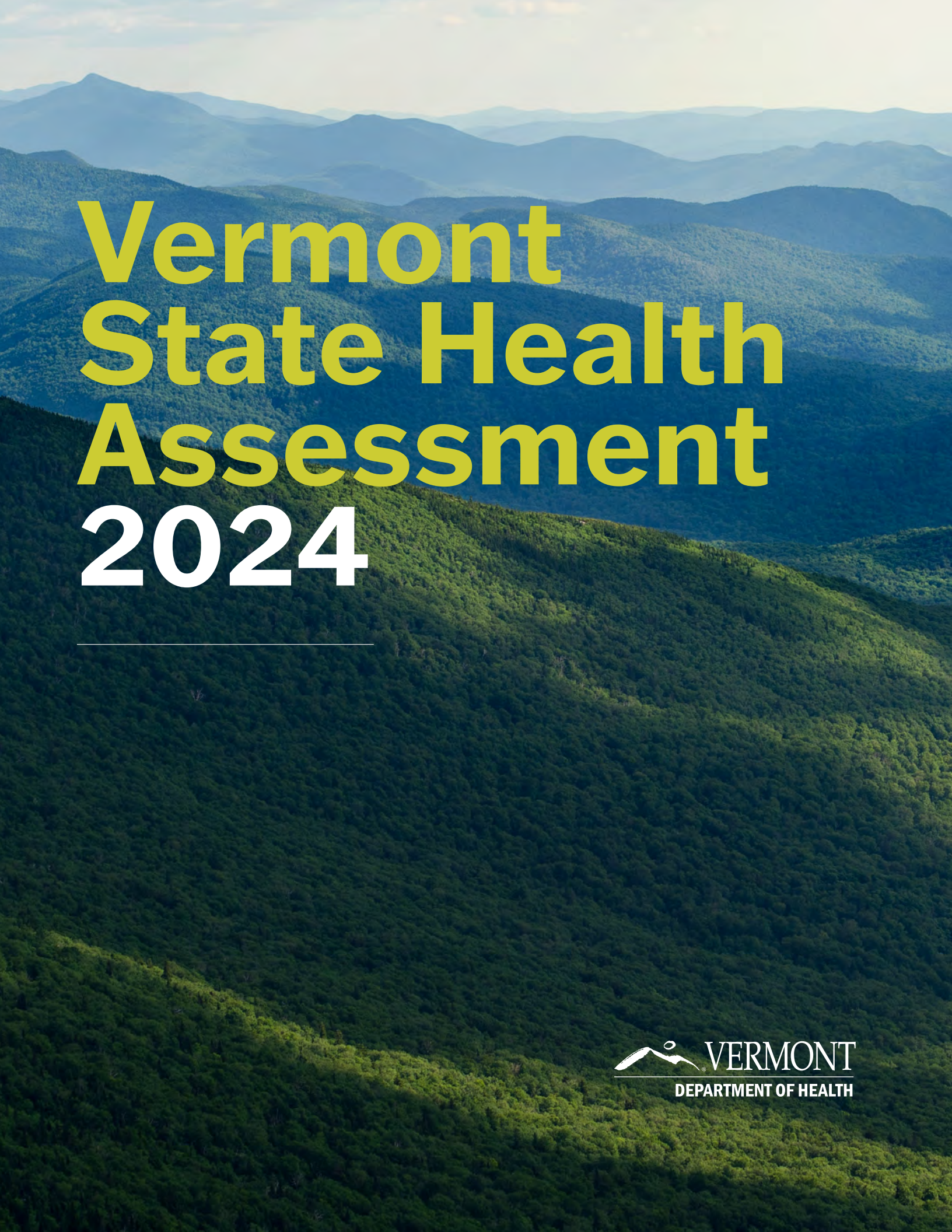


Vermont State Health Assessment 2024

VERMONT
DEPARTMENT OF HEALTH

Contents

Purpose and Use

The 2024 State Health Assessment (SHA) is an overview of what we know about the health and well-being of people in Vermont at a point in time. It provides important data for examining health inequities by race and ethnicity, age, gender, sexual orientation, disability, and socioeconomic status. Results of the SHA will be used to develop the next State Health Improvement Plan for 2025-2030. The plan will prioritize key goals to promote health and health equity and to monitor trends, identify gaps, and track progress. It is a way for different sectors and organizations around the state to coordinate on key issues to improve the health of Vermonters.

In addition to using the findings from this assessment to develop the State Health Improvement Plan, organizations and communities can also use these data to inform their own efforts to improve health and well-being.

The State Health Assessment answers the question: *"What do we know?"*

The State Health Improvement Plan answers the question: *"What are we going to do about it?"*

Data from the assessment can help to:

- Elevate the voices of people with lived experience to provide context to quantitative data.
- Understand the factors that impact health and well-being.
- Identify solutions to address some of the most important health needs facing people in Vermont.
- Inform planning and decision-making for an organization or community.
- Identify opportunities for collaboration with other organizations or sectors.

Approach

The State Health Assessment is based on a review of existing public health data sources and the collection of new data through a robust community engagement process. The work was led by a consultant, the Center for Behavioral Health Integration, with support from a cross-sector Steering Committee chaired by the Commissioner of the Department of Health. The Steering Committee crafted a vision statement and defined a set of core values to guide the process:

Vision

All people and communities in Vermont have inclusive, equitable, affordable, and sustainable access to opportunities for health and well-being.

Values

Community-centered:
Center the needs and perspectives of communities experiencing inequities and actively engage them from the beginning.

Intersectional:
Acknowledge and address the many identities individuals hold and how that impacts their access to and experience of health and wellbeing.

Respectful:
Respect and honor the different perspectives of individuals living in Vermont.

Data-driven:
Use data—both the numbers and the voices of people with lived experience—to make decisions and guide efforts towards improvement.

This State Health Assessment is centered largely around qualitative data—the voices and stories behind the numbers. These voices help to understand the root causes of health issues, how social and environmental factors shape individual experiences, and offer solutions that will work best for different communities. The SHA aimed to hear from and prioritize the strengths and needs of communities in Vermont that experience the greatest health inequities due to systemic and structural racism, class oppression and other forms of injustice.

This work was possible thanks to the people of Vermont who participated in focus groups and interviews for the State Health Assessment and the partner organizations who supported the community engagement process. Their contributions lay a solid foundation for the next five-year State Health Improvement Plan, which will mark the path forward to improve health and health equity for all people in Vermont.

The communities of focus were:

+ Indigenous People
+ People of Color
+ People with Disabilities
+ People who are Unhoused
+ LGBTQ+ Vermonters
+ Older Vermonters

Overview of the State

The Public Health Authority

Public health authority in Vermont is established in Title 18. To achieve this mandate, the state has a centralized public health department with 12 local district offices. The health commissioner has broad authority to act to protect the health of people in Vermont. The mission of the Department of Health is to promote the physical, mental, and social well-being of people in Vermont by advancing equity, protecting against disease and injury, and preparing for health emergencies. In addition, Vermont's public health system includes public, private, and community partners from across the state and many sectors beyond health, such as agriculture, housing, transportation, education, criminal justice, natural resources, and social justice. These partners collaborate to ensure access to services and create conditions for people to be healthy.

Health Service Systems

For a small, rural state, Vermont has a well-established health care system. A network of hospitals, clinics and primary care medical homes, coupled with nearly universal insurance coverage, provides a strong foundation for most clinical care. There are 14 hospitals in the state, along with a VA Medical Center, two psychiatric hospitals, and an interstate relationship with Dartmouth Health in neighboring New Hampshire. Both Dartmouth and the University of Vermont Medical Center have strong medical education programs.

Vermont has 11 Federally Qualified Health Centers, 10 Rural Health Clinics and 11 Free Clinics. These health centers and clinics are spread out across the state, providing improved access to primary, dental and mental health services for the uninsured and under-insured.

There is also an extensive system of health and social services throughout the state that are offered by a variety of community organizations, such as mental health agencies, substance use prevention and treatment organizations, Parent Child Centers, home health agencies, and community action partnerships.

Key Vermont Demographics

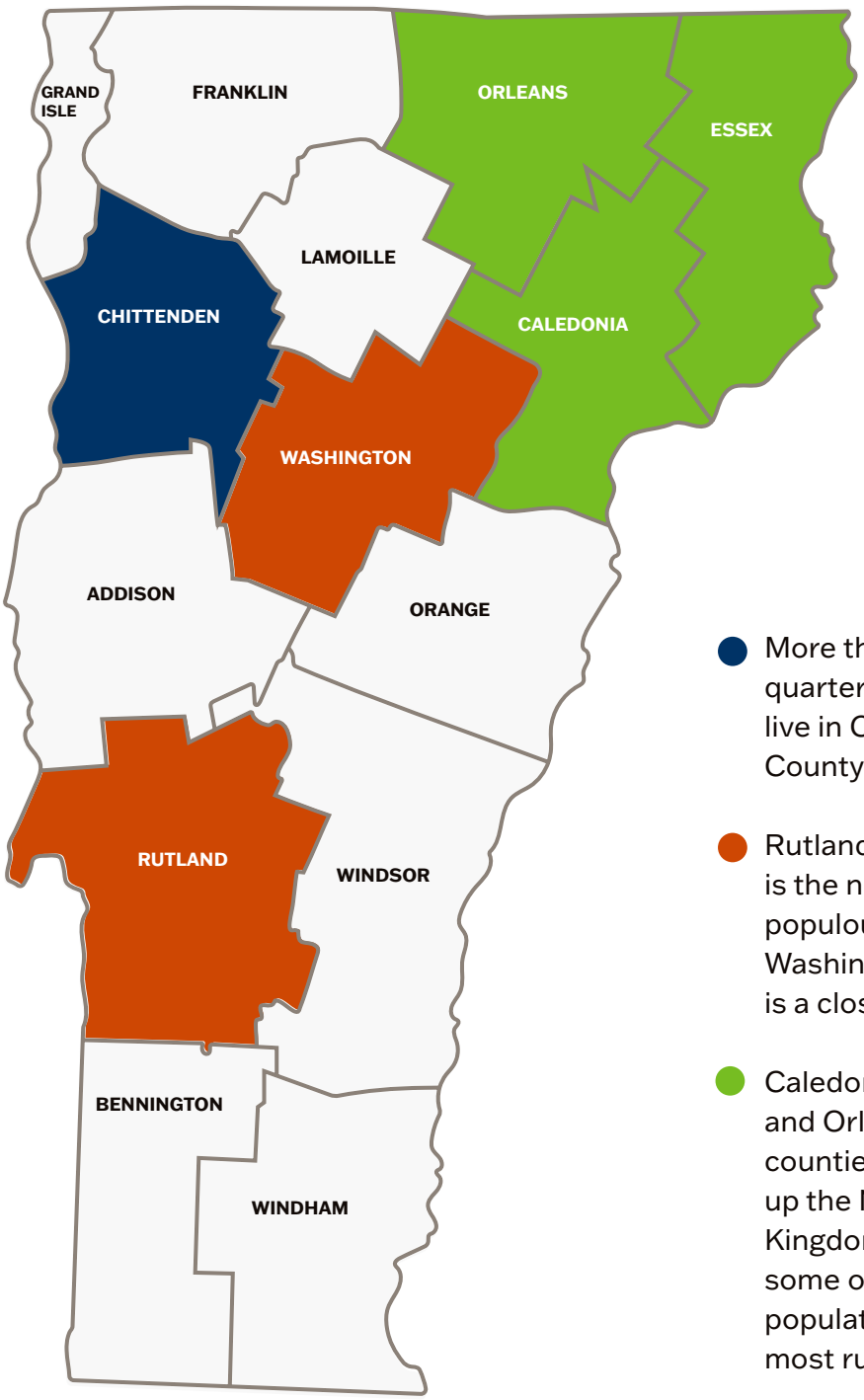
A small, rural state:

647,464
people call Vermont home[1]

9,217
square miles

70
people average per square mile[2]

14
counties



- More than one-quarter of people live in Chittenden County.
- Rutland County is the next most populous, and Washington County is a close third.
- Caledonia, Essex and Orleans, the counties that make up the Northeast Kingdom, are some of the least populated and the most rural.

1. State Population Totals and Components of Change: 2020-2023, U.S. Census Bureau
2. State Area Measurements and Internal Point Coordinates, U.S. Census Bureau

An Aging Population

- One in four residents are over the age of 60 (28% or 183,000 adults), making it the 4th oldest population in the country.
- Since 2001, Vermont has experienced a decreasing youth and an increasing older adult population.[3]

Racial, Ethnic, and Linguistic Diversity

- The population of people of color is growing in Vermont (7.7%), but still proportionately small compared to the rest of the U.S.
- Among people in Vermont, 1.2% identify as Black or African American, 2.1% as Hispanic, 1.7% as Asian, 0.2% as American Indian/Alaska Native, 0.6% as some other race, and 4.0% as two or more races.[4]
- Four tribes are currently recognized by the State of Vermont: the Elnu Abenaki Tribe, the Nulhegan Abenaki Tribe, the Koasek Traditional Band of the Koas Abenaki Nation, and the Abenaki Nation of Missisquoi.
- Among people age 5 and older, 94.6% speak only English at home.[5] The other most common languages include Arabic, Burmese, French, Kirundi, Nepali, Somali, Spanish. The Agency of Human Services (AHS) requires that all vital documents be translated into these languages, as they are most used by clients of AHS programs who speak or sign languages other than English.[6]

Income and Education

- There is a high degree of educational attainment in the state—94.2% of adults age 25 and older have a high school education or more, and 41.7% have at least a bachelor's degree.[7]
- The median household income in Vermont is $74,014 (in 2022 inflation-adjusted dollars), approximately the same as nationally.[8] The state's unemployment rate is 2.1%.[9]

[3] Healthy Aging in Vermont: An Overview of Adults 60+ Years Old, Vermont Department of Health
[4] American Community Survey 2022, 5- year estimates, U.S. Census Bureau
[5] American Community Survey 2022, 5-year estimates, U.S. Census Bureau
[6] 2023 Language Access Report, Vermont Office of Racial Equity
[7] American Community Survey 2022, 5-year estimates, U.S. Census Bureau
[8] American Community Survey 2022, 5-year estimates, U.S. Census Bureau
[9] Labor Market Data by County, Vermont Department of Labor

Methodology

Key Partners

Center for Behavioral Health Integration, LLC

The Department of Health contracted with the Center for Behavioral Health Integration (C4BHI) to conduct an environmental scan and to design and implement a community engagement process for the State Health Assessment. C4BHI was responsible for engaging organizational partners serving the community and individuals with lived experience to understand and document the health and well-being of people in Vermont, including strengths, needs, and priorities for action.

The Department of Health also established a Steering Committee to guide the State Health Assessment. Members included representatives from state agencies, community organizations, and individuals with lived experience. The Committee met monthly beginning in May 2023. Their responsibilities included:

- Providing advice to C4BHI as they engaged the community in the project.
- Identifying gaps in our understanding of the health of Vermonters and data to collect.
- Helping to interpret and give context to qualitative and quantitative data.
- Prioritizing health needs for the State Health Improvement Plan.
- Contributing to the development and implementation of the State Health Improvement Plan.

A list of Steering Committee members is in Appendix A.

Environmental Scan

C4BHI conducted an extensive review of publicly available data sources. The Department of Health supplied an initial list of sources to review, which included information in the following categories: general data, tobacco, mental health, maternal and child health, health equity, older Vermonters, resource needs, health care systems, and environmental health.

Although most were strictly quantitative data sources, some of these sources included qualitative data. In addition to these data sources, searches about the communities of focus (Indigenous People, people of Color, people with disabilities, people who are unhoused, LGBTQ+ Vermonters, and older Vermonters), the state, and each county in Vermont provided additional information.

The CARES database, from the University of Missouri, provided a significant data compilation of resources, including the U.S. Census Bureau, the American Community Survey (ACS) 2017-2021, the Centers for Disease Control and Prevention (CDC), the U.S. Department of Agriculture (USDA), the Department of Transportation, and the Federal Bureau of Investigation.

C4BHI consulted the County Health Rankings, from the University of Wisconsin Population Health Institute, which uses multiple resources and partnerships to arrive at data, including the State of VT Agency of Education Data and reporting, VT Cancer Registry, VT Crime Information Center, VT State Highway Safety Office, and VT vaccination coverage. C4BHI also conducted a comprehensive review of all current Community Health Needs Assessments for all Vermont hospitals to understand health needs being addressed across the state. This review provided a clear picture of priority health needs across Hospital Service Areas.

A list of all data sources consulted in the environmental scan is in Appendix B*.*

Each of these data sources was reviewed to identify major health needs, populations affected, the prevalence and severity of each need, and the relative importance compared to other health challenges. The results were used to create a composite picture of known health needs and to prioritize health challenges to explore further during the community engagement process.

The results were summarized and visualized in data briefs for:

- Vermonters statewide
- Indigenous People
- People of Color
- People with Disabilities
- People who are Unhoused
- LGBTQ+ Vermonters
- Older Vermonters

Upon reviewing and discussing findings from the environmental scan, the Steering Committee arrived at the following health needs to be explored in more detail:

- **Access to care:** Factors that influence a person's ability to seek and receive health care.
- **Climate change:** How the changing physical environment affects physical and emotional health.
- **Cost of living:** How financial standing impacts, and is impacted by, health.
- **Discrimination**: How being treated differently by individuals and institutions due to personal and cultural characteristics can impact health.
- **Housing**: How the housing environment in Vermont affects health directly or indirectly.
- **Mental health and substance use**: Issues related to mental health conditions or substance use that influence overall health and well-being.
- **Specific health conditions**: Specific health concerns people are facing.

This sequential approach to the data collection process, beginning with a quantitative data review to understand the landscape of health needs and then collecting qualitative data to provide depth of understanding, allowed for a detailed review of health needs, drivers to health challenges, the impacts of health needs, and potential solutions. The environmental scan data was helpful in identifying needs, but did not speak to what people are experiencing and what is and could be helpful to them. Proceeding with focus groups and key informant interviews to learn more about the context of the health needs identified in the scan was a critical next step.

Community Engagement

A priority in this State Health Assessment process was seeking guidance from people who are most impacted by structural inequities. Community engagement informed what health needs to explore further, how to assign meaning, and to identify potential opportunities to improve those health needs.

Over 130 organizations were contacted to help arrange focus groups and interviews with people representing the communities of focus and subject matter experts. C4BHI maintained detailed tracking of the organizations contacted to ensure equitable representation of the communities of focus and counties in Vermont in the outreach. Partner organizations helped to connect the interview team with participants, schedule focus groups, and create the conditions that allowed for meaningful and authentic conversations to take place. The time, care, and collaboration put forth by these organizations to make this a meaningful process is immensely appreciated.

Key partner organizations included:

Abenaki-Elnu Band

Abenaki-Koasek Band

Abenaki-Missisquoi Band

Abenaki-Nulhegan Band

Alliance for Community Transformations (ACT) and Queer Connect

Atowi

Building Bright Futures State Advisory Council

Community and Economic Development Office (CEDO)—Trusted Community Voices

Health Care and Rehabilitation Services

Healthworks/Blueprint

Lamoille Health Partners

NAACP of Windham County Health Justice Committee

Northeast Kingdom Learning Services

Northeast Kingdom Prosper! Caledonia and Southern Essex Accountable Health Community

Northeastern Vermont Regional Hospital

Open Door Clinic

Out in the Open

ReLeaf Collective

Rutland County Pride

Samaritan House

Social Tinkering

Sunrise Family Resource Center

Support and Services at Home (SASH)

The Clarina Howard Nichols Center

The Elmore Pods and Harbor Place (Champlain Housing Trust)

The Family Place

The Janet S. Munt Family Room

The HUB

Turning Point Center

Vermont Association for Mental Health and Addiction Recovery

Vermont Department of Health

Vermont Department for Children and Families, Office of Economic Opportunity

Vermont Afterschool

Vermont Professionals of Color Network

Focus groups were conducted with community members and staff from organizations that serve the community. Key informant interviews were conducted with subject matter experts.

In all:

45	351	40	16
focus groups were completed	focus group participants	key informant interviews	additional participants*

*Community members who preferred to be interviewed individually and individuals who provided feedback in writing.

The interviewing team for each focus group was composed of an **interviewer** and a **note-taker**. To show respect for their time and expertise, participants were offered $50 gift cards after a focus group or interview took place. Focus groups and interviews were completed in person, online, or in a hybrid format depending on the preferences of the participants. Food was provided for all in-person and hybrid groups. Childcare and interpretation services were also available as needed.

The interviewing team included consultants from:

- Jennifer Jewiss at Jewiss Consulting
- Cindy Char at Char Associates
- The Vermont Professionals of Color Network
- The Center for Behavioral Health Integration

The interviewing team developed a detailed interview guide in collaboration with the Department of Health. It focused on factors affecting participants' health and the health of their community. Three polls were shared with the groups, which collected data on the county the participant lives in, if the participant identifies as belonging to one or more of the communities of focus, and the top three health needs that most affect them and their community. These polls and the conversations that followed helped in prioritizing the health needs from the environmental scan.

Polling Results

The following table shows the percent involvement of the community in focus groups in each county in comparison to the percent of the state population in that county. These results are based on self-report data provided by participants during the focus groups.

County	Focus Group Involvement	State Population
Addison	7%	6%
Bennington	13%	6%
Caledonia	7%	5%
Chittenden	25%	26%
Essex	1%	1%
Franklin	6%	8%
Grand Isle	<1%	1%
Lamoille	4%	4%
Orange	1%	5%
Orleans	6%	4%
Rutland	6%	9%
Washington	8%	9%
Windham	4%	7%
Windsor	5%	9%
Missing	6%	NA

The following table shows the percent involvement of each of the communities of focus as reported by participants.

Community	Focus group involvement	Key Informants
Vermonters Statewide	8%	23%
Indigenous People	4%	5%
People of color	14%	18%
People with disabilities	19%	14%
People who are unhoused	10%	13%
LGBTQ+ Vermonters	15%	11%
Older Vermonters	19%	15%
Missing data	11%	NA

Each participant chose their three highest priority health needs from the list of identified health needs. The following are the top health needs identified statewide and by each of the communities of focus:

	Vermonters Statewide	Older Vermonters	Vermonters of Color	Indigenous People	LGBTQ+ Vermonters	Unhoused Vermonters	Vermonters with Disability
Housing	23%	23%	26%	28%	21%	30%	21%
Cost of Living	22%	23%	26%	17%	14%	24%	21%
Mental Health and Substance Use	22%	16%	12%	23%	29%	28%	22%
Access to Care	16%	15%	23%	19%	20%	9%	12%
Discrimination	8%	9%	10%	8%	9%	6%	11%
Climate Change	3%	6%	1%	2%	1%	0%	6%
Specific Health Conditions	5%	8%	3%	4%	5%	4%	7%

Analysis Methodology

C4BHI transcribed recordings of focus groups and key informant interviews using the online service Transcription Puppy. All transcripts were then imported to Dedoose, a collaborative application that helps analysis teams organize and analyze qualitative data. The process of 'coding' or 'tagging' the data was done in Dedoose.

A code book for analysis was developed according to health needs, questions asked per need, interconnectedness of the needs, communities of focus, and quotes and illustrative stories. While often overlapping, the topics of mental health and substance use were coded and analyzed separately, as each offered some of its own constellation of drivers, impacts, and suggested actions. Only during reporting were these topics combined again. Additional codes were added following a review of transcripts and discussions with interviewing team members. For example, the subcode of 'Emotional Toll' was added under the parent code of 'High Cost of Living' to indicate when participants speak of the cognitive and emotional stress and stakes of making financial decisions. This financial juggle was often described as a health issue and was frequently mentioned by participants. Along with additions to the codebook, immigrants and refugees were added as a distinct group from People of Color. This population experiences unique and separate needs impacting their health, such as language and acculturation.

The team conducting this qualitative analysis was comprised of two consultants from C4BHI and two consultants from Fireside Consulting, a Southern California-based evaluation company. The analysis team was often humbled by the sheer volume of data, and by the lived experiences of what one of the interviewers coined as "courageous Vermonters." The team was thankful to be entrusted with these accounts and worked diligently to ensure that the complexity of human experience and the contexts they described were not reduced by the synthesis and reporting needs. The report reflects participants' expressed views from their unique points of view and should not be taken as the opinions of the Vermont Department of Health or other entity. Feedback from the Steering Committee, Department of Health staff, and key stakeholders was incorporated through multiple reviews of the data into this synthesis to ensure it accurately represented the experiences of the community.

The views expressed in the findings of this report represent the opinions of those interviewed, not the Vermont Department of Health, the Center for Behavioral Health Integration, or any individual or group involved in the data analysis process.

Findings by Health Need

Housing, Cost of Living, Mental Health and Substance Use, Access to Care, Discrimination, Climate Change, and Specific Health Concerns are each described here according to what participants shared, and often in their own words. Many participants commented on the interconnectedness of the health needs, and often discussion of one need would diverge into discussion of other needs. Therefore, while the discussion that follows is per need, these are not mutually exclusive.

Housing

At a glance: Lack of affordable, safe, and accessible housing leads to housing insecurity, mental health deterioration and financial strain. Key housing issues include substandard housing environments due to neglected maintenance, the high cost of housing, a limited number of contractors available to make repairs, landlords raising rents while not maintaining properties, and economic support, policies, and initiatives for affordable housing that are not addressing the acute needs. Housing discrimination further limits access for many marginalized communities. The number of people in Vermont who are unhoused continues to grow. As one participant says, **"For the homeless, which I consider my community, until I became it, I didn't realize how many in the area were homeless."**

Participants described living in very low-quality conditions: **"I think that the biggest problem with the housing is substandard quality. I don't think the town inspects buildings enough… apartment buildings…and the motels that the state is paying for are not in human condition."** Some live in temporary housing situations like motels or cars, and others are in rentals that lack proper inspections and landlord oversight to ensure they are safe and livable. Some reside in older buildings that need better maintenance and repairs to address concerns like lead paint, asbestos, or impacts from flooding. For some the house becomes the direct source of illness, through mold or lead exposure. An indirect source of illness is that living in these conditions is an enormous stressor.

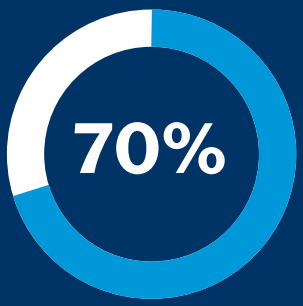
Many described a limited housing stock. Some participants expressed frustration due to underutilization of vacant properties, as one participant said: **"One of the things that frustrates me tremendously is knowing there are people in need of a home, and you drive around the area and there are so many houses that people don't live in."** Participants also talked about housing units that were taken off the market to be used as second homes or short-term rentals. One participant describes, **"Rent is rising and rising and rising, we're paying more for no changes in conditions of housing, right? It's just like an astronomical rise for no additional benefit. I understand from reading and talking to people that the housing market [has] really shot up in Vermont especially during the pandemic as a result of people moving here from out of state, for kind of retreat homes."** There is a strong belief among people in Vermont that an influx of people from out-of-state moving to Vermont during and after the COVID-19 pandemic made the housing market increasingly competitive: **"I also have been hearing a lot**

these past few years of folks who have been renting forever and ever at places and then their landlord decides to sell the house or decides to turn it into an Airbnb so that they're being forced to go and find a new place to live and that rental unit is now off the market." Recent floods also altered the number of habitable housing units. Low workforce capacity, high supply costs, and supply shortages are barriers to maintaining or repairing living environments. Repairs after natural disasters are essential to ensure living situations are safe, but often the costs are significant and the timeline for repairs is very long.

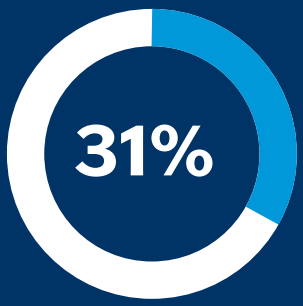
Many participants described deprioritizing their health while living in compromised conditions. As one participant shared: **"The lack of affordable housing is pushing people down and into losing their home into much, much, much increased economic stress for their households. Much more vulnerability on all fronts."** People are experiencing deteriorating living conditions, less ability to afford and access basic needs, and high levels of stress. One participant offered this example: **"...let's say, there's two people...and the relationship is not healthy. Someone wants to leave their relationship and they're unable to. Sometimes I've heard of situations with violence and state, but because of housing, they stay. Because there's just not a lot of options."**

Economic support, policies, and initiatives for affordable housing are viewed as insufficient to communities' needs. The state cannot help everyone who qualifies for affordable housing and many people in need are excluded based on the stringent qualification requirements. Extensive timelines and bureaucracy, lack of language supports, and limitations based on previous justice-involvement or past financial instability (like low credit scores) were

Vermont Housing Statistics



About 70% of homes in Vermont were built before 1978, the year lead in house paint was banned. *(Childhood Lead Poisoning Vermont Department of Health)*

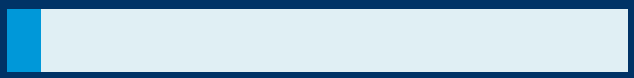


31% of Vermont household spend 30% or more of their income on housing. *(U.S. Census American Community Survey 1-year estimates, 2021)*

In 2022, the rental vacancy rate in VT was 3.2%. A rental housing market is typically considered healthiest with vacancy rates between 4-6%. *(HousingData.org)*

Percent of Vermonters that were unable to pay their mortgage, rent or utilities some time in the past year. These groups are statistically more likely to experience housing insecurity than White, non-Hispanic adults and those without a disability. *(VT Behavioral Risk Factor Surveillance System, 2022)*

12% of Black, Indigenous, and People of Color



14% of people with a disability

mentioned, resulting in those needing housing supports not getting them. Some people with a need for housing support live in difficult living conditions, such as overcrowding, living with no heat or water, increased exposure to violence and substance use, or unhygienic environments. Evictions, particularly no-fault evictions, were mentioned numerous times as a concern and for some people lead to becoming unhoused. In an extremely tight rental market, landlords can be very selective about who they rent to, which puts those with an eviction on their record at a serious disadvantage. There is a lack of landlord oversight, and landlords putting off necessary repairs but continuing to charge higher rent prices.

The growing number of people who are unhoused (whose needs are discussed on page 78) creates further demands for housing and supports that compound already considerable housing difficulties. The 'housing first' sentiment was shared by many participants, for example **"I really do believe in the housing-first model. We don't have enough housing. We don't have enough high-quality affordable housing. So, we need to address the barriers to building more housing, to the cost of housing, to giving people wraparound and supportive services when we do provide housing."** The health impacts experienced by those who become unhoused are severe and multifaceted, and there are impacts for a community in which so many are struggling. One participant describes the situation at motels saying, **"I've heard from a lot of people, the level of drug use and prostitution and other associated activities is just off the charts everywhere you go. You got to subject your kids to that if you want a warm place to stay, so that's a hard choice."**

The housing system is seen as being stuck, with housing not fitting the needs of its inhabitants. Many examples were offered, including families staying in spaces smaller than their needs, single elders living in family homes, and renters in places that are not accessible for people with disabilities. One participant shared the struggle to find housing for those who are in recovery and are unhoused, **"Even once they're stabilized and we get them sober and people are committed to a program, then we're stuck looking for housing, right? They're going from motels to motels fighting this struggle…doing everything they need to do. Then, we finally get them a housing voucher. Yay. Oh my God, we're so much closer. Then, we apply for housing in this area. It's a year."**

> "Rent is rising and rising and rising, we're paying more for no changes in conditions of housing, right? It's just like an astronomical rise for no additional benefit."

Paired with the high cost of living, the impact is far reaching, especially for members of the communities of focus, those who rent, children and families, people with low- or fixed-incomes, those with justice-involved histories, or past or current financial instability, households facing food insecurity, and those who have experienced domestic violence. Challenges for youth and young adults were noted, as they face trying to afford housing independently, which seems impossible to many given the costs. As one participant describes: **"We see it all the time with students, especially young students who**

may just be floating couch surfing because they don't have any place to go."

"Buying a house as a person of color is really impossible. You will have to have someone, even if you have income."

Housing discrimination was also described as challenging for people of color, the LGBTQ+ community, large families, particularly those from refugee or immigrant populations, and those seeking housing who had previous justice-involvement, substance use challenges, or financial instability. As one participants shows, **"Sometimes even if you're a person of color, they cannot rent you. Buying a house as a person of color is really impossible. You will have to have someone, even if you have income."**

One participant explains the interconnectedness of these health needs, as housing, access, cost of living, mental health and substance use are all impacted by socioeconomic status: **"These are families who work but live in poverty. These are families who are living in areas that are, the housing is poor quality, and so that affects their health. The housing is often crowded, that affects their health. The housing is often in areas that don't necessarily have the same kinds of resources around or are often public housing, and so we run into issues with more behaviors of poverty. So, sometimes, some of those are coping skills that have led to drug and alcohol use, maybe more violence. Again, some of those things that happen as a result of chronic poverty."** Food insecurity, the inability to afford health care, exposure to substance use, and high levels of stress were commonly described as consequences of housing difficulties. Access to care limitations introduced by housing issues are common. Workforce shortages are also exacerbated, as one participant notes, **"Another way it ties in with housing; it's hard to bring in new staff when there's no place for them to live."**

On a positive note…

With the unhoused population increasing, there are varied demands placed on shelter staff.

One participant stated, **"They are honestly the superheroes of this work. What shelter providers do and what shelter staff do is incredible and underappreciated most of the time. It's really hard work. There's huge turnover and they're not equipped to do most of the things that are now required."**

Cost of Living

At a glance: Interviewees discussed the high cost of living in Vermont as a major barrier to health and well-being. They described how rising costs of essentials like housing, food, transportation, and health care force people to make difficult trade-offs and prioritize certain needs over others, often at the expense of their physical and mental health. Many mentioned that even those with decent incomes are struggling to make ends meet. Food insecurity is an increasing concern for many. Increased costs are outpacing wages. Socioeconomic needs are burdening the health care system. Specific challenges for rural areas, older Vermonters, and the other communities of focus were highlighted. Housing is the biggest expense for most people, but since it is addressed extensively in the preceding section, this review will largely focus on non-housing costs of living.

Participants spoke of increasing costs of basic needs like housing, food, transportation, childcare, and health care creating barriers to health. Food banks are reported to be seeing an unprecedented demand. Rising food prices are causing food insecurity and reliance on inexpensive, unhealthier options. People must choose between which essentials to pay for, forcing them to deprioritize medical care and healthy lifestyles. Greater isolation due to lack of affordable transportation options, and unsafe or unstable housing situations impact many in Vermont.

These increasing costs are outpacing wages. Cost of living distress is felt deep into the middle class. For many, socioeconomic support is not provided when desperately needed because benefit requirements have not caught up to cost increases: **"Those making just enough to not qualify for benefits, but not enough to afford essentials…Losing benefits like insurance when starting a job, despite still not making enough to survive."** The high cost of living and low wages contribute to difficulty attracting and retaining professionals, especially in health care and other essential fields, further impacting access to care.

Constant stress around affording basic needs takes a huge toll on the mental health of many people in Vermont. The impacts on families with children were noted several times. Parents work multiple jobs and have less time for their children or to care for their own health. One participant noted the impact on the family unit, stating, **"… there isn't space often for parenting, there isn't space for parental well-being. They're living in a**

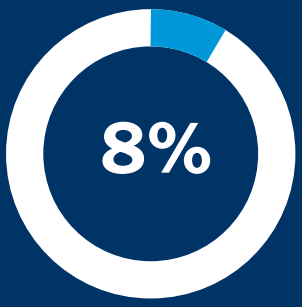
high cortisol environment, they then provide that high cortisol environment, and its negative effects impact their children…"

The high cost of living highlights inequities as it disproportionately impacts certain populations who are already experiencing greater rates of health disparities. Older people, people with disabilities, Indigenous, people of color, and immigrant communities face compounded challenges that put their health and well-being at even greater risk. For people with disabilities, the high cost of living intersects with already high medical and support services costs. Interviewees described how people with disabilities often must spend their savings to qualify for assistance, leaving them in precarious financial situations.

"Those making just enough to not qualify for benefits, but not enough to afford essentials…"

Socioeconomic needs burden the health care system as well. Providers struggle to address patients' socioeconomic issues during brief medical appointments, especially given the limited resources available to aid with the multiple needs for which patients request support. As one participant notes, **"It winds up eating up time because the providers don't have unlimited time…They feel frustrated when…the person is in for like a health care medical issue but really the issues are more about economics and how crappy your apartment is and the fact that you didn't buy your medication last month because you were paying your rent, or your**

Vermont Cost of Living Statistics

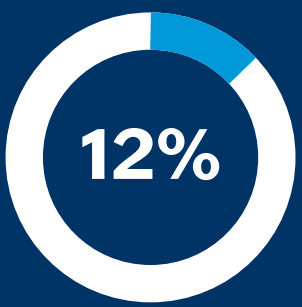


8% of households in Vermont experienced food security in the last 12 months. *(Current Population Survey Food Security Supplement, 2021)*

10% of people in Vermont lived below the poverty level in the past 12 months. *(U.S. Census American Community Survey 1-year estimates, 2021)*

Poor mental health

22% of Black, Indigenous, and People of Color, 33% of people who identify as LGBTQ+, and 33% of people with a disability report poor mental health. *(VT Behavioral Risk Factor Surveillance System, 2022)*



12% of LGBTQ+ adults say there was a time in the past year they did not go to the doctor because of cost, compared to 6% of all Vermont adults. *(VT Behavioral Risk Factor Surveillance System, 2022)*

utilities were doubled." This leads to increased frustration for providers and patients and less time spent on medical needs.

> **"...the person is in for like a health care medical issue but really the issues are more about economics and...the fact that you didn't buy your medication last month because you were paying your rent..."**

Rural communities grapple with limited affordable housing stock, limited transportation options, fewer job opportunities, and higher costs for heating and transportation, as one participant notes, **"I think it's largely around the fact that we are probably the most rural part of the state. That brings in the problems...having transportation, having to drive a distance for anything. But it also affects the prices, the cost of everything. Because with less supply, less competition, it keeps prices higher."** In rural areas with limited public transportation and few grocery stores, affording gas to drive to distant stores with better produce or to distant health care can be impossible.

Some spoke about the impacts on youth, forcing many young adults to move out of state or preventing them from achieving self-sufficiency. High student loan debt compounds challenges of affording basic needs.

Medical needs often do not get adequate attention if socioeconomic needs are greater, as one participant notes, **"...people will neglect other things like the electric bill because they'd rather eat than be warm. So then that plays into things like asthma, and if you have really small kids, that's obviously a problem, so that you'd stay alive. So that's first and foremost there and everything else gets pushed."** Participants reported frequently not getting preventive and needed medical care because they cannot afford it, even with insurance. For many who were interviewed, reduced access to health-promoting resources and longer travel times for medical care and needed services decreases well-being.

On a positive note...

There are services in the community to support people in accessing resources that help alleviate the burden of the high cost of living. One participant said, **"I feel like whatever my patients need, they go to (a local community organization) and they get it taken care of, so whether it's food vouchers, whether it's gas money, whether it's clothing, whether it's Christmas toys for their kids, whatever it is I feel like (their staff) figures out a way to make that happen, and I don't know their funding source or how they continue to meet the needs, but they do a fantastic job. I feel like they're the answer for a lot of my patients."**

Mental Health & Substance Use

At a glance: Mental health and substance use issues are closely related. Participants observed that some people with mental health concerns who lack access to services will self-medicate to escape from negative feelings. Some of the drivers of both mental health and substance use (housing insecurity, high cost of living, lack of access, trauma, and living with chronic stress) are similar and many organizations provide services to address both needs.

Feelings of isolation and loneliness were commonly described. Lack of providers, especially diverse providers, high turnover, and high cost of services makes it difficult to get mental health services. Insufficient crisis response services create a hole in the mental health system.

Many of those interviewed indicated that the amount of people with substance use issues continues to increase each year. There are treatment complications due to the nature of the drug supply, such as the increased presence of fentanyl and xylazine. The timing of treatment is critical, and it is difficult to match individual needs to available services, since treatment options are inadequate in volume or type, and insurance adds barriers. Lack of recovery housing is also a gap in the service continuum. Everyone in a community is impacted by substance use, and it is a challenge that is related to all other health needs. **“The word pervasive keeps popping into my head,”** one participant underscored, and another explained, **“it feels like the need is expanding in almost every area and impacting large sections of our community.”**

Mental health and substance use needs impact every aspect of a person's life: **"People are deeply unwell right now…There is a remarkable amount of grief, there is a tremendous amount of stress that's being experienced on figuring out how to live a relatively stable life."** Participants described depression, anxiety, high levels of stress, and lack of engagement with prevention or treatment activities. Many cited the use of substances to medicate mental health conditions such as anxiety, to be more socially confident or to numb trauma. Other impacts include overdoses, death, xylazine wounds, the inability to maintain housing, education, jobs, or care for health conditions. With mental health and substance use struggles, there are often concerns with how people show up for their families, friends, and work, as one person said **"…oftentimes substance use means that you are not exactly behaving your best towards your kids."**

"It is unrecognizable. There are actual crimes, shootings, murders, stabbings, and needles are everywhere."

Many participants spoke of the increase in prevalence of mental health issues, especially since the beginning of the COVID-19 pandemic. Providers report seeing more people suffering from incapacitating anxiety and depression. Increased social media exposure, video gaming culture, working from home, and being stay at home parents were mentioned as part of the increase in isolation, anxiety, and depression.

Mental health issues are foundational for many

Vermont Mental Health and Substance Use Statistics

54% of all high school students—and only 42% of LGBTQ+ students—feel like they matter to people in their community.
(Vermont Youth Risk Behavior Survey, 2023)

54% of high school students feel they matter

42% of LGBTQ+ students feel they matter

During the past 30 days, 34% of all high school students—and 54% of LGBTQ+ students—experienced poor mental health (stress, anxiety, and depression) most of the time or always.
(Vermont Youth Risk Behavior Survey, 2023)

34% of high school students felt poor mental health

42% of LGBTQ+ high school students felt poor mental health

37/100,000

The rate of opioid-involved accidental or undetermined drug overdose deaths was 37 per 100,000 people.
(Vermont Vital Statistics, 2021)

other public health challenges. Interviewees noted that when someone is depressed or struggling with their mental health, paying rent or behaving appropriately to be able to stay in a temporary rental apartment or hotel room can be difficult. Mental health issues may cause someone to lose their housing entirely. A participant stated, **"...the state and federal government needs to realize that we wouldn't have all the substance abuse issues, crimes, homelessness, if we had a better mental health system."**

Substance use is described as a large-scale crisis that is worsening in frequency and severity: **"What we're experiencing right in the city is people injecting substances in the middle of the street. Needles everywhere, human feces, gauze, paraphernalia...It's harmful to not only the individuals that are experiencing that, but also just the community at large."** The drug supply's safety is a concern due to the increased presence of fentanyl and xylazine, which carry with them sharply increased overdose risks. The treatment of multi-drug use is more complicated. The impact on communities is noted by one participant speaking of where they live, stating **"It is unrecognizable. There are actual crimes, shootings, murders, stabbings, and needles are everywhere."** Illicit drugs are readily available and are seen as a cheaper alternative to medications prescribed for mental health challenges. Multigenerational drug use, poverty, and trauma impact entire families and support systems.

Both the mental health and substance use workforces are seen to be suffering from a lack of providers. For mental health providers, contributors to this shortage include burnout, high turnover, and providers moving out of the state. For substance use providers,

Vermont Mental Health and Substance Use Statistics

382 Licensed alcohol and drug use counselors in Vermont

1,017 Mental health counselors providing patient care in Vermont

More than 90% of these counselors are White. *(VT Health Care Workforce Census, 2023)*

6,000 Vermonters age 12-17 reported depression symptoms in 2021

Of those reported, 41% did not get treatment.

25% of all people who chose not to get mental health treatment did so because of cost. *(National Alliance on Mental Illness, 2021)*

14 days 47% of the time, people on Medicaid begin substance use disorder treatment within 14 days of diagnosis. *(VT Medicaid Claims, 2022)*

Rate of suicide The rate of suicide deaths is 19 per 100,000 people. *(VT Vital Statistics, 2023)*

contributors to the workforce shortages include compassion fatigue, high levels of burnout, and health care providers and emergency personnel having to deal with violent patients. The lack of providers is compounded by housing difficulties and high cost of living in Vermont, such that attracting new professionals is not always possible.

Some participants raised concerns about the quality of mental health and substance use care. Lack of providers' lived experience and diversity and the inability to form a trusting and therapeutic relationship with so much turnover were mentioned as barriers to high quality care. Discrimination from health care providers based on having a substance use history is seen as pervasive. Some participants report that health care providers are often unable to tease out the individual medical concern and focus only on substance use needs instead. Stigma and discrimination make people feel unsupported and devalued, therefore making it harder for them to seek help.

Another frequent barrier is the high cost of services. Copays with each individual mental health service make it unaffordable to many. Participants reported that it is hard to find providers accepted by their insurance or insurance that covers mental health services. One participant describes, **"We have a lot of Vermonters…who might not be deemed able to receive Medicaid who aren't maybe on food stamps, but who are barely making ends meet. If they have a high insurance payment to access mental services, it may be a challenge for them to be able to get the support that they need in terms of mental health. There is also the fact that there is an overwhelming need for services and not enough providers to be able to meet the need of those services in this area."** There is a perception that providers are not accepting Medicaid because the reimbursement rates are too low and there is extra administrative work required. One participant describes the challenge saying **"…local, small organizations that can't hire massive administrative teams to manage Medicaid and Medicare."**

Some participants noted having to give up taking psychiatric medications, taking them only occasionally, or not going to therapy to be able to afford food. Disruptions in care and in medications due to lack of providers, wait times for services, or financial constraints can result in worsening conditions.

One participant shared that they have **"…witnessed a lot of friends turn to substance abuse instead of getting the mental help that they need because it wasn't available to them."** One participant shared their personal experience of the connection between mental health and substance use, **"I can't get into a counselor, there is no one is going to help me, so I am going to take a pill. I'm going to shoot up, I'm going to do whatever I got to do to get these bad thoughts out of my head. The help is just not there."**

> "People are deeply unwell right now…There is a remarkable amount of grief, there is a tremendous amount of stress that's being experienced on figuring out how to live a relatively stable life."

Participants consistently described an insufficient crisis response system, with not enough beds for people in full mental health crisis. One participant describes the loss of their home due to the inability to find appropriate crisis response, stating, **"We couldn't get him to help, even though he was a danger to himself and to others, so he ended up getting evicted and now is homeless."**

Unqualified professionals are viewed as handling mental health issues regularly due to the increasing demand and lack of mental health services and providers. Among them are primary care providers, shelter staff, school personnel, police officers, and EMTs. These staff are placed in difficult positions because they do not have the necessary training, expertise and often the time to properly intervene. Respondents described consequences to mental health or substance use crisis not responded to by qualified and trained personnel, including criminalization of mental illness, trauma, self-harm or violence, and burnt-out professionals. Emergency department staff are often not fully equipped to handle mental health crises. This overburdens already busy emergency resources and does not address the root causes of mental health concerns. It also creates a difficult reality for emergency professionals. One participant states, **"When someone is stabilized in the ER, but they can't go to a treatment center because there's not a bed available, the hospital turns them out on the street, and we chase them around town."**

For substance use, insurance coverage is a major barrier to engaging in treatment. One participant notes, **"There is a new residential facility, but it's pretty far away from us. And taking insurance is a huge thing, so this new residential facility doesn't take insurance. Valley Vista, I know, takes Medicaid, and that's a lot of the times why people end up at Valley Vista because typically, a lot of these people are on Medicaid."** Some participants believe there are only two inpatient rehabilitation facilities in the state that accept Medicaid, and that Medicaid provides payment for only very short term inpatient substance use treatment to Vermonters.

> "We are endlessly cycling people through because 14 days is just enough to lift some of the fog, but not to get to the next chapter."

For example, two Vermonters discussed their experience:

Participant 1: **"See, when I went to rehab Vermonters only got 14 days. New Yorkers get 21."**
Participant 2: **"Yeah. Same thing that I listed, right?"**
Participant 1: **"Yes."**
Participant 2: **"They got their wing over there because New York guys get 21 or 22 days, we get 14."**

Substance use treatment options that are insufficient in duration, quality, or follow up, both outpatient and inpatient, result in resistance for some people to seek care or stay in services. There are not many opportunities for people to safely detox from opioids. It is hard for pregnant people to be honest with

"When someone is stabilized in the ER, but they can't go to a treatment center because there's not a bed available, the hospital turns them out on the street, and we chase them around town."

providers due to being judged, which limits their access to treatment. One participant describes, **"I think making it very easy to not be judgmental to pregnant women who are using, in order for them to continue to receive their prenatal care. Because once you are using, you may be judged… Women, pregnant women are not receiving [...] care because they have substance misuse. So, they prefer to not go to the hospital or talk about it if this happens. If this happened, having a birth in the house…"** Relapse and people changing their minds about going to treatment are frequent occurrences: **"We are endlessly cycling people through because 14 days is just enough to lift some of the fog, but not to get to the next chapter."**

The timing of treatment was described as critical: once someone is ready to engage in treatment services, removing barriers to getting them to treatment quickly is of the essence. Common barriers include the availability of beds, transportation, and insurance coverage. Similarly, no recovery housing is seen to be available for those exiting treatment. Recovery housing is key to allow people to transition into daily living and reintegrating them without the influence of where they were living before.

One provider also explained that there are many resources to help but people must want to engage. They said that if a patient goes to their emergency department, **"…they can get started on Suboxone and we will grease the skids to get them into a primary care physician, but they have to be ready to change…So, if you come in, you show up, you're ready to change, we will prescribe Suboxone. You're going to get the next person who has a spot on their schedule. It's not 'wait to see who's taking new patients', we will find you a space. We are that invested in helping those folks."**

Participants expressed some ambivalence towards Medication Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD), with both positive and negative attitudes shared. Some felt that people were addicted to or abusing Suboxone in a similar way to opioids. For example, they mentioned that people who come out of jail are addicted to Suboxone who were not prior opioid users. Without continued recovery supports, addiction is maintained with **"a different dealer."** Others said that it is a safe alternative without the threat of overdosing or being contaminated. Some believe the goal of MOUD should be tapering off it.

Many who struggle with substance use do not attend to the medical conditions they may have. One person describes the need, stating **"Lot [of] people don't know the way the drugs affect their body. If you're sick, you're colder, you get very cold…you're going to die if you don't get your drugs to regulate your temperature or keep warm somehow. And if you're sick off of drugs, you can't mentally do anything until you get your drugs. And then maybe you can focus on getting to the doctor…"**

Visit Data and Reports | Vermont Department of Health to find data briefs, reports, assessments, evaluations, survey results and other publications on alcohol, opioids, cannabis and overall substance use in Vermont.

On a positive note…

There are many positive activities in Vermont to promote a sense of community and belonging. Here are some shared by one participant: **"…that idea that if we are supporting, whether it's young people or marginalized populations or whoever to create something for the community and something that you can see and touch and feel. They can walk by it and look at that and say, I did that. You know, I contributed to this community. It's a two-way street. It's not just I want my community to give to me…We've done all kinds of projects over the years. There have been murals done about basically people of color, […] there's been some climate change awareness murals, people are painting things. We've had events. There was a community Iftar* in Burlington that we funded where kids celebrated broadly in the community. There's been programming at schools. They've done things like LGBTQ-inclusive books being purchased for school libraries […] We've had different schools start gardens and chicken coops to give fresh food to the school lunches and school breakfasts. […]And these are all youth-generated ideas."**

*Iftar is the fast-breaking meal of Ramadan.

Access to Care

At a glance: Most participants ranked access to health care as the biggest problem they are facing. Participants described a variety of challenges, such as not being able to secure a primary care provider, lack of service availability, concerns about quality of services, high costs, language and cultural barriers, lack of diversity of providers, issues with insurance cost and coverage, and lack of transportation. One of the repeating consequences for patients, health care providers, and cost of care is that often these challenges result in overburdening emergency departments, as one participant underscored, **"there are not enough providers, so emergency rooms are being overutilized."**

Throughout the system of care, strong advocacy skills are necessary to get needs met. Many participants discussed the need for more prevention and wraparound services to help coordinate and address gaps in services.

Access to care intersects with other health needs previously discussed—housing, the high cost of living, and mental health and substance use. Participants shared many examples of how the high cost of living has impacted their ability to access and engage in health care. Lack of available housing is impacting employers and making health care workforce problems worse. The lack of providers and people delaying care due to cost also impacts ability to get physical or mental health and substance use services.

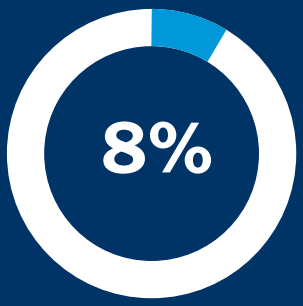
Many participants made comments about how insurance policies and coverage impact their health. Participants described challenges with high insurance premium costs, as well as needed services and medications not being covered. A few participants shared the financial burden of health insurance. One participant said they have **"state insurance"** and reported paying $200 a month with a $9,600 deductible, stating **"I have close to $20,000 in medical debt with health insurance."** Another participant articulated, **"My biggest health problem is the price of insurance. I own my own business, and I can't afford the price of health insurance, so I don't have any."**

Health insurance policies impact the way health care is administered by deciding what procedures, visits, and medications the insurer will cover. Many participants shared stories of insurance companies not covering certain procedures or medications their provider recommended. One participant underscored, **"The drug companies said they are not going to pay for the medication that my doctor prescribes so we had to get something different."** One provider explained that their practices were trying to have nurses do wellness visits virtually so they can spend more time with patients on preventive care and resource referrals. However, Medicare would not cover these telehealth visits. Participants without coverage shared they are choosing to delay care. One participant shared that they do not go into the doctor for routine checkups, eye, or dental appointments due to their lack of insurance; they only go if something is wrong.

Participants with Medicaid shared they are careful not to make above a certain amount of money because they need to qualify for Medicaid to get their services and medications and do not want to lose their eligibility. One participant said, **"...even if he offered him a raise, we'd have to say no because if you're not super wealthy and can afford to pay things out of pocket, you really want to be poor enough to get Medicaid."** Another participant said they wish everyone could have Medicaid because it covers many procedures and services. They elaborated, **"I do not make any money but go to therapy once a week, have free medications, can go do the doctor whenever, get every procedure for absolutely nothing."**

A provider shared a conversation they had with a patient on Medicaid who said they

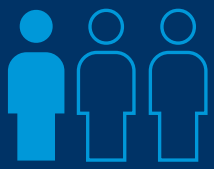
Vermont Access to Care Statistics



8% of people in Vermont delayed dental care due to cost in the past 12 months. American Indians were most likely to delay needed dental care because of affordability issues (26%). *(VT Household Health Insurance Survey, 2021)*

In the last 12 months

30% of people without insurance and 13% of people with insurance report difficulty paying their medical bills. *(VT Household Health Insurance Survey, 2021)*



One-third of all Vermonters with long service wait times had physical and psychological pain and declines in overall health as a result. *(State of Vermont Wait Times Report, 2022)*

80.2% of people living in rural areas in Vermont (outside of Chittenden County) have access to broadband, as do 85.4% of people in non-rural areas (Chittenden County). *(Rural Data Analysis Dashboard, 2017-2021)*

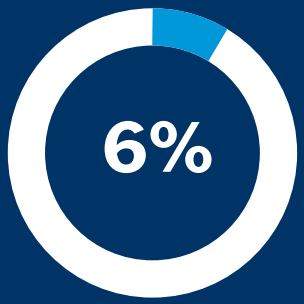
visit the emergency department when they need help because Medicaid covers it. Using the emergency department as primary care overburdens the health care system and is more expensive. The provider explained, **"...the reality is that that nickel is landing on somebody's wallet, and we need to change a culture by talking more proactively instead of reactively about it."** That so many are choosing to get their health care in the emergency department creates a bottleneck. Many with life-threatening emergencies are not getting their needs met in the emergency department, lowering quality of care, and increasing costs and provider burnout, **"Doctors at urgent care are becoming some people's primaries because they don't have anybody else."**

"Every routine checkup and screening I miss is putting me at major risk down the road."

Health care and medications are unaffordable to many with and without insurance. Participants underscored that it feels that the health care system is a for-profit system—the sicker and more vulnerable a person is, the more costs they incur. They shared experiences about 15-minute hurried appointments, and many believe providers are pushing medications and needlessly complicate care to increase profit. Lack of cost transparency coupled with high levels of bureaucratic mazes make patients highly confused about their health care.

Not being able to afford insurance means not having routine checkups and screenings,

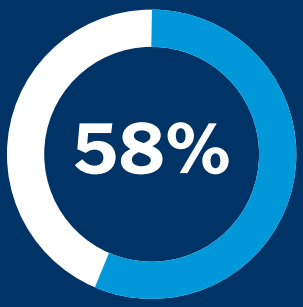
Vermont Access to Care Statistics



6% of adults experienced transportation insecurity in the past year. This includes a lack of reliable transportation that kept someone from medical appointments, meetings, work or from getting things needed for daily living. *(VT Behavioral Risk Factor Surveillance System, 2022)*

4X

Adults with a disability were more than four times as likely to experience transportation insecurity in the past year than those without a disability. *(VT Behavioral Risk Factor Surveillance System, 2022)*



58% of Medicaid-enrolled children age 1 to 17 received a preventive dental service in the calendar year. *(VT Medicaid Claims, 2022)*

getting care only in an emergency, ending up with expensive bills from crisis situations, and not being able to afford medications. One participant shared about their experience living with the dread of missing care, explaining **"Every routine checkup and screening I miss is putting me at major risk down the road."** The risk is also financial, with large debt being a possible consequence of delayed care. Having insurance does not guarantee someone can get care because people cannot afford high deductibles. Anyone not getting recommended care, medications, and follow up is giving up any benefits of prevention, early detection and treatment, leading to worsening of existing conditions.

Many participants described staffing and workforce challenges leading to absent or delayed care. For example, one participant notes, **"They are on a waitlist now because there are no doctors open. They're overcrowded. I have one person who's been on a waitlist for a year and a half now. They go to urgent care, or they go to Open Door clinic. That's a big issue here."** Many places are reported to be understaffed, experience high staff turnover and are unable to attract a workforce due to low wages. As one participant notes, **"We need to address the fact that Vermont is not as attractive a place for a physician to come and work due to getting paid 25% of what you get paid nationally."** Provider dissatisfaction and burnout due to enormous administrative stressors, insurance demands, and email and messaging volumes is commonplace. Many providers are believed to be retiring or leaving their profession. New providers cannot always secure housing when coming from out-of-state. Many are frustrated by the levels of crisis care needed and lack of power to affect change. There are not enough primary care doctors, which leads to struggles connecting with other resources and treatment. There are not enough specialists, with long wait times or long travel for appointments. There is a lack of pediatric providers, with patients having to wait years to meet with some specialists. Children need a primary care provider and a dentist to join Head Start, but the lack of availability of both makes it hard for families to qualify for a program funded to help them.

> **"I think, generally, BIPOC, people of color, we feel more comfortable with other people of color especially Black, since we face a lot of discrimination."**

Many people noted the lack of diversity of providers, which is a critical barrier for many of the communities of focus. One participant described the consequences of an overburdened system that is indifferent or discriminatory as missing the point of care. Many in the communities of focus discussed the challenges in finding providers that are knowledgeable about their needs or that have a common background. For example, one participant said: **"Speaking on behalf of the BIPOC community… the biggest access issue has been finding BIPOC doctors, nurses, therapists. We found a couple of therapists. I have 1 surgeon. He does internal medicine… Constantly online, in our group chats, people are like, 'Hey, do you know any doctors of color, OB/GYNs, or dermatologists?' No one. I think, generally, BIPOC, people of color, we**

feel more comfortable with other people of color especially Black, since we face a lot of discrimination." One participant stated that it is the lack of cultural awareness and curiosity that leads to missing opportunities for trust and connection, **"I think it's the lack of understanding and curiosity about the experiences of those communities, the lack of appreciation of the strengths of those communities turns into distrust in many cases which then takes us down a spiral of missed opportunities."**

A few participants noted that even if they can gain access to a provider, sometimes their concerns are brushed off or not taken seriously. People need to be good advocates for themselves and learn the systems of care or **"...it is going to be much harder for you to connect to the services you need."** Many participants shared stories of providers not believing their concerns or having their health needs dismissed or minimized. One participant shared their provider made them go through extensive testing before getting an MRI, **"By the time they got my MRI done, the tumor was so big it was pressing against my optic nerves that I almost lost my eyesight because I had to do all these other things first."** Another person shared that they have lots of health care anxiety and her provider disregards her concerns. There were reported to be many issues with language barriers, lack of cultural awareness, and discrimination. People described needing to find someone to be their health care advocates so they can get the treatment they need.

Being able to access the internet is a vital component to engaging in health care. Statewide internet coverage is not consistent or reliable. One participant highlighted, **"...a lot of the state is not set up for internet and cell phones."** Participants observed they need to be able to look up bus routes to providers' offices online, access their electronic health record to see lab results and communicate with providers, sign up to receive COVID-19 vaccinations, or participate in telehealth visits.

Participants described many transportation barriers, especially in rural areas. Without consistent transportation, people struggle to access many types of services and supports, including health care. Walking can be hazardous in the winter or not feasible due to the distance. Cars are expensive to maintain, register, repair, and operate. Rural areas lack bus routes, and rides can be very long. There were also concerns about bus safety. The transportation solutions in place are inadequate: participants stated that one rural transportation service checks to see if you have a vehicle and will not drive you, even if the car is broken, without a doctor's note. Other available transportation services are hard to schedule, unreliable, restrict which doctor can be seen, and may not allow the patient to bring a support person. A participant reported being forgotten and not picked up from appointments.

"By the time they got my MRI done, the tumor was so big it was pressing against my optic nerves that I almost lost my eyesight because I had to do all these other things first."

Not having reliable transportation makes medical appointments hard to attend. Missed doctor appointments, being dropped by providers, and losing hours of work or school are some of the consequence people reported. This barrier is felt greatly in rural areas, **"If you live in the more rural parts, you have to figure out how to get yourself there and if you cannot drive, do not have a vehicle, do not have a friend, good luck to you."**

On a positive note…

Relationships and trust between patients and providers strongly impact access to care, and participants provided examples of what that looks like in practice. As one participant stated, **"I really think at the core of so much of this is relationships and trust between a patient, a family, a health care provider, and a system… I think the communities that I think, where there's real success here are where there's been a practitioner and/or a practice or group that's been a rock in a community for a long time and been a consistent presence, is known in the community, plays a role in the community beyond just going seeing patients billing and going home. Right? But is really where the providers have played other roles, have been elevated as leaders in their community and have built relationships. Sometimes across multiple generations. That trust is second to none that they've developed and is commendable…"**

Discrimination

At a glance: Participants discussed institutional and interpersonal discrimination in the health and social service system that negatively impacts health outcomes in Vermont. They highlighted discrimination based on race, ethnicity, immigration status, ability, socioeconomic status, insurance level, gender identity, age, and substance use disorders. Participants emphasized that discrimination is a systemic issue deeply rooted in society and the healthcare system, leading to disparities in health outcomes for marginalized communities. They stressed the need for systemic changes, cultural competency training, and actively involving impacted communities in finding solutions.

Participants described health care and service provider discrimination, including assumptions about patients, rude treatment, and lower quality care. Not being listened to and taken seriously were discussed by communities of focus. One participant spoke about the importance of providers listening and getting to know the patient, **"In that, just to listen to the patient more and get to know them and not make general decisions on what you think, what your opinion is of them."** Many different types of discrimination were described, starting with the paperwork they are asked to complete in the waiting room, which often omits gender, race, and ability groups of which people are a part. That, coupled with providers who lack lived or professional experiences that match their needs, led many interviewed to describe health care offices that feel uninviting.

Any discrimination from the health care system can result in negative interactions in those places where people are vulnerable and in which they seek help and healing. It may lead to general distrust in the medical field and health institutions, avoidance of care, feelings of isolation, and anxiety about health care personnel and procedures. It results in misdiagnosis, lack of access to appropriate treatment, exacerbation of mental health and substance use issues, and poorer health outcomes. It impacts future interactions, communication, and level of engagement with providers.

Some participants who face discrimination based on socioeconomic and insurance level described being treated like **"second class citizen,"** that they **"run you out"** if you have Medicaid, and these participants perceived it taking longer for them to be seen compared to those who have higher income levels.

Some discussed experiencing racial and ethnic discrimination in health care settings, manifesting as provider bias, lack of cultural competency, and limited diversity among health care staff. One person notes, **"I hear from patients all the time that they feel like they're discriminated against because they're a person of color."** The very definition of health is different for Indigenous People, involving aspects of spirituality, ritual, community, and relationships that are often dismissed, overlooked, or hurried in medical settings. Historical discrimination and medical trauma for some communities is still very much present when seeing a provider. It impacts communication, engagement, and receptivity to treatment.

Gender-based discrimination was described by many participants. Issues are not paid attention to that disproportionately impact women, femmes, queer and trans individuals, such as gender-based, domestic, or intimate partner violence. An intersectionality of gender- and race-based discrimination that was brought up several times is the experience of Black women in Vermont, where systemic, repeated, and at times, traumatic mistreatment in health care for themselves and their children occurs. Poor quality care towards Black women was described as hurried, rude care, medical procedures done without medication, or without medical staff introducing themselves or paying attention to the human aspects of care. Participants reported high levels of stress and anxiety when dealing with medical services as a result.

Discrimination faced by the LGBTQ+ community includes misgendering, lack of gender-affirming care, and lack of knowledgeable and accepting providers. There are very few available providers in the state

Vermont Discrimination Statistics

People who identify as Black or African American, American Indian or Alaska Native, or LGBT and people under age 65 with a disability are more likely to report experiencing discrimination or prejudice during health care encounters than Vermonters overall. *(VT Household Insurance Survey, 2021)*

In the past month

In the past month, 10% of Black, Indigenous, and People of Color experienced physical symptoms (such as headache, an upset stomach, tensing of muscles or a pounding heart) as a result of how they were treated based on their race. *(VT Behavioral Risk Factor Surveillance System, 2022)*

Black youth who experience racial discrimination are more likely to have elevated depressive symptoms in adolescence and early adulthood. *(Kenan Institute of Private Enterprise: Health disparities were devastating BIPOC communities. Then came COVID-19.)*

who can competently provide gender-affirming care, leading people to travel long distances and suffer through long wait times.

Participants described discrimination against individuals with disabilities including a lack of accessible housing, lack of confidentiality in health care settings, and provider assumptions about abilities.

Language discrimination is a significant concern for populations who do not speak English as their first language, and for people with varied literacy levels. Many in these groups might not have the right words at the moment or the high level of language/reading comprehension necessary to check the right boxes on forms in medical clinics or to get benefits. While medical jargon and complicated and nuanced insurance language impacts everyone, those with language challenges lose access to care over it.

"I hear from patients all the time that they feel like they're discriminated against because they're a person of color."

Discrimination due to mental health or substance use difficulties were also brought up as barriers to health care, as is illustrated by this participant saying **"A very specific example is maybe somebody who uses substances, presents with a wound related to xylazine at the ED. The wound needs full care, but perhaps the provider doesn't treat them as kind because they're like 'Well, if you weren't injecting, then you wouldn't have this issue.'"** People who are unhoused feel strongly discriminated against, being seen as violent or as drug-seeking rather than being heard and treated, and note that providers are not putting in the effort to hear and address the issues. One person says, **"Not every unhoused person in the stairwells and community spaces is an addict, and not every addicted person squatting or haunting us here in the building is deliberately doing harm to anyone but themselves."**

Some report that discrimination due to being unhoused is compounded by other types of discrimination. One participant notes, **"...homelessness disproportionately affects minorities and the LGBTQ community. We see that here in the shelter, too. Those are the same folks who historically have also not had equal access to health care. Homelessness disproportionately affects them."** Many examples were given of housing discrimination, including racial discrimination, preference for people who are not currently unhoused when there are many applications for an apartment, not giving apartments to people who have a criminal record, and landlords raising rents because they do not want people on Section 8 housing in their buildings. The following conversation between two focus group members illustrates this:

Person 1: **"I'd like to just add onto that, the discrimination. At one point I was a single (parent). I wasn't able to get an apartment because I had a criminal record and my criminal record was 20 years old and they still denied me."**

Person 2: **"Under the matter, people just Google your name, anything comes up. That's why I can't get a job right now, it's because my reputation... I mean, it doesn't matter that I used to work for all these agencies and I went**

to college and all this, it doesn't matter... My reputation because of things that have happened since I become unhoused, now, I can't get a job."

Person 1: **"It's used against you."**

The inability of providers to see the needs of the whole person in front of them impacts health outcomes. In some cases, the lack of individualized care leads to more frequent utilization of the emergency department: **"It's hard when you see the same people come in and out. I get it. It's got to be taxing on medical, on a hospital, or whatever, to see the same fifty people come in and out with the same problems over and over and over, over, and over. Probably there's something going on that's causing them to have those problems over and over again. So rather than looking down your nose at them...maybe you should try to figure out how to help them not have that same problem over and over again."**

Discrimination affects mental health, how a person sees themselves, and how a person interacts with their peers. The term 'weathering' was cited, **"... to describe the invisible erosion of a person's essential life energy by being looked down upon and treated less than in a million of tiny ways probably every day of their lives in a culture that doesn't see them as worthwhile people with other colored skin."**

On a positive note...

Many people who spoke about how discrimination affects health shared how and where they have experienced mistreatment due to their personal characteristics and background. They also talked about the many places this is being actively addressed and confronted. There are organizations that include diversity, equity, and inclusion in their mission statements and incorporate this into their everyday work. There are health care and community groups that provide training and support in meeting all people where they are regardless of their language, nationality, individual needs, or characteristics.

Participants noted that there is a long way to go so that all people in Vermont receive equitable care, but they also spoke of where there was hope. It is becoming more common for institutional and interpersonal discrimination to be explicitly named. The impacts of discrimination are more understood, which allows for intentional steps to address them. At the individual level, within communities, and across the state, including in state government, people can see how their work, their lives, and their health are improved when discrimination in all forms is faced head on.

Climate Change

At a glance: Despite the increasing prevalence of climate-related disasters and the impact of climate change in Vermont, it was not consistently cited as a major health need by participants. When asked why, participants noted that the more immediate needs of housing, cost of living, and access to care were more critical. Some of the challenges participants shared about climate change were housing constraints, transportation complications, mental health issues, increasing number of tick exposure and illness, exacerbation of and flare ups of medical conditions, experiences of decreased food access, and the inequitable impact of issues on people living in poverty. There is anxiety over climate change and the lack of action to address it.

Changes in climate conditions bring about new health-related challenges. Warming winters result in less freezing, which increases the length of tick season. Providers noted seeing patients with tick bites more months of the year. The increased amount of rain through the year challenges the ability to support personal gardens and impacts farmers, making it harder to get locally grown, fresh, and healthy produce. Food lost in power outages impacts food quality and food access. Temperature fluctuations, a longer hot season, and fires and smoke impact the air everyone breathes. With extreme high temperatures, some medical conditions like asthma and diabetes flare up and smoke from fires can also worsen asthma and make it hard for people to exercise.

Flooding leads to many housing and transportation complications, including living in homes with mold, road infrastructure being washed away, poor water quality, and wastewater contamination. With the loss of so many houses, the existing housing crisis has worsened due to reduced inventory and increased rent prices. One participant explained, **"the same units that were $1,000 in June are now $1,500 after a flood, even if nothing's new in the unit, even if they haven't fixed the problem."** People are renting places they know were flooded and have appliances that might have been badly damaged in the flood, but they cannot afford another option. In some cases, landlords were not able to get their units back up to code with the money they received from the Federal Emergency Management Agency (FEMA), further reducing the housing inventory. Even if landlords can afford to do repairs, contractors can be hard to find to help rebuild and financial supports are limited. **"I've had to spend more money beyond what FEMA provided to continue to clean my basement from the water damage."** Flooding impacts

transportation, which can affect people's ability to get to work. This participant explains, **"There are certain roads that still haven't even been fixed 8 months later. So, when the next round of flooding comes around, there's only one route you can take. And if that floods out, you're trapped. I've lost 3 or 4 days of work because the flooding is bad enough where I'm afraid if I leave, I can't get back in."** Flooding consequences were also discussed as a path to becoming unhoused: **"I have a good friend whose home was declared unfit to live in because of the flooding. She is of limited financial means and has numerous health problems. And so, she's houseless."**

> "...we have to shift, we have so much work to do to build better resilience on climate change."

Participants shared that they feel anxiety with the uncertainty associated with climate change and frustration with the lack of serious resources and action taken to address it. As illustrated by the words of one focus group participant, **"...there is one-and-a-half staff dedicated to climate change resilience in public health and we are so far behind in preparing for this."** Another participant shared the following frustration, **"...we have to shift, we have so much work to do to build better resilience on climate change."** This participant emphasized, **"I have a hard time understanding how you cannot understand that we need trees and bees. We need these things to survive, ourselves. If you destroy the environment, if we poison the water and the food supply and the air, it does**

Vermont Climate Change Statistics

In 2023, there were 134 days where air quality in Vermont posed a moderate or greater risk to sensitive populations, an increase from 56 days in 2022. *(VT Department of Environmental Conservation, 2021)*

35 in 10,000 children

The rate of emergency department visits with a primary cause of asthma is 35 per 10,000 children under age 5. *(VT Uniform Hospital Discharge Data System, 2021)*

12 in 100,000 people

The rate of heat-related emergency department visits is 12 per 100,000 people. *(VT Uniform Hospital Discharge Data System, 2021)*

1,312 reported cases

Reported cases of Lyme disease have increased over the years. In 2022, there were 1,312 cases in Vermont. *(VT Department of Health, 2022)*

not matter how much money you make, you're going to die along with the rest of us."

People are anxious about losing their homes or seeing their homes damaged, and the day-to-day reality with which they are left. One participant described, **"...that impacts physical and mental health, if you're dealing with water damage and mold, nothing like having to clean up after every time it rains or worry every time it rains you know you are going to have flooding."** Many participants said they were feeling worried about the future.

On a positive note...

Participants noted that people and commnuities are working together to help those impacted by flooding. A participant describes this stating, **"...the good thing that came out of it was people coming together as neighbors and just really supporting each other..."**

Specific Health Conditions

At a glance: Participants discussed many specific health concerns, including mental health disorders like anxiety, depression, and schizophrenia, substance use disorders, respiratory disorders such as asthma and chronic obstructive pulmonary disease (COPD), high blood pressure, cancer, diabetes, developmental delays, autism, and dementias. Living with chronic stress was mentioned repeatedly as a factor in worsening health challenges and overall quality of life. Participants spoke of these conditions as they interact with the ability to get appropriate medical services, access affordable care and medications, access healthy foods and living environments, and the severe costs of any delays in care and resources. Of particular concern was the difficulty in getting timely access to specialty providers, or the need to travel long distances to see them. There are challenges in finding independence and success for youth with illnesses or disabilities transitioning to adulthood.

Diabetes was commonly mentioned as a health concern. Numerous people who have diabetes feel they do not have the resources, support, or education to treat it. Lack of specialists, unaffordable medications and medical equipment, and stigmatizing provider attitudes impede chronic disease management in general, and especially for diabetes.

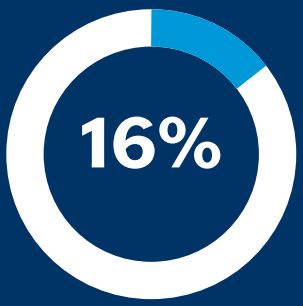
Respiratory issues were also mentioned frequently. Asthma is associated with environmental factors, such as smoking, wood burning heating, housing conditions, and climate change issues like fires. Long COVID was also mentioned, as one person notes **"...not even acknowledging that long COVID is a thing, and we have so many people that come to us because there's no other doors, no other places that are really acknowledging in the way that they should be."**

Dental concerns were also on many participants' minds. Dental care is expensive, and it can be very challenging to find a dentist, especially one that takes specific types of insurance. A few participants said most dentists in Vermont

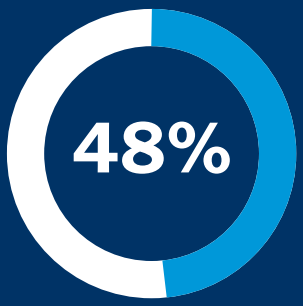
do not accept Medicaid, leading to painful realities described here: **"Dentures, oh my god, dentures, and like tooth extractions with anesthesia. I don't know who thinks it's okay to just let people be awake while their teeth get yanked out of their face. But there is only one health care provider in the state that takes Medicaid that will put you under anesthesia for extractions."** People who face barriers to see dentists report living with dental pain, having problems eating, and at times struggling with their confidence as a result.

With the increasing aging population, dementia was mentioned as a chronic health condition for which the state needs to intentionally plan. For those living with dementia, they may have behaviors that are increasingly hard to manage, and with little available and affordable support, family members who become caregivers are put under enormous stress. It was reported to be nearly impossible to get appointments with neurologists for diagnosis and medication, and difficult to get appropriate care. Emergency departments and shelters for people who are unhoused are seeing this population when no appropriate care is available. One participant notes the complexity of the issue stating, **"Dementia is a big one. We see a lot of people, quite a shocking amount that have cognitive decline diagnoses of Alzheimer's, Parkinson's, and other dementias. The other one that I would say we see a lot is just chronic conditions due to not really taking care of themselves, and not having regular doctor visits. There are people who haven't been to the doctor in decades. And then there's an event, or their health is truly starting to decline just because they're getting older. And then there's this whole cascade effect, where then they have more and more issues. And then we get into all those problems we were just talking about**

Vermont Specific Health Conditions Statistics



Among the 29% of adults who have tested positive for COVID-19, 16% experienced symptoms that lasted for three months or longer that did not exist before having the virus. *(VT Behavioral Risk Factor Surveillance System, 2022)*



48% of third graders in Vermont have dental decay. *(Basic Screening Survey, 2023)*

42% of all adults ages 45-64—and 73% of adults making less than $25,000 per year—have had at least one permanent tooth removed. *(VT Behavioral Risk Factor Surveillance System, 2022)*

where they don't want to leave home, but they really can't care for themselves, and there's nobody to take care of them, and there's no funding to pay for somebody to take care of them."

"...not even acknowledging that long COVID is a thing, and we have so many people that come to us because there's no other doors, no other places that are really acknowledging in the way that they should be."

When discussing youth, some participants spoke about developmental delays and autism, with not enough resources and providers for neuropsychological testing, resulting in long wait periods for testing, diagnosis, and getting services. There is considerable frustration around this, as the impact could be devastating to youth and families. One participant explains, **"If you don't get access to certain therapy early on in autism, some of the skills that child could gain, it's more difficult for them to gain them. It marks them for their entire life. It's almost sometimes irreparable, the damage, that is caused by not having access at the right time specifically for this group."** The financial burden of waiting for a diagnosis was also discussed, **"We have families right now, who have to wait a year, you don't have access to SSI [Supplemental Security Income]. So if a parent has to limit their working hours or stop working altogether**

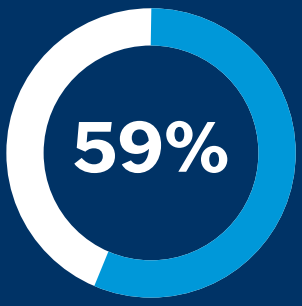
Vermont Specific Health Conditions Statistics

Age 45+

10% of adults ages 45 and older have experienced subjective cognitive decline in the past year. *(VT Behavioral Risk Factor Surveillance System, 2022)*

6X more likely

Adults with a disability are nearly six times as likely to experience cognitive decline than adults without a disability. *(VT Behavioral Risk Factor Surveillance System, 2022)*



59% of children had a developmental screening in the first 3 years of life. *(Vermont Health Care Uniform Reporting and Evaluation System, 2021)*

to be able to tend to their child. They do not have that additional support of SSI because without a diagnosis, you can't apply, you can't do anything."

Older youth with illnesses or disabilities transitioning into adulthood and seeking independence find it difficult to succeed due to lack of housing, high costs of basic needs, and high costs of medications and health services. Major medical cost burdens and anxiety around how to manage their condition on their own are paramount, **"My parents have always found a way to pay, but I am terrified about how I am ever going to afford this when I graduate from college, get dropped from their insurance, and have to figure this out on my own. There has to be a way to make it more affordable to get/keep insurance, pay hospital bills and afford medication especially for young adults facing serious health issues."**

Many interviewees spoke about structural problems that make it easy for chronic health issues to flourish. Wait times for services are long, and people spoke of often waiting while dealing with active health problems. This can lead to faster disease progression, living with pain, and a poorer quality of life. When they are parents or are responsible for caring for others, financial concerns become paramount, as in this participant's stating, **"My liver is getting worse and worse weekly, and I've got a 2-month wait to even see…a specialist about what to do, biopsying it. And it's one of those, like, it's scary for me. I'm the sole provider for a family."**

Stressful economic realities for many bring a higher susceptibility to physical and mental health conditions, **"…when you're living in constant stress, and your brain is being occupied by making sure that there's food, by paying the rent, paying the bills, trying not to get evicted, that's a high cortisol environment. We know that has physical damaging effects on the body, so you're more likely to have hypertension…you're more likely to have diabetes, you're more likely to have a heart attack, you're more likely probably to be overweight, you're more likely to have depression."**

Many people, including those with diabetes, lack access to affordable, fresh and nutritious food. The inability to fully recover when living with constant housing or food concerns or living with chronic pain makes it harder for people to stay healthy.

"My liver is getting worse and worse weekly, and I've got a 2-month wait to even see…a specialist about what to do, biopsying it. And it's one of those, like, it's scary for me. I'm the sole provider for a family."

Living with trauma was also discussed in several different contexts. Many people come into medical environments living with or having histories of significant trauma. Sources of trauma include living with gender-based violence, PTSD for veterans and some refugees, being unhoused, and exposure to drug violence. For those living with trauma, all aspects of well-being are impacted including sleep, interaction

with medical professionals and mental health. Many report they or those they know engage in self-medication.

People struggling with chronic health conditions are less able to participate in social activities, may experience higher levels of stress, and often live with pain. These impacts can themselves cause more chronic health conditions, such as hypertension, mental health or substance use issues. Mental health and substance use issues may further decrease one's ability to care for any medical condition, creating a spiraling cluster of needs.

On a positive note…

Participants described how valued the health care workforce is in addressing complex health conditions and how they have come together as a means of support and communication. **"During the pandemic, we had pediatricians four days a week around this entire state on a webinar. Four days a week. We had 1,400 of these. We still do it every month. We unified the state, we dealt with the pandemic incredibly well. Every practice had the same protocols. We talk practices off the ledge. I'm quitting, I'm quitting. We would talk to them.**

"The people who are doing some of the work in these communities, they bring me hope. The people who are making tough decisions to stay here, to do these worthwhile jobs because they know it makes a difference."

Findings by Communities of Focus

People of color, the LGBTQ+ community, Indigenous People, people with disabilities, older Vermonters, and people who are unhoused experience higher rates of health inequities than others in Vermont. The overall health challenges for these communities are similar to what was described in earlier sections of this report. However, their individual needs and the drivers of their health challenges are unique and are highlighted in the following section.

Here are some of the recurring drivers observed across communities of focus:

- Institutional practices within service settings make members of the communities of focus feel unwelcome or unsafe.
- Limited engagement with needed services due to institutional or service quality barriers.
- Limited cultural competency of providers makes people feel unwelcome or unsafe.
- An extreme lack of diversity among service providers of all kinds.
- Increased social and cultural isolation.
- Financial and insurance-related barriers to getting needed care when available.
- Limited economic and employment opportunities for the communities of focus.
- Frequently perceived discrimination in housing practices.
- Institutional and interpersonal discrimination across the service spectrum.
- The need to cope with high levels of stress in the face of adversity.
- An increased demand for mental health and substance use services despite major service gaps.
- The ongoing effects of living with acute and chronic trauma.

The communities of focus were:

+ Indigenous People
+ People of Color
+ People with Disabilities
+ People who are Unhoused
+ LGBTQ+ Vermonters
+ Older Vermonters

Vermonters of Color

At a glance: Participants of color described a constant awareness and need to cope with living in a predominantly White state. There is an intense social, cultural, and service isolation. The need to explain and make others aware of issues that are obvious and part of the life of people of color is exhausting to many. Dealing with bullying and discrimination, as well as learning to expect it, can be traumatizing. Trying to deal with any health issues with a racially homogenous health care workforce exacerbates the feeling of being "othered"; excluded, separated, or marginalized. As one participant explains, "Trying to explain to a White therapist what being microaggressed about your hair all day is like, is an exercise in futility and probably going to make your mental health worse."

Findings for Indigenous People and immigrants and refugees are reported separately from the findings for People of Color due to their distinct cultures, history, and needs.

The lack of racial diversity among health care providers is acutely felt. There are not enough providers who represent people of color. Practitioners of color are believed to be leaving the state because they need a livable wage. With each one leaving, there is less of a network for others. Similar concerns were expressed when discussing mental health and substance use. One participant shared, **"...a Black woman called up and say she wanted a clinician who's Black. I can't provide that. We don't have that. Thinking about those kinds of barriers, those barriers are huge and really need to be front and center thought about and figured out in such a White state."**

Participants also discussed the importance of being recognized in the system of care, for example in basic health care administrative documents. If multi-race Vermonters must choose White or Black on intake forms, then a simple act of filling intake forms can become alienating. One key informant interviewee noted that some of the health impacts and health disparities for this population are unknown because of lack of data, saying, **"There isn't**

extensive existing data measuring the differences in health outcomes for BIPOC Vermonters, so that the impact of barriers and discrimination is less clear than is ideal."

People of color in Vermont experience both overt and subtle discrimination in the health care system. Many White people are unaware how prevalent discrimination is. A health care worker of color described the need to carry their health care worker badge to be treated as a human being when going to their provider. Interviewees described a painful reality of trying to make providers believe symptoms.

People note multiple occurrences of not being believed, either for their own symptoms or the symptoms of their children, resulting in a need to confront barriers to health and well-being where other people do not. Black women describe many situations of discrimination and trauma, like health care professionals belittling symptoms and health conditions and making rude and judgmental comments: **"If you have to go online for your therapy, if you have to cross state borders…if you can't go and have a baby without being violated and almost dying, it's so much…there's so much that other people just don't have to worry about, don't have to go through and it does wear on your ability to take care of yourself, keep your job, and keep your housing. It's just so heavy."** For Black women, the quality of medical care is diminished: hurried, rude care, medical procedures done without medication, without medical staff introducing themselves or paying attention to the human aspects of care, and high levels of stress and anxiety when dealing with medical services. This can lead to serious concerns about their own health and the health of their families. While this results in a lower quality of care, there is a lack of trust in medical care that impacts future health and

Vermonters of Color Statistics

14x more likely

Black or African American Vermonters are 14 times more likely to report experiencing discrimination or prejudice often during health care encounters than Vermonters overall (19% vs. 1%). *(VT Household Insurance Survey, 2021)*

Only 1/3 get help

Among students of color who feel sad, empty, hopeless, angry, or anxious, only about one third are able to get the help they need (28% of high school students and 35% of middle school students). *(VT Youth Risk Behavior Survey, 2023)*

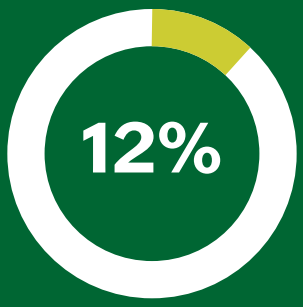
For at least two weeks during the past year, 35% of high school students of color and 30% of middle school students of color felt so sad or hopeless almost every day that they stopped doing some usual activities. *(VT Youth Risk Behavior Survey, 2023)*

well-being potential as well.

Participants said that not having a culturally competent health care, mental health care or substance use treatment workforce results in feelings of isolation and loneliness. Always having to adapt to unique challenges or represent their community means carrying an invisible weight and additional stress to all situations. Finding a community was also a concern for children of color who have White parents. There is a sense of being excluded or marginalized, that care is not for them. The term 'weathering' was cited, **"... to describe the invisible erosion of a person's essential life energy by being looked down upon and treated less than in a million of tiny ways probably every day of their lives in a culture that doesn't see them as worthwhile people with other colored skin."** Discrimination and inequities interfere with wellness, mental health, how a person sees themselves, self-talk, and how a person associates with peers. The aggregation of interpersonal and institutional racism takes a very real toll on people's health.

The impacts of discrimination, lack of mental health and substance use providers for youth and adults, and a mental health system that is complex and hard to navigate results in an increasing number of people who are struggling with mental health concerns. Participants described intense mental health struggles for children and youth, such as behavioral disruptions, emotional dysregulation, anger, and oppositional behavior. Students of color are said to be frequently struggling with substance use. Participants discussed anxiety, depression, and disordered eating among older youth. At the same time, participants said there were not enough youth mental health and substance use providers to address this

Vermonters of Color Statistics



12% of high school students of color attempted suicide during the past year. *(VT Youth Risk Behavior Survey, 2023)*

Vermont adults who are Black, Indigenous, and People of Color are statistically more likely to experience housing insecurity and food insecurity in the past year than White, non-Hispanic adults. *(VT Behavioral Risk Factor Surveillance System, 2022)*

increased need, and many observe decreasing funding of mental health positions in schools.

Participants noted that mental health needs are acute for adults as well. Calls to police related to emotional outbursts, rather than crime, have gone up significantly. In some smaller towns the police force spends most of its time working with people on mental health and substance use issues. This is seen to pose a particular risk to Black people and other people of color given a lack of trust in the ability of police officers to safely meet their needs.

People who do not work in the mental health and substance use fields are often asked to respond to the needs of this crisis, such as people working in schools. Without the mental health care they need, some youth of color engage in self-harm, and some know people who have died by suicide. One participant describes the impact on LGBTQ+ youth and youth of color, **"...when you don't have qualified mental health providers with the background, they can do a lot of harm as well. So, when I look at the youth risk behavior surveys for my area, I am just in tears because there are more than half of queer kids that not only have thought about and planned but attempted suicide in junior high. We have a real problem. The numbers are higher for BIPOC and queer students and we don't have mental health care."**

"There's not an emergency around the fact that people of color are disproportionately being displaced and harmed by the rise in cost of living and the wages barely increased."

"...if you can't go and have a baby without being violated and almost dying, it's so much...there's so much that other people just don't have to worry about..."

Institutional racism was at the forefront of discussions about the housing crisis in Vermont. The proportion of Black people who are unhoused is believed to be much larger than the proportion of Black people in the state. One person notes, **"We think about who owns a home and who doesn't in Vermont. It's just like for me, what's really hard is that when we look at how much the cost of living has increased and who it disproportionately affects, and the narrative is not around cost of living, it's about the inflation rates. There's not an emergency around the fact that people of color are disproportionately being displaced and harmed by the rise in cost of living and the wages barely increased."** Some participants said rent amounts change depending on skin color.

Many participants expressed significant, constant worries about how to pay the bills, if they will be able to have heat this winter, and where they would live. Housing, food, internet,

electricity, clothing, and child care are items with which people are struggling. The cost of insurance is on many participants' minds. There is no transparency of how much services will cost; for example, if there are additional fees like facility fees or fees for reading test results. Wages are not increasing compared to inflation, creating growing financial hardships. Some participants describe not qualifying for state assistance and being unable to afford insurance through their employer. The high cost of medical services means that some cannot get needed high-cost services like scans or report being burdened with a surprising cost which then impacts all aspects of life. Some people spoke of choosing between food and medications.

Parents with multiple jobs are still not making enough to meet the needs of the household. Even when health care is available and affordable, many parents and families cannot leave work to access care and will prioritize their children's health care appointments over their own. The high cost of living creates stressful family life. Parents are very tired, anxious, and report feeling helpless while working multiple jobs and receiving low wages.

On a positive note…

Progress and growth can be made from within the community when resources and support are there. One participant said that during the COVID-19 pandemic,

"There was a lot of resources that were infused into our communities. We … had the opportunity to take some of those resources and translate them into community initiatives, which I believe was incredibly powerful… the work that we've done, we've been able to keep a hope alive in terms of some of the community-based type work that we do, because of the social determinants of health it's not just the health care system. It is housing and education, employment and health services access, economic development, and the so-called criminal justice system, as well as transportation and so forth. So, we've made some progress in bringing people together and creating some of the programs and services that are needed and desired in our community."

Immigrants and Refugees

At a glance: Even when separating out the health needs of this community from the broader People of Color community, it is important to note this is not a homogenous group, as it has varying needs according to length of stay, immigration status, reason for residing in the U.S., country of origin, level of education, and other factors.

Participants reported that the immigrant and refugee communities arriving to the U.S. have often experienced trauma, and have trouble navigating housing and benefits, securing a livable wage, and advocating for medical care with limited English and in large, bureaucratic systems.

The medical system in the U.S. is very unfamiliar, as are the foods and culture. Many people struggle with social and cultural isolation and finding ways to cope.

The barriers to health care are tremendous and include language barriers, limitations to interpretation, many being uninsured or underinsured, discrimination, and providers not fully understanding patients' daily constraints. People reported experiencing discrimination based on language, race, literacy, and socioeconomic status. Barriers for everyone in the state, such as lack of providers, high cost of health care, and insurance and health care bureaucracy, are felt immensely among immigrants and refugees. Health concerns include feeling they are in poorer health in the U.S. than in their country of origin, substance use, diabetes, hypertension, PTSD, developmental delays, and respiratory issues.

Some immigrants and refugees lived through violence to themselves and their families, persecution, or war. Some lived in refugee camps, and experienced long journeys and difficult border crossings prior to coming to the United States. Many are grieving. Some families are fragmented, and it was noted that there are many single income families in the immigrant and refugee communities, resulting in having fewer financial options. There is uncertainty about their situation here; many are experiencing and adjusting to living in poverty, cold Vermont winters, and a new language, culture and expectations. Some fear immigration officers.

It was described that refugees upon arrival are introduced to what one participant described as 'American poverty 101', explaining, **"...a lot of the refugee experience is, particularly upon arrival, I've heard it described as American poverty 101, and that basically is what happens. You interact immediately with a lot of state services, you don't know necessarily where your income is going to come from, and that's depending on level of English and availability of jobs."** Substantial paperwork and processes discourage them from seeking help. Each agency has its own documentation and bureaucracy. Securing a livable wage is difficult.

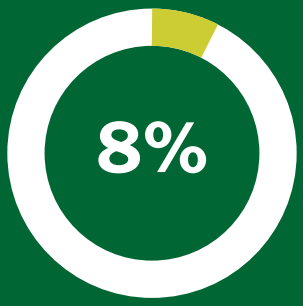
Upon arrival there is a need to find out how to pay rent, many times without having a job yet. This community reports not having access to high paying jobs. Many end up working multiple minimum wage jobs, and work for long hours. There is frustration about how this is being planned for and managed, as one participant explains, **"I get frustrated because people just look at them as numbers on a spreadsheet and go, we**

Vermont Immigrants and Refugees Statistics

430
refugees in 2024

430 refugees arrived in Vermont in fiscal year 2024, most of whom came from the Democratic Republic of the Congo and Afghanistan. *(Refugee Processing Center, Refugee Arrivals by State and Nationality, 2024)*

In Vermont, 5% of people age 5 and older speak a language other than English and 22.9% speak English less than "very well." *(U.S. Census Bureau, American Community Survey 2023, 1-year estimates)*



8% of children under age 18 in Vermont are foreign-born or live with at least one foreign-born parent. *(Annie E. Casey Foundation, Kids Count Data Center, 2022)*

settled 500 people…we settled 500 more people…well what happened to those first 500 people you settled…we have all these people that have been settled here and who desperately need services and help, but yet they're not getting it." The fundamental basic needs of housing, food, and health care are not being met for many immigrants and refugees in Vermont. There is frustration about being set up to fail.

Assistance with finding housing is available initially, and housing is provided for three months to one year, and then there is nowhere to go. Many find themselves in overcrowded, very low-quality, unsafe, or temporary housing. For many immigrants and refugees, housing needs interact with experiences of discrimination. Landlords raise rent, do not like multiple families living in the same space or large families living together, and may push families out; for example, families have been falsely accused of bringing bedbugs with them from their country of origin.

"It's hard for kids to study, concentrate on school, focus on their lives ahead when they're focused on are we going to be in this same home next month?"

The cost of food, transportation, child care, heating in winter and high taxes are challenges. The high cost of living is **"a weight over many of their heads."** A participant spoke of an inability to pay for burying bodies in their community. The enormous pressures around housing and securing basic needs impact all other aspects of life, as one participant describes **"It's hard for kids to study, concentrate on school, focus on their lives ahead when they're focused on are we going to be in this same home next month? Am I getting everything I need to eat?"** Housing impacts continuity in work, school, and socially. It Impacts hygiene, the ability to rest and recover, and if living in crowded conditions it exposes residents to transmittable illnesses. The constant worry about housing increases depression and anxiety. It is viewed as impossible to prioritize good health outcomes without housing.

Language accessibility was discussed at length, as many people are accessing care with little English fluency, as one participant explains, **"If you are working with someone who doesn't read and write in English, if you're working with someone who doesn't read and write in any language, how are you providing them with information that they can use to independently take care of themselves after they have an appointment about their specific ongoing medical condition?"** Being able to communicate and understand health care interactions is crucial. Participants shared confusion around how to take medications, care for a medical condition, enter the building to find the clinic, access care after hours, or schedule appointments and procedures. Accessing and understanding benefits, Medicaid, and other services without strong English language skills is difficult. It may be dangerous if they do not understand instructions of how to take medications, prepare for medical procedures, or follow up with the health care system.

While some providers try to make interpretation services available, many interpretation limitations were noted, including very few interpretation entities authorized to work in Vermont, not using interpretation services

reliably in all points of patient contact, and it being inadequate for certain types of appointments, such as mental health, gynecology, or allergy appointments.

Participants shared experiences of discrimination based on language, race, literacy, and socioeconomic status, such as being spoken down to, not being taken seriously, and health care providers making assumptions about them. Subtle statements like **"I guess we got to get the translator out"** indicate they are an extra burden. The quality of health care can be affected as providers do not understand patients' day-to-day constraints. Many are avoiding care at a medical office due to not understanding the system, because they cannot afford it, or because of mistrust due to discrimination. This leads to increased use of the emergency department.

"The longer our patients stay in the U.S., the sicker they get."

This community is surprised by health care bureaucracy and the low quality of care. Many are used to getting efficient and quality health care in the country from which they come. In Vermont, patients must insist on getting care, and then are given incomplete care if at all. Gaining awareness of available services and navigating the health care system is challenging. Participants reported finding themselves in poorer health in the U.S. than they were in their country of origin, and **"The longer our patients stay in the U.S., the sicker they get."** Along with difficulties accessing health care, they newly encounter restricted access to nutritious, familiar, and varied food, physical inactivity, living away from sunshine, and a for-profit health system.

Many in the immigrant and refugee community are uninsured or underinsured. Many arrive not knowing anything about the insurance system in the U.S. and Vermont. They may get an insurance card in the mail and not know what it is or how to use it. Insurance bureaucracy is immense for providers and clinics: providers' offices spend countless hours with patients who have lost insurance coverage or figuring out medication changes that were initiated by insurance companies. One participant described a scenario where insurance denied service, stating **"...an insurance company saying that this person's hospital stay was not medically necessary. And we work really hard to make sure that people who come...actually have to be there because we don't have places to put people... We're just trying to take care of people and get them home as soon as possible, safely. And the insurance company will call and say, their hospitalization was not medically necessary. They're not going to pay for it."**

Participants are shocked by the high cost of care in an emergency. Payment is confusing because there are different systems of determining financial assistance, so people do not know what cost to expect.

"I have seen people smoking...just because mentally they cannot keep up with work. They're not able to take a week or two weeks off and say, I need my time."

Participants noted an acute crisis for youth. The school system is seen as being unprepared to handle so many youth with trauma, teach them a new language, and engage them with the regular curriculum. Safety nets for children are fragmented. Parents may work multiple jobs and have limited community support, and drugs and alcohol are readily accessible. Parents feel further helplessness, not knowing how to help their children or prevent substance use. Substance use is also seen as an immense problem for adult men in this community, as one participant describes **"I have seen people smoking…just because mentally they cannot keep up with work. They're not able to take a week or two weeks off and say, I need my time. I'm not feeling well, because your job won't accept that, or they won't pay you if you don't go to work."**

On a positive note…

There are organizations in Vermont that are committed to listening to and addressing the needs of immigrants and refugees.

"…they are working with people and helping them find doctors. And then in certain cases, they're even translating for people. They're helping them with bills as well and trying to even find sometimes the right health care plan they should be on. So it's really amazing work what they do. I don't think maybe people fully appreciate the level of care they're giving individuals. So I think that's a big thing. There are, I know local groups and government settlement agencies that are helping people in the beginning to find health care and getting them in that help."

Indigenous People

At a glance: There is important context to understand when considering the health needs of Indigenous People living in Vermont. Historical mistreatment led to distrust and fear of state and government institutions. The outcomes of these actions impact the health and well-being of Indigenous People today.

Participants described a community that lives in poverty and experiences economic hardships despite hard work.

Many health concerns were described, some unique to this population and some intersecting with others in the state. Affordable, healthy fresh food is a frequent concern, and many are struggling with housing. There is a high need for and many barriers to dental and vision care. Living with multiple sources of trauma is a challenge. There are high rates of suicide, and many barriers to mental health care. There are also high rates of alcohol, opioid, and cannabis use.

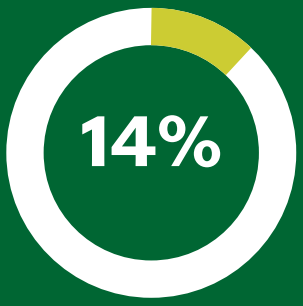
While feeling excluded in health care, this community is clear on its needs. For example, maintaining a well-being that has spiritual, relational, and communal elements is important. The relational aspects can begin to be addressed by decreasing turnover in interactions with state representatives and health care providers. Having Indigenous providers, and recognition of tribal structure and its implications for health of the community and communication are also important. To establish well-being, it is critical to empower and give resources to the community and build strong ongoing relationship with the state.

Distrust and fear of state and government institutions based on institutional racism and mistreatment in past and present were highlighted as a major barrier to accessing health care. One participant reminds us that **“In 1978, almost 5,000 Indigenous women were sterilized without consent…It’s fresh. It’s an open wound.”** Another participant explains, **“We live in a state of Vermont. They had eugenics that came and took our kids. We had a choice, either you went to jail, you were sterilized, or they took your kid. That was what was choices. So, when the state of Vermont shows up or anything that has that identity, we don’t trust them, because they’ve shown their true colors. We say you can speak all you want, but action shows your true colors…”**

One health consequence is that many members of the Indigenous community are unwilling to engage in traditional health care initiatives. This is seen in this example during the COVID-19 pandemic, **“Many folks in our communities who did not get any COVID vaccines and still do not, they do not trust the establishment because the establishment was imposed unwillingly a long time ago, and that still hasn’t changed, and that’s why there needs to be options for people to look for solutions within their communities.”**

Not only does the health care system not recognize this history and its impact on current health care interactions, but it also makes invisible the current needs of this community. As one participant shares, **“If you’re not even seen, you don’t exist…It’s really hard to say, well, there’s this great program and we can’t get into it, or we need to adapt this program. I would just say what program? The programs that we need - they**

Vermont Indigenous People Statistics



14% of Native American, Indigenous, or First Nation people in Vermont have up to date COVID-19 vaccinations, lower than the rates for White (59%), Black (43%), Asian (52%) and multiracial (62%) Vermonters. *(Vermont COVID-19 Vaccination Rates by County, Race and Ethnicity, 2022)*

$35K median income

Median incomes for Indigenous households were $35,000 in 2022. For White households they were $64,412. *(VT County Health Rankings)*

13% of American Indian or Alaska Native students have attempted suicide, compared to 4% of students overall. *(The State of Health Equity in Vermont, June 2024)*

don't exist. We can't fix them." Participants shared that health institutions do not see the importance of native spirituality as part of health, fresh food as medicine, the impact of natural medicines, and the importance of the well-being of community as part of the health of the individual for Indigenous people. For example, recognizing spirituality as part of health is an essential part of healing for the Indigenous community. Many spiritual practices are not allowed in hospitals, are not given space to occur, or medical personnel disrespect them. These practices can include the use of eagle feathers for prayer and comfort, burning sweetgrass or sage, or the ability to go outside to do a ceremony.

Participants described health in a communal and relational way, needing time to build trust and relationships with providers and state employees to be able to engage. Clinics closing and the constant turnover of providers makes relationships unattainable. One participant describes how this plays out at an encounter with a provider, saying **"Then they ask you when you get to the doctor's office, do you feel safe at home? Are you depressed? We don't know these people. Why would we tell them yes, we are, no, we're not. We wouldn't do that. We have to have some kind of relationship with somebody to be able to open up with them."**

Participants feel excluded when not being able to identify themselves as Indigenous when completing paperwork. On the other hand, some feel that identifying as Indigenous is not safe. Interviewees described multiple ways in which identity is attacked, questioned, or belittled, and described ignorance and lack of awareness as contributing to further fear and distrust. For example, one participant described how a therapy clinic was set up that

Vermont Indigenous People Statistics

More likely to have diabetes

American Indian or Alaska Native (26%) adults are statistically more likely to have diabetes than all adults in the state (8%). *(The State of Health Equity in Vermont, June 2024)*

Less likely to visit a dentist

American Indian or Alaska Native (34%) adults are half as likely than all adults in the state (68%) to have visited a dentist in the last year. *(The State of Health Equity in Vermont, June 2024)*

American Indian or Alaska Native (32%) adults report using cigarettes at more than twice the statewide rate (14%). *(The State of Health Equity in Vermont, June 2024)*

did not provide confidentiality, explaining **"Our people are not going to air their dirty laundry, so there's no privacy when you get there [the mental health agency]. Everybody knows you're there and that's just not something that works for our people either."** Not being able to identify oneself and embrace that identity in a medical setting influence how much someone reveals to providers, how heard someone feels, and how prepared providers are to treat that person well.

Community members described the impacts of living in poverty. Many live in rural areas and described factors such as having to work low-income jobs, difficulty maintaining health insurance, finding health care unaffordable, having insufficient transportation, receiving low quality care, accessing low quality food, having high levels of stress, and not having enough providers. Many services are clustered in Burlington, so clinicians are 30 minutes to 2.5 hours away. Not everyone has a car, can pay for gas, or take time off work for appointments. Busing that exists on the islands, as one example, is extremely inconvenient, as people are picked up at 7am and dropped off at 5pm, so a medical appointment takes an entire day. Medicaid patients can use public transportation to go to medical appointments, but the quality of services is inconsistent, with reports of being forgotten and not picked up before or after appointments, being picked up hours after an appointment ends, and not being able to reach anyone at the transit office.

"In 1978, almost 5,000 Indigenous women were sterilized without consent…It's fresh. It's an open wound."

Economic hardships are felt despite hard work. Many are struggling with tight budgets to keep their businesses going, working multiple jobs, and are still unable to afford basics. This hardship is felt in many professions into the middle class, as one participant notes, **"If we could expand Medicaid to include marginal people, I qualify because I'm broke, but there's teachers who make a pretty decent salary and can afford to live, but they can't afford the health care too, so they're forced into making those decisions. Do I eat or do I go to the doctor?"** Others note that the benefit structure does not make sense: **"It seems like people who try to help themselves and better themselves never get ahead. But if I quit my job, my family would have a low enough income that we would all be covered by health insurance, my kids could get free college, and some of my household bills would be paid for. But we won't do that so instead we struggle."** Veterans and older Indigenous People were recognized as two populations especially vulnerable in the current housing and high cost of living conditions.

The affordability of health care is a huge stressor, and when there is an acute need, the lack of providers and affordable care combine to make a huge impact. As one participant states, **"Most people can't afford dental or offer those plans, or even subsidies towards it. So then you go without because you can't afford it, and then I told you the scenario, you walk into the emergency room, you come out with a $40,000 bill, and you never get out from under that debt for the rest of your life."** One participant describes the impact of the lack of providers and affordable care stating, **"Even if you can find**

somebody out of state, is Medicaid going to pay for it? I live on a very fixed income, and even for me to put out $30 a month it's going to affect other parts of my life tremendously, and I'm lucky in that I'm not ready to kill myself, but there are people out there that probably are, and they still can't get the help either." Health care itself is the cause of significant stress and instability.

People in the community live with multiple sources of trauma; elders still remember some of the actions taken by the state, intergenerational trauma, and PTSD of veterans returning from services.

There are believed to be high rates of suicide and many barriers to mental health care, as one participant states, **"We have the highest suicide rate…There's like 50 people to 100 people per counselor and they're waiting in line for somebody not to need services so that people can actually get services."** There are not enough mental health providers. People seeking therapists are put on waiting lists, and some providers who are available cannot bill insurance because of the therapeutic modality they use, such as art therapy: **"How Medicaid allows you to be charged and who can charge and who can't, and how the state of Vermont allows certain people to charge, and others can't. The same thing with the VA [Veterans Administration], if you don't have certain credentials, and you're not on their list, you can't use us or anybody else."** Those who find care for mental health and substance use needs encounter providers with a lack of cultural awareness, the history involved, and who provide treatment with no knowledge of trauma-informed care specific to this community. While seeking help, people find that they also must give a history lesson and bring therapists up to speed culturally. As a result, many people are not getting therapy and psychiatric needs met, even when in crisis. Readily accessible alcohol, opioids, and cannabis in the community are being abused. Some expressed frustration about dispensaries opening readily in the community.

Affordable healthy fresh food is a significant concern. For the Indigenous community, natural fresh food is considered medicine. There is gardening knowledge of sustainable practices that can feed everyone, reduce costs, and foster community identity and mental health. People noted the contrast of this with a reality in which parents go hungry so their children can eat the heavily processed foods they can afford. With food insecurity being an issue throughout the state, it is of note that participants said Indigenous People are further susceptible to specific health concerns from processed foods than other populations. Health complications also arise when choosing between medications and food.

"While seeking help, people find that they also must give a history lesson and bring therapists up to speed culturally."

Participants discussed specific health concerns, including higher rates of diabetes, pancreatic cancer, glaucoma and degenerative eye issues, liver issues unassociated with alcohol and drugs, and ear infections for children. There is a high need for and many barriers to dental and vision care, **"Getting to a specialist in the state of Vermont is ridiculous. Let alone a dentist, let alone an eye doctor, and it can take you six months to get into an eye doctor."** Several

interviewees attributed some specific health challenges, in particular diabetes, to poverty, high cost of living, and a result of eating food to not feel hungry rather than as nourishment. Participants shared that Indigenous People have specific medical susceptibilities that providers are often unfamiliar with, for example, **"Our bodies do not digest certain foods, so it causes problems with livers because we don't have the same type of chromosomes as other people."**, and **"Ear infections for our kids are higher than some others because our jaws are longer, so the tubes and the ears don't get to drain properly."** It makes a difference when there is a provider who understands that, as this participants states, **"We have a nurse practitioner in Swanton, and she's almost got her doctorate. This woman knows her stuff. She knows about Indigenous people, she knows what she's doing and you go in and she knows it. She's like, 'You're indigenous so no wonder you're having ear issues.' We don't have to explain that stuff, which is kind of nice."**

On a positive note…

There are many examples of positive actions towards health, working together, and helping each other within the Indigenous community. As one participant stated,

"We do COVID and flu vaccinations for the community…It was December when we were able to fit it in. But to my surprise, all the local farmers came and they brought their employees. And that just made my heart happy […] did skin cancer screenings this fall. We're going to do it again in June because a lot of the teachers […] said, 'Why do you do that during the day?' So we're going to do it again and make it a community event, have a barbecue and what have you. […]. We started the food shelf, which is just still blowing my mind. We're open every week. And people come from everywhere. They arrive. It's amazing […] we're not only just reaching out to our own people, we are reaching out to community because that's what we are. We all have to help ourselves and we all have to support each other and we all have to advocate for each other. And so this is just, for me personally, a tiny step in a right direction to provide what is not available to some of these folks."

People with Disabilities

At a glance: Participants highlighted high costs, insurance limitations, lack of transportation, and discrimination that prevent people with disabilities from receiving needed care. There is an extreme struggle to afford care even with insurance. Medicaid income restrictions can be detrimental by limiting access to needed services. Chronic disease management is impeded by lack of ongoing support services and the high costs of care, and many are living with pain and in poorer health.

Participants also noted how having a disability intersects with other health needs. Disability is closely connected to mental health and substance use issues. There is a shortage of mental health providers and programs and very few intensive, long-term substance use treatment options. Crisis response was reported to be inaccessible and or ill-suited to immediate needs. Housing instability and a lack of affordable and accessible housing further exacerbate health risks. People with disabilities who hold other marginalized identities also face compounding effects of multiple forms of discrimination that can further health inequities. The growing aging population is learning to live with increasing levels of disability.

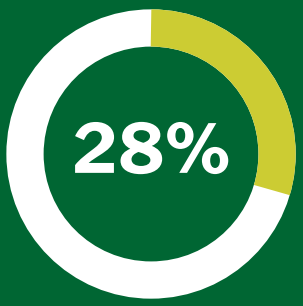
People with disabilities face numerous financial barriers to accessing health care. High costs of services, medications, and medical equipment were frequently mentioned, with many struggling to afford care even with insurance. One participant notes, **"It can be a situation where someone might need the particular piece of medical equipment to take care of themselves whatever that medical equipment might be. I don't know like a CPAP machine or whatever. And that issue is between that or buying healthy food at the grocery store that type of thing. Or choose between that and paying their rent or paying their electric bill."** Limited employment opportunities and benefits that do not cover expenses are a continual stressor for many. A participant describes their situation, **"A lot of people can't afford health care or have**

a ton of medical debt, so they're avoiding going to the doctor because they literally can't afford it. I have Medicare and Medicaid, and on disability income. I'm not making ends meet." Another shares these details, **"... if I didn't have Green Mountain Health, and Medicare, and Green Mountain Health was paying my Blue Cross Part B, that's $107 a month. I'd have to cancel Blue Cross Part B, because they'd be just taking it out of my check, and then I'd have almost nothing... an MRI is five grand. Just the picture. I had to have one done a couple of weeks ago. I got a bad back. It's bothering my walking, and I can't feel my fingers. But if it wasn't for the insurance that I have, which is...I call it poverty insurance, I wouldn't have anything."**

The lack of affordable, accessible housing in Vermont has major impacts on the health of people with disabilities. Many are forced to live in substandard conditions with issues like mold, pests, and disrepair that worsen health issues. People who are unhoused face even greater risks, lacking access to health care and a safe and hygienic environment. Shelters and hotels are often inaccessible for people with disabilities.

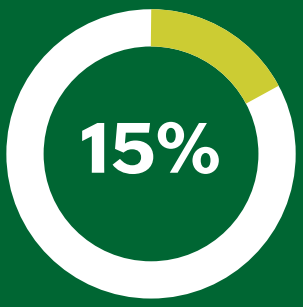
Participants explained that people with disabilities face stigma and institutional discrimination in health care settings. Many face extra hurdles when interacting with medical providers or unaccommodating providers, as one participant describes **"I'm blind, I use a screen reader to access stuff on the internet...the portals that Southwestern Vermont Medical Center, Bank Hill Valley have for you to get information. I can get into the damn things, but they're not set up for my screen reader to read them. Because there's like things in the screen reader doesn't understand."** Another participant states,

Vermont People with Disabilities Statistics

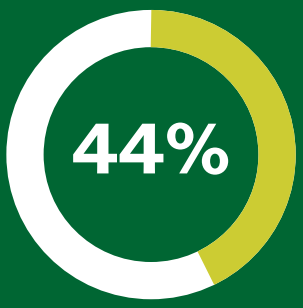


In Vermont, 28% of adults with a disability report poor physical health, compared to 11% of all adults. *(VT Behavioral Risk Factor Surveillance System, 2022)*

Adults with a disability are statistically more likely to delay care due to cost than adults without a disability. *(VT Behavioral Risk Factor Surveillance System, 2022)*



15% of adults with a disability rarely or never get the social and emotional support they need, compared to 8% of all adults. *(VT Behavioral Risk Factor Surveillance System, 2022)*



High school students with a disability are more likely to report experiencing poor mental health most of the time or always during the past 30 days (44%), compared to students without a disability (32%). *(VT Youth Risk Behavior Survey, 2023)*

People under age 65 with a disability are more likely to report experiencing discrimination or prejudice during health care encounters than Vermonters overall. *(VT Household Insurance Survey, 2021)*

"The doctors don't speak in plain language. You don't understand how to sign up for the appointment…Do you think somebody with an IQ of 70 is managing that effectively? Not so much."

Access to care barriers, such as high costs and lack of specialists, leave people with untreated physical and mental health conditions, worsening chronic illnesses, and poorer overall health outcomes. One participant notes: **"…home and community-based services are in a shambles…That system has been underfunded in various ways for more than three decades. The people in that pot…that qualify for 30 hours a week of community support, respite on the weekends, whatever that is, they're not getting any of those services. They might be getting three hours."**

"A lot of people can't afford health care or have a ton of medical debt, so they're avoiding going to the doctor because they literally can't afford it."

Disabilities like diabetes, heart disease, COPD, dementia, and mobility impairments have inherent health impacts, but also make it more difficult for individuals to access appropriate care because of the need for more specialized, ongoing, and expensive care. Lack of support for these conditions leads to avoidable complications, faster disease progression, living with chronic pain, and poorer quality of life. Co-occurring disorders can worsen existing health problems, increase the risk of injury and chronic disease, and lead to premature death. Secondary disabilities acquired through traumatic injury or complications from existing conditions were also mentioned.

People with disabilities also face greater rural disparities and climate change impacts. Rural residents with disabilities may face additional barriers to health care access, such as limited transportation options, long distances to providers, and a lack of local specialists. Participants highlights the need for accessible emergency shelters and the health risks posed by extreme weather events.

Participants discussed how disability is closely linked with mental health and substance use issues. With many health care systems in the state overwhelmed by the level of need and staffing challenges, there is a lack of support and coordination for individuals with disabilities who also need mental health care. As one participant describes, **"Our community mental health system is like, 'That's the other side of the house. You have an intellectual disability. I don't want to hear about your depression'… there is a real difficulty in accessing good mental health care for people who also happen to have developmental disabilities and are very stressed and lonely people because they're not getting any services right now."**

Barriers to mental health treatment include a severe shortage of providers, long waitlists, and high costs. There is also a perceived lack of intensive, long-term substance use treatment. Caregiving responsibilities can take a toll on the physical and mental health of those supporting people with disabilities, particularly when additional support services are lacking.

Participants specifically highlighted mental health

and substance use issues among youth with disabilities. They noted a worrying rise in youth experiencing mental health crises, which they linked to factors like social media use, isolation during the COVID-19 pandemic, climate change anxiety, and economic hardship. At the same time, there is a severe shortage of mental health providers and programs equipped to serve youth, especially those with co-occurring disabilities. Families face long waitlists, high costs, and difficulty finding accessible, appropriate care. Schools and community organizations are not adequately resourced to fill the gaps. Inadequate support can increase the levels of stress on their families, as one participant notes, **"If kids have learning disabilities and they're not getting adequate supports or medication around those learning disabilities. It creates problems within the family that then puts the family and the individuals in the family at elevated risk for all sorts of negative mental health and substance abuse outcomes."** These impacts can then derail a young person's health, education, and social development. Lack of support during key transition periods can set youth on a path to chronic health challenges and lifelong disability.

The transition-age years, ages 18-25, seem to be a particularly high-risk time, with disruptions in support services as youth age out of pediatric care and into the adult system. Substance use is also a growing problem in this population. Overall, youth with disabilities are an underserved group whose mental health and substance use needs are often overlooked in a strained system.

Participants also discussed the growing number of older Vermonters, as many experience increasing levels of disability with age. Dementia and Alzheimer's were noted as growing problems with limited support services.

On a positive note…

During the recent floods, organizations worked to prioritize the needs of people with disabilities.

As one participated shared,

"…recently shown in our floods in July, the impact that it had for folks who had mental health challenges. Folks with intellectual and developmental disabilities, and I'll just talk about Washington County because the flooding here was so bad, but we had (community organizations) literally in kayaks and delivering medication to folks in their homes."

LGBTQ+ Community

At a glance: The LGBTQ+ community in Vermont reports a great need for information, support, and resources from providers. While some leading providers in the field practice in Vermont, many still encounter difficulties finding the set of available, aware, knowledgeable, and qualified providers. LGBTQ+ elderly need housing with services and programming to match needs. There is a higher proportion of LGBTQ+ in the unhoused population, with shelters set up in a binary manner.

This community describes encountering daily barriers to accessing services and faces discrimination that can impact health and well-being. The assumption of a binary system results in service gaps. Without gender-affirming care, youth result to 'DIY' management of puberty. There is a need to navigate discrimination in places where others enjoy healthy physical and social activities, and there are high levels of stress from it as well as from political climate, lack of support, and internalized messages about being bad or a burden. These harm confidence, sense of control, self-image, and self-esteem.

Addressing the needs of this growing community was described by one participant: **"the youth risk behavior survey from 2021, showed that 30% of Vermont youth, both in high school and in high school and middle school are identifying as LGBTQ. And that is up from previous years where about 14%, were identifying. And so this is an up and coming population, that will need care as young people that will need care as adults."**

Participants report added financial barriers for LGBTQ+ youth and young adults as they may be disconnected from families, and not have that support and financial safety nets to rely on. There may also be added barriers to employment due to discrimination, as one participant describes **"... employment discrimination is so real. It's not worth staying in a toxic job. So, folks will work under the table or do transient work."** Another participant states, **"We also see the impact of**

this in job discrimination, honestly, for young people looking to start jobs or looking for careers that are going to be supportive of their identity. We have protective laws here in Vermont, but again, the shift from law to lived experience can be pretty drastic. So, if a young person doesn't have the wherewithal to self-advocate or the ability to take on an employer who is causing harm, that can be really difficult." One way in which the financial burden shows is that there is a higher proportion of LGBTQ+ in the unhoused population in Vermont than in the state as a whole.

The current political climate across the country, including observing national patterns of legislative attempts to institutionalize discrimination against the LGBTQ+ community, contributes to high degrees of worry and stress for many interviewees. For transgender youth, this becomes a barrier to wellness, for example when needing to navigate discrimination in places others enjoy healthy physical and social activities, such as afterschool activities. Some providers say outright they are not going to serve them. One participant describes, **"When the parent advocated for urgent care to be using the name and pronouns that this kid uses rather than their legal name, the medical provider in urgent care immediately withdrew their hands from the young person and would not continue to give them a physical examination."**

One participant explains how the lack of acceptance from others creates an ongoing mental health struggle, **"If families were using this kid's name and pronouns, would they have the acute need for medication? If the communities that these young people were navigating were accepting of their whole authentic selves, including their gender identity, would they experience that same**

Vermont LGBTQ+ Community Statistics

29%
high school

26%
middle school

29% of high school students and 26% of middle school students identify as LGBTQ+. This represents an increase from 2019, when 14% of high school students and 11% of middle school students identified as LGBTQ+.
(VT Youth Risk Behavior Survey, 2023 and 2019)

2x
more likely to have employment negatively affected

LGBTQ+ adults (17%) are nearly twice as likely to have lost employment or had their hours at work reduced in the past year than heterosexual and cisgender adults (9%).
(VT Behavioral Risk Factor Surveillance System, 2022)

LGBTQ+ students are statistically more likely than heterosexual and cisgender students to have used tobacco and marijuana in the past 30 days.
(VT Youth Risk Behavior Survey, 2023)

level of anxiety?" Many noted it is hard to build trust with mental health and medical providers who do not understand or are not accepting, as one participant notes, **"And that means having to tell a narrative that sounds like I was born in the wrong body. I've always known it. I need a very binary transition in order to stay alive. And if can't have that. I cannot stay alive."** Teens report finding it easier to talk to friends rather than mental health providers because they understand, are not mandated reporters, and do not write everything down.

Stress from being discriminated against and having to live with what one participant describes as **"Be who you are, and be hated on for it"** contributes to some adverse coping mechanisms like substance use. There are higher rates of anxiety, depression, insomnia, and self-harm as coping strategies, particularly among youth. Some participants mentioned concerns about suicide rates, for example, **"I am just in tears because there are more than half of queer kids that not only have thought about and planned but attempted suicide in junior high."** Another stated, **"We see really high rates of suicidal ideation and planning. And those risk factors that contribute to young people thinking or planning suicide are connected to feeling like you're a burden to having the capacity for self-inflicted violence."** Due to negative experiences with the health care system, many report delaying medical care, not getting care at all, or traveling long distances or out of state to get the care they need.

A repeated theme across the state is that there are very few available medical and mental health providers. For the LGBTQ+ community, there are even fewer possible providers. One participant states that it is hard to find mental health clinicians because **"...the pool**

Vermont LGBTQ+ Community Statistics

1 in 3 people in Vermont go out of state for gender-affirming care surgery. *(Green Mountain Care Board, Health Resource Allocation Plan Update, January 2024)*

Less likely to see a doctor regularly

Compared to the statewide rate (74%), transgender (55%) adults are statistically less likely to see a doctor regularly. *(The State of Health Equity in Vermont, June 2024)*

In Vermont, 9% of people who identify as transgender, genderqueer, or non-binary often experience discrimination or prejudice in health care, compared to 1% of people overall. *(VT Household Insurance Survey, 2021)*

of clinicians is not big enough for everybody to begin with. The pool of clinicians that are going to express comfort or some level of skill in working with the LGBTQ+ community is a smaller subset of people still. And then within that group, the actual people that are skilled and can help that are going to be comfortable sitting down across from somebody and working through whatever issues they might have is also a smaller subset." Another participant describes the loss of primary care for a transgender youth, saying **"...once a young person comes out as transgender non-conforming to them, will immediately refer out care for that young person to a specialist, usually an endocrinologist and young people might need an endocrinologist, but they might not, right? Like they still have tonsillitis. They still have like sports related injuries. They still need to get periodic checkups. And so if the instinct of that provider is to always and immediately refer out that loses primary care access for a lot of young people."** There is often a requirement among providers that both mental health and medical health providers need to collaborate on the care of transgender and non-confirming people, especially young people. Requiring medical and mental health care to be linked when both systems are so stressed and not accessible means the loss of care for many. Long waiting lists to begin having this conversation with both medical and mental health providers is an enormous obstacle, especially as anxiety builds and puberty continues.

"If we even get in the door, and then if they're misgendering us, or their intake forms are really outdated, we don't see ourselves represented and welcomed in other ways, we're unlikely to ever go back."

"...those risk factors that contribute to young people thinking or planning suicide are connected to feeling like you're a burden to having the capacity for self-inflicted violence."

Along with ongoing mental health needs, some participants are distraught to have no care for people in acute crisis. One participant said needing to wait six months for mental health care during a crisis is devastating. Another said going to the emergency department in a mental health crisis only to be released is unhelpful. Multiple people stopped their medications and cannot get prescriptions refilled until they see a psychiatrist, which is extremely difficult to do with the lack of providers. Families are at a loss as to how to help their children who are struggling.

Regarding gender affirming care, interviewees describe providers, hospital systems, and billing systems built on binary gender identities, a pre-determined script for how to administer care, and consequently basing health care decisions around that. It is a challenging experience going to a provider who has no idea of the health care needs of someone who is transgender. They

find themselves needing to inform and educate providers rather than the other way around. Interviewees discussed experiences with medical and mental health professionals in which providers do not believe them, think pronouns are a preference, surgeries are elective, and identities are a choice. This in turn makes it hard to trust providers, further decreasing the support and affirmation a person receives. One participant describes the impact stating, **"It sounds like a simple thing, but when somebody is misgendering you every single time, when it feels like it's purposeful, then it feels like the health care system is purposefully not going to be providing you appropriate care."**

Unavailable or unknowledgeable primary care means a lack of preventative measures such as cancer prevention. Interviewees reported people in their community finding ovarian cancer and breast cancer too late in male identifying people with some biological female aspects. Another gap reported was having to insist on getting reimbursed for a pap smear. From intake forms through medical surveys, transgender people report being left out in demographics sections, where their identity is not an option. Survey questions do not directly ask about access to gender-affirming care: **"If we even get in the door, and then if they're misgendering us, or their intake forms are really outdated, we don't see ourselves represented and welcomed in other ways, we're unlikely to ever go back. And so that preventative stuff really gets lost out the door."** Billing and insurance gaps similarly occur, for example when there is an unexpected denial of claims when someone is pregnant and their gender on documents may not match what Medicaid reports. People are going out of state to give birth, to get emergency care, or to get life-affirming procedures.

"When young people can't get their needs met by adults, they are evil geniuses at DIY jobs."

For youth and supportive families, there is a great need for information and resources about safe tucking and compression to minimize the appearance of external genitals under clothing, or about safe access to puberty blockers. Lack of gender-affirming care for youth can mean additional medical needs as an adult. As one participant explains, **"For this population in particular, waiting on medical affirmation has a snowball effect where young people who say don't have access to pubertal suppressants and then experience a biological puberty will over time require more medical intervention to achieve the things that they need rather than less. So, if you never grew a jawline or if your Adam's apple never developed, or if your hormonal surges never contributed to your secondary sex characteristics coming in the way your biological puberty would have them, you don't have to reverse any of those things. But if you're made to wait until you're 18, all of those things will happen. And then you require shaving down your jawbone or surgical alterations to your Adam's apple or a whole host of interventions."**

Some examples of the statement **"When young people can't get their needs met by adults, they are evil geniuses at DIY jobs."** were given, including bypassing a prescription or insurance and getting medication online, using substances to self-medicate, using household materials like duct tape for tucking and compression, and talking to other young people rather than to professionals to get information and support.

These 'DIY jobs' have many risks, including rib damage over time, skin damage, testicular torsion, and bladder and breathing problems. Some young people reportedly experience high rates of disordered eating because they do not want to grow breasts, hips, or get their period. They may seek control over their bodies through anorexia.

On a positive note…

Participants expressed excitement about professional development opportunities underway to build health care providers' capacity to provide culturally competent care for the LGBTQ+ community. Another participant shared about the impact of putting out Black Lives Matter flag and rainbow stickers in their health care setting to enhance a sense of belonging and inclusion.

"One thing that is already in the works that I'm very excited about is a partnership between (a community group and hospital staff) to create a learning module for primary care providers, not teaching them adolescent medicine, or anything out of scope for what outright can offer, but really helping them understand the importance of gender affirming care."

"…when we started to put out the different flags we certainly got a lot of positive feedback from people. I even remember when I interviewed someone, they saw the flag and I said, 'I've never interviewed at a place where I've seen the flag and felt so welcome.' And I know patients have also commented on the rainbow stickers in the room of like, it's just a little signal to know that you sort of support and care about me…"

People who are Unhoused

At a glance: People who are unhoused face constant concerns about shelter, safety, and basic needs. The harsh conditions of living while unhoused are traumatizing, and do not leave much room to take care of health or well-being. Any extreme weather effects are magnified when living outside. Many people find it difficult to make and keep medical appointments. Some are turning to alcohol and drugs to medicate and handle the living conditions. There is a new level of the substance use crisis for those without housing.

There are not enough services, shelter and treatment beds, and safe places. There is also not enough daily living support for those living with moderate and severe mental health conditions, and the state is not providing a crisis response adequate for those in dire mental health need. The acute need for dentists and other specialists was described frequently.

People who are unhoused encounter discrimination in most aspects of life, including when they seek medical care. Widespread discrimination and poor quality of health care were reported based on socioeconomic status or substance use backgrounds.

Many chronic conditions and new illnesses flourish due to these factors. Many experience severe untreated physical and mental health conditions with repeated use of the emergency department for all health needs. The people who work with this community are overworked and overwhelmed because of the increasing demands for services and lack of shelters, services, and available and affordable housing units.

Findings by Communities of Focus:
People who are Unhoused

Focus group and interview participants perceive the unhoused population in Vermont to be growing. There is a worrying increase in families and children who are unhoused for the first time. Some young adults are aging out of families that experienced homelessness, creating a cycle of multigenerational houselessness. One participant noted **"... homelessness disproportionately affects minorities and the LGBTQ community. We see that here in the shelter, too. Those are the same folks who historically have also not had equal access to health care. Homelessness disproportionately affects them, too, and kind of compound."**

Participants reported a worrying increase in older Vermonters who are unhoused, which was often noted with disbelief and outrage, **"The increase...that we've been dealing with the most that is heartbreaking is the elderly. We have more and more and more people that either are 65 or older or close and it breaks your heart wondering how are they homeless? Why are they homeless? If anything, where are the adult homes? Where are the nursing homes? They're full too."** There are also people with significant health concerns who are being evicted from their homes when unable to take care of themselves, as is illustrated here, **"...we had an individual who was living independently, who had some significant health concerns, and was evicted from apartment because he was unable to take care of himself, clean up after himself, and do housekeeping kind of things. He was evicted and ended up out on the street."** Another participant describes a mental health crisis leading to being evicted, **"We had a [person] who was having a psychotic episode for a couple of weeks and he ended up throwing his toilet out of his apartment [...] caused significant damage to apartment.**

Vermont People who are Unhoused Statistics

3,458 people unhoused

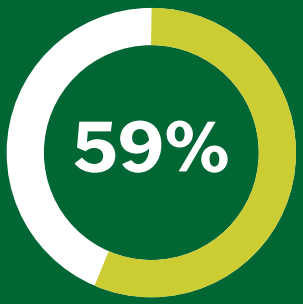
In 2024, there were 3,458 people who were unhoused, representing a 300% increase over pre-COVID levels. *(VT Point in Time Count of Those Experiencing Homelessness, 2024)*

5.6x more likely to be unhoused

Black Vermonters are 5.6 times more likely to be unhoused compared to White Vermonters. *(VT Point in Time Count of Those Experiencing Homelessness, 2024)*

18% experienced transportation insecurity

18% of people making less than $25,000 per year experienced transportation insecurity in the past year. This includes a lack of reliable transportation that kept someone from medical appointments, meetings, work or from getting things needed for daily living. *(VT Behavioral Risk Factor Surveillance System, 2022)*



59% of Vermont adults with any mental health conditions are receiving treatment. *(SAMHSA Behavioral Health Barometer, 2019)*

From 5% to 25%

The percentage of cold-related illness visits involving people who are unhoused has steadily increased from 5% in the 2018-2019 cold season to 25% in the 2023-2024 cold season, a statistically significant increase. *(VT Department of Health Cold-Related Illness Seasons Summary, 2024)*

And we weren't able to get him to help, even though he was a danger to himself and to others. He ended up getting evicted and now is homeless."

Other pathways to becoming unhoused were described:

1. Domestic violence and leaving an abusive relationship.
2. Losing insurance coverage and being unable to afford medical bills and housing.
3. Having a falling out with a family member, or the death of family member who provided financial support.
4. Housing organizations may remove people from a housing wait list if they do not hear from a person by mail. This is difficult for people not familiar with that expectation and not accustomed to communicating through mail.
5. Medical conditions that prevent people from being able to work, for even a limited time, leading to an inability to pay rent or mortgage.
6. People who had a house that was flooded and deemed unfit to live in, and do not have financial means to find another place.
7. A common belief is that Vermont has strong social services for the unhoused, and people who are unhoused are moving into the state as a result.
8. Landlords intentionally raising rent until it forces people to leave.

Obstacles to finding or keeping housing include being unaware of Section 8 housing rules, poor previous landlord references, poor credit history, being in debt, no-cause evictions, or evictions for reasons such as having too many people in the home or not keeping the home clean. Multiple housing discrimination issues were reported, with landlords taking tenants with housing vouchers over people who are working due to the guaranteed rent. It was reported that people may not get an apartment if they have a criminal record or may be discriminated against based on race. There was a belief that property owners are not held accountable for their treatment of tenants.

People who are unhoused are reported to live in cars, couches, forests, encampments, abandoned buildings, motels, and under bridges. They are living in hard physical conditions: being exposed to the elements, sleeping in difficult positions to stay warm, living in unsanitary conditions, with no access to drinking water, limited food, and being exposed to unsafe situations. It is hard to manage illnesses, take care of an injury or wound without it getting infected, or keep medications, especially those that need refrigeration. Some would rather be in jail than on the streets because that way they know they will have a meal and a place to sleep. Others generate crisis situations to go to the emergency department to be safe, sheltered, and away from extreme weather conditions: **"If the only option that you might have for staying indoors when it's negative 10 outside is to figure out a health crisis so you can stay in the ER for the night, you're going to do that."**

There are numerous health impacts of not being permanently and safely housed. As one participant stated, **"If we don't have stable housing, none of the rest of it's going to come together. There won't be stable mental health. There won't be stable physical health. There won't be stable nutrition. There can be stable nothing if we don't have stable housing."** People become less healthy as they live outdoors or in a hotel, and as a result they may need a higher level of services after they find housing. One person summarizes, **"While people's health care and safety in their body is so important, it gets**

kicked down lower on the list when the basic need of shelter is not met."

Finding a safe and permanent shelter is the first step towards health and well-being for this population. People may arrive at shelter with multiple health issues or experiences of trauma. Once they know they are safe, they are better able to focus on connecting with community services and supports.

There is not enough capacity in shelters to house all those experiencing homelessness. Some shelters do not allow residents with a criminal history or active substance use. There are night-by-night shelters, where people line up and hope their number will be called and they will get a bed for the night. **"I'll talk to somebody unhoused and say, 'Well, does somebody know when the shelter opens? Is there somebody keeping tabs on you that will tell you it's open?' They say, 'No, we hear it through the grapevine.'"** Participants state that shelters are not designed to meet a diverse array of needs, such as accommodations for people with disabilities, older people and people who are transgender. For example, there may be no single rooms, and group rooms are by gender. Shelter staff want to support all people who need housing but are unsure what to do given the constraints of the system.

Some shelters allow residents to stay until they have stable housing. These longer-term shelters are said to have case managers who help the unhoused access needed resources. Due to the limited housing options in Vermont, people often stay in these temporary shelters for more than a year. There are people ready to rent, who have reached that stability, but there are no available places for them to move to, so they remain in the shelter.

Multiple bureaucratic hurdles to accessing health care were shared: people need identification, birth certificate, and records from previous providers to start Medicaid or to make a medical appointment. It is hard to do this without a permanent address, as one participant explains **"If you don't have an address, how are you going to update your forms? How are you going to fill them out? Do everything? How are you going to know if you get Medicaid, food, or Snap benefits? Because you don't have a way to get mail."**

> **"We have more and more and more people that either are 65 or older or close and it breaks your heart wondering how are they homeless? Why are they homeless?"**

Participants report that information about health and social services is not easily found or understood by those who desperately need it. Many people are not sure what benefits they can access, what the rules are, or when changes to these rules are made. They spend a lot of time filling out documents or trying to access help. This is made more difficult when there are language barriers.

People who are unhoused report receiving poor quality health care. Medical professionals are not believed to put in the effort to hear and address their issues. One participant explains, **"It's hard when you see the same people come in and out…It's got to be taxing…to see the same fifty people come in and out with the**

same problems…Probably there's something going on that's causing them to have those problems over and over again. So rather than looking down your nose at them…maybe you should try to figure out how to help them not have that same problem over and over again…"

People who are unhoused spoke of widespread discrimination based on socioeconomic status: not being taken seriously in the emergency department, being dismissed as drug-seeking or dangerous. They are told to get a job, and that they have brought their housing situation on themselves. Discrimination based on substance use background was brought up frequently as well, expressing they are not taken seriously when they have health concerns, are dismissed when they seek help, and feel ostracized, looked down upon and judged for their circumstances. One participant describes **"I'm like, so nervous, like when I've had to go to the emergency room when something's been wrong. And they look at my records and it's, you know, in my records that I have substance use disorder, their whole demeanor, their whole attitude, the way they treat me completely shifts and changes, and then I'm treated like some junkie that just can't manage to get narcotics…I don't want the drugs. I can get better drugs on the street myself. What I want is to know what's wrong with me and fix that situation. And I shouldn't be made to feel like I'm less than because I happen to have a drug problem."** Another participant illustrates the frustration of not being taken seriously by health care providers, describing the role they played as an advocate for a person who was unhoused, **"…it was only because I screamed that this needs to be fixed right now…you shouldn't need that advocate, the advocate should be the medical provider. You should be able to take the time to figure out what's going on and hear all the issues and make it comfortable so that the person can tell the issues they have."**

People who are unhoused were said to often have unmet health care needs, as health insurance does not cover some essentials, such as eyeglasses, podiatrist care, or tooth extractions. This population lives with a lot of dental pain, going without dentures, with infected teeth, only eating soft foods, and not smiling. Patients are being discharged into the streets from a hospital bed after a medical procedure or rehab. One participant states, **"When I think about somebody who goes to the ER and their issues are addressed, it blows my mind that we then let them go back out to the street. Do you know what I mean? They are discharged from the ER and then back to the street."**

"If we don't have stable housing, none of the rest of it's going to come together."

Transportation is a significant barrier to accessing services. People are much less likely to get to medical appointments, pick up medications, get food, access recovery centers, or apply for public benefits if these are not within walking distance. Participants describe the added difficulty of walking or using public transport in the winter and in rural areas where there is very limited public transportation.

Mental health struggles are inherent to the experience of being unhoused. Constantly thinking of survival is stressful, and participants describe living in constant fight or flight, feeling drained and hopeless, and struggling to live with low to no income and no support system. People

experience significant emotional stress not knowing where they will sleep each night, where their children are going to school, how and if they can get to work, if they will be moved to a different shelter or housing location having to start anew, and if temporary shelter will be taken away. This leads to a feeling of powerlessness over one's circumstances.

"Every addiction is because of mental health."

The process of getting mental health support is lengthy, waiting months before getting appropriate medication or treatment. When getting services at a mental health or substance use facility, some people receive a diagnosis they do not fully understand or are put on medication without understanding how to manage their condition.

Across the board, people believe the state is not providing a crisis response and mental health treatment for those in need. One participant says, **"We have people coming into the shelter with mental health and substance abuse issues that we can't handle alone on our own and it's just very challenging to find there's not enough mental health or substance use or abuse help out there."** There are not enough beds for people in mental health crisis. Many people are living with mental health needs that are far greater than the services they can access. One participant underscores the extent of the lack in mental health services, stating **"Whatever you guys can do to help make the state and federal government really realize that we wouldn't have all the substance abuse issues. We wouldn't have all the crimes, we wouldn't have all this homelessness, there's so many things we wouldn't have if we had a better mental health system."**

"Every addiction is because of mental health." Many people note that some are turning to alcohol and drugs to medicate mental health conditions. In addition, there are seen to be triggers for use in the streets and shelters. In low barrier shelters, where people are not required to be totally abstinent at all times, it is reported that 100% of residents have a history of substance use or are currently using. Many people relapse quickly after getting out from short rehabilitation stays. Emphasizing the interrelatedness of mental health and substance use, one participant states, **"Mental health and substance use disorder really overlap a lot. They're using for a reason. Most of the time, it's to escape something and once you stop using, it's just all back, it's all there again, now everything you're trying to escape is still there."** Many are not connected with a mental health provider. Those who are, may feel they are not treated well or sufficiently supported in their needs. Instead, they may turn to substances to cope, as this focus group discussion shows: **"Interviewer: 'If somebody wants to get help with mental health problems or substance abuse problems, where do they go?' Participant: '...you go to your local dealer.'"**

Others turn to alcohol and drugs to be able to handle the harsh conditions of living unhoused, as this participant notes, **"We stayed in a tent all along last year, the only things that mattered were staying warm and having food and stuff. Honestly, for myself, it pushed me into using more drugs and alcohol and stuff, so I can feel like I'm not freezing to death that night just so I can get some sleep."**

Those living with substance use disorders may experience overdoses and wounds, such as from xylazine. Many in this community experience multiple chronic health conditions, such as diabetes, pulmonary issues, wounds (frostbite,

diabetes, xylazine), infections, broken bones, living with chronic pain, substance use, mental illness, and cancer. These conditions often go untreated, or people turn to the emergency department for care.

On a positive note…

There is promising work already happening to bring services and resources into temporary housing and shelters. As one participant said,

"I think [it] is helpful in creating relationships and building a team of providers through other service providers and having contracts with those agencies to provide services on site. So, we have case management on site… We just connected with our low barrier shelter to have (a local provider) come in for skilled nursing two days a week for wound care and foot care and address other acute needs of our guests that don't have access to transportation, maybe to get to the clinic."

Older Vermonters

At a glance: Vermont has one of the oldest populations per capita in the country. The proportion of people living in Vermont who are of an advanced age is growing quickly, and the workforce capacity needed to provide them with care is shrinking.

People who are aging face difficulties such as avoiding injury, social isolation, increasing costs of basic needs, fixed income, and declining vision and hearing. Transportation is an enormous barrier, as are limitations in inventory of accessible housing options. Increasing medical needs include hip fracture, dental concerns, dementia, and having multiple conditions to manage at the same time and often clash with fixed incomes and unaffordable medical care and medication. Many desperately need Medicaid and are over the income limits. Insurance and Medicaid are often not sufficient to address increasing medical needs.

This population is very vulnerable to situations that could cause loss of housing. There are not many options for downsizing homes in Vermont, leading people to stay in homes that are difficult and expensive to maintain, and there is an increase in the number of older Vermonters who are unhoused.

The proportion of people living in Vermont who are older is growing quickly. The older people get, the more likely it is that their medical and physical limitations are becoming more significant. At the same time, the workforce and services needed to provide them with care is shrinking. There are inadequate levels of services and housing for this population. That is especially felt in rural locations, where those who can no longer drive have little access to transportation, to getting groceries or medications, and to attending medical appointments. One participant states, **“It’s getting a little scary when you look towards the future and you look at more and more**

people aging, and how are we going to care for all these people…particularly when you have people out on the outskirts that are 40 minutes from anything, from getting a gallon of milk."

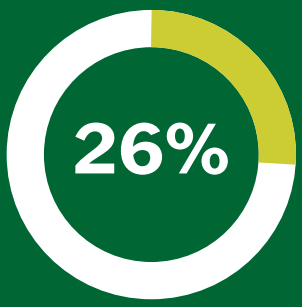
The capacity to care for those with increasingly significant physical or medical limitations is more involved. When this happens, there are very few places for older people to go if they do not have the financial means. As a result, many older Vermonters age at home, where they may not be safe any longer or where they do not have support coming into the home on regular basis. While there are some existing organizations to help, like UVM Home Health, Meals on Wheels, and Home Instead, these programs are very stretched. Participants also discussed the impact of care on able-bodied spouses or adult children who provide care. Some aging adult children in their 60s and 70s also take care of their elderly parents. Providing this care is very intensive and time-consuming and can have negative effects on the caregiver's financial, physical, and mental health. For older people who are unhoused, shelters may not be equipped to meet their personal health needs. Older Vermonters may experience more falls and accidents, have a higher exposure to sickness, and higher levels of stress if they are not safely housed with the needed level of care and services.

Participants expressed several housing concerns for this population. Older Vermonters are more vulnerable to loss of housing than in the past. Situations like a spouse dying, getting COVID-19, or needing intensive care or hospitalization may result in getting behind on rent or mortgage payments. There is an increasing number of older Vermonters who are unhoused: **"You got 70- and 80-year-olds out on the street."** There are no appropriate

Older Vermonters Statistics

2/3
have trouble accessing health services

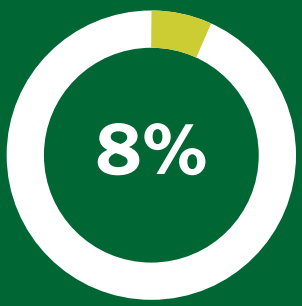
Two-thirds of older Vermonters report challenges accessing needed community health services. *(2020 Needs Assessment of Vermonters Age 60+ and Their Family Caregivers, evaluation report)*



About 26% of older Vermonters live alone. *(Vermont State Data Center, 2021)*

20+
hours per week

Among Vermonters providing care to family members or partners, over half provide support more than 20 hours per week. *(2020 Needs Assessment of Vermonters Age 60+ and Their Family Caregivers, evaluation report)*



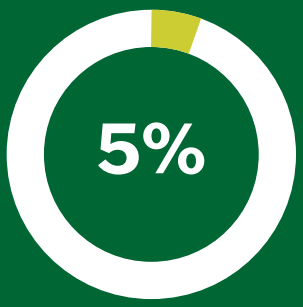
8% of adults age 65 and older lived below the poverty level in the past 12 months. *(U.S. Census American Community Survey 1-year estimates, 2021)*

and affordable housing alternatives available when wanting to downsize, as one person describes, **"We haven't thought about the fact that part of the weird pressure on the system is that more and more people are aging alone in old houses that no longer serve them."** People are aging with their housing. Housing accessibility options are limited, as there are very few housing options for people with walkers, canes, and chairs. People need accessibility options such as downstairs apartments, ramps, and accessible bathrooms.

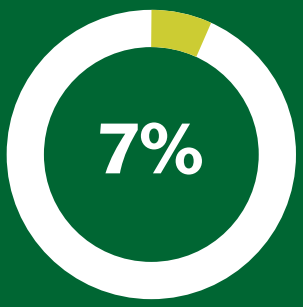
This community profoundly feels the high cost of medical care and increased need. Adult day care, hospital stays, emergency department, ambulance services, home health, and nursing homes are all very costly. Many of those with any significant diagnosis—cancer, lung infection, needing dialysis—cannot afford services. Some describe situations where they cannot pay the enormous bill and have no other option than being sent to collection. **"The cost is just totally ridiculous to afford. We're talking a hundred thousand dollars here that this hospital got out of me. It's not right. It shouldn't be that expensive. They're making a profit. Half the time I spent down in the ER because there was no bed. There's no reason to keep raising the cost of health care."** Older people who cannot afford eyeglasses, hearing aids, and dentures have a harder time being a part of and interacting with their community and are further isolated.

Insurance and Medicaid do not cover, partially cover, or have stopped covering essential medications, eyeglasses, hearing aids, dentures, insulin, vitamin D, antihistamines, vaginal estrogen, and other items that are important for this population. Medicaid

Older Vermonters Statistics



5% of adults age 65 and older report always or usually feeling socially isolated from others. *(VT Behavioral Risk Factor Surveillance System, 2022)*



7% of adults age 65 and older delayed dental care due to cost. *(VT Household Insurance Survey, 2021)*

41%
are caring for someone with dementia

Among Vermonters providing care to family members or partners, 41% said they are supporting someone with a form of dementia. *(2020 Needs Assessment of Vermonters Age 60+ and Their Family Caregivers, evaluation report)*

income and age restrictions are a huge barrier to accessing direct care, such as long-term care and home care. Many families with family members who need regular assistance with daily living cannot afford private pay caregiving services, make a little over the limit to qualify for Medicaid, and are stuck with no care at all as a result. **"A married couple is early 60s where one spouse is disabled and the other is making $30,000 a year with crappy insurance or no insurance who don't qualify for Medicaid because they're over the income limits are stuck."**

Housing and medical needs make up a big part of the overall high cost of living picture for this community. People in retirement have limited fixed income, and no ability to respond to inflation, and increases in taxes, food, medications, house maintenance, bills, medical bills, and rent. The cost-of-living increases in benefits are inadequate. **"When you know you're on a fixed income and you're keeping it all together, every letter that comes in the mail can be scary and hard to read and understand. So, "Is this from Medicaid? Medicare? Is it a Medicare Advantage plan? Is this from Social Security? What's going to happen next? Am I going to get less of this? Is my health insurance going to go up? Will I still be able to make ends meet? And then if they raise my rent..."** There's just a razor-thin line to make it every month.

Many older Vermonters describe working hard their entire lives and contributing to their communities, only to struggle at the end of their lives. They cannot afford care, while increasingly needing it more.

Isolation is a repeating theme due to grief and loss of loved ones, chronic illness, and having small and declining friend networks.

One participant described elderly people in their community sitting inside their apartments and not talking to anyone all day. There are increased requests to respond to isolation, loneliness, depression, and anxiety. Those in rural communities, who are unable to work, have a disability, or those who never had children, feel further isolated. **"There used to be a really tight community, and we're losing that, and that is terrifying. Community is what makes life worth living, whether it's family within your home, neighbors, townspeople, or church; it's what makes the world go around. And I feel like that is kind of crumbling."**

"There used to be a really tight community, and we're losing that, and that is terrifying. Community is what makes life worth living..."

Some describe discrimination based on socioeconomic status and the type of insurance they carry. Age-based discrimination by health care providers was also described. Participants described providers not trying to get to the root of their problem, not giving the time to talk about their ailments, and prescribing medication without looking at their overall health and functioning. Participants spoke about being treated poorly in health care settings for moving slower or not understanding what someone is saying.

Among the specific health concerns discussed were diabetes, hip fractures and falls, dental care, cost of medications, and dementia. There are very few beds, skilled nursing, and rehabilitation

services available after a fracture. Participants voiced dental concerns, especially affordability of dentures and the overall lack of dental providers in the state. Another common theme was being unable to afford medications. One example was of a retired teacher who pays $400 a month for medications with insurance. There are hearing and vision concerns, including concerns about being able to afford hearing aids and eyeglasses. Alzheimer's, Parkinson's, and other dementias are increasing in the state. These issues are made more challenging when a person is managing multiple conditions at the same time. Participants expressed concerns about depression, anxiety, and higher suicide rates in this community.

One illustrative quote shows how many of these barriers and conditions come together: **"It took months to get [elderly person] in who had rotting teeth, who couldn't get [their] hip surgery because of…rotting teeth. So it took us months to get that appointment and coordinate the transportation and do all those fun things in order for now…hip to get replaced. And we only figured that out because [they were] about to get evicted because…housing was in squalor because [they] couldn't move to clean it. […They have] fallen into a great depression because [they] can't move around…apartment or use anything, and…body hurts so much. Now we've been working with [them] for a year, [they] gotten all…teeth removed, but have no teeth. [They have] no dentures because now we need to figure out how to pay for that and get assistance with that and [then] hand surgery, and then…scheduling [their] hip."**

On a positive note…

Participants discussed existing services available for older Vermonters, including effective care coordination. They also discussed the commitment from state and community partners to expand access to services.

"We have a program here which works with our elderly population. All of those folks sort of really work together and they work with our care coordinators as well. If our care coordinators know a patient lives in [our] facility they work with those people. So, it's just sort of having a quarterback in the middle of it. And so, in our office, that quarterback happens to be our care management team, and they sort of assemble the resources that the patients may need."

"I think right now there are agencies or entities in the state…who are very, very eager to improve dementia services and resources in the state…the desire is really strong to improve these services."

Data Limitations

The following are limitations to the data included in this report. They are all common to secondary data reviews and community-based qualitative data collection and do not undermine the value of these findings.

- Many of the communities of focus included in the secondary data review are relatively small and are consistently underrepresented in large, public data sets. Their data may be intentionally withheld in these data sets so as not to identify people. This can lead to a limited understanding of how health factors affect these communities.
- Some communities have considerably fewer data sources reporting on their health status overall, especially for Indigenous People and people who are unhoused.
- The purposive and snowball sampling techniques used in the community engagement process may be skewed towards organizations and people that are naturally inclined to be involved in a health needs assessment, which can influence the nature of the data received. Specifically, it can shift the data received towards those who already have a vested interest in their own approaches to addressing public health needs.
- Although there was strong representation of people who identify as members of the communities of focus, that does not mean that the data provides a complete, unbiased plurality of opinions from these groups, which can affect the generalizability of the data.
- The framework for health for this process was mostly developed by those who hold power (public health institutions, state government groups, and community organizations involved in similar work). Concepts like health or health needs may in themselves be looked upon differently, depending on culture and community.

Where to Learn More

The findings presented in this State Health Assessment are not an exhaustive overview of what we know about the health and well-being of people in Vermont. The Department of Health provides access to other data, including local and community-specific data, visualizations and maps, and trends in how data has changed over time. Examples include:

- Population health surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS), and Pregnancy Risk Assessment Monitoring System (PRAMS)
- Reports, briefs, dashboards about health equity, inequity, and disparities
- Topic-specific data, such as Substance Use Data and Reports, Health Care Systems Reporting, and Environmental Public Health Tracking.

View additional data resources from the Vermont Department of Health at How Healthy Are We? Data Resources and Health Statistics & Vital Records.

Appendix A: Key Partners

Steering Committee members

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Jacqueline Rose
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Abby Erwin
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Vermont Association of Hospital and Health Systems

Mary Kate Mohlman
BiState Primary Care Association

Breena Holmes
Vermont Chapter of the AAP / Vermont Child Health Improvement Program

Matt Wolf
Vermont Afterschool

Yacouba Bogre
Association of Africans Living in Vermont

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LISTEN Community Services

Sam Peisch
Vermont Legal Aid

Sarah Launderville
Vermont Center for Independent Living

Weiwei Wang
Vermont Health Equity Initiative/ Vermont Professionals of Color Network

Chief Don Stevens
Chief of the Abenaki Nulhegan Band

Jasper Lorien
Vermont Youth Council

Ruth Steinmetz
Consultant and community advocate

Organizations that helped arrange focus groups

Abenaki Missisquoi Band

Abenaki Koasek Band

Abenaki Nulhegan Band

Abenaki Elnu Band

Alliance for Community Transformation (ACT) and Queer Connect

Atowi

Building Bright Futures State Advisory Council

Community and Economic Development Office (CEDO)-Trusted Community Voices

Vermont Department of Children and Families

Vermont Department of Health

Elmwood Pods and Harbor Place (Champlain Housing Trust)

Health Care and Rehabilitation Services

Healthworks/Blueprint

Lamoille Health Partners

NAACP of Windham County Health Justice Committee

Northeast Kingdom Learning Services

Northeast Kingdom Prosper!

Northeastern Vermont Regional Hospital

Open Door Clinic

Out in the Open

ReLeaf Collective

Rutland County Pride

Samaritan House

Social Tinkering

Sunrise Family Resource Center

Support and Services at Home (SASH)

The Clarina Howard Nichols Center

The Janet S. Munt Family Room

The Family Place

The HUB

The Vermont Professionals of Color Network

Turning Point Center

Vermont Afterschool

Vermont Association for Mental Health and Addiction Recovery

Appendix B: Environmental Scan Data Sources

1. County Health Rankings, University of Wisconsin Population Health Institute. Resources include:
    a. VT Department of Health Population Health Surveys and Data
    b. VT Department of Health Environmental Public Health Data Tracking
    c. VT Agency of Education Data and Reporting
    d. VT Cancer Registry
    e. VT Crime Information Center
    f. VT State Highway Safety Office
    g. VT Health Statistics and Vital Records
    h. VT Vaccination coverage
2. CARES database, University of Missouri. Data compilation is from many resources, including but not limited to:
    a. US Census Bureau
    b. American Community Survey (ACS)
    c. Centers for Disease Control and Prevention (CDC)
    d. United States Department of Agriculture (USDA)
    e. Department of Transportation
    f. Federal Bureau of Investigation
3. Behavioral Risk Factor Surveillance System (BFRSS 2021)
4. VT 211 Referrals 2022
5. Health Equity for Abenaki Indigenous People: Improving Access to Quality Mental Health and Substance Use Services by Maria Mercedes Avila, Christine Begay Vining, Joshuaa Allison-Burbank, and Christine Velez
6. 2021 Vermont Household Health Insurance Survey
7. Title V Maternal and Child Health Block Grant FY23 Application/FY21 Annual Report
8. 2022 Vermont Point in Time Report of People Experiencing Homelessness

9. 2023 Vermont Point in Time Report of People Experiencing Homelessness
10. Health Center Program Uniform Data System (UDS) Data
11. Census Brief: 60+ Elders in Vermont
12. Vermont Local Opinion Leader Survey, April 2022
13. VT Department of Mental Health Vision 2030
14. State Youth Advisory Group Health Equity Report
15. WIC participant satisfaction surveys
16. Monthly Opioid Morbidity and Mortality Report, VT Department of Health
17. Fatal Overdoses in Vermonters by Age and Circumstance, VT Department of Health
18. Vermont Cannabis Data Pages, VT Department of Health
19. Alcohol Related Deaths Among Vermonters, VT Department of Health, January 2023
20. Listening Session Report: Vermont Action Plan for Aging Well
21. Mental Health in Vermont, National Alliance on Mental Illness (NAMI)
22. Health Services Wait Times Report Findings, February 2022
23. Rural Literacy and Public Libraries, VT Department of Libraries
24. Vermont: Why Arthritis Matters, Arthritis Foundation
25. How Extreme Heat Affects our Mental Health, NPR
26. With Pandemic Aid Ending, Vermont's Homeless Are Forced From Hotels, New York Times
27. Vermont's population estimates by age group: 2021 compared with 2010, VT Legislative Joint Fiscal Office
28. State of Homelessness: Vermont, National Alliance to End Homelessness
29. Unmet health needs and barriers to health care among people experiencing homelessness in San Francisco's Mission District: a qualitative study, Thorndike, A.L., Yetman, H.E., Thorndike, A.N. et al. BMC Public Health 22, 1071 (2022).
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31. Heat and Houselessness: Health Impacts and Unmet Needs, VT Department of Health, June 2023

32. Climate and Health, Infectious Diseases, VT Department of Health
33. COVID Conversations: Preliminary Findings & Recommendations, REJOICE Project, December 2020
34. The State of Vermont's Children: 2022 Year in Review
35. Policy Recommendations from Vermont's Early Childhood State Advisory Council Network
36. VT Cancer Data Pages, VT Department of Health, February 2023
37. State-level health care expenditures associated with disability, Khavjou, et al. 2021 Public health rep.
38. The Health of Vermonters Living with Disabilities, VT Department of Health, August 2018
39. Healthy People 2030, U.S. Department of Health and Human Services
40. 3>4>50 Vermont, VT Department of Health
41. Homelessness and Health, What's the Connection?, National Health Care for the Homeless Council, February 2019
42. Health Disparities Faced by LGBT Students of Color, April 2022