VERMONT DEPARTMENT OF HEALTH

Identifying and Understanding the Vermont SNAP-Ed Focus Population

March 2022

In 2021, the Vermont Department of Health (VDH) asked Professional Data Analysts (PDA) to conduct a needs assessment to help inform the next Supplemental Nutrition Assistance Program Education (SNAP-Ed) three-year plan (fiscal year (FY) 2023-2025). This document summarizes the findings and implications of the needs assessment for the state plan.

Introduction

The Supplemental Nutrition Assistance Program (SNAP) is a federally funded and state-administered program that provides eligible households with monthly vouchers to purchase food at participating retailers.[1] In Vermont, SNAP is called 3SquaresVT, but will be referred to as SNAP throughout this report. Vermont residents may be eligible for SNAP if their gross household income is ≤185% of the Federal Poverty Level (FPL), if they have children and receive the VT Earned Income Tax Credit, or if they live in a household with someone age 60+ or living with a disability. Eligible individuals and households must also have assets below a certain amount and be U.S. citizens or lawfully present non-citizens.

The goal of SNAP-Ed is to improve the likelihood that persons eligible for SNAP will make healthy food choices within a limited budget and choose physically active lifestyles consistent with the current Dietary Guidelines for Americans and the USDA food guidance.[2] The SNAP-Ed program pursues this goal through three types of evidence-based strategies: direct education, social marketing, and policy, systems, and environmental (PSE) changes. While SNAP-Ed aims to reach SNAP-eligible people, PSE changes often reach wider audiences of varying income levels (i.e., all students in a school or all residents of a community).

SNAP-Ed strategies are implemented by partner organizations. In FY 2021, Vermont SNAP-Ed had four implementing partners – Come Alive Outside (CAO), University of Vermont Extension (UVM), Vermont Foodbank, and Hunger Free Vermont – that offered programs in the seven Vermont regions determined in the last needs assessment to be most in need of services:

Region	Passport Programs	ESMM	Text4 HealthVT	VT Fresh	Veggie Van Go	SL	NAP SACC	Hunger Councils
Barre		✓	✓	✓	✓			✓
Bennington		✓	✓	✓	✓	✓	✓	✓
Brattleboro	✓	✓	✓	✓	✓			✓
Newport		✓	✓	✓	✓		✓	✓
Rutland	✓	✓	✓	✓	✓			✓
St. Albans		✓	✓	✓		✓		✓
St. Johnsbury		✓	✓	✓	✓		✓	✓*

ESMM = Eat Smart, Move More

SL = Smarter Lunchrooms

NAP SACC = Nutrition and Physical Activity Self-Assessment for Child Care

*St. Johnsbury shares a Hunger Council with Newport

Related State Health Initiatives

Beginning in 2017, VDH convened more than 80 organizations and partners to develop a State Health Assessment (SHA)[3] and State Health Improvement Plan (SHIP)[4] organized around the root causes of health disparities and inequities – race and ethnicity, sexual orientation, disability status, socioeconomic status, gender, age, and geography. The data from the SHA informed the process for choosing health priorities and the evidence-based strategies for improvement using these criteria: closes the health equity gap among population groups, focuses on prevention as the highest priority for health, addresses the root causes of inequities, and impacts multiple health outcomes.

Vermont also uses "3-4-50," a simple concept to describe the role of three health behaviors – poor nutrition, lack of PA, and tobacco use – which lead to four chronic diseases – lung disease, diabetes, cancer, and cardiovascular disease (CVD) – that are responsible for 50% of deaths in Vermont each year, with these numbers even higher among marginalized populations.[5] The 3-4-50 framework is used to educate state partners and the public about the benefits of healthy behaviors and encourage them to make positive changes within their spheres of influence. The goals and objectives of SNAP-Ed and the SNAP-Ed population of focus directly align with the SHIP and 3-4-50.

Needs Assessment Methodology

The overall approach to the needs assessment was developed using a health equity lens, which influenced both the questions asked and the methods used. The motivating question for the needs assessment was, "Which communities or populations should SNAP-Ed focus on reaching in order to reduce nutrition-related health inequities in the SNAP-eligible population?" To answer this question, demographic data, health statistics, and interview data were examined to identify communities and populations that are disproportionately likely to be eligible for SNAP *and* marginalized as a result of their race, ethnicity, place of birth, sexual orientation, gender identity, disability status, socioeconomic status, age, or geography. Evaluation findings from FY 2021 were also considered to identify gaps between current program activities and future goals.

Existing information

The previous state plan identified Vermonters who are SNAP-eligible, with a special emphasis on families with children ages 2-18, as the focus population for SNAP-Ed activities. Seven regions of Vermont were selected to receive SNAP-Ed services: Rutland, Barre, Bennington, Brattleboro, Newport, St. Albans, and St. Johnsbury. These regions include some of the most rural areas of the state with limited infrastructure, capacity, and services.

New information collection

With support and collaboration from VDH, PDA used the following methods to identify an appropriate focus population and their nutrition- and PA-related service needs:

- Reviewed previous years' SNAP-Ed assessment data and reports
- Reviewed academic literature on nutrition- and PA-related interventions for communities that face greater barriers to accessing nutrition-related services due to social and economic marginalization

- Examined 2020 census data and 2015-2019 American Community Survey (ACS) data to describe Vermont demographics
- Assessed data from the Vermont Behavioral Risk Factor Surveillance System (VT BRFSS) to understand chronic disease, obesity/overweight, and any leisure time PA (2017-2018); as well as fruit and vegetable consumption and PA aerobic guidelines (2017-2019) by income, race/ethnicity, disability status, and county of residence
- Ranked Supervisory Unions/School Districts using data from the VT Youth Risk Behavior Survey (YRBS), ACS, and VT Agency of Education (AoE) Child Nutrition Programs Report
- Engaged the Vermont Nutrition Education Committee and regional Chronic Disease Designees in a discussion of the geographic distribution of SNAP-eligible individuals by age, race/ethnicity, and disability status, and interviewed four individuals who work with specific marginalized populations: Abenaki; refugees; Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ+); and living with a disability.

Demographic Characteristics

Vermont is a small (9,620 square mile), rural state with 645,570 residents.[6] Sixty-five percent (65%) of Vermonters reside in rural areas, 18.3% are under 18 years of age, and 20% are age 65 years or older.[7] According to the U.S. Committee for Refugees and Immigrants, Vermont has welcomed over 8,000 refugees since 1980.[8] In the 2018 VT BRFSS, 8% of the Vermont adult population identified as lesbian, gay, bisexual, or another sexual orientation, while 0.7% identified as transgender.[9] In the 2019 VT BRFSS, 24% of Vermont adults reported living with at least one disability.[10]

Vermont Race/Ethnicity Estimates	
American Indian or Alaska Native alone[i]	0.4%
Asian alone	1.9%
Black or African American alone	1.4%
Hispanic or Latino	2.0%
Native Hawaiian and Other Pacific Islander alone	Number too small
Two or More Races	2.0%
White alone, not Hispanic or Latino	92.6%

Source: Census Population Estimates, 2021[6]

After reviewing numerous demographic characteristics, several populations disproportionately eligible for or currently receiving SNAP-Ed services were identified: [ii]

- Families with children under 18 (particularly unmarried householders and households with children under age 5),
- Households with one or more persons living with a disability, and
- Households led by a person of color.

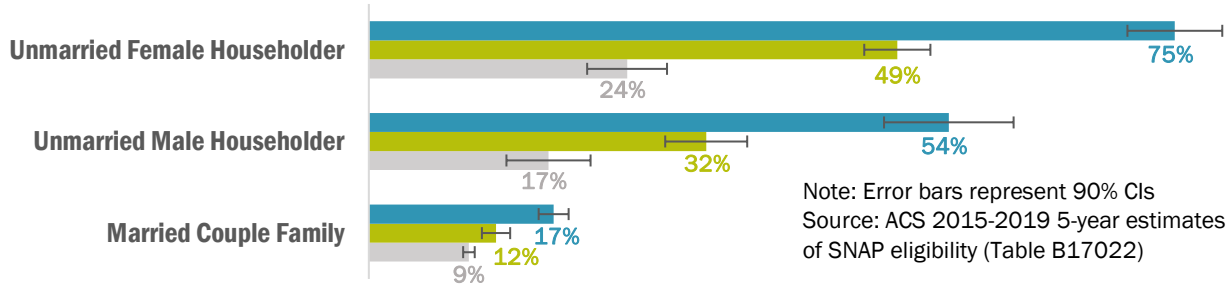
Notably, these data come from 2015-2019 ACS estimates and therefore do not reflect changes in eligibility patterns resulting from the COVID-19 pandemic. The charts on the next page show the proportion of households with these characteristics that are eligible for or receiving SNAP benefits, compared to households without these characteristics.

[i] An Abenaki key informant and individuals working in Vermont noted that census data are not a reliable representation of Abenaki population estimates. Many Abenaki individuals are unwilling to identify as such in light of historic state violence and ongoing discrimination and mistreatment.

[ii] PDA also examined SNAP receipt by age. Despite being a rapidly aging state, SNAP receipt among households that include older adults (60+) were similar to levels among households without older adults (10% and 11%, respectively).

Households with an unmarried female or male householder[iii] were much more likely to have incomes that made them eligible for SNAP compared to married couple families. For each of these household types, the prevalence of SNAP eligibility was highest among those with children <5 years and lowest among those with no children <18 years. Unmarried householders with children under 18 made up two thirds (65%) of SNAP-eligible families with children (data not shown).

Household eligibility for SNAP by family composition, with children <5, children 5-17 only, and no children <18

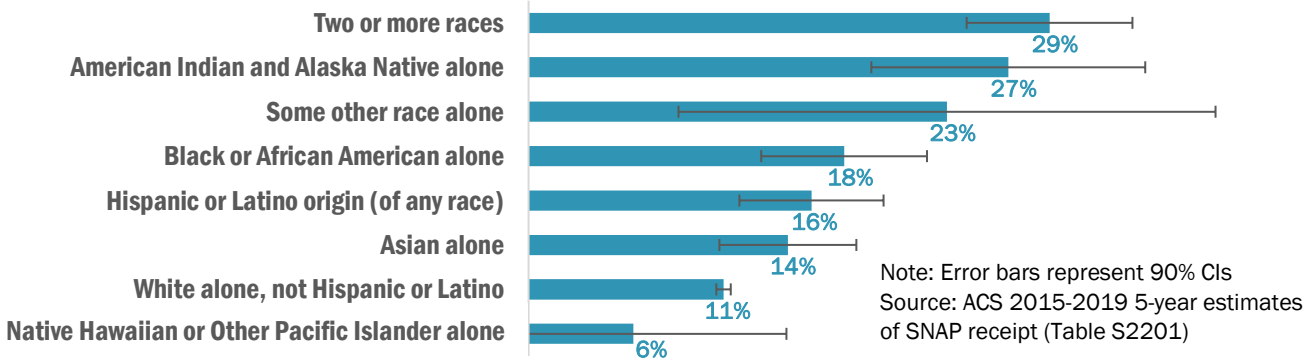


Households including an individual with a disability received SNAP at more than three times the rate of households with no individuals with a disability (see chart below). Fifty-five percent (55%) of households that received SNAP included one or more individuals with a disability (data not shown).

Percent of households receiving SNAP by disability status

Race/ethnicity of householder was related to the likelihood of SNAP eligibility. Non-Hispanic white individuals made up 91% of all SNAP recipients (data not shown), but households led by a householder identifying as American Indian or Alaska Native, Black, Hispanic, Asian, two or more races, or some other race received SNAP more frequently than their white counterparts.

Percent of households receiving SNAP by race/ethnicity of householder



[iii] Unmarried householders include unmarried male or female householders living with one or more individuals related by birth, marriage, or adoption. Unmarried householders with children are not necessarily single parents; respondents identified as unmarried householders could include adults in cohabitating relationships or adults coparenting with other adults inside or outside of the household.

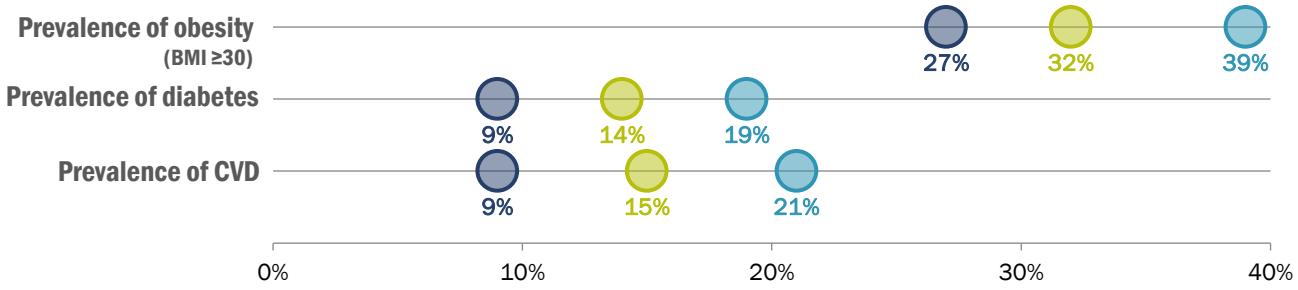
State-Specific Diet and Physical Activity-Health Statistics

VT BRFSS data on diet-related chronic conditions and protective behaviors were examined for all adults and stratified by income and disability status. The findings demonstrate clear disparities in health conditions and protective behaviors among people living with any disability and people with lower incomes.

Chronic conditions related to nutrition and PA were unevenly distributed across disability status and income levels. People with any disability were significantly more likely to be diagnosed with obesity, diabetes, or CVD than people with no disabilities. Prevalence rates between non-Hispanic white people and people of color were similar and not statistically significant.

Diet-related chronic conditions, 2017-2019 VT BRFSS

All Vermont residents, people with lower incomes (<$25,000 per year), and people with any disability

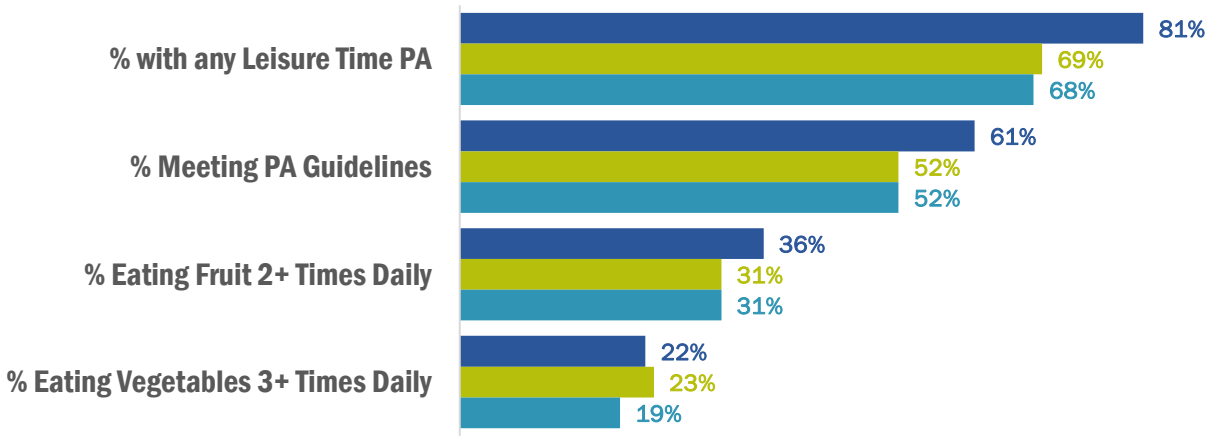


Note: Estimates for obesity are age-adjusted and include adults age 20 years and older. Other estimates are not age-adjusted and include adults age 18 years and older.

Protective behaviors were also unevenly distributed. People with any disability were significantly less likely to report leisure time PA or meet PA guidelines than people with no disability. While people with any disability and people with lower incomes reported eating less fruit than Vermonters as a whole, vegetable consumption was less varied among subpopulations. Prevalence of protective behaviors between non-Hispanic white people and people of color were similar and differences were not statistically significant.

Protective behaviors for chronic diseases, 2017-2019 VT BRFSS

All Vermont residents, people with lower incomes (<$25,000 per year), and people with any disability



Note: Estimates are age-adjusted and include adults age 18 years and older.

County-level estimates were also calculated for the same health indicators. Orleans County had significantly worse results than the state overall in half of the indicators, and Chittenden County had significantly better results than the state overall in obesity and leisure time PA, but most indicators showed few significant differences by county.

Diet and PA-related health indicators by county, 2017-2019 VT BRFSS

	Prevalence of obesity*^	Prevalence of diabetes	Prevalence of CVD	Any Leisure Time PA*	Meet PA Guidelines*	Eat Fruit 2+ Times Daily*	Eat Vegetables 3+ Times Daily*
	%	%	%	%	%	%	%
Vermont	**27**	**9**	**9**	**81**	**61**	**36**	**22**
Addison	25	8	6	81	61	43	22
Bennington	30	11	11	80	59	37	23
Caledonia	27	13	10	77	58	34	19
Chittenden	22	7	6	86	63	39	22
Essex	38	16	13	77	46	42	34
Franklin	33	9	7	77	61	38	21
Grand Isle	42	8	12	78	61	35	22
Lamoille	24	8	7	79	60	40	24
Orange	36	9	9	79	60	40	25
Orleans	35	11	12	74	53	34	23
Rutland	38	10	10	78	57	33	16
Washington	24	9	8	84	65	39	19
Windham	28	7	8	82	63	37	23
Windsor	29	11	9	81	58	41	25

Note: Statistically significant differences between county and state measures are highlighted: counties that performed better than the state are highlighted in blue and counties that performed worse than the state are highlighted in orange. *age-adjusted ^limited to adults age 20 years and older

Supervisory unions/schools districts (SUs/SDs) were ranked based on multiple youth health indicators. Of the 53 SUs/SDs in the state, the ten with the highest rates of income eligibility and poorest health indicators were spread across the state and not clustered in any geographic region. Most were located in counties that performed similarly to the state in adult health indicators, indicating that community-level disparities may not be visible in county-level data.

Vermont SUs/SDs with highest ranking on low income and poor health indicators, 2015-2019

Ranking	Supervisory Union/ School District	Town	County
1	Southwest Vermont SU	Bennington	Bennington
2	Maple Run SD	St. Albans City	Franklin
3	Orleans Central SU	Orleans	Orleans
4	Windham Northeast SU	Westminster	Windham
5	Barre SU	Barre	Washington
6	Franklin Northeast SU	Richford	Franklin
7	Slate Valley Unified SU	Fair Haven	Rutland
8	Orange Southwest SD	Randolph	Orange
9	Rutland City SD	Rutland	Rutland
10	Winooski SD	Winooski	Chittenden

Vermont's 53 SUs/SDs were ranked based upon a review of six health indicators: percent of residents who lived at ≤185% FPL; percent of students who lived at 130-185% FPL; percent of high schoolers who consumed fewer than five fruit and vegetables per day or were not meeting aerobic PA guidelines; and percent of high schoolers who were overweight or obese. Data sources include the 2019 Vermont YRBS, 2019-2020 AoE Child Nutrition Programs Annual Statistical Report, and 2015-2019 ACS 5-year estimates.

Other Nutrition-Related Programs

This section summarizes eligibility and activities of other nutrition-related programs operating in Vermont to avoid duplicating efforts with SNAP-Ed, although there may be overlap or coordination with other programs to enhance implementation and reach. Many of these programs serve families with children and older adults and have similar income eligibility requirements as SNAP.

Women, Infants, and Children (WIC) Program is funded by the USDA Food and Nutrition Service (FNS).[11] This program aims to increase access to healthy foods, nutrition education and counseling, and breastfeeding support.[12] This is done through four components of the program: nutrition education, breastfeeding support (including providing breast pumps and other resources, classes, peer counselors, and referrals to community lactation consultants), monetary food benefits, and health care referrals (including pregnancy and pediatric care, smoking cessation and substance use services, SNAP and other food resources, and preschool programs). Individuals who are pregnant and caregivers of children under five, including parents, grandparents, and foster parents are eligible. WIC is implemented statewide through Local Health Offices, of which there are 12 throughout Vermont.

Expanded Food and Nutrition Education Program (EFNEP) is a community outreach program using education to promote nutritional health and well-being.[13] It is funded by the USDA National Institute of Food and Agriculture and implemented by the University of Vermont (UVM) Extension.[14] Adult and youth programs, typically comprised of six classes, involve group discussion and developmentally appropriate nutrition education activities. Topics include preparing basic meals and snacks, shopping smarter on a budget, food safety, following and modifying healthy recipes, and appreciating the benefits of PA. EFNEP is designed to serve limited-income families. Free programs serve parents and guardians of youth 19 years old and under, pregnant women, teens, and children. Individuals who are eligible for SNAP, WIC, Head Start and/or free school meals are likely to also qualify for EFNEP. Adult group classes, youth group classes, and individual home visits with adults are available anywhere in Addison, Caledonia, Chittenden, Lamoille, Rutland, and Windham counties. Adult group classes and youth group classes are also held in some parts of Bennington, Essex, Franklin, Orleans, Washington, and Windsor counties.

National School Lunch Program (NSLP) and **School Breakfast Program (SBP)** are funded by the USDA FNS and implemented by the Vermont AoE.[15,16] NSLP reimburses public and private non-profit schools for free, reduced-price, and full-price breakfasts and lunches served to students enrolled in 12th grade and under.[17] Families may apply to receive free or reduced-price meal benefits. Families with incomes below 130% FPL are eligible for free meals; families with incomes between 130% FPL and 185% FPL are eligible for reduced price lunch. All public schools are required to participate in the NSLP and SBP unless the school board votes to exempt the district from the requirement.

Children with Special Health Needs (CSHN) at the Vermont Department of Health offers individualized nutrition services for children with special health needs.[18,19] Registered Dieticians (RDs) offer nutrition education and in-home support on adaptive feeding strategies and optimal nutrition for children with specific growth, feeding, and dietary needs. Caregivers of children with special health needs can initiate a referral from a health care provider or their Children's Integrated Services/Early Intervention team, at which point eligibility will be determined based on nutritional needs. Services are available in all regions of Vermont.

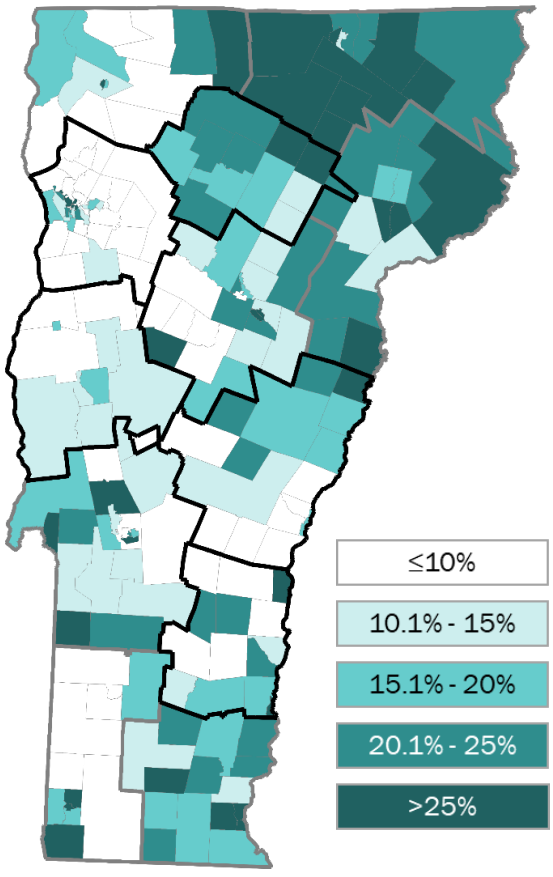
Child and Adult Care Food Program (CACFP) is funded by the USDA FNS and implemented by the Vermont AoE.[20,21] CACFP reimburses participating child care centers, day care homes, and adult day centers for providing nutritious meals and snacks to eligible children and adults. CACFP also reimburses for meals served to children and youth in afterschool care programs or residing in emergency shelters, as well as adults aged 60+ or living with a disability who are enrolled in day care facilities. The following locations are eligible to participate: licensed child care and adult day centers; Department of Disabilities, Aging, and Independent Living (DAIL) certified adult day centers; and at-risk afterschool care centers, outside of school hours care centers, and homeless/emergency shelters meeting state and local health and safety codes. The program is implemented statewide.

Nutrition services for older adults are implemented by the Five Area Agencies on Aging (Age Well serving Northwestern Vermont, Central Vermont Council on Aging, Northeast Kingdom Council on Aging, Senior Solutions serving Southeastern Vermont, and Southwestern Vermont Council on Aging) within DAIL.[22] These agencies serve the entire state, which is divided into five service regions, with funding from the Older Americans Act (OAA).[23,24] Nutrition services for seniors include home-delivered meals (also known as Meals on Wheels) and community meals (also known as congregate meals). Meals on Wheels is available to individuals aged 60+ who are unable to leave the home without considerable difficulty or assistance or are experiencing a physical or mental condition making them unable to obtain food or prepare a meal. Community meals are available free of charge to individuals aged 60+ (individuals <60 can participate for a small fee). These services are available statewide. Vermont Foodbank also implements the Commodity Supplemental Food Program (CSFP) with funding from the USDA FNS, which supplements the diets of adults over 60 living under 130% FPL with packages of nutritious USDA foods.[25,26,27] Northeast Organic Farming Association of VT implements the Seniors Farmers' Market Nutrition Program), which is also funded by the USDA FNS and aims to help older adults and local farmers by providing adults over 60 living under 185% FPL with access to locally-grown produce through farmers' markets, roadside stands, and community-supported agricultural programs.[28,29]

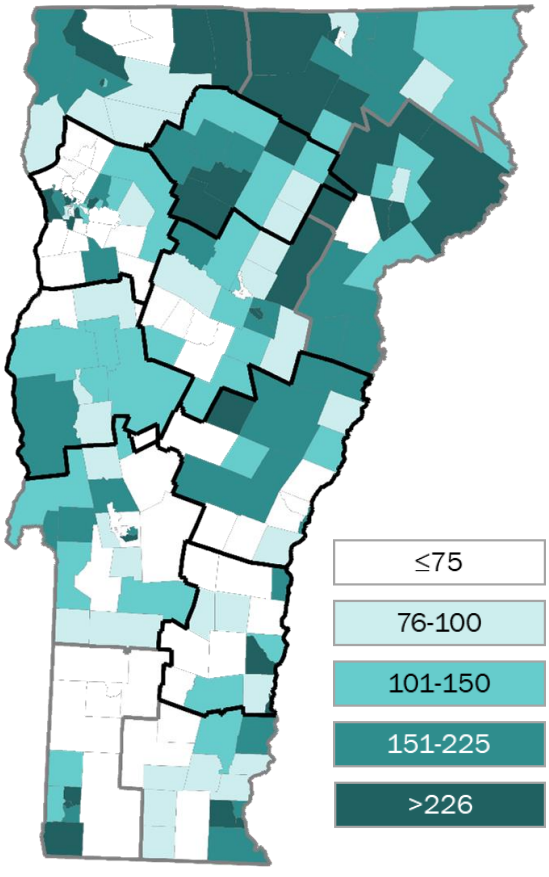
Areas of the State with Inadequate Access to SNAP-Ed and Related Programs

Vermont is divided into 12 regions based on the location of district health offices. The previous needs assessment identified seven regions as the focus for receiving SNAP-Ed services in part because they are the most rural areas of the state, with limited infrastructure, capacity, and services. The maps below show the location of households eligible for SNAP, measured by the percent of households (Map 1) and number of households (Map 2) eligible in each census tract. While some areas of the state, such as the Northeast Kingdom, have both a large percentage and a high number of SNAP-eligible households, other areas show greater eligibility on only one measure due to differences in population density across regions. Furthermore, the maps demonstrate that county-level data masks local-level differences in SNAP eligibility. For example, Chittenden County (in the Burlington region) has better average health indicators than the rest of the state; however, there are more than a few census tracts in Burlington with a high level of SNAP-eligible households, particularly when looking at the number of eligible households. These maps demonstrate that restricting access to SNAP-Ed services to certain regions of the state is neither an equitable nor effective way of reaching SNAP-eligible households.

Map 1. Percent of households eligible for SNAP, by census tract, ACS 2015-2019



Map 2. Number of households eligible for SNAP, by census tract, ACS 2015-2019



Regions currently served by SNAP-Ed (Barre, Bennington, Brattleboro, Newport, Rutland, St. Albans, St. Johnsbury)

Regions not currently served by SNAP-Ed (Burlington, Middlebury, Morrisville, Springfield, White River Junction)

Census Tract boundary

Source: ACS 2015-2019 5-year estimates of SNAP Eligibility (Table B17022)

Population-Specific Needs and Assets Related to Nutrition and Physical Activity

PDA conducted a targeted literature search and key informant interviews to understand barriers to healthy eating and PA for populations that face social and economic marginalization. Key informants included Vermont-based individuals working directly with Abenaki people, people living with a disability, refugees, and LGBTQ+ people. Unless otherwise specified, findings from the literature are not specific to Vermont.

People with lower incomes and/or people with SNAP-eligible incomes identified the following barriers to healthful eating in peer-reviewed studies: taste (including managing cravings for others foods/snacks and having to balance preferences among children and other household members); access (in terms of financial cost and time/effort required to procure and prepare healthful ingredients); lack of knowledge around how to make healthful choices or prepare healthful ingredients; and being embedded in social environments where less healthful choices are the norm.[30,31,32,33] Aspects of food systems and the built environment were also often cited as barriers, such as geographic distance from grocery stores (which is worsened by limited transportation options) and cultural barriers to feeling accepted at locations like farmers' markets.[34,35]

Indigenous/Native American populations often cite not having access to culturally appropriate traditional foods as a barrier to engaging with healthful traditional behaviors.[36,37] The same studies concluded that most traditional foods are healthful, comprise a balanced diet, and provide the added benefit of helping folks feel connected with other Indigenous peoples through traditional practices. However, research indicates that competing demands – such as limited finances, managing mental health challenges, and balancing family obligations – present barriers to engaging in healthful behaviors for many Indigenous individuals.[36,37] Some Indigenous participants also cited regulations around traditional hunting, gathering, and crop management practices as hindrances to eating traditional foods and drivers of food insecurity.[38] One key informant, a member of an Abenaki tribe, also identified intergenerational and historic trauma as contributors to high rates of diabetes, heart disease, depression, and suicide. They also shared that historic and ongoing institutional mistreatment of Abenaki communities in Vermont make many Abenaki individuals reluctant to identify as such on government forms; as a result, Abenaki communities are largely misrepresented in Vermont data sources. Additionally, the key informant noted that their tribal office has limited capacity to design and implement an intervention without additional funding to bring in more staff.

Refugees resettled in the United States identified limited time and money as barriers to healthful behaviors, as well as a lack of familiarity with food and PA structures in their new homes (for example, not knowing if parks are available to everyone or if there is a fee required for access).[39,40,41] In the same studies, some refugees perceived foods available in the United States as more processed and less healthful than the fresh, local foods they consumed in their countries of origin. One key informant interview made it clear that most refugees come to the United States accustomed to healthy diets rich in vegetables; the greatest challenge is retaining access to monetary food benefits such as SNAP. This key informant also noted that language and literacy barriers make it difficult for refugees to understand and meet each program's administrative demands, so efforts to reach this population must include video/audio communications in multiple languages. They reported that many refugees also have trouble finding or affording familiar and culturally appropriate foods in their new environments, which is often exacerbated by transportation barriers. Additionally, many refugees served by this key informant's organization were accustomed to lifestyles where PA was more integrated into activities of daily living than is standard in the United States, where days tend to be structured around work and/or child care and exercise is a deliberate activity.

LGBTQ+ people continue to experience discrimination and social stigma, which widen physical and mental health disparities.[42] A key informant who works with and identifies as a member of the LGBTQ+ community emphasized that stigma pushes LGBTQ+ Vermonters to the margins of society and makes it easier for them to fall into "sickness loops," which can lead to further stigmatization and poor health. This key informant also noted that spaces can be unwelcoming or unsafe for LGBTQ+ people in blatant or covert ways, from overt homophobic statements to unnecessarily gendered restrooms; similarly, a study of transgender and gender-nonconforming college students in the Midwest found that binary gendered locker rooms can be a barrier to PA because they create a less inclusive and potentially unsafe environment.[43] The same study noted that nutrition resources and food access spaces can be unwelcoming due to a lack of cultural competence and tailoring for the unique situation of LGBTQ+ people. The key informant noted that LGBTQ+ people are at higher risk of food insecurity than the general population because they are more likely to be isolated from their families of origin and experience economic insecurity due to hostility in the workplace. This trend was confirmed by a recent study of LGBTQ+ people in Vermont, which found that they were significantly more likely to experience food insecurity both before and during the COVID-19 pandemic.[44] The same study found that food insecurity can present barriers to healthy habits: food-insecure Vermonters were significantly less likely to consume fruits and vegetables and be physically active than their food-secure counterparts.

People living with a disability often have a unique relationship to nutrition education because society does not always treat them as autonomous adults, in the perspective of one key informant. This key informant noted that this dynamic leads many individuals with disabilities to resist health education, which can be experienced as condescending and prescriptive. According to available literature, people with disabilities also encounter several barriers to healthy habits, including limited personal capacity for food preparation and exercise, not being able to afford healthy foods, and limited opportunities for accessible PA.[45] Additionally, people with disabilities face myriad structural barriers to obtaining healthy foods, such as lower wages, restrictions within food benefit programs, transportation challenges, and physically inaccessible food access spaces.[46]

Implications and Application to the SNAP-Ed State Plan

Vermont SNAP-Ed's goal is to reduce nutrition-related health inequities in the SNAP-eligible population. Based on the findings of the needs assessment, this goal can best be pursued by allowing implementing partners to serve SNAP-eligible households in all areas of the state, provided they justify how their outreach strategies and services offered are likely to reach individuals and households who are likely to be eligible for SNAP *and* are marginalized as a result of their race, ethnicity, place of birth, sexual orientation, gender identity, disability status, or geography. It is important to note that many individuals and households hold many of these identities at the same time.

Vermont SNAP-Ed will focus on reaching SNAP-eligible individuals and households who are marginalized as a result of their race, ethnicity, place of birth, sexual orientation, gender identity, disability status, or geography.

The table below summarizes the results of a gap analysis that was used to develop this conclusion. The gap analysis revealed that previous SNAP-Ed requirements were effective in directing SNAP-Ed services to specified regions of the state and households with children. At the same time, services did not reach many Abenaki people or people of color, and no data were collected on the extent to which services reached refugees, LGBTQ+ people, and people with disabilities. This result is not surprising since the FY 2019-2021 state plan did not identify these populations as a particular focus for directing services.

Population Characteristic	Implications of Needs Assessment Findings for SNAP-Ed Plan	Current Situation Based on FY 2021 Evaluation Findings
Geographic residence	SNAP-eligible people live in all corners of the state. County- and region-level data mask disparities that exist at smaller geographic levels (e.g., census tract, SU/SD). SNAP-Ed services should be offered to people in all regions of the state, with special emphasis on localized areas with high numbers or proportions of households eligible for SNAP.	Services limited to only seven regions of the state
Household composition	Households with unmarried householders and children under 18, and particularly with children under 5, are disproportionately likely to be eligible for SNAP. Intentional outreach efforts for these groups are expected to reach households likely to be eligible for SNAP.	Only NAP SACC focuses on reaching children under 5 NAP SACC, Smarter Lunchrooms, and Passport Program all focus on reaching children under 17 VT Foodbank serves households that are food insecure, and food insecurity is higher among children than the general population (14% vs. 11%).[47] VT Foodbank's mobile food shelf visited 6 schools in FY21.

Population Characteristic	Implications of Needs Assessment Findings for SNAP-Ed Plan	Current Situation Based on FY 2021 Evaluation Findings
Native American/ Abenaki	Abenaki people have the highest rate of SNAP eligibility of all racial identity groups in Vermont, except for those who identify as two or more races. Many tribal offices lack the capacity to design and implement their own interventions.	CAO: 18 individuals (out of 4,032) UVM: 1 individual (out of 70) No data for PSE strategies
People of color	Vermonters who identify as Black, Hispanic, Asian, two or more races, or some other race are more likely to be eligible for SNAP compared to those who identify as White or Native Hawaiian/Pacific Islander. Intentional outreach efforts for these groups are expected to reach people likely to be eligible for SNAP.	CAO: 194 Black/ Asian/ Hawaiian-Pacific Islander individuals and 159 Hispanic individuals (out of 4,032) UVM: 3 Hispanic individuals and 1 Asian individual (out of 70) No data for PSE strategies
Refugees	Refugees resettled in Vermont may face language and literacy barriers to accessing food and economic benefits, and many are eligible for SNAP. Efforts to reach this population need to include video/audio communications in multiple languages.	No data collected
LGBTQ+ people	LGBTQ+ Vermonters face higher rates of food insecurity, stigma, and overt/covert hostility than gender conforming and heterosexual Vermonters. LGBTQ+ Vermonters need to be involved in the creation of welcoming SNAP-Ed initiatives.	No data collected
People living with a disability	People living with a disability are disproportionately likely to be eligible for SNAP, so intentional outreach is expected to reach people likely to be eligible for SNAP. People with disabilities need to be involved in developing inclusive SNAP-Ed strategies.	No data collected

The next SNAP-Ed state plan can increase the number of individuals and households reached from the above populations by:

- Prioritizing direct funding for organizations that work in and with focus populations
- Prioritizing formal partnerships (e.g., MOUs, letters of commitment) between implementing organizations and organizations working in and with the focus populations
- Requiring implementing partner plans to include descriptions of how intentional outreach strategies will reach the focus populations, based on data and/or organizational experience
- Widening dissemination strategies to ensure RFP reaches organizations that work in and with focus populations
- Investing in capacity building during the first year of the state plan to build partnership and inclusively design program activities
- Requiring data collection on the identities of people reached by SNAP-Ed activities for accountability and to inform program improvement.

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References

[1] *3SquaresVT*. Vermont Department for Children and Families. (2022). Retrieved February 23, 2022, from https://dcf.vermont.gov/benefits/3SquaresVT

[2] *FY 2022 Supplemental Nutrition Assistance Program Education Plan Guidance.* USDA Food and Nutrition Service. (2021). Retrieved February 28, 2022, from https://snaped.fns.usda.gov/sites/default/files/documents/FY%202022%20SNAP-Ed%20Plan%20Guidance_0.pdf

[3] *Vermont State Health Assessment.* Vermont Department of Health. (2018, June). Retrieved February 24, 2022, from https://www.healthvermont.gov/sites/default/files/documents/pdf/VT%20State%20Health%20Assessment%202018%20Full%20Report.pdf

[4] *Vermont State Health Improvement Plan.* Vermont Department of Health. (2018, December). Retrieved February 24, 2022, from https://www.healthvermont.gov/sites/default/files/documents/pdf/ADM_State_Health_Improvement_Plan_2019-2023.pdf

[5] *3-4-50: Prevent Chronic Disease*. Vermont Department of Health. (n.d.). Retrieved February 24, 2022, from https://www.healthvermont.gov/3-4-50

[6] *U.S. Census Bureau QuickFacts: Vermont*. United States Census Bureau. (n.d.). Retrieved January 28, 2022, from https://www.census.gov/quickfacts/VT

[7] *State Data: Vermont*. USDA Economic Research Service. (n.d.). Retrieved January 28, 2022, from https://data.ers.usda.gov/reports.aspx?StateFIPS=50&StateName=Vermont&ID=17854

[8] *USCRI Vermont.* U.S. Committee for Refugees and Immigrants. (n.d.). Retrieved March 14, 2022, from https://refugees.org/uscri-vermont/

[9] *Behavioral Risk Factor Surveillance System 2018 Report.* Vermont Department of Health. (n.d.). Retrieved March 1, 2022, from https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_2018_BRFSSReport.pdf

[10] *Demographics: Vermont Adults with a Disability 2019 Behavioral Risk Factor Surveillance System.* Vermont Department of Health. (2021, June). Retrieved March 1, 2022, from https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR-BRFSS-2019-DisabilityDemographics-DataBrief.pdf

[11] *Special Supplemental Nutrition Program for Women, infants, and children (WIC)*. USDA Food and Nutrition Service. (n.d.). Retrieved January 11, 2022, from https://www.fns.usda.gov/wic

[12] *WIC*. Vermont Department of Health. (2021). Retrieved January 11, 2022, from https://www.healthvermont.gov/family/wic

[13] *About EFNEP*. USDA National Institute of Food and Agriculture. (n.d.). Retrieved January 11, 2022, from https://nifa.usda.gov/program/about-efnep

[14] *Expanded Food & Nutrition Education Program (EFNEP)*. UVM Extension. (n.d.). Retrieved January 11, 2022, from https://www.uvm.edu/extension/efnep

[15] *National School Lunch Program*. USDA Food and Nutrition Service. (n.d.). Retrieved January 11, 2022, from https://www.fns.usda.gov/nslp

[16] *School Lunch and Breakfast*. State of Vermont Agency of Education. (n.d.). Retrieved January 11, 2022, from https://education.vermont.gov/student-support/nutrition/school-meals/school-lunch-and-breakfast

[17] *National School Lunch Program*. USDA Economic Research Service. (n.d.). Retrieved January 11, 2022, from https://www.ers.usda.gov/topics/food-nutrition-assistance/child-nutrition-programs/national-school-lunch-program/

[18] *Nutrition Services for Children with Special Health Needs*. Vermont Department of Health. (2020, June 18). Retrieved January 11, 2022, from https://www.healthvermont.gov/children-youth-families/children-special-health-needs/nutrition-services

[19] *Children with Special Health Needs*. Vermont Department of Health. (n.d.). Retrieved January 11, 2022, from https://www.healthvermont.gov/family/special-health-needs

[20] *Child and Adult Care Food Program*. USDA Food and Nutrition Service. (n.d.). Retrieved January 11, 2022, from https://www.fns.usda.gov/cacfp
[21] *Child and Adult Care Food*. State of Vermont Agency of Education. (n.d.). Retrieved January 11, 2022, from https://education.vermont.gov/student-support/nutrition/child-and-adult-care-food
[22] *Programs and Services*. Department of Disabilities, Aging and Independent Living. (n.d.). Retrieved January 19, 2022, from https://dail.vermont.gov/services/programs
[23] *Area Agency on Aging (AAA) Older American's Act (OAA) Services*. State of Vermont Adult Services Division. (n.d.). Retrieved January 11, 2022, from https://asd.vermont.gov/services/aaa-oaa-services
[24] *Older Americans Act*. US Department of Health and Human Services Administration for Community Living. (n.d.). Retrieved January 11, 2022, from https://acl.gov/about-acl/authorizing-statutes/older-americans-act
[25] *Food for Older Adults: The Commodity Supplemental Food Program*. Vermont Foodbank. (2021, October 5). Retrieved January 19, 2022, from https://www.vtfoodbank.org/share-food/csfp
[26] *Commodity Supplemental Food Program*. USDA Food and Nutrition Service. (n.d.). Retrieved January 19, 2022, from https://www.fns.usda.gov/csfp/commodity-supplemental-food-program
[27] *Commodity Supplemental Food Program: Income Guidelines for 2021*. USDA Food and Nutrition Service. (n.d.). Retrieved January 19, 2022, from https://www.fns.usda.gov/csfp/income-guidelines-2021
[28] *Seniors Farmers' Market Nutrition Program*. USDA Food and Nutrition Service. (n.d.). Retrieved January 19, 2022, from https://www.fns.usda.gov/sfmnp/senior-farmers-market-nutrition-program
[29] *Senior Farm Share Program*. NOFA Vermont. (n.d.). Retrieved January 19, 2022, from https://nofavt.org/seniorfarmshare
[30] Birkett, D., Johnson, D., Thompson, J. R., & Oberg, D. (2004). Reaching low-income families: Focus Group results provide direction for a behavioral approach to WIC services. *Journal of the American Dietetic Association*, *104*(8), 1277–1280. https://doi.org/10.1016/j.jada.2004.05.211
[31] Eikenberry, N., & Smith, C. (2004). Healthful eating: Perceptions, motivations, barriers, and promoters in low-income Minnesota communities. *Journal of the American Dietetic Association*, *104*(7), 1158–1161. https://doi.org/10.1016/j.jada.2004.04.023
[32] Krall, J.S., Wamboldt, P. & Lohse, B. (2015). Telephone and Face-to-Face Interviews with Low-Income Males with Child Care Responsibilities Support Inclusion as a Target Audience in SNAP-Ed. *J Community Health 40*, 448–456 . https://doi.org/10.1007/s10900-014-9955-2
[33] Lucan, S. C., Barg, F. K., & Long, J. A. (2010). Promoters and barriers to fruit, vegetable, and fast-food consumption among urban, low-income African Americans—a qualitative approach. *American Journal of Public Health*, *100*(4), 631–635. https://doi.org/10.2105/ajph.2009.172692
[34] Wetherill MS, Williams MB, & Gray KA. (2017). SNAP-Based Incentive Programs at Farmers' Markets: Adaptation Considerations for Temporary Assistance for Needy Families (TANF) Recipients. *J Nutr Educ Behav*. *49(9)*, 743-751.e1. doi: 10.1016/j.jneb.2017.06.002..
[35] Wetherill MS, Gray KA. (2015). Farmers' markets and the local food environment: identifying perceived accessibility barriers for SNAP consumers receiving temporary assistance for needy families (TANF) in an urban Oklahoma community. *J Nutr Educ Behav*. *47(2),*127-33.e1. doi: 10.1016/j.jneb.2014.12.008.
[36] Keith, J. F., Stastny, S., Brunt, A., & Agnew, W. (2018). Barriers and strategies for healthy food choices among American Indian Tribal College Students: A qualitative analysis. *Journal of the Academy of Nutrition and Dietetics*, *118*(6), 1017–1026. https://doi.org/10.1016/j.jand.2017.08.003
[37] Stotz, S. A., Brega, A. G., Gonzales, K., Hebert, L. E., Moore, K. R., Austin, G., Bellinger, D., Conti, K., Couture, N., Garrow, H., Hinchcliff, C., Juarez-Colunga, E., McNulty, M., O'Banion, N., & Pontius, H. (2021). Facilitators and barriers to healthy eating among American Indian and Alaska native adults with type 2 diabetes: Stakeholder perspectives. *Current Developments in Nutrition*, *5*(Supplement_4), 22–31. https://doi.org/10.1093/cdn/nzaa114
[38] Sowerwine, J., Mucioki M., Sarna, D., and Hillman, L. (2019). Reframing food security by and for Native American communities: A case study among Tribes in the Klamath River Basin of Oregon and California*, Food Security, 11*(3), 579-607. https://doi.org/10.1007/s12571-019-00925-y
[39] Wang, Y., Min, J., Harris, K., Khuri, J., & Anderson, L. M. (2016). A systematic examination of food intake and adaptation to the food environment by refugees settled in the United States. *Advances in Nutrition: An International Review Journal*, *7*(6), 1066–1079. https://doi.org/10.3945/an.115.011452
[40] Wen Meng, H., Sin, K., Pye, M., Chernenko, A., Hagerty, D., Sarray, A. A., & Kamimura, A. (2018). Barriers and facilitators to healthy lifestyle among refugees resettled in the United States. *Diversity & Equality in Health and Care*, *15*(1). https://doi.org/10.21767/2049-5471.1000149

[41] Wieland, M. L., Tiedje, K., Meiers, S. J., Mohamed, A. A., Formea, C. M., Ridgeway, J. L., Asiedu, G. B., Boyum, G., Weis, J. A., Nigon, J. A., Patten, C. A., & Sia, I. G. (2013). Perspectives on physical activity among immigrants and refugees to a small urban community in Minnesota. *Journal of Immigrant and Minority Health*, *17*(1), 263–275. https://doi.org/10.1007/s10903-013-9917-2

[42] Hafeez H, Zeshan M, Tahir M A, et al. (2017, April 20) Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature *Review. Cureus 9(4): e1184. doi:10.7759/cureus.1184*

[43] Kirby, S. R., & Linde, J. A. (2020). Understanding the nutritional needs of transgender and gender-nonconforming students at a large public Midwestern University. *Transgender Health*, *5*(1), 33–41. https://doi.org/10.1089/trgh.2019.0071

[44] Laurent, J., Bertmann, F., Alpaugh, M., Belarmino, E., Bliss, S., Malacarne, J., McCarthy, A.C., Merrill, S., Schattman, R.E., Yerxa, K., Niles, M.T. (2022). Change in Food Security and Health Outcomes Since the COVID-19 Pandemic in Northern New England. https://scholarworks.uvm.edu/cnhsfac/4/

[45] Wetherill, M. S., Duncan, A. R., Bowman, H., Collins, R., Santa-Pinter, N., Jackson, M., Lynn, C. M., Prentice, K., & Isaacson, M. (2021). Promoting nutrition equity for individuals with physical challenges: A systematic review of barriers and facilitators to healthy eating. *Preventive Medicine*, *153*, 106723. https://doi.org/10.1016/j.ypmed.2021.106723

[46] Coleman-Jensen, A., & Nord, M. (2013, May 6). *Disability is an important risk factor for food insecurity*. USDA Economic Research Service. Retrieved February 17, 2022, from https://www.ers.usda.gov/amber-waves/2013/may/disability-is-an-important-risk-factor-for-food-insecurity

[47] Feeding America. Mind the Meal Gap. "Food Insecurity in Vermont, 2019." Retrieved January 31, 2022, from https://map.feedingamerica.org/county/2019/overall/vermont