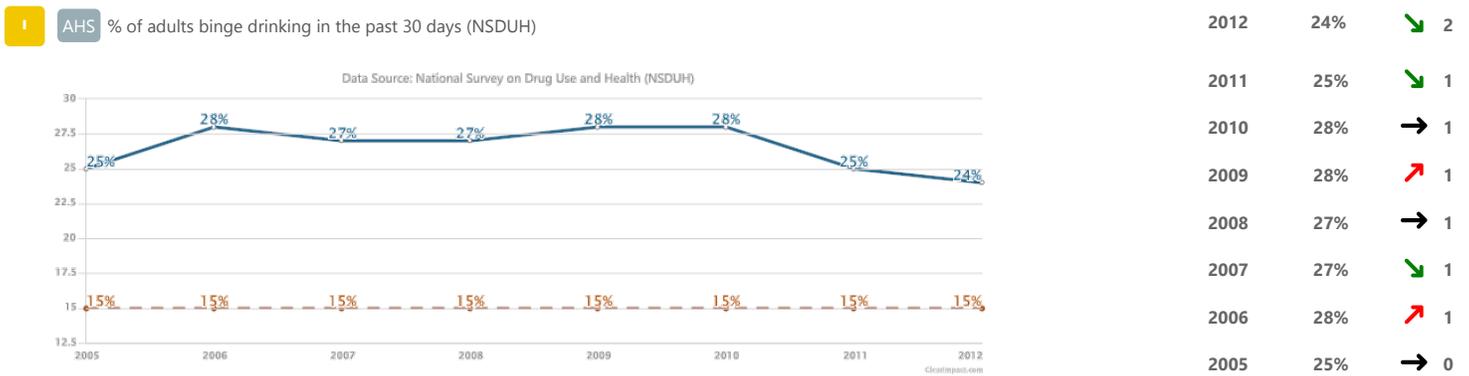
Tobacco use is the #1 preventable cause of death. In Vermont, smoking costs approximately \$348 million in medical expenses and results in an estimated 1,000 smoking-related deaths each year. 10,000 kids now under 18 and alive in Vermont will ultimately die prematurely from smoking. Countless other lives, 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.

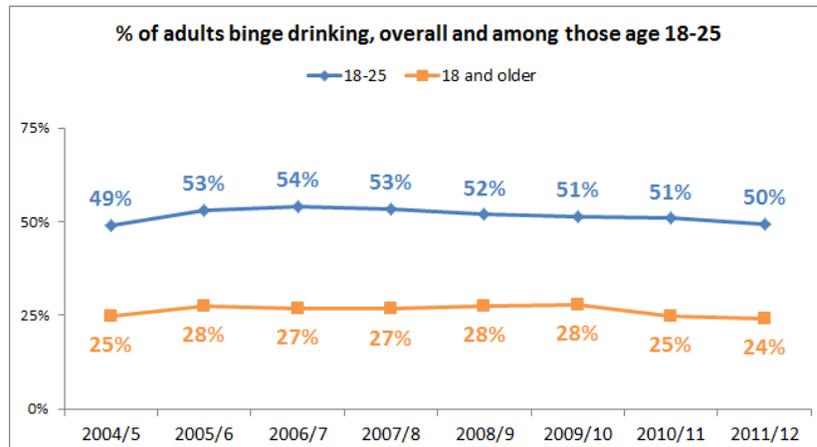


Story Behind the Curve

Last Updated: April 2014

Author: State Epidemiological Outcomes Workgroup, Vermont Department of Health

Binge drinking is defined by the National Survey on Drug Use and Health (NSDUH) as having 4 (females) or 5 (males) drinks in one sitting. NSDUH reports state-level data across 2-year time frames due to sample size considerations. From 2005/6 to 2010/11 (the latest state data to report age 18+ binge drinking) the rate has remained steady at approximately 27%. Over that time period, the prevalence in the 18-25 year old age group has also been steady at approximately 51% and remains the highest of any age group (see figure).



Until 2005 the data on this indicator were categorized by NSDUH into 2 adult age ranges: age 18-25 and age 26+. In 2005, NSDUH started reporting data for the age 18+ category. Even though the minimum legal drinking age in Vermont and all US states is 21, the age of majority is usually defined as 18. At this age an individual can legally vote, marry, enter into financial contracts, etc. Efforts to “bend the curve” have not proven successful for either age group so far. The good news is that there has been no increase in prevalence of binge drinking.

Up until recently most Health Department binge drinking prevention efforts were targeted to adolescents ages 12-17 because we could have the greatest impact given limited resources. To that end, binge drinking prevalence significantly decreased from 2002 to 2012 among individuals in that age group (see additional VDH links). However, binge drinking prevalence of age 18+ (especially among age 18-25) remained at unacceptably high levels.

It is important to realize that adults age 18-25 who are in college engage in binge drinking at a much higher rate than their non-college peers which is why there is a focus on college drinking.

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#### Partners

- Community Coalitions
- College and University Administrators, Staff and Students
- Healthcare Providers
- Law Enforcement
- Division of Maternal & Child Health, Vermont Department of Health
- Regional Substance Abuse Prevention Consultants, Office of Local Health, Vermont Department of Health

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#### 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 youth and families, as well as community-wide strategies such as media advocacy and community education.

There are several programs and practices specifically directed to college age individuals. Increases to the tax on alcohol are directly related to rates of consumption – the higher the cost of alcohol, the less alcohol consumed. Restricting the number of alcohol outlets also reduces alcohol consumption and associated negative consequences such as crime, domestic violence, etc.

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#### Strategy

The Agency of Human Services has recognized this problem and begun to engage all divisions and departments that have a stake in reducing binge drinking, particularly among high risk groups. Together with partners, the Agency plans to continue to employ a comprehensive strategy including: education; screening, brief intervention, and referral to treatment; and policy enforcement.

Specific initiatives include:

- 0-4-9 Campaign: The Vermont Department of Health's (VDH) Divisions of Maternal and Child Health and Alcohol and Drug Abuse Programs are implementing the 0-4-9 Campaign which urges health care professionals to remind their patients that any drinking during pregnancy carries serious potential risks to the fetus.
- Colleges and universities: VDH partners with colleges and the University of Vermont to address binge drinking on college campuses because adults age 18-25 who are in college engage in binge drinking at a much higher rate than their non-college peers. College symposia provide institutions of higher education the opportunity to share experiences with programs and policies that may be effective in reducing binge drinking and associated negative consequences. In addition, the Division of Alcohol and Drug Abuse Programs (ADAP) is underwriting the [National College Health Assessment](#) which will survey college students on a number of health related issues including alcohol consumption and binge drinking. Individual schools can then develop prevention and intervention programs tailored to the needs of the specific school including evidence-based initiatives such as restricting alcohol availability, restricting alcohol in public spaces and/or community events.
- Partnership for Success: The Partnerships for Success initiative supports partnerships between community and colleges in three regions of the state. They implement policy approaches on restricting alcohol in public places and/or at community events, electronic screening and brief intervention.
- SBIRT: VDH is implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) among individuals age 18 and older to identify potential high risk drinkers and direct them to an appropriate level of care. The goal is to screen 95,000 Vermonters over a five year period.

Why Is This Important?

Notes on Methodology

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.

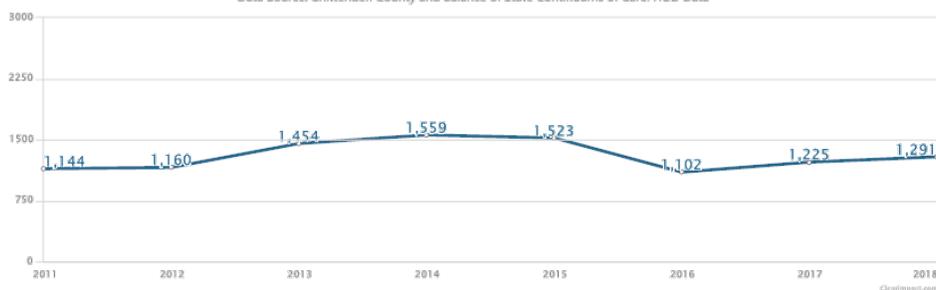


VAHS Act186

Number of persons who are homeless (adults and children)

2018	1,291	↗	2
2017	1,225	↗	1
2016	1,102	↘	2
2015	1,523	↘	1
2014	1,559	↗	3
2013	1,454	↗	2
2012	1,160	↗	1
2011	1,144	→	0

Data Source: Chittenden County and Balance of State Continuums of Care: HUD Data



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.

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

Updated in September, 2015

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## 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.

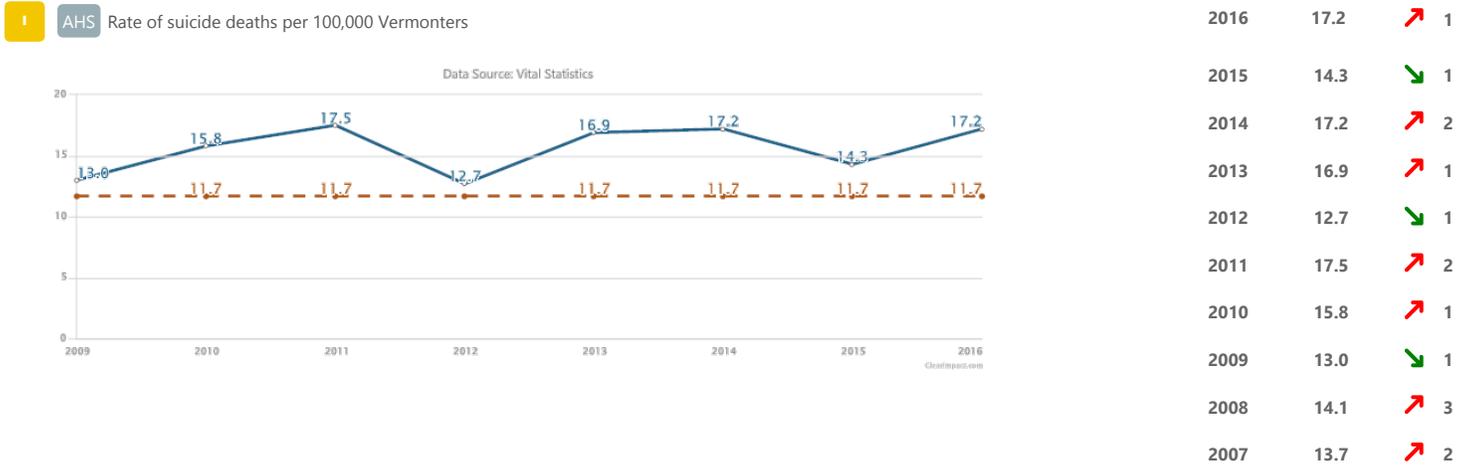
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## What Works

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

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. Vermont rates of suicide are also higher than the rates of neighboring states and the New England Region. The overall rate for the past 10 years has been increasing. Deaths by suicide in Vermont appear to follow national patterns. More men die by suicide than women. Firearms are the method used for nearly two-thirds of the deaths by suicide.

*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 2015

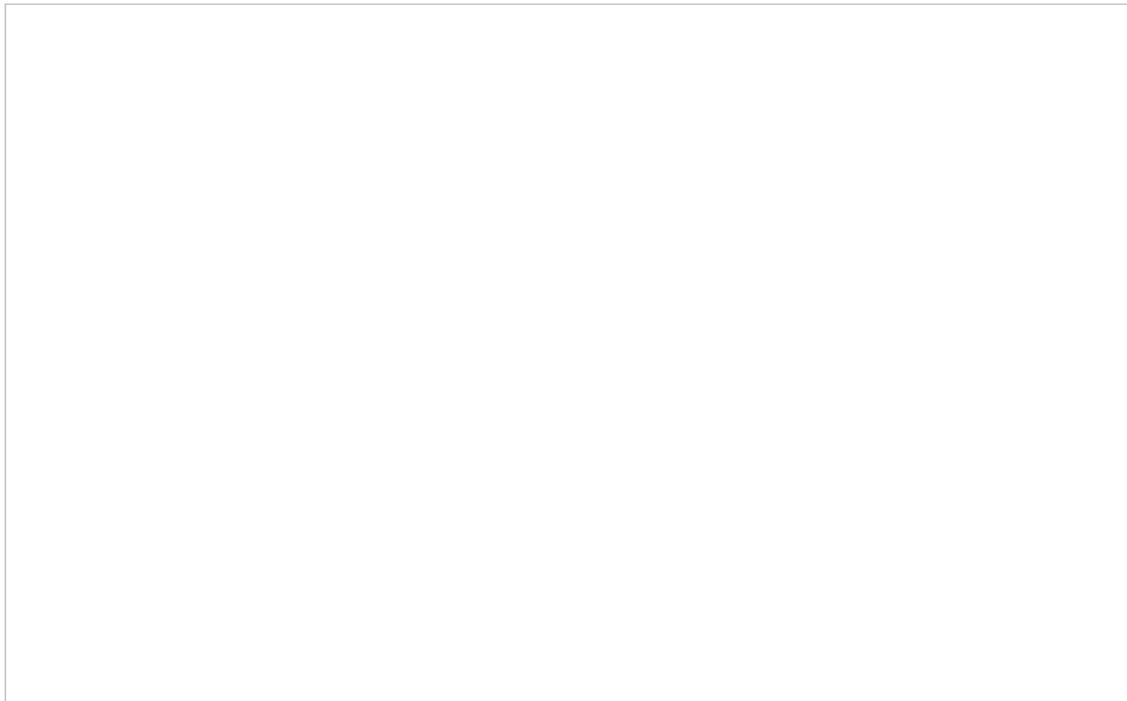
Partners

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.



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#### 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. **UMatter** campaign plans to accomplish the following:

- Promote the message that suicide is preventable
- Equip gatekeepers with the knowledge and skills to respond effectively to those in distress
- Increase public awareness of the importance of addressing mental health issues
- Establish a broad-based suicide prevention and intervention strategy throughout Vermont
- Sponsor a media campaign to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
- Promote positive youth development
- 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:
  - DA crisis services
  - 211 - National Suicide Prevention hotline
  - Peer run warm line
  - Domestic violence hotline
  - 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:
  - Counselling about Access to Lethal Means (CALM)
  - 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
  - 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.
  - 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.

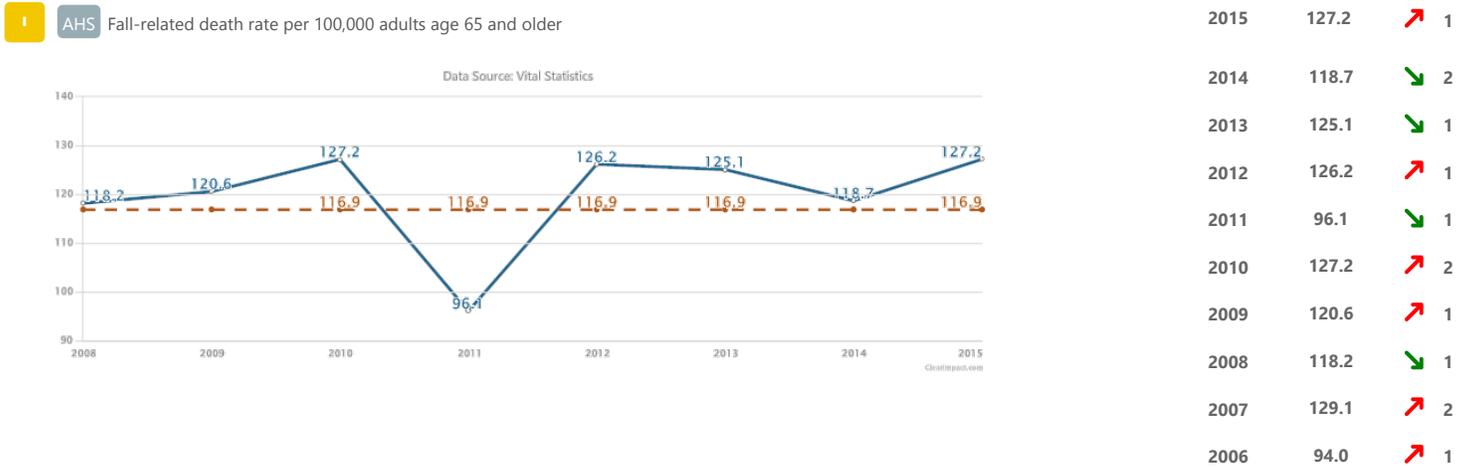
Act 186 was passed by the Vermont Legislature in 2014 to quantify how well State government is working to achieve the population-level outcomes the Legislature sets for Vermont’s quality of life. It will assist the Legislature in determining how best to invest taxpayer dollars. The Vermont Department 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**

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 <http://www.cdc.gov/nchs/data/statnt/statnt20.pdf>.

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



**Story Behind the Curve**

*Last Updated: November 2016*

*Author:*

*Injury Prevention Program Team, Vermont Department of Health*

Over the time period between 2002 and 2014, the number and rate of fall-related deaths have increased. The 2014 Vermont death rate of 118.7 per 100,000 adults age 65 and older is significantly higher than that in 2002. Vermont's elderly (over age 65) fall-related mortality rate is higher than the national rate. In 2007, Vermont's fall-related death rate for this age group was 129.1 compared to [45.3 nationally](#).

There are no major population-based events that are recognized as influencing the data in this time frame however, Vermont's ability to recognize and document fall-related deaths may have improved. Vermont's data provides useful information on the targeting of both primary and secondary prevention activities.

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#### 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

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#### 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

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#### Strategy

- The Vermont Department of Health received grant funding to run a state falls prevention program in 2014. 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.
  - Deliver the evidence-based program FallScape and use the resulting data, along with EMS falls-related 911 calls data, to support pursuit of reimbursement and evaluate program efficacy.
  - 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

This work is funded in part by:

- National Council on Aging and Administration on Community Living
- Association of State and Territorial Health Organizations
- Older American's Act funding; DAAL provides oversight of the distribution to the Area Agencies on Aging and therefore collaborates with the local AAA's on programming.
- Blueprint reimbursement for providers, community health teams and SASH

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](#).

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#### 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.

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#### 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.

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#### 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.

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#### **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.

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#### **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).

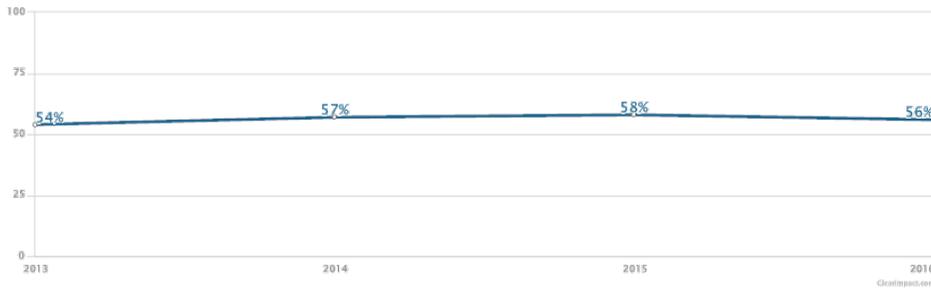
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Act186 % of Vermont adults with any mental health conditions receiving treatment

2016	56%	↓ 1
2015	58%	↑ 2
2014	57%	↑ 1
2013	54%	→ 0

Data Source: SAMHSA Behavioral Health Barometer - Vermont



#### Story Behind the Curve

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

This is a Vermont Department of Health [Healthy Vermonters 2020 objective](#).

Author: Vermont Department of Mental Health

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

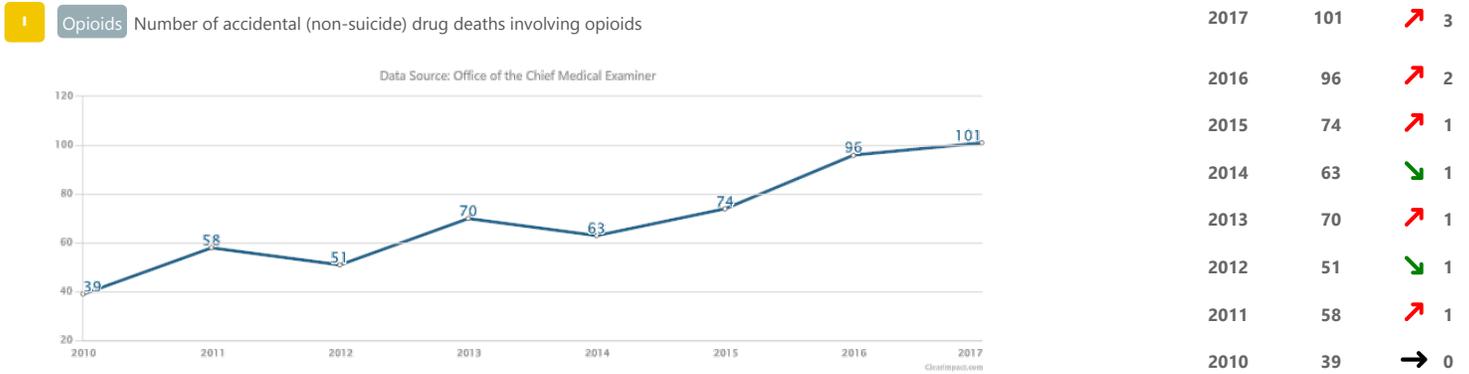
Percentages are from the SAMHSA Behavioral Health Barometer report for Vermont, available online at for each state at [http://www.samhsa.gov/data/us\\_map](http://www.samhsa.gov/data/us_map).

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.



Story Behind the Curve

Mar 2018

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 for the regularly updated drug-related fatalities data brief](#). In particular, the data brief includes information at the county level. Please note that in 2017, both the current and history.

Partners

What Works

Strategy

Why Is This Important?

Notes on Methodology

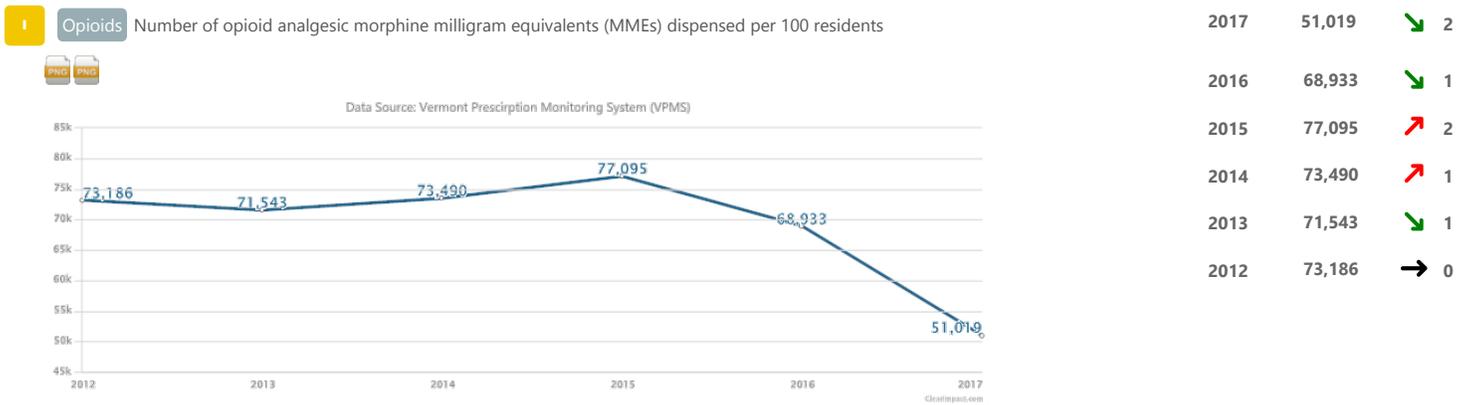
Vermont drug-related fatalities data come from the Vermont Department of Health Vital Statistics System and are based on deaths of Vermonters.

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

April 2018

The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.

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.

Most individuals who become dependent on opioids begin through the use of prescription opioids. 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 is encouraging patients and prescribers to use opioids only when essential due to these risks, and instead use other means for controlling pain.

Morphine milligram equivalents (MMEs) are the amount of morphine an opioid dose is equal to when prescribed. Many research experts, federal agencies (e.g., CDC, BJA, SAMHSA) and the VPMS use MMEs prescribed to standardize the dose across different formulations of drugs in order to better understand the abuse and overdose potential of opioid analgesics. The total MME is a good indication of total amount of opioids dispensed in the state and reducing the amount of opioids dispensed and used 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 increase in MME is attributable in part to the August 14, 2014 rescheduling of tramadol from a schedule V to a schedule IV drug. Prior to rescheduling tramadol was not reported to VPMS and is not included in the calculations. There was a 26% decrease in dispensed opioids between 2015 and 2017, the full years since tramadol was rescheduled.**

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#### Partners

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

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#### 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: <http://www.healthvermont.gov/s...>

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#### Notes on Methodology

Data are from the Vermont's prescription drug monitoring program, known as the Vermont Prescription Monitoring System (VPMS), a statewide electronic database of controlled substance prescriptions dispensed from Vermont-licensed pharmacies. 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.

The VPMS is a statewide electronic database of controlled substance prescriptions dispensed from Vermont-licensed pharmacies. It does not include all prescriptions.

- 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: <http://www.healthvermont.gov/a...>

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/drugoverdo...>

National Institute on Drug Abuse: <https://www.drugabuse.gov/publ...>

OUTCOME 3

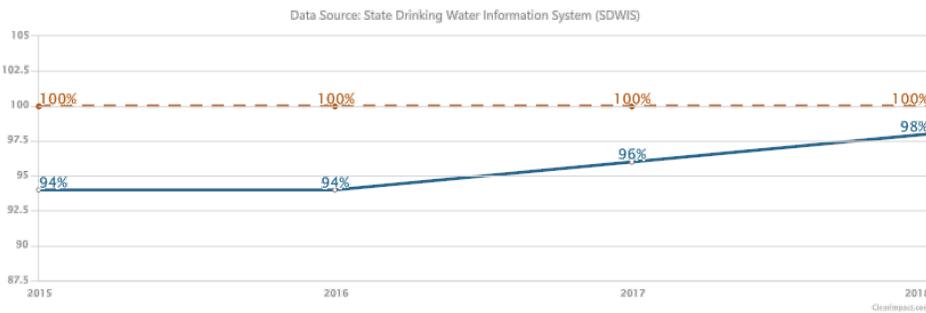
**O** Act186 VERMONT'S ENVIRONMENT IS CLEAN AND SUSTAINABLE

Time Period    Actual Value    Current Trend



Act186 % of public drinking water supplies in compliance with health-based standards

2018	98%	↗ 2
2017	96%	↗ 1
2016	94%	→ 1
2015	94%	→ 0



Story Behind the Curve

The percentage has increased because more water systems have come into compliance in the last several years.

Partners

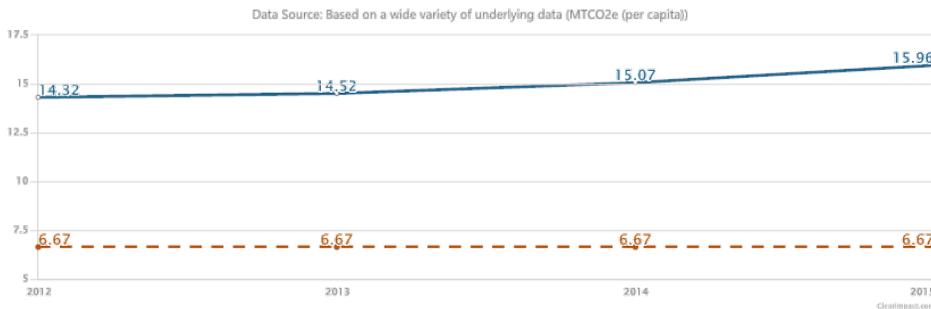
What Works

Strategy



Act186 Total greenhouse gas emissions per capita, in units of annual metric tons of equivalent carbon dioxide per capita

2015	15.96	↗ 3
2014	15.07	↗ 2
2013	14.52	↗ 1
2012	14.32	→ 0



Story Behind the Curve

Story Behind the Curve

The Target emissions per capita is based on population data for 2028 estimated from the average of two economic growth scenarios in a study from ACCD for 2010 and 2030. The "Current" year metric is from the latest VT GHG Emissions Update issued July 2018. The data are for cy2015, and are the most current data available.

Units MTCO2e is thousand tons of carbon dioxide equivalents; MMTCO2e == Million tons of CO2e.

Partners

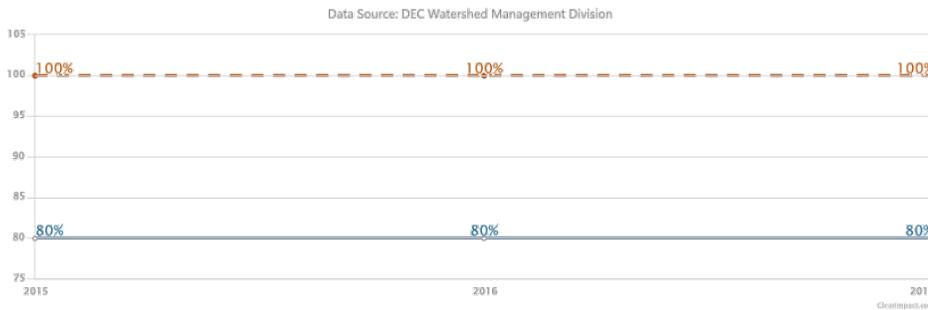
What Works

Strategy



**Act186** % of Vermont's rivers and lakes (excluding Lake Champlain) that meet State water quality standards for fishing

2017	80%	→ 2
2016	80%	→ 1
2015	80%	→ 0



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 not changed significantly during the reporting period. In 80% of Vermont's rivers and streams, the aquatic organisms are considered healthy and support fishing uses. The remaining 20% 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.

Partners

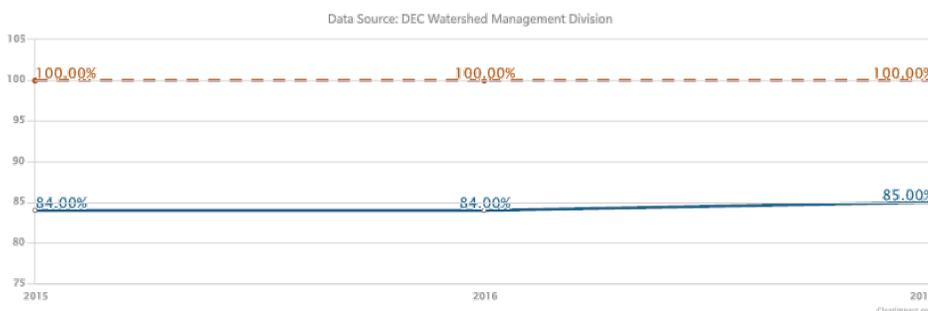
What Works

Strategy



**Act186** % of Vermont's rivers and lakes (excluding Lake Champlain) that meet State water quality standards for swimming

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 85% support swimming/recreational uses (75% consistently, and 10% where they are occasionally limited due to conditions that make swimming less desirable at times). The remaining 15% are consistently limited due to aquatic invasive species, and/or cyanobacteria (blue-green algae) blooms. The 1% increase in support swimming/recreational use from last reporting period was due largely to progress with Ticklenaked pond and progress within some water bodies in managing aquatic invasive species.

Partners

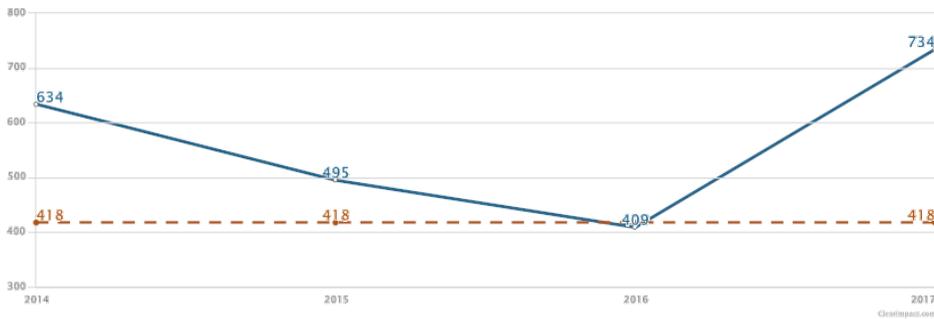
What Works

Strategy



Act186 Changes in total phosphorus loading to Lake Champlain from Vermont sources in metric tons per year

2017	734	↗ 1
2016	409	↘ 2
2015	495	↘ 1
2014	634	→ 0



Story Behind the Curve

The phosphorus data shown here represents the estimated annual load of phosphorus to Lake Champlain from the major Vermont tributaries. Phosphorus loading to the lake fluctuates annually due to weather and precipitation patterns. Higher amounts of precipitation, particularly heavy rainfall (as was seen in 2017), 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).

Partners

What Works

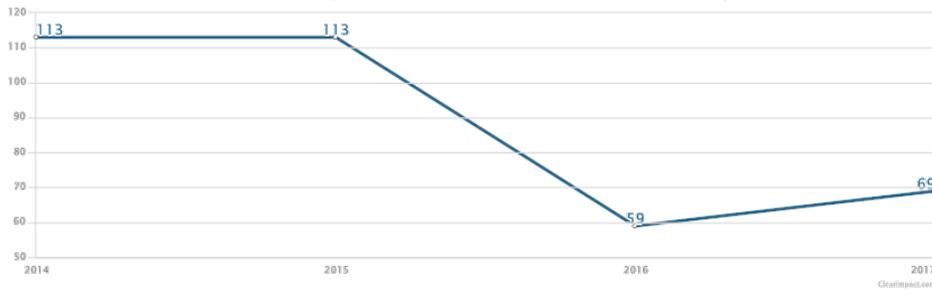
Strategy



Act186 Number of days air quality in Vermont posed a moderate or greater risk to sensitive populations;

2017	69	↗ 1
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Data Source: DEC Air Quality and Climate Division, and distributed EPA AIRNOW and EnviroFlash systems



2016	59	↓ 1
2015	113	→ 1
2014	113	→ 0

#### 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. The Rutland ozone monitor was installed in 2016, therefore years prior to 2016 may have had a few more days of poor air quality than are reported here. 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 2017. The target number of days with poor air quality is zero.

Partners

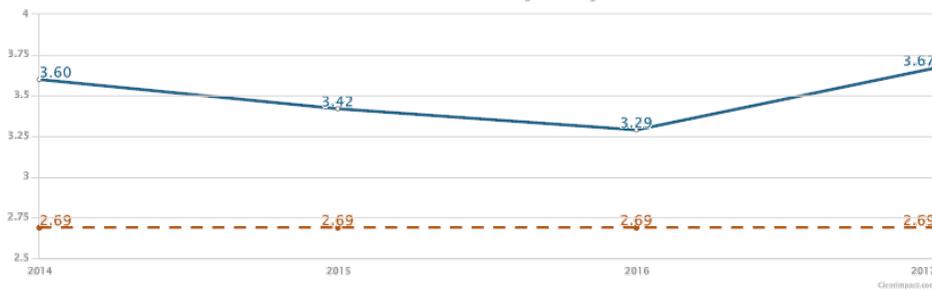
What Works

Strategy

**I** Act186 Disposal rate of municipal solid waste in pounds per person per day

2017	3.67	↑ 1
2016	3.29	↓ 2
2015	3.42	↓ 1
2014	3.60	→ 0

Data Source: DEC Solid Waste Management Program



#### Story Behind the Curve

On the whole, Vermont generated more waste in 2017, but diverted (recycled, composted etc.) a higher tonnage of recyclables than ever before. Although disposal rates increased significantly this past year, they remain comparable to historic values.

Partners

What Works

Strategy

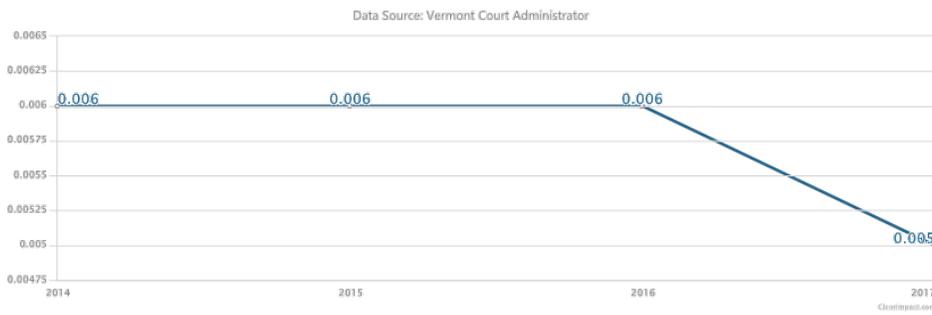
## OUTCOME 4

**O** Act186 VERMONT IS A SAFE PLACE TO LIVE

Time Period Actual Value Current Trend

**Act186** Rate of petitions granted for relief from domestic abuse per 1,000 residents

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 Court Administrators Office and is considered a reliable data source. Population for analysis taken from Vermont Department of Health 2016 estimates.

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. DPS will continue discussion on how best to accomplish this.

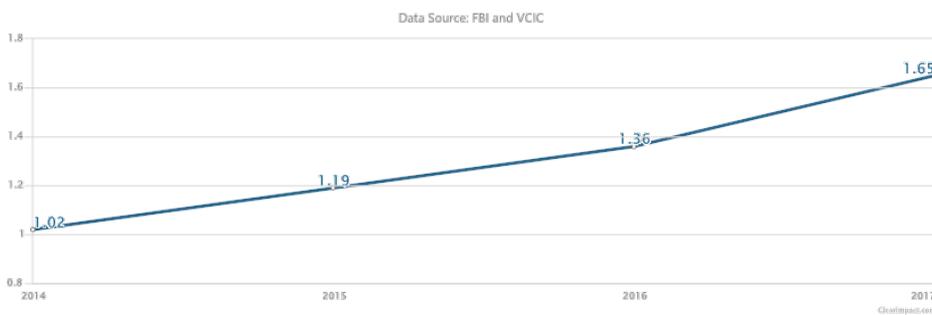
**Partners**

**What Works**

**Strategy**

**Act186** Rate of violent crime per 1,000 crimes

2017	1.65	↑ 3
2016	1.36	↑ 2
2015	1.19	↑ 1
2014	1.02	→ 0



**Story Behind the Curve**

The indicator showed an increase in 2017. However, DPS is concerned that this may be due to improved reporting systems rather than actual changes in crime rate. Since many local police departments transitioned away from the Spillman Records Management System to the Valcour records management system reporting crime statistics has not been reliable. The 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 over time which should be indicative of better reporting. Prior data updated to reflect information provided through the FBI Crime Data Explorer.

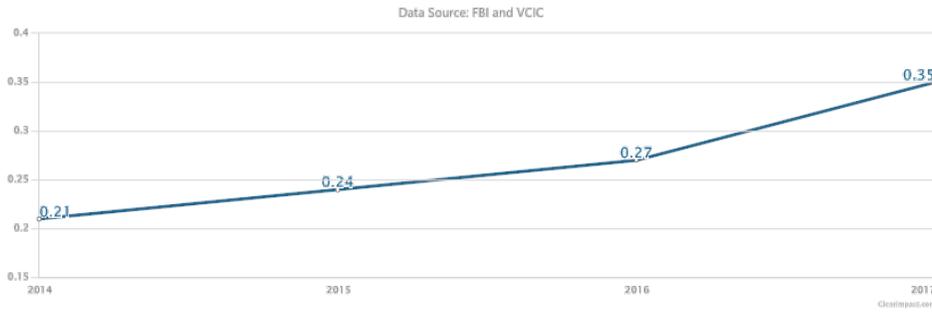
**Partners**

**What Works**

**Strategy**

**Act186** Rate of sexual assault committed against residents per 1,000 residents

2017	0.35	↗ 3
2016	0.27	↗ 2
2015	0.24	↗ 1
2014	0.21	→ 0



**Story Behind the Curve**

The indicator showed an increase in 2017. However, DPS is concerned that this may be due to improved reporting systems rather than actual changes in crime rate. Since many local police departments transitioned away from the Spillman Records Management System to the Valcour records management system reporting crime statistics has not been reliable. The 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 over time which should be indicative of better reporting. Prior data updated to reflect information provided through the FBI Crime Data Explorer.

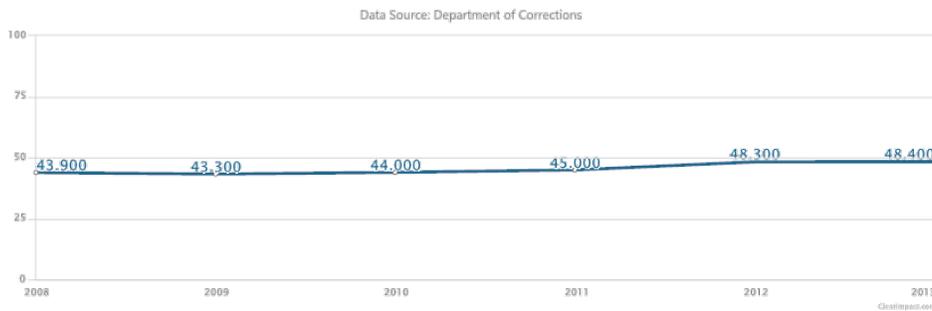
**Partners**

**What Works**

**Strategy**

**BO** Recidivism Rate

2013	48.400	↗ 4
2012	48.300	↗ 3
2011	45.000	↗ 2
2010	44.000	↗ 1
2009	43.300	↘ 1
2008	43.900	→ 0



**Story Behind the Curve**

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

The data tell us that the average recidivism rate has remained consistent over time. The fluctuations from year to year do not represent significant differences in the rate. It is common for recidivism rates to remain stable due to the nature of the measure. The goal is for this trend to go down.

*The Recidivism rate reflects the average risk level of individuals existing Vermont prisons and reentering the community. The data reports on prisoners (a person sentenced to serve more than one year) released between 2007 and 2012. These prisoners were followed for three years in court disposition records and corrections daily housing records to assess if they had been charged with a new crime or returned to prison for more than 90 days.*

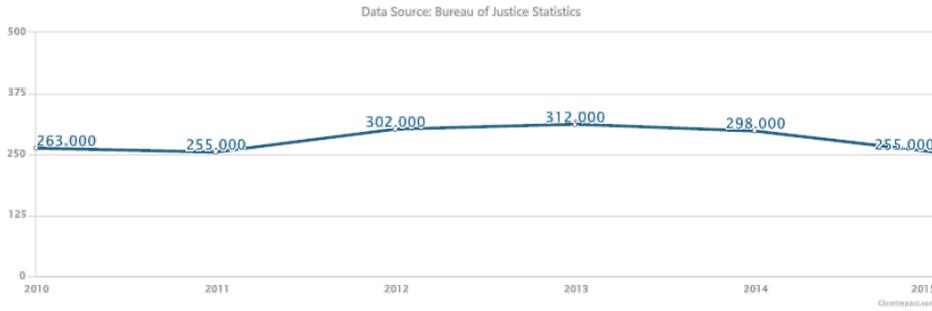
**Partners**

Strategy



Incarceration rate per 100,000 residents

2015	255.000	↘	2
2014	298.000	↘	1
2013	312.000	↗	2
2012	302.000	↗	1
2011	255.000	↘	1
2010	263.000	→	0



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). Our overall incarceration rate, regardless of sentence length, is 255/100K residents. This compares to the US Imprisonment rate of 593/100K. In all categories of inmate, Vermont's rate 50% less than the national average.

Partners

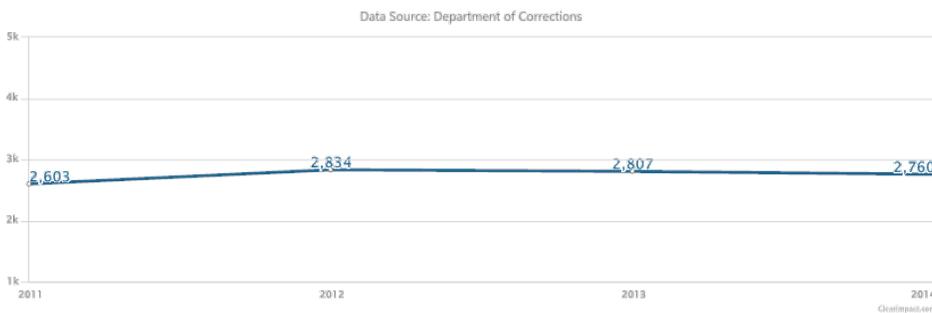
What Works

Strategy



Number of first time entrants into the corrections system

2014	2,760	↘	2
2013	2,807	↘	1
2012	2,834	↗	1
2011	2,603	→	0



Story Behind the Curve

There is significant evidence that demonstrates the effectiveness of diverting people early in the system will reduce future interactions with the criminal justice system. Across Vermont, there are many efforts working to intervene with individuals at earlier point along the sequential intercept. Many of these strategies are Pre-Charge (e.g. referral to Community Justice Center); Post Arrest (e.g. Court Diversion) or Pre-Trial (e.g. Rapid Referrals to other services). The success of these efforts contributes to the reduction of new entries into the DOC system.

Partners

What Works

Strategy

**I** Act186 Number of highway fatalities involving no or the improper use of seatbelts

2018	19	↓ 2
2017	22	↓ 1
2016	24	↑ 1
2015	23	→ 0



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

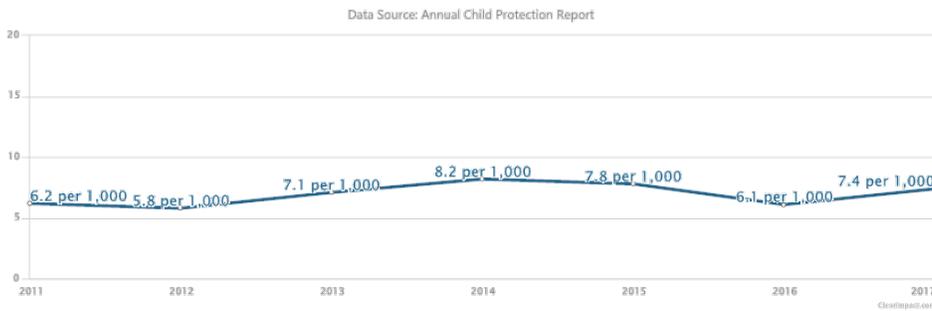
**OUTCOME 5**

**O** Act186 VERMONT'S FAMILIES ARE SAFE, NURTURING, STABLE, AND SUPPORTED

Time Period	Actual Value	Current Trend
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**I** Act 186 Rate of substantiated reports of child abuse and neglect per 1,000 children

2017	7.4 per 1,000	↑ 1
2016	6.1 per 1,000	↓ 2
2015	7.8 per 1,000	↓ 1
2014	8.2 per 1,000	↑ 2
2013	7.1 per 1,000	↑ 1
2012	5.8 per 1,000	↓ 1
2011	6.2 per 1,000	→ 0



Notes on Methodology

This indicator draws on data from the annual Child Protection Report.

Last updated: September 2017

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 increased in the past several years, from a low of 5.6 in 2010 to a high of 8.2 in 2014. In 2015, the rate decreased slightly to 7.8. Increased rates of poverty, substance abuse (particularly opiate use), and family and community violence have been linked to this increase. During the same period of time, the national average was 9.1 to 9.3 maltreatment victims per 1,000 children. Vermont's slightly lower rate may indicate that Vermont's investment in child abuse prevention, early childhood services, and comprehensive family supports is having an impact.

However, there is much more work to be done to assure child safety and support vulnerable families. It is anticipated that the rate of substantiated reports of abuse and neglect will increase in the coming months, based on findings from the [2015 Report on Child Protection in Vermont](#) by the Department for Children and Families (DCF). Ongoing child abuse prevention efforts at DCF include intensive family support home visiting (Strengthening Families Demonstration Project), a wide range of [anti-poverty initiatives](#), and increased capacity for substance abuse screening in Family Services Division (FSD) district offices through contracts with community partners. In addition, [Integrating Family Services](#) within the Agency of Human Services seeks to bring state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont's children, youth and families.

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*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.*

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#### 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

- VCFEA

- VFAPA
- KIN-KAN
- VT KIN AS PARENTS

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#### 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.

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#### 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](#).

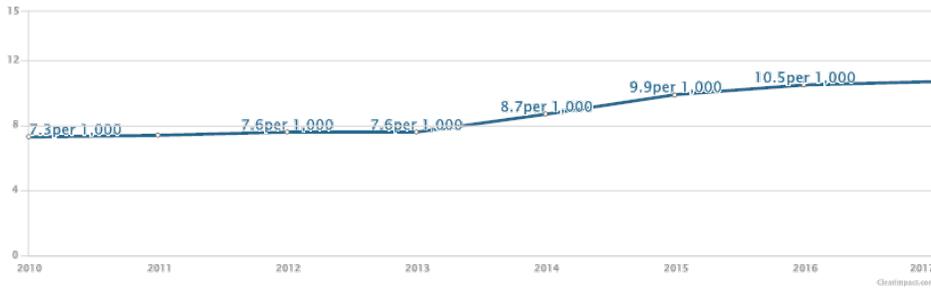


Act 186 Rate of children and youth in out-of-home care per 1,000 children and youth

2017

10.7per  
1,000

4



2016	10.5per 1,000	↗	3
2015	9.9per 1,000	↗	2
2014	8.7per 1,000	↗	1
2013	7.6per 1,000	→	1
2012	7.6per 1,000	↗	2
2011	7.4per 1,000	↗	1
2010	7.3per 1,000	→	0

Notes on Methodology

Out of home care includes foster care, kinship care, treatment 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 2017

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 number of children in out of home care has increased steadily since 2010. Over the past 3 years, there has been a 34% increase in the number of children in DCF custody, bringing the total to nearly 1,400 children. This is the highest number of children in custody in over a decade, and places Vermont above the national average for children in out of home care. The trend is most startling for children under the age of six, which increased 81%. This rise in the rate of children in out of home care can be partially attributed to substance abuse (particularly opiates) among families with young children. In 2015, substance abuse was a factor in 28% of the reports received by the Child Protection Line.

There is more work to be done to assure child safety and support vulnerable families. It is anticipated that the rate of children and youth in out of home care will continue to rise, based on findings from the [2015 Report on Child Protection in Vermont](#):

- Calls to DCF’s Child Protection Hotline increased by 4.8%; over 20,000 calls were received. Substance abuse was identified as a contributing factor in 28% of those calls.
- The number of children who were substantiated victims of child abuse decreased from 992 to 945.
- Since July 2014, Family Services has added 36 social workers in district offices. Even with these additional resources, due to rising number of children and families we are serving, caseloads for social workers are still high. At the same time, we must also acknowledge the substantial addition of resources that we have experienced in the last 2 years. In 2014, we had 141 district office social workers. Today, we have 177. That is a 25% increase in the number of social workers in 2 years.

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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#### Strategy

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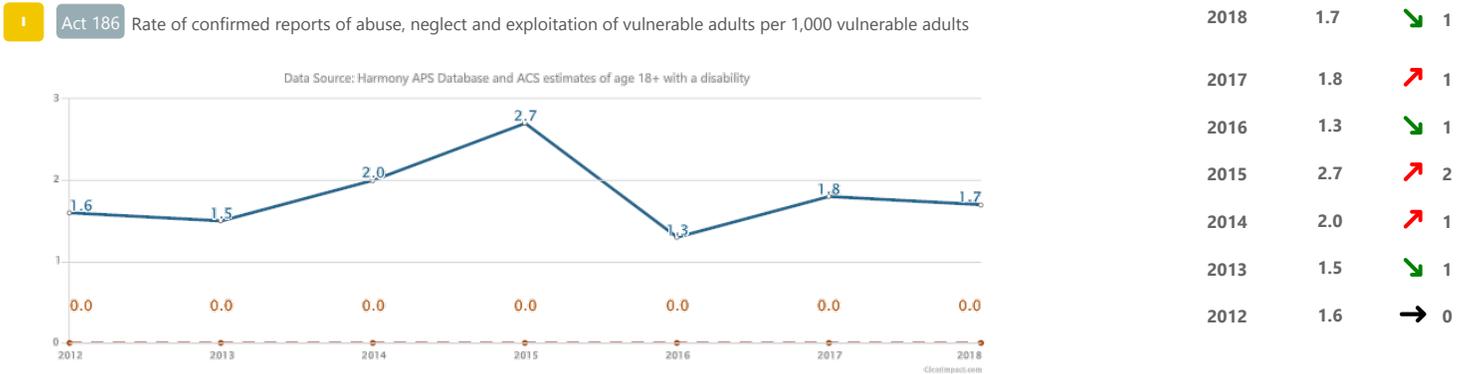
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- Implemented new policies requiring management consultation in cases of serious physical abuse;
- Held a statewide conference in March 2015 for staff and partners focusing on the needs of young children and how to improve our focus on the safety and 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](#).

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- 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
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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.

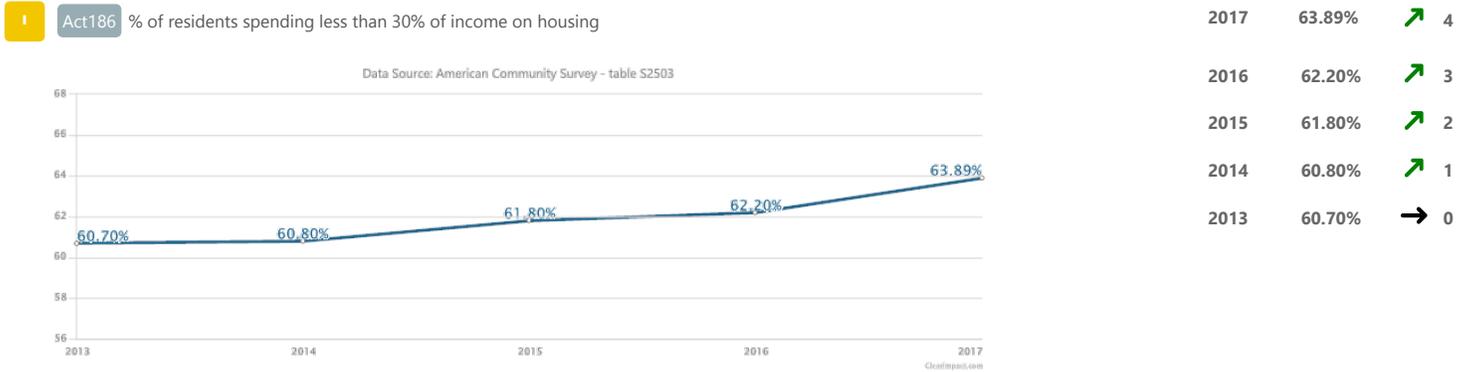
#### What Works

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

Strategy

Notes on Methodology

Numbers of substantiations are from DAIL DLP Adult Protective Services. DAIL DLP produces an estimated rate based on the estimated numbers of vulnerable adults.



Story Behind the Curve

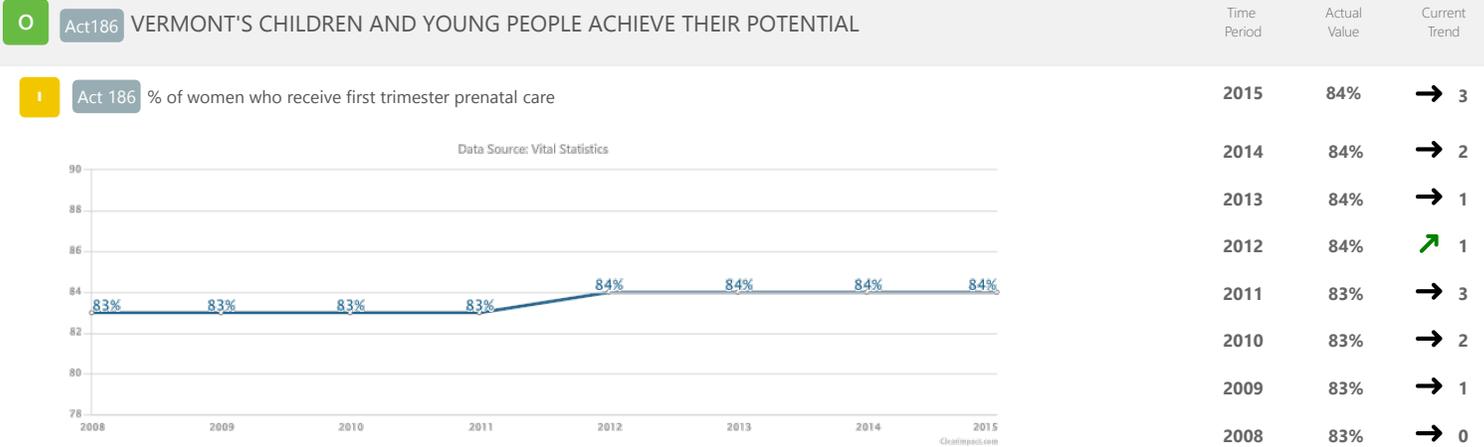
Monthly housing costs as a percentage of household income for the past 12 months.

Partners

What Works

Strategy

OUTCOME 6



Story Behind the Curve

Last Updated: September 2016  
 Author: Vermont Department of Health

The proportion of women reporting first trimester prenatal care remains steady at 84% as measured on the birth certificate.

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Partners

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What Works

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Strategy

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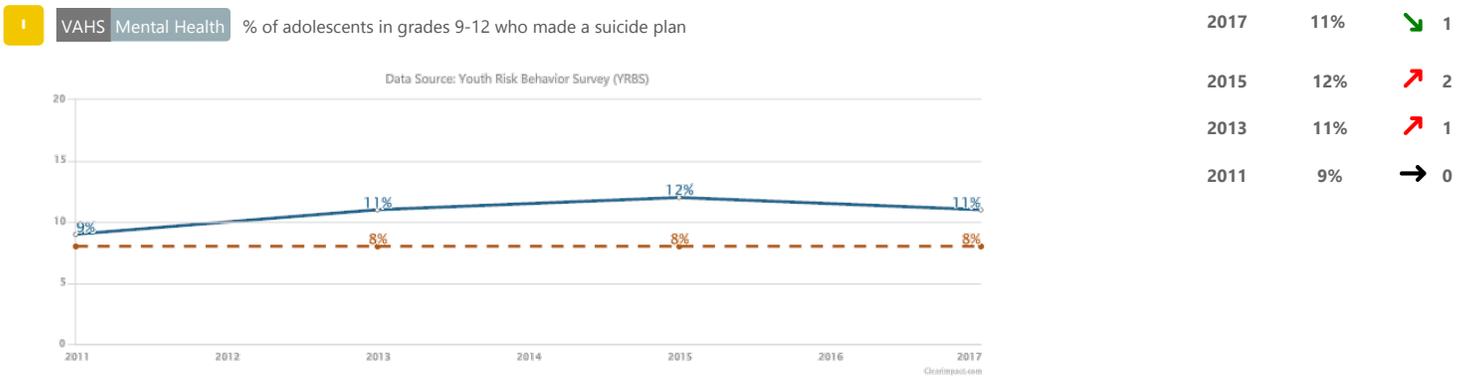
Why Is This Important?

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.

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Notes on Methodology

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Story Behind the Curve

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Partners

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What Works

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Strategy

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Why Is This Important?

This indicator was added to Healthy Vermonters 2020 in 2016 in recognition that suicide planning identifies youth who need mental health support better than a previous indicator (suicide attempts that required medical attention). In general, Health Vermonters 2020 (the State Health Assessment) documents the health status of Vermonters and the population health indicators and goals that will guide the work of public health through 2020. [Click here](#) for more information.

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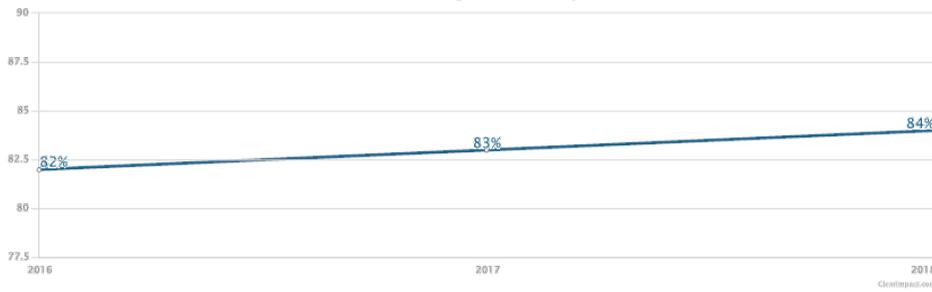
Notes on Methodology

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**I** Act186 % of children ready for school in all four domains of healthy development

2018	84%	↗ 2
2017	83%	↗ 1
2016	82%	→ 0

Data Source: Kindergarten Readiness Report



Story Behind the Curve

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Partners

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What Works

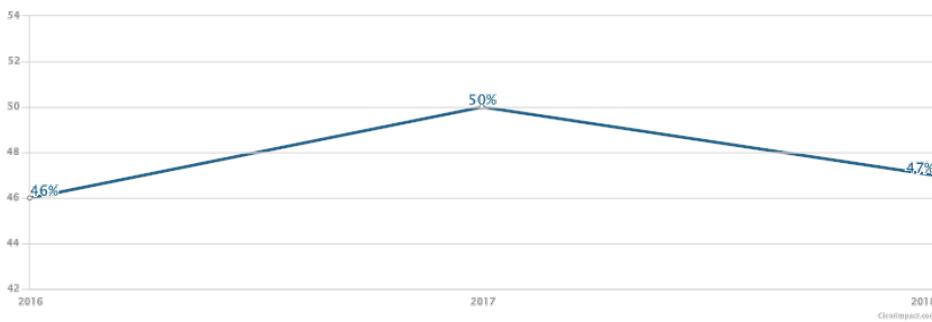
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Strategy

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**I** Act186 % of children below the basic level of fourth grade reading achievement under State standards

2018	47%	↘ 1
2017	50%	↗ 1
2016	46%	→ 0



Story Behind the Curve

2016 is the first year of data for this metric.

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Partners

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What Works

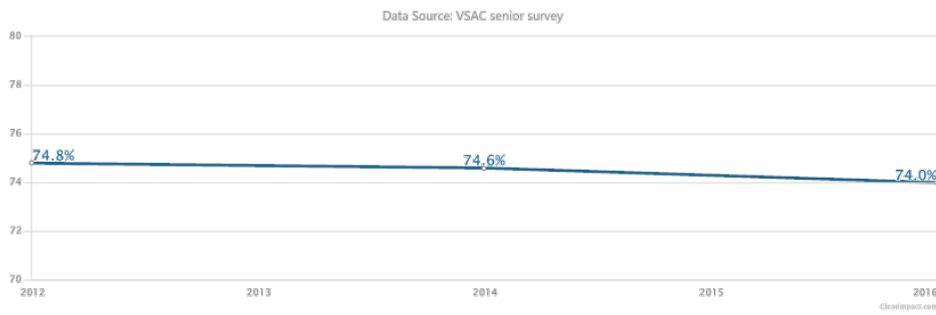
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Strategy

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**I** Act186 % of high school seniors with plans for education, vocational training, or employment

2016	74.0%	↘ 2
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2014	74.6%	↘	1
2012	74.8%	→	0

Story Behind the Curve

conducted every 'even' year (2018, 2016, 2014, etc.) 2018 data is not yet available.

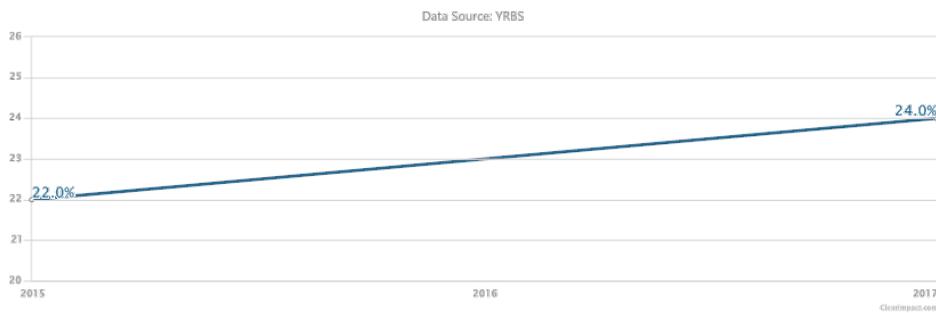
Partners

What Works

Strategy

**I** Act186 % adolescents in grades 9-12 using marijuana within the last 30 days

2017	24.0%	↗	1
2015	22.0%	→	0



Story Behind the Curve

YRBS is conducted every 'odd' year in the spring

Partners

What Works

Strategy

OUTCOME 7

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

Time Period	Actual Value	Current Trend
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**Act 186** Hospice enrollment: Percentage of chronically ill Medicare decedents age 65 and older who were enrolled in hospice during the last 6 months of life

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 46th among US states in 2014 (2017 report). Target values are US values, i.e. across all states.

**Partners**

**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 2014 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 from 30.7% in North Dakota to 65.8% in Arizona. Nationally, 52.0% of Medicare decedents were enrolled in hospice care in the last six months of life.

Source: United Health Foundation Senior Health Rankings. <https://www.americashealthrank...>

**Act 186** Long-Term Services & Supports State Ranking (AARP, Scan Foundation, Commonwealth Fund)

2017	3	↘	2
2014	6	↘	1
2011	20	→	0



**Story Behind the Curve**

The State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers measures five dimensions of LTSS system performance:

- Affordability and Access** Consumers can easily find and afford services, with a safety net for those who cannot afford services.
- Choice of Setting and Provider** A person-centered approach allows for consumer choice and control of services.
- Quality of Life and Quality of Care** Consumers are treated with respect and preferences are honored when possible, with services maximizing positive outcomes.
- Support for Family Caregivers** Family caregivers' needs are assessed and addressed, so they can receive the support they need to continue their essential roles.

5. **Effective Transitions** Integration of health, LTSS, and social services minimizes disruptions such as unnecessary hospitalizations, institutionalizations, and transitions between settings.

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:

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

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

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

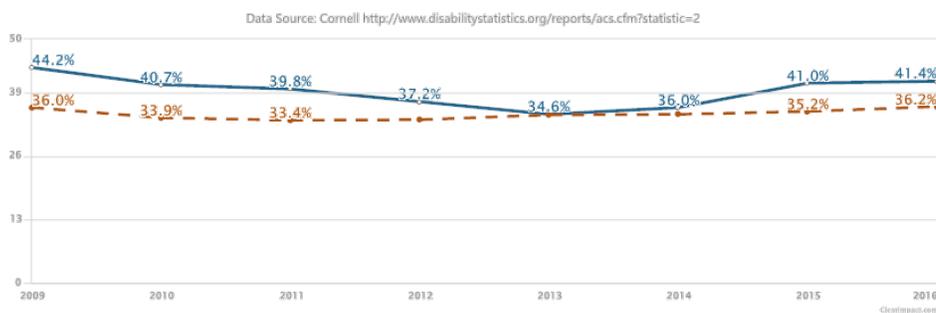
OUTCOME 8

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

Time Period Actual Value Current Trend

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

Time Period	Actual Value	Current Trend
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
2009	44.2%	↘ 1
2008	48.8%	→ 0



Story Behind the Curve

This population indicator shows the estimated employment rate of all Vermonters with disabilities who are age 18-64. 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 developmental disabilities services.

Note that the employment rate is higher in Vermont, but related earned wages are lower in Vermont.

Partners

What Works

Notes on Methodology

<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](http://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 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?

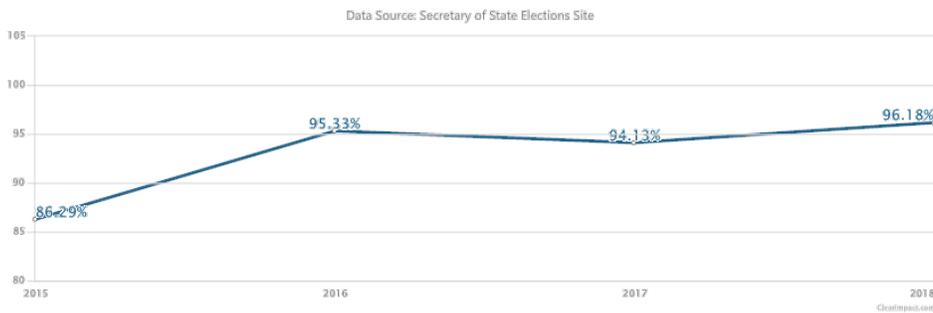
**Self-care Disability** (asked of persons ages 5 or older): Does this person have difficulty dressing or bathing?

**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

<b>O</b>	<b>Act186</b> VERMONT HAS OPEN, EFFECTIVE, AND INCLUSIVE GOVERNMENT	Time Period	Actual Value	Current Trend
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<b>I</b>	<b>Act186</b> % of people who are eligible to register to vote and who have registered	2018	96.18%	↗ 1
		2017	94.13%	↘ 1
		2016	95.33%	↗ 1
		2015	86.29%	→ 0



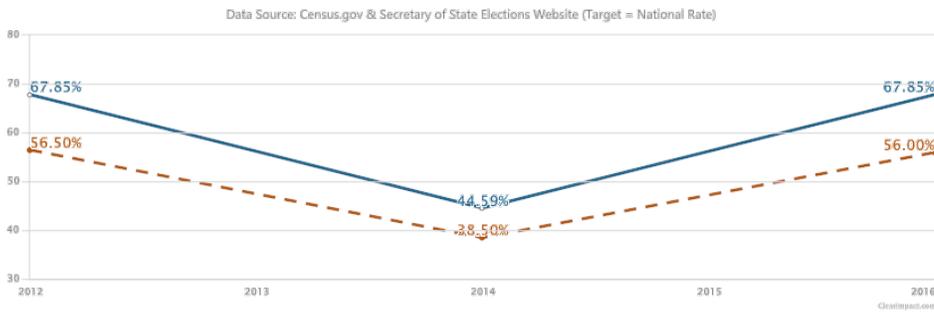
Story Behind the Curve

Partners

What Works

Strategy

**Act186** % of registered voters voting in the general election 2016 67.85% ↗ 1



2014 44.59% ↘ 1  
2012 67.85% → 0

Story Behind the Curve

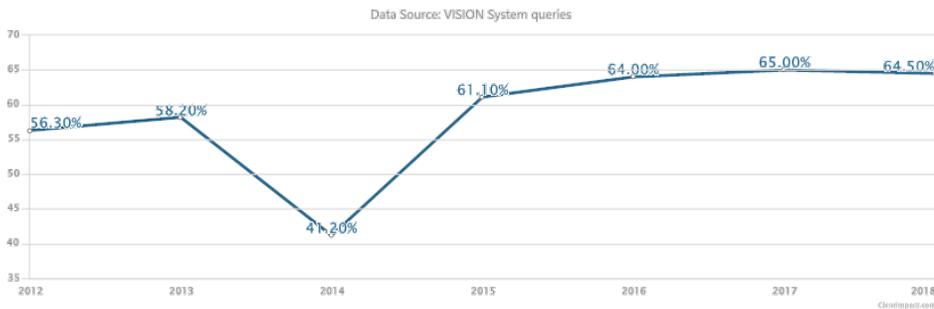
Vermont scores higher than the National Average generally including 2016 (XX%). However, we see fewer voters turning out that we would like.

Partners

What Works

Strategy

**Act186** % of State contracts awarded that include performance measures 2018 64.50% ↘ 1



2017 65.00% ↗ 3  
2016 64.00% ↗ 2  
2015 61.10% ↗ 1  
2014 41.20% ↘ 1  
2013 58.20% ↗ 1  
2012 56.30% → 0

Story Behind the Curve

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

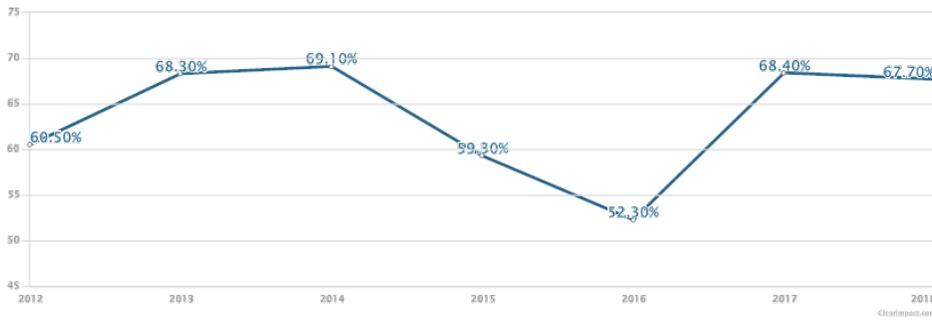
Partners

What Works

Strategy

**Act186** % of State grants awarded that include performance measures

2018	67.70%	↘	1
2017	68.40%	↗	1
2016	52.30%	↘	2
2015	59.30%	↘	1
2014	69.10%	↗	2
2013	68.30%	↗	1
2012	60.50%	→	0



Story Behind the Curve

Like contracts, and excepting for 2016, grants with performance measures remain in the 60's%.

Partners

What Works

Strategy

**Act186** Number or percent of departments that are able to accept online payments

2018	15	→	0
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Data Source: Vermont.gov Web Portal (individual units of State Government)



Story Behind the Curve

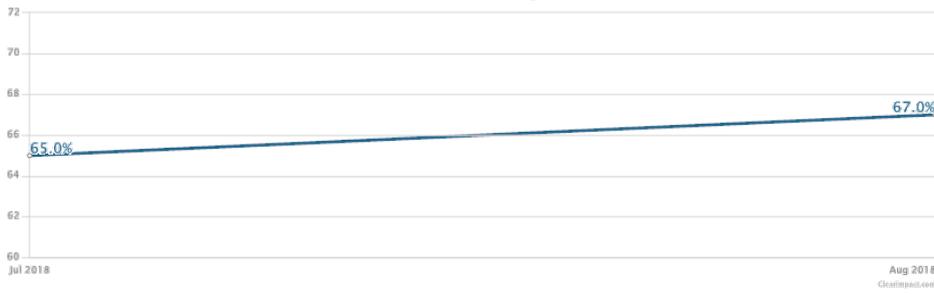
Partners

What Works

Strategy

**Act186** Number or percent of agencies or departments using an up-to-date website template

Aug 2018	67.0%	↗	1
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Story Behind the Curve

ADS is engaged in workign with all remaining agencies, departments and Boards/Commissions to redesign their website on the newest template. Websites are coming up to the new template regularly.

Partners

What Works

Strategy

**I** Act186 Number of agencies and departments that have a policy regarding response time to constituent inquiries and that measure that response time

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Story Behind the Curve

Partners

What Works

Strategy

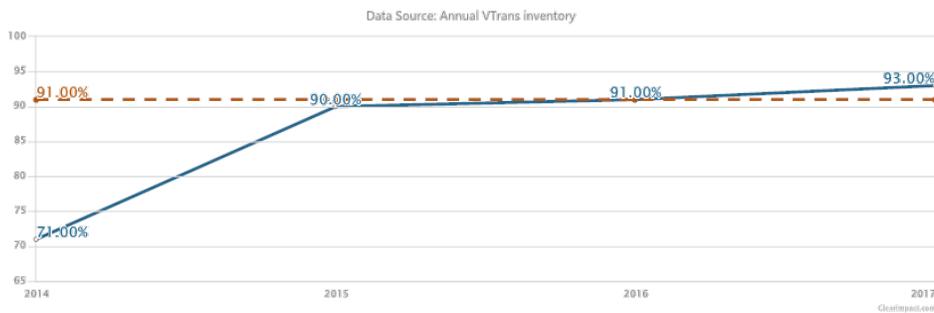
OUTCOME 10

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

Time Period Actual Value Current Trend

**I** Act186 % of Vermont covered by state-of-the-art telecommunications infrastructure

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



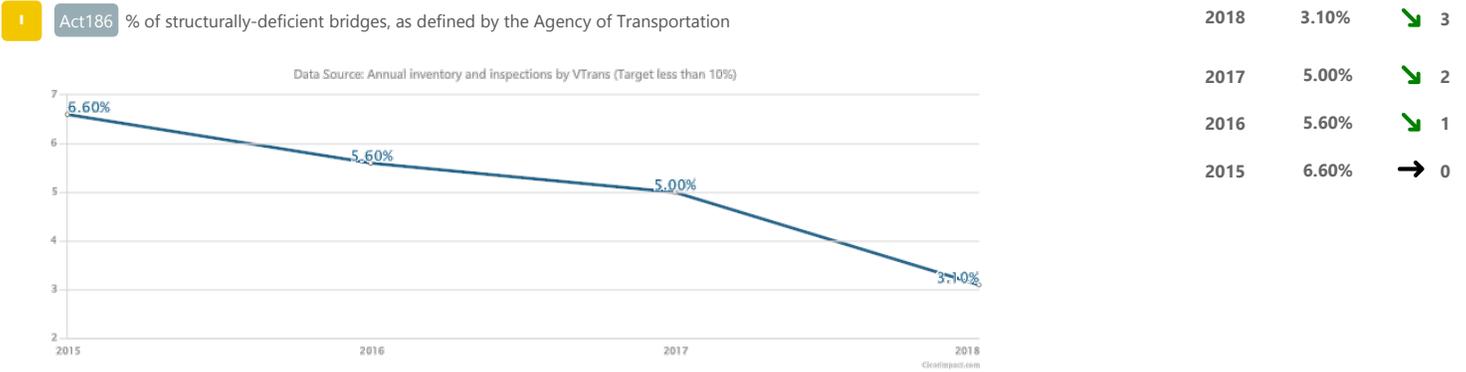
Story Behind the Curve

Percentage of Vermont business and residential E-911 locations have access to broadband internet access with speeds of at least 4 Mbps down and 1 Mbps up.

Partners

What Works

Strategy



Story Behind the Curve

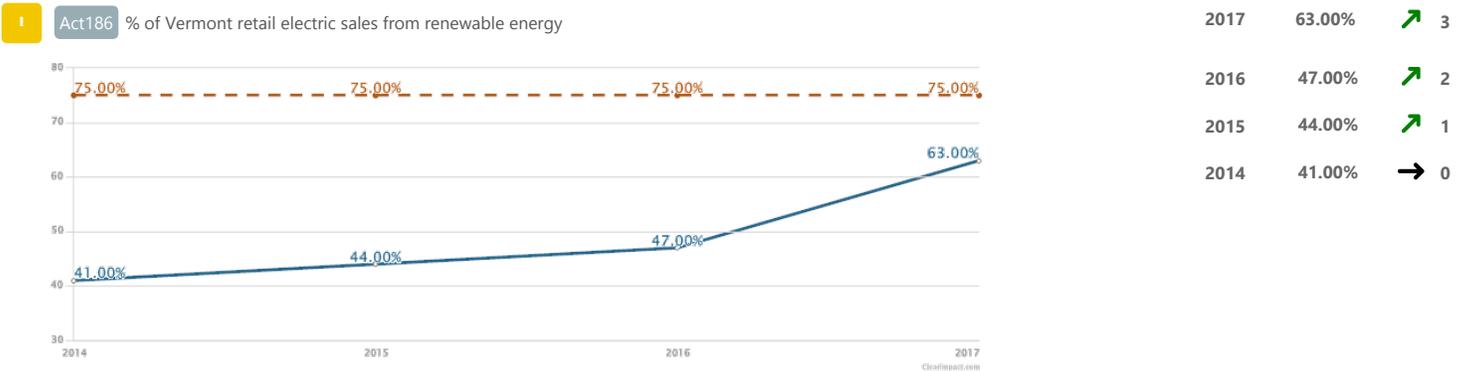
Annual inventory and inspections by VTrans of bridges with spans > 20 ft on state and town highways, and short structures with spans between 6 and 20 ft on the state highway system.

There has been 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].

Partners

What Works

Strategy



Story Behind the Curve

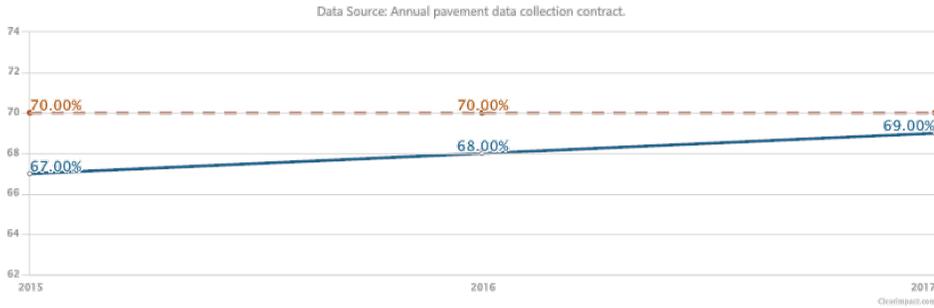
The percentage of power supplied to customers for which utilities held a corresponding amount of Renewable Energy Certificates, required by law to be 55% in 2017, rising to 75% by 2032.

Partners

What Works

Strategy

**Act186** State highway pavement condition ratings 2017 69.00% ↗ 2



2016 68.00% ↗ 1  
2015 67.00% → 0

Story Behind the Curve

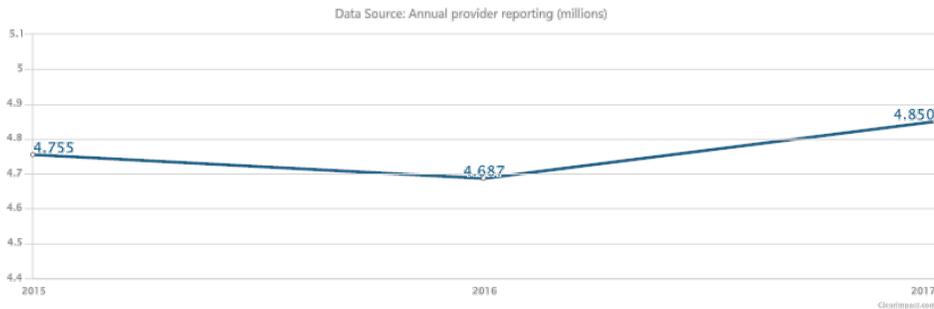
Pavement condition shall achieve a TWA (travel weighted average) of 70% or greater.

Partners

What Works

Strategy

**Act186** Public transit ridership 2017 4.850 ↗ 1



2016 4.687 ↘ 1  
2015 4.755 → 0

Story Behind the Curve

Total annual transit ridership is collected and compiled from all providers on an annual basis. Target is 2% increase per year. 2018 data not available until January 2019.

Partners

What Works

Strategy