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*Susanne R. Young, Secretary*

## MEMORANDUM

**TO:** Vermont General Assembly; Government Accountability Committee and Joint Fiscal Committee  
**CC:** Susanne Young and Brad Ferland  
**FROM:** Susan Zeller, Chief Performance Officer  
**RE:** Annual Outcomes Report – 3 VSA §2311 (c)  
**DATE:** October 11, 2019

Attached please find the 2019 Outcomes Report, originally due 9/30/2018. As was the case last year, the report is presented on-line in the Clear Impact Scorecard – electronic dashboard and data visualization tool. To meet the statutory requirement of a “report”, we are also providing a download of the electronic visualization into pdf format.

The best way to view this data is on-line through the interactive Scorecard link at:  
<https://app.resultsscorecard.com/Scorecard/Embed/62649>

Thank you for your patience in waiting for this report.

# 2019 OUTCOMES REPORT ("Act 186")

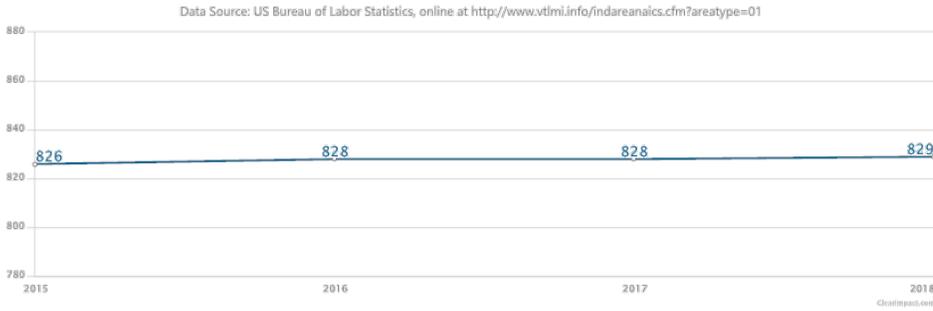
THE STATEWIDE POPULATION-LEVEL OUTCOMES REPORT WAS ESTABLISHED UNDER 3 V.S.A. SEC. 2311 (2014 ACT 186).

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

## OUTCOME 1

**O** 2019act186 VERMONT HAS A PROSPEROUS ECONOMY Most Recent Period: Current Actual Value: Current Trend:

**I** 2019act186 % or rate per 1,000 jobs of non-public sector employment 2018: 829 ↗ 1



### Story Behind the Curve

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

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

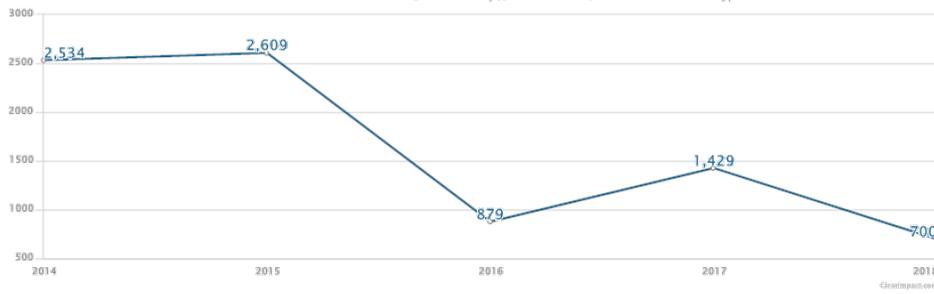
### Partners

### What Works

### Strategy

**I** 2019act186 Net change in nonpublic sector employment 2018: 700 ↘ 1

Data Source: US Bureau of Labor Statistics, online at <http://www.vtmi.info/indareanaics.cfm?areatype=02>



2017	1,429	↗ 1
2016	879	↘ 1
2015	2,609	↗ 1
2014	2,534	→ 0

## Story Behind the Curve

This long period of economic expansion continued through CY2018. Private sector jobs continue to be added.

Yr	State	Chittenden	Non-Chittenden
2018	700	280	420
2017	1429	585	844
2016	879	716	163
2015	2609	1308	1301
2014	2534	523	2011

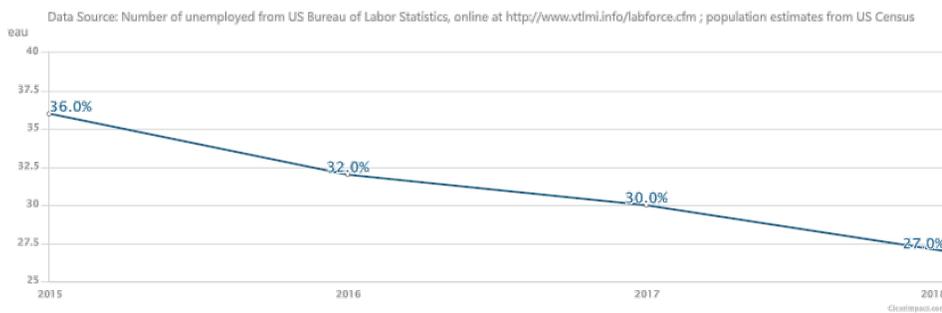
## Partners

## What Works

## Strategy

**2019act186** rate of unemployment per 1,000 (labor force)

2018	27.0%	↘ 3
2017	30.0%	↘ 2
2016	32.0%	↘ 1
2015	36.0%	→ 0



## Story Behind the Curve

This long period of economic expansion continued through CY2018. The number of unemployed persons continues to fall.

Year	State	Chitt Cty	non_Chitt
2018	27	21	29
2017	30	22	33
2016	32	25	35
2015	36	27	39

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Partners

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What Works

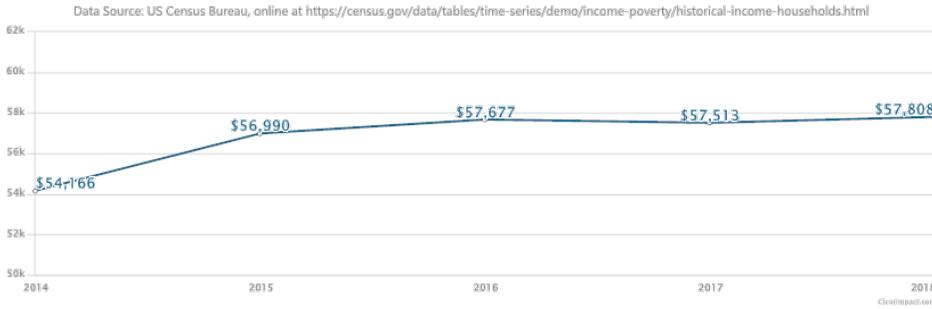
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Strategy

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**2019act186** Median household income

2018	\$57,808	↗	1
2017	\$57,513	↘	1
2016	\$57,677	↗	2
2015	\$56,990	↗	1
2014	\$54,166	→	0



### 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
2018	57808	66906	n/a
2017	57513	64444	n/a
2016	57677	68843	n/a
2015	56990	67997	n/a
2014	54166	62004	n/a

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Partners

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What Works

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Strategy

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2018	848	↓ 1
2017	1,380	↑ 1
2016	965	↓ 2
2015	2,542	↓ 1
2014	2,940	→ 0



### Story Behind the Curve

This long period of economic expansion continued through CY2018. Jobs continue to be added.

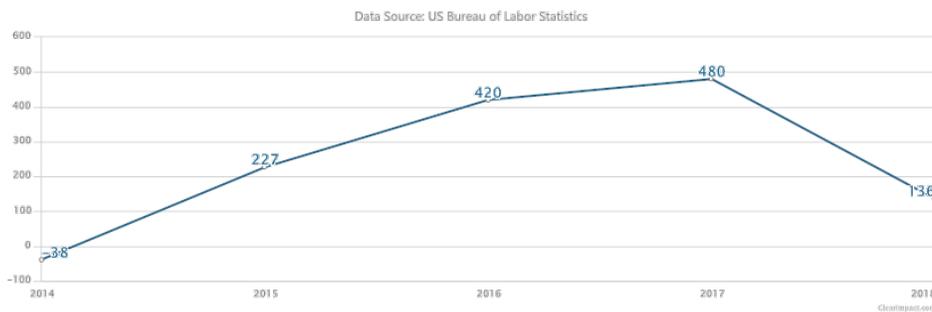
Yr	State	Chittenden	Non-Chittenden
2018	848	353	545
2017	1380	500	880
2016	965	365	600
2015	2542	1492	1050
2014	2940	601	2339

### Partners

### What Works

### Strategy

2018	136	↓ 1
2017	480	↑ 3
2016	420	↑ 2
2015	227	↑ 1
2014	-38	→ 0



### Story Behind the Curve

This long period of economic expansion continued through CY2018. Business establishments continue to be added.

	State	Chittenden	Non-Chittenden
2018	136	119	17
2017	480	178	302

2016	420	180	240
2015	227	162	65
2014	-38	99	-137

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Partners

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What Works

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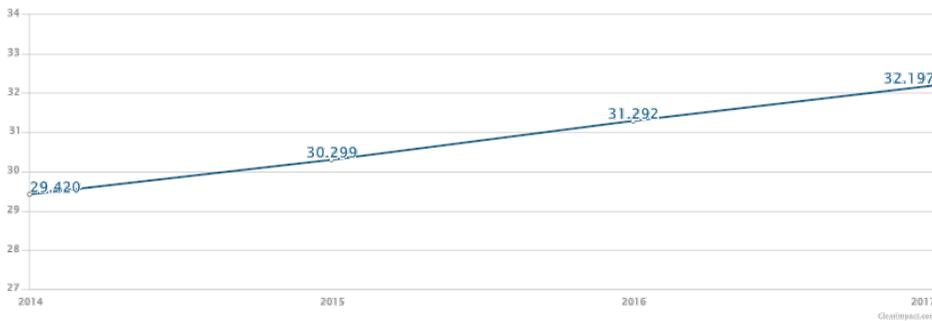
Strategy

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2019act186 Gross State product (GSP) per capita

2017	32.197	↗	3
2016	31.292	↗	2
2015	30.299	↗	1
2014	29.420	→	0



### 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.

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Partners

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What Works

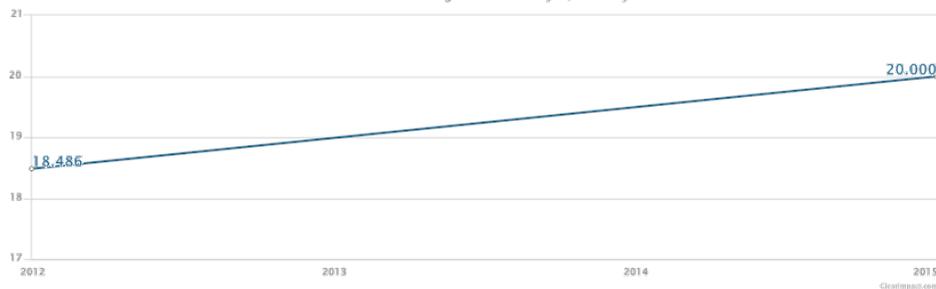
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Strategy

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Data Source: Vermont Genuine Progress Indicator Project, University of Vermont



## Story Behind the Curve

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

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

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

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## Partners

University of Vermont, Gund Institute for the Environment

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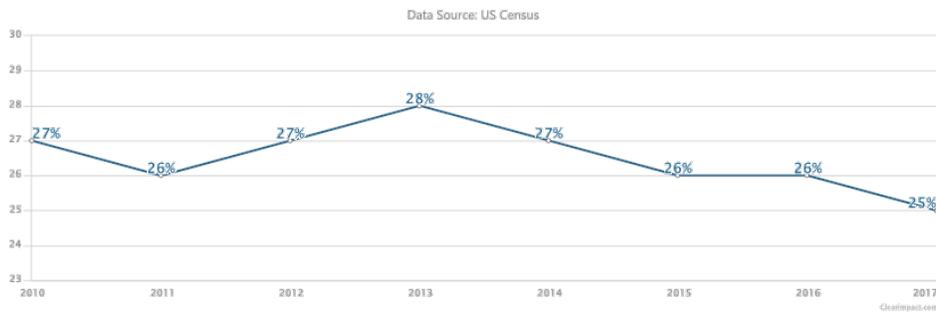
## What Works

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## Strategy

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2016	26%	→	1
2015	26%	↓	2
2014	27%	↓	1
2013	28%	↑	2
2012	27%	↑	1
2011	26%	↓	1
2010	27%	↑	1

## Story Behind the Curve

## Partners

## What Works

## Strategy

### OUTCOME 2

**2019act186 VERMONTERS ARE HEALTHY**

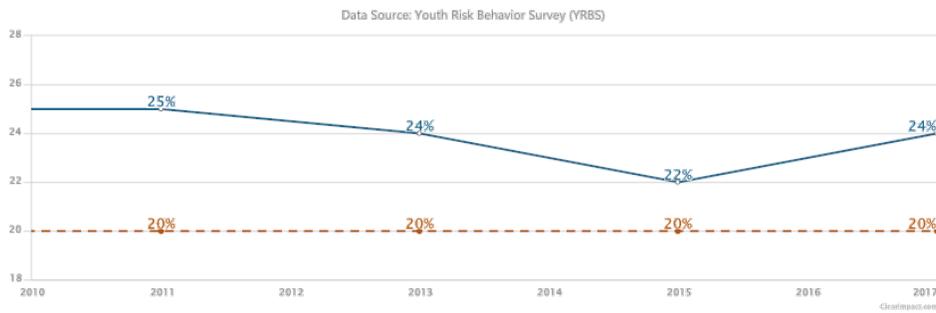
**VDH % of adults age 20 and older who are obese** | Most Recent Period: 2017 | Current Actual Value: 28% | Current Trend: → 1



**VDH % of adults who smoke cigarettes** | Most Recent Period: 2017 | Current Actual Value: 17% | Current Trend: ↓ 1



**VDH % of adolescents in grades 9-12 who used marijuana in the past 30 days** | Most Recent Period: 2017 | Current Actual Value: 24% | Current Trend: ↑ 1



2015	22%	↓	2
2013	24%	↓	1
2011	25%	→	1
2009	25%	↑	1
2007	24%	↓	5
2005	25%	↓	4
2003	28%	↓	3
2001	30%	↓	2

## Story Behind the Curve

*Last Updated: Feb 2019*

*Author: State Epidemiological Outcomes Workgroup, Vermont Department of Health*

According to the Youth Risk Behavior Survey (YRBS), past 30-day marijuana use among high school students has not significantly changed since it was first asked in 2011, however, use during the past 30 days significantly increased between 2015 and 2017. In 2017, six percent of students reported using marijuana before age 13, a significant decrease from 2007 at 9%. While this is good news, during the past 30 days, nearly one in four high school students (24%) used marijuana, a significant increase from 22% in 2015. While all demographic groups are at risk for using substance such as marijuana, some groups report higher use than others. LGBT high school students (33%) are significantly more likely than their heterosexual peers (23%) to report using during the past 30 days.

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

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

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## Partners

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

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## What Works

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

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## Strategy

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

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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.](#)

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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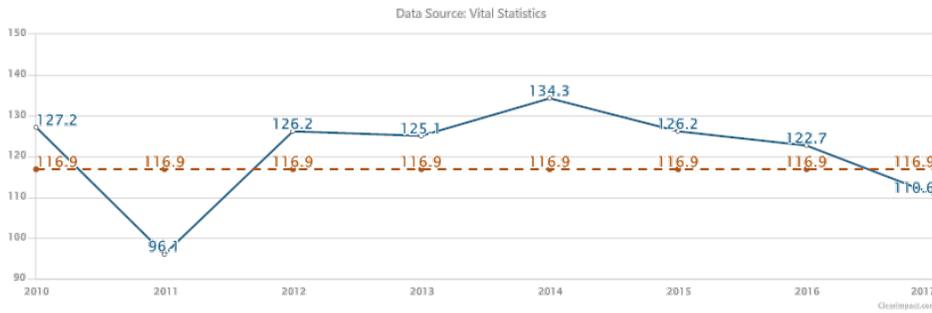
## Notes on Methodology

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

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



2017	110.6	↓ 3
2016	122.7	↓ 2
2015	126.2	↓ 1
2014	134.3	↑ 1
2013	125.1	↓ 1
2012	126.2	↑ 1
2011	96.1	↓ 1
2010	127.2	↑ 2
2009	120.6	↑ 1



## Story Behind the Curve

Last Updated: August 2019

Author:

Injury Prevention Program Team, Vermont Department of Health

Over the time period between 2002 and 2017, the number and rate of fall-related deaths have increased, though not significantly. The 2017 Vermont death rate of 110.6 per 100,000 adults age 65 and older is higher than the national rate of 63.3.

## Partners

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

## What Works

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

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

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

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

- Making sure the home environment is safe and supportive

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## Strategy

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

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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

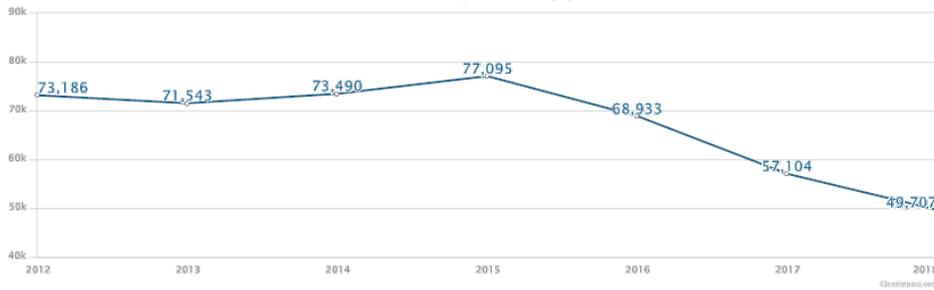
Data is updated as it becomes available and timing may vary by data source. For more information about this indicator, [click here.](#)

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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Data Source: Vermont Prescription Monitoring System (VPMS)



2018	49,707	↘ 3
2017	57,104	↘ 2
2016	68,933	↘ 1
2015	77,095	↗ 2
2014	73,490	↗ 1
2013	71,543	↘ 1
2012	73,186	→ 0

## 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.**

## Partners

- Patients

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

## What Works

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

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## 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...>

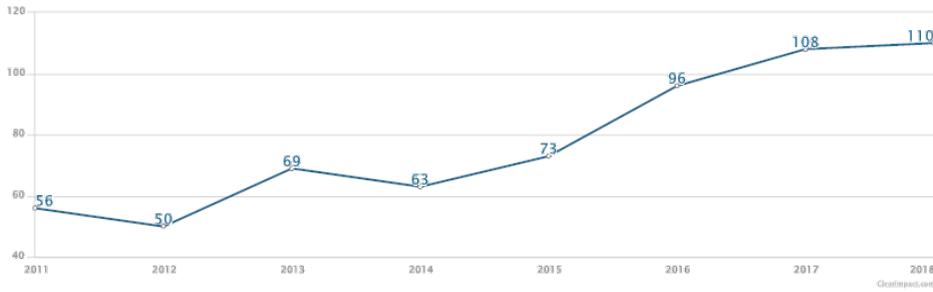
National Institute on Drug Abuse: <https://www.drugabuse.gov/publ...>

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2018	110	↗ 4
2017	108	↗ 3
2016	96	↗ 2
2015	73	↗ 1
2014	63	↘ 1
2013	69	↗ 1
2012	50	↘ 1
2011	56	↗ 1

Data Source: Office of the Chief Medical Examiner



## 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.

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### Partners

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### What Works

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### Strategy

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### Why Is This Important?

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### 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.

2019	1,089	↓	1
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

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.

*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

## 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:

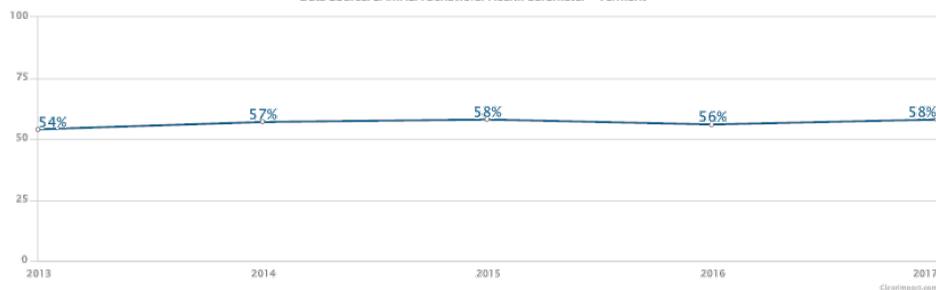
- **Significant development of more rental housing** which is affordable and accessible to Vermont households earning less than 30% of area median income. Once built, this housing must be available to the homeless. A culture change may be required to move us from a position of “who is eligible for housing?” 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.



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

2017	58%	↗ 1
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

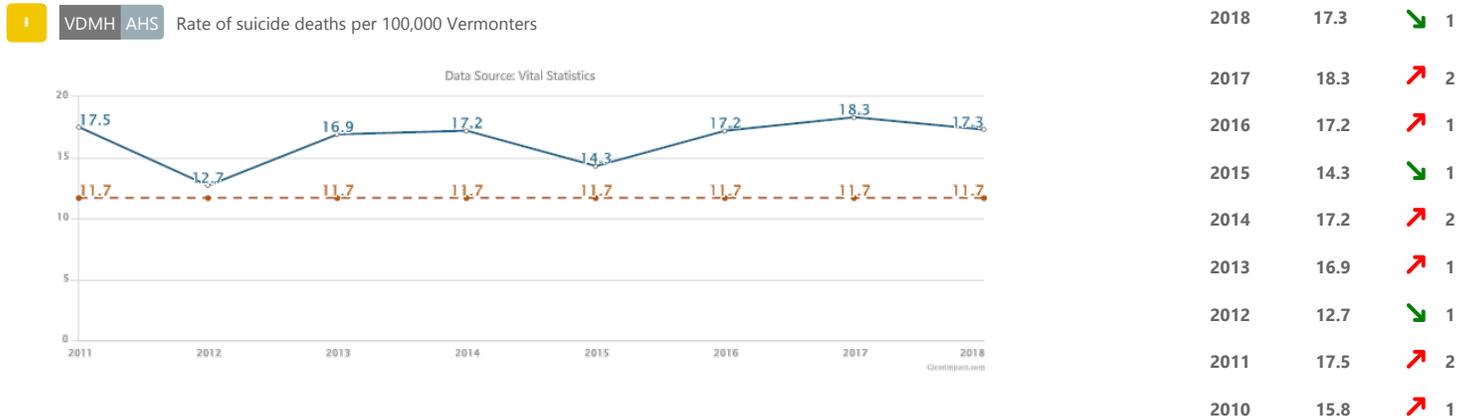
Percentages are from the SAMHSA Behavioral Health Barometer report for Vermont, available online at for each state at [http://www.samhsa.gov/data/us\\_map](http://www.samhsa.gov/data/us_map).

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

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

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

Author: Vermont Department of Mental Health

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

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.<sup>1</sup> Deaths by suicide in Vermont appear to follow national patterns in terms of age and gender breakdowns. More men die by suicide than women. Firearms are the method used for nearly two-thirds of the deaths by suicide.<sup>1</sup>

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

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

### Sources

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

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

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

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

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

Updated in July 2019

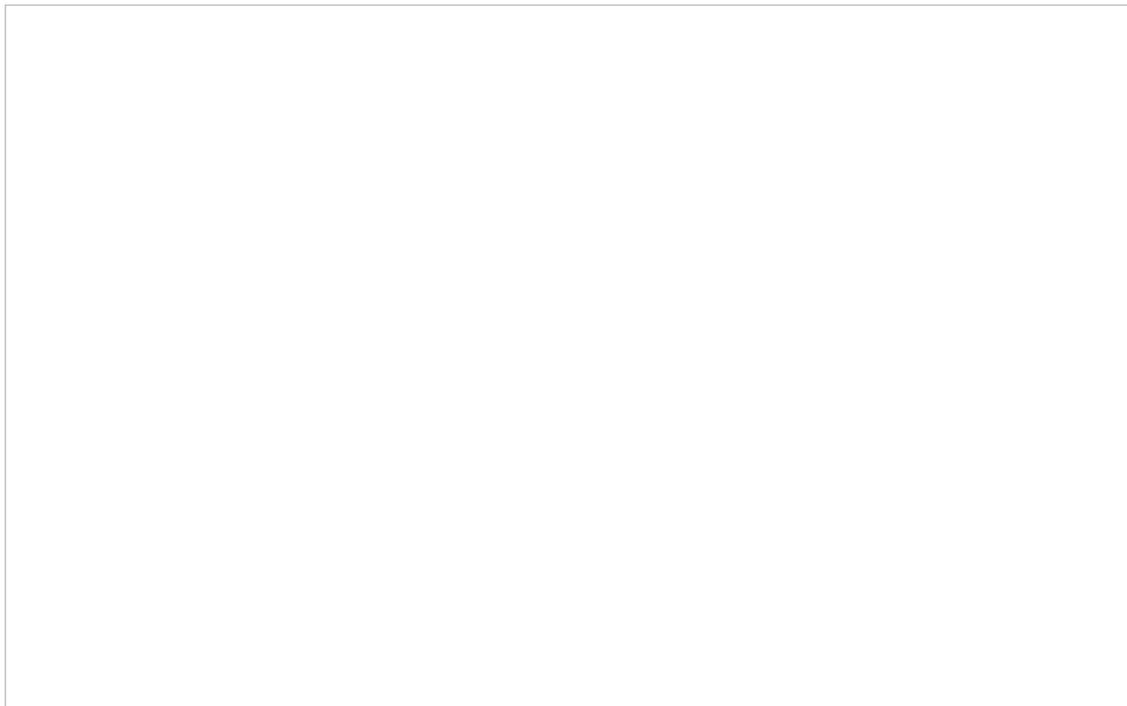
## Partners

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

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

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

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



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

4. Vermont Gun Shop Project:

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

**Selective Prevention**

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

**Indicated Strategies:**

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

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

1. **Screening:** Embed widespread screening of depression and suicidality in healthcare settings including primary care practices. The Blueprint for Health Medical Home practices to enhance their screening regarding suicidality by using Patient Health Questionnaire (PHQ) questions about depression and suicidal thoughts in Primary care settings.
2. **Assessment:** For those patients who screen positive to then do an enhanced screening/severity assessments regarding severity of suicidality e.g. Columbia Suicide Severity Rating Scale (CSSRS). Support Blueprint's community health teams to help patients access appropriate treatment with the local DAs for individuals who screen as needing an intervention
3. **Suicide focused/ competent treatment:** Support Designated Agency (DA) pilot sites to access training in modalities specifically about care for the suicidal person:
  - a. Counselling about Access to Lethal Means (CALM)
  - b. Assist DA pilot sites to train clinicians in using Collaborative Assessment and Management of Suicide (CAMS) which includes an online initial training followed by a learning collaborative style continuous education on CAMS. Build capacity for ongoing training in Vermont by developing a Train the Trainer model
  - c. Reinforce use of Cognitive Behavioral Therapy and Dialectical Behavioral Therapy as the best treatment practices for problems commonly associated with suicidality such as depressive disorders, anxiety disorders and personality disorders. The CAMS methodology is complimentary to these treatments methods.
  - d. Roll training out to providers outside of the DAs: Community Health Teams, therapists embedded in Medical Homes, etc.

- 4. Follow-up:** Partner with the inpatient psychiatric units as well as emergency rooms at hospitals to develop and send caring letters after a person who had suicidal thoughts is discharged from their facility. Designated Agency Crisis Centers to develop and send caring letters after a person who had suicidal thoughts is discharged from the hospital.

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

## Why Is This Important?

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

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

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

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

## Notes on Methodology

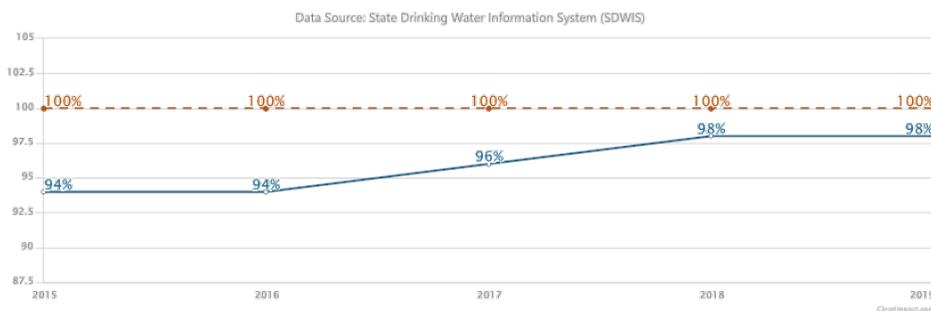
This indicator is age-adjusted to the 2000 U.S. standard population. In U.S. data, age adjustment is used for comparison of regions with varying age breakdowns. In order to remain consistent with the methods of comparison at a national level, some statistics in Vermont were age adjusted. In cases where 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.

### OUTCOME 3

<span style="color: green;">O</span>	2019act186	VERMONT'S ENVIRONMENT IS CLEAN AND SUSTAINABLE	Most Recent Period	Current Actual Value	Current Trend
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<span style="color: orange;">I</span>	2019act186	% of public drinking water supplies in compliance with health-based standards	2019	98%	→ 1
			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. .

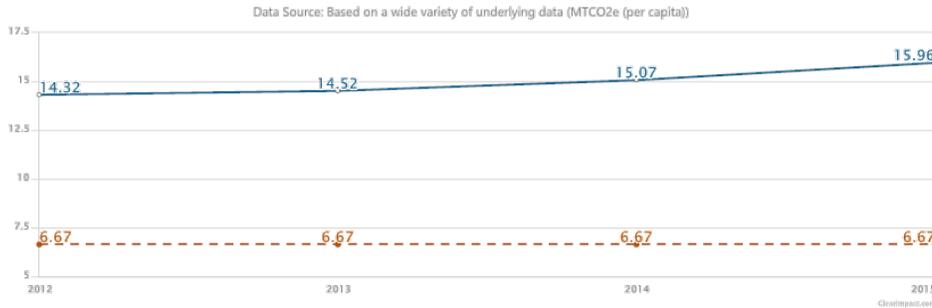
## Partners

## What Works

## Strategy

**2019act186** 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

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 MTCO<sub>2</sub>e is thousand tons of carbon dioxide equivalents; MMTCO<sub>2</sub>e == Million tons of CO<sub>2</sub>e.

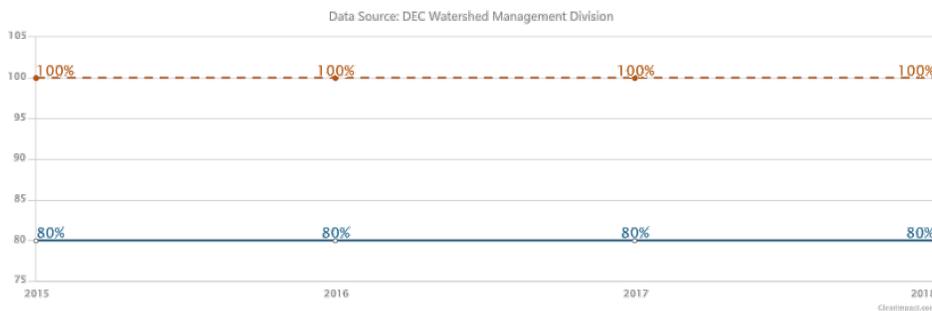
## Partners

## What Works

## Strategy

**2019act186** % of Vermont's rivers and lakes (excluding Lake Champlain) that meet State water quality standards for fishing

2018	80%	→ 3
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. The source of CY2018 data is the 2018 305(b) report; this data was available late in 2018 so there are no changes from 2017; however there will be updated information for CY2019 with the publication of the 2020 305(b) report which will be available the spring of 2020.

Partners

What Works

Strategy



Story Behind the Curve

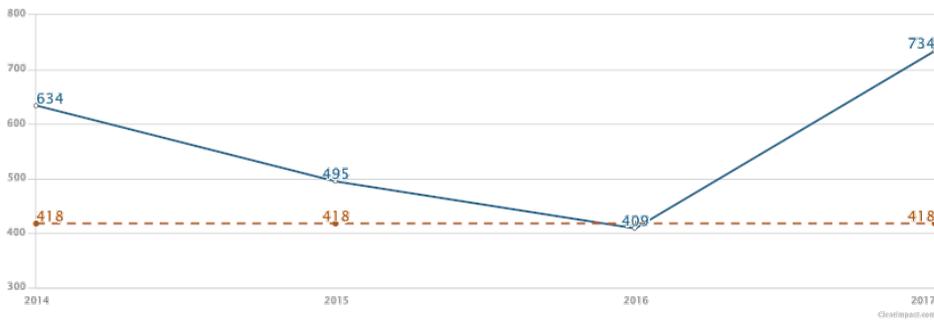
This data is compiled and analyzed every two-years/bi-annually; annual fluctuations are expected due to updated assessment data reflecting the current conditions on our waters. There are over 55,000 acres of lakes in the state of Vermont; of these acres 85% support swimming/recreational uses (75% consistently, 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. There was no change in the overall condition of the health of Vermont lakes during this most recent reporting period.

Partners

What Works

Strategy





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). **2018 results won't be available until at least spring of 2020.**

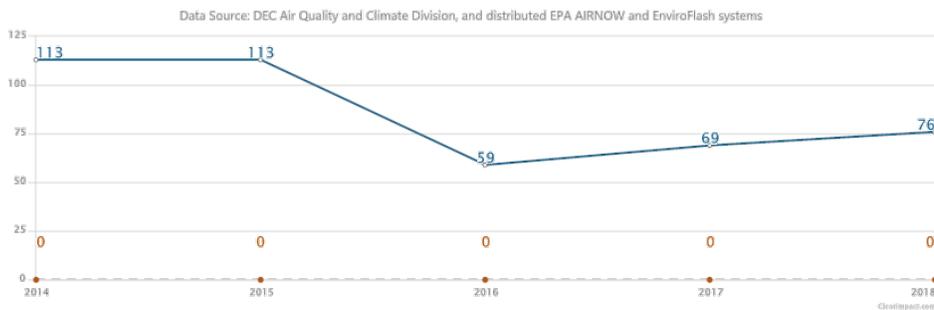
## Partners

## What Works

## Strategy

**2019act186** Number of days air quality in Vermont posed a moderate or greater risk to sensitive populations;

2018	76	↗ 2
2017	69	↗ 1
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 2018. The target number of days with poor air quality is zero.

Partners

What Works

Strategy



### Story Behind the Curve

On the whole, Vermont generated more waste in 2018, continuing a two year trend of increasing waste production. But, from this produced waste, Vermonter's diverted (recycled, composted etc.) a higher tonnage of recyclables than ever before. Although disposal rates increased for the second year in a row, it is notable that this years increase was approximately half of that that occurred in 2017, so the rate of change is slowing.

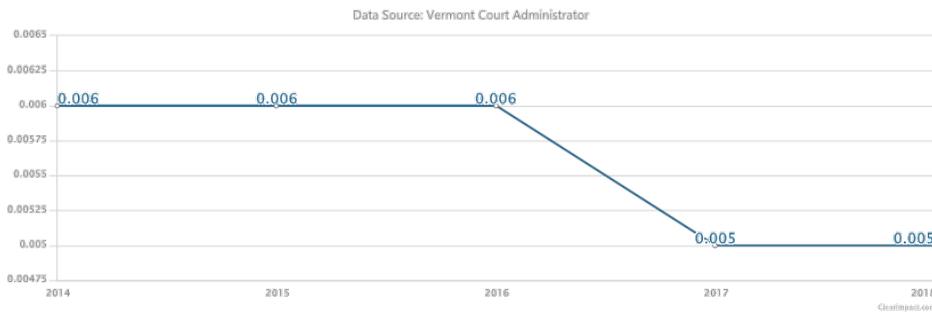
Partners

What Works

Strategy

## OUTCOME 4

Indicator	Value	Most Recent Period	Current Actual Value	Current Trend
<b>2019act186</b> VERMONT IS A SAFE PLACE TO LIVE				
<b>2019act186</b> Rate of petitions granted for relief from domestic abuse per 1,000 residents	2018	0.005	→	1



2017	0.005	↘ 1
2016	0.006	→ 2
2015	0.006	→ 1
2014	0.006	→ 0

## Story Behind the Curve

This indicator remains relatively constant. This information is provided by the Court Administrators Office and is considered a reliable data source. Population for analysis taken from Vermont Department of Health 2017 estimates.

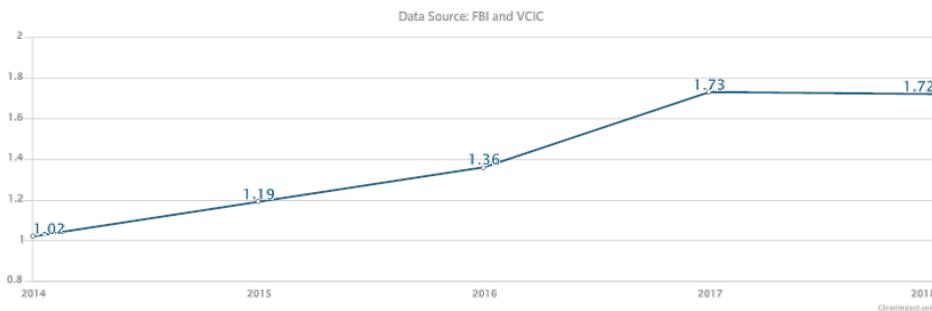
An analysis would need to be undertaken of the Vermont, Maine and New Hampshire court systems to determine a Northern New England benchmark for this measure to ensure an accurate comparison.

## Partners

## What Works

## Strategy

### 2019act186 Rate of violent crime per 1,000 crimes



2018	1.72	↘ 1
2017	1.73	↗ 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. The indicator showed an increase in 2018. However, DPS is aware this may be due to improved reporting systems rather than direct changes in crime rate. Since many local police departments transitioned away from the Spillman Records Management System (RMS) to the Valcour RMS reporting of crime statistics fluctuated for some entities. 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 submitted to the state over time which may be indicative of better reporting (as opposed to increases in criminal activity). Prior data updated to reflect information provided through the FBI Crime in the United States Report. The US national average for the period in question was 3.81.

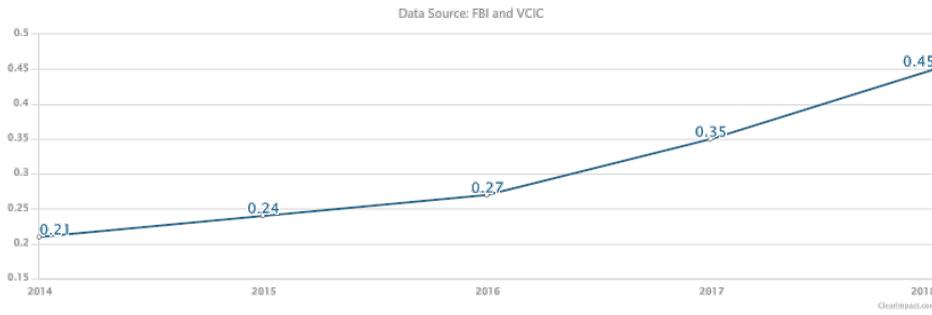
## Partners

## What Works

## Strategy

**2019act186** Rate of sexual assault committed against residents per 1,000 residents

2018	0.45	↗	4
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 2018. However, DPS is aware this may be due to improved reporting systems rather than direct changes in crime rate. Since many local police departments transitioned away from the Spillman Records Management System (RMS) to the Valcour RMS reporting of crime statistics fluctuated for some entities. 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 submitted to the state over time which may be indicative of better reporting (as opposed to increases in criminal activity). Prior data updated to reflect information provided through the FBI Crime in the United States Report. The US national average for the period in question was .43.

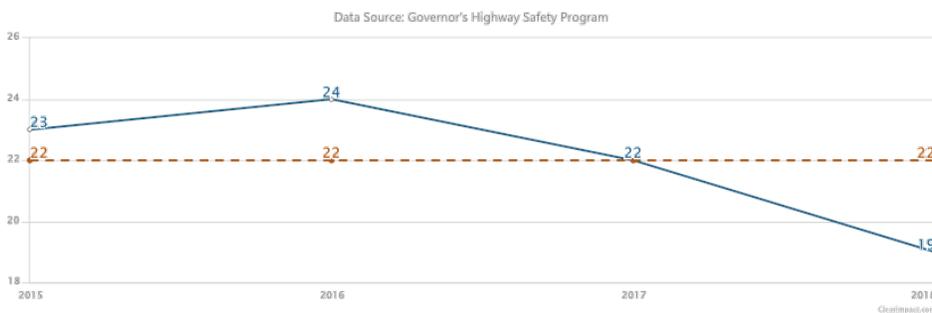
### Partners

### What Works

### Strategy

**2019act186** 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.

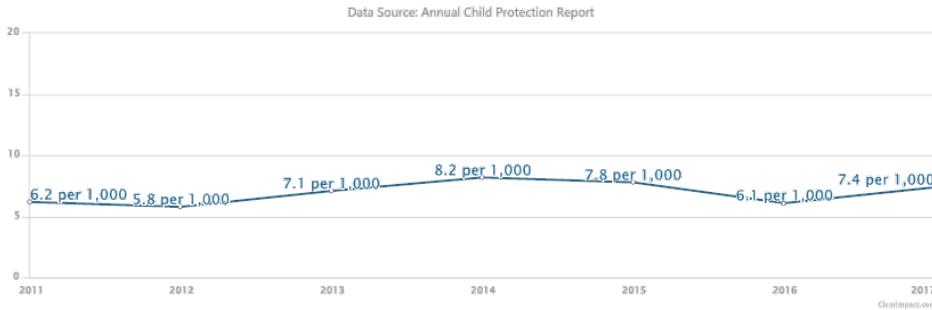
### Partners

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### Strategy



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.

*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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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.

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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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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.

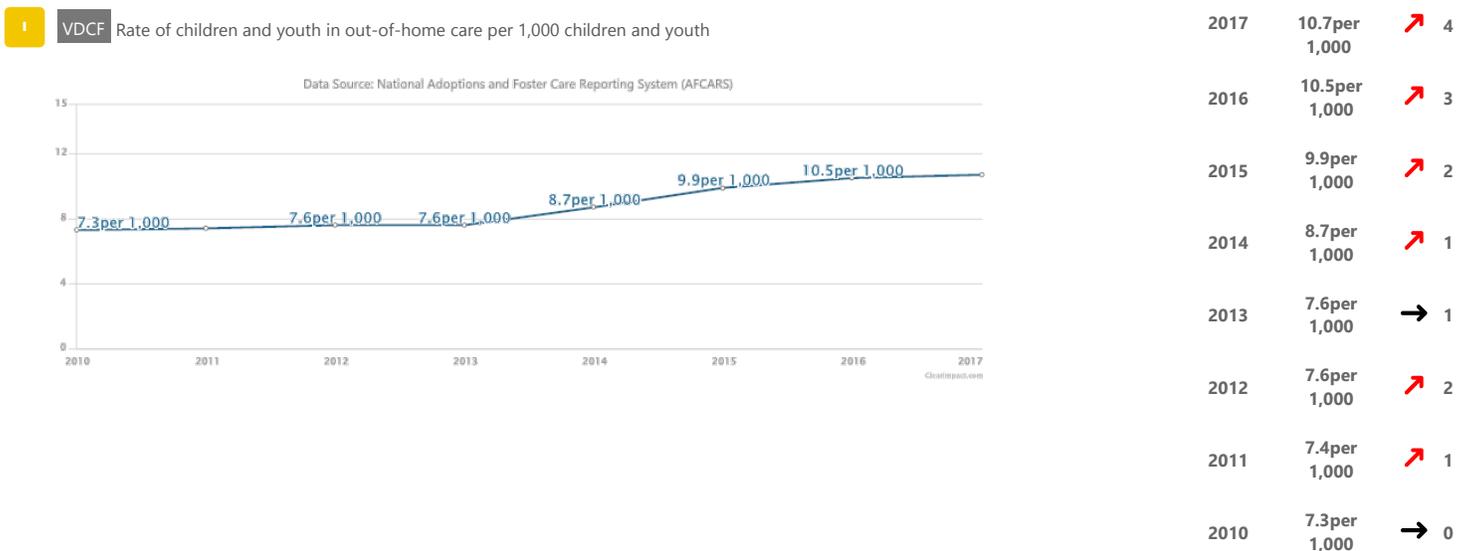
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- Increased staffing capacity in the districts and in the DCF Central Office, with support from AHS, the Governor’s Office and Legislature;
- Contracted with community partners to provide the services of six substance abuse specialists who will help 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;
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- 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
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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

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## 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.**

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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.
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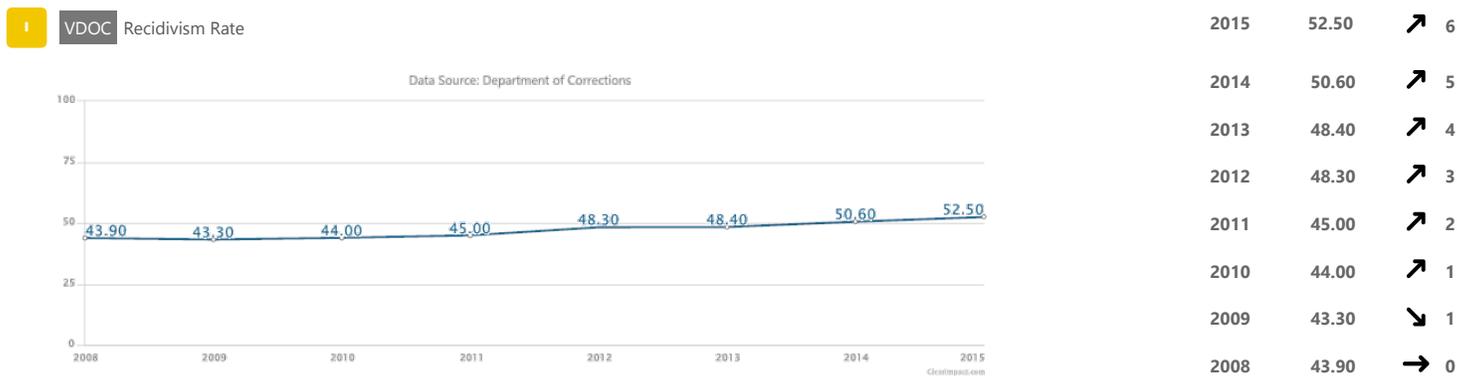
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- Updated training on child safety and risk assessment in partnership with Casey Family Programs and the Children’s Research Center;
- Introduced a comprehensive coaching program to support continual skill development for staff;
- Implemented a qualitative 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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## Story Behind the Curve

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

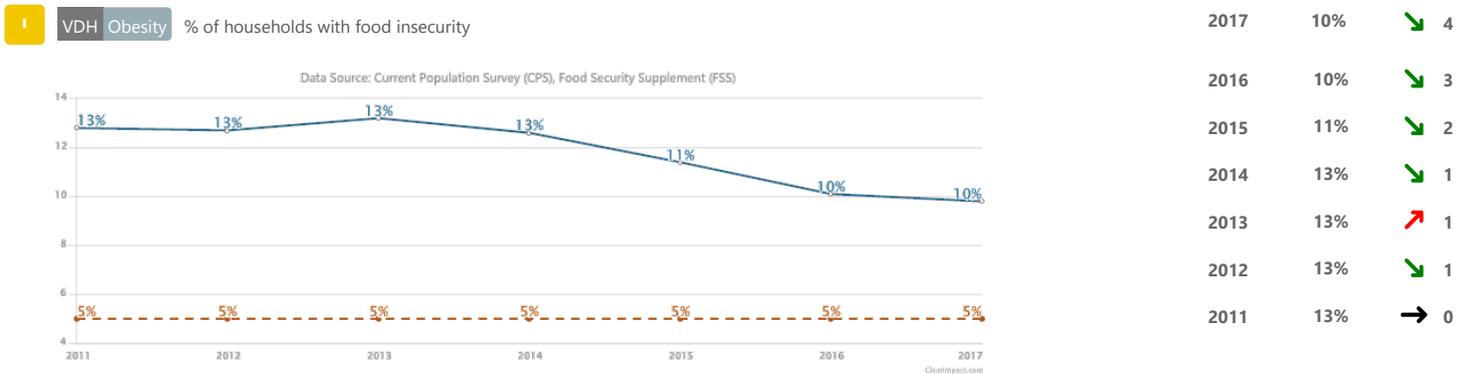
The data tell us that the average recidivism rate has remained consistent over time. The fluctuations from year to year do not represent significant differences in the rate. It is common for recidivism rates to remain stable due to the nature of the measure. The goal is for this trend to go down.

*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 2015. 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

## What Works

## Strategy



## Story Behind the Curve

Updated September 2019

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

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

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

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

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

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## Partners

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

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## What Works

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

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

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## Strategy

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

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

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

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

## Why Is This Important?

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

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

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

## Notes on Methodology

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

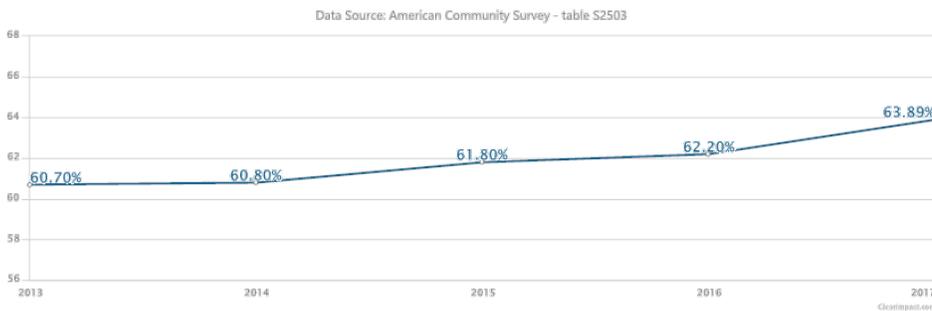
### OUTCOME 5

#### 2019act186 VERMONT'S FAMILIES ARE SAFE, NURTURING, STABLE, AND SUPPORTED

Most Recent Period	Current Actual Value	Current Trend
--------------------	----------------------	---------------

#### 2019act186 % of residents spending less than 30% of income on housing

2017	63.89%	↗ 4
2016	62.20%	↗ 3
2015	61.80%	↗ 2
2014	60.80%	↗ 1
2013	60.70%	→ 0



## Story Behind the Curve

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

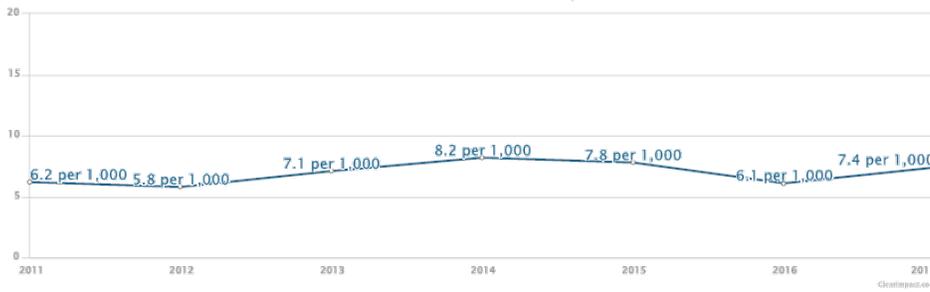
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## What Works

## Strategy

#### 2019act186 VDCF Rate of substantiated reports of child abuse and neglect per 1,000 children

2017	7.4 per 1,000	↘ 1
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2016	6.1 per 1,000	↓	2
2015	7.8 per 1,000	↓	1
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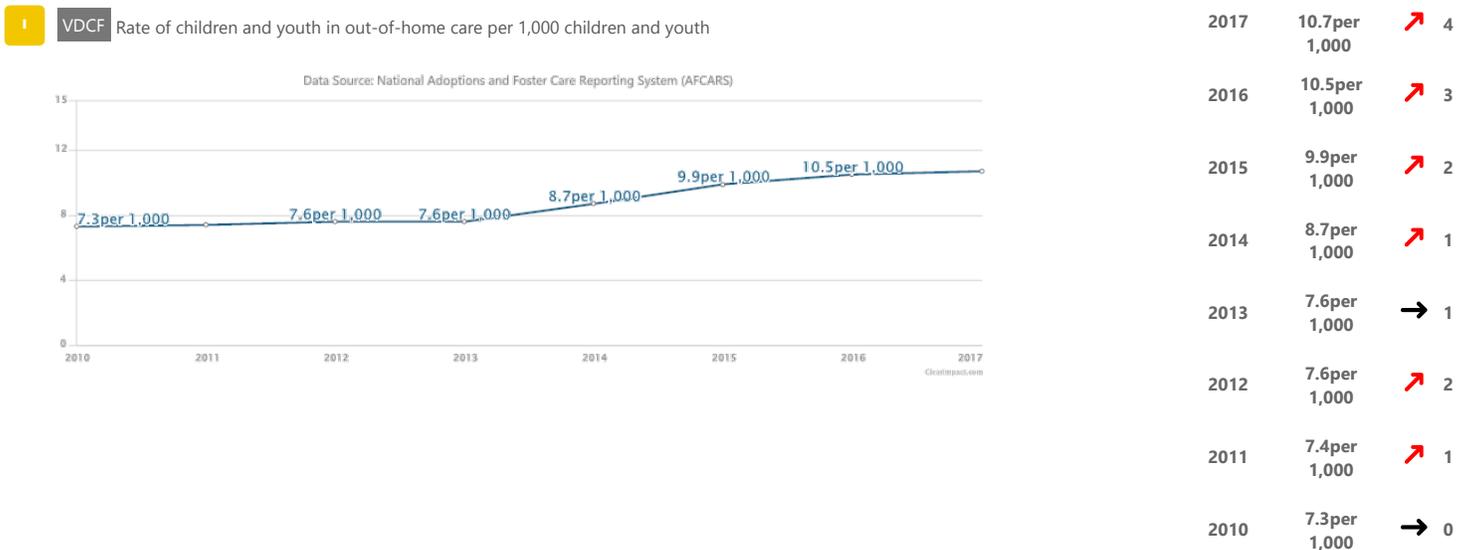
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- Calls to DCF's Child Protection Hotline increased by 4.8%; over 20,000 calls were received. Substance abuse was identified as a contributing factor in 28% of those calls.
  - The number of children who were substantiated victims of child abuse decreased 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.

In the AHS 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 (for SSI determinations for children 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
- Agency of Education
- Casey Family Programs
- Designated Agencies
- Educators and other school personnel
- Health Care Professionals
- KIN-KAN
- Local law enforcement and Special Investigation Units
- Mandated reporters
- Parent Child Centers
- Prevent Child Abuse Vermont
- Project Family with Lund
- UVM Child Welfare Training Partnership
- Vermont Judiciary, attorneys, and other court personnel
- VFAFA
- VT Kin as Parents
- VT-FACTS
- VT FUTRES

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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

## 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.

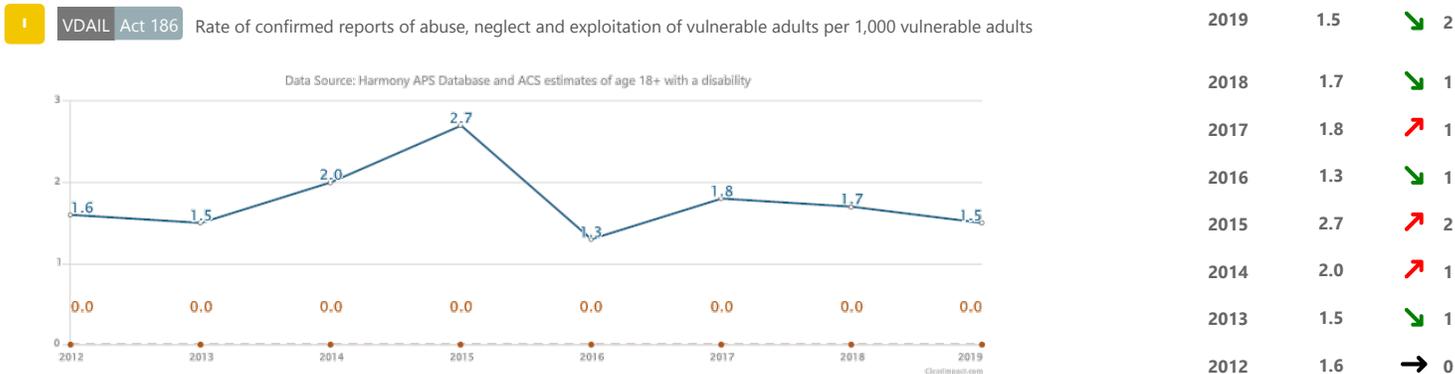
DCF has implemented significant improvements based on reviews conducted by Casey Family Programs and the Vermont Citizen’s Advisory Board. DCF also sought feedback from its staff, community partners, and the public to develop a plan to improve our policies and support our workforce. Changes implemented by DCF 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;
- Implemented a qualitative case review system to help inform our progress on achieving outcomes for children and families; and
- Improved the DCF website to provide better information to the public about FSD policies and practices.

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

- Information sharing among professionals across the child protection system
- Closer collaboration between DCF and Vermont’s Special Investigation Units
- 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](#).



## Story Behind the Curve

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

## Partners

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

## What Works

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

## Strategy

## Notes on Methodology

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

[https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_17\\_5YR\\_S1810&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S1810&prodType=table)

### OUTCOME 6

**O** 2019act186 VERMONT'S CHILDREN AND YOUNG PEOPLE ACHIEVE THEIR POTENTIAL

Most Recent Period Current Actual Value Current Trend

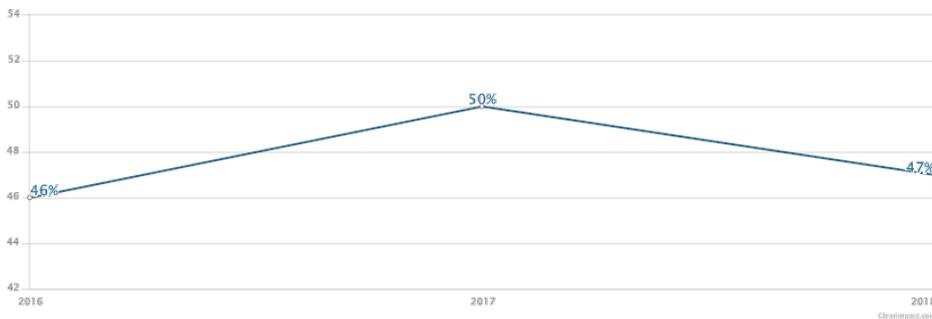
**I** 2019act186 % of children ready for school in all four domains of healthy development 2018 84% ↗ 2



**I** 2019act186 % 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

The 2019 SBAC data is finalized, but it can't be shared yet. AOE plans to release it when the Annual Snapshot is released (between December 2019 - Spring 2020).

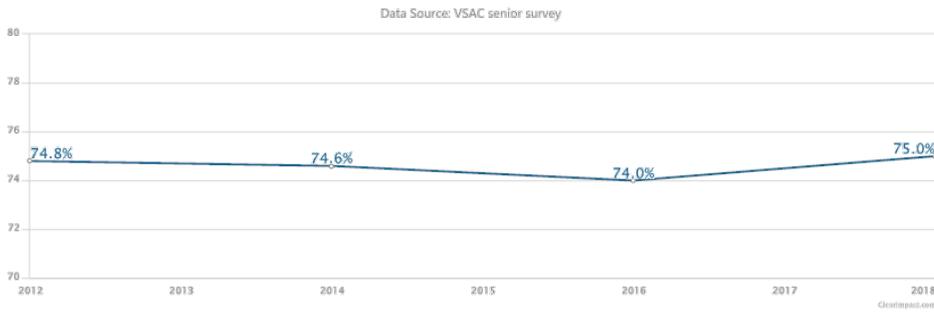
## Partners

# What Works

## Strategy

**2019act186** % of high school seniors with plans for education, vocational training, or employment

2018	75.0%	↗ 1
2016	74.0%	↘ 2
2014	74.6%	↘ 1
2012	74.8%	→ 0



### Story Behind the Curve

conducted every 'even' year (2018, 2016, 2014, etc.). Next report due for 2020.

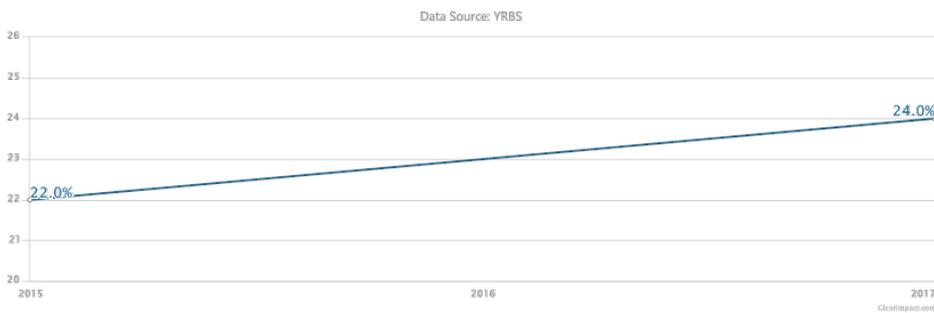
### Partners

### What Works

### Strategy

**2019act186** % 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

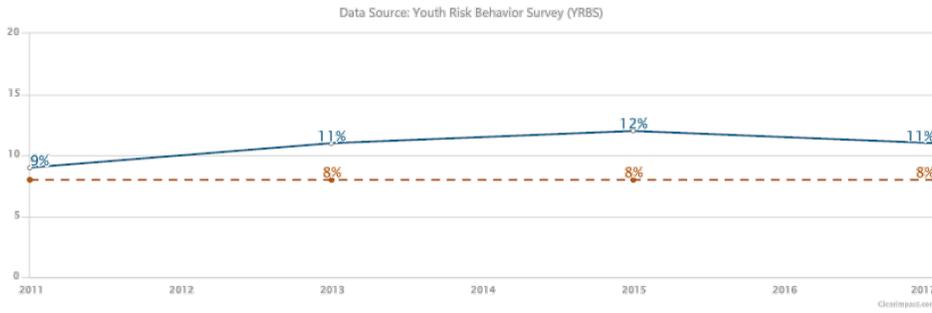
### Partners

### What Works

### Strategy

**VDH** % of adolescents in grades 9-12 who made a suicide plan

2017	11%	↘	1
2015	12%	↗	2
2013	11%	↗	1
2011	9%	→	0



## Story Behind the Curve

### Partners

### What Works

### Strategy

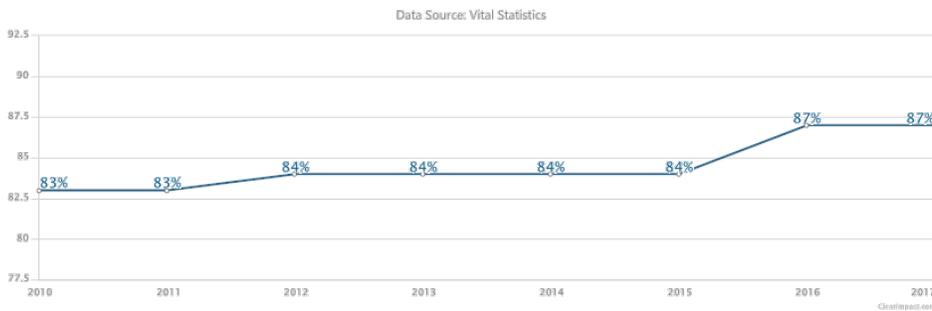
### Why Is This Important?

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.

### Notes on Methodology

**VDH** % of women who receive first trimester prenatal care

2017	87%	→	1
2016	87%	↗	1
2015	84%	→	3
2014	84%	→	2
2013	84%	→	1
2012	84%	↗	1
2011	83%	→	3
2010	83%	→	2
2009	83%	→	1



## 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.

### Partners

Why Is This Important?

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

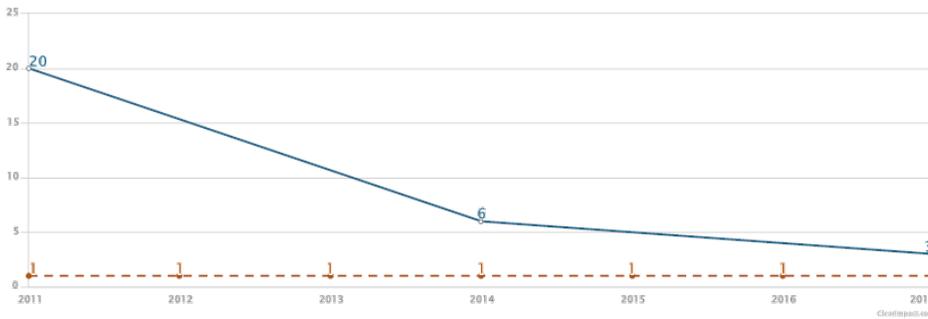
Notes on Methodology

OUTCOME 7

<span style="background-color: #008000; color: white; border-radius: 50%; padding: 2px 5px;">O</span> 2019act186	VERMONT’S ELDERS LIVE WITH DIGNITY AND IN SETTINGS THEY PREFER	Most Recent Period	Current Actual Value	Current Trend
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I VDAIL Act 186 State Ranking on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers (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.
- Effective Transitions** Integration of health, LTSS, and social services minimizes disruptions such as unnecessary hospitalizations, institutionalizations, and transitions between settings.

In this third (2017) *Scorecard*, Washington edges out Minnesota for the top slot, followed by Vermont, Oregon, and Alaska.

The three *Scorecards* all have somewhat different methodologies and indicator sets, due primarily to changes in data availability. Ranks are not directly comparable between years, but the results across all three editions of the *Scorecard* indicate that Washington and Minnesota are consistently leading the pack.

State Rankings: Vermont

- Overall: 3
- Affordability and Access: 3
- Choice of Setting and Provider: 5

- Quality of Life & Quality of Care: 19
- Support for Family Caregivers: 10
- Effective Transitions: 9

Number of indicators for which Vermont ranked in the:

- Top Quartile: 13
- 2nd Quartile: 9
- 3rd Quartile: 3
- Bottom Quartile: 0

## 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:

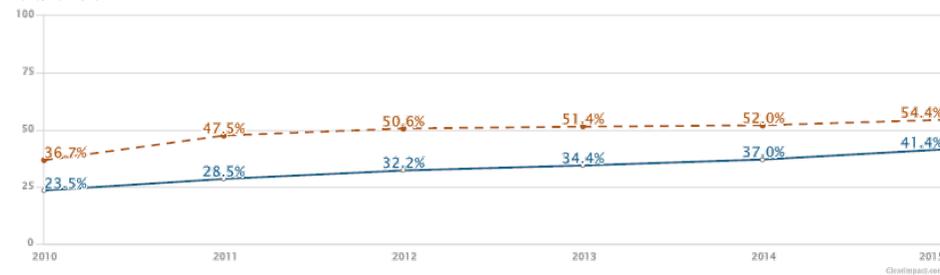
<http://www.longtermscorecard.org/2017-scorecard>

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

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

**VDAIL 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

Data Source: United Health Foundation America's Health Rankings Senior Reports <https://www.americashealthrankings.org/learn/reports/2019-senior-maries-vermont>



2015	41.4%	↗ 5
2014	37.0%	↗ 4
2013	34.4%	↗ 3
2012	32.2%	↗ 2
2011	28.5%	↗ 1
2010	23.5%	→ 0

# Story Behind the Curve

Vermont ranked 46th among US states in 2014 (2018 report). Target values are US values, i.e. across all states.

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

## Partners

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

## What Works

## Strategy

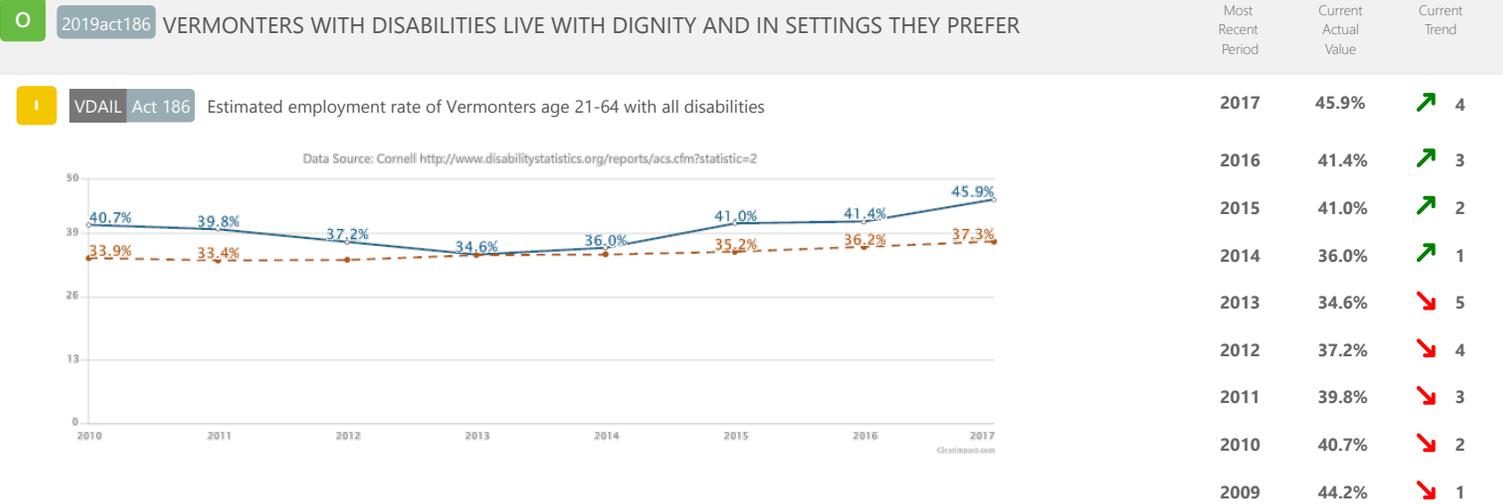
## Notes on Methodology

Hospice Care is the percentage of Medicare decedents aged 65 years and older enrolled in hospice care in the last six months of life after a diagnosis of one of nine chronic conditions with a high probability of death. The senior ranks are based on 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.americashealthrankings.org/learn/reports/2019-senior-report/state-summaries-vermont>

### OUTCOME 8



# Story Behind the Curve

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

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

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

## Partners

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

## What Works

## Strategy

## Notes on Methodology

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

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

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

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

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

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

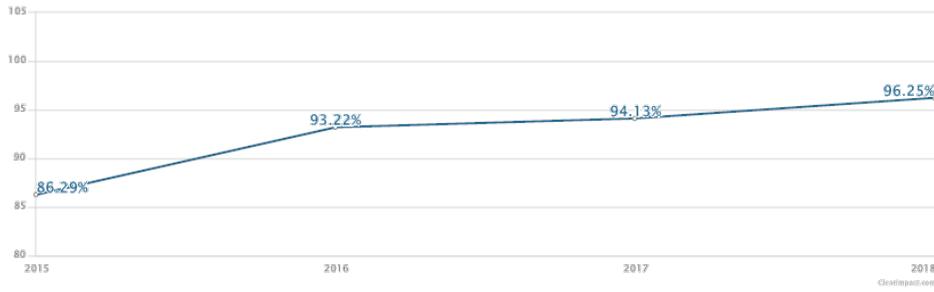
**Self-care Disability** (asked of persons ages 5 or older): Does this person have difficulty dressing or bathing?

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

### OUTCOME 9

		Most Recent Period	Current Actual Value	Current Trend
	2019act186 VERMONT HAS OPEN, EFFECTIVE, AND INCLUSIVE GOVERNMENT			
	2019act186 % of people who are eligible to register to vote and who have registered	2018	96.25%	 3

Data Source: Secretary of State Elections Site



2017	94.13%	↗ 2
2016	93.22%	↗ 1
2015	86.29%	→ 0

Story Behind the Curve

Partners

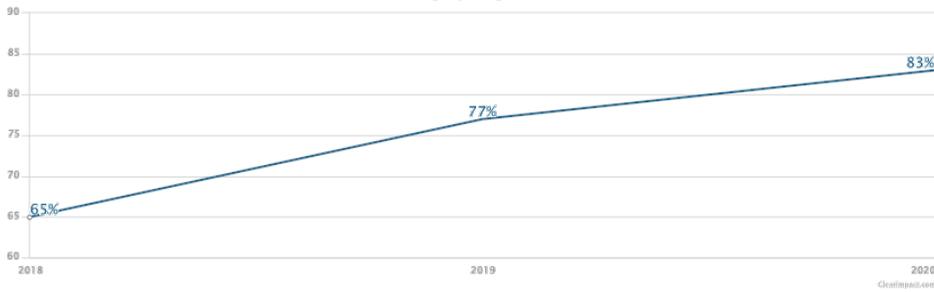
What Works

Strategy



2019act186 Number of departments using up-to-date website template

Data Source: Agency of Digital Services/VIC



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

Story Behind the Curve

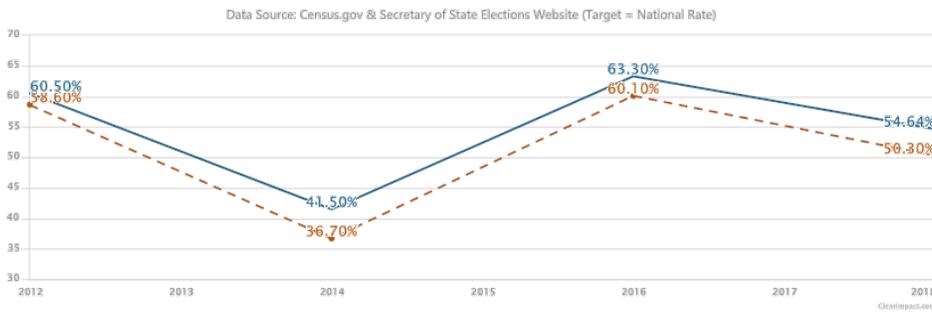
Partners

What Works

Strategy

**2019act186** % of registered voters voting in the general election

2018	54.64%	↓	1
2016	63.30%	↑	1
2014	41.50%	↓	1
2012	60.50%	→	0



### Story Behind the Curve

Vermont scores higher than the National Average generally including 2018 (XX%). However, we see fewer voters turning out that we would like.

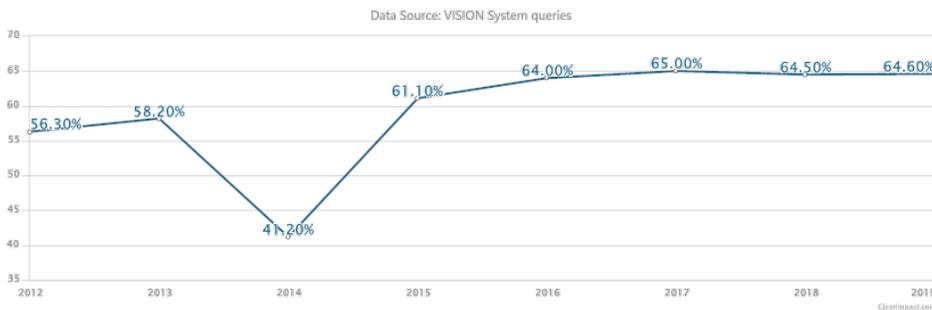
Partners

What Works

Strategy

**2019act186** % of State contracts awarded that include performance measures

2019	64.60%	↑	1
2018	64.50%	↓	1
2017	65.00%	↑	3
2016	64.00%	↑	2
2015	61.10%	↑	1
2014	41.20%	↓	1
2013	58.20%	↑	1
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

**2019act186** % of State grants awarded that include performance measures

2019	69.90%	↑	1
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2019act186 Number or percent of departments that are able to accept online payments 2019 26 → 1



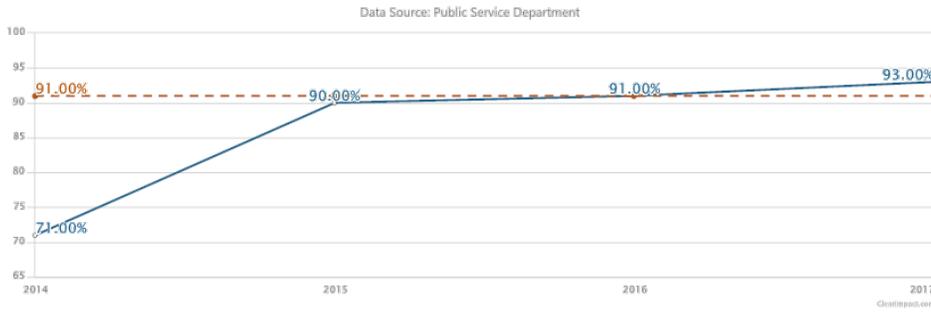
2019act186 Number of agencies and departments that have a policy regarding response time to constituent inquiries and that measure that response time — — —



OUTCOME 10

2019act186 VERMONT'S STATE INFRASTRUCTURE MEETS THE NEEDS OF VERMONTERS, THE ECONOMY, AND THE ENVIRONMENT Most Recent Period Current Actual Value Current Trend

2019act186 % 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

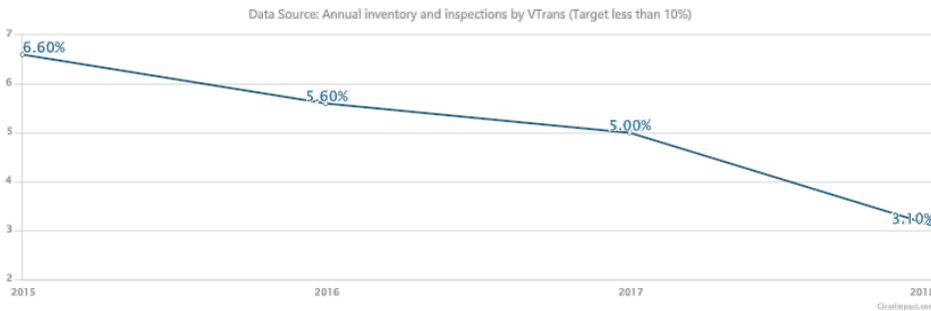
Percentage of Vermont business and residential E-911 locations have access to broadband internet access with speeds of at least 4 Mbps down and 1 Mbps up.

Partners

What Works

Strategy

2019act186 % of structurally-deficient bridges, as defined by the Agency of Transportation 2018 3.10% ↘ 3



2017 5.00% ↘ 2

2016 5.60% ↘ 1

2015 6.60% → 0

Story Behind the Curve

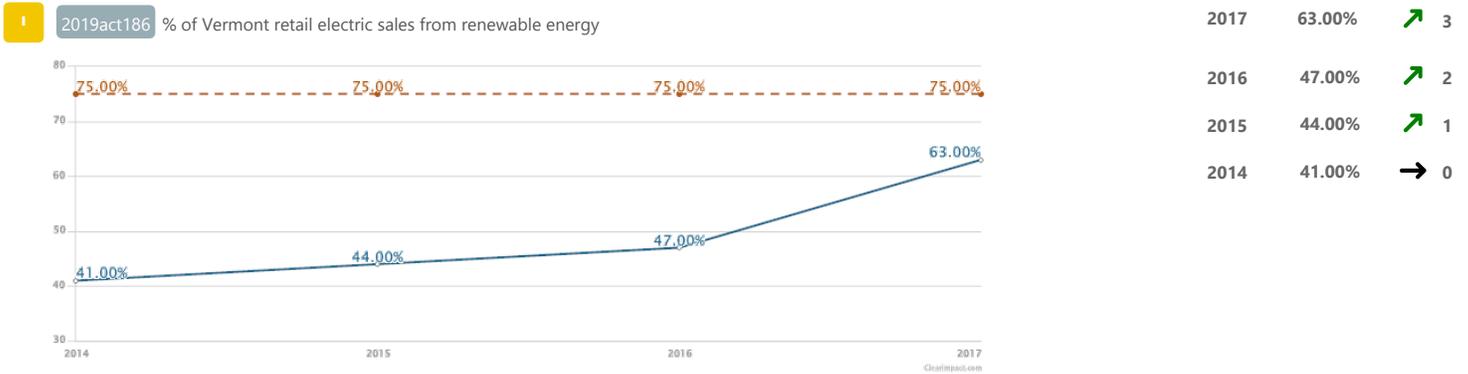
Annual inventory and inspections by VTTrans of bridges with spans > 20 ft on state and town highways, and short structures with spans between 6 and 20 ft on the state highway system.

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



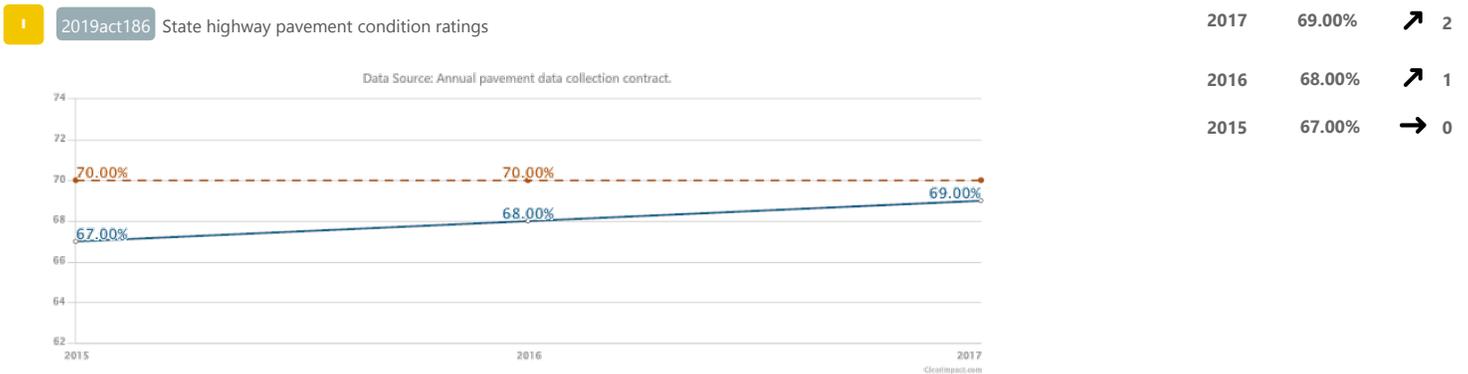
### Story Behind the Curve

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



### Story Behind the Curve

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

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Partners

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What Works

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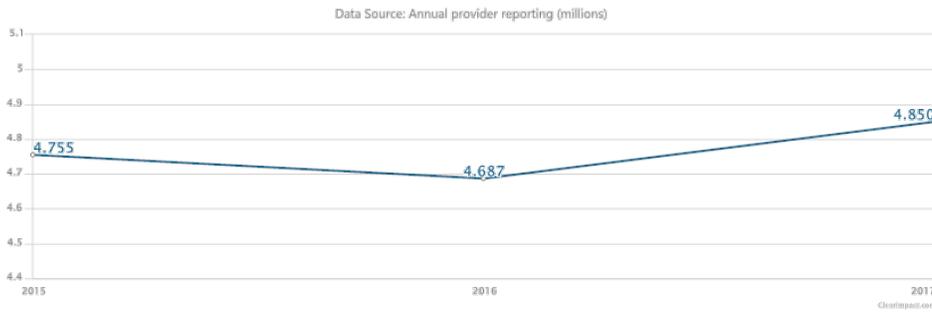
Strategy

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2019act186 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.

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Partners

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What Works

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Strategy

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