

# VERMONT DEPARTMENT OF HEALTH MATERNAL AND CHILD HEALTH DIVISION

## TITLE V FIVE-YEAR NEEDS ASSESSMENT

SEPTEMBER 2020

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# EXECUTIVE SUMMARY

As a recipient of Title V funds, the Vermont Department of Health (VDH) Division of Maternal and Child Health (MCH) is required to complete a statewide, comprehensive needs assessment every five years to identify needs for, and capacity to provide:

- Preventive and primary care services for pregnant women, mothers, and infants up to age one
- Preventive and primary care services for children
- Services for children with special health care needs

This needs assessment was conducted from July 2019 through February 2020 in accordance with Vermont's State Health Improvement Plan, which envisions that *"All people in Vermont have a fair and just opportunity to be healthy and to live in healthy communities."* The assessment focused on understanding strengths and needs across Vermont for MCH's five identified population domains, (1) women's and maternal health; (2) perinatal and infant health; (3) children's health; (4) adolescent health; and (5) children with special health needs.

Across these population domains, Vermonters tend to be healthier than their peers nationally on most health conditions and behavioral risk indicators. Overall, the services MCH provides under Title V are well aligned with the needs that were identified across Vermont. The generally strong health outcomes MCH indicators reveal provide strong evidence of all that is "working well" within MCH systems of care. The needs assessment found several important themes that cut across all MCH's work:

- 1. Addressing basic needs and social determinants has a direct impact on the health of MCH populations.** Especially in light of the COVID-19 pandemic, the primacy of meeting basic needs as a cornerstone of public health was well founded throughout this assessment. To the extent that the health care system (and children's medical homes) is the point of access for families to address physical, emotional, developmental, and behavioral needs, integrating (and potentially shifting resources to) basic needs responses such as affordable housing or accessible transportation may alleviate the resource gaps that eventually show up as unmet health needs and risks.
- 2. Consumers and providers are concerned about the prevalence of mental health issues and the availability of care.** Topics related to depression, anxiety, suicide and postpartum/ maternal mental health issues were identified for all MCH populations. Needs assessment participants were especially concerned about the limited availability of mental health providers who specialize in serving families, young children, and adolescents as well as those who are trained to address postpartum mental health conditions.
- 3. Regional differences in levels of care may undermine equity and positive results in some areas of Vermont.** In Vermont's most remote counties, residents must travel outside of their region to receive many kinds of services and specialty care. Identifying opportunities to standardize

the quality and level of care for MCH-supported services has the potential to mitigate a variety of identified needs.

- 4. Building relationships and informal connections contributes to health and wellness for MCH populations.** Individuals in all MCH populations seek more opportunities to reduce isolation and connect, including through informal and peer support settings.
- 5. Seek opportunities to replicate effective programs and services** such as the Developmental Understanding and Legal Collaboration for Everyone (DULCE) model (see *Formal and Informal Collaborations and Partnerships for a description*), home visiting, and many traditional Title V/ MCH programs such as those that support breastfeeding, provide postpartum and well-baby care, and pregnancy prevention.
- 6. Address the full scope of MCH health needs among Black, Indigenous, and People of color (BIPOC) communities.** In this assessment, MCH providers and services users rarely discussed the health needs and concerns among BIPOC communities who are not immigrants or refugees. The low visibility for the health concerns that BIPOC mothers, infants, children and adolescents face warrants continued investigation. Amid Vermont's shifting racial demographics, and in light of historic health disparities and structural inequities, all health and human services must consider how well they are equipped to provide high quality care for BIPOC communities.

**The Vermont Department of Health (VDH) Division of Maternal and Child Health (MCH)** provides programming across the life course: before, during and after pregnancy, and throughout infancy, early childhood and the school years, with an emphasis on adolescents and young adults, recognizing that the health and wellness of Vermont's women, children and families is fundamental to the health of all Vermonters, under the its vision that *"strong, healthy families power our world,"* and mission to *"invest in people, relationships, communities and policies to build a healthier Vermont for future generations."*

Vermont MCH provides direct services, linkages and referrals, population-based supports, education and monitoring, quality oversight, and policy and systems development. MCH supports professionals who work with children and families in health care, early care and education settings, and with human service agencies, and collaborates with partners across Vermont and nationally to achieve high quality health and health care for children and families. These efforts are family-centered, evidence-based and data-driven. The Title V funds Vermont receives are applied across all of MCH's efforts, directly or indirectly serving thousands of Vermonters every year.

# 1. INTRODUCTION

Title V is one of the largest federal block grant programs, and a key source of support for promoting and improving the health and well-being of mothers, children, including children with special needs, and their families across the United States. In 2018, it was estimated that Title V supported services reached 91% of all pregnant women, 99% of infants, and 54% of children nationwide.

The federal funding goals for Title V are to create federal and state partnerships that support:

- Access to quality health care for mothers and children, especially for people with low incomes and/or limited availability of care
- Health promotion efforts to reduce infant mortality and the incidence of preventable diseases, and to increase the number of children immunized against disease
- Access to comprehensive prenatal and postnatal care for women, especially low-income and/or at-risk pregnant women
- An increase in health assessments and follow-up diagnostic and treatment services, especially for low-income children
- Family-centered, community-based systems of coordinated care; access to preventive and childcare services; and rehabilitative services for children with special health needs

*“The ideal system of care: Health professionals, human service professionals, patients and families working together with shared goals of excellent population health supported by optimal connections to myriad community services that can help achieve great outcomes.”*

*~ MCH Agency Partner*

As a recipient of Title V funds, the Vermont Department of Health (VDH) Division of Maternal and Child Health (MCH) is required to apply for funding each year, to submit an Annual Report, and to complete a statewide, comprehensive needs assessment every five years. Each state has discretion over what services and programs to support with Title V funding within the scope of its statutory purpose as set forth by Congress each year. Each state’s funding allotment is determined by a formula, which considers the proportion of low-income children compared to the total number of low-income children in the entire U.S.

This statewide maternal and child health needs assessment has been conducted in accordance with the federal mandate that states must conduct an assessment every five years to identify needs for, and capacity to provide:

- Preventive and primary care services for pregnant women, mothers, and infants up to age one
- Preventive and primary care services for children
- Services for children with special health care needs

This needs assessment was conducted from July 2019 through February 2020 in accordance with these statutory mandates and priorities, with a broad goal of ensuring that Vermont’s women, adolescents, children, children with special health needs, as well as all parents and families have what they need to be healthy and well, in accordance with Vermont’s State Health Improvement Plan, which envisions that *“All people in Vermont have a fair and just opportunity to be healthy and*

*to live in healthy communities.*” The assessment focused on understanding strengths and needs across Vermont for MCH’s five identified population domains:

- women’s and maternal health
- perinatal and infant health
- children’s health
- adolescent health
- children with special health needs

Results will inform future MCH efforts to improve health and access to care for women, infants, children, adolescents, and families.

## 2. GOALS, FRAMEWORK AND METHODOLOGY

Assessment activities were conducted independently by Noonmark Services, a Burlington-based consulting firm with expertise in public health assessment and evaluation, strategic planning, and organizational development. Noonmark worked closely with MCH staff leaders to establish the scope of the assessment inquiry, to develop assessment plans and instruments, and to reach a wide cross-section of MCH leadership partners, stakeholders, service users, and members of the community at-large. Vermont's Title V assessment was conducted concurrently with a five-year needs assessment for the Maternal, Infant, Early Childhood Home Visiting (MIECHV) program, as many states have done, in accordance with federal guidance from both programs. Vermont stakeholders concurrently conducted a statewide needs assessment of Vermont's early childhood systems under the Administration for Children and Families Preschool Development Birth through Five (PDG B-5) grant, which provided some additional data because MCH is a PDG B-5 stakeholder. Data from this assessment have been used for both the Title V and MIECHV needs assessment reports. The assessment received a Vermont Agency of Human Services Institutional Review Board (IRB) waiver.

Noonmark conducted interviews with Vermont state agency partners and leaders, as well as MCH division staff members. Data from these interviews were summarized and used to formulate plans to reach priority populations from all regions of the state, and to reflect MCH's five identified population domains:

- women's and maternal health
- perinatal and infant health
- children's health
- adolescent health
- children with special health needs

The assessment team collected and reviewed data from a variety of state-level public health surveillance systems to identify key topics for the assessment. The assessment team generated two open-ended focus group question lists for (1) service providers and practitioners and (2) consumers/service users and community members. A focus group plan was established to reach identified groups in each region of Vermont. Question lists are provided in Appendix 1.

An online community survey using Survey Monkey was developed, drawing on published MCH community needs assessments from other states to develop the survey questionnaire. The survey was disseminated via MCH partners and stakeholders, as well as by purchasing statewide distribution via Front Porch Forum, a statewide email listserv for community information exchange (Figure 1). These methods engaged individuals who reside in and/or who provide services for individuals in every Vermont county. The assessment included focused efforts to reach Vermont BIPOC residents, including immigrant and refugee parents and families, as well as youth (ages 13 to 18).

## STAKEHOLDER INVOLVEMENT, INCLUDING FAMILIES, INDIVIDUALS AND FAMILY-LED ORGANIZATIONS

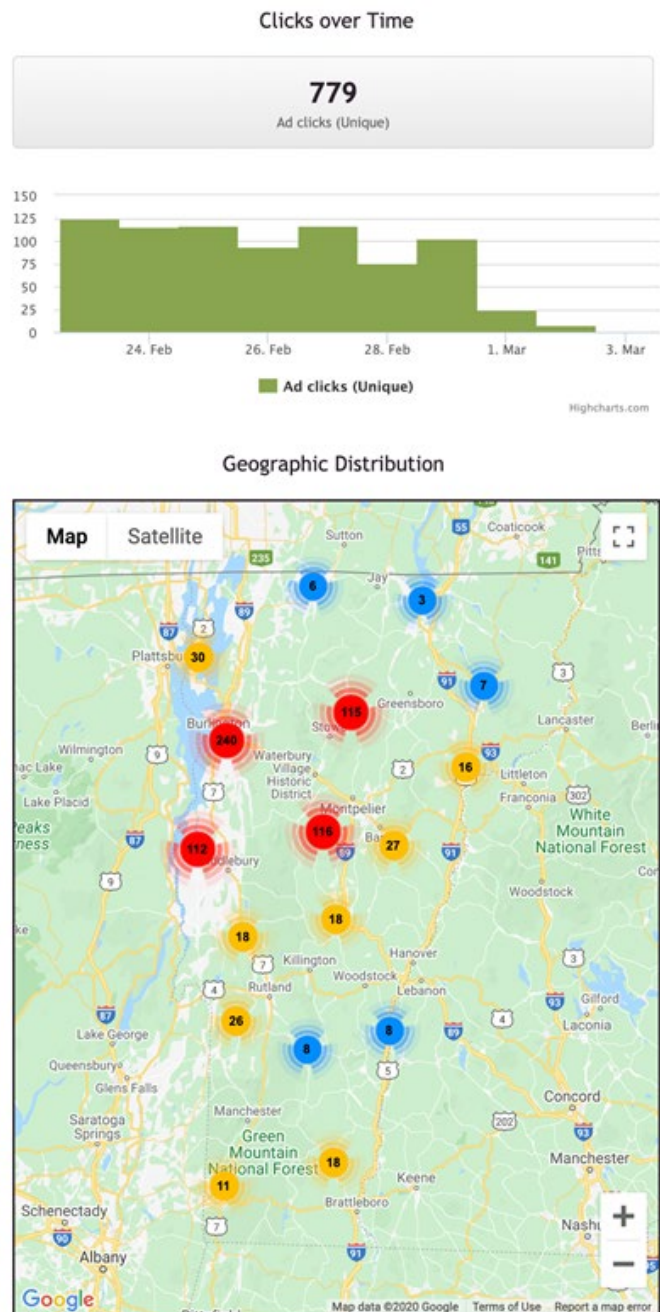
Using the methods described above, Noonmark collected assessment data from 466 individual contacts, as described in Table 1. In total, 28% of contacts were people who administer or provide services to MCH populations and 72% were people who use MCH services, have used services in the past, or are members of the larger community, including parents, grandparents, foster parents and guardians, and people who care for children with special health needs.

*State agency and service provider stakeholders:* Noonmark conducted interviews with 17 key stakeholders and ten focus groups with service providers, which engaged 85 individuals. State agency representatives, service providers, and practitioners who participated in interviews and focus groups included representatives from the VT Department for Children and Families, VT Department of Mental Health, One Care Vermont (the state's Accountable Care Organization), Vermont Child Health Improvement Program (VCHIP), VDH Alcohol and Drug Abuse Programs (ADAP), Help Me Grow Vermont, Vermont Family Network, Burlington School District Diversity and Equity Team, the State Refugee Coordinator.

In addition, MCH Coordinators (public health nurses at the local level), Children's Integrated Services (CIS) coordinators, MIECHV nurses, supervisors and other home visiting program staff, primary care and OB/GYN physicians and nurses, MCH Children with Special Health Needs staff, Parent Child Centers, school nurses, and community organizations (mental health, early childhood, youth) participated in the assessment.

*Service users and community members:* The community at large primarily participated via a statewide survey (described under *Quantitative Data*, below). Noonmark worked closely with MCH partners to conduct five focus groups with consumers and community members:

**Figure 1. Front Porch Forum Survey Reach**





- Two groups of immigrant/ refugee parents in Burlington (grouped by language for translation) (20 participants)
- VT Rays high school youth (5 participants)
- Prevent Child Abuse Vermont Parent Support Group- Caledonia County (2 participants)
- Clarina Howard Nichols Center Moms Group- Lamoille County (5 participants)

Each focus group participant who was a service user or community member received a \$20 gift card or cash incentive for their participation. Childcare and interpretation in multiple languages were provided as needed.

## **QUALITATIVE DATA SOURCES**

Interviews, focus groups, and open-ended survey questions provided a substantial body of qualitative data. In these sessions, interviews/ facilitators asked open-ended questions about health and wellness, access to care, needs and concerns, and emerging issues using a pre-planned list of questions. Each focus group or interview had a designated note-taker who documented the session. The assessment team standardized transcripts from each session, removed identifying information, and generated a master transcript. From the master transcript, qualitative data was coded and grouped into domains and themes. Focus group questions are provided in Appendix 1.

## **QUANTITATIVE DATA SOURCES**

Data collected via VDH annual, semi-annual, and special reports, and responses to survey data comprise the quantitative data collected and reviewed for this assessment. Survey results were analyzed using Survey Monkey, Microsoft Excel, and STATA to provide descriptive statistics including totals, averages, percentages, and medians. Raw population-level indicator data from public health surveillance systems was standardized, and Z-scores were calculated to indicate health risks for MCH domains at the state and county levels. Front Porch Forum's analytics and Survey Monkey user data provided information about the survey's reach across the State of Vermont (Fig. 1). Figures 2 through 5 summarize characteristics of those who completed the survey. The survey instrument is provided in Appendix 2.

### Statewide survey responses

- 332 people completed surveys
- Survey responses covered every county except Essex
- 29 survey respondents only identified as service providers (not parents/guardians, grandparents, or caregivers)
- In addition to the multiple-choice questions, respondents provided 192 short-answer responses to open-ended questions about needs, barriers, places they get health information, and emerging issues.

## **DATA SOURCES USED TO INFORM THE NEEDS ASSESSMENT PROCESS**

MCH staff provided state-level indicator data from public health surveillance system sources such as the Behavioral Risk Factor Surveillance System (BRFSS)<sup>1</sup>, Vermont Youth Risk Behavior Survey

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<sup>1</sup> <https://www.healthvermont.gov/health-statistics-vital-records/population-health-surveys-data/brfss>

(YRBS)<sup>2</sup>, the Pregnancy Risk Assessment Monitoring System (PRAMS)<sup>3</sup>, School Health Profiles<sup>4</sup>, and other population-level data systems. Other data sources included recent publications and data summaries from state agencies such as the Vermont Child Health Improvement Program (VCHIP) at UVM and Vermont Department for Children and Families (DCF) annual and legislative reports, and from collaborative efforts such as the recent report from Building Bright Futures, “How are Vermont’s Young Children and Families?”<sup>5</sup>, the Vermont Early Childhood and Afterschool Workforce Report<sup>6</sup>, and the Stalled at the Start report<sup>7</sup> from Let’s Grow Kids and numerous others.

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<sup>2</sup> <https://www.healthvermont.gov/health-statistics-vital-records/population-health-surveys-data/youth-risk-behavior-survey-yrbs>

<sup>3</sup> <https://www.healthvermont.gov/health-statistics-vital-records/population-health-surveys-data/pregnancy-risk-assessment-and>

<sup>4</sup> <https://www.healthvermont.gov/health-statistics-vital-records/population-health-surveys-data/school-health-profiles>

<sup>5</sup> <https://buildingbrightfutures.org/what-we-do/how-are-vermonts-young-children-families-report/>

<sup>6</sup>

[https://dcf.vermont.gov/sites/dcf/files/CDD/Reports/VT\\_EarlyChildhood\\_Afterschool\\_Workforce\\_Report\\_2018.pdf](https://dcf.vermont.gov/sites/dcf/files/CDD/Reports/VT_EarlyChildhood_Afterschool_Workforce_Report_2018.pdf)

<sup>7</sup> [https://www.letsgrowkids.org/client\\_media/files/pdf/StalledatStart2020.pdf](https://www.letsgrowkids.org/client_media/files/pdf/StalledatStart2020.pdf)

Fig. 2. Survey respondents by County

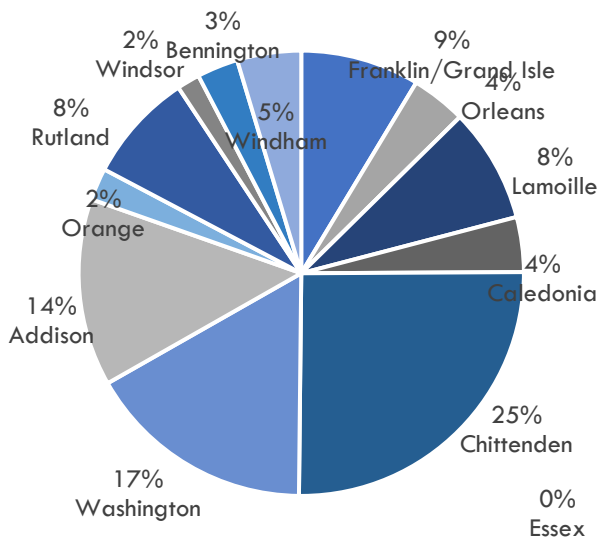


Fig. 3. Gender of survey respondents

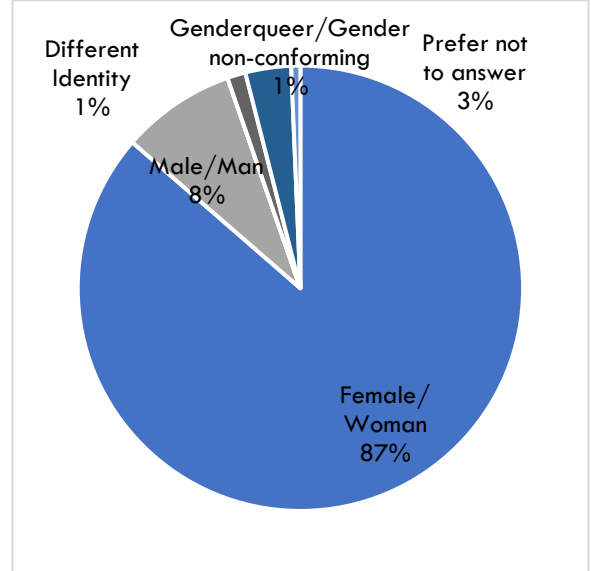


Fig. 4. Race/ethnicity of survey respondents

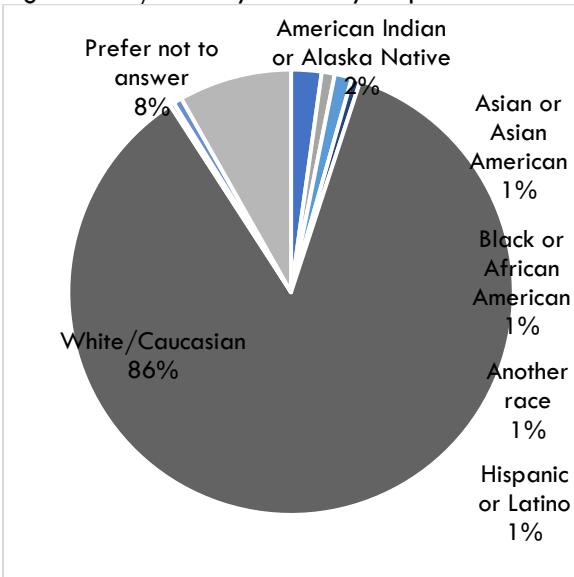
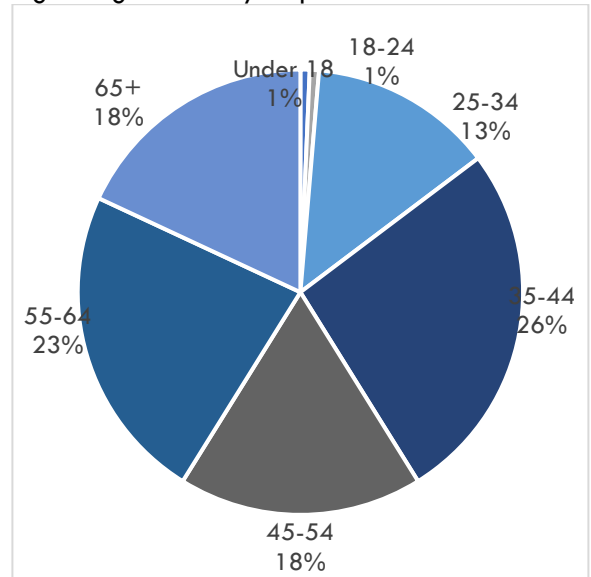


Fig. 5. Age of survey respondents



### 3. FINDINGS

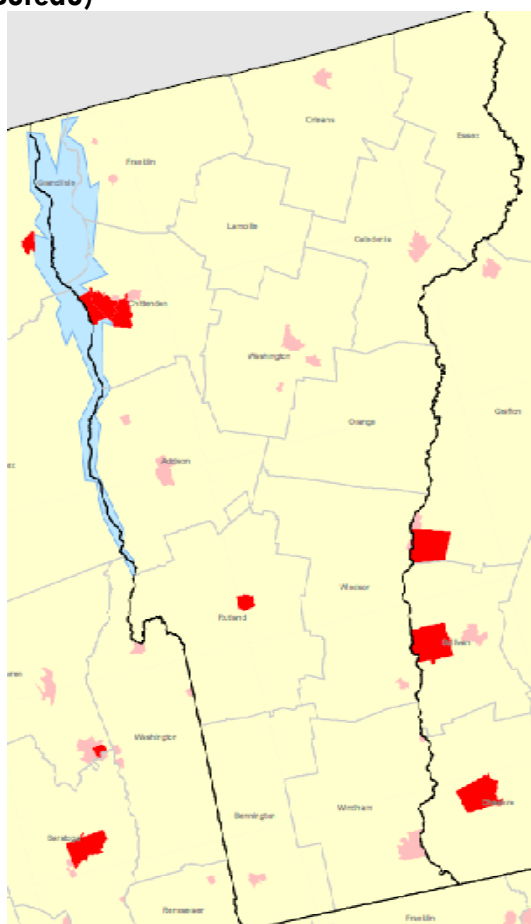
#### MCH POPULATION HEALTH STATUS OVERVIEW

Vermont is home to 257,000 adult women and 118,425 children and youth ages 0 to 18. In FY 18, Vermont's Title V services reached 86% of pregnant women, 94% of infants, 98% of children and youth ages 1 to 21, and 98% of children with special health needs. Women, infants, children, and youth across the life course are generally found to be healthier than their U.S. counterparts across numerous health status indicators. At the same time, factors related to Vermont's rurality, and the unique obstacles rural geography creates for low-income women and families provide a critical context for understanding and interpreting identified needs.

**The role of rurality in maternal and child health:** According to the U.S. Census Bureau, Vermont is the second least populated state and has the highest percentage of rural residents, with 82.6% of the population residing in rural areas compared to only 14% nationwide. Among Vermont's 255 municipalities, only eight have a population greater than 10,000 residents, with an average of fewer than 2,500 residents per incorporated town or city (Fig. 6). Vermont's rural geography and context give the state a distinct social and political character.

Low-income residents of rural counties encounter poorer health outcomes for all ages and sub-populations. In rural Vermont, conditions for low-income women and families can be obscured by state and county-level data because of their small proportion of the population. Vermont's mountainous geography, the limited availability of many kinds of services in small, geographically remote communities, lack of access to public transportation, and difficult winter driving conditions exacerbate the barriers vulnerable populations encounter in accessing services and support. Having access to a vehicle plays a critical role for most Vermonters in their ability to receive healthcare and social services.

**Figure 6. Vermont's Rural status by county (U.S. Census Bureau)**



Areas in dark red are those with a population between 10,000 and 49,999 residents.

Areas in light red are those with a population of 2,500 to 9,999.

Unshaded areas have fewer than 2,500 residents

For MCH populations, access to care, including access to prenatal, OB/GYN, maternity, and perinatal services are more limited in rural areas. In Vermont, declining and aging populations in rural communities contributed to two hospital maternity program closures in the last two years, meaning that women in some southeastern Vermont towns must travel an hour or more to reach labor and delivery services, with greater variability in their access to prenatal care. A recent report on declining access to healthcare in rural New England found that living a greater distance from hospitals has been shown to increase out-of-hospital and pre-term births.<sup>10</sup> HRSA identifies 41 Health Professional Shortage Areas (HPSAs) and 25 Medically Underserved Area/s Populations (MUA/Ps) in Vermont, a measure of limited access to care, in every Vermont county.

**Table 2. Health risk factors among women in Vermont and the U.S.**

Condition or Risk Factor	Vermont Female Adults	United States Adults
Diabetes	8%	11%
Gestational Diabetes	4%	~ 2% to 10% <sup>8</sup>
Prediabetes	6%	34.5% <sup>9</sup>
Cardiovascular disease	6%	9%
Hypertension	21%	30%
Obesity	27%	30%
Overweight	25%	36%
Meet CDC Aerobic Physical Activity Guidelines	59%	51%
Consumed 2 or more fruits per day	38%	29%
Consumed 3 or more vegetables per day	25%	17%
Smoking	12.7%	13.6%
Substance Use		

Adult women in Vermont are generally healthier than their peers in other states, with lower rates of diabetes, hypertension, obesity, and cardiovascular disease, and higher rates of physical activity, as well as consuming a nutritious diet with fruits and vegetables are promising signs. At the same time, there is a continued opportunity to reduce health risks for adult women. More than half of adult women are identified as overweight or obese, and only one in four consumes at least three servings of vegetables per day. Increasing the percentage of women (and especially low-SES women) who participate in regular physical activity, and consume a nutritious diet has the potential to reduce the incidence of chronic disease and lower health risks (Table 2).

The Vermont Blueprint for Health compared a number of women’s health indicators for women ages 15 to 44 to the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) population. These data indicated that:

- Medicaid enrollment makes up a larger proportion of women 15 to 44 (43.3%) compared to the VHCURES population (30.4%), potentially because pregnant women have broader Medicaid eligibility.

<sup>8</sup> Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2020. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2020.

<sup>9</sup> Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2020. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2020.

<sup>10</sup> Sullivan, R. (2019). Regional Brief: Declining access to health care in Northern New England. Federal Reserve Bank of Boston, New England Public Policy Center.

- The percentage of women with moderate or significant chronic health conditions has increased from 25.3% in 2013 to 29.2% in 2018.
- Women had similar primary care utilization as the VHCURES population; many women rely on an obstetrician-gynecologist for their primary care, suggesting a need for additional analysis to understand their primary care utilization patterns.
- Women had higher rates of avoidable emergency department visits and readmission within 30 days of an inpatient discharge than the VHCURES population.

	<b>2013</b>	<b>2018</b>	<b>% change</b>
Population	70,908	74,573	5.2%
Avg. Age	29	30	
% Medicaid	38.9%	43.3%	11.2%
% Medicare	3.7%	3.1%	-14.5%
% Commercial insurer	57.4%	53.6%	-6.7%
% Healthy	47.7%	44.1%	-7.5%
% Acute or Minor Chronic	26.6%	26.3%	-1.2%
% Moderate Chronic	19.3%	22.1%	15.0%
% Significant Chronic	6.0%	7.1%	17.7%
% Cancer or Catastrophic	0.42%	0.40%	-4.8%

#### ADDRESSING BASIC NEEDS

Addressing basic needs such as housing, food security, and transportation are integral to the health and wellbeing of all Vermonters. In focus groups and surveys, access to housing was the most commonly identified unmet need for families.

Housing issues centered around the lack of affordable housing in all regions of the state, where 46% of renters pay more than 30% of their income for housing,<sup>12</sup> and as do 33% of homeowners. The average Vermont renter earns \$13.40 per hour and can afford to spend about \$700 per month on rent, but the average two-bedroom apartment costs \$1,184 per month.<sup>13</sup> A minimum wage worker would need to work 85 hours per week to afford a basic two bedroom apartment. The DCF Office of Economic Opportunity reported that it served 3,872 people at publicly funded homeless shelters in FY18, including 1,102 children. While the total number of people served has declined from a high of 4,303 in 2015, the number of homeless children was at its highest in 2018.<sup>14</sup>

Transportation barriers, including lack of public transportation in rural areas, no usable vehicle (including no winter tires, need for repairs, vehicle not insured or not inspected), difficulty accessing family-friendly transportation for low-income households where a child or adult has special health needs were common themes. In many instances service providers identified unmet housing needs, while community members/service users identified needs for employment or a stable source of

<sup>11</sup> Tanzman, B. (2020). *Annual Report on The Vermont Blueprint for Health*, January 2020. Vermont Agency of Human Services.

<sup>12</sup> American Community Survey (ACS), 5-year estimates United States Census Bureau, Table B25070, Table B25091

<sup>13</sup> National Low-Income Housing Coalition. *Out of Reach 2019: Vermont*

<sup>14</sup> Vermont Department for Children and Families. 2019. *Annual Report on Outcomes for Vermonters*. Vermont Agency on Human Services.

income, reflecting their different orientation to fundamental basic needs concerns. For families, having a secure income may be viewed as a pathway to meeting all basic needs, including housing.

For low-income households, access to affordable, healthy food was a frequently identified challenge. The rate of food insecurity has decreased since 2014, from 20.5% to 17.0% in 2017. Despite the decrease, one in seven children in Vermont is food insecure.<sup>15</sup>

The Annie E. Casey Foundation’s Kids Count report ranked Vermont 17th in the United States in economic well-being, acknowledging the close connection between child and family health and economic well-being. In 2017, 38% of children under age 6 lived in households with an income below 200% of the federal poverty level. Among Vermont’s children:

- 30% live in single-parent families.
- 22% of children under age 18 live in households that receive SNAP benefits.
- 15% of children under age 18 live in households where there was an uncertainty of having, or an inability to acquire, enough food because of insufficient money or other resources.
- 5% of children under age 18 live in families in extreme poverty (incomes less than 50% FPL).
- 31% of children live in households where more than 30% of the monthly income was spent on rent, mortgage payments, taxes, insurance, and/or related expense.
- 25% of children’s parents lacked secure employment.

In many cases, the extent to which families can effectively address children’s and adolescents’ health needs was viewed as secondary to addressing basic needs. Families that struggle to maintain stable housing or adequate food viewed these concerns as the most significant issues they face. According to individuals who responded to the *Access to Health and Wellness Survey*, housing, food, and accessible and affordable healthcare were the three most “critically necessary factors for women,

	<i>n= “Critically necessary” or “the most critically necessary”</i>	<i>Percent</i>
1. Housing	304	94%
2. Food	301	93%
3. Accessible and affordable healthcare	299	92%
4. Mental well-being	296	91%
5. Childcare	286	89%
6. Financial security	285	88%

children, and families to thrive.” (Table 4). Because Title V services are especially focused on meeting the needs of low-income families, identifying creative and innovative strategies to increase equity and mitigate obstacles to meeting basic needs must continue to be a high priority.

Survey respondents were the least likely to view support for breastfeeding (56%), culturally relevant support and services (56%), and help navigating systems (63%) as critically necessary. Community members who responded to the survey frequently commented on a need to address “social isolation” and “connectedness.” The frequency of open-ended responses which named needs for interpersonal support, and those which described positive relationships as a significant

<sup>15</sup> Feeding America. (2019). Child food insecurity in Vermont 2014-2017.

contributing factor to health and wellness suggest that there are additional opportunities to strengthen approaches that nurture the interpersonal connections that promote health.

**Access to services:** Maternal and child health services before, during, and after pregnancy were the most commonly identified as “always” or “usually” accessible resources. Survey respondents were least likely to identify services to reduce stress, train parents on care coordination, and promote health and safety for youth (Table 5).

<b>Table 5. “These are some maternal and child health services and resources that may be available in your community. How often can you and your family get these services if you need them?”</b>	
<b>Most Accessible</b>	<b>Percent “usually” or “always”</b>
1. Prenatal care when pregnant	90%
2. Assistance getting, understanding, and using birth control	87%
3. Well-baby and well-child visits with a pediatric provider or family doctor	86%
4. Newborn screening information	79%
5. Pregnancy planning services	79%
<b>Least Accessible</b>	
1. Services to reduce stress, such as respite	25%
2. Training for parents/ caregivers on care coordination	26%
3. Bullying prevention	31%
4. Programs that help youth develop social, ethical, emotional, physical and cognitive skills needed during adolescence and the transition into adulthood	34%
5. Transition to adult health care system support	34%

**“Which barriers prevent you or your family from receiving services or resources?”**

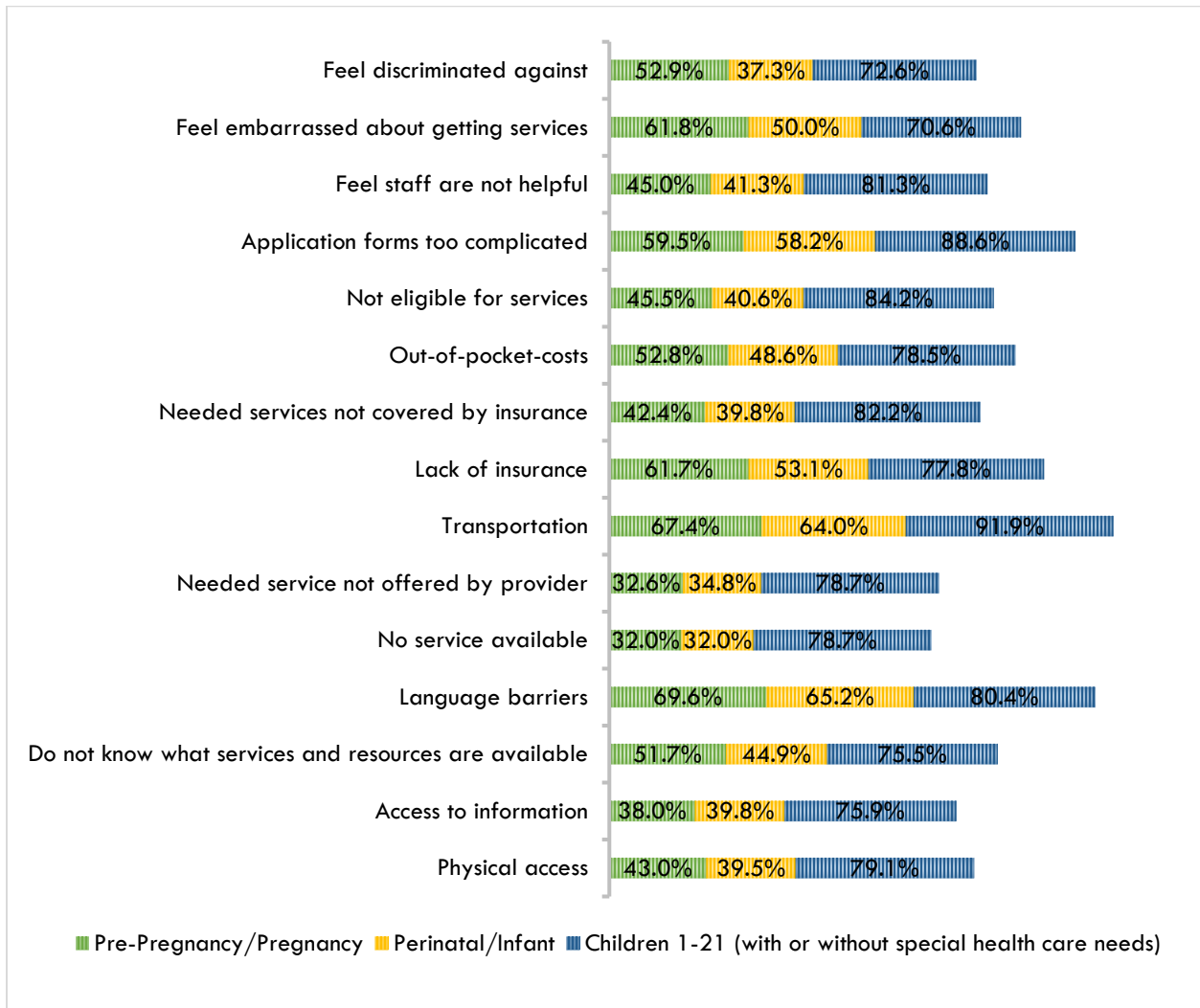
Survey respondents were asked to identify barriers that they or a family member had encountered, for three focus populations (pre-pregnancy/pregnancy, perinatal/infant, and children and youth under 21 including those with special health needs). Survey respondents identified the following barriers to care:

- For **pre-pregnancy/ pregnancy-related care**, language barriers (69.6%), transportation (67.4%), feeling embarrassed (61.8%) and lack of insurance (61.7%) were the most commonly identified barriers. Respondents were the least likely to identify a lack of services as a barrier to their care (32.0%).
- For **perinatal/infant care**, language barriers (65.2%), transportation (64.0%), and complicated application forms (58.2%) were the most commonly identified barriers. Respondents were the least likely to identify a lack of services available as a barrier to their care (32.0%).
- For **children and youth under age 21, including those with special health needs**, transportation (91.9%), complicated application forms (88.6%), and not eligible for services (84.2%) were the most commonly identified barriers. Respondents were the least likely to identify “embarrassed about getting services” (70.6%) and “feel discriminated against” (72.6%) as barriers to their care. The high percentage of respondents who identified even the lowest



ranking barriers (with no barrier receiving less than 70%) suggests that all of these issues are of concern for families with children under age 21.

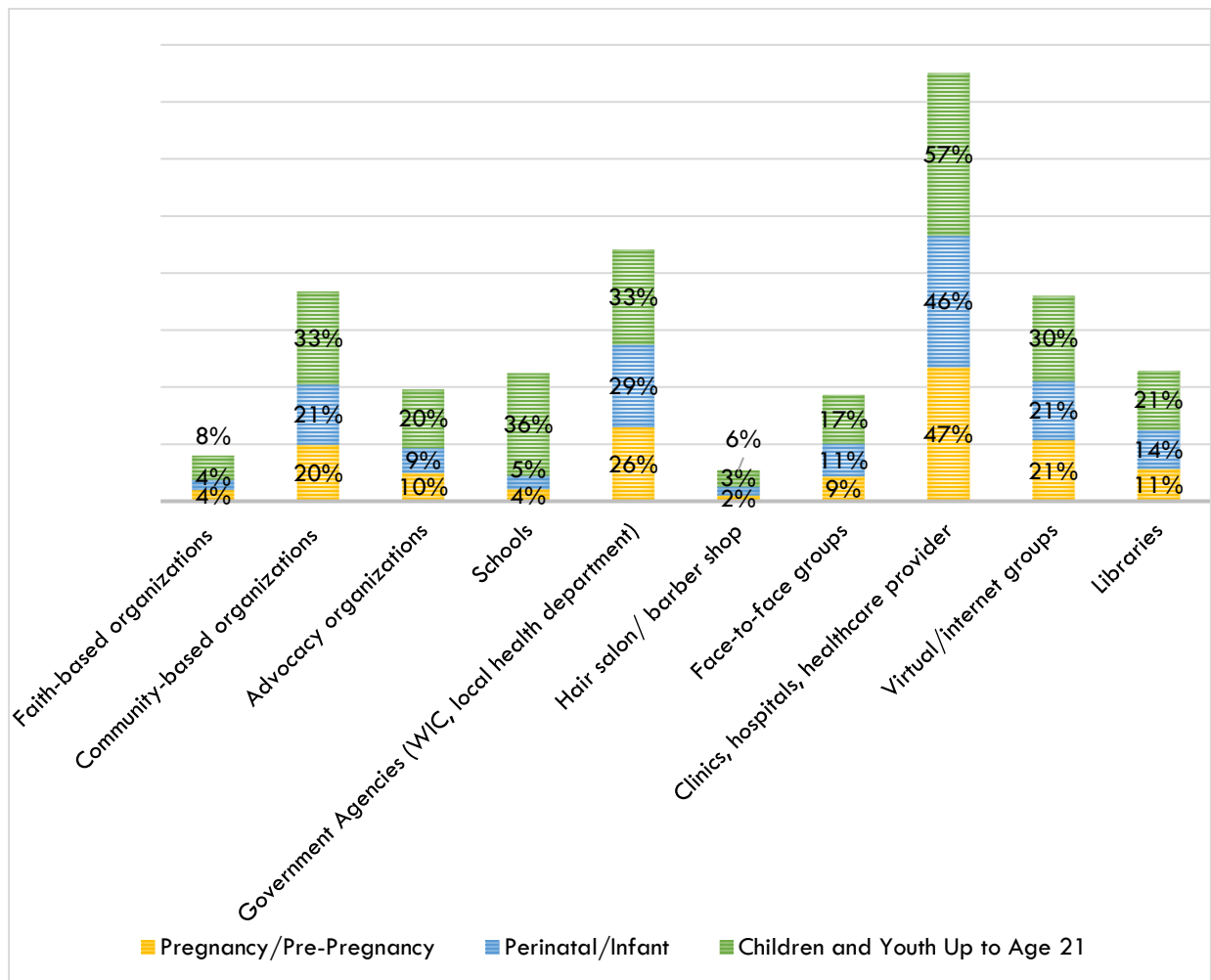
**Figure 6. Perceived barriers to care by focus population, Access to Health and Wellness survey.**



**“Where do you physically go in your neighborhood or community for health information or discussion about health issues or health information?”**

Survey respondents overwhelmingly seek health information from health care providers and formal health settings, for all three populations. Informal spaces such as hair salons were the least likely resource for health information (Fig. 7). Schools were the second most commonly identified health information resource for children and youth, but were less commonly identified for other groups.

**Fig. 7. Sources of health information**



**WOMEN/ MATERNAL HEALTH**

**Summary:** Vermont’s Title V women’s and maternal health programs and services address prenatal care, pregnancy planning and prevention, sexual and domestic violence, and maternal mental health, among others. Assessment participants generally identified prenatal and maternal health care services as a strength in Vermont. In the 4<sup>th</sup> quarter of 2019, 5,922 individuals received free or low-cost family planning services, exceeding the quarterly goal to serve 3,500 individuals.

Vermont Medicaid covers pregnancy care up to 200% FPL, facilitating access for a substantial proportion of those with the greatest barriers to access.

In focus groups, providers referenced a variety of maternal health efforts that are working well, including the Women's Health Initiative, home breastfeeding support, and perinatal depression services funded under Vermont's STAMPP grant (described below). The maternal and child health workforce was frequently cited as a strength, with many examples of stakeholders who view the nurses, social workers, home visitors, OB/GYNs, primary care providers and numerous others as exhibiting tremendous professionalism, dedication to their roles, and an investment in maintaining a high level of expertise within their fields.

*"There are so many people in Vermont doing good work, and countless folks throughout the state wanting to make things work. This is the strength of the state."*

#### PRECONCEPTION HEALTH & FAMILY PLANNING

According to Vermont's 2017 PRAMS data, 79% of Vermont women had a visit to a health care provider during the 12 months before pregnancy<sup>16</sup>. Of these:

- 78% were asked about what kind of work they did
- 70% were asked if someone was hurting them emotionally or physically
- 67% were asked if they were feeling down or depressed
- 56% were asked whether they wanted to have or not have children
- 44% had a talk about using birth control
- 39% were told to take a vitamin with folic acid
- 39% discussed maintaining a healthy weight
- 32% had a talk about improving health before a pregnancy
- 27% had a talk about STIs
- 25% were tested for HIV

33% of women talked to a doctor, nurse or other health care worker about preparing for a pregnancy. Topics included:

- getting their vaccines updated before pregnancy (54%)
- how drinking during pregnancy can affect a baby (50%)
- the safety of medicines during pregnancy (48%)
- how smoking during pregnancy can affect a baby (47%)
- how illegal drugs during pregnancy can affect a baby (43%)
- visiting a dentist/dental hygienist before pregnancy (42%)
- counseling for genetic diseases (30%)
- counseling or treatment for depression or anxiety (23%)

**Strengths:** The state has the highest first trimester prenatal care rates in the country, with 87.1% of infants were born to mothers who began prenatal care in the first three months of pregnancy

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<sup>16</sup> Vermont Department of Health. Vermont 2018 PRAMS Highlights. October 2019.  
<https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-Stats-PRAMS-Overview-2018.pdf>

(2017). In the 4<sup>th</sup> Quarter of 2019, Vermont exceeded its goal for providing free and low-cost family planning services by 69.2%, serving 5,922 individuals.

**Needs:** Vermont’s overall rate of live births from intended pregnancies is the same as the national average (59.6% compared to 58.9%)<sup>17</sup>. However, according to 2018 PRAMS data, young women and low-income women in Vermont experience substantially higher rates of unintended pregnancies (Table 6). While the number live births to women age 19 or younger was too small to be disaggregated in PRAMS data, the high rates of unintended pregnancies for those under 24 suggest that there continues to be a need for pregnancy prevention and family planning services for younger women.

In focus groups, immigrant and refugee women described numerous differences in their expectations about the prenatal and labor/delivery care they received, including cultural factors about motherhood and childbirth. For example, many immigrant and refugee women stated that they wanted longer hospital stays after delivery. Most agreed that they received a high quality of care.

The closure of the childbirth center at the Springfield Hospital in Springfield, Vermont in 2019 was identified as a challenge for women in Southeast Vermont. Two hospitals with maternity services are located within a 45-minute drive from Springfield. This closure follows the closure of the maternity ward at nearby Alice Peck Day Memorial Hospital in Lebanon, New Hampshire in 2018. Women in this region may need to travel up to one hour for prenatal care.

	<i>% intended</i>
Age Group	
24 or younger	30.8%
25 to 34	72.9%
35 or older	75.0%
Income	
<100% of FPL	39.9%
100-199% of FPL	53.6%
200% of FPL or higher	79.6%

#### MATERNAL/ PRENATAL SUBSTANCE USE

Substance use and dependence during pregnancy is a significant problem in Vermont, where the rate of substance use during pregnancy (28.2 per 1,000 births) is four times higher than the U.S. rate (6.8 per 1,000 births).

- 22% of women smoked in the 3 months prior to pregnancy; 12% smoked in the last trimester
- 68% of women drank alcohol at least some alcohol in the 3 months prior to pregnancy; 18% had at least one binge during this time
- 15% of women drank during the last 3 months of their pregnancy, including 23% of women age 35 or older
- 8% of women smoked marijuana during pregnancy

The incidence rate of infants born with a diagnosis of drug withdrawal syndrome peaked in 2014 at 35.3 per 1,000 live births in 2014, and was 29.5 in 2017.<sup>18</sup> The incidence remains more than double the 2007 rate of 12.8 cases per 1,000 live births, suggesting that substance use treatment intervention for pregnant women continues to be a high priority concern. Quality improvement data have shown that most women delivering an infant with neonatal abstinence syndrome (NAS) are on

<sup>17</sup> [https://www.cdc.gov/prams/prams-data/mch-indicators/states/pdf/2018/All-PRAMS-Sites-2016-2017\\_508.pdf](https://www.cdc.gov/prams/prams-data/mch-indicators/states/pdf/2018/All-PRAMS-Sites-2016-2017_508.pdf)

<sup>18</sup> Vermont Uniform Hospital Discharge Data Set (VUHDDS) (2019). Data analysis was performed on the Vermont Uniform Hospital Discharge Data Set (VUHDDS) 2007-2017, as published in the 2019 *How Are Vermont’s Young Children and Families* report.

Medication-Assisted Treatment (MAT). Among women who delivered an infant with NAS, 89% were insured under Medicaid.<sup>19</sup>

Few consumers who participated in the assessment raised topics related to maternal and prenatal substance use. MCH providers agreed that addressing substance use among pregnant women is difficult, largely because of the significant stigma women encounter. Providers stated that pregnant women may be reluctant to identify and seek care for substance use, fearing negative responses from physicians and other health care providers. Home visitors noted that they may receive and follow different guidance pertaining to alcohol, marijuana, and substance use during pregnancy than the physicians who are providing prenatal care.

Nurse home visitors stated that evidence of parental substance use is increasingly common during home visits. Providers identified the lack of specialized services available for low-income pregnant women who need substance use disorders treatment as a persistent challenge in many regions of the state. Providers generally agreed that when a postpartum mother with SUD treatment needs is effectively linked to services, the system works well. At the same time providers found that stress during the postpartum period can jeopardize SUD recovery, and that many families would benefit from more intensive support for a longer period during this time.

### **Maternal Mental Health**

All MCH populations identified mental health conditions and access to mental health care as important concerns. Among pregnant women in 2018:<sup>20</sup>

- 24% had depression at some point during the three months before pregnancy.
- 20% had a health care visit for depression or anxiety in the year before pregnancy.
- 20% reported having depression at some point during pregnancy.
- 90% of women with a prenatal care visit were asked if they were feeling down or depressed.
- 11% had symptoms indicating a risk for depression in the postpartum period.

## **PERINATAL/INFANT HEALTH**

**Summary:** Vermont offers far-ranging services for new parents and infants, touching the lives of approximately 94% of all newborns and 86% of all pregnant women.

- 6.7% of Vermont resident births were low birth weight (less than 2,500 grams or 5 pounds, 8 ounces) and 1.1% were very low birth weight (less than 1,500 grams or 3 pounds 5 ounces). The U.S. low birth weight rate for 2017 was 8.3%.
- The sudden, unexpected death rate for infants was 0.29 per 1,000 live births.
- 37% of infants breastfed exclusively for six months, up from 26% in 2010; Vermont's goal is that 40% of infants will be breastfed for six months.

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<sup>19</sup> Vermont Department of Health. Neonatal Abstinence Syndrome Surveillance Pilot Project, 2015 Vermont results. August, 2019. [https://www.healthvermont.gov/sites/default/files/documents/pdf/HS\\_Stats\\_NAS\\_pilot\\_project.pdf](https://www.healthvermont.gov/sites/default/files/documents/pdf/HS_Stats_NAS_pilot_project.pdf)

<sup>20</sup> Vermont Department of Health. Vermont 2018 PRAMS Highlights. October 2019.

<https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-Stats-PRAMS-Overview-2018.pdf>

- 11,300 pregnant women, infants, children are enrolled in WIC, constituting approximately 62.4% of eligible participants. There are an additional 6,700 people who are eligible, but not enrolled.

**Strengths and Assets:** Both service providers and service users generally identified perinatal and infant health needs as being well addressed, and view these services as valuable to public health. MCH programs such as DULCE (see *Formal and Informal Collaborations and Partnerships for a description*), home visiting, breastfeeding support, immunization and well-child services were identified as “working well.” Service providers who were familiar with the DULCE model of integrated care cited a variety of benefits to the program and endorsed the idea of making this approach available statewide.

The quality of home visiting services available for eligible families, including those with newborns, young parents, low-income parents, and parents with a history of or risk for substance use, was identified as a strength. Home visiting providers agreed that there is less stigma about receiving home visiting services than they found in the past, and that families are generally respond positively to receiving home-based care.<sup>21</sup> When MCH has had funding to provide portable cribs and other tangible infant care items for families, home visitors noted that these material supports facilitated engagement for low-income families.

**Needs:** Providers who deliver perinatal and infant health services identified needs to improve the quality or accessibility of services, especially for low and middle-income mothers and those with complex circumstances and support needs. In general, providers noted that low-income families’ needs have become more complex, and that providers are rarely called upon to address only one category of need. For example, a family with a newborn may have older children with special health needs, a parent dealing with substance use issues, and have difficulty maintaining stable housing. Fully addressing families’ diverse needs requires substantial cross training among providers of services for families, and well-coordinated team approaches when multiple kinds of specialized expertise are needed.

In keeping with national trends, the number of WIC participants in Vermont has declined steadily, from more than 14,000 in January of 2014 to 11,300 in 2018, reaching roughly two-thirds of eligible households. Focus group participants noted that the 2016 transition to eWIC has facilitated better access for some households, but posed challenges for the most isolated, underserved, and remote families. Several home visitors stated that they have been asked to pick up WIC groceries for families that do not have a vehicle and cannot otherwise access these benefits.

As with other MCH populations, access to mental health care, including mental health providers for women who experience postpartum depression, was identified as a significant unmet need throughout the state. According to PRAMS data, 96% of women with a postpartum checkup were asked if they were feeling down or depressed. Few consumers discussed maternal mental health concerns. One survey respondent used an open-ended survey field to describe her experience:

*“More support-- and early on-- for postpartum depression would have been hugely helpful after giving birth. I felt there were limited resources given to me when I was struggling.”*

Providers identified the current HRSA-funded **Screening, Treatment and Access for Mothers & Perinatal Partners (STAMPP)** project as a promising opportunity to improve responses to postpartum depression and address maternal mental health needs. The STAMPP project aims to improve mental

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<sup>21</sup> Home visiting assessment results are addressed in Vermont’s Maternal, Infant, and Child Home Visiting Program (MIECHV) Needs Assessment report, prepared concurrently with the Title V Needs Assessment.

health and well-being for pregnant and postpartum women and their children and families, by developing and sustaining a coordinated system of mental health supports, with plans to increase health care and social service providers' capacity to educate, screen, diagnose, prevent, and treat maternal depression and other related behavioral disorders.

Providers identified regional differences in the availability and/or quality of prenatal and maternal health care. Specifically, some regions identified needs for more free or low-cost prenatal/ birth planning classes for women with Medicaid, access to same-day contraceptive care, and general gynecology resources and services for women who are not pregnant, including those addressing fertility concerns, as well as better support for middle income families who have less access to income-based services.

## CHILD HEALTH

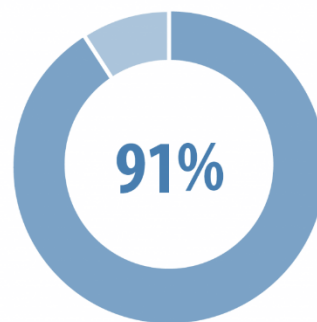
**Summary:** Vermont children have high rates of developmental screening, immunizations, and health insurance coverage. Most Vermont children are enrolled in health insurance (98%) and 91% of young children saw a health care provider in the last year. All pediatric providers in Vermont accept Medicaid. For most children, factors related to health and well-being are directly connected to family stability and economic security.

**Strengths:** Children in Vermont have access to pediatric primary care and school-based health services such as screenings and prevention programs. Regions where primary care providers are operating as the child's medical home were described as working well and effectively connecting children and families to the range of physical, emotional, behavioral, and developmental supports they need most. Vermont has one of the highest rates of child health care coverage in the United States, with 98% of children covered by a health insurance plan.

- 56.7% of Vermont children up to age 19 are insured through Medicaid, which provides for comprehensive health, dental, behavioral health, and related services.
- 40.4% of infants and 35.0% of children are enrolled in WIC.
- 84% of kindergarteners met the five domains of healthy development (physical development, social-emotional development, approaches to learning, language, and cognitive development) associated with being "ready for school," an increase from 56% in 2010.

**Help Me Grow Vermont** is administered by MCH, and is part of the national *Help Me Grow* program, which seeks to ensure all young children receive developmental screenings to support healthy development by engaging families, pediatricians, childcare providers, and others in the early childhood system. Help Me Grow's child development specialists provide information and referrals, provide developmental monitoring and screening, offer care coordination among multiple service delivery systems, and also assist women and families in accessing

### HEALTH CARE VISITS



91% OF CHILDREN UNDER 6 HAVE SEEN A HEALTH CARE PROVIDER DURING THE LAST YEAR

perinatal support. Help Me Grow’s work has generated important results<sup>22</sup>:

- The percentage of children screened in the first three years of life using a standardized screening tool increased from 48% in 2013 to 63% in 2018.
- In 2019, Help Me Grow provided 117 community outreach events reaching 5,753 families and 709 partners with information about increasing protective factors for young children.
- 1,665 families were served through the Help Me Grow centralized contact center, and families received 2,923 referrals, a 67% increase from the prior year.
- In 2019, families that contacted Help Me Grow most often sought support for Basic Needs, followed by income support and employment, individual or family wellness, and criminal justice and legal services.

**Needs:** According to the National Survey of Children’s Health 2017, approximately 23% of children and youth in Vermont have experienced two or more adverse experiences, compared to 19.3% nationally.<sup>23</sup> Family adversity may directly and indirectly impact children’s physical, social, and emotional development.

- 8.7% Vermont children live in a home where the family demonstrates little to no qualities of resilience during difficult times.
- 9.1% Vermont children live in a household where mother’s mental/emotional health is fair or poor.
- 5.0% Vermont children live in a household where father’s mental/emotional health is fair or poor.
- 6.9% Vermont children have parents who felt aggravated by parenting during the past month.

Vermont’s child protection system under the Department for Children and Families (DCF) has encountered rising caseloads and increasingly complex cases, including rising cases where parental substance use is a factor (Table 7). In its *Annual Report on Outcomes for Vermonters* (2019), DCF reported conducting 20,758 child abuse and neglect intakes, with very little change from the prior year (20,985 intakes).<sup>24</sup> From 2014 to 2019, the number of children in DCF custody increased by 29%.

Total DCF child safety interventions	5,385
investigations	2,872
assessments	2,513
Children and youth in custody on 9/30/18	1,301
Ages 0 to 5	485
Ages 6 to 11	340
Ages 12 to 17	453
Age 18 or older	23

<sup>22</sup> Help Me Grow Annual Report. 2019. <https://www.helpmegrowvt.org/>

<sup>23</sup> Kasehagen, L. 2015. Adverse Family Experiences: The Vermont Story, Power Point Presentation. Vermont Care Partners and Vermont Department of Mental Health.

<sup>24</sup> Vermont Department for Children and Families. 2019. The Annual Report on Outcomes for Vermont Families. Vermont Agency on Human Services.



Recent trends include:

- 44% more families received ongoing services after an investigation or assessment determined there was a high to very high-risk of future maltreatment.
- 100% more children were in the conditional custody of a parent, relative or other person known to the child and family, while DCF remained involved to supervise, provide services and ensure children's safety
- 56.4% of children ages 0 to 5 were in custody due to a parent's substance use issue (November 2018).
- In November 2018, 41.3% of children ages 0 to 5 were in custody due to an opioid use issue (compared to 49.8% in 2017 and 53.2% in 2016)

**Need for pediatric mental health care and screening:** School-based mental health services for school-aged children are available in some regions of the state but not others. Many MCH providers stated that mental health support for children, including screening, psychiatric evaluations, outpatient counseling, and intensive/inpatient treatment services are largely unavailable, or that there are long waitlists for pediatric mental health specialists. The number of children who accessed mental health services has increased substantially in the last two decades, from 1,708 children in 1999 to 3,322 in 2018.<sup>25</sup>

Other children's health needs that were identified via the survey and focus groups are addressed under the *Adolescent Health* and *Children with Special Health Needs* sections that follow.

## ADOLESCENT HEALTH

**Summary:** Vermont youth fare better than their same-aged peers nationwide on numerous indicators. The Vermont Youth Risk Behavior Survey (YRBS)<sup>26</sup> is a valuable tool for collecting statewide, county, and school-level data about the health, emotional health, and social welfare of middle and high school students, and is widely used by providers who work with adolescent populations. Many stakeholders commented on the relative invisibility of services for youth within MCH's scope, noting that the transition points that come with aging out of programs for younger children make adolescent populations uniquely vulnerable.

**Strengths:** In 2017, 89% of students completed high school in four years. Over the past decade there has been a 50% decrease in the number of students who smoked cigarettes during the past 30 days. Current cigarette use decreased among youth between 2017 and 2019 to 7%, dropping below the HV2020 Goal of 10%. On most YRBS indicators, Vermont youth fare better than their peers nationally. While only 22% of high school students reported participating in 60 minutes of daily physical activity, 46% of students reporting physical activity at least five days in the previous week.

Vermont's adolescent health systems are well served by effective collaborations with a number of youth-serving efforts, including:

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<sup>25</sup> Vermont Department of Mental Health (2019). Data provided by the Vermont Care Partners Data Repository through the Department of Mental Health Interagency Planning Director.

<sup>26</sup> Vermont Youth Risk Behavior Survey. 2019. Vermont Department of Health.

- **Vermont Afterschool**, a public-private statewide partnership dedicated to supporting and sustaining innovative learning opportunities that extend beyond the school day for all Vermont’s children and youth, by working to increase the quality and availability of education programs during non-school hours.
- **The Vermont RAYS**, a youth-driven council of teens who are committed to improving adolescent health and well-being in Vermont that amplifies the youth voice in health care systems throughout Vermont. Vermont RAYS collaborates with the Youth Health Improvement Initiative at the Vermont Child Health Improvement Program (VCHIP) as they coach Vermont primary care practices working to improve health services for adolescents and young adults.

**Needs:** In the *Access to Health and Wellness Survey*, when “N/A” responses are removed from the denominator, 43.9% of respondents said developmental programs for youth are either “never” or “seldom” available, compared to only 34.4% of respondents who indicated that such programs are “usually” or “always” available (Table 8). Most survey respondents were adults who are parents and caregivers, who may not be well aware of services that do exist or may have been responding based on a perception about what was available for themselves, their children or grandchildren. According to Vermont Afterschool, between 12% and 30% of Vermont middle and high school students do not participate in any sort of group activity supervised by trained adults when they are not at home or school.<sup>27</sup> Similarly, bullying prevention and support to transition to the adult health care system were identified as “never” or “seldom” available by most respondents (other than those who selected “N/A”). As the majority of respondents indicated that such programming is not accessible, these areas may warrant additional investigation.

<b>Table 8. Access to Health and Wellness Survey, youth-focused items</b>							
<i>Availability of "Programs that help youth develop social, ethical, emotional, physical and cognitive skills in adolescence and the transition into adulthood"</i>							
	<i>Never</i>	<i>Seldom</i>	<i>About Half the Time</i>	<i>Usually</i>	<i>Always</i>	<i>N/A</i>	<i>Total</i>
Percent	11.4%	18.1%	14.9%	11.8%	11.4%	32.4%	
Number	36	57	47	37	36	102	314
<i>Bullying Prevention</i>							
	<i>Never</i>	<i>Seldom</i>	<i>About Half the Time</i>	<i>Usually</i>	<i>Always</i>	<i>N/A</i>	<i>Total</i>
Percent	9.9%	19.5%	16.6%	11.2%	9.3%	33.6%	
Number	31	61	52	35	29	105	317
<i>Transition to adult health care system support</i>							
	<i>Never</i>	<i>Seldom</i>	<i>About Half the Time</i>	<i>Usually</i>	<i>Always</i>	<i>N/A</i>	<i>Total</i>
Percent	11.7%	18.6%	7.9%	10.4%	9.2%	42.3%	
Number	37	59	25	33	29	134	313

A 2018 survey of more than 500 Vermont high school youth identified drug and alcohol use, sexism (body shaming and harassment), personal emotional safety, and bullying as major concerns.<sup>28</sup> Family poverty and lacking resources were identified as a top concern for older youth and for LGBTQ youth. At home, youth were concerned about stress, mental health for themselves and other household members, and emotional safety. This survey, YRBS data, and input from focus group

<sup>27</sup> Schwab, E. “VYP Data Shows Lack of Third Space Activities for MS/HS Youth.” Blog post dated February 10, 2020 retrieved from <http://www.vermontafterschool.org/fall2019-vypdata>.

<sup>28</sup> Vermont Network Against Domestic and Sexual Violence. 2018. *Askable Adults: A survey of Vermont's Youth*. Vermont Network Against Domestic and Sexual Violence.

participants identify mental health, substance use, sexual violence, and transitioning to adult systems of care as significant needs for youth.

**Substance use:** Youth and adults who work with youth who participated in focus groups expressed concerns about the rapid increase in rates of vaping and prevalence of electronic vaping products among youth, and the need for continued effort to reduce risk behaviors that are associated with substance use for youth. According to the 2019 YRBS for high school students:

- 55% of students reported ever consuming alcohol, a decrease from 66% in 2009; 31% reported consuming alcohol in the past 30 days.
- Among students who reported consuming alcohol, 57% reported binge drinking at least once in the last 30 days.
- 40% of students have ever used marijuana, including 27% who used it in the past 30 days. Students of color and LGBT students had higher rates of frequent marijuana use.
- 50% of students reported ever trying an Electronic Vapor Product (“vaping”), up from only 30% in 2015. Twenty-six percent of students reported EVP use in the past 30 days, compared to only 12% in 2017. Among high school students who reported EVP use, 31% reported daily use.

At the system level, stakeholders acknowledged that addressing substance use for youth is under-resourced in Vermont. Treatment programs for young adults are specialized in nature, making it difficult for small communities to provide an adequate level of care. Providers noted that these services aren’t well integrated into the adult treatment systems.

**Sexual and dating violence<sup>29</sup>:**

- Nearly one in five high school students (18%) have ever had unwanted sexual contact (kissing, touching, sexual intercourse), including 28% of female students and 8% of male students. More than one in three LGBT youth (38%) reported experiencing sexual harm.
- 27% of high school students reported emotional abuse in an intimate relationship; 8% reported physical violence in a dating relationship.
- 27% of high school students sent or received a revealing or sexual photo of someone in the past 30 days.

In 2018, Vermont’s CDC-funded Rape Prevention Education (RPE) Program conducted interviews and focus groups with roughly 40 adults who work with youth, including prevention educators, youth specialists, and school personnel.<sup>30</sup> The assessment identified opportunities to strengthen sexual violence prevention (and other risk-behavior focused prevention) systems for youth. The study identified needs to: 1) provide sexual violence prevention efforts across the age span, through numerous channels and layered approaches, in home, school, and community settings; 2) define and adopt a common approach to sexual violence prevention that expands the ‘ecosystem’ of youth-serving entities in Vermont that are well-prepared to prevent violence to include education, health, and social service organizations; 3) focus on adults’ roles in preventing sexual violence and reducing risks; 4) address the sexual violence prevention needs of youth of color, whose needs are not well served by existing resources; and 5) enhance and expand promising efforts to increase protective factors and reduce risks for youth that are already in place.

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<sup>29</sup> Vermont Department of Health. 2019 Vermont Youth Risk Behavior Survey Statewide Results. March 2020.

<sup>30</sup> Vermont Department of Health. 2019. Vermont RPE Sexual Violence Prevention Stakeholder Assessment.

**Mental health needs:** The percentage of students who reported feeling sad or hopeless in the past 12 months increased from 21% in 2009 to 31% in 2019. Notably, 40% of female high school students reported feeling sad or hopeless. Thirteen percent of students made a suicide plan, and the percent of students who attempted suicide increased from 4% in 2009 to 7% in 2019. Among youth and adults who work with youth who participated in focus groups identified mental health concerns (and especially stress, anxiety, and depression) as one of the most important topics for Vermont youth. Youth spoke about the prevalence of mental health concerns among peers, while providers spoke about the scarcity of youth-friendly clinical resources, long waits for counseling, and need for more outreach and education to increase recognition of mental health concerns when they arise, and to decrease the stigma associated with seeking help. Relatedly, youth focus group participants agreed that more is needed to help young adults “find purpose,” learn about goal setting, and receive support as they enter adulthood.

**Systems of support for the transition to adulthood:** Adults who work with youth indicated that systems of healthcare and support are not seamless when youth reach adulthood, and that youth may not have sufficient health literacy to navigate the transition from pediatric to adult care systems. Adults who work with youth also frequently identified concerns about how well youth access services as they reach adulthood. This time of transition was identified as a time when many young adults discontinue receiving primary medical care, with wide recognition that many young adults are also making transitions to living independently, managing personal finances, and navigating adult systems of health and mental health care on their own. This transition period presents a unique opportunity for service providers, who acknowledge that there are a variety of firm barriers and boundaries between programs and services for youth and those intended for adults.

**LGBT youth reported more high-risk behaviors and worse mental health than their non-LGBT peers.** LGBT populations are a priority for MCH programming. MCH partners with, and has received training from Outright Vermont, a statewide organization that serves LGBT-identified youth and their families. According to the 2019 YRBS:

- The percentage of youth who are overweight and obese has remained stable at 27% but 39% of LGBT youth are overweight or obese.
- The percentage of LGBT high school students who reported feeling sad or hopeless (63%) and who made a suicide plan (36%), was nearly three times the rate of their non-LGBT peers.
- LGBT youth reported high rates of substance use.

## **CHILDREN WITH SPECIAL HEALTH NEEDS (CSHN)**

**Summary:** VDH’s CSHN team coordinates care for approximately 700 children. Medical social workers provide care coordination to help families navigate the healthcare system; provide respite funding for parents and caregivers; bring teams of providers and educators together to coordinate care; and help families manage specialized care. Vermont’s high rate of children with Medicaid coverage is a strength, because it ensures that CSHN can access medical care, developmental and behavioral therapy, dental care, and other needed support. Among Vermont’s roughly 90,900 children ages 1 through 17, 15.1% have an identified chronic condition. Of these, approximately 9,100 children have a condition that is identified as minor chronic or acute (19.4%), moderate chronic (12.0%), significant chronic (1.7%) or cancer/catastrophic (0.3%).<sup>31</sup>

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<sup>31</sup> Department of Vermont Health Access, Vermont Blueprint for Health (2018). Community Health Profiles.

**Strengths:** Providers and consumers find that the level of coordinated care families with CSHN receive, systems for early identification/ developmental screening, and “collaborative teaming” to provide care are “working well.” Statewide, approximately 61% of children ages 0 to 3 received recommended developmental screenings, which are one of the tools that identify CSHN.<sup>32</sup>

**Needs:** Unmet needs and areas where the system is not working well for CSHN were among the most frequently discussed topics focus group participants identified, even in instances where the group was not specifically focused on CSHN populations. MCH providers identified needs for a stronger CSHN workforce, with a more robust system of training and support for personal care assistants (PCAs) and paraprofessionals. Providers expressed concerns about the stress that inadequate workforce resources place on providers and on families, citing a lack of available respite providers even when a family receives funds to support respite care.

Providers stated that in most regions of Vermont families with CSHN encounter difficulty when children reach any transition point, including as CSHN age (from 0-3 to pre-K/school-age services, across grade levels, and from pediatric to adult systems), as well as when families are “handed off” from and/or served by multiple systems. When asked about the availability of services, 41.5% of *Access to Health and Wellness* survey respondents said **support to navigate the system of care for children with special health care need** was seldom or never available, compared to only 35.7% who said this support was usually or always available.

In focus groups, providers gave several examples of ways transition points are difficult for families:

- *“We have a ways to go to figure out young children’s [transition] to school age – transition points need to be more seamless from early childhood to school age to adolescence to transition age. Children age and bump into new systems – transitions and hand offs need to be smoother.”*
- *“The transition from early intervention to EEE is traumatizing for parents-- support looks so different. . . families struggle to get what they need”*
- *“CSHN services are set up with a goal to transition-- not a goal to provide consistent care-- this leads to families having to continually retell their stories”*
- *When kids age out of CIS there are not enough resources-- school districts are not resourced to meet these needs-- school districts do not serve whole families-- they only deal with the child and this isn’t always enough or the right kind of help.*

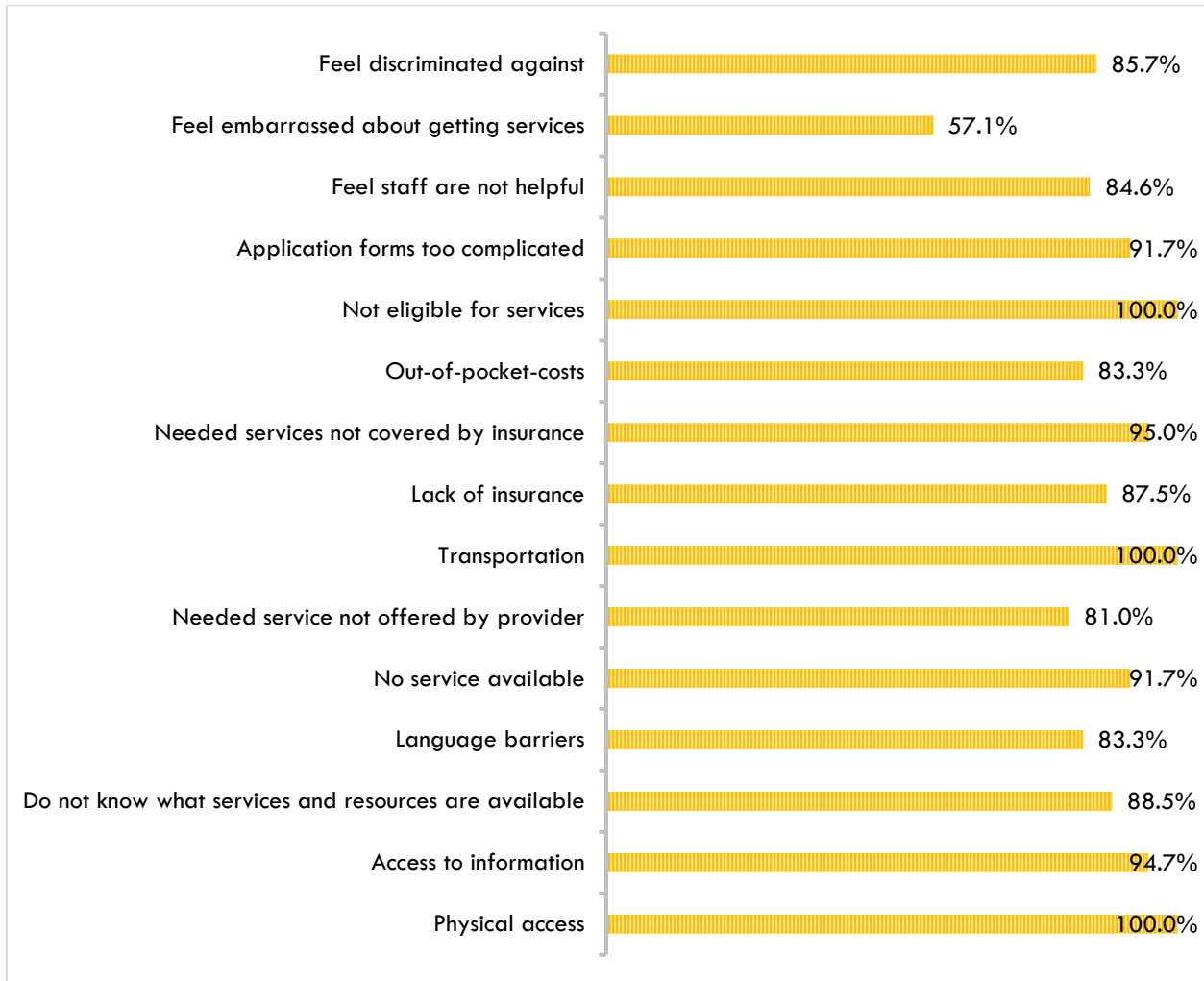
Providers and consumers described difficulty finding local childcare providers who are trained and registered to provide care for CSHN; issues with providers “expelling” young children with CSHN (and especially CSHN with spectrum disorders) from care; and a lack of providers for specialized services such as physical therapy, speech language therapy, occupational therapy, and other services outside of Chittenden County.

All survey respondents who identified as the parent/ guardian/ caregiver of a child with special health needs identified transportation, eligibility, and physical access as barriers that they or their child has experienced (Fig.8). “Needed services not covered by insurance” (95%) and “access to information” (94.7%) were also commonly identified barriers. Feeling embarrassed was the least common response among parents/ caregivers of children with special health needs (57.1%).

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<sup>32</sup> Department of Vermont Health Access, Vermont Blueprint for Health (2018). Community Health Profiles.

**Fig. 8. Which barriers prevent parents/ caregivers of CSHNs from receiving services or resources?**



## CROSSCUTTING/ PRIORITY POPULATIONS

### IMMIGRANT AND REFUGEE POPULATIONS

**Summary:** Vermont welcomed 7,956 refugees from 1989 through 2019, majority of whom reside in Chittenden County. The largest numbers of migrants in Vermont have come from Bosnia, Vietnam, Bhutan, the Democratic Republic of Congo, and Somalia. There is limited health data about these populations because most systems only ask about race and ethnicity, which aggregates migrant and non-migrant populations without distinguishing them. In addition, some migrant populations from a single ethnic or cultural group may have only a few hundred people, making it difficult to provide accurate summary data because of the small sample sizes available, for example, when looking at a specific age or geographic group within an already small population.

Noonmark interviewed several key stakeholders who work with immigrant and refugee populations, and conducted two focus groups with immigrant and refugee parents within the Burlington School District. Each group was composed of ten adults with one or two translators. One group was

primarily Bhutanese and Nepali participants and one group was primarily participants from West African countries. Participants in both groups were low-income parents of school aged children, including children with special health needs.

**Needs:** Needs that were identified included limited access to dental care, needs for more culturally responsive mental health care services, and needs for culturally responsive prenatal, maternity, and perinatal services and supports. For the most part, mothers stated that the maternity care they received was good, despite differences in what they expected (such as surprise that new mothers do not stay in the hospital for more than one or two days). Even when services exist, members of these communities may be reluctant to access them because of cultural and linguistic barriers, and described a lack of self-advocacy skills within medical care settings. When a doctor, nurse, or social worker gives information that is not well understood, many focus group participants described a reluctance to ask questions, and stated that they often feel that “something is not right,” but feeling uncomfortable raising concerns.

Establishing relationships with medical homes, including by using community liaisons and nurse home visitors, was identified as a promising approach, when medical homes can provide services that are culturally responsive, have adequate access to translation, and can provide for patient confidentiality given the small size of Vermont’s immigrant and refugee communities.

Some immigrant and refugee focus group participants and program providers expressed concern that demonstrating “self-sufficiency” is critical to refugees’ immigration status, creating a reluctance to seek care if they perceive that doing so will jeopardize their immigration status or has the potential to undermine the appearance that they are able to maintain self-sufficiency.

Among the concerns that immigrant and refugee adults named for themselves and their children, stress and anxiety, meeting basic needs, and having adequate time and places to build positive social connections were high priorities.

## 4. TITLE V PROGRAM CAPACITY

### ORGANIZATIONAL STRUCTURE

Situated within the Vermont Agency on Human Services, Department of Health (VDH), Maternal and Child Health Division, Vermont's Title V is actively engaged in ensuring a statewide system of services, which reflect principles of comprehensive, community-based, coordinated, family-centered care. VDH is the single public health agency that serves all Vermonters, with its central offices and lab in Burlington, and 12 district offices located around the state. State health reform efforts have included a focus on promoting health and preventing chronic illness. Public Health is written into the state's health reform law.

VDH and all public health efforts, including Title V, are overseen by Commissioner of Health, Dr. Mark Levine. VDH is one of six departments within the Agency of Human Services. Within AHS, VDH is closely connected to the leadership and resources of the Departments of Mental Health, Health Access (Medicaid & health reform), Disabilities, Aging, & Independent Living, Children & Families, & Corrections. The AHS Secretary reports directly to Vermont Governor Phil Scott. The Governor's administration has prioritized increasing early childhood and higher education funding as a critical continuum of support for Vermont's children and youth. The AHS Secretary and Governor have a strong interest in prevention and have identified home visiting as a promising strategy for supporting statewide health improvement goals.

The MCH Division has been led by Dr. Breana Holmes since 2010 and oversees all Title V programming. In September 2020, Dr. Holmes will be transitioning to a new part-time role as MCH Medical Advisor and Ilisa Stalberg, MCH Deputy Director since 2013 will be taking on the role of MCH Director. Other federal initiatives housed within the MCH Division include WIC administration, MIECHV, Title X, PREP, EPSDT/school health and significant pieces of the Preschool Development Grant. Vermont's CSHN program is under the MCH Division.

Vermont's *State Health Assessment (SHA)* and *State Health Improvement Plan (SHIP)* are used to prioritize goals and objectives for health, monitor trends, identify gaps and track progress. The SHA/SHIP use a health equity framework, evaluating MCH (and other health) data by key populations that have experienced historical injustice or have documented health disparities. VDH used a collaborative process to develop the SHA/SHIP; key department and external stakeholders reviewed health status indicators of Vermonters with the goal of identifying three to five statewide strategic health priorities.

The SHIP presents the priorities and improvement strategies agreed upon by multiple public health partners and provides the framework for creating healthier communities over the next five years. Several the outcomes identified for the five-year SHIP are MCH focused, including: Optimal Child Development and Resilience. Title V/MCH is perfectly positioned to take a leadership role in the development and implementation of strategies to achieve this outcome.

Vermont public health planning relies on the Prevention Model, an adapted five-level Social-Ecological Model framework. This model recognizes that, although individuals are ultimately responsible for making healthy choices, behavior change is more likely and more sustainable when the environment supports individual efforts. Comprehensive prevention and health promotion programs, to be most effective for the long term, and to reach the largest number of people, should address multiple levels of the model, and attend to social determinants of health. VDH leaders recognize that public health efforts need to influence not only health care and health systems, but



also areas such as education, early care and education, housing, law, economic opportunity, community planning, transportation and agriculture.

VDH emphasizes that public health actions are based in researched strategies and in measurement and accountability. Resources from national agencies, such as the Centers for Disease Control & Prevention, Substance Abuse and Mental Health Services Administration, and the Maternal and Child Health Bureau (MCHB) are used to guide staff and policymakers to select successful evidence-based interventions. For example, VT Title V has benefited from the technical assistance available from the MCHB Collaborative Improvement & Innovation Network, the AMCHP resource center, and the MIECHV evaluation resources.

VDH has a comprehensive performance management framework in place to improve the health status of Vermonters by ensuring the efficacy and evidence base of services delivered. Staff employ performance management systems to identify and regularly report on population objectives and performance measures, perform quality improvement activities, and assess and emphasize the need to fund and implement evidence-based practices to change population outcomes. These measures are designed to be evidence-based and describe how the department holds itself accountable to making population-level change.

Vermont is a rural state and relies on an extensive system of center and home-based services throughout the state that are offered by a variety of community organizations, which include mental health agencies, Parent Child Centers, home health agencies, and community action partnerships (*See Formal and Informal Collaborations and Partnerships for descriptions*). VDH ensures statewide coverage through 12 local health district offices. Clinical services are provided through a comprehensive statewide network of private providers, Federally Qualified Health Centers, and family planning services (Title X) offered by Planned Parenthood clinics.

#### VERMONT'S TITLE V CAPACITY TO PROVIDE AND ASSURE SERVICES WITHIN THE FIVE POPULATION HEALTH DOMAINS.

MCH applies Title V funding broadly across program areas to achieve its mission. Title V funds are frequently used to seed novel and innovative efforts and partnerships, explore emerging topics for MCH service populations, and to assure that MCH leaders are represented in collaborative multi-agency and interdepartmental efforts.

Interviews with key stakeholders and state agency leaders found that at the leadership level, there is a substantial investment in, and eagerness to support high-quality interagency/ multi-stakeholder collaboration to improve health for MCH populations. The key ingredients of successful coordination/ partnership with MCH that stakeholders most identified included:

- Effective leadership
- Intentional relationship building
- Efforts to find a common language when values/ approaches differ
- Agreement about the benefits of prevention and value of “upstream” approaches for Vermonters

Title V stakeholders who participated in interviews and focus groups are eager to support and committing resources to effective prevention efforts. Under the Administration for Human Services, agencies have worked to adopt frameworks that increase protective and promotive factors, build

resilience, address social determinants of health, and prevent adversity for families. With the “prevention” theme, stakeholders spoke about the value of investing in early childhood supports, systems that address social determinants when needs are identified, and expanding the reach of early screening, education, and intervention as widely as possible. While some issues related to providing integrated systems of care and coordination across agencies appeared to work well at the leadership level but encounter challenges at the direct service level, providers and administrators at every level voiced support for robust investments in prevention efforts that serve MCH populations. From providing prenatal care and strong programs to support youth to expanding the DULCE model, MCH Title V stakeholders strongly support programs and services that reduce the need for more complex social and health services for individuals and communities.

## **MCH WORKFORCE CAPACITY**

Vermont’s MCH workforce includes professional staff who hold degrees in medicine, nursing, public health, social work, and numerous allied health and social service professions. During FFY18, 13.9 FTEs, representing 49 staff worked directly on behalf of Title V programming. These staff are located at the VDH central office in Burlington, in the local health offices across the state, within the division of Health Surveillance (immunization, health research and statistics), and within the division of Health Promotion and Disease Prevention. There are 56 staff in the MCH Division (including CSHN). Vermont leverages Title V funding along with other federal grants and Vermont’s Global Commitment Waiver to support these staff.

MCH Coordinators (MCHCs) are public health nurses working at within Office of Local Health to provide direct connections to every region and community of the state. The MCHCs positions are not funded by Title V but play a critical role in administering Title V activities. School Liaisons work with schools to promote the MCH mission and further EPSDT mandates. MCHCs and School Liaisons are administered under the organizational structure of the Offices of Local Health and are not managed by MCH, but MCH directs their workplans and areas of focus. MCHCs and school liaisons at the local level support breastfeeding coalitions; represent MCH and best practice-based public health initiatives with women’s health providers, pediatric providers, and other professionals serving MCH populations; and serve as members of local community and planning teams; and more.

### **MCH SENIOR MANAGEMENT AND PROGRAM STAFF**

**Breana Welch Holmes, MD** is the Director of Maternal and Child Health for Vermont. After finishing her pediatric residency at Seattle Children’s Hospital and a chief resident year at University of Massachusetts Medical School, she had a pediatric practice in Middlebury, Vermont, focusing on adolescent health from 1997-2008. In 2008, Breana left her clinical practice to teach Health Literacy and Decision Making at Middlebury Union High School. In 2010, Breana became director of the Maternal and Child Health division. Dr. Holmes is the immediate past chair of the Council on School Health for the American Academy of Pediatrics, and on the pediatric faculty at University of Vermont College of Medicine.

**Ilisa Stalberg, MSS, MLSP** provides leadership and oversight of strategic planning, operations, human resources, workforce development, and communications with the division of maternal and child health. Ms. Stalberg leads the Title V application development and submission process and has been the senior liaison to the 2020 and 2015 Title V Needs Assessments. Prior to her role as Deputy Director, Ms. Stalberg served as the Director of Preventive Reproductive Health and

oversaw the CSHN State Improvement Grant in 2010. Before this, Ms. Stalberg serves as Director of Public Health Programs at the Maternity Care Coalition in Philadelphia. Ms. Stalberg has a Masters in Social Service and Law and Social Policy from Bryn Mawr College and has been working at the Department of Health since 2010.

**Strengths:** MCH direct service providers, including nurse home visitors and CSHN staff, are highly dedicated to their profession and to the families and children for whom they care, and have personal and professional values that strongly align with the work they perform. Providers recognize that working in the public health arena (and outside of hospital settings) affords them greater flexibility and autonomy than positions (and particularly nursing roles) in inpatient settings.

**Needs:** Staffing and workforce issues were among the most frequently discussed topics for focus group participants. Nurse home visitors, CSHN staff, and other MCH providers identified workforce shortages as a significant issue. Concerns related to this theme included high turnover, limited professional pathways for public health nurses, need to protect staff from burnout, lower pay in public nursing settings when compared to hospital-based positions, and a desire for greater flexibility and autonomy within their roles. Many direct service providers stated that their roles require “too much paperwork,” and that the time burden of administrative tasks detracts from their professional satisfaction.

For nurse home visiting, supervisors expressed concern that many nurse home visitors have an income below the median in Vermont, and face similar basic needs concerns as they families they work with, such as difficulty finding affordable housing and childcare, or being unable to afford winter tires to safely drive to home visits. At the same time, many nurse home visitors spoke about the benefits available to them including strong support from supervisors and peers, feeling like their work makes a meaningful contribution, and greater flexibility than many other kinds of nursing positions may allow.

For CSHN services, assessment participants identified needs for more personal care assistants (PCAs); better systems to train, support, and compensate PCAs; more specialized care providers with pediatric specialties and more accessible providers throughout the state; and more respite care providers who can alleviate the burnout that CSHN care providers and parents experience.

There are several recent reports describing workforce concerns among MCH stakeholder groups, including those within the CIS system, early childhood care (and primarily early childhood education), and other DCF systems.

## **TITLE V PROGRAM PARTNERSHIPS, COLLABORATION, AND COORDINATION**

MCH works very closely with other divisions within VDH to carryout activities under and connected to Title V. Vermont is served by a statewide network of local offices at the district level. MCH Coordinators and School Liaisons in each district office carry out Title V and other MCH activities within communities. The Division of Health Promotion and Disease Prevention houses programmatic activities related to tobacco control and prevention, oral health, physical activity and nutrition, and chronic disease. MCH works with the Division of Emergency Preparedness, Response, and Injury Prevention to address childhood injury, Environmental Health around toxic exposure, and the Alcohol and Drug Abuse Programs on shared planning around substance use in pregnancy and youth substance use. MCH epidemiology, data analysis, and surveillance is conducted by staff within the Division of Health Surveillance, as is our immunization program.

As a small rural state, Vermont has proportionally small state government agencies. Committed staff at children and family-serving state agencies and nonprofit organizations collaborate to address the needs of Vermont children and families.

MCH holds strong partnerships with the professional organizations that serve women of childbearing age, pregnant women, children, and families.

- Through ties to the Vermont chapters of the AAP, AAFP, ACOG, AMA and the VT NP Association, MCH ensures that public health information, messaging, and skill-building opportunities are imparted to these workforces.
- MCH convenes the School Nurse Advisory Committee, charged with advising and supporting the development of school nurse workforce clinical practice and leadership skills, including the promotion of the School Nurse Leader model and development/revision of the new school nurse orientation program. MCH's State School Nurse Consultant leads two courses Leadership Skills for Nurses 101 (communication, delegation, mentorship, performance measurement) and 201(ongoing learning community).
- Vermont MCH is a major sponsor of the VT Family Network's annual conference to educate health, human service, and educational providers, as well as a contributor to many professional conferences and forums each year.

#### FORMAL AND INFORMAL COLLABORATIONS AND PARTNERSHIPS

Vermont MCH works with a large number of state agency and community partners, too many to name them all here. Below are a few examples:

**Children's Integrated Services** provides support to families, children, and childcare programs through specialized childcare, early childhood and family mental health, early intervention and nursing/family support programs. These efforts provide a continuum of prevention and early intervention services for eligible prenatal/postpartum women, infants and children 0-6 and their families.

**Department for Children and Families (DCF) Family Services Division (child welfare).** Efforts are underway to ensure the medical and dental needs of children in custody are known to FS Caseworkers and foster parents, as well as the clear identification of children with special health needs, as these cases are often overlooked with serious consequences. Additionally, MCH and DCF are jointly planning around Family First prevention funds that will be coming and how MCH programs, especially home visiting, is an essential and effective child maltreatment prevention strategy.

**Department of Mental Health (DMH).** MCH partners with DMH on numerous projects. Most recently joint work includes the HRSA-funded maternal depression and other related disorders grant, suicide prevention, the child and family trauma workgroup, and a host of projects related to promoting resilience and strengthening families.

**Vermont Child Health Improvement Program (VCHIP).** VCHIP is a population-based child & adolescent health services research & QI program of the UVM. Since 2000, the partnership between the MCH and VCHIP has resulted in measurable improvements in child health outcomes across the pediatric age spectrum and a variety of health service areas.

**Dr. Dinosaur,** Vermont's Medicaid program for children insures income-eligible children up to age 19 and pregnant women, providing coverage for 56.7% of children in the state. Consequently,

98% of Vermont's children have some insurance coverage, the highest rate of any state. The program provides comprehensive health, dental, behavioral health and related services. Every pediatric practice in Vermont accepts Medicaid.

**American Academy of Pediatrics VT Chapter (AAPVT).** VDH collaborates with AAPVT to assist VDH in the development of more efficient and effective health care services for children and families through consultation with the health care professional community and to identify and improve systems of care for children at risk. A monthly Primary Care and Public Health Integration meeting convenes the leadership of MCH, VCHIP, AAP, AAFP, Planned Parenthood, ObGyns, & internal medicine providers, to coordinate various projects.

**University of Vermont Medical Center/University of Vermont Children's Hospital.** Vermont MCH works very closely with UVMHC to improve the system of care for children and families.

**Agency of Education.** MCH collaborates with health education consultant at Agency of Education to align skills and content in our state's approach to health education in public schools. MCH also works closely with AOE around essential school health services through the state school nurse consultant.

**Parent Child Centers** are a network of 15 non-profit organizations across Vermont that provide support and education to families with young children. PCCs help all Vermont families get off to a healthy start, promote well-being and build on family strengths. This support and education helps to prevent problems such as school failure, poor health, welfare dependency, family violence and abuse. Parent Child Centers offer help for at-risk families by forming trusting relationships while engaging them in services.

**Vermont Family Network (VFN)** is committed to a mission that promotes better health, education and well-being for all children and families, with a focus on children and young adults with special needs. VFN regularly participates in our annual Title V submission, needs assessment, and attends the block grant review yearly.

**Vermont Afterschool** is a public-private statewide partnership dedicated to supporting and sustaining innovative learning opportunities that extend beyond the school day for all Vermont's children and youth. Activities are directed toward increasing the quality and availability of education programs during non-school hours.

**Developmental Understanding and Legal Collaboration for Everyone (DULCE)** is an evidence-based program in three states, including Vermont. DULCE is an innovative intervention embedded within pediatric primary care. DULCE proactively screen for and address SDOH to promote the healthy development of infants from birth to six months and provide support to their parents. A key feature of the DULCE intervention is a Family Specialist – a Parent Child Center employee and member of the pediatric team - who connects families to resources based on parents' needs and priorities. DULCE employs the Medical-Legal Partnership model to provide families more intensive assistance obtaining concrete. DULCE incorporates a Strengthening Families™ Protective Factors approach. To date, 99% of families agree to participate, with 330 families having been served. Families are universally screened for intimate partner violence, maternal depression, and concrete supports and referred to services.

**Planned Parenthood** makes up Vermont's network of family planning centers. Vermont recently made the decision to decline federal Title X funding due to recent rule changes that were in direct conflict to Vermont's approach. Although this could have created significant challenges to meeting

the family planning needs of low-income Vermonters, state officials made the decision to use state funds to fill this gap until the federal rule is overturned.

**Outright VT** is a statewide organization whose mission is to build safe, healthy, and supportive environments for LGBTQ youth. Outright worked with MCH to increase knowledge and skills among employees around gender-inclusive language and identify opportunities to use more inclusive language in programming and communication. Now that we have been trained, we are currently working on an action plan to continue implementation of these critical topics.

**Women's Health Initiative** Women receive primary care and preventative care services in both Patient-Centered Medical Homes, obstetrics and gynecology practices, and Planned Parenthood. Through the Women's Health Initiative, all of these settings are offering the women they serve enhanced health and psychosocial screening, comprehensive family planning counseling, and timely access to long acting reversible contraception (LARC). The aim is to help women be well, avoid unintended pregnancies, and build thriving families. Women who visit participating practices are screened for mental health and substance use conditions, interpersonal violence, and access to housing and food. If they are identified as at-risk, they have immediate access to a licensed social worker for brief intervention, counseling, and navigation to community-based services and treatment as needed. Participating practices also commit to offering comprehensive family planning counseling for their current patients and for women newly referred by partnering community-based organizations. Women who wish to become pregnant receive services to support healthy pregnancy. Women who wish to delay or avoid becoming pregnant have access to the full spectrum of contraception options, including same-day access to LARC.

## 5. CONCLUSIONS

Overall, the services MCH provides under Title V are well aligned with the needs that were identified across Vermont, and the generally strong health outcomes MCH indicators reveal are strong evidence of all that is "working well" in MCH systems of care. The needs assessment found several important themes that cut across all of MCH's work that relate to the domain-specific themes and findings:

**1. Addressing basic needs and social determinants has a direct impact on the health of MCH populations.** Especially in light of the COVID-19 pandemic, the primacy of meeting basic needs as a cornerstone of public health was well founded throughout this assessment. For low-income families, meeting basic needs is the highest priority, and when these needs are not well addressed, it is difficult to engage in any other kinds of service or support, no matter how well intended or likely it may be to alleviate individuals' health and wellness conditions and concerns. To the extent that the health care system (and children's medical homes), is the point of access for families to address physical, emotional, developmental, and behavioral needs, integrating (and potentially shifting resources to) basic needs responses such as affordable housing or accessible transportation may alleviate the resource gaps that eventually show up as unmet health needs and risks.

**2. Consumers and providers are concerned about the prevalence of mental health issues and the availability of care.** Topics related to depression, anxiety, suicide and postpartum/ maternal mental health issues came up in every focus group. On the Access to Health and Wellness Survey, 265 respondents provided a response other than "N/A" regarding their ability to access mental health services. More than one in four respondents (26.4%) indicated that they can "never" or "seldom" access mental health services, and an additional 21.9% indicated that they could access mental

health services “about half the time” (Table 9). The Vermont Vulnerability Index includes a ranking of counties based on their availability of mental health providers. Half of Vermont counties (Addison, Bennington, Caledonia, Essex, Franklin, Grand Isle, and Orleans) were identified as having an inadequate supply of licensed mental health providers.<sup>33</sup> Participants were especially concerned about the limited availability of mental health providers who specialize in serving families, young children, and adolescents as well as those who are trained to address postpartum mental health conditions.

Table 9. Access to mental health services									
Never		Seldom		About Half the Time		Usually		Always	
7.5%	20	18.9%	50	21.9%	58	23.4%	62	28.7%	76

**3. Regional differences in levels of care may undermine equity and positive results in some areas of Vermont.** As discussed above, Vermont’s rural nature means that many kinds of health and human services are concentrated in a few larger towns. In Vermont’s most remote counties, residents may have to travel outside of their region to receive services. Needs assessment participants were especially concerned about access to a variety of kinds of specialist care, as these services are often not available and require travel of up to three hours. While MCH services are delivered through MCH coordinators at local offices of health and therefore available throughout the state, how community needs are identified, prioritized, and resourced varies from region to region. Services that are provided via contracts with local service agencies may be especially likely to provide different levels of care for similar services.

**4. Building relationships and informal connections contributes to health and wellness for MCH populations.** A surprising finding of the needs assessment was the large number of individuals who provided input via open-ended survey responses or focus groups about a desire for more opportunities to connect. Concerns about the negative impact of isolation on health and wellness came up across all MCH population domains. Immigrant and refugee populations, youth, and parents in general identified benefits from peer supports, and from informal community spaces and opportunities to build and maintain positive social connections. In MCH service delivery, nurse home visitors and CSHN medical social workers spoke about the value they see for families who have strong social connections, and the critical role they can play in connecting parents to other parents.

**5. Seek opportunities to replicate effective programs and services.** MCH stakeholders especially value the DULCE model, home visiting, and many traditional Title V/ MCH programs such as those that support breastfeeding, provide postpartum and well-baby care, and pregnancy prevention. STAMMP and the VCHIP Women’s Health Initiative were named as strategies that consumers and/or providers have especially valued.

**6. Address the full scope of MCH health needs among Black, Indigenous, and People of color (BIPOC) communities.** The need to direct resources toward ensuring that BIPOC communities are included in MCH efforts emerged because it is largely absent from this needs assessment. Very few BIPOC individuals who are not immigrants or refugees participated in assessment activities. Likewise, BIPOC individuals are almost non-existent in Vermont’s MCH and stakeholder provider workforce. Likewise, no VDH-funded efforts or initiatives that expressly serve non-immigrant or refugee BIPOC communities to address MCH needs were identified. While a handful of service providers

<sup>33</sup> Vermont Vulnerability Assessment. 2019. Vermont Department of Health.

referenced issues related to “equity and inclusion,” the low visibility for the specific health concerns that low-income BIPOC mothers, infants, children and adolescents face warrants continued investigation. Amid Vermont’s shifting racial demographics, and in light of historic health disparities and structural inequities, all health and human services must consider how well they are equipped to provide high quality care for BIPOC communities.



## APPENDIX

1. Focus Group Questions

2. Vermont Access to Health and Wellness Survey

## **Vermont MCH Title V/ MIECHV Focus Group questions**

### **PATIENTS/CONSUMERS**

1. How well/ to what extent are your basic needs met?
2. How can Vermont's health and wellness systems serve you better?
3. Have you [now/ ever?] stopped participating in the health care system?
4. How well can you access mental health care for myself and my children?
5. Who in VT is looking out for your health and well being?
6. What issues about your health or the health of members of your family are you most concerned about today?
7. Are you concerned about:
  - a. health during pregnancy?
  - b. substance use?
  - c. specialized health needs?
  - d. mental health issues or care?
8. Are you eligible for home visiting?
  - a. If you have used home visiting, how well is it working?
9. What gets in the way of your ability to meet your health and wellness needs?
10. Where do you go when you have a health concern?
11. What care did you receive during pregnancy? After pregnancy?
12. If you have had a housing crisis what did you do?
13. Are there ways others in your community (neighbors, extended family) help you with health issues or concerns?
14. Who do you talk to when you are concerned about your health or the health of someone in your family?

### **PROVIDERS**

1. What questions are you asked by your patients/ clients that you don't know how to answer?
2. What kinds of screenings do you routinely conduct? How well is it working?
3. Do you have summary screening data that you can share related to prenatal wellness and substance use and children developmental screening, domestic violence?
4. What gaps do you see in the resources that are available for the population/s you serve?
5. What questions are not being asked?
6. How are the health literacy and advocacy skills of people you serve? What are you doing about improving /increasing that?
7. How do you promote preventative care?
8. Among people you serve which basic needs are most unattended?
9. What are the new/ emerging health-related trends for the people you serve?
10. Do you feel that you know where to refer people (for specific services)? Ex. Suicide prevention, vaping.

### **Questions for all:**

1. What do you think the Vermont Maternal and Child Health division is doing well?
2. If you could choose one way to improve the health of any Vermont's maternal, family and child health populations what would it be and why?

Access to Health and Wellness Survey

Thank you for taking the time to tell us what you think about the needs of women, children, and families in your community! The information gathered from you will be used as part of a large needs assessment in which we are examining the gaps, challenges and successes in the health & human services delivery system for families with children in Vermont.

Please respond with as much information as you'd like to share. Your answers are confidential and will never be individually identified. The survey should take 15 minutes or less to complete.

Thank you

1. Please rank the following factors on a scale of 1-4 with 4 representing the factors that are the most critically necessary for women, families and children to thrive.

	1 the least critically necessary	2 somewhat critically necessary	3 critical necessary	4 the most critical necessary
Childcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accessible and affordable healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial security	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental well-being	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access to mental health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support and education for parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paid family leave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling safe in the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help navigating systems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reproductive Care & Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	1 the least critically necessary	2 somewhat critically necessary	3 critical necessary	4 the most critical necessary
Maternity Care & Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safe and healthy family dynamics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol, smoking or substance use treatment and support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Culturally relevant support and services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support for breastfeeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did we miss some factors? enter here

2. These are some maternal and child health services and resources that may be available in your community. How often can you and your family get these services if you need them?

	Never	Seldom	About Half the Time	Usually	Always	N/A
Assistance getting, understanding and using birth control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual health education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnancy planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prenatal care when pregnant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
After pregnancy and between pregnancy care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnancy or birth-related depression services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adult well visits with a primary care provider or family doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Well-baby and well-child visits with a pediatric provider or family doctor/provider	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home visiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Never	Seldom	About Half the Time	Usually	Always	N/A
Services to reduce stress, such as respite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance use treatment, such as drug or alcohol counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support for quitting smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services addressing intimate partner/domestic violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services to prevent injuries and violence, including self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parenting information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Information on preventing infant deaths	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Newborn screening information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Early intervention to identify the need for testing and support for babies with developmental delays	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services and treatment for babies born with health issues related to drug or alcohol exposure/use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Creating safe sleep areas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specialists and treatment centers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnostic testing as a result of newborn screening (such as follow up hearing test or genetic test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infant feeding, including breastfeeding support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wellness services such as those to increase healthy eating and physical activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Never	Seldom	About Half the Time	Usually	Always	N/A
Lead poisoning prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Programs that help youth develop social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transition to adult health care system support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bullying prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Training for parents/caregivers on care coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support to navigate the system of care for children with special health care needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Here is a list of barriers that might prevent people from receiving services or resources. For each population, select all barriers or groups of barriers that you, as a service recipient or family member of a service recipient, have experienced.

	Pre-Pregnancy/Pregnancy	Perinatal/Infant	Children 1-21 (with or without special health care needs)
Physical access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do not know what services and resources are available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No service available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needed service not offered by provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needed services not covered by insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-of-pocket-costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not eligible for services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Application forms too complicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel staff are not helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel embarrassed about getting services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel discriminated against	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

4. Where do you physically go in your neighborhood or community for health information or discussion about health issues or health information? For each population, select all places that you think apply.

	Pre-Pregnancy/Pregnancy issues	Perinatal/infant	Children 1-21 (with or without special health care needs)
Faith-based organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community-based organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advocacy organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Government Agencies (WIC, local health department, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair Salon/ Barber Shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face-to-face groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health clinics/hospitals and/or Health Care Provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Virtual/internet groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Libraries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)



Access to Health and Wellness Survey

Information About You

The next 5 questions are all about you. Please share as much or as little as you are comfortable with. Thanks!

5. I am responding to these questions as a..... (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Mother  | <input type="checkbox"/> Child Development Division Staff                       |
| <input type="checkbox"/> Father  | <input type="checkbox"/> Department of Children and Families Staff              |
| <input type="checkbox"/> Grandparent   | <input type="checkbox"/> Other state agency staff                               |
| <input type="checkbox"/> Other guardian  | <input type="checkbox"/> Other Maternal & Child Health Workforce                |
| <input type="checkbox"/> Adolescent or Youth   | <input type="checkbox"/> Elected official/policy maker                          |
| <input type="checkbox"/> Parent/Guardian/Advocate of a Child with Special Health Needs | <input type="checkbox"/> Community-based Organization or Nonprofit Staff Member |
| <input type="checkbox"/> Healthcare Professional                                       | <input type="checkbox"/> Community Member                                       |
| <input type="checkbox"/> Local Public Health Staff                                     | <input type="checkbox"/> Community Leader                                       |
| <input type="checkbox"/> Maternal Child Health Staff                                   |   |
| <input type="checkbox"/> Other (please specify)  |   |

6. What county do you live in?

- |   |                                  |
|---|----------------------------------|
| <input type="radio"/> Franklin/Grand Isle | <input type="radio"/> Addison    |
| <input type="radio"/> Orleans             | <input type="radio"/> Orange     |
| <input type="radio"/> Essex               | <input type="radio"/> Rutland    |
| <input type="radio"/> Lamoille            | <input type="radio"/> Windsor    |
| <input type="radio"/> Caledonia           | <input type="radio"/> Bennington |
| <input type="radio"/> Chittenden          | <input type="radio"/> Windham    |
| <input type="radio"/> Washington          |                                  |

7. What is your age?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

8. How do you identify your race/ethnicity? (Select all that apply)

- American Indian or Alaska Native
- Black or African American
- Hispanic or Latino
- Asian or Asian American
- White/Caucasian
- Native Hawaiian or other Pacific Islander
- Another race
- Prefer not to answer

9. What best describes your sexual orientation?

- Lesbian
- Gay
- Bisexual
- Queer
- Other (please specify)
- Two Spirit/Native
- LGBTQ
- Straight/Heterosexual
- Prefer not to answer

10. What is your gender identity?

- Female/Woman
- Male/Man
- Trans female/Trans woman
- Different Identity (please specify)
- Trans male/Trans man
- Genderqueer/Gender non-conforming
- Prefer not to answer

11. If there anything else you would like us to know about how you identify yourself, please share it below.

12. If there is anything else you would like us to know about your experience interacting with Vermont 's Health and Human Services System, please share it below. Thank-you.

13. If you would like to be entered into a drawing for a Target Gift card please enter your contact information below. This is optional.

**Name**

**Email Address**

**Phone Number**