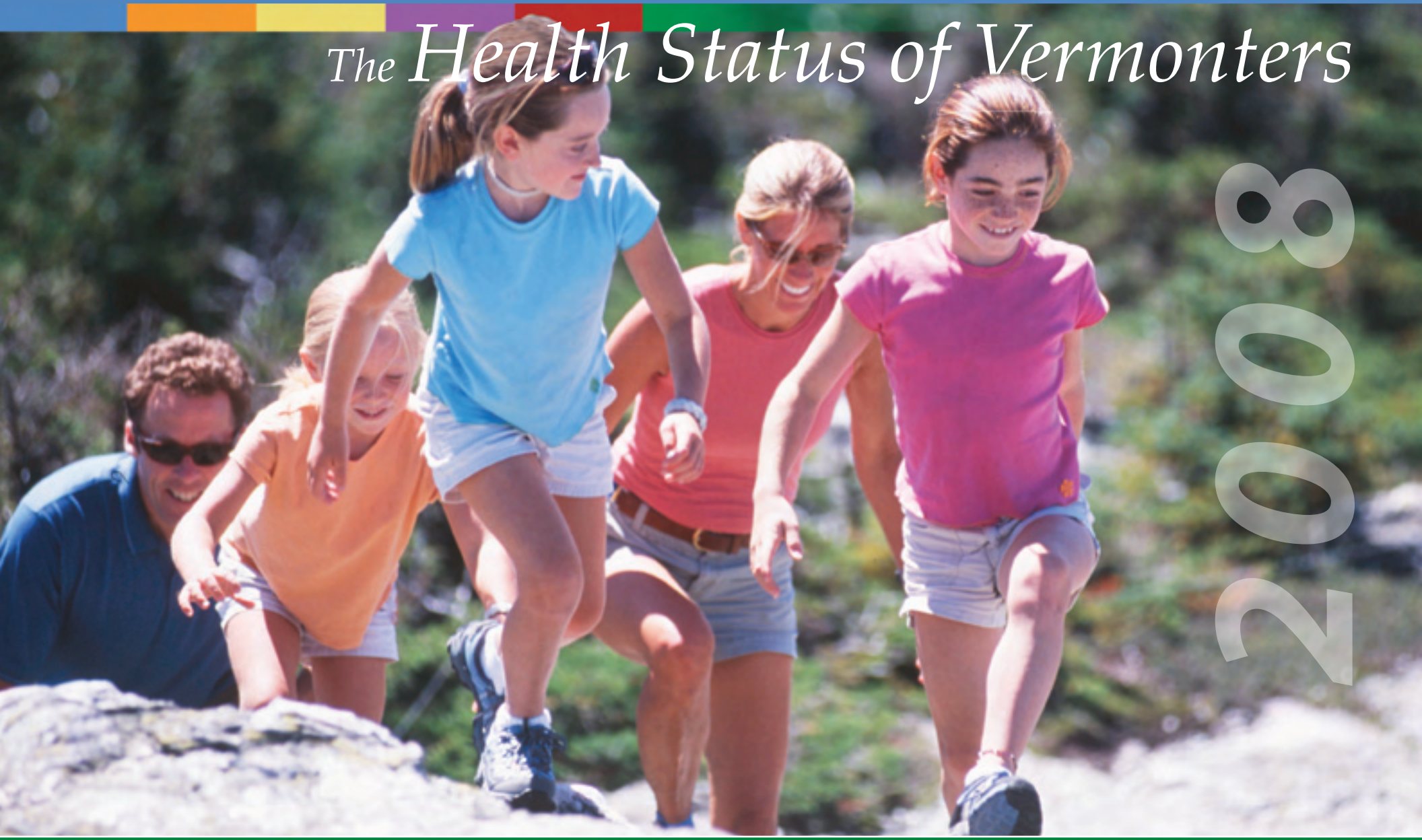
The Health Status of Vermonters

2008



VERMONT
DEPARTMENT OF HEALTH

Contents

The Health Status of Vermonters 2008
is also available at:
HealthVermont.gov

Vermont Department of Health 108 Cherry Street, PO Box 70, Burlington, Vermont 05402

ON THE COVER — *front: hikers at Mount Mansfield*
back (clockwise from left): Burke Mountain; Kingsland Bay State Park; Green River Reservoir; Girls on the Run day at UVM's Gutterson Field House; Vermont Apple Festival at Justin Morrill Historic Site

March 2008

VERMONT
DEPARTMENT OF HEALTH

Dear Vermonter,

By many measures, Vermont is among the healthiest of the United States.

In the 2007 edition of *America's Health Rankings* our state was named the healthiest in the country. We should be proud of this distinction. Vermont is notable for lower smoking rates, lower prevalence of obesity, higher rates of childhood immunization, and lower rates of preventable death.

Such health gains don't just happen. One of the essential functions of public health is to continually analyze data and trends — and apply what we can learn to improving the health of the population. With this report, the Vermont Department of Health again brings together data from an array of sources into a single document to present a picture of the health of Vermonters.

The following pages show data and trends through 2005 related to illness and disease, clinical preventive services, health insurance, access to medical care, and personal health behaviors. Here we can see how well our state is doing in key areas, our progress in meeting *Healthy Vermonters 2010* goals, and where we stand compared with the U.S. as a whole.

Are we as healthy as we can be? As measured midway to our 2010 goals, the answer is *not yet*.

Too many of us suffer from conditions that are largely preventable. We must continue to apply the public health approach to problems such as obesity, binge drinking and the health disparities that exist for too many Vermonters. Obesity takes a disproportionate share of our health care dollars, and is well on its way to displacing tobacco as the #1 killer. We need goverment, communities and individuals to make even greater improvements — and inspire the rest of the nation to keep up.

Sharon Moffatt, RN, MSN
Commissioner of Health

Reader's Guide

• Healthy Vermonters 2010 Objectives

This report is organized into 17 focus areas. In addition to key graphs and facts, each focus area describes the progress Vermont has made toward meeting its Healthy Vermonters 2010 objectives.

These 2010 objectives were identified in 1999 by educators, policymakers, health professionals and consumers as the priority focus areas for improving the health of Vermonters.

In this status update, mid-way to 2010, Vermont data for 2005 are presented for each objective and compared to the Healthy Vermonters 2010 goal target. (In cases where 2005 data are not available, the most recent year is presented.)

Readers making a comparison between the objectives presented in Vermont's *Health Status Report 2002* and this report will note several differences:

Revised objectives: Healthy Vermonters 2010 objectives were originally selected from among hundreds of the national Healthy People 2010 objectives. After a recent mid-course review, some national 2010 objectives were changed, either in their definition or goal target. Vermont has chosen to change as well, to stay consistent with national objectives.

Dropped objectives: A handful of Healthy Vermonters 2010 objectives were dropped – because the equivalent national objective was dropped after the mid-course review, Vermont priorities have changed, or because the objective could not be measured.

New objectives: In addition to Healthy Vermonters 2010 objectives, some additional objectives have been added. These are mostly clinical service objectives and they are noted simply as "goals" as opposed to "2010 goals".

When Vermont has met an objective, it is noted with a check symbol: ✔

• Vermont/U.S. Comparisons

As of 2005, the percentage of racial and ethnic minorities in Vermont was approximately 3.3 percent, as compared to 25 percent for the nation as a whole.

Because risk factors and other health indicators often vary by race or ethnicity, where applicable, Vermont data are compared to U.S. non-Hispanic white data. For convenience, these data are labeled simply as "US" throughout the report, unless otherwise noted.

• Statistical Significance

If there is a statistically significant difference between Vermont and the U.S. white non-Hispanic rates, it is noted with these symbols:

Vermont is statistically better than the U.S. ✪
Vermont is statistically worse than the U.S. ✘

• Federal Poverty Level

In Vermont, disparities in health outcomes are not so much a function of geographical location, but of income (or poverty) levels. For this reason, much data in this report has been charted by income level comparisons, rather than mapped.

Federal Poverty Guidelines are issued each year by the U.S. Department of Health and Human Services. They are a national measure of poverty and are used to determine eligibility for an array of programs and services. These guidelines are sometimes referred to as the Federal Poverty Level (FPL), as they are in this report.

In 2005, the FPL for an individual was income of $9,500/year and for a family of four, $19,350. By 2008, the FPL rose to $10,400 for one person- and $21,200 for a family of four.

• Appendix

More information on data sources, technical notes and definitions is provided in a separate appendix to this report. The appendix also provides geographic breakdowns of all the objectives – by county, by Vermont Department of Health district office, and by Hospital Service Area, wherever possible. If the sample size is sufficient, these data are compared to the rest of the state – again noting statistical significance.

Data Sources & References

The information used to report health status comes from a variety of sources, including birth and death records, hospital discharge data, personal interviews and telephone surveys. Major references, data sources, and databases are listed here.

United States

Agency for Healthcare Research & Quality
- Health Care Cost & Utilization Project

National Cancer Institute
- Surveillance, Epidemiology & End Results Registries

National Highway Traffic Safety Administration

U.S. Census Bureau & U.S. Bureau of Labor Statistics
- The Annual Social & Economic Supplement to the Current Population Survey

U.S. Department of Health & Human Services

Centers for Disease Control & Prevention
- Healthy People 2010
- National Health & Nutritional Examination Survey
- National Immunization Survey
- National Notifiable Disease Surveillance System

Substance Abuse & Mental Health Services Administration
- National Survey on Drug Use and Health

U. S. Department of Labor/Occupational Safety & Health Administration
- Annual Survey of Occupational Injuries and Illnesses

Vermont

Department of Banking, Insurance, Securities & Health Care Administration
- Vermont Uniform Hospital Discharge Data Set

Department of Environmental Conservation

Agency of Human Services

Department of Health
- Adult Tobacco Survey
- Behavioral Risk Factor Surveillance System
- Blood Lead Surveillance System
- Cancer Registry
- HIV, AIDS & Sexually Transmitted Diseases Data
- Immunization Registry
- Oral Health Survey
- Pregnancy Risk Assessment Monitoring System
- Reportable Disease Surveillance Data
- Special Supplemental Nutrition Program for Women, Infants & Children (WIC)
- Vermont Dentist Survey
- Vermont Physician Survey
- Vital Statistics System
- Youth Health Survey
- Youth Risk Behavior Survey

Department of Mental Health

Department of Taxes
- Cigarette Excise Tax Stamp Data

Governor's Highway Safety Program

Vermont Association of Hospitals & Health Systems

Vermont Crime Information Center

Physical Activity & Nutrition

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of people who engage in regular physical activity * *

• youth grades 9-12		• adults age 18+	
2010 Goal	35%	2010 Goal	50% ✔
VT 2005	27%	VT 2005	58% ✪
US 2005	27%	US 2005	34%

Decrease % of people who have no leisure time physical activity

• adults age 18+	
2010 Goal	20% ✔
VT 2005	19% ✪
US 2005	35%

Decrease % of people who watch TV or use a computer 5+ hours/day

• youth grades 9-12	
Goal	8%
VT 2005	10%
US 2005	*

Increase % of people who eat 2+ servings of fruit/day

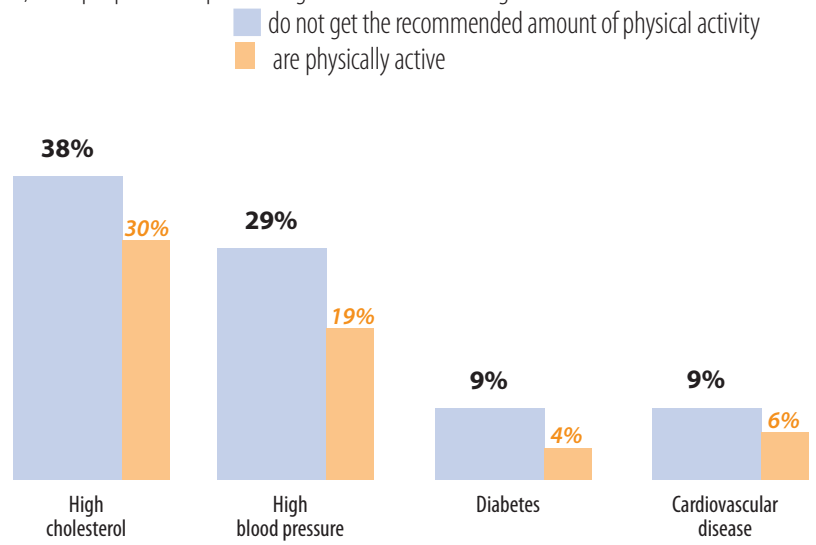
• youth grades 9-12		• adults age 18+	
2010 Goal	75%	2010 Goal	75%
VT 2005	37%	VT 2005	39% ✪
US 2005	*	US 2005	31%

Increase % of people who eat 3+ servings of vegetables/day

• youth grades 9-12		• adults age 18+	
2010 Goal	50%	2010 Goal	50%
VT 2005	14%	VT 2005	31% ✪
US 2005	*	US 2005	29%

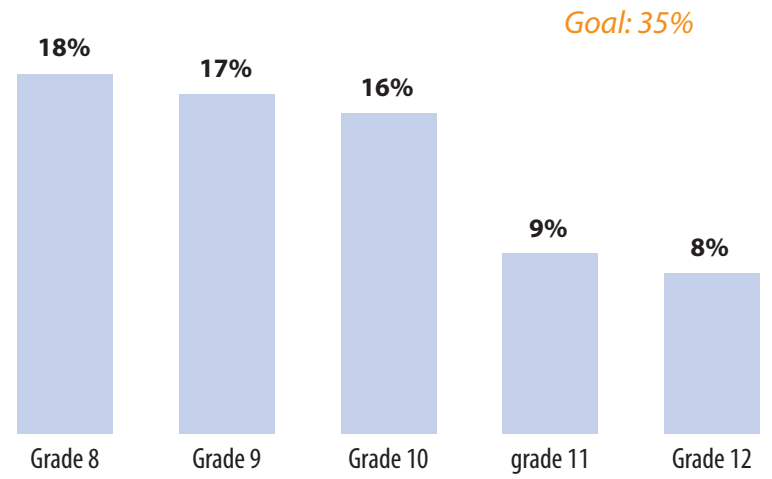
Chronic Disease & Physical Activity

In 2005, % of people who report having chronic disease among those who –



Daily Physical Education

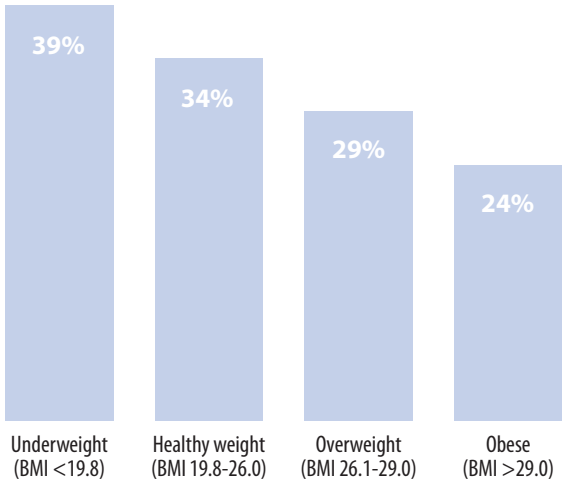
% of 8th-12 graders who have gym every school day, 2005
(30 minutes of moderate physical activity 5+ times/week)



** data not available* ** * 30 minutes of moderate physical activity 5+ times/week*

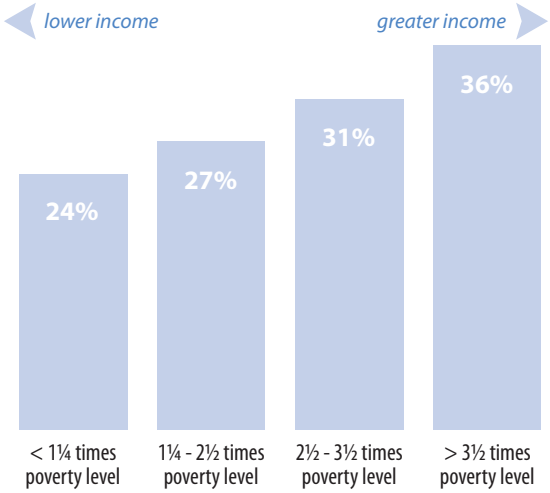
Eating Fruit/Vegetables & Weight

% of adults who eat 5 or more servings of fruits and vegetables per day, 2005



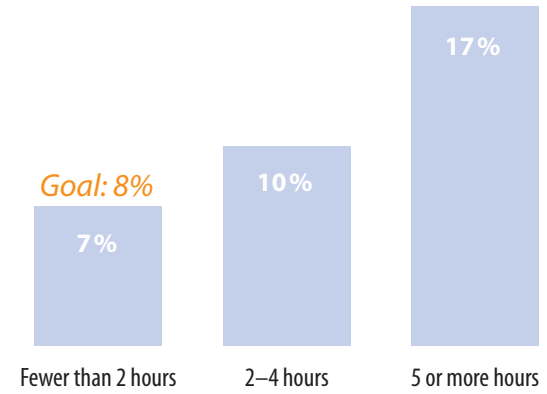
Eating Fruits/Vegetable & Income

% of adults who eat 5 or more servings of fruits and vegetables per day, by Federal Poverty Level, 2005



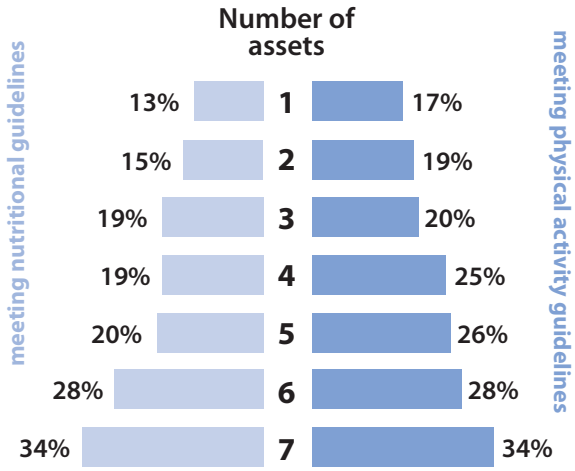
Overweight & Screen Time

% of 9th-12 graders who are overweight, by hours of leisure time per day spent in front of a TV or computer screen, 2005



Health Behaviors & Assets

% of 9th-12 graders who who eat 5+ servings of fruits or vegetables daily, and % who get moderate exercise 5+ days/ week, by number of assets, * * * 2005



• Benefits of Physical Activity

Regular exercise helps build and maintain healthy bones and muscles, controls weight, reduces feelings of depression and anxiety, and promotes wellbeing.

Exercise need not be strenuous to be beneficial. Moderate intensity physical activity—such as brisk walking or active play—may be added in several 10 or 15 minute sessions.

• Move More

Adults need at least 30 minutes of moderate exercise five or more days a week, or 20 minutes of vigorous exercise three or more days a week. Children and teens need at least 60 minutes of moderate exercise on most days.

School physical education programs help students participate in physical activity and develop the knowledge, attitudes and skills they need for lifelong physical activity.

Television viewing, video gaming and computer use are the most common sedentary leisure time activities in the U.S.

• Eat More Colors

Fruits and vegetables are naturally high in fiber, and low in calories, adding volume to meals and allowing people to eat more and feel fuller with fewer calories.

Most adults should eat at least 2 cups of fruit and 2-1/2 cups of vegetables a day.

** * * Assets include good grades, interaction with and support from parents, involvement in clubs and volunteer activities, and self-perceived value in communities and in school decision-making. For more info: childtrendsdatabank.org*

Overweight & Obesity

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Decrease % of adults age 20+ who are obese

(as measured by BMI * *)		
	2010 Goal	15%
	VT 2005	21% ✪
	US 2005	23%

Decrease % of youth (grades 9-12) who are obese or overweight

(as measured by age-specific BMI)		
	2010 Goal	5%
	VT 2005	10%
	US 2005	12%

Increase food security to reduce hunger

(as measured by % of adults who report having enough food to eat and enough money to buy food)

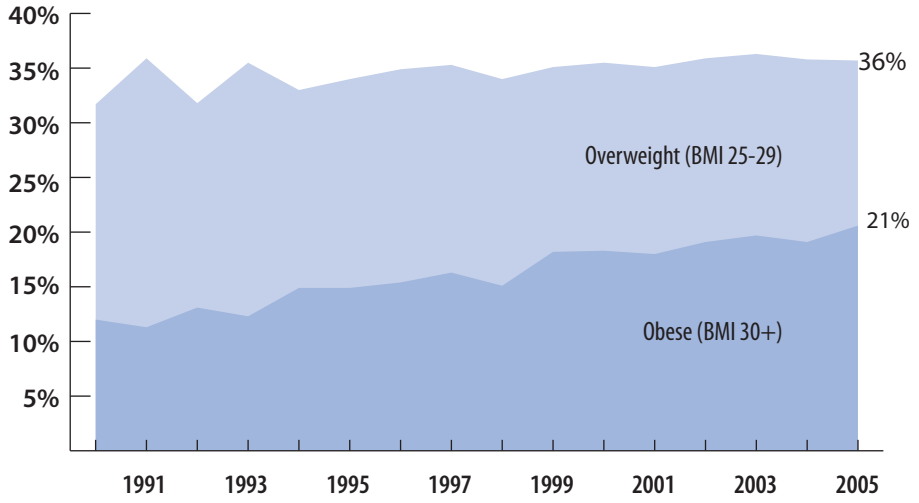
2010 Goal	94%
VT 2004	91%
US 2004	*

Decrease % of WIC participants (age 2-5) who are overweight

(as measured by age-specific BMI)		
	Goal	5%
	VT 2005	12%
	US 2005	12%

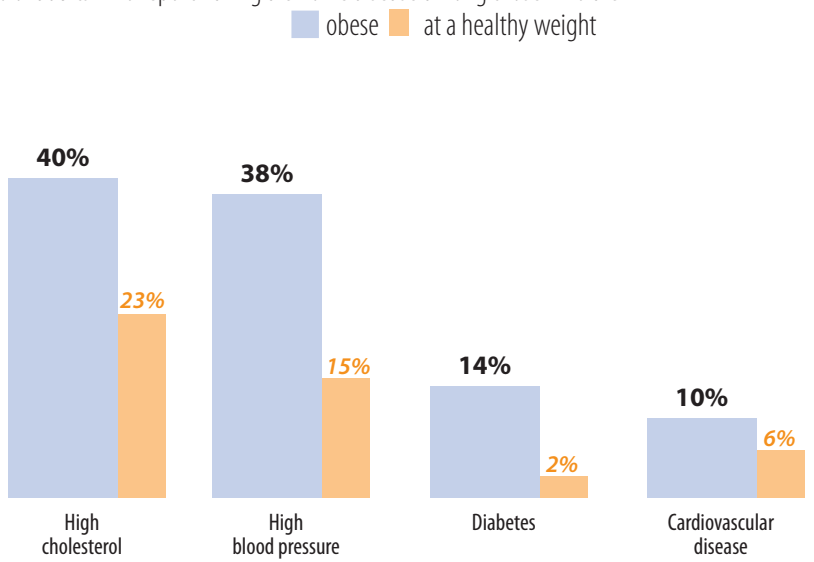
Prevalence of Overweight

% of adults age 20+ with Body Mass Index of 25 and higher



Obesity & Chronic Disease

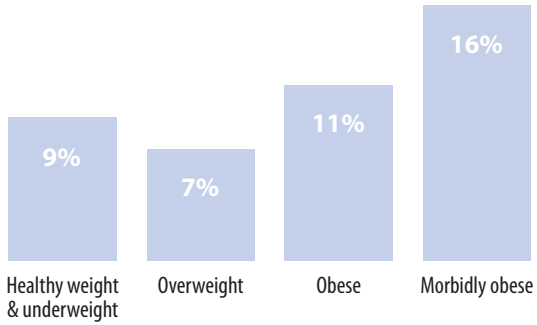
In 2005, % of adults who report having a chronic disease among those who are –



* *data not available* ** *To calculate Body Mass Index (BMI) for adults: go to healthvermont.gov, then select Fit & Healthy Vermonters.*

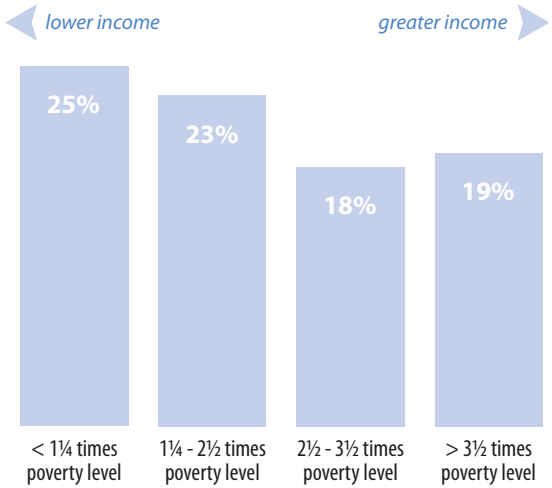
Weight & Inadequate Food Supply

% of adults who report they don't have enough food or enough money to buy food, by weight category, 2004



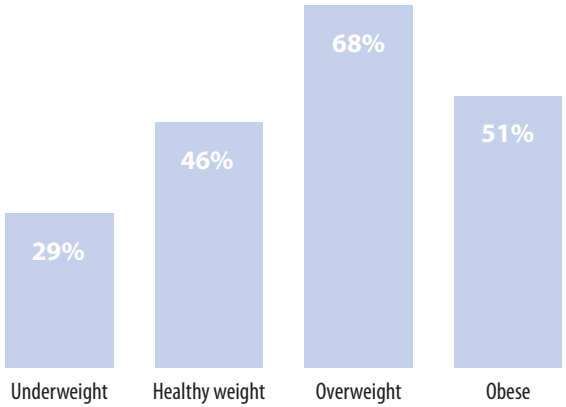
Weight & Income

% of obese adults, by Federal Poverty Level, 2005



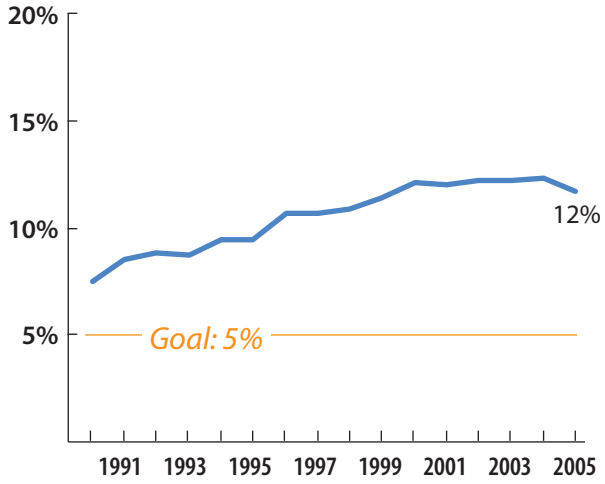
Weight Gain in Pregnancy * * *

% of women who gain excess weight during pregnancy, by pre-pregnancy weight category, 2004



Overweight among Children

As measured by % of children age 2-5 in WIC Program who are at 95th percentile of BMI



• Prevalence of Obesity

Vermonters, like other Americans, are growing more overweight—a trend that holds true for both adults and children.

For Vermont adults, an estimated 21% or 95,000 age 20+ are obese, and 56% or 165,000 more are overweight. In general, women who are overweight or obese gain more than the recommended amount of weight during pregnancy.

About 5% or 2,800 students in grades 9-12 are overweight or obese, and 4,100 more are at risk for becoming overweight.

The highest rates of obesity are among low income Vermonters. Adults without food security must often compromise quality for quantity, eating higher-calorie but lower-cost foods.

• Risk for Chronic Disease

Being overweight greatly increases a person's risk for many chronic diseases, including high blood pressure, diabetes, osteoarthritis, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances, breathing problems and certain cancers.

• Physical Activity & Nutrition

Achieving and keeping a healthy weight requires a balanced, lower-calorie diet and more physical activity. Even modest weight loss for people who are overweight can lower risk for chronic disease. Studies now suggest that breastfeeding lowers a child's risk for obesity.

** * * Excess weight gain in pregnancy = > 40 lbs for underweight women >35 lbs for healthy weight women > 25 lbs for overweight or obese women*

Tobacco Use

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Decrease % of adults who smoke cigarettes

2010 Goal	12%
VT 2005 * *	20% ✪
US 2005	22%

Decrease % of youth in grades 9-12 who –

- smoke cigarettes

2010 Goal	16%
VT 2005	18% ✪
US 2005	26%

- use spit tobacco

2010 Goal	1%
VT 2005	8%
US 2005	10%

- smoke cigars, cigarillos, little cigars

2010 Goal	8%
VT 2004	12%
US 2005	*

Increase % of adult smokers who attempt to quit

2010 Goal	75%
VT 2005	53%
US 2005	52%

Increase % pregnant women who quit smoking during first 3 months of pregnancy

2010 Goal	30%
VT 2004	29%
US 2004	*

Increase % smokers with children who don't allow smoking –

- in their home

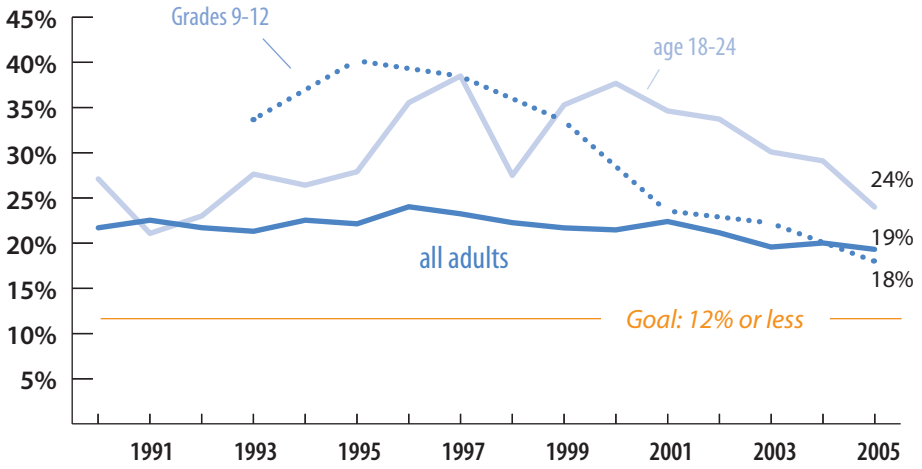
2010 Goal	70%
VT 2005	66%
US 2005	*

- in their car

2010 Goal	75%
VT 2005	72%
US 2005	*

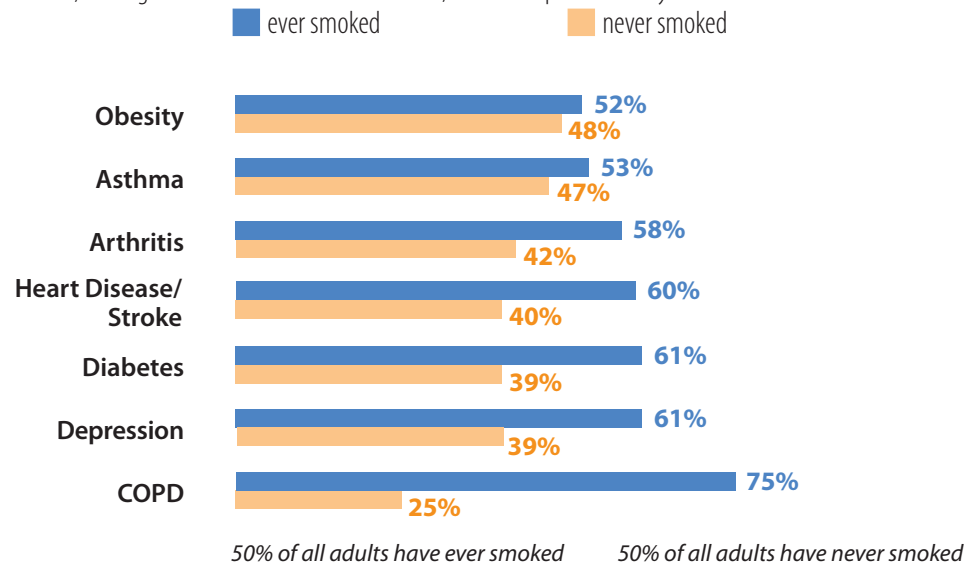
Cigarette Smoking

% of adults who are current smokers * *



Smoking & Chronic Disease

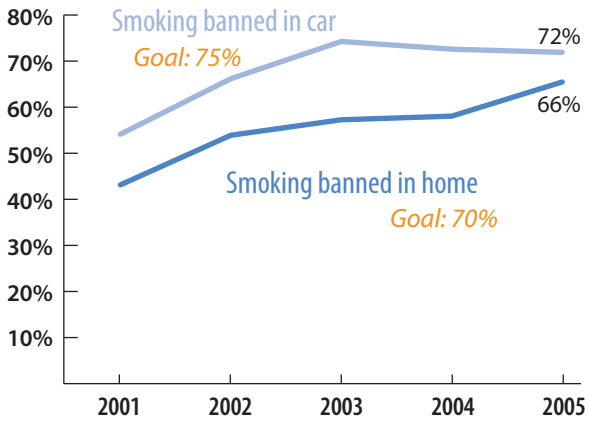
In 2005, among adults who have chronic disease, % who report that they have —



* *data not available*

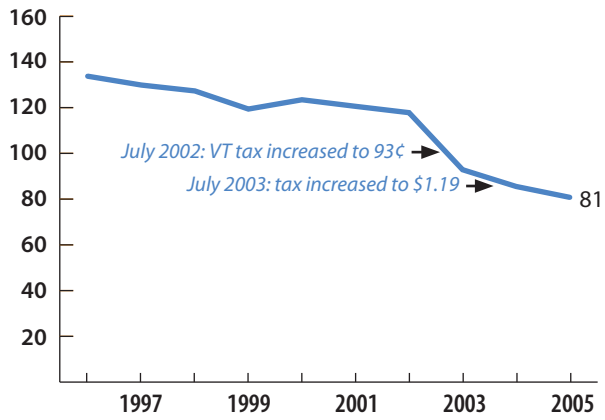
Secondhand Smoke

% of adult current smokers and recent quitters with children younger than age 1 who report –



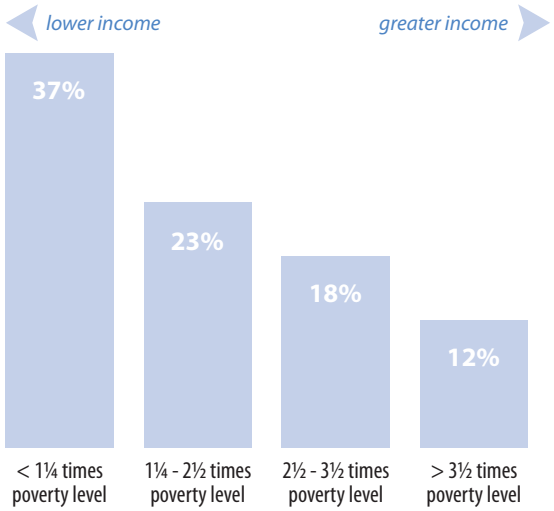
Cigarette Sales

As measured by # cigarette packs sold per person, per year



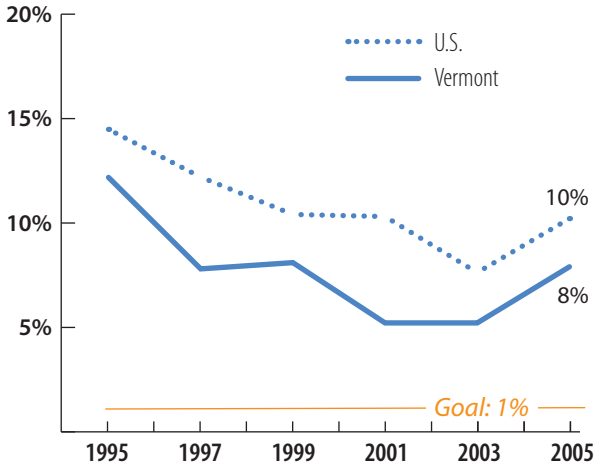
Smoking & Income

% of adult current smokers, by Federal Poverty Level, 2005



Youth & Spit Tobacco

% of 9th-12th graders who use chewing (spit) tobacco



• Tobacco: Still the #1 Real Killer

Tobacco use is still the leading cause of preventable death. In 2005, about 800 deaths could be tracked to smoking. Smoking leads to or complicates asthma, heart disease, cancer, lung disease, stroke, pneumonia, low birth weight in babies and infant mortality.

An estimated 87% of all lung cancer cases in the U.S. can be attributed to smoking. The longer a person smokes, the greater risk they have for lung cancer.

• Secondhand Smoke

Exposure to secondhand smoke causes early death and disease in children and adults who do not smoke themselves. About 38,000 smokers have children under age 18 at home.

• Smoking Disparities

Two groups of people have the highest rates of smoking in Vermont. About 19,000 adults (37%) living below 125% of the Federal Poverty Level smoke. About 11,300 adults (40%) who have mental illness smoke.

Also in Vermont, 31% of racial and ethnic minorities are current smokers, compared to 20% of whites.

• Quitting Takes Practice

Quitting has almost immediate health benefits, but it typically takes six to eight attempts before a smoker can quit successfully. A smoker can double his or her chances of success by using quit-coaching in combination with nicotine replacement therapy.

** * Age-adjusted data is slightly different than crude data presented elsewhere in this report.*

Alcohol & Other Drug Use

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Decrease % of youth in grades 9-12 who –

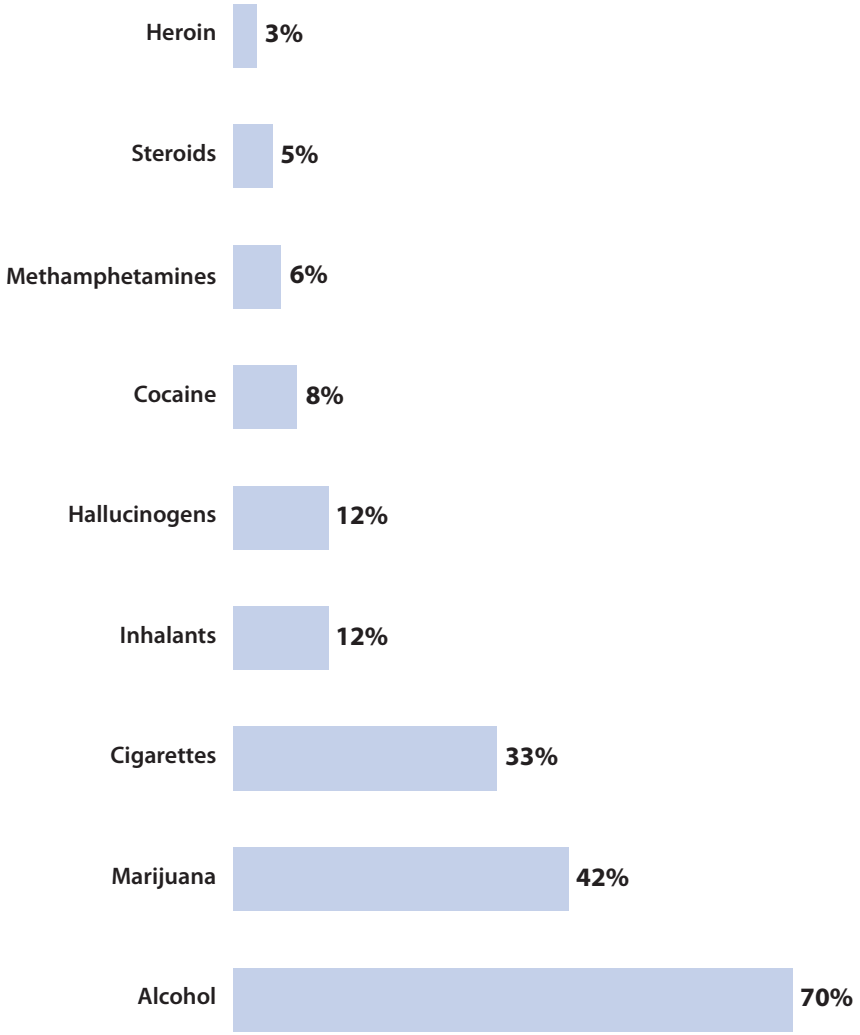
• binge drink *	2010 Goal	3.2%
	VT 2005	25%
	US 2005	30%
• use marijuana	2010 Goal	0.7%
	VT 2005	25%
	US 2005	20%
• used alcohol before age 13	2010 Goal	0%
	VT 2005	21%
	US 2005	24%

Reduce alcohol-related motor vehicle deaths

(per 100,000 people)	2010 Goal	4.8 ✔
	VT 2005	4.5
	US 2005	5.7

Youth Alcohol / Other Drug Use

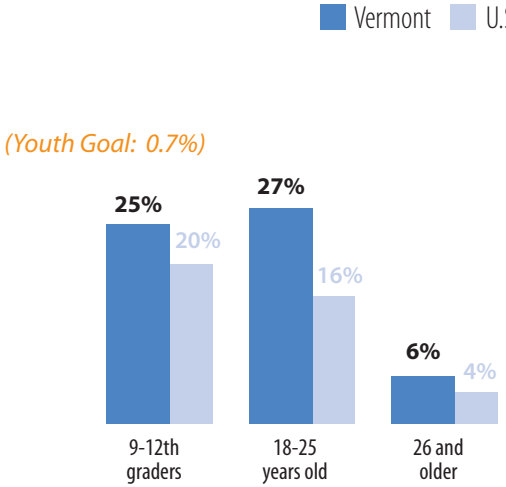
% of 9th–12th graders who have ever used drugs or alcohol, 2005



** 5 or more drinks on a single occasion, once or more often in the past 30 days*

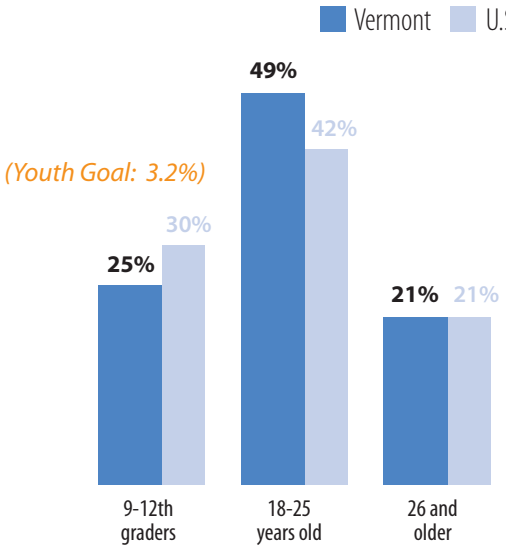
Marijuana Use

% of people who report using marijuana in the past 30 days, 2005



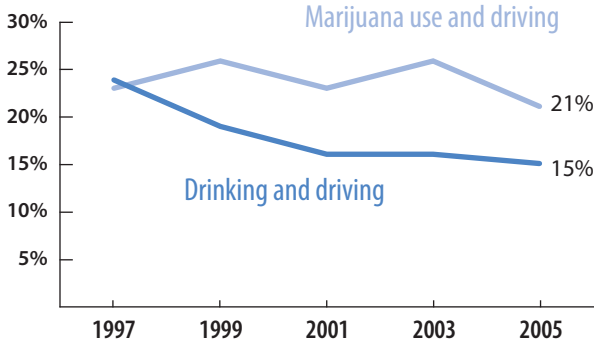
Alcohol Use

% of people who report binge drinking in the past 30 days, 2005



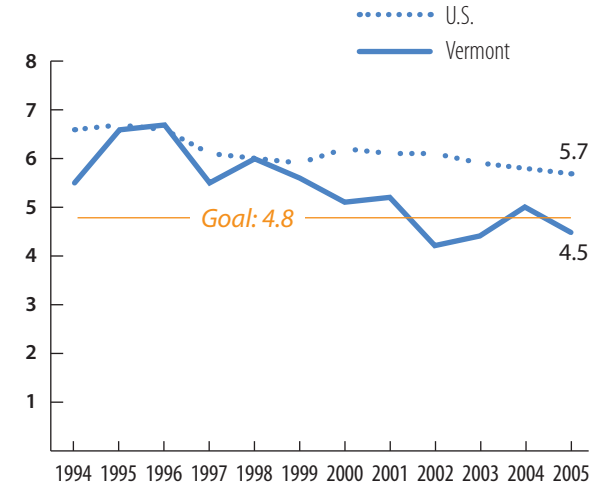
Youth Driving Under the Influence

% of 12th graders who drove a vehicle during past 30 days while under the influence of alcohol or marijuana



Alcohol & Motor Vehicle Deaths

people who die in alcohol-related motor vehicle accidents, per 100,000 people



• Health Consequences

Alcohol is a major factor in many preventable causes of fatalities—such as motor vehicle crashes, suicides, domestic violence and unintentional injuries.

Fetal exposure to alcohol (and drugs) causes developmental, neurological and physical health problems. A baby born with Fetal Alcohol Effects may face a lifetime of serious and irreversible problems.

Recent scientific evidence suggests that using marijuana may adversely affect thinking, judgment, physical and mental health.

• Youth & Alcohol

The age when a young person starts drinking is a strong predictor of alcohol dependence. Easy access and perception of risk matter, too. In 2005, 53% of 8th graders reported that alcohol is easy to get, and 45% believe there is little risk in drinking nearly every day.

Alcohol and illicit drug use are often co-occurring problems: In 2005, 58% of Vermont high school seniors reported using alcohol or marijuana in the past 30 days, and 40% reported using both.

• Youth & Drugs

In 2005, 20% of Vermont 9th-12th graders reported using cocaine, heroin, methamphetamines, inhalants or hallucinogens at least once. Young Vermonters age 18 to 25 have one of the highest rates in the U.S. of recent marijuana use; 12- to 17-year-olds rank in the top fifth percentile.

Injury & Violence

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of people who always use safety belts –

• among adults age 18+	2010 Goal	92%
	VT 2005	85%
	US 2005	82%
• among 9th-12th graders	2010 Goal	92%
	VT 2005	83%
	US 2005	79%

Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity

(per 100 full-time workers)	2010 Goal	4.3
	VT 2005	6.1 ✘
	US 2005	4.6

Reduce residential fire deaths

(per 100,000 people)	2010 Goal	0.2 ✔
	VT 2004	0 ✪
	US 2004	0.8

Reduce child abuse substantiated cases among children under age 18

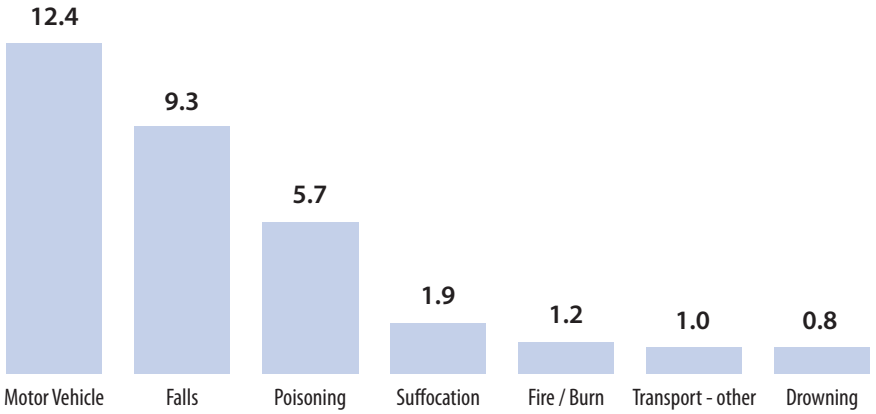
(per 10,000 children)	2010 Goal	10.3
	VT 2005	67.6
	US 2005	121.0

Reduce physical assaults by intimate partners

(per 1,000 people)	2010 Goal	3.3 ✔
	VT 2005	1.5
	US 2005	*

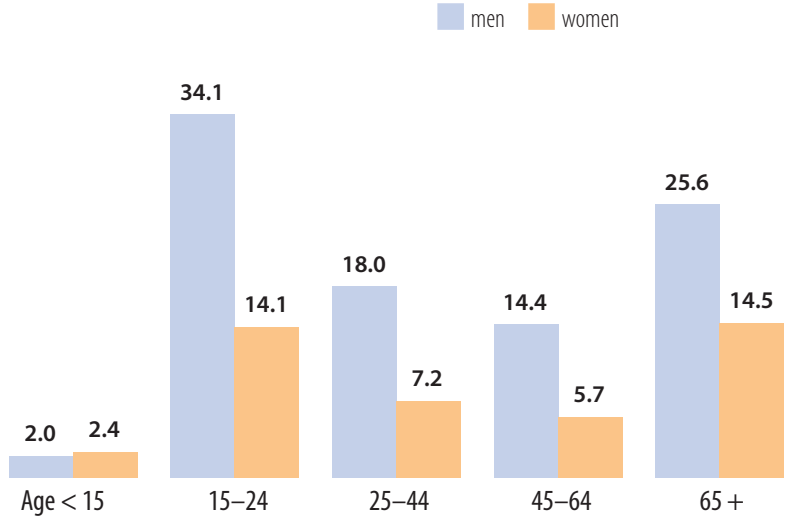
Injury Deaths

Leading causes of unintentional injuries, average # per 100,000 people, 2000-2004



Motor Vehicle Crash Deaths & Age / Gender

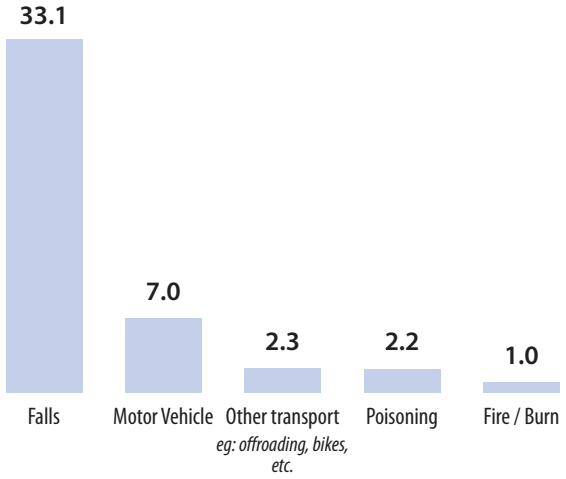
Average # people killed in motor vehicle crashes each year, per 100,000 people, 2000-2004



* *data not available*

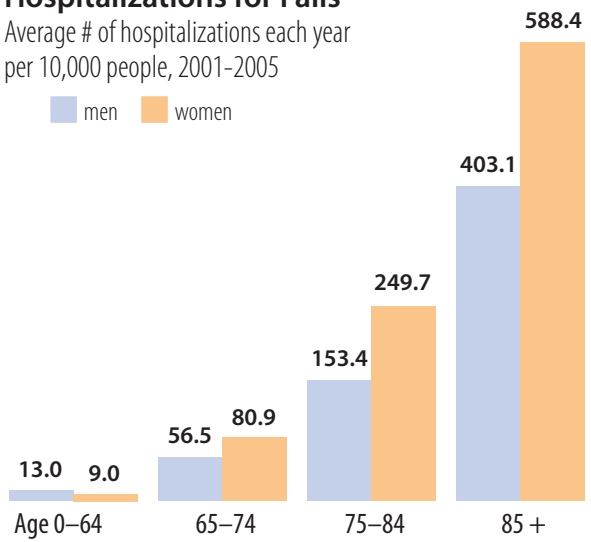
Injury Hospitalizations

Average # of hospitalizations each year per 10,000 people, by cause of unintentional injury, 2001-2005



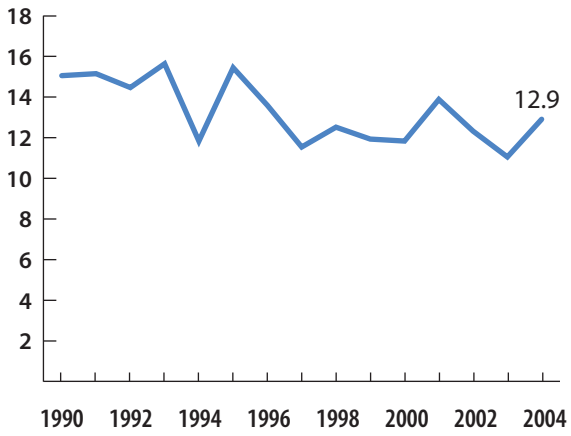
Hospitalizations for Falls

Average # of hospitalizations each year per 10,000 people, 2001-2005



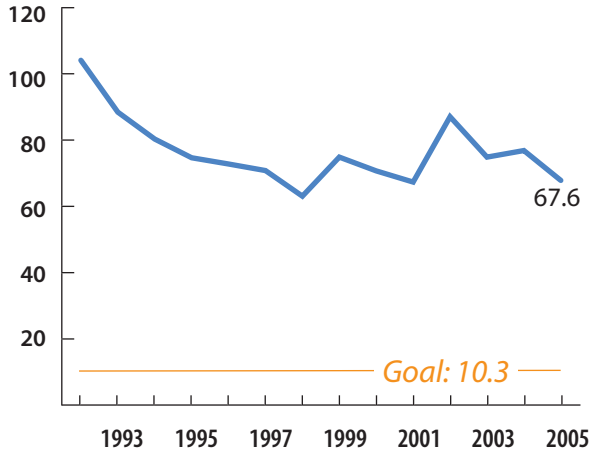
Motor Vehicle Crash Deaths

Total # deaths each year per 100,000 people



Child Abuse & Neglect

substantiated victims per 10,000 children



• Many injuries are Preventable

Unintentional injury is the fifth leading cause of death for Vermonters, with approximately 340 deaths per year.

• Motor Vehicle Crashes

Vermont averages 76 crash deaths a year. After falls, crashes are the second leading cause of traumatic brain injuries. More than one-third of all crashes involve alcohol. In 2005, 57% of vehicle occupants killed in Vermont crashes were not properly restrained.

• Falls

Falls are the second most common cause of injury deaths – and the most common cause of injury-related hospitalizations, emergency room visits, hip fractures and traumatic brain injuries.

• Fires

From 2000-2004, 36 Vermonters died in fires that were not a result of arson. Lack of a working smoke detector is a major risk factor.

• Domestic Violence

In Vermont, physical abuse, sexual abuse and neglect of children have all declined since 1990. Compared to the U.S., Vermont has a lower rate of child abuse and neglect, but it still far exceeds the 2010 goal.

Of all homicides in Vermont from 1994 to 2005, nearly half are the result of domestic violence. With suicides included (as in murder-suicide), 61% are domestic violence. Firearms are used to commit more than half of the homicides and more than three-quarters of the suicides.

Environmental Health

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Eliminate elevated (≥ 10 ug/dl) blood lead levels in children age 1 -5

Goal	0%
VT 2005	3%
US 2004	1%

Increase % of 1-year-olds who have had a blood lead test

Goal	100%
VT 2005	77%
US 2005	*

Increase % of 2-year-olds who have had a blood lead test

Goal	100%
VT 2005	38%
US 2005	*

Increase % of the population on community public water systems whose drinking water meets safe standards

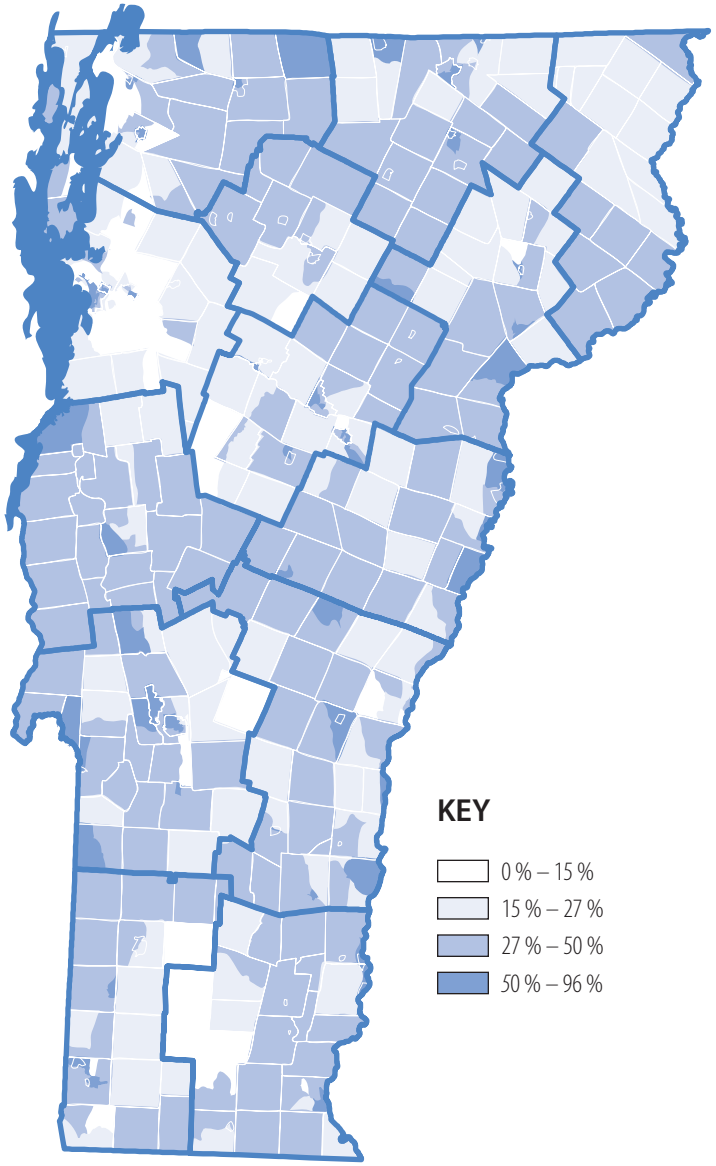
2010 Goal	95% ✔
VT 2005	95%
US 2003	90%

Increase % of adults who live in homes that have been tested for radon

2010 Goal	20% ✔
VT 2004	22%
US 2005	*

Older Housing Stock

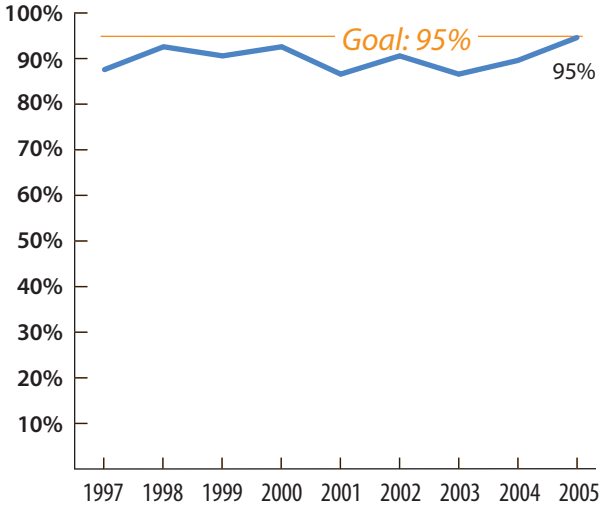
% of housing that pre-dates 1950 and may present lead hazard



* *data not available*

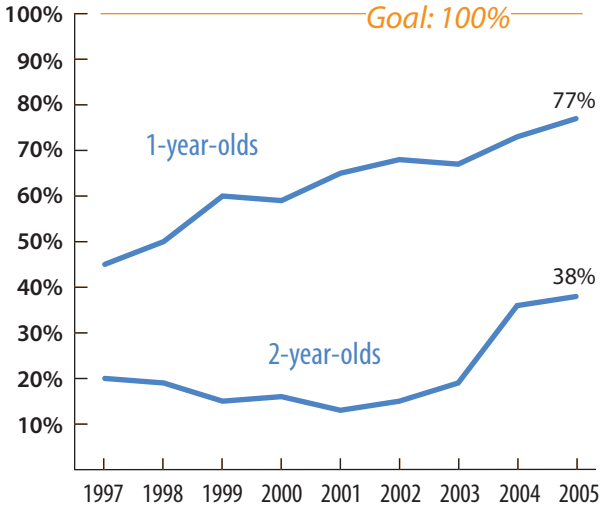
Safe Drinking Water

% of people on public drinking water systems whose water consistently meets standards



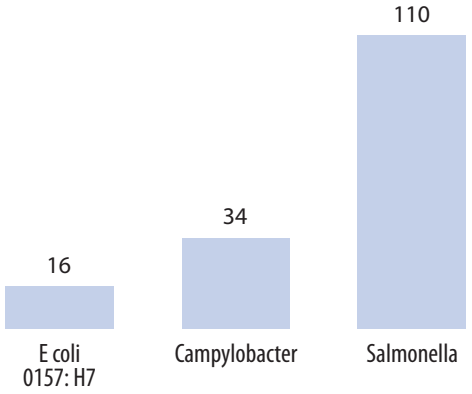
Blood Lead Level Testing

% of children tested for lead poisoning



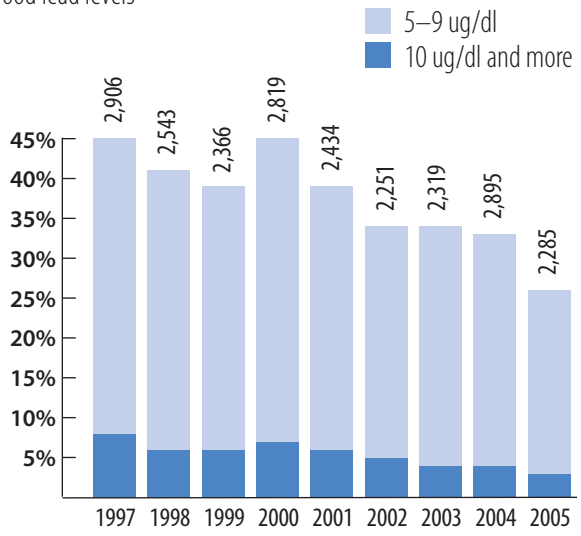
Common Food or Waterborne Diseases

of confirmed cases of E. coli, salmonella and campylobacter, 2005



Elevated Blood Lead Levels

Of 47,940 children age 1- 5 tested for lead, children with elevated blood lead levels –



• Lead

There is no safe level of lead in the body. In children, exposure to lead may result in learning disabilities, behavioral problems, decreased intelligence and poisoning. Lead paint and dust from lead paint are the main sources of lead exposure for children.

• Safe Drinking Water

About 70 percent of Vermonters get their drinking water from public water systems, which are routinely monitored for contamination from harmful bacteria, chemicals and radionuclides. Everyone else gets their drinking water from private wells or springs, which homeowners should have periodically tested.

• Food Safety

The greatest risks (at home and eating out) for foodborne disease outbreaks are keeping food at improper temperatures, inadequate cooking, contaminated equipment, food from an unsafe source, and poor personal hygiene among food handlers. In 2005, the Vermont Department of Health inspected 86% of all restaurants in the state.

• Radon

Radon is the second leading cause of lung cancer. You cannot see, smell or taste radon. The only way to determine if radon is present in your home is to test for it.

• A Healthy Environment

For more information about lead, safe drinking water and testing guide, food safety, restaurant scores, and radon, visit *healthvermont.gov*, then select *A Healthy Environment*.

Access to Health Care

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of adults with a usual primary care provider

	Goal	85% ✔
	VT 2005	87% ✪
	US 2005	83%

Increase % of people who have health insurance

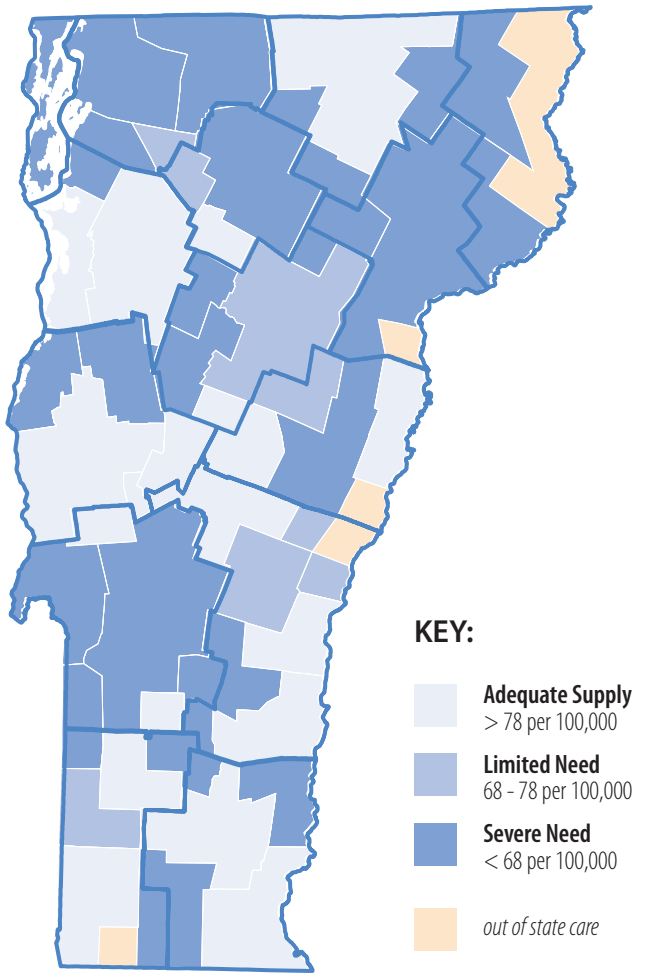
• age 18-64	2010 Goal	100%
	VT 2005	86%
	US 2005	87%
• younger than 18	Goal	100%
	VT 2005	95%
	US 2005	93%

Increase % of schools that provide comprehensive health education –

• on alcohol and other drug use	2010 Goal	95% ✔
	VT 2002	98%
	US 2005	*
• on tobacco use/addiction	2010 Goal	95% ✔
	VT 2002	96%
	US 2005	*
• on unintended pregnancy, HIV/AIDS and Sexually Transmitted Diseases	2010 Goal	95% ✔
	VT 2002	95%
	US 2005	*

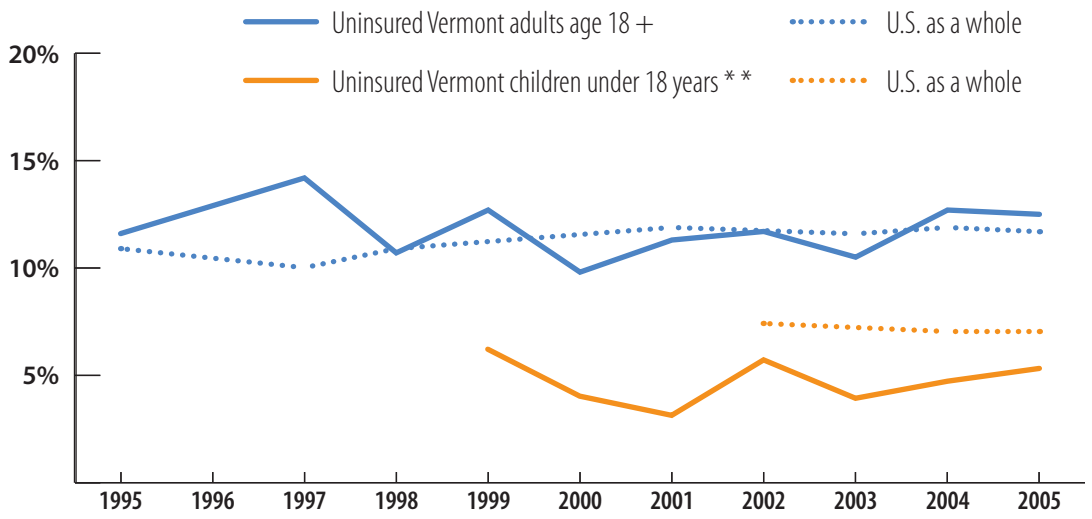
Supply of Primary Care Physicians

full-time equivalent (FTE) primary care physicians per 100,000 people, 2005



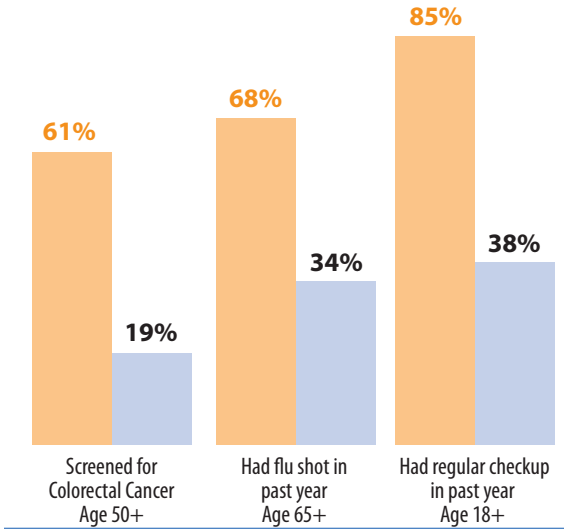
* *data not available*

Adults and Children with No Health Insurance



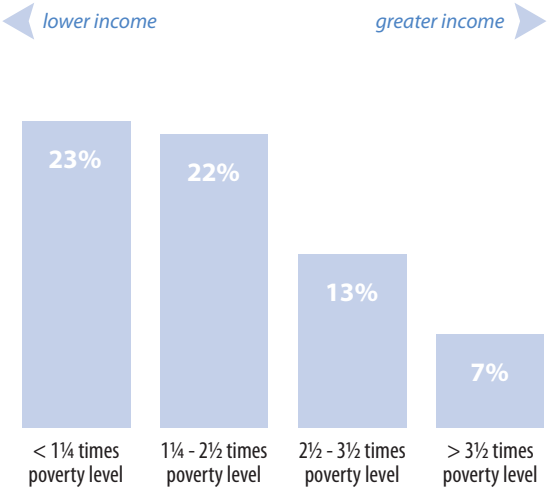
Access to Routine Health Care

% of people following recommended preventative health measures
among those who have a primary care physician, and
among those who don't, 2005



No Health Insurance & Income

% of adults age 18-64 who have NO health insurance, by Federal Poverty Level, 2005



** fluctuations in Vermont data may be due to small sample size*

• Supply of Health Care Providers

Rational service areas are groups of towns within which residents typically receive their primary care. Fourteen of 38 rational service areas in Vermont meet the national standard for access to primary care physicians.

The ratio of primary care physicians to 100,000 population ranges from a low of 11.8 (severe need) in Grand Isle County to a high of 95.1 (adequate supply) in Bennington County.

The per capita supply of Registered Nurses, Advanced Practice Registered Nurses, Physicians' Assistants, and pharmacists falls below national averages. Vermont ranks 50th for RNs, 45th for APRNs, 47th for PAs, and 47th for pharmacists.

• Health Insurance Disparities

Health insurance coverage is lower in rural areas: In 2005, 85% of Vermont adults living in rural areas have health insurance, compared to 90% of adults who live in urban areas.

Also, 82% of racial and ethnic minorities in Vermont have health insurance, compared to 89% of whites.

Physicians Accepting New Patients

% of primary care physicians who accepted —

	1994	2000	2004
any new patients	**88%**	**80%**	**81%**
new Medicaid patients	82%	72%	70%
new Medicare patients	81%	73%	71%

Maternal & Child Health

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Reduce infant deaths

(per 1,000 live births)	2010 Goal	4.5 ✔
	VT 2004	4.4
	US 2004	5.7

Decrease % of low birth weight births

• ≤ 5.5 pounds	2010 Goal	5%
	VT 2004	6%
	US 2004	7%
• ≤ 3.3 pounds	2010 Goal	0.9% ✔
	VT 2004	0.9%
	US 2004	1.2%

Increase % of pregnant women who receive –

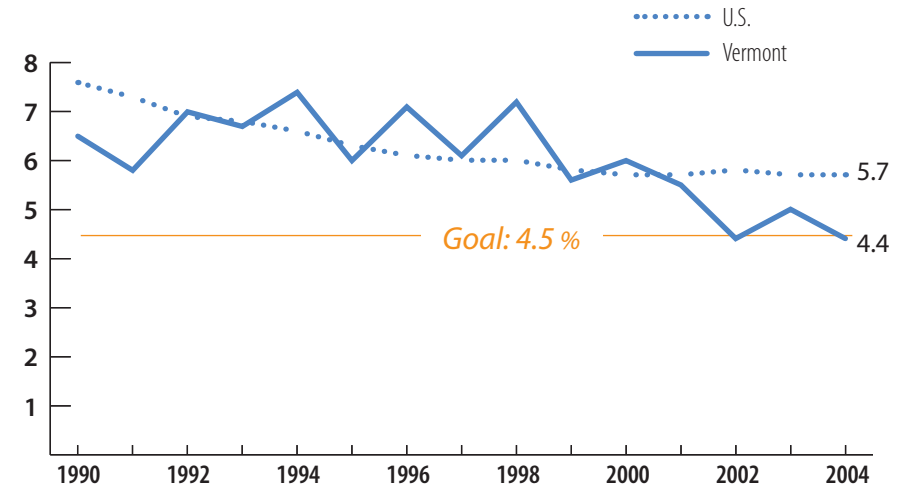
• prenatal care in the first 3 months of pregnancy	2010 Goal	90% ✔
	VT 2004	90%
	US 2004	89%
• early and adequate prenatal care *	2010 Goal	90%
	VT 2004	89% ✪
	US 2004	80%

Further reduce pregnancies among girls age 15-17

(per 1,000 females age 15-17)	2010 Goal	43.0 ✔
	VT 2004	15.8
	US 2002	25.1

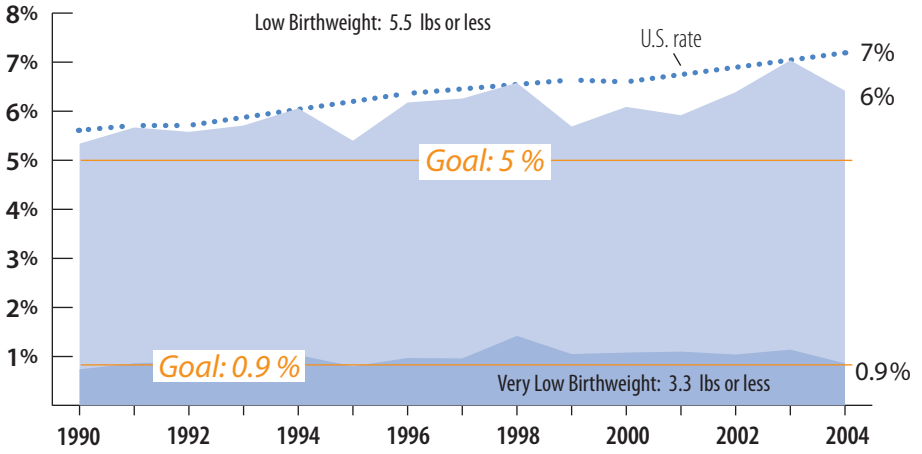
Infant Mortality

deaths among infants age less than 1 year, per 1,000 live births



Low Birth Weight

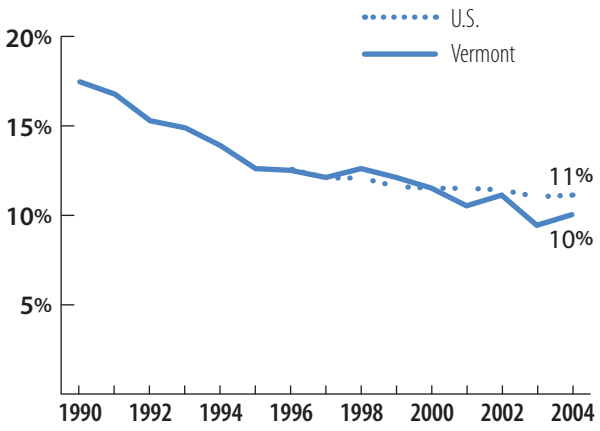
% of Vermont babies born at low birthweight



* *Early and adequate prenatal care = entry into care no later than the fourth month of pregnancy, and having at least 80 percent of the expected number of visits.*

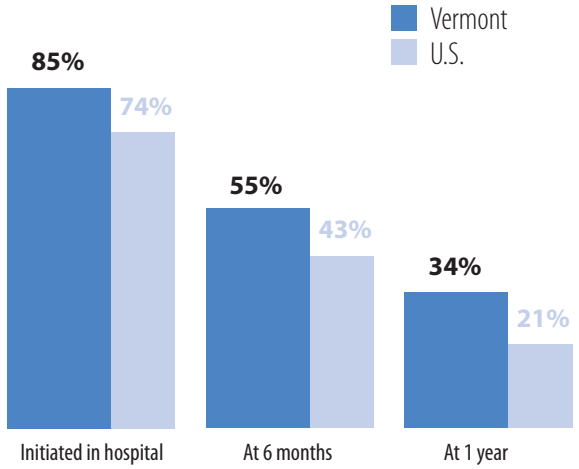
No Prenatal Care

% of mothers who did not have prenatal care during the first three months of pregnancy



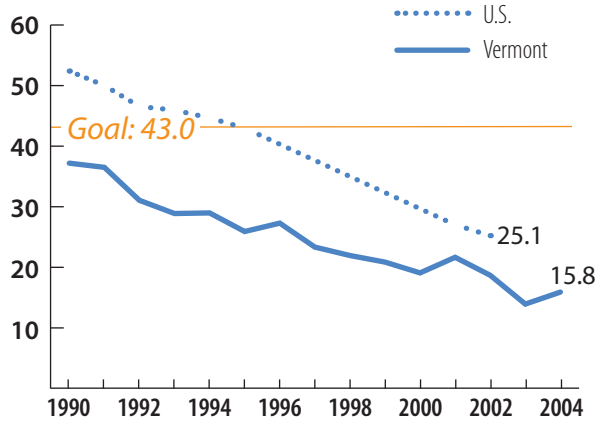
Breastfeeding

% of mothers who are breastfeeding during the first year, 2004



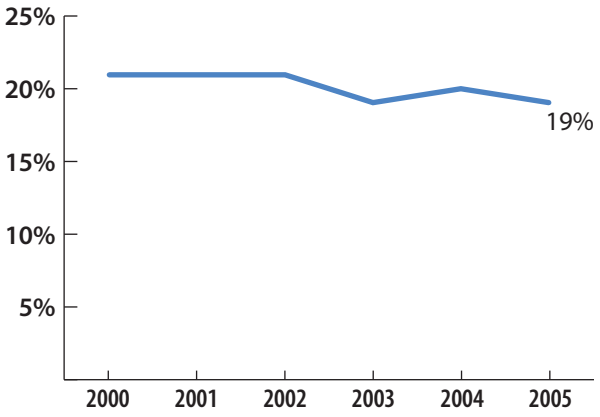
Teen Pregnancy

pregnancies among girls age 15-17, per 1,000



Smoking in Pregnancy

% of women who smoked during at least 1 trimester of pregnancy



Intended Pregnancy

In 2004, 68 percent of new mothers in Vermont reported that their pregnancies were intended.

Preventing Low Birth Weight

Vermont's rate of low birth weight babies has been growing since 1991. Most of this increase is due to moderately low birth weight—rather than very low birth weight—babies. Starting prenatal care early, NOT smoking or drinking, appropriate weight gain during pregnancy, and allowing enough time between pregnancies, all help prevent low birth weight.

Risk from Smoking

About 20% of women smoke during pregnancy. Smoking during pregnancy is the single most important preventable risk factor for low birth weight in Vermont. Low birth weight is closely linked to infant mortality.

Sudden Infant Death

In the past, when an infant died suddenly of no apparent cause, the death was classified as Sudden Infant Death Syndrome, or SIDS. New research shows that many of these deaths can be attributed to a cause such as a birth defect, unsafe sleep environment, or infection. In 1995, six infant deaths in Vermont were classified as SIDS, and in 2005, two.

Importance of a Medical Home

A medical home is a consistent health care setting with a regular primary care provider or team to ensure appropriate care. In Vermont, 58% of all children (and only 52% with serious special health needs) have a medical home.

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of children age 19-35 months –

- who receive universally recommended vaccines

2010 Goal	80%	✔
VT 2005	82%	
US 2005 * *	81%	

- who receive 1+ doses of varicella vaccine at or after 12 months

2010 Goal	90%
VT 2005	69%
US 2005 * *	88%

Increase % adults age 65+ –

- who receive annual influenza immunizations

2010 Goal	90%	
VT 2005	66%	✪
US 2005	63%	

- who have ever been vaccinated against pneumococcal disease

2010 Goal	90%	
VT 2005	67%	✪
US 2005	61%	

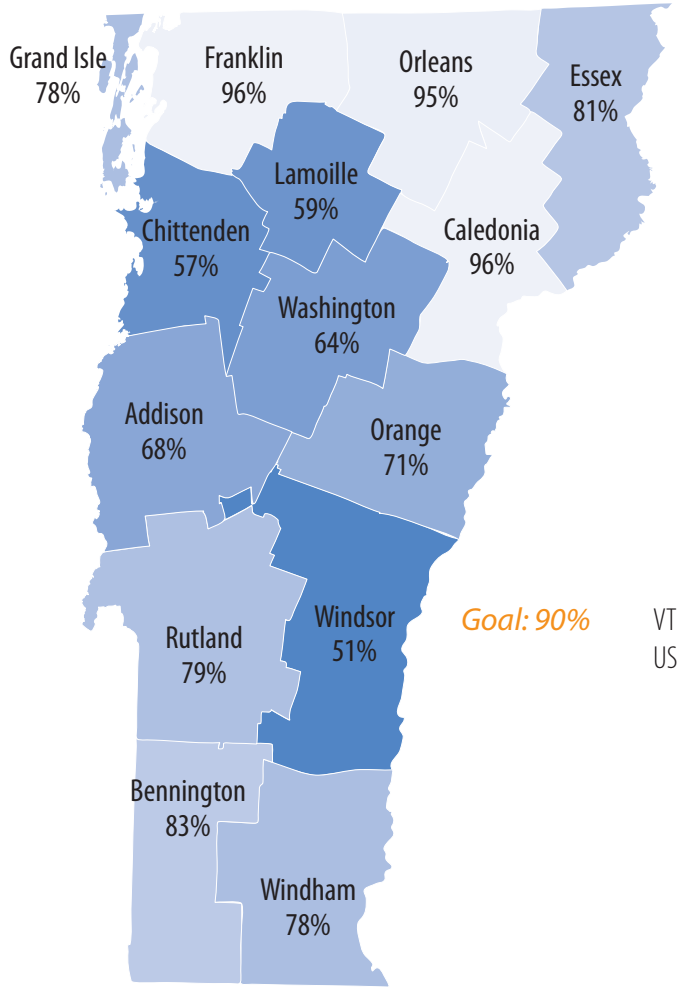
Reduce pneumonia/influenza hospitalizations among adults age 65+

(per 10,000 people)

2010 Goal	8.0
VT 2005	16.1
US 2005 * *	21.6

Immunization Registry

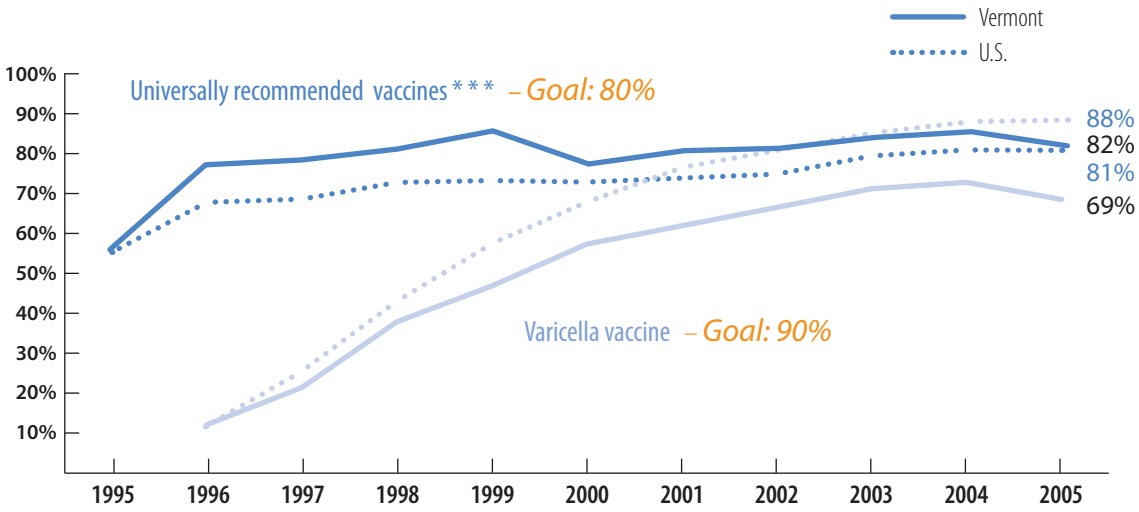
% of children under age 6 who have two or more vaccinations recorded in the Vermont Immunization Registry, 2005



* *data not available* ** *U.S., all races*

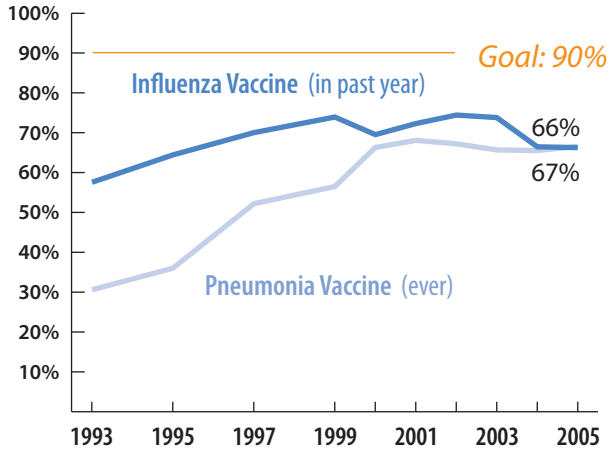
Childhood Immunization

% of children age 19 to 35 months who have had recommended vaccinations



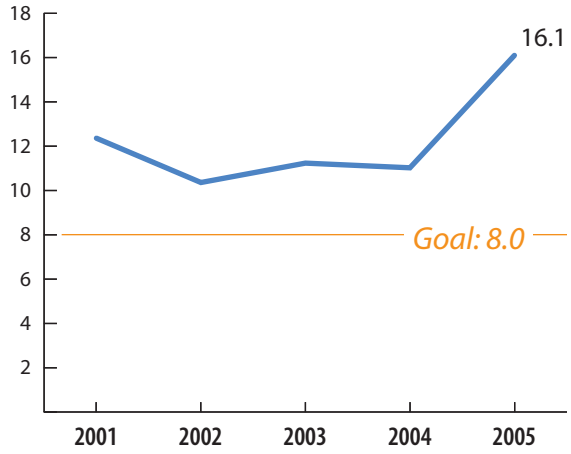
Influenza/Pneumonia Immunization

% of people age 65+ who are vaccinated



Adults Hospitalized for Pneumonia/Influenza

people age 65+ hospitalized, per 100,000 people



• Child, Teen & Adult Immunizations

A person who is fully immunized is protected against vaccine-preventable diseases (or severe illness), and helps protect the community from disease outbreaks. For Vermont's recommended immunization schedule, go to healthvermont.gov, then select Children & Families.

• Varicella (Chickenpox)

Varicella vaccine protects against severe disease. Before the vaccine was available, about 100 people in the U.S. died each year from chickenpox. In 2005, there were only three deaths.

• Influenza/Pneumonia

Influenza and pneumonia are the leading causes of hospitalization among people age 65 and older, and especially among older people who have chronic disease. Still, vaccines are underutilized.

Unvaccinated community health care workers can be a major source of influenza outbreaks. A person can spread flu before showing symptoms. In the first two months of 2005, 57% of health care workers had been vaccinated for influenza compared to 40% of non-health care workers.

Reduce or eliminate vaccine-preventable diseases –

	VT Goal	VT 2005 * * * *
Hib B (age <5)	0 ✔	0
Measles	0 ✔	0
Rubella	0 ✔	0
Hepatitis B (age 2-18)	0 ✔	0
Pertussis (age <7)	4	21

** * * to prevent: Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio, Measles, Mumps, Rubella, Hepatitis B, Haemophilis Influenzae b, Varicella (Chickenpox)*

** * * * cases reported to Vermont Department of Health*

Oral Health

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of adults who use the dental health system each year

2010 Goal	56%	✔
VT 2004	73%	✪
US 2004	69%	

Decrease % of children who –

- have ever had decay (age 6-8)

2010 Goal	42%	✔
VT 2003	40%	
US 2005	*	

- have untreated decay (age 6-8)

2010 Goal	21%	✔
VT 2003	16%	
US 2005	*	

Increase % of children who –

- get dental sealants (age 8)

2010 Goal	50%	✔
VT 2003	64%	
US 2005	*	

Increase % of population served by community public water systems that have optimally fluoridated water

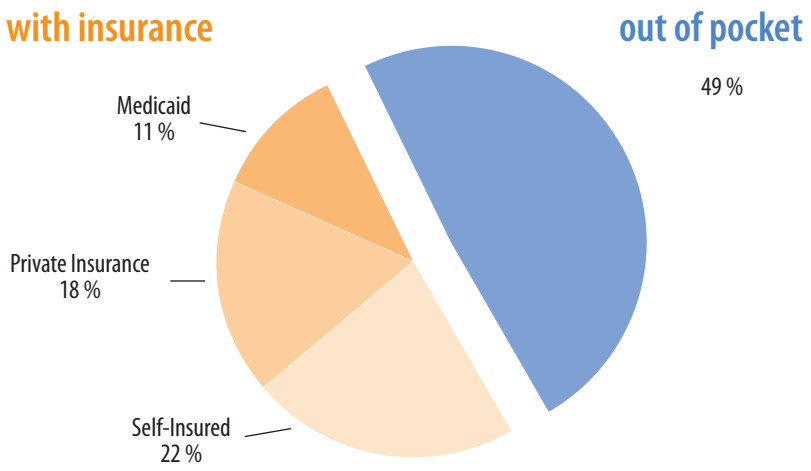
2010 Goal	75%
VT 2003	56%
US 2002	67%

Increase % of dentists who counsel patients to quit smoking

2010 Goal	85%
VT 2005	35%
US 2005	*

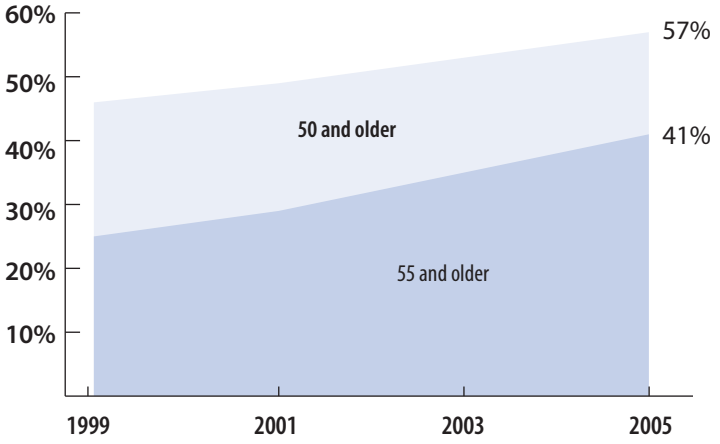
How Vermonters Pay For Dental Care

% by payer, 2005



Aging of Dentists

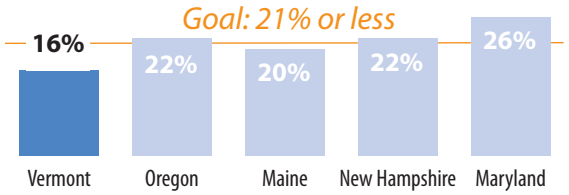
% of dentists age 50+ and 55+



* *data not available*

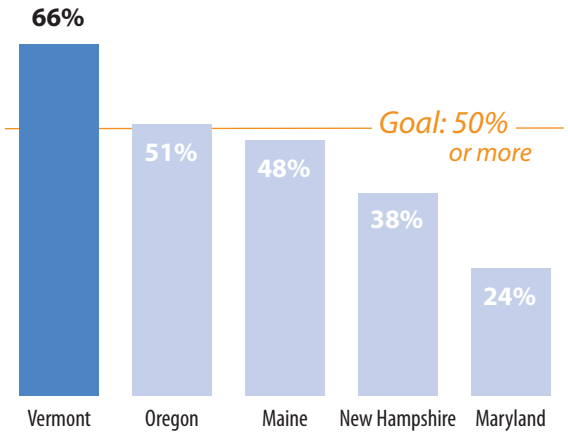
Tooth Decay in Children

% of 3rd graders with untreated dental decay, Vermont compared to other states with oral health surveys, 2002-2003



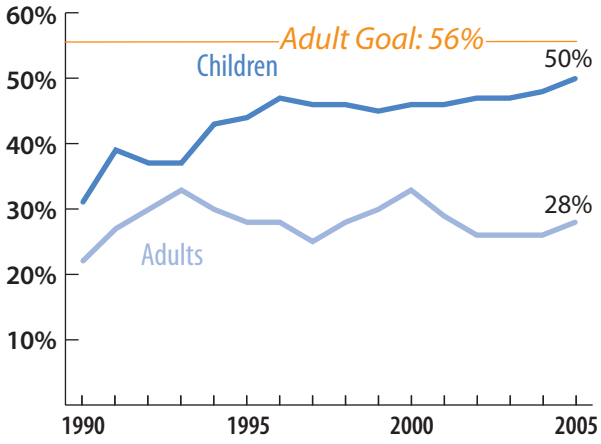
Sealants in Children

% of 3rd graders with sealants, Vermont compared to other states with oral health surveys, 2002-2003



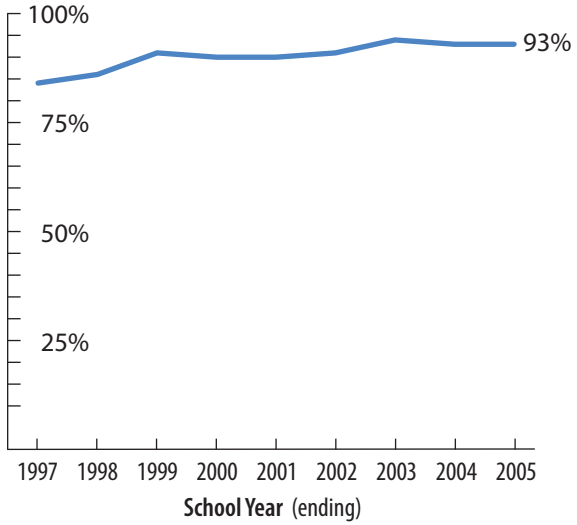
Dental Visits among Medicaid Recipients

% of enrolled children age 0-20 and adults age 21+ who had at least one dental visit per year



Schools Providing Fluoride Mouthrinse

% of Vermont schools without fluoridated water that provide fluoride mouthrinse for students in grades 1-8



• Access to Dental Care

Dentists are aging toward retirement: 57% of all dentists and 78% of pediatric dentists are 50+. In 2005, 88% of dentists accepted new patients, but only 59% accepted new Medicaid patients. Average wait-time for a new patient to have an appointment is about three weeks.

• Dental Care Disparities

About half of children covered by Medicaid have dental decay, compared to one-third of children with private insurance. Twice as many Medicaid-covered children have 3 or more teeth with decay or fillings than children with private dental insurance. They are also less likely to have a regular dental visit.

In Vermont, 63% of racial and ethnic minorities have had an oral health exam in the past year, compared to 76% of whites.

• Healthier Teeth for Children

From 1993 to 2002, first- through third-graders who are free of dental decay increased from 51% to 60%, and those who had untreated decay decreased from 20% to 16%. Also, 8-year-olds with at least one sealant on a permanent molar increased from 43 to 64%.

• Oral Health is Important to Overall Health

Tooth decay is one of the most common chronic diseases in children, and gum disease affects a high percentage of adults. Infection and inflammation in the mouth have been linked to complications of pregnancy, type 2 diabetes, heart disease and stroke.

Mental Health

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Reduce suicide deaths

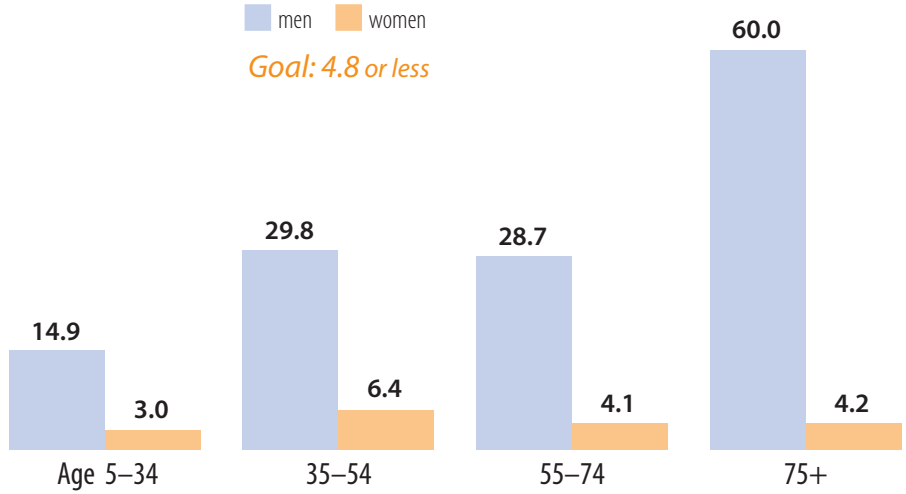
(per 100,000 people)		
	2010 Goal	4.8
	VT 2004	14.0
	US 2004	12.0

Decrease suicide attempts by youth in grades 9 - 12

	2010 Goal	1%
	VT 2005	2%
	US 2005	2%

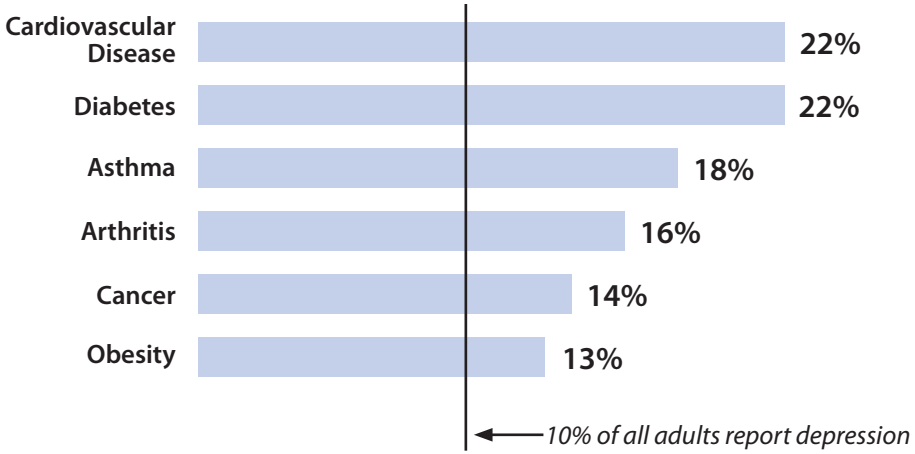
Suicide Deaths

Average # deaths each year, per 100,000 Vermonters, 2000-2004



Depression & Chronic Illness

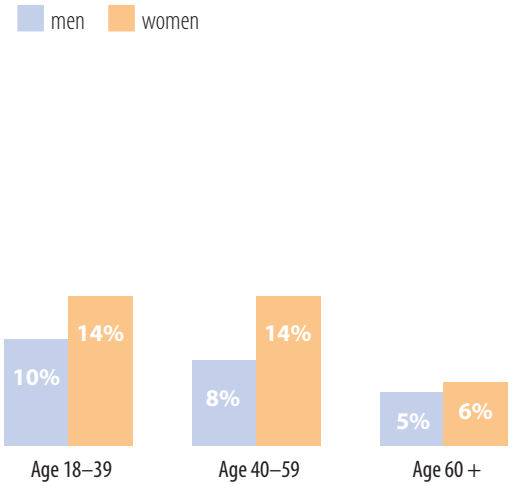
% of adults who report having a chronic disease and depression, 2005



* *Risk Factors = exposure to violence, abuse, neglect; homelessness; lead poisoning; loss of a loved one; experiencing rejection or severe stress due to disability, race, sexual orientation, religion or poverty.*

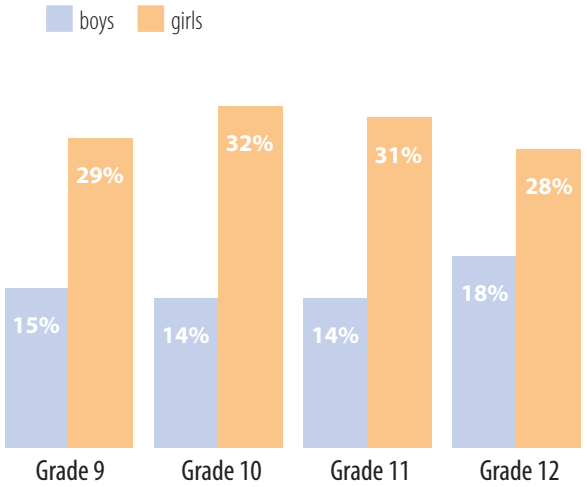
Adult Depression & Age/Gender

% of adults who report depression, 2005



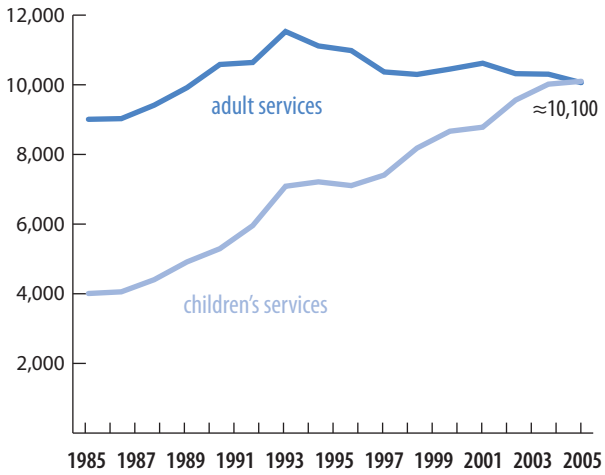
Youth Depression & Age/Gender

% of youth in grades 9-12 who report depression, 2005



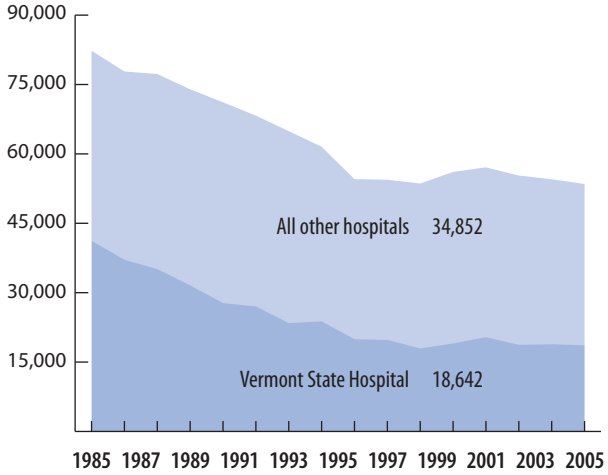
Community Mental Health Services

of clients served in community mental health programs



Hospitalizations for Mental Health Care

days of inpatient behavioral health care services provided to Vermont residents



• Youth Need for Treatment

The U.S. Surgeon General estimates that in any year, nearly one in five Vermont children and adolescents (nearly 29,000) will have a diagnosable mental health or addictive disorder. Nearly 7,000 experience severe impairment to life functions, and 15,000 need treatment.

Without prevention, early screening and intervention for these youth, their problems will become more acute and severe, they will take longer to heal, and they will require more intensive and expensive treatment.

• Social & Behavioral Health

Many mental health problems for children, adolescents and their families could be prevented by promoting social and emotional health in community environments, limiting risk factors * and promoting protective factors. * *

• Depression & Chronic Illness

Depression is a chronic illness, and it is linked with other chronic illnesses. Symptoms of mental illness often lessen over time, and people can enjoy considerable improvement or full recovery.

• Community Mental Health Services

In 2005, more than 10,000 adults and 10,000 children were served by Vermont's community-based mental health agencies.

Services include: planning and coordination; case management; clinical interventions (assessment, diagnosis, individual/family/group therapy; emergency response; medication and community supports.

* * *Protective Factors = a loving, stable family; sense of belonging, personal value, having something to contribute; involved in school or community; support to succeed in school; clear messages about benefits of being alcohol and drug-free; difficult to access alcohol and other drugs; readily available information about mental health and developmental stages; readily available support/treatment for mental health, with no stigma attached.*

Heart Disease & Stroke

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Reduce coronary heart disease deaths

(per 100,000 people)	2010 Goal	162.0 ✔
	VT 2004	137.7 ✪
	US 2004	157.2

Reduce stroke deaths

(per 10,000 people)	2010 Goal	50.0 ✔
	VT 2004	43.6
	US 2004	48.0

Decrease % of adults with high blood pressure

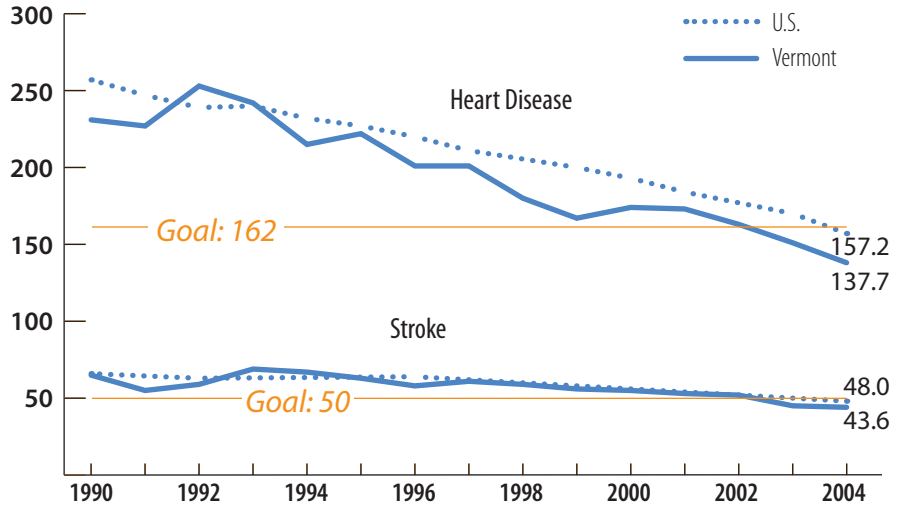
2010 Goal	14%
VT 2005	23% ✪
US 2005	25%

Increase % of adults who have had their cholesterol checked within the past 5 years

Goal	80%
VT 2005	74%
US 2005	75%

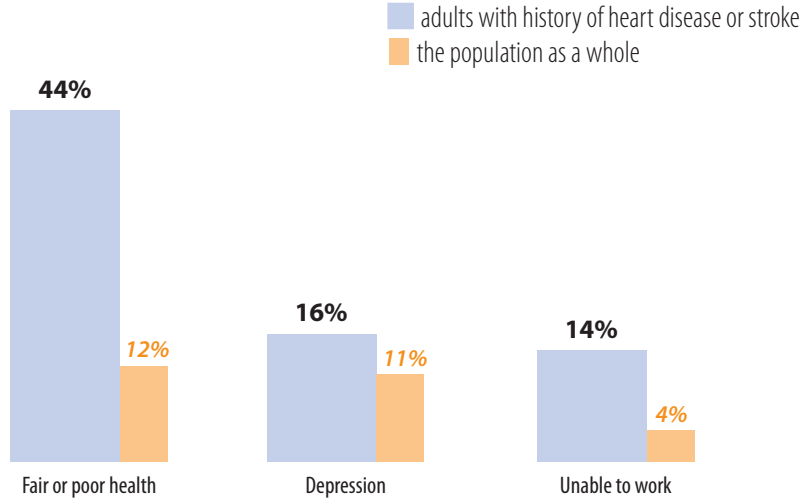
Heart Disease & Stroke Deaths

per 100,000 people



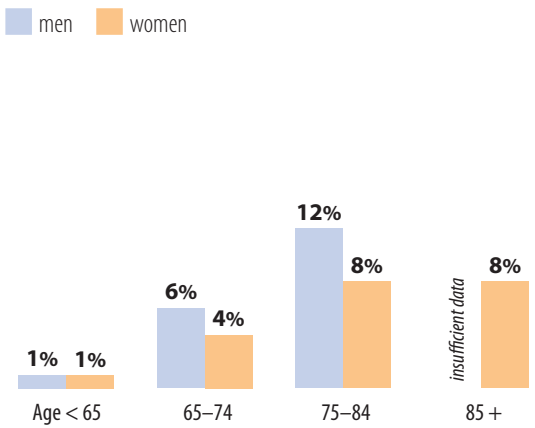
Heart Disease/Stroke & Quality of Life

% of adults who describe themselves as being in fair or poor health, having depression, or being unable to work in 2005



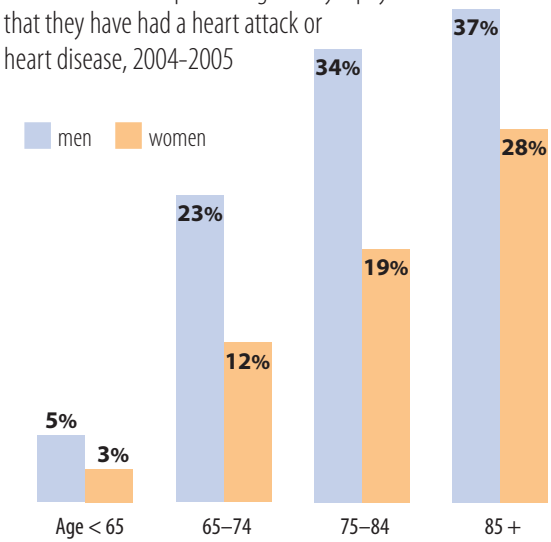
Stroke Prevalence

% of adults who report being told by a physician that they have had a stroke, 2004-2005



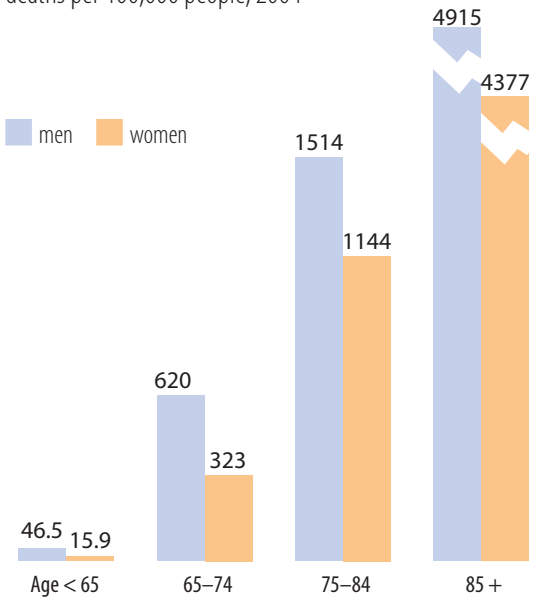
Heart Disease Prevalence

% of adults who report being told by a physician that they have had a heart attack or heart disease, 2004-2005



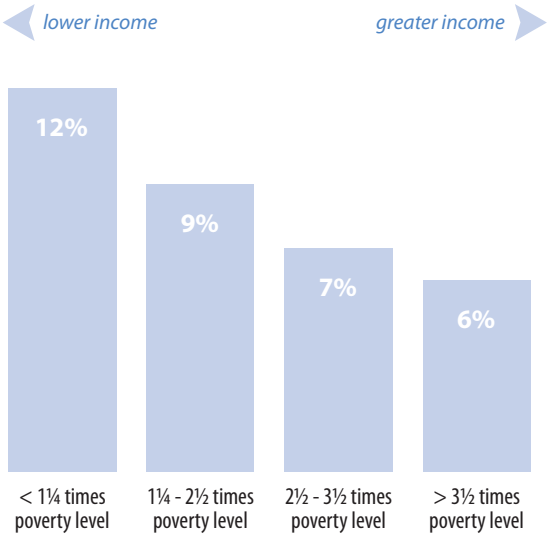
Heart Disease & Stroke Deaths

deaths per 100,000 people, 2004



Heart Disease/Stroke & Income

% of adults who have had heart disease or a stroke, by Federal Poverty Level, 2005



• What is Heart Disease?

Heart disease is any disorder that affects the heart's ability to function normally. The most common cause of heart disease is a narrowing or blocking of the arteries supplying blood to the heart muscle (coronary heart disease).

• Incidence & Mortality

Approximately 7%, or 31,000 Vermont adults, have ever had a heart attack, angina, heart disease or stroke. Nationally and in Vermont, death rates from heart disease and stroke have been steadily declining over the past 30 years. Still, heart disease is the leading cause of death and stroke is the third leading cause of death.

Every year, about of 917 Vermonters die from heart disease, and 260 die from stroke.

• Preventing Heart Disease & Stroke

Behaviors that help lower a person's risk of dying from heart disease or stroke are: not smoking, staying at a healthy weight, eating fewer fatty and high cholesterol foods, exercising regularly, and knowing signs and symptoms and what to do in case of a heart attack or stroke.

Clinical preventive services shown to lower risk of disease: counseling to stop smoking, periodic blood pressure and cholesterol screening, and controlling high blood pressure and cholesterol.

• Call 9-1-1

Know the signs and symptoms of heart attack and stroke. Calling 9-1-1 right away and getting timely treatment saves lives and lowers risk of disability.

Cancer

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of women age 40+ who have had a mammogram in the past two years

2010 Goal	70% ✔
VT 2005	77% ✪
US 2005	75%

Increase % of women age 18+ who have had a Pap test in the past three years

2010 Goal	90%
VT 2005	83%
US 2005	82%

Increase % of adults age 50+ who have had a fecal occult blood test (FOBT) in the past two years

2010 Goal	33%
VT 2004	32% ✪
US 2004	27%

Increase % of adults age 50+ who have ever had a sigmoidoscopy or colonoscopy

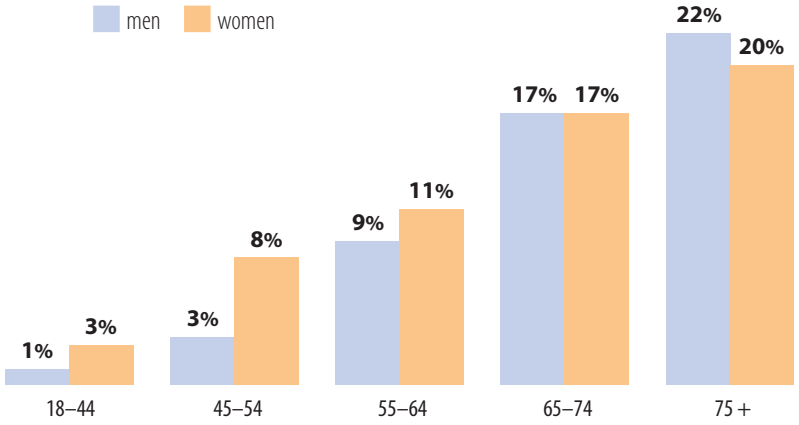
2010 Goal	50% ✔
VT 2004	59% ✪
US 2004	54%

Increase % of adults who take protective measures to reduce risk of skin cancer

2010 Goal	85%
VT 2001	76%
US 2005	*

Cancer Prevalence & Age/Gender

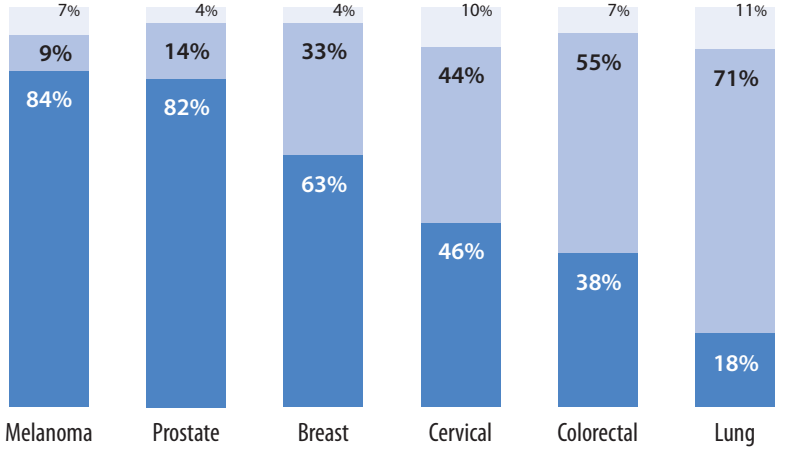
% of adults who report they have ever been diagnosed with cancer, 2005



Cancer Stage at Diagnosis

% of total cases of cancer, by type, according to stage at diagnosis, 2000-2004:

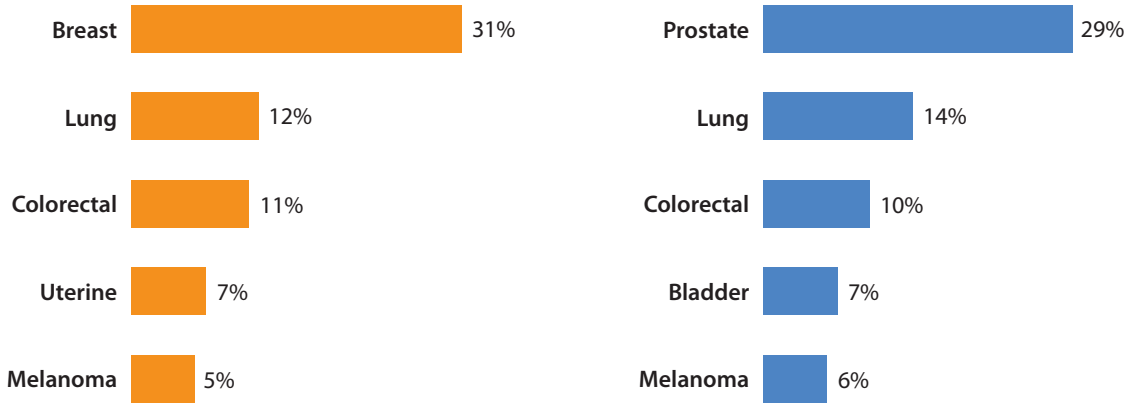
localized (early diagnosis) regional or distant (spread) (not staged)



** data not available*

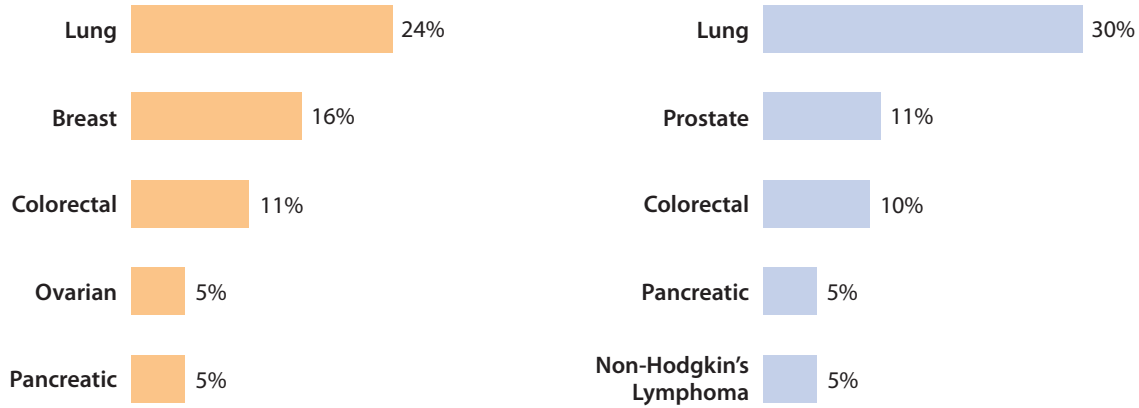
The Most Commonly Diagnosed Cancers

% of all cancer diagnoses, by type: in women in men



The Most Common Causes of Cancer Deaths

% of all cancer deaths, by type: in women in men



• Cancer is Not One Disease, but Many

Cancer is a group of more than 100 different diseases that often develop gradually as the result of a complex mix of factors.

• Incidence & Mortality

Each year more than 3,000 Vermonters are diagnosed with some form of cancer. Nearly one-half of all men and one-third of all women will develop cancer in their lifetime. Cancer is the second leading cause of death. Each year, more than 1,200 Vermonters die from some form of cancer.

• Risk Factors

Cancer occurs in people of all ages, but risk increases significantly with age. Nearly two-thirds of cancer deaths in the U.S. can be linked to tobacco use, poor diet, obesity and lack of exercise. Not all cancers are preventable, but risk for many can be reduced by a healthy lifestyle.

• Screening & Early Detection

Many cancers can be prevented, or successfully treated if detected early. Cancers in parts of the body that can be easily seen or felt (skin, breast) are first detected with more direct methods than internal cancers (lung), which require imaging procedures or laboratory tests. Screening tests can find pre-cancerous or small tumors.

• Living with Cancer

Currently, 23,000 to 31,000 Vermonters are living with a current or prior diagnosis of cancer. For survivors, cancer is a chronic illness—they are more likely to report fair or poor health, be physically inactive, and be unable to work.

Breast Cancer

• Incidence & Mortality

Breast cancer is the most common cancer diagnosed in women. Each year in Vermont, about 475 women are diagnosed. A woman's lifetime risk of developing breast cancer is one in eight. Vermont's breast cancer death rate has decreased since the 1990s. Still, each year in Vermont, about 97 women die from the breast cancer.

• Risk Factors

Incidence of breast cancer increases with age. Women who have had breast cancer or have a mother, sister or daughter with breast cancer have a greater risk. Risk may also be related to hormonal factors and diet.

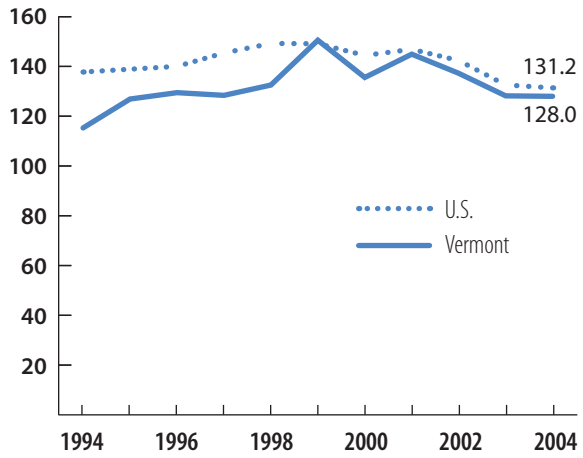
• Screening & Early Detection

Mammography, combined with a clinical breast exam, is still the most effective means of early detection. In Vermont, 63% of breast cancers are diagnosed at the localized stage—the most treatable stage before the cancer has spread. Nearly all women in the U.S. who found their breast cancer at an early stage lived more than five years, while only 27% lived more than five years if their cancer had spread to distant sites in the body when it was first detected.

In Vermont, 67% of racial/ethnic minority women age 40+ have had a mammogram in the past two years, compared to 77% of white women.

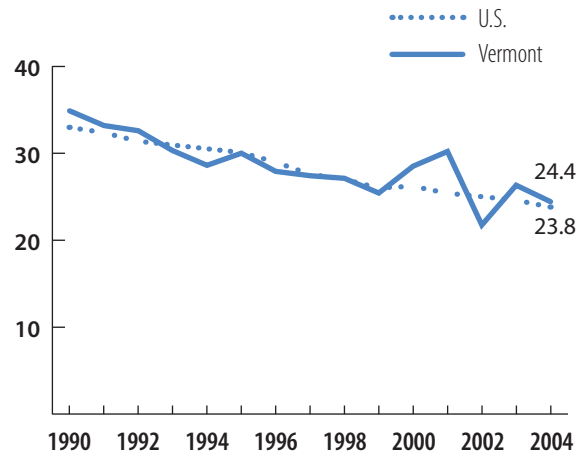
Breast Cancer Incidence

new cases diagnosed each year per 100,000 women



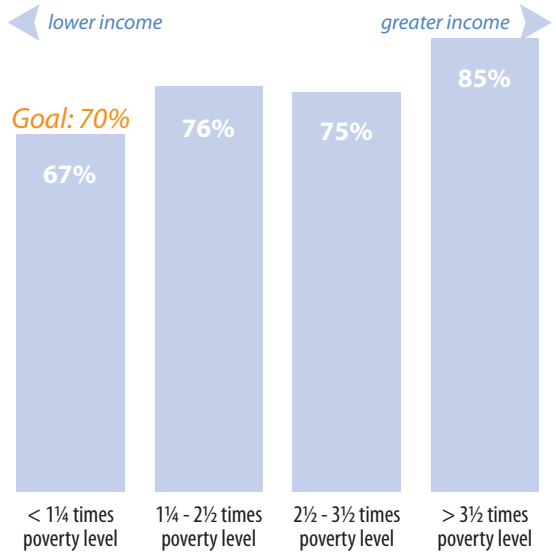
Breast Cancer Mortality

of deaths each year, per 100,000 women,1990-2004



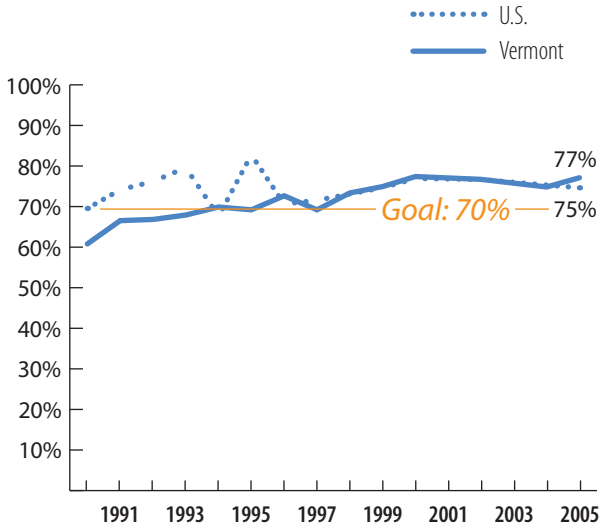
Mammograms & Income

% of women age 40+ who report having a mammogram in past 2 years, by Federal Poverty Level, 2005

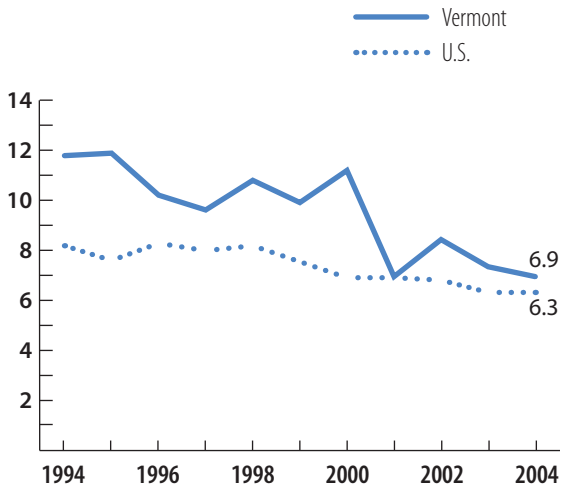


Breast Cancer Screening

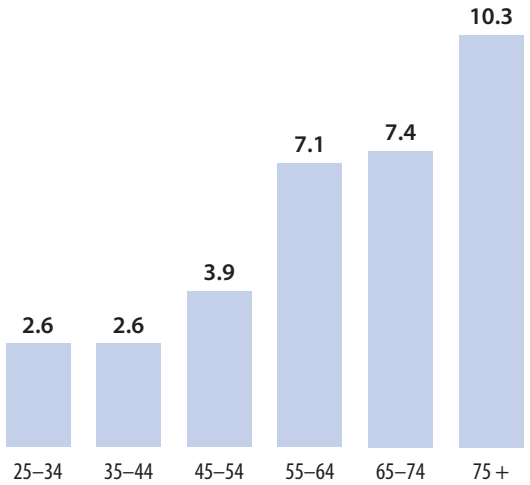
% of women age 40+ who have had a mammogram in the past 2 years



Cervical Cancer Incidence
new cases diagnosed each year per 100,000 women

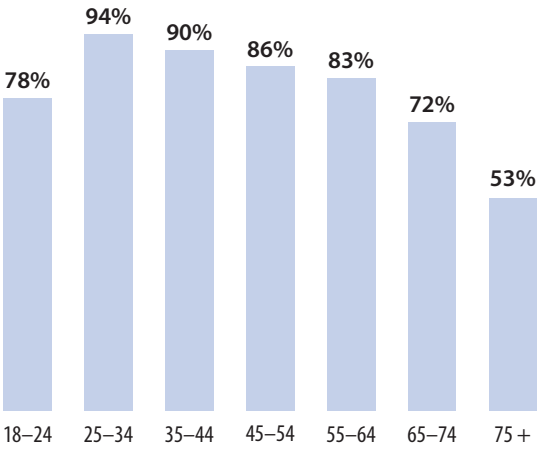


Advanced Stage Cervical Cancer & Age
cases diagnosed at the regional or distant stage per 100,000 women, 1995-2004

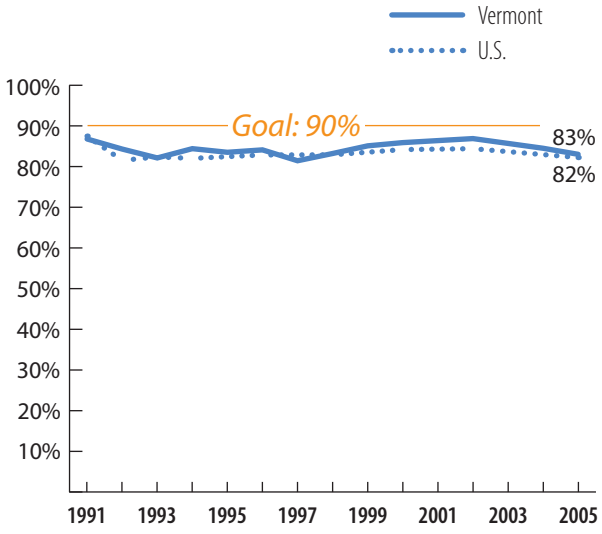


Cervical Cancer Screening & Age
% of women who report having had a Pap test in the past 3 years, 2005

Goal: 90%



Cervical Cancer Screening
% of women age 18+ who have had a Pap test in the past 3 years



Cervical Cancer

• Incidence & Mortality
Each year, approximately 27 cases of cervical cancer are diagnosed among Vermont women and nine die from the disease. Incidence rates are higher in Vermont than in the U.S.

• Risk Factors
Cervical cancer results from infection with one of the strains of HPV, the human papiloma virus. HPV is the most common sexually transmitted infection in the U.S. More than 80% of sexually active women will have been infected by age 50. There are over 100 different strains of HPV, and more than 30 of them are transmitted sexually.

• Prevention
The first vaccine to prevent HPV infection was licensed in 2006. It prevents four types of HPV, two that cause about 70% of cervical cancers and two that cause 90% of genital warts.

• Screening & Early Detection
Cervical cancer deaths are nearly always preventable through Pap test diagnosis at its earliest, most treatable stage. The HPV vaccine doesn't protect against all strains, so women should start having Pap tests three years after first vaginal intercourse, and no later than age 21.

In Vermont, 78% of racial and ethnic minority women age 18+ have had a Pap test in the past three years, compared to 84% of white women.

Colorectal Cancer

• Incidence & Mortality

Colorectal cancer is the third most commonly diagnosed cancer. Every year, about 336 new cases of colorectal cancer are diagnosed, and about 130 Vermonters die from the disease.

• Risk Factors

Anyone who has previously been diagnosed with colorectal cancer, or who has a family member diagnosed is at greater risk.

• Screening & Early Detection

Detecting colorectal cancer early is critical for survival. The five-year survival rate for people with colorectal cancer is 90% when diagnosed early, 67% when it has spread to nearby organs and only 10% if diagnosed in the latest stage.

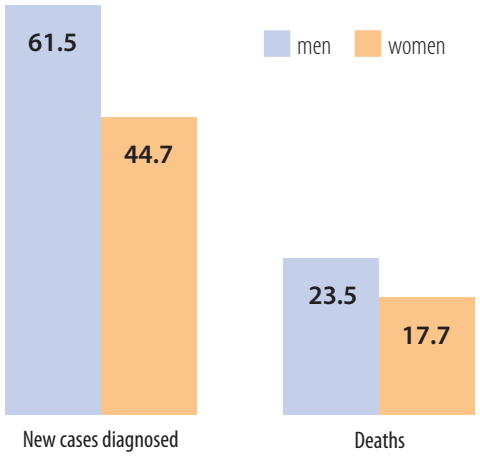
Research shows that colorectal cancer develops gradually over time from benign polyps. Polyps detected by sigmoidoscopy or colonoscopy can be removed before they become malignant.

Screening recommendations for people age 50+: fecal occult blood test (FOBT) every year, sigmoidoscopy every five years, colonoscopy every 10 years or double-contrast barium enema every five to 10 years.

In Vermont, 45% of racial and ethnic minorities age 50+ have ever had a colonoscopy or sigmoidoscopy, compared to 57% of whites.

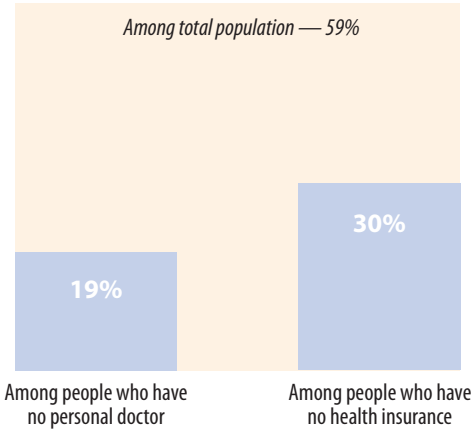
Incidence & Mortality of Colorectal Cancer

Average # each year per 100,000 people, 2000–2004



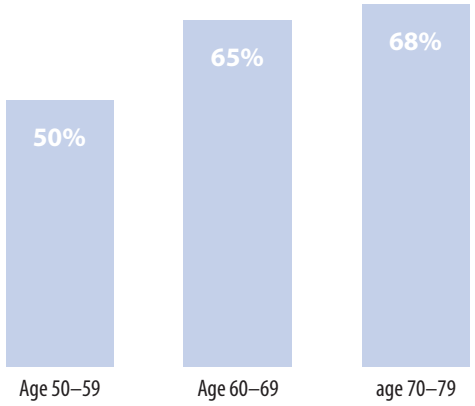
Colorectal Cancer Screening & Health Care

% of people age 50+ who report having either an FOBT in the past year or a colonoscopy/sigmoidoscopy in the past 5 years, 2004



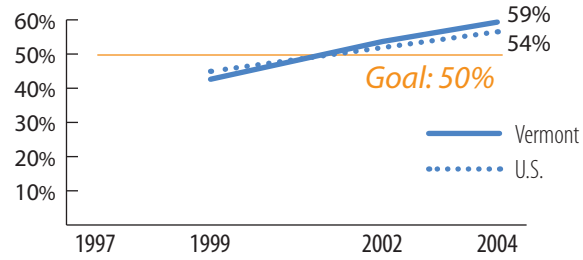
Colorectal Cancer Screening & Age

% reporting either an FOBT in the past year or a colonoscopy/sigmoidoscopy in the past 5 years, 2004

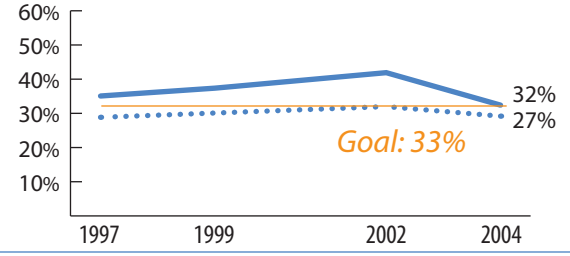


Colorectal Cancer Screening

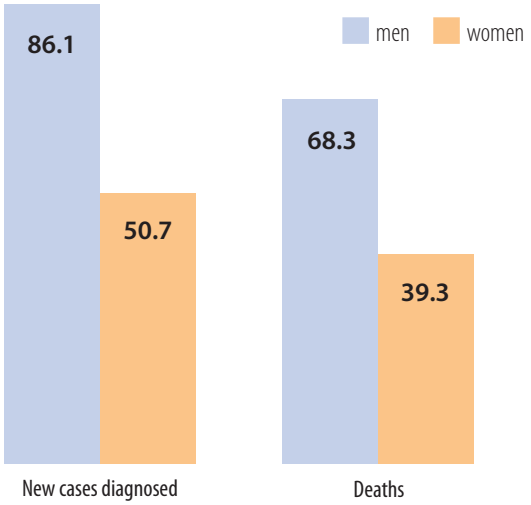
Adults age 50+ who have ever had a sigmoidoscopy/colonoscopy



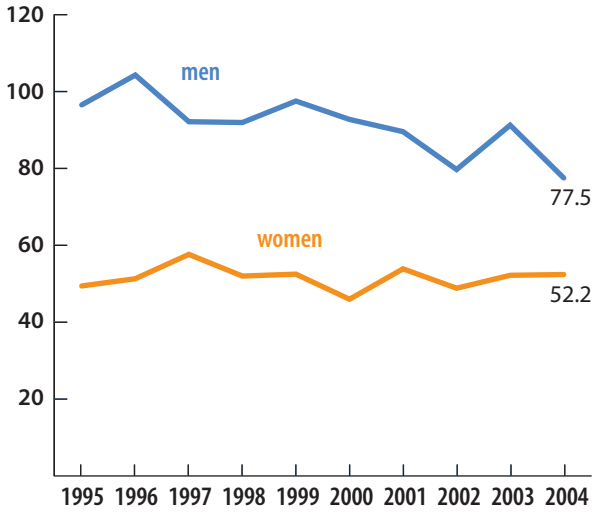
Adults age 50+ who have had FOBT in past two years



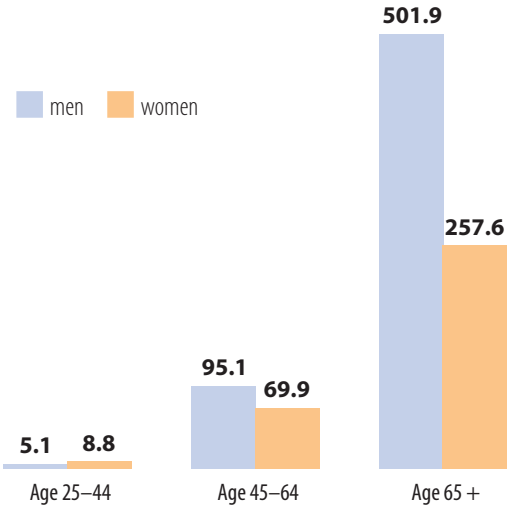
Incidence and Mortality of Lung Cancer
Average # each year per 100,000 people, 2000–2004



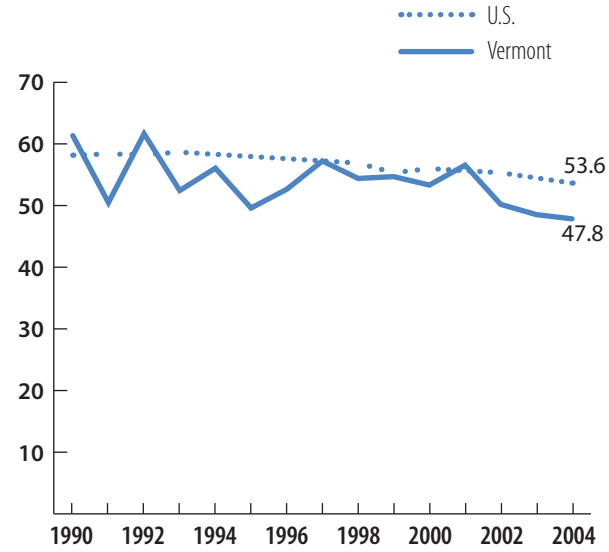
Lung Cancer Incidence
new cases diagnosed per 100,000 people



Lung Cancer & Age
Average # of new cases diagnosed each year per 100,000 people, 2000–2004



Lung Cancer Deaths
deaths per 100,000 people



Lung Cancer

• Incidence & Mortality
Every year in Vermont, about 421 new cases of lung cancer are diagnosed. Incidence of lung cancer is higher among men than women.

Lung cancer is the leading cause of cancer death in the U.S. and in Vermont, causing more deaths than breast, prostate and colorectal cancers combined. Each year in Vermont, about 329 people die from lung cancer.

• Risk Factors
Using tobacco in any form is the major cause of lung cancer. An estimated 87% of all lung cancer cases in the U.S. can be attributed to smoking. The more a person smokes, the greater risk they have for lung cancer.

People who do not smoke themselves, but who breathe the smoke of others, also have a higher risk.

Exposure to radon gas in the home accounts for about 9% of lung cancer deaths in the U.S. Smokers are especially vulnerable to the effects of radon.

• Prevention
The single most effective way to prevent lung cancer is to never start smoking. The second is to quit smoking. There are no recommended screening tests for lung cancer at this time.

Prostate Cancer

• Incidence & Mortality

Prostate cancer is the most common cancer diagnosed among Vermont men, with about 493 cases per year. A man's lifetime risk of developing prostate cancer is one in six.

Prostate cancer is the third leading cause of cancer death among men – about 69 men die from prostate cancer every year.

• Risk Factors

The causes of prostate cancer are not well understood, but certain characteristics are linked to the disease: older age, African ancestry, family history, diet high in red meat and high-fat dairy products.

• Screening & Early Detection

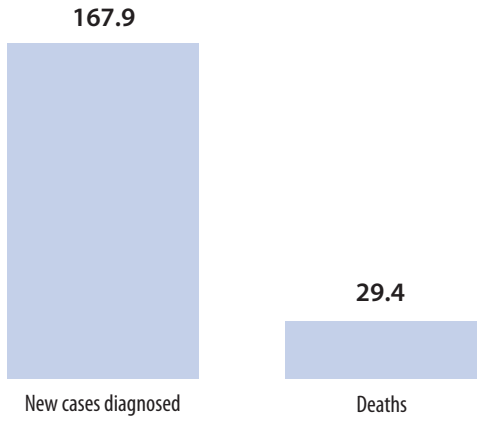
Medical experts disagree about whether regular screening for prostate cancer should be recommended for all men age 50+.

There is agreement that men should receive all available information on the pros and cons of prostate cancer screening before making a decision.

There are two screening tests: a blood test for Prostate-Specific Antigens (PSA) or a physical exam of the prostate called a Digital Rectal Exam (DRE).

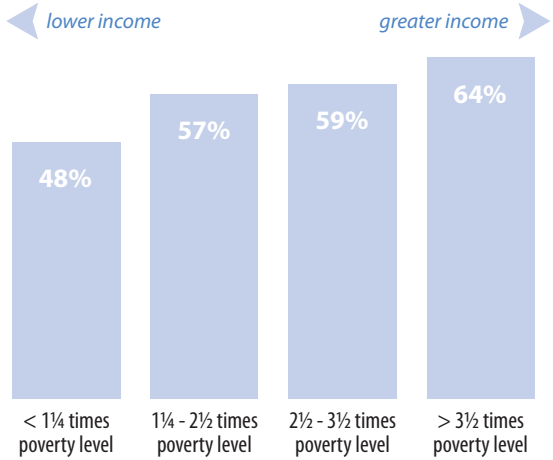
Incidence & Mortality of Prostate Cancer

Average # each year per 100,000 men, 2000–2004



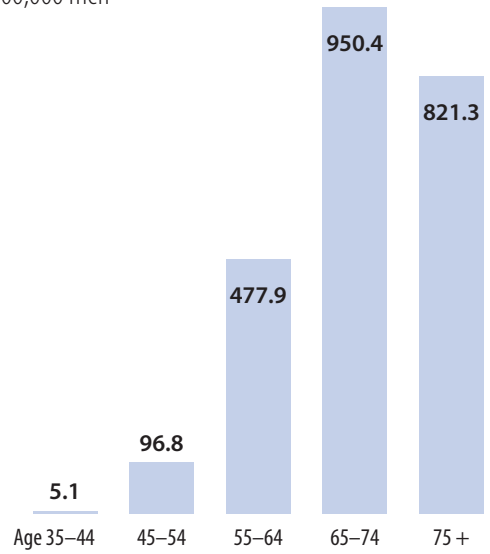
PSA Testing & Income

% of men age 50+ who had a Prostate-Specific Antigens test in the past 2 years, by Federal Poverty Level, 2004



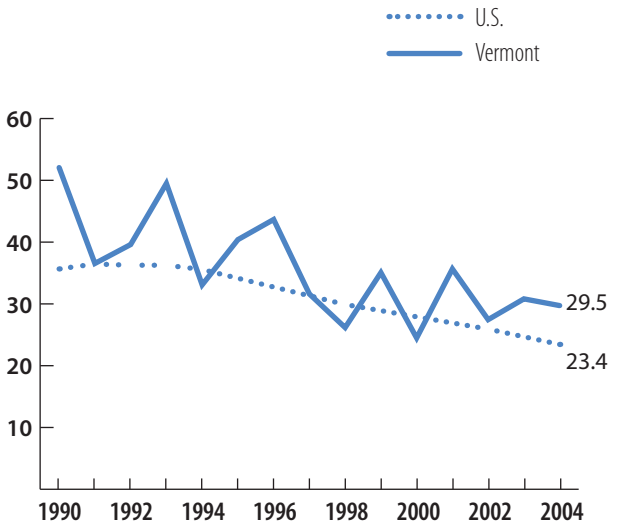
Prostate Cancer & Age

Average # of new cases diagnosed each year, 2000–2004, per 100,000 men

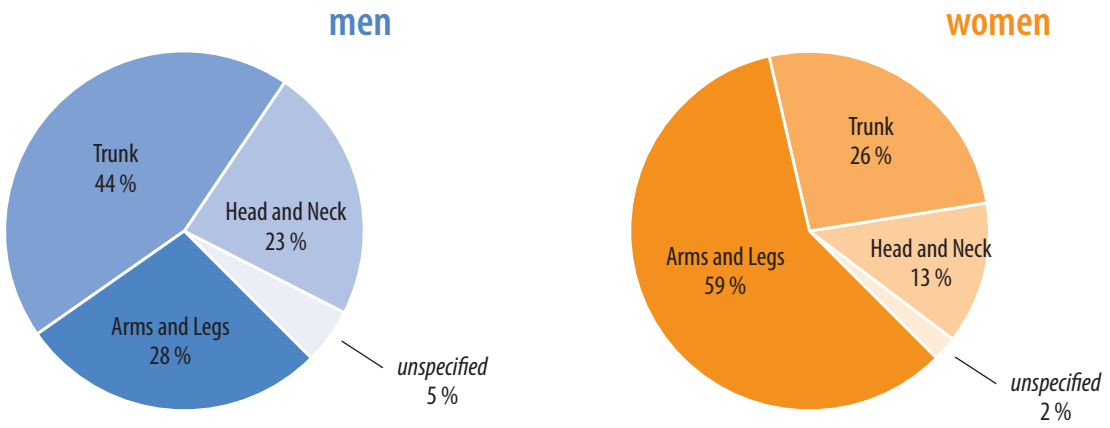


Prostate Cancer Mortality

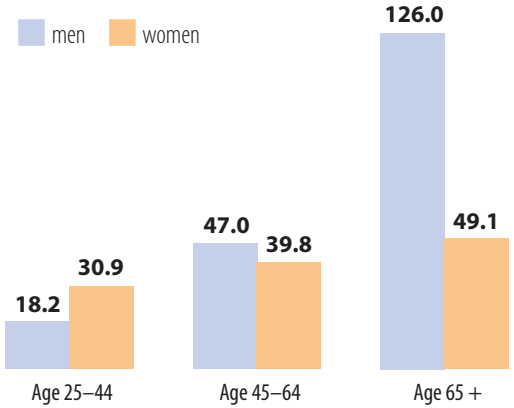
deaths per 100,000 men



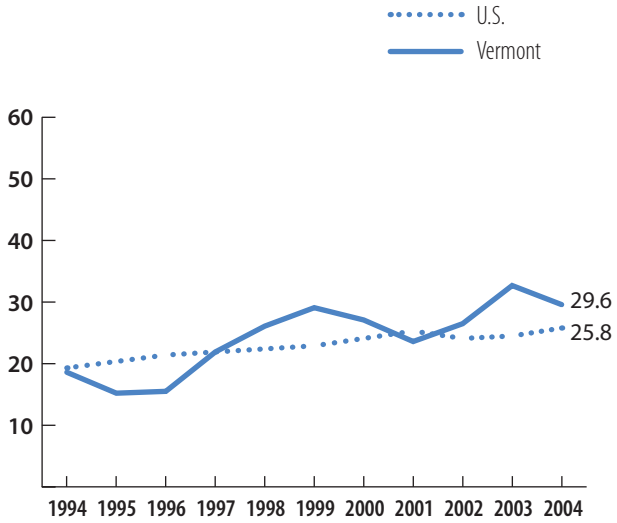
Location of Diagnosed Melanomas
% of total diagnosed melanomas at each site on the body, 2000-2004



Melanoma Incidence & Age
Average # of new cases diagnosed each year, 2000–2004, per 100,000 people



Melanoma Incidence
new cases per 100,000 people



Skin Cancer

• Incidence & Mortality
Melanomas are the most severe form of skin cancer. Melanoma can be treated if detected early. If left untreated, most melanomas will eventually spread to other parts of the body and become much more difficult to treat.

Melanoma is the fifth most common cancer diagnosed in Vermont. Incidence of melanoma is higher in Vermont compared to the U.S. Incidence is about three times higher among men than women, and mortality is about three times higher among men than women.

Melanoma is one of the most common cancers in adults age 20 to 49. Each year in Vermont, about 96 melanomas are diagnosed in men and 84 in women, and 14 men and six women die from the disease.

• Risk Factors & Prevention
Risk factors for melanoma are: too much exposure to sunlight or artificial sources of UV radiation (tanning beds), fair skin, unusual moles, and family or personal history.

To prevent skin cancer, limit direct sun exposure at mid-day, wear protective clothing and hats, use a sunscreen with SPF of 15+, and do not use tanning beds.

Diabetes

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Reduce diabetes-related deaths

(per 100,000 people)	2010 Goal	46.0
	VT 2004 *	91.1 ✘
	US 2004	68.0

Reduce hospitalizations for uncontrolled diabetes among adults age 18-64

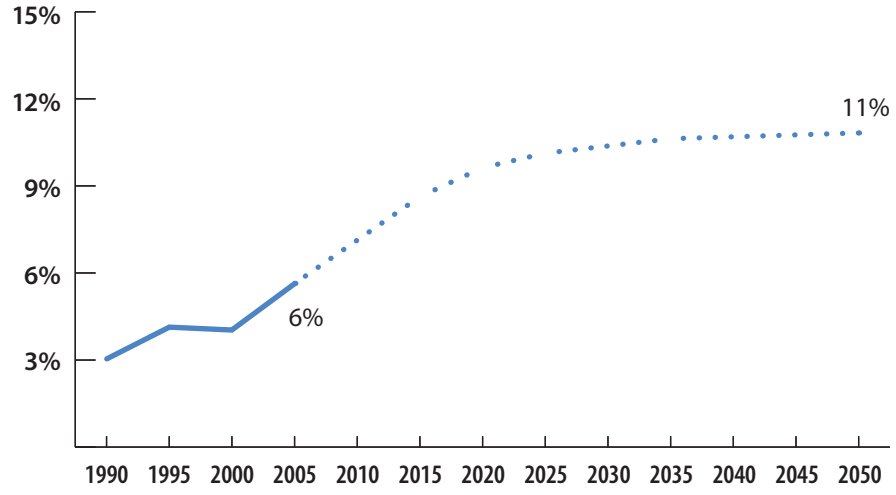
(per 100,000 people)	2010 Goal	5.4 ✔
	VT 2005	3.4
	US 2003 * *	7.8

Increase % of people with diabetes who –

• receive diabetes education	2010 Goal	60%
	VT 2005	56%
	US 2005	57%
• have an annual dilated eye exam	2010 Goal	76%
	VT 2005	72%
	US 2005	62%
• have A1C * * * test at least 2x/year	Goal	65% ✔
	VT 2005	69%
	US 2004	68%
• have a foot exam at least 1x/year	Goal	91%
	VT 2005	75%
	US 2004	67%
• had a flu shot in past 12 months	Goal	72%
	VT 2005	46%
	US 2005	43%
• have ever had a pneumonia vaccination	Goal	60%
	VT2005	46%
	US 2005	40%
• have had cholesterol measured at least 1x in past year	Goal	75%
	VT 2005	72%
	US 2005	83%

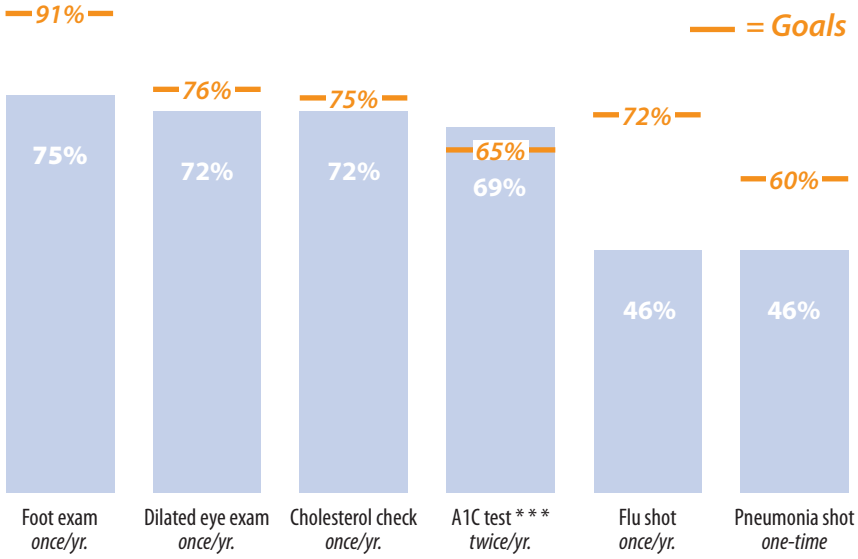
Projected Prevalence of Diabetes

% of adults who have diabetes



Clinical Care for Diabetes

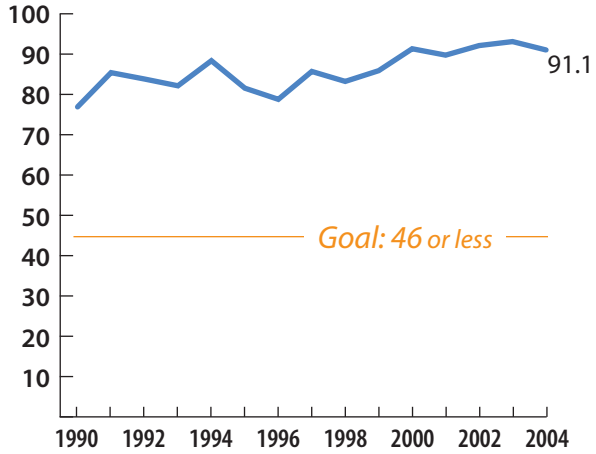
% of adults with diabetes who have medical care that meets clinical guidelines, 2005



** may reflect more accurate reporting in Vermont than nationally * * U.S., all races*

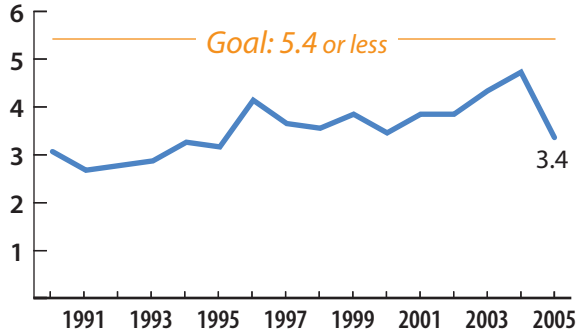
Diabetes-related Deaths

per 100,000 people *



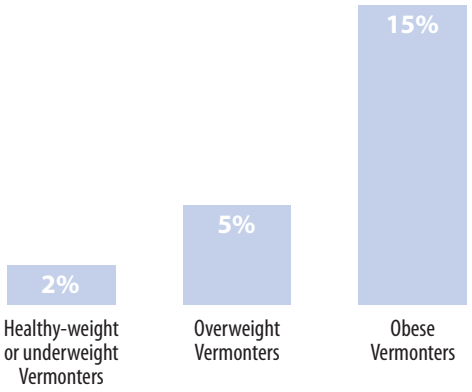
Diabetes Hospitalizations

per 10,000 people * *



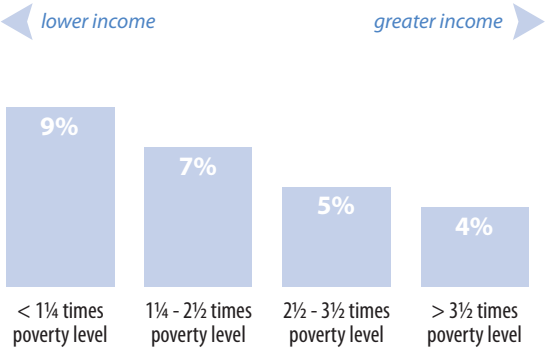
Diabetes & Weight

% of adults who have diabetes, among — 2005



Diabetes & Income

% of adults who have diabetes, by Federal Poverty Level, 2005



** * A1C test is a measure of diabetes control*

• Incidence & Mortality

An estimated 29,000 Vermonters have diagnosed diabetes – and about 90,000 age 40 to 74 are at risk of developing diabetes.

Every year, about 650 Vermonters die from diabetes-related causes: heart disease, kidney disease and other serious health problems.

The growing prevalence of type 2 diabetes is linked to the obesity epidemic.

• Risk Factors

Overweight and inactivity, high blood pressure, high LDL or low HDL cholesterol, age 45+, or family history of diabetes put a person in danger of developing diabetes.

Also at risk –
People of African, Hispanic/Latino, Asian/Pacific Islander or American Indian ancestry.

Women who have had gestational diabetes, delivered a baby over 9 pounds, or have had polycystic ovary syndrome.

• Prevention & Control

Improved diet and exercise habits are essential for controlling and reducing the complications of diabetes. This can actually prevent or delay type 2 diabetes, or may be the only treatment required.

In 2005, only 27% of Vermonters who had diabetes received medical care that met all of the clinical guidelines.

Respiratory Disease

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Reduce COPD deaths among people age 45+

(per 100,000 people)	2010 Goal	62.3
	VT 2004	122.8
	US 2004	119.5

Reduce asthma hospitalizations among people under age 18

(per 10,000 people)	2010 Goal	17.3 ✔
	VT 2005	9.1
	US 2003 * *	22.7

Increase % of people with asthma who receive –

- patient education, with information about community and self-help resources

2010 Goal	30%
VT 2005	*
US 2003	13%

- written asthma management plans from their health care provider

2010 Goal	38%
VT 2005	23%
US 2003	35%

Decrease % of children under age 18 who are regularly exposed to tobacco smoke at home

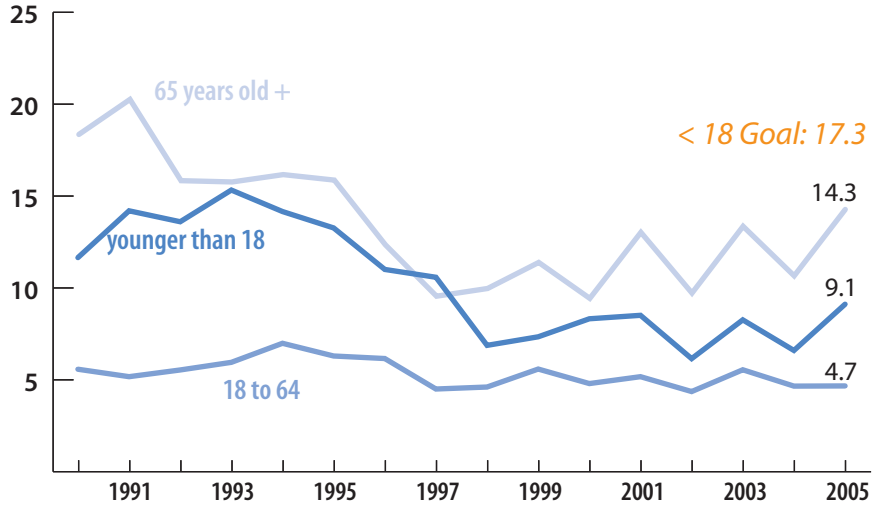
Goal	10%
VT 2005	11%
US 2005	*

Decrease % of adults exposed to tobacco smoke at home during past 7 days

Goal	10%
VT 2005	15%
US 2005	*

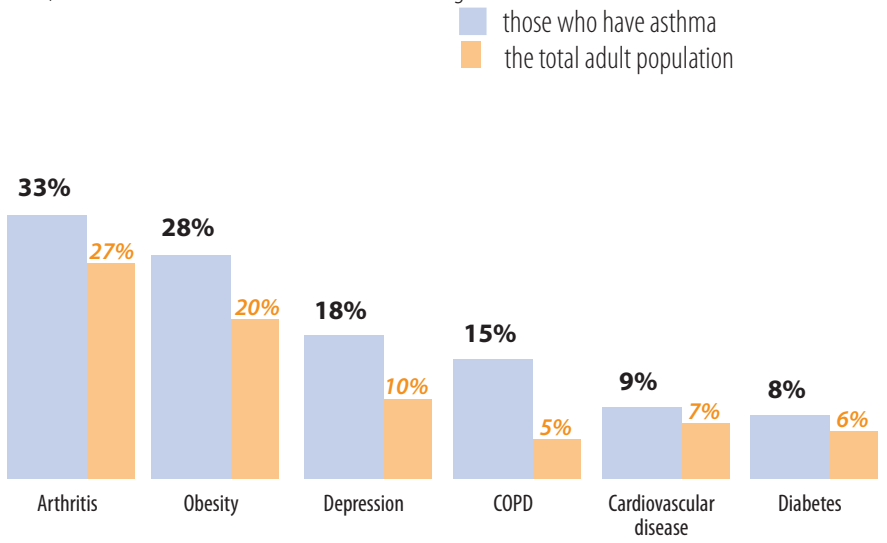
Asthma Hospitalizations

hospital discharges per 10,000 people



Asthma & Chronic Disease

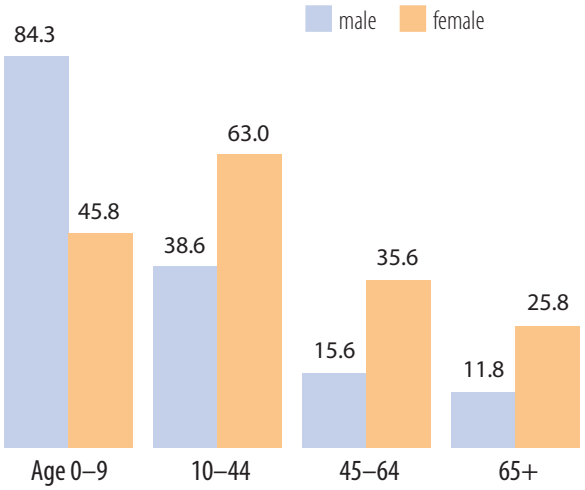
In 2005, % of adults who have chronic disease among –



** data not available ** U.S., all races*

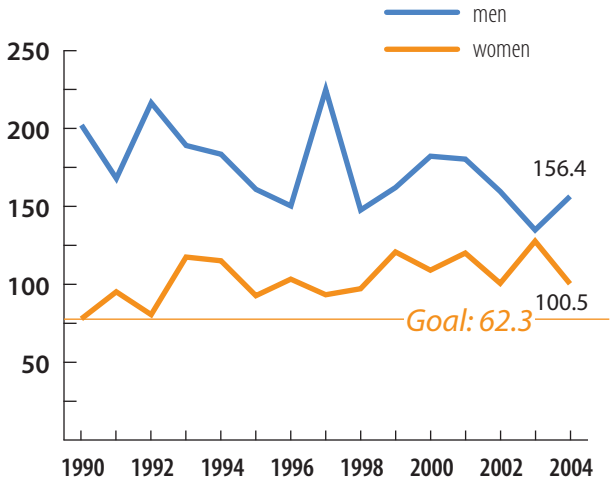
Emergency Dept. Visits for Asthma

visits per 10,000 people, 2005 * * *



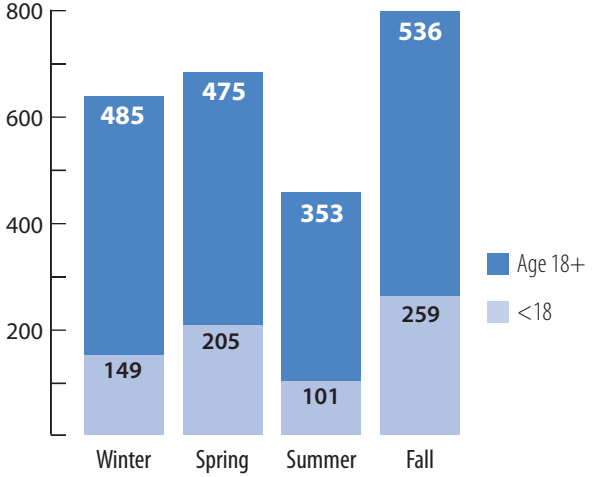
COPD Deaths

Chronic Obstructive Pulmonary Disease deaths among adults age 45+, per 100,000 people



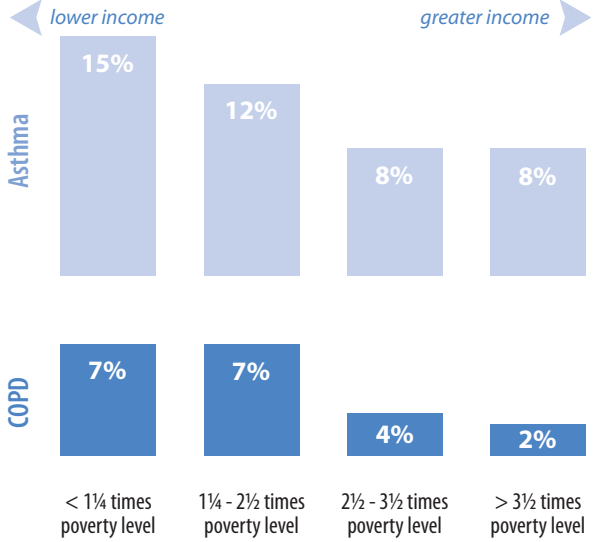
Seasonal Emergency Dept. Visits for Asthma

visits per 10,000 people, 2005 * * *



Respiratory Disease & Income

% of adults who have respiratory disease, by Federal Poverty Level, 2005



• Asthma

Asthma is a serious chronic respiratory illness that affects both children and adults. In Vermont, about 10% or 47,000 adults have asthma (compared to 8% of the U.S. white population) and about 8% or 11,000 children have asthma.

In 2005, about half of Vermonters with asthma reported that their symptoms made it difficult to sleep at night. One in five reported that asthma kept them from work or carrying on daily activities at least once in the past year.

• Chronic Obstructive Pulmonary Disease

COPD is a group of diseases, including emphysema and chronic bronchitis, that obstruct airflow within the lungs. In Vermont, about 5%, or 22,000 adults have ever been diagnosed with COPD. Nearly all COPD can be attributed to smoking.

• Asthma Action Plan

People with asthma should routinely check in with their health care provider and get an asthma action plan to help identify environmental triggers to avoid, recognize symptoms, and know when and how to use medications and seek medical care. In Vermont, not having medical insurance, low income, smoking and obesity are characteristics of people who have difficulty managing their asthma.

• Environmental & Seasonal Triggers

Allergens (animal and plant proteins), pollutants in the environment, and workplace exposures have been linked to asthma.

** * * includes all visits for asthma, whether or not visit resulted in hospitalization*

Arthritis & Osteoporosis

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of adults with chronic joint symptoms who have seen a health care provider for their symptoms

2010 Goal	61% ✔
VT 2005	72%
US 2005	72%

Increase % of adults with doctor-diagnosed arthritis who have received –

- effective, evidence-based arthritis education

Goal	13%
VT 2003	12%
US 2003	12%

- counseling on weight reduction (for overweight/obese adults)

Goal	46%
VT 2003	31%
US 2003	32%

- counseling on physical activity

Goal	67%
VT 2003	58% ✪
US 2003	52%

Decrease % of adults with doctor-diagnosed arthritis who are limited in their ability to work for pay due to arthritis

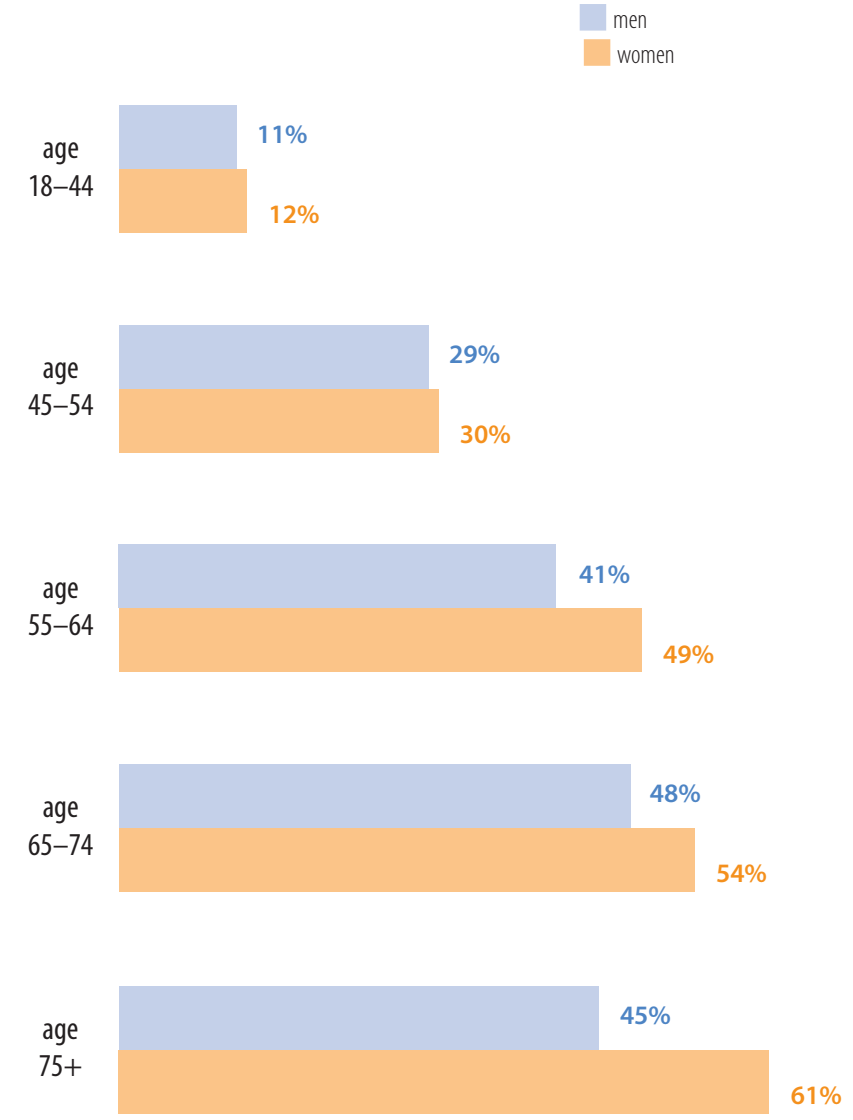
Goal	23%
VT 2005	31%
US 2003	35%

Increase % of adults with disabilities who report having sufficient emotional support

2010 Goal	79%
VT 2005	72%
US 2005	72%

Arthritis & Age

% of adults who have doctor-diagnosed arthritis, by age (2005)

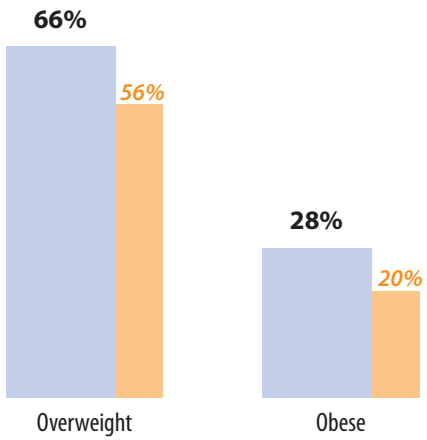


Arthritis & Weight

% of adults who are overweight or obese (2005), among:

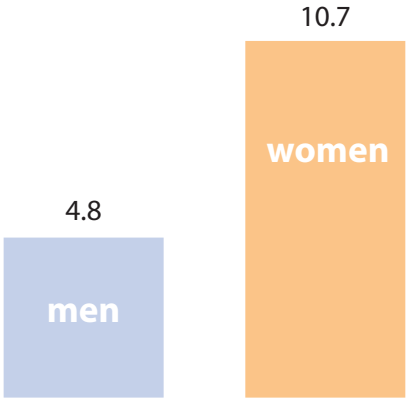
those who have arthritis

the population as a whole



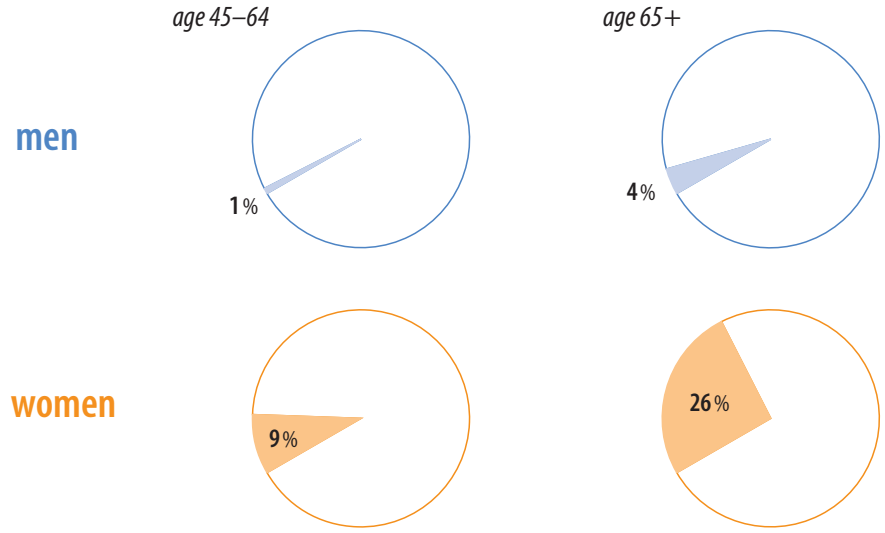
Prevalence of Hip Fractures

hospital discharges for hip fractures among Vermonters age 65+ per 1,000 people, 2004



Osteoporosis by Age/Gender

% of adults ever diagnosed with osteoporosis, 2004



• Arthritis

The term arthritis is used to describe more than 100 conditions that affect the joints and tissues, including osteoarthritis, rheumatoid arthritis, lupus, carpal tunnel syndrome, gout and fibromyalgia.

About 169,000 or 35% of adult Vermonters have chronic joint symptoms—and about 132,000 or 27% have doctor-diagnosed arthritis.

As the population ages, the number of adults with doctor-diagnosed arthritis is projected to grow to more than 181,000 by 2030.

• Osteoporosis

Approximately 23,000 or 5% of adult Vermonters are diagnosed with osteoporosis. Highest rates are among older women. Most hip fractures (90%) in people age 65+ are due to osteoporosis. In this age group, 499 women and 172 men were hospitalized for hip fractures in 2005.

• Prevention & Treatment

All forms of arthritis can be treated, and some can be prevented. Maintaining a healthy weight can reduce a person's risk of developing osteoarthritis. Physical activity helps control the joint swelling and pain of arthritis.

• Arthritis & Physical Disability

Arthritis is the most common cause of physical disability. Among Vermont adults with arthritis or chronic joint symptoms, 60,000 or 29% report limited activity due to their condition.

OBJECTIVES

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Increase % of sexually active unmarried people age 18 to 44 who use condoms

• women	2010 Goal	50%
	VT 2005	42%
	US 2005	*
• men	2010 Goal	54%
	VT 2005	50%
	US 2005	*

Increase % of youth in grades 9-12 who have never had sexual intercourse

	2010 Goal	56% ✔
	VT 2005	59%
	US 2005	57%

Increase % of sexually experienced youth in grades 9-12 who are not currently sexually active

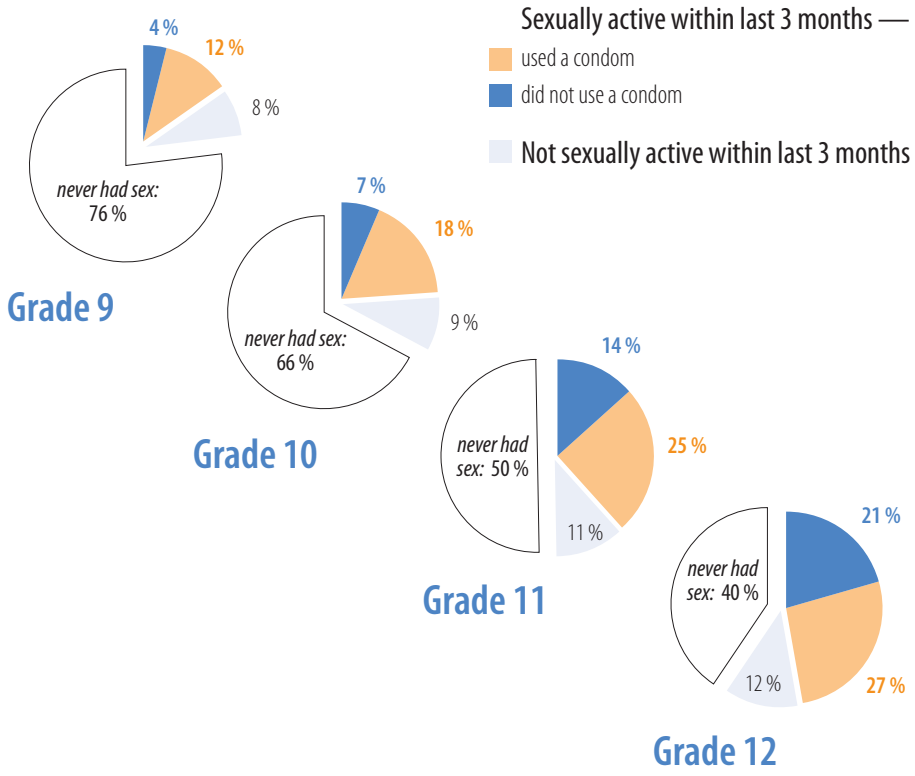
	2010 Goal	30%
	VT 2005	24%
	US 2005	*

Increase % of sexually active youth in grades 9-12 who used a condom the last time they had sexual intercourse

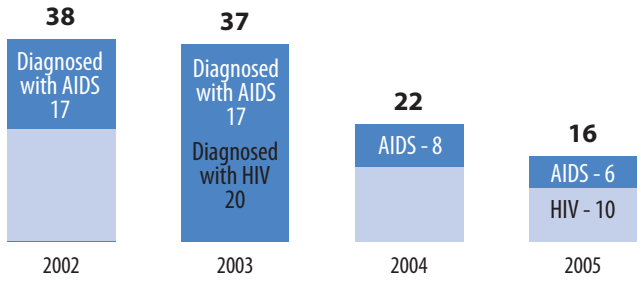
	2010 Goal	65% ✔
	VT 2005	65%
	US 2005	63%

Youth Sexual Behavior by Grade

By self-report, 2005



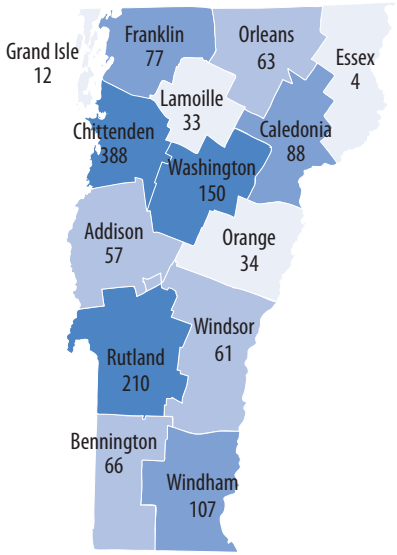
HIV / AIDS Trends — # newly diagnosed cases



* *data not available*

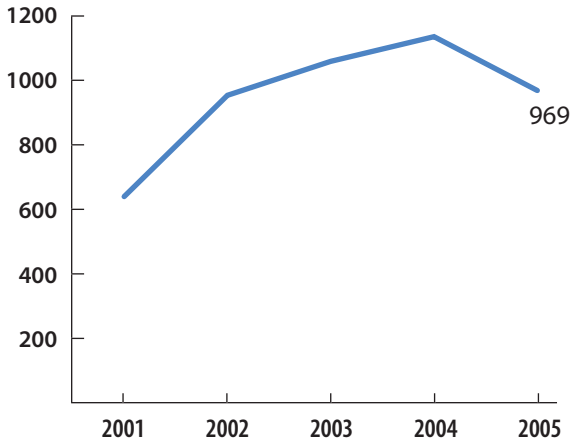
Hepatitis C Cases

Total # chronic/resolved and acute cases reported to the Vermont Department of Health, 2003-2005



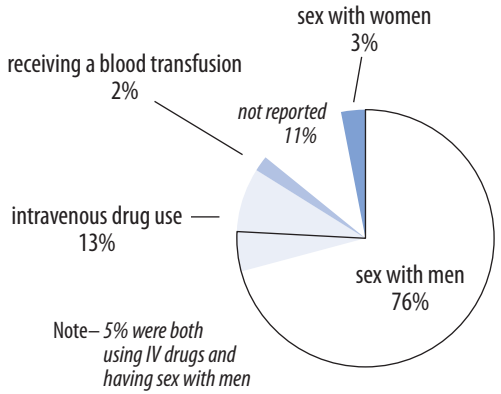
Chlamydia Diagnoses

cases reported to the Vermont Department of Health

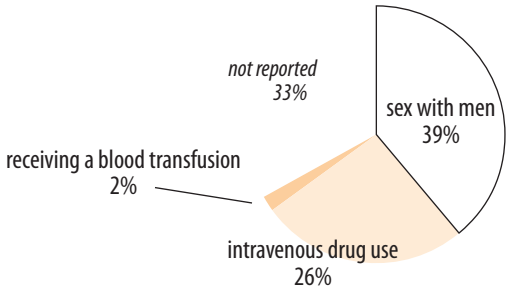


Exposure to HIV

Mode of exposure 2001-2005



men



women

• HIV and AIDS

In 2000, HIV became a reportable disease in Vermont. At the close of 2005, there were 429 people diagnosed with HIV/AIDS in the state. At time of diagnosis, 41% lived in Chittenden County.

• Sexually Transmitted Diseases (STDs)

Chlamydia is by far the most-reported STD. Because many people infected with chlamydia do not have symptoms or do not seek testing or care, cases go undiagnosed and unreported. If left untreated, up to 40% of women with chlamydia will develop Pelvic Inflammatory Disease and up to 20% will become infertile.

Gonorrhea is the second most reported STD. People age 14 to 39 account for nearly all reported cases of chlamydia and gonorrhea.

• Hepatitis C

Hepatitis C is a bloodborne virus that infects the liver. It is the most commonly reported chronic infection in Vermont. From 2003 to 2005, the Vermont Department of Health identified 1,350 cases of hepatitis C, but national data suggest that the number infected may be closer to 12,000, or 2% of the state's population.

Testing and early diagnosis is important to improve care for people living with hepatitis C and prevent others from becoming infected.

Between 55% to 80% of people infected become chronic carriers. Chronic infection may result in liver cancer, and is the main reason for liver transplants in the U.S.

Summary

✔ met goal ✪ statistically better than US ✘ statistically worse than US

Behaviors, Environment & Health

INCREASE % OF –

youth who engage in regular physical activity (p.4)
✔ ✪ adults who engage in regular physical activity (p.4)
youth who eat 2+ servings of fruit/day (p.4)
✪ adults who eat 2+ servings of fruit/day (p.4)
youth who eat 3+ servings of vegetables/day (p.4)
✪ adults who eat 3+ servings of vegetables/day (p.4)
adults who have food security (p.6)
adults who attempt to quit smoking (p.8)
pregnant women who quit smoking during first trimester (p.8)
smokers with children who don't allow smoking at home (p.8)
smokers with children who don't allow smoking in their car (p.8)
adults who always use safety belts (p.12)
youth who always use safety belts (p.12)
1-year-olds who have had a blood lead test (p.14)
2-year-olds who have had a blood lead test (p.14)
✔ population on systems that meet safe drinking water standards (p.14)
✔ adults who live in homes that have been tested for radon (p.14)

DECREASE % OF –

✔ ✪ adults who have NO leisure time physical activity (p.4)
youth who watch TV or use a computer 5+ hours/day (p.4)
✪ adults who are obese (p.6)
youth who are obese or overweight (p.6)
WIC participants age 2-5 who are overweight (p.6)
✪ adults who smoke cigarettes (p.8)
✪ youth who smoke cigarettes (p.8)
youth who use spit tobacco (p.8)
youth who smoke cigars, cigarillos, little cigars (p.8)
youth who binge drink (p.10)
youth who use marijuana (p.10)
youth who used alcohol before age 13 (p.10)

REDUCE RATE OF –

✔ alcohol-related motor vehicle deaths (p. 10)
✘ work-related injuries resulting in medical treatment, lost time from work, or restricted work activity (p.12)
✔ ✪ residential fire deaths (p. 12)
child abuse substantiated cases (p.12)
✔ physical assaults by intimate partners (p.12)
eliminate elevated blood lead levels in children age 1-5 (p.14)

Providing for Better Public Health

INCREASE % OF –

✔ ✪ adults with a usual primary care provider (p.16)
people who have health insurance (p.16)
✔ pregnant women who receive prenatal care in first trimester (p.18)
✪ pregnant women who receive early and adequate prenatal care (p.18)
✔ children who receive universally recommended vaccines (p. 20)
children who receive varicella vaccine (p.20)
✪ adults who receive annual influenza immunizations (p.20)
✪ adults who have ever been vaccinated against pneumoccal disease (p.20)
✔ ✪ adults who use the dental health system each year (p.22)
✔ children who get dental sealants (p.22)
population served by fluoridated community public water systems (p.22)
dentists who counsel patients to quit smoking (p.22)

INCREASE % OF schools that provide comprehensive health education on –

✔ alcohol & other drug use (p.16)
✔ tobacco use/addiction (p.16)
✔ unintended pregnancy, HIV/AIDS and STDs (p.16)

DECREASE % OF –

low birth weight births (p.18)
✔ very low birth weight births (p.18)
✔ children who have ever had decay (p. 22)
✔ children who had untreated decay (p. 22)
suicide attempts by youth (p.24)

REDUCE RATE OF –

✔ infant deaths (p.18)
✔ pregnancies among girls age 15-17 (p.18)
pneumonia/influenza hospitalizations among adults age 65+ (p.20)
✔ reduce or eliminate vaccine-preventable diseases: Hib B, Measles, Rubella, Hepatitis B (p.21)
reduce or eliminate vaccine-preventable diseases: Pertussis (p.21)
suicide deaths (p.24)

Chronic Diseases & Health Conditions

INCREASE % OF –

adults who have had their cholesterol checked within the past 5 years (p.26)
✔ ✪ women age 40+ who have had a mammogram in the past 2 years (p. 28)
women age 18+ who have had a Pap test in the past 3 years (p.28)
✪ adults who have had a FOBT in the past 2 years (p.28)
✔ ✪ adults age 50+ who have ever had a sigmoidoscopy or colonoscopy (p.28)
adults who take protective measures to reduce risk of skin cancer (p.28)
adults with disabilities who have sufficient emotional support (p.40)
sexually active unmarried people age 18-44 who use condoms (p.42)
✔ youth who have never had sexual intercourse (p. 42)
sexually experienced youth who are not currently sexually active (p.42)
✔ sexually active youth who used a condom the last time they had sex (p. 42)

INCREASE % OF people with diabetes who –

receive diabetes education (p.36)
have an annual dilated eye exam (p.36)
✔ have A1C test at least twice a year (p. 36)
have a foot exam at least once a year (p.36)
had a flu shot in past 12 months (p.36)
have ever had a pneumonia vaccination (p.36)
have had cholesterol measured at least once in past year (p.36)

INCREASE % OF people with asthma who receive –

patient education with info about community/self-help resources (p.38)
written asthma management plans from their health care provider (p.38)

INCREASE % OF people with chronic joint symptoms –

✔ who have seen a health care provider for their symptoms (p.40)

INCREASE % OF adults with doctor-diagnosed arthritis who have –

received effective, evidence-based arthritis education (p.40)
received counseling on weight reduction (for overweight/obese adults (p.40)
✪ counseling on physical activity (p.40)

DECREASE % OF –

✪ adults with high blood pressure (p.26)
children who are regularly exposed to tobacco smoke at home (p.38)
adults exposed to tobacco smoke at home during past 7 days (p.38)
adults with arthritis who are limited in their ability to work (p.40)

REDUCE RATE OF –

✔ ✪ coronary heart disease deaths (p. 26)
✔ stroke deaths (p.26)
✘ diabetes deaths (p.36)
✔ hospitalizations for uncontrolled diabetes among adults (p.36)
COPD deaths among people age 45+ (p.38)
✔ asthma hospitalizations among people under age 18 (p. 38)

YOUR HEALTH DEPARTMENT & YOU

Guidance • Support • Prevention • Protection

March 2008