VERMONT MATERNAL, INFANT, EARLY CHILDHOOD HOME VISITING PROGRAM

STATEWIDE NEEDS ASSESSMENT UPDATE NARRATIVE

SEPTEMBER 2020

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1) INTRODUCTION

The Vermont Department of Health (VDH) Division of Maternal and Child Health (MCH) receives Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) funding for services to support pregnant Vermonters, and parents and caregivers of children under age 5. MIECHV provides resources and skills to help at-risk parents and caregivers raise children who are physically, socially, and emotionally healthy and ready to learn. MIECHV is administered by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau, provided in partnership with the Administration for Children and Families (ACF). Goals for programs in every state and territory are to:

- Improve maternal and child health
- Prevent child abuse and neglect
- Encourage positive parenting
- Promote child development and school readiness

In 2019, 154,000 parents and children benefited from MIECHV services across the United States, including 795 in Vermont. Of Vermont program beneficiaries, 57.5% had a household income at or below the federal poverty level ($25,750 for a family of four). MIECHV is designed to strengthen and improve the programs and activities carried out under Title V of the Social Security Act; to improve coordination of services for at-risk communities; and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

Purpose of the MIECHV Statewide Needs Assessment: MIECHV-funded states are required to conduct a periodic statewide needs assessment to identify and understand the diverse needs of at-risk families. This needs assessment was conducted by MCH from July 2019 through February 2020 with a broad goal of ensuring that Vermont's parents, families, and young children have what they need to be healthy and well, in accordance with Vermont's State Health Improvement Plan[1], which envisions that "*All people in Vermont have a fair and just opportunity to be healthy and to live in healthy communities.*" Assessment activities were conducted in accordance with the guidance from HRSA.

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

- We believe in a strength-based approach that promotes protective factors and recognizes that families have many strengths and the capacity to learn, grow and change.
- We believe in a two-generation framework that creates opportunities for, and addresses the needs of, both children and the adults in their lives.
- We believe there is a fundamental need to partner with state agencies, health care providers, human service organizations, and families to succeed at our vision.

[1] Vermont Department of Health. State Health Improvement Plan. 2019. Vermont Department of Health. www.healthvermont.gov/SHIP

MCH provides direct services, linkages and referrals, population-based supports, education and monitoring, quality oversight, and policy and systems development. MCH supports professionals who work with children and families in health care, early care and education settings, and with human service agencies, and collaborates with partners across Vermont and nationally to achieve high quality health and health care for children and families. These efforts are family-centered, evidence-based and data-driven, and include MIECHV home visiting services.

2) IDENTIFYING AT-RISK COUNTIES WITH CONCENTRATIONS OF RISK

An estimated 3,545 Vermont households are believed to be eligible to receive home visiting services based on the estimated number of children up to age five living in households that meet MIECHV eligibility criteria (parents' income, education, and risk factors) (Table 1).

Table 1. Estimated MIECHV eligible families

County	Number of families in need of home visiting services
Addison	191
Bennington	187
Caledonia	96
Chittenden	671
Essex	20
Franklin	203
Grand Isle	29
Lamoille	80
Orange	338
Orleans	85
Rutland	307
Washington	185
Windham	504
Windsor	649
Total	3,545

Populations and communities at the county-level where there are concentrations of risk were identified using the HRSA-defined simplified method, with added indicators to uncover areas of risk within the five risk domains: (1) low socioeconomic status, (2) adverse perinatal outcomes, (3) child maltreatment, (4) crime, and (5) substance use disorder (SUD), based on nationally available county-level data. The simplified method identifies a county as at-risk if at least half of the indicators within at least two domains had Z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state. Some counties were identified using additional measures within each domain, added in "Phase 2." After phase one, the team reviewed additional Phase 2 data to identify communities with high or emerging needs that algin with the statutory definition of risk.[2]

RISK CONCENTRATIONS IN VERMONT'S 14 COUNTIES

Six counties were identified as having concentrated risk as <u>using the simplified method</u> with additional indicators

Bennington County: Bennington County is identified as being at-risk based on high rates of adverse perinatal outcomes (pre-term births, low birth weight babies, a high rate of infants born to mothers receiving MAT, a high rate of women who smoked during pregnancy) and crime (juvenile arrests, domestic violence). Bennington County was also identified as having a low rate of SUD treatment initiation and engagement. Bennington County includes the Arlington HRSA-designated rural Primary Care Health Professional Shortage Area (HPSA).

[2] Statutory definition of risk: https://www.ssa.gov/OP_Home/ssact/title05/0511.htm

Chittenden County: Chittenden County is identified as being at-risk based on high rates of substance use disorders (rates of use of alcohol, marijuana, illicit drugs, and pain relievers), and crime (crime reports and juvenile arrests).

Franklin County: Franklin County is identified as being at-risk based on high rates of substance use disorders (rates of use of alcohol, marijuana, illicit drugs, and pain relievers) and child maltreatment (rate of child maltreatment). Franklin County was further identified as having high rates of domestic violence, and high rates of births to mothers ages 15 to 19.

Grand Isle County: Grand Isle County is identified as being at-risk based on high rates of substance use disorders (rates of use of alcohol, marijuana, illicit drugs, and pain relievers, , and low rates of SUD treatment initiation and engagement) and child maltreatment. Grand Isle County has a high rate of infants born to mothers receiving MAT (Table 12). Notably, Grand Isle County was found to have the lowest rate of breastfeeding initiation in the state.

Table 2. Counties with concentrated risk in two domains (simplified method)

County	2017 Population	SES	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	Number of At Risk Domains
Bennington County	37,082	0.25	0.8	0.14	0.75	0	2
Chittenden County	156,752	0.125	0	0.57	0.5	0	2
Franklin County	47,814	0.125	0.2	0.57	0.25	1	2
Grand Isle County	6,948	0.125	0.2	0.86	0	0.5	2
Orleans County	27,245	0.5	0.4	0	0.5	0	2
Windham County	44,500	0.25	0	0.14	0.5	0.5	2
Addison County	36,825	0	0	0.86	0	0	1
Caledonia County	31,163	0.25	0	0.14	0	0.5	1
Lamoille County	24,517	0.5	0	0	0	0	1
Windsor County	56,598	0.125	0	0.14	0	0.5	1
Essex County	6,312	0.375	0.2	0	0	0	0
Orange County	28,943	0	0	0	0	0	0
Rutland County	61,573	0.125	0.2	0	0	0	0
Washington County	59,570	0.125	0	0	0	0	0

Orleans County: Orleans County is identified as being at-risk based on residents' socioeconomic status (unemployment rate, poverty, severe housing costs, and overall VT Vulnerability Index) and crime (misdemeanor and felony domestic assault). Orleans County was identified as having a high rate of infants born to mothers receiving MAT (Table 12), as well as having Vermont's highest rates of domestic violence. The county has the highest rate of teen births in the state, with a teen birth

rate of 27 per 1,000 females, compared to only 16 statewide. Orleans County includes the Newport HRSA-designated rural Dental Health Professional Shortage Area (HPSA).

Table 3. Misdemeanor and felony domestic assault, 2017

Misdemeanor domestic assault charge dispositions by county, 2017

	Total Cases			Cases Disposed by Plea or Trial		
County	**Number**	**Rate per 1,000**	**Z-Score**	**Number**	**Rate per 1,000**	**Z-score**
Bennington	68	1.91	1.21	39	1.10	1.22
Franklin	96	1.96	1.30	53	1.08	1.17
Orleans	58	2.16	1.68	40	1.49	2.45
Windham	85	1.98	1.34	36	0.84	0.42
Vermont	***797***	1.28		**393**	0.63	

Felony domestic assault charge dispositions by county, 2017

	Total Cases			Cases Disposed by Plea or Trial		
County	**Number**	**Rate per 1,000**	**Z-Score**	**Number**	**Rate per 1,000**	**Z-score**
Bennington	47	1.32	1.73	15	0.42	1.14
Orleans	40	1.49	2.19	17	0.63	2.47
Vermont	**409**	0.66		**132**	0.21	

Total domestic assault charge dispositions by county, 2017

	Total Cases			Cases Disposed by Plea or Trial		
County	**Number**	**Rate per 1,000**	**Z-Score**	**Number**	**Rate per 1,000**	**Z-score**
Bennington	115	3.23	1.56	54	1.52	1.24
Franklin	137	2.79	1.02	69	1.41	1.00
Orleans	98	3.65	2.07	57	2.12	2.55
Vermont	1206	1.93		**525**	0.84	

Windham County: Windham County is identified as being at-risk based on its crime (crime reports and misdemeanor domestic violence) and child maltreatment rates. According to County Health Ranking data, Windham County has the highest rate of violent crime in the state. According to DCF data, Windham County has a high number of child victims under the age of 18 (12.9 per 1,000 children), as well as a high rate of children under the age of 18 in DCF Custody (19.2 per 1,000 children). Additionally, in 2019, Springfield Hospital closed its childbirth center, leaving the county with no hospital maternity service. A New Hampshire hospital located in an adjacent county closed its maternity facility in 2018, further reducing access to obstetric services for women in southeastern Vermont. These hospital closures not only limit access to labor and delivery services but mean that some women must travel an hour or longer for prenatal and perinatal care.

Counties with concentrated risk as identified in Phase 2

Addison County: Addison County is identified as being at-risk based on high rates of substance use disorders (rates of use of alcohol, marijuana, illicit drugs, and pain relievers). Addison County was identified as having the state's lowest rate of SUD treatment initiation (29% compared to a

state average of 41%) and engagement among adults with a diagnosed SUD.[3] Children in the Middlebury Hospital Service Area had the highest rate of potentially avoidable emergency department visits in the state, at a rate of 120.6 per 1,000 children up to age 18, compared to a state rate of 73.2.[4]

Table 4. Counties with lowest SUD treatment initiation and engagement rates

	Any substance						Alcohol						Opioids					
County	Initiation	STD	Z-score < 1	Engagement	STD	Z-score < 1	Initiation	STD	Z-score < 1	Engagement	STD	Z-score < 1	Initiation	STD	Z-score < 1	Engagement	STD	Z-score < 1
Addison	8.9	-1.2	1	15.6	-1.9	1	29.0	-1.2	1	9.7	-1.9	1	59.5	-0.6	0	33.3	-1.3	1
Bennington	11.4	0.2	0	17.6	-1.5	1	45.4	1.3	0	11.0	-1.3	1	55.2	-1.1	1	28.5	-1.7	1
Caledonia	12.5	0.9	0	19.7	-1.0	1	34.1	-0.4	0	13.7	-0.2	0	61.5	-0.4	0	45.1	-0.3	0
Essex	15.5	2.6	0	26.3	0.4	0	32.1	-0.7	0	10.7	-1.4	1	81.3	1.6	0	68.8	1.6	0
Grand Isle	8.2	-1.7	1	18.8	-1.2	1	20.6	-2.4	1	14.7	0.3	0	47.4	-1.9	1	31.6	-1.4	1
Vermont	11.0			**25.0**			39.0			14.6			65.4			48.5		

Northeast Kingdom

Caledonia, Essex, Orleans and Lamoille counties comprise Vermont's Northeast Kingdom, the most geographically remote and sparsely populated region of Vermont. Recent studies have shown that in this region, 80% of the land is covered by forest,[5] 74% of roads are rated as being in poor or very poor condition; and up to one-third of addresses in the region do not have broadband access.[6] These conditions contribute to the isolation, distance from services, geographic and transportation barriers, and socio-economic climate of the region. By most measures, all residents of Northeast Kingdom counties, and especially those in low-income households, are substantially underserved. Given these conditions, it was surprising to Vermont's MIECHV needs assessment team that counties in this region were not identified as having concentrated risk based purely on the simplified method, particularly as all four counties have extraordinary socio-economic disadvantages at the population level.

Caledonia County: Caledonia County is found to have a high rate of child maltreatment victims, substance use risks, including a high rate of infants born to mothers receiving MAT (Table 12), and low rates of SUD treatment initiation and engagement (Table 4). Northern Counties Health Care Inc, a federally qualified health center (FQHC) located in Hardwick Vermont, is a designated mental

[3] Vermont Blueprint for Health. 2018. Adult Community Health Profile: Middlebury. https://blueprintforhealth.vermont.gov/sites/bfh/files/BlueprintCommunityProfilesCY2018_Middlebury.pdf

[4] Vermont Blueprint for Health. 2018. Pediatric Community Health Profile: Middlebury. https://blueprintforhealth.vermont.gov/sites/bfh/files/Blueprint-Community-Profiles-PediatricCY2018-Middlebury.pdf

[5]

[6] Vermont Department of Public Service. Broadband High-speed internet availability in Vermont by County. 2019.

health HPSA, with a HPSA score of 21 (on a 26-point scale), making it one of the state's highest priority shortage areas.

Table 5. Births to women ages 15 to 19 by county, 2018

	Ages 15-17			Ages 18-19			Ages 15-19		
County	Rate per 1,000	STD	Z-score > 1	Rate per 1,000	STD	Z-score > 1	Rate per 1,000	STD	Z-score > 1
Essex	12.8	1.4	1	54.1	1.2	1	26.1	1.3	1
Franklin	7.7	0.1	0	53.2	1.1	1	23.2	0.8	0
Lamoille	15.6	2.2	1	27.1	-0.5	0	21.0	0.5	0
Orleans	9.9	0.6	0	67.0	2.0	1	30.1	1.9	1
Vermont	6.9			22.6			14.6		

Essex County: Essex County is identified as being at-risk based on residents' socioeconomic status (poverty and unemployment rates), a high rate of infants born to mothers receiving MAT; high rates of births to mothers ages 15 to 19; low rates of SUD treatment initiation and engagement; as well as a high rate of women who smoked during pregnancy (Table 6). According to Vermont Blueprint for Health 2018 data, only 34% of children in the Newport Hospital Service Area received developmental screening within their first three years of life, compared to a state rate of 63%.[7] As described below, Essex County has the third highest social vulnerability score in the state.

Table 6. Rate of smoking during pregnancy by County, 2018

County	Smoking Rate	STD
Bennington	27.1	1.7
Essex	26.3	1.6
Vermont	16.7	

Lamoille County: Lamoille County was identified as having risks in several domains, including a high rate of births to mothers ages 15 to 19 (Table 5). 2019 County Health Ranking data reveal that Lamoille County has several socioeconomic risks, including having the greatest income inequality ratio in the state, severe housing problems including a severe housing cost burden (Table 7), and Vermont's highest rate of uninsured children. In addition, Lamoille County has the highest rates of alcohol use disorder treatment in the state, at a rate of 7.5 individuals per 1,000 residents, compared to a state average of 5.2. No other county has a rate higher than 6.3 individuals per 1,000 residents.

Orange County: Orange County was identified as having risks in several domains. Orange County includes the Chelsea/Corinth HRSA-designated rural Primary Care Health Professional Shortage Area (HPSA). This designation is based on the shortage of providers for the entire population in the designated area; having a high percentage of the population living at less than 100% of the Federal Poverty Level; the infant health index (including infant mortality and low birth weight rates); and travel time to the nearest source of care. Vermont's MIECHV home visiting services are a direct response to these barriers. According to U.S. Census data, 41.8% of Orange County children age 6 or younger live below 200% of the federal poverty level, compared to only 38% statewide.[8] Orange County's teen birth rate is 19.2 per 1,000 females compared to 15.9 statewide.

[7] Vermont Blueprint for Health. Pediatric Community Profile: Newport. https://blueprintforhealth.vermont.gov/sites/bfh/files/Blueprint-Community-Profiles-PediatricCY2018-Newport.pdf

[8] American Community Survey (ACS), 5-year estimates. United States Census Bureau, Table B17024

Table 7. Severe housing problems by Vermont County[9]			
County	*% Severe Housing Problems*	*% Severe Housing Cost Burden*	*Z-Score*
Grand Isle	19	17	1.04
Lamoille	20	19	1.65
Orleans	19	17	1.02
Rutland	19	17	1.09
Windham	19	18	1.45
Vermont	17	15	

Rutland County: Rutland County was identified as having risks in several domains, including a high rate of infants born to mothers receiving MAT with a rate of 82.0 per 1,000 compared to 55.4 per 1,000 births statewide. As described below, Vermont's Social Vulnerability Index ranks Rutland County as the most socially vulnerable county, primarily based on the high rates of substance use, residents' low socioeconomic status (including a high percentage of households with a severe housing cost burden), and the most households without access to a vehicle in the state.

Table 8. Children in single-parent households[10]		
	% Single-Parent Households	**Z-Score**
Bennington	41	1.94
Washington	38	1.17
Vermont	32	

Washington County: Washington County was identified as having risks in several domains. Of the fifty Washington County individuals who responded to the Access to Health and Wellness Survey conducted for this assessment, food (78%), accessible/affordable health care (69%), housing (64%), and childcare (51%) were identified as significant needs. Survey respondents identified "not knowing what services and resources are available" (42%), and "out of pocket costs" (44%) as the most significant barriers to accessing maternal and child healthcare. Washington County includes the Waitsfield HRSA-designated rural Dental Health Professional Shortage Area (HPSA).

Because Washington County has the second highest percentage of single-parent households in Vermont (38%), the need for affordable, accessible childcare is especially critical (Table 8). In Washington County, only 41% of children who are eligible to receive childcare subsidy are enrolled in a high-quality early childhood education program, compared to 63% statewide.[11]

Table 9. Drug overdose deaths per 100,000 residents[12]		
County	*Drug Overdose Mortality Rate*	*Z-Score*
Windham	24.0	1.06
Windsor	25.9	1.49
Vermont	19.3	

In addition, mental health risks, including high rates of mental health disorders and low access to mental health treatment are a high priority concern statewide. In Washington County, 26% of adults have a depression diagnosis compared to 22% statewide and 17% in the US. Among high school-aged youth, 15% of Washington County teens report that they have a suicide plan compared to 12% statewide. Northeast Washington County Community Health Inc, a federally qualified health center (FQHC) is a designated mental health HPSA, with a HPSA score of 21 (on a 26-point scale), making it one of the state's highest priority shortage areas.

[9] University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps State Report, Vermont 2020.
[10] University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps State Report, Vermont 2020.
[11] Horwitz, J. (2020). *Stalled at the Start* Report. Let's Grow Kids. https://www.letsgrowkids.org/client_media/files/pdf/StalledatStart2020.pdf
[12] University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps State Report, Vermont 2020.

Windsor County: Windsor County is identified as having concentrated risks based on a high rate of child maltreatment victims and income inequality that exceeds the state average. Windsor County has the state's highest rate of drug overdose deaths (Table 9).

A. IF ADDING DATA TO THE SIMPLIFIED METHOD OR USING AN INDEPENDENT METHOD

I. Description of Added Data—

A variety of data within the five MIECHV risk domains were examined to understand concentrations of risk in Vermont counties. Some added indicators respond to risks and outcomes in more than one domain, such as a high birth rate among women receiving medically assisted treatment (MAT), which addresses SUDs and adverse perinatal outcomes. Additional data indicators are listed in Table 10.

Table 10. Added indicators by MIECHV domain

Domain	*Added Indicator/s*
Low socioeconomic status	Income inequality Severe housing cost burden Vermont social vulnerability index indicators Children in single parent homes
Adverse perinatal outcomes	Births to young women ages 15 to 19 Births to women receiving MAT Rates of smoking during pregnancy
Child maltreatment	Rate of children in Vermont DCF custody
Crime	Misdemeanor and felony domestic assault rates
Substance use disorder	SUD treatment initiation and/or engagement rates Drug overdose mortality rates

All risk domains are best understood in the context of Vermont's predominantly rural context. According to the U.S. Census Bureau, Vermont is the second least populated state and has the highest percentage of rural residents, with 75.4% of the population residing in rural areas (Table 11) compared to only 14% nationwide. Among Vermont's 255 municipalities, only eight have a population greater than 10,000 residents, with an average of fewer than 2,500 residents per incorporated town or city (Figure A1). Vermont's rural geography and context give the state a distinct social and political character.

Low-income residents of rural counties encounter poorer health outcomes for all ages and sub-populations. In rural Vermont, conditions for low-income women and families can be obscured by state and county-level data because of their small proportion of the population. Vermont's mountainous geography, the limited availability of many kinds of services in small, geographically remote communities, lack of access to public transportation, and difficult winter driving conditions exacerbate the barriers vulnerable populations encounter in accessing services and support. These conditions compound and contextualize many risk factors. For example, in Rutland County 3.6% of households do not have access to a vehicle, worsening risks for the most vulnerable households. Geographic and transportation barriers especially burden households that have an identified risk factor even in only one domain, because they compound families' ability to get needed help. Vermont's MIECHV services provide a direct response to the obstacles by facilitating access to care through home visits.

Within the MIECHV domains, most added data that were identified address risks that are evident in multiple counties. Key additional data indicators are detailed as follows.

1) Vermont Social Vulnerability Index: The Vermont Social Vulnerability Index[13] is a planning tool to evaluate the relative social vulnerability across the state by drawing together 16 different measures of vulnerability in three different themes: socioeconomic, demographic, and

[13] Vermont Vulnerability Assessment (2019). Vermont Department of Health.

housing/transportation. These indicators primarily correspond to the MIECHV low socioeconomic domain.

- Rutland County was ranked as the most socially vulnerable county, primarily based on the high rates of substance use, opioid use, and MAT, as well as high rates of Hepatitis C virus (HCV).
- Windham County was ranked as the second most socially vulnerable county, based on these same factors. Windham County had Vermont's second highest rate of mortality from overdose, at a rate of 2.38 per 10,000, and highest rate of SUD-related emergency room visits at a rate of 318 per 10,000, more than double the rate of the second highest county (Rutland, with a rate of 158 per 10,000).
- Essex County was ranked as the third most socially vulnerable county, based on having the highest overall social vulnerability index score, attributed to a lack of mental health providers, new HIV infections and persons living with HIV, and rates of HCV.

Table 11. Rural residents by county

	# Rural	*% Rural*
Addison	28,879	78.4
Bennington	23,950	64.5
Caledonia	23,230	74.4
Chittenden	40,680	26.0
Essex	6,306	100.0
Franklin	34,241	71.7
Grand Isle	6,970	100.0
Lamoille	24,475	100.0
Orange	28,137	97.2
Orleans	23,227	85.3
Rutland	37,610	61.0
Washington	31,437	52.8
Windham	30,378	68.2
Windsor	42,836	75.6

2) Births to women on Medically Assisted Treatment (MAT): This indicator responds to both the SUD and adverse perinatal outcomes domains. Vermont has had high rates of births to women with SUDs, which are partially attributed to high rates of screening and an integrated, system-wide response to the state's opioid epidemic. In Rutland County, the rate of births to women on MAT was 82.0 per 1,000 compared to 55.4 per 1,000 births statewide (Table 12). According to the 2018 PRAMS survey, 4% of women used methadone, Suboxone®, or another maintenance treatment drug during the 12 months before pregnancy; 4% received MAT during pregnancy; and 4% used MAT after their baby was born[14].

Improving Care for Opioid-exposed Newborns (ICON), a partnership of VDH and Vermont Child Health Improvement Program (VCHIP) to respond to the rising number of infants born to mothers receiving MAT began in 2017, connecting data across 10 hospitals and Department for Children and Families (DCF). In the first six-months of Vermont's the use of Plans of Safe Care (POSC), DCF Family Services received over 100 de-identified notifications for the following criteria:

- 46% were mothers receiving Medication Assisted Treatment (MAT)
- 42% were mothers who used marijuana during their pregnancy
- 13% were mothers who were receiving MAT and used marijuana during their pregnancy

Of this high-risk group of mothers:

- 86% agreed to create a Plan of Safe Care which was provided to the infant's primary care provider.
- 58% were receiving services prior to delivery.
- 25% received additional referrals before hospital discharge.

[14] Vermont Department of Health. 2018 PRAMS Highlights. https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-Stats-PRAMS-Overview-2018.pdf

Table 12. Rate of births among women receiving Medically Assisted Treatment, 2016-2018[15]									
	Women with live births in MAT through Hub			Women with live births in MAT through Spoke			Women with live births in MAT Overall		
County	Rate per 1,000	Z-Score	Z-score > 1	Rate per 1,000	Z-score	Z-score > 1	Rate per 1,000	Z-score	Z-score > 1
Rutland	34.6	0.80	0	47.4	0.91	0	82.0	1.67	1
Grand Isle	11.2	-0.89	0	67.4	2.07	1	78.7	1.46	1
Bennington	13.6	-0.72	0	61.7	1.74	1	75.2	1.24	1
Essex	46.1	1.63	1	19.7	-0.70	0	65.8	0.65	0
Orleans	49.7	1.89	1	13.4	-1.07	0	63.1	0.48	0
Caledonia	41.2	1.28	1	13.3	-1.08	0	54.5	-0.05	0
Vermont	23.5			31.8			55.4		

3) High rates of poor maternal mental health and/or limited access to mental health care: Poor maternal mental health, including postpartum depression, addresses the MIECHV adverse perinatal outcomes domain. Vermont BRFSS data show that 26% of female adults have depression, and that this number has steadily risen over the last six years.[16] The rate of depressive disorders in the general population (21%) exceeds the U.S. rate (18%); 28% of Windham county adults reported depression.

Vermont's primary data source for information about maternal mental health conditions is the PRAMS, which cannot be disaggregated for populations of fewer than 500,000 people. Vermont's small population therefore makes it impossible to use these data to support concentrated risks at the county or regional level. Despite this critical data gap, Vermont's MIECHV program recognizes that poor maternal mental health is a significant contributor to poor wellbeing for mothers and young children.

Eleven of Vermont's fourteen counties have a HRSA-designated mental health HPSA, each associated with a federally qualified health center (FQHC). HPSA scores range in severity from 13 to 21. Access to mental health care, including mental health providers for women who experience postpartum depression, was identified as a significant unmet need throughout the state by needs assessment focus group participants and survey respondents. One survey respondent used an open-ended survey field to describe her experience:

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

According to Vermont's 2018 PRAMS survey:

- 24% of women had depression at some point during the three months before pregnancy (an increase from 18% in the previous year).
- 20% of women had a health care visit for depression or anxiety in the year before pregnancy.
- 20% reported having depression at some point during pregnancy.
- 90% of women with a prenatal care visit were asked if they were feeling down or depressed.

[15] Vermont Vulnerability Assessment (2019). Vermont Department of Health.
[16] Vermont Department of Health. Behavioral Risk Factor Surveillance System (BRFSS). 2018.

- 11% had symptoms indicating a risk for depression in the postpartum period.
- 96% of women with a postpartum checkup were asked if they were feeling down or depressed.

In focus groups, MCH providers identified the current HRSA-funded ***Screening, Treatment and Access for Mothers & Perinatal Partners (STAMPP***) project as a promising opportunity to improve responses to postpartum depression and address maternal mental health needs. The STAMPP project aims to improve mental health and well-being for pregnant and postpartum women and their children and families, by developing and sustaining a coordinated system of mental health supports, with plans to increase health care and social service providers' capacity to educate, screen, diagnose, prevent, and treat maternal depression and other related behavioral disorders. County Health Ranking data identify Essex and Orleans adults as being especially at-risk for mental distress (Table 13).

Table 13. High rate of reported mentally unhealthy days per month[17]

	% of adults reporting mental distress	Z-Score
Essex	12.8	1.46
Orleans	12.8	1.57
Vermont	11.9	

4) Rising child protection caseloads: Under the MIECHV child maltreatment domain, indicator data about rising caseloads for Vermont's child protection system under the Department for Children and Families (DCF) were identified in numerous counties. In addition to a larger number of cases, DCF has identified increasingly complex cases (in which families have multiple risk factors), including rising cases where parental substance use is a factor. In its Annual Report on Outcomes for Vermonters (2019)[18], DCF reported conducting 20,758 child abuse and neglect intakes, with very little change from the prior year (20,985 intakes). Of 5,385 child safety interventions, 2,872 were investigations and 2,513 were assessments. On September 30, 2018, DCF reported 1,301 children and youth in custody, including 485 ages 0 to 5, 453 ages 12 to 17, 340 ages 6 to 11, and 23 who were 18 or older.

In 2019, there were 659 children in DCF custody, a 29% increase from 509 children in 2014. Nine counties identified an increase in cases, with the percentage of increase ranging from 16% in Chittenden County to 257% in the Orleans/ Northern Essex DCF service region.[19]Recent trends include:

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

5) Need for high quality childcare programs: Through the needs assessment, and especially in focus groups with MCH providers, the need for high quality childcare was identified as a significant concern for families with infants and toddlers, as well as for families with children who have special health needs. The availability of high-quality childcare and related indicators do not fit directly

[17] University of Wisconsin Population Health Institute. County Health Rankings and Roadmaps State Report, Vermont 2020.
[18] Vermont Department for Children and Families. 2019. Annual Report on Outcomes for Vermonters
[19] Building Bright Futures. How are Vermont's Young Children and Families, 2019. www.buildingbrightfutures.org

within the MIECHV domains, but have implications that cut across multiple domains of well-being for vulnerable young families. High quality childcare programs are designated by Vermont's STARS quality-rating system and have been shown to promote child development and readiness to learn for children ages 0 to five. According to *Let's Grow Kids*, the statewide supply of regulated infant and toddler care programs has decreased over the last decade.[20] The state has far fewer high quality regulated early childhood programs than would be needed to address the current demand, with the largest gap for infant care. Statewide, 78% of infants do not have access to high quality regulated childcare programs. In Essex, Franklin, Lamoille, Caledonia, Washington, Orange, Addison, and Rutland counties 80 to 94% of infants do not have access to care. As childcare programs have responded to the COVID-19 crisis, several have permanently closed, making it likely that gaps in available care will continue to worsen.

II. DESCRIPTION OF METHODOLOGY

B. DESCRIBE HOW THE COUNTIES IDENTIFIED BY YOUR SELECTED METHOD REFLECT THE LEVEL OF RISK AS YOU UNDERSTAND IT IN YOUR STATE

Assessment activities were conducted independently by Noonmark Services, a Burlington-based consulting firm with expertise in public health assessment and evaluation, strategic planning, and organizational development. Noonmark worked closely with MCH staff leaders to establish the scope of the assessment inquiry, to develop assessment plans and instruments, and to reach a wide cross-section of MCH partners, stakeholders, service users, and members of the community at-large. Vermont's MIECHV assessment was conducted concurrently with its five-year needs assessment for the Title V program, as many states have done, in accordance with federal guidance from both programs. Data from this assessment have been used for both the MIECHV and Title V needs assessment reports. The assessment received a Vermont Agency of Human Services Institutional Review Board (IRB) waiver.

Noonmark conducted interviews with Vermont state agency partners and leaders, as well as MCH division staff members. Data from these interviews were summarized and used to formulate plans to reach priority populations from all regions of the state. The assessment team collected and reviewed data from a variety of state-level public health surveillance systems to identify assessment inquiry topics, including topics under the MIECHV domains. The assessment team generated two open-ended focus group question lists, one for service providers and practitioners and another for consumers/service users and community members. A focus group plan was established to reach identified groups in each region of Vermont. Question lists are provided in the Appendix.

Table 14. Needs Assessment Stakeholder Involvement

Stakeholder group	Number of contacts
State agency and partner interviews	17
Provider and practitioner focus groups	10 groups with 85 participants
Consumer/ community member focus groups	5 groups with 32 participants
Community Survey	332 respondents including 303 consumers and 29 providers

The *Access to Health and Wellness* Survey, an online community survey using Survey Monkey was developed, drawing on published MCH community needs assessments from other states, as well as input from MCH staff members, to

[20] Horwitz, J. (2020). *Stalled at the Start* Report. Let's Grow Kids. https://www.letsgrowkids.org/client_media/files/pdf/StalledatStart2020.pdf

develop the survey questionnaire. The survey was disseminated via MCH partners and stakeholders, as well as by purchasing statewide distribution via Front Porch Forum, a statewide email listserv for community information exchange (Figure 3). These methods engaged individuals who reside in and/or who provide services for individuals in every Vermont county. The assessment included focused efforts to reach Vermont residents who are low-income parents, caregivers and parents, including caregivers who are Black, Indigenous, and People of color (BIPOC), as well as immigrant and refugee parents and families.

C. STAKEHOLDER INVOLVEMENT, INCLUDING FAMILIES, INDIVIDUALS AND FAMILY-LED ORGANIZATIONS

Using the methods described above, Noonmark collected assessment data from 466 individual contacts, as described in Table 10. In total, 28% of contacts were people who administer or provide services to MCH populations and 72% were people who use MCH services, have used services in the past, or are members of the larger community, including parents, grandparents, foster parents and guardians, and people who care for children with special health needs.

State agency representatives, service providers, and practitioners who participated in interviews, focus groups and surveys included representatives from the VT Department for Children and Families, VT Department of Mental Health, One Care Vermont (Vermont's Accountable Care Organization), VCHIP (Vermont's Improvement Partnership), VDH Alcohol and Drug Abuse Programs (ADAP), Help Me Grow Vermont, Vermont Family Network, Agency of Human Services (AHS) Child Development Division, Burlington School District Diversity and Equity Team, the State Refugee Coordinator.

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

Noonmark worked closely with MCH partners to conduct four focus groups with consumers and community members, all of whom were low-income parents/caregivers. Each focus group participant who was a service user or community member received a $20 gift card or cash incentive for their participation. Childcare and translation in multiple languages were provided as needed.

QUALITATIVE DATA SOURCES

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

QUANTITATIVE DATA SOURCES

Data collected via VDH annual, semi-annual, and special reports, County Health Ranking data, recent needs assessments conducted by key stakeholders such as DCF and Head Start, and survey responses comprise the quantitative data collected and reviewed for this assessment. Survey results were analyzed using Survey Monkey, Microsoft Excel, and STATA to provide descriptive statistics including totals, averages, percentages, and medians. Raw population-level indicator data from public health surveillance systems was standardized, and Z-scores were calculated to indicate health risks for MCH domains at the state and county levels. Front Porch Forum's analytics and Survey Monkey user data provided information about the survey's reach across Vermont (Appendix). Characteristics of respondents appear in Figures 1-4. The survey instrument is provided in the Appendix. A VDH public health analyst provided quantitative data analysis, including selecting, refining, and reviewing data to identify counties with concentrated risks.

Fig. 1. Survey Respondents by County

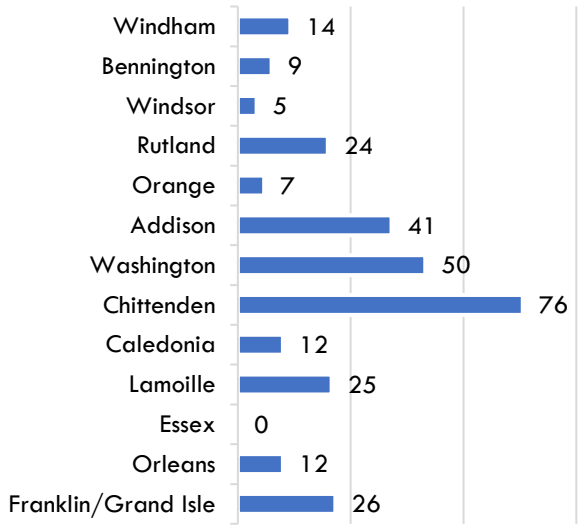
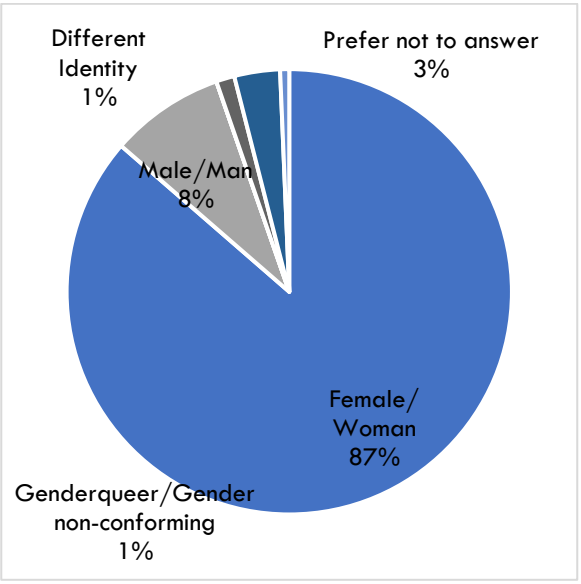


Fig. 2. Gender of Survey Respondents



Access to Health and Wellness Survey responses

- 332 people completed surveys
- Survey respondents came from every county except Essex
- 29 survey respondents only identified as service providers (not parents/guardians, grandparents, or caregivers).
- In addition to the multiple-choice questions, respondents provided192 short-answer responses to open-ended questions about needs, barriers, places they get health information, and emerging issues.

Fig. 3. Race/ethnicity of Survey Respondents

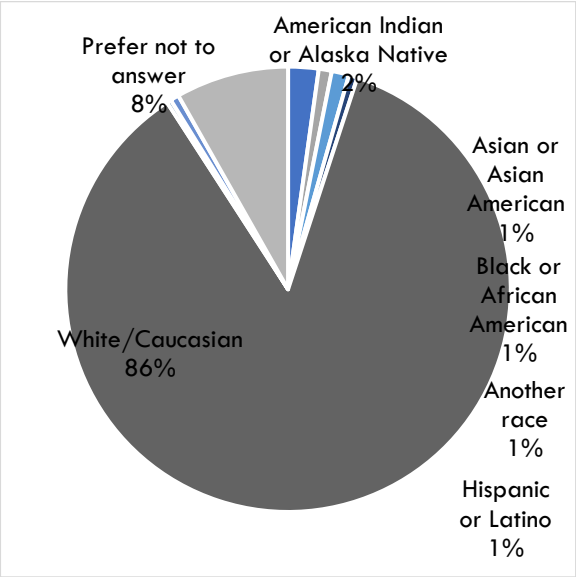
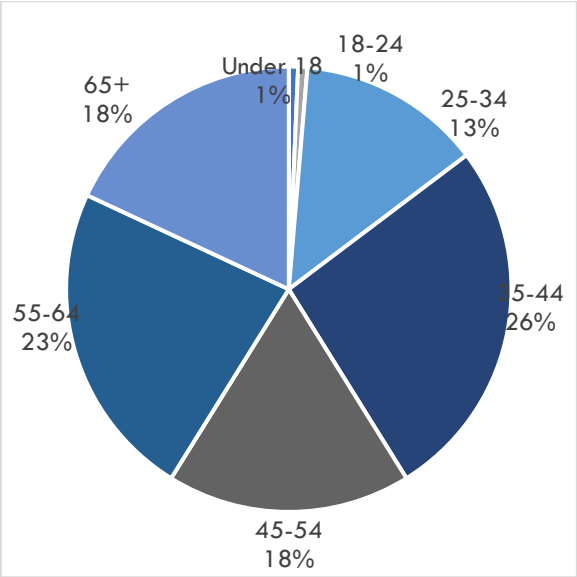


Fig. 4 Age of Survey Respondents



D. DATA SOURCES USED TO INFORM THE NEEDS ASSESSMENT PROCESS

VDH staff provided state and county-level indicator data from public health surveillance system sources such as the Behavioral Risk Factor Surveillance System (BRFSS), Vermont Youth Risk Behavior Survey (YRBS), Pregnancy Risk Assessment Monitoring System (PRAMS), School Health Profiles, and other population-level data systems. Other data sources included recent publications and data summaries from MCH programs, the Vermont Vulnerability Index, and from collaborative efforts such as the recent report from Building Bright Futures, "*How are Vermont's Young Children and Families?*" (2019), *the Vermont Early Childhood and Afterschool Workforce Report* (2018), Let's Grow Kids *Stalled at the Start* (2020), the *2018 Vermont Head Start and Early Head Start Needs Assessment Report* (2018).

3) IDENTIFYING QUALITY AND CAPACITY OF EXISTING PROGRAMS

A. REFLECT ON THE DATA ABOUT THE QUALITY AND CAPACITY OF HOME VISITING SERVICES IN YOUR STATE

Number and types of individuals and families receiving services: Home visiting programs reported the following funding sources, enrollment capacities, areas served and numbers of families served in the most recent year. The most recent year reported varied from program to program based on that program's fiscal year and reporting capabilities, but reflects the most recent 12-month period for which data was available. Some programs reported changes in numbers served or current capacity in response to the COVID-19 pandemic.

Table 15. Inventory of Existing Home Visiting Programs				
Program Name	***Funder/s***	***Funded Enrollment Capacity***	***Area Served***	***Number of families served***
Strong Families VT Nurse Home Visiting Program *Maternal Early Childhood Sustained Home visiting (MECSH)*	MIECHV grant	375	Statewide	488
Strong Families VT Family Support Sustained Home Visiting Program *Parents as Teachers (PAT)*	Unfunded	0	Statewide	30
Strong Families VT Responsive Nurse Home Visits	Medicaid and State of Vermont general funds	Determined locally	Statewide	132
Strong Families VT Responsive Family Support Work Home Visits	Medicaid and State of Vermont general funds	Determined locally	Statewide	184
Helping Everyone Access Resources & Thrive (HEART) Program, Universal Home Visits	State Parent Center Master grant, Integrated Family Services	86	Franklin, Grand Isle	123
Postpartum Angel Family Support Program, Universal Home Visits	Fundraising, State funding one year	100	Washington, parts of Lamoille and Orange	72
Early Head Start and Head Start with Home Based Services	Office of Head Start, Administration for Children and Families	482	Lamoille, Washington, Chittenden, Franklin, Grand Isle, Caledonia, Orleans, Essex, and Windham	294 children

i. Gaps in the delivery of early childhood home visiting services

Addressing basic needs such as housing, food security, and transportation are integral to the health and wellbeing of all Vermonters. For both community members and service providers, access to housing was the most commonly identified unmet need for families.

Lack of affordable housing: Taken together, Vermont's shortage of affordable housing, low median wages, and high cost of living rank the state the 16th highest "housing wage" in the United States. A worker would need to earn $22.78 per hour to afford a two bedroom apartment; a minimum wage worker would need to work 85 hours per week.[21] Assessment participants identified issues related to the lack of affordable housing in all regions of the state, where 46% of renters pay more than 30% of their income for housing,[22] and as do 33% of homeowners. The average Vermont renter earns $13.40 per hour and can afford to spend about $700 per month on rent, but the average two-bedroom apartment costs $1,184 per month.[23]

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

[21] National Low-Income Housing Coalition. Out of Reach 2019: Vermont
[22] American Community Survey (ACS), 5-year estimates United States Census Bureau, Table B25070, Table B25091
[23] National Low-Income Housing Coalition. Out of Reach 2019: Vermont

identified unmet housing needs, while community members/service users identified needs for employment or a stable source of income, reflecting their different orientation to fundamental basic needs concerns. For families, having a secure income may be viewed as a pathway to meeting all basic needs, including housing. For low-income households, access to affordable, healthy food was a frequently identified challenge. The rate of food insecurity has decreased since 2014, from 20.5% to 17.0% in 2017.

> "Yes, feeling safe in the community, but also feeling included by the community, with opportunities for contributing to, supporting, and celebrating community. Feeling like one is a part of something good that is larger than oneself goes a long way toward connectedness (opposite: loneliness), meaning in life, joy, and good physical and mental health."
>
> ~ Parent survey respondent

In many cases, the extent to which families can effectively address children's and adolescents' health needs was viewed as secondary to addressing basic needs. Families that struggle to maintain stable housing or adequate food viewed these concerns as the most significant issues they face. According to individuals who responded to the *Access to Health and Wellness Survey*, housing, food, and accessible and affordable healthcare were the three most "critically necessary factors for women, children, and families to thrive." (Table 16).

Table 16. The "most critically necessary factors for women, children, and families to thrive" (n= 329)

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

Survey respondents were the least likely to view support for breastfeeding (56%), culturally relevant support and services (56%), and help navigating systems (63%) as critically necessary. Community members who responded to the survey frequently commented on a need to address "social isolation" and "connectedness" as critical factors in their health and well-being. The frequency of open-ended responses which named needs for interpersonal support, and those which described positive relationships as a significant factor contributing to health and wellness suggest that there are additional opportunities to strengthen approaches that nurture the interpersonal connections that promote health.

Table 17. *"These are some maternal and child health services and resources that may be available in your community. How often can you and your family get these services if you need them?"*

Service or resource	**Seldom/Never**	**About half the time**	**Usually/Always**
Prenatal care when pregnant	7.6%	2.8%	89.6%
Assistance getting, understanding and using birth control	10.8%	2.7%	86.5%
Well-baby and well-child visits with a pediatric provider or family doctor	6.6%	7.9%	85.5%
Newborn screening information	10.9%	10.4%	78.7%

Pregnancy planning	15.4%	6.0%	78.6%
Adult well visits with a primary care provider or family doctor	10.7%	12.8%	76.5%
After pregnancy and between pregnancy care	13.2%	11.2%	75.6%
Information on preventing infant deaths	14.0%	11.4%	74.6%
Sexual health education	17.2%	11.6%	71.2%
Infant feeding, including breastfeeding support	15.4%	13.9%	70.6%
Diagnostic testing as a result of newborn screening (such as follow up hearing test or genetic test)	18.5%	13.3%	68.2%
Creating safe sleep areas	18.4%	14.8%	66.8%
Early intervention to identify the need for testing and support for babies with developmental delays	19.8%	14.6%	65.6%
Services and treatment for babies born with health issues related to drug or alcohol exposure/use	21.9%	14.6%	63.5%
Support for quitting smoking	19.2%	17.3%	63.5%
Parenting information	18.5%	21.4%	60.1%
Lead poisoning prevention	27.5%	14.0%	58.6%
Services addressing intimate partner/domestic violence	24.5%	17.2%	58.3%
Pregnancy or birth- related depression services	24.3%	18.3%	57.4%
Mental Health Services	26.3%	21.8%	51.9%
Specialists and treatment centers	26.3%	22.3%	51.4%
Wellness services such as those to increase healthy eating and physical activity	25.3%	25.6%	49.1%
Substance use treatment, such as drug or alcohol counseling	28.4%	22.8%	48.8%
Services to prevent injuries and violence, including self-harm	34.9%	17.4%	47.7%
Home visiting	42.1%	15.9%	42.1%
Support to navigate the system of care for children with special health care needs	41.5%	22.8%	35.7%
Training for parents/caregivers on care coordination	55.2%	18.4%	26.4%
Services to reduce stress, such as respite	60.8%	14.1%	25.1%

Availability of maternal and child health services: Survey respondents were most likely to report that they could "usually" or "always" access prental care (89.6%), assistance getting, understanding and using birth control (86.5%), and well-baby and well-child visits with a pediatric or family provider (85.5%) (Table 17). Respondents were the least likely to report that they could "usually" or "always" access services to reduce stress, such as respite (35.1%), training for parents/ caregivers on care coordination (26.4%), and support to navigate the system of care for children with special health care needs (35.7%). An equal number of respondents identified home visiting as something they "always" or "usually" have been able to access, or "never" or "seldom" had access to (42.1% for each group). Both groups of respondents include individuals from all counties.

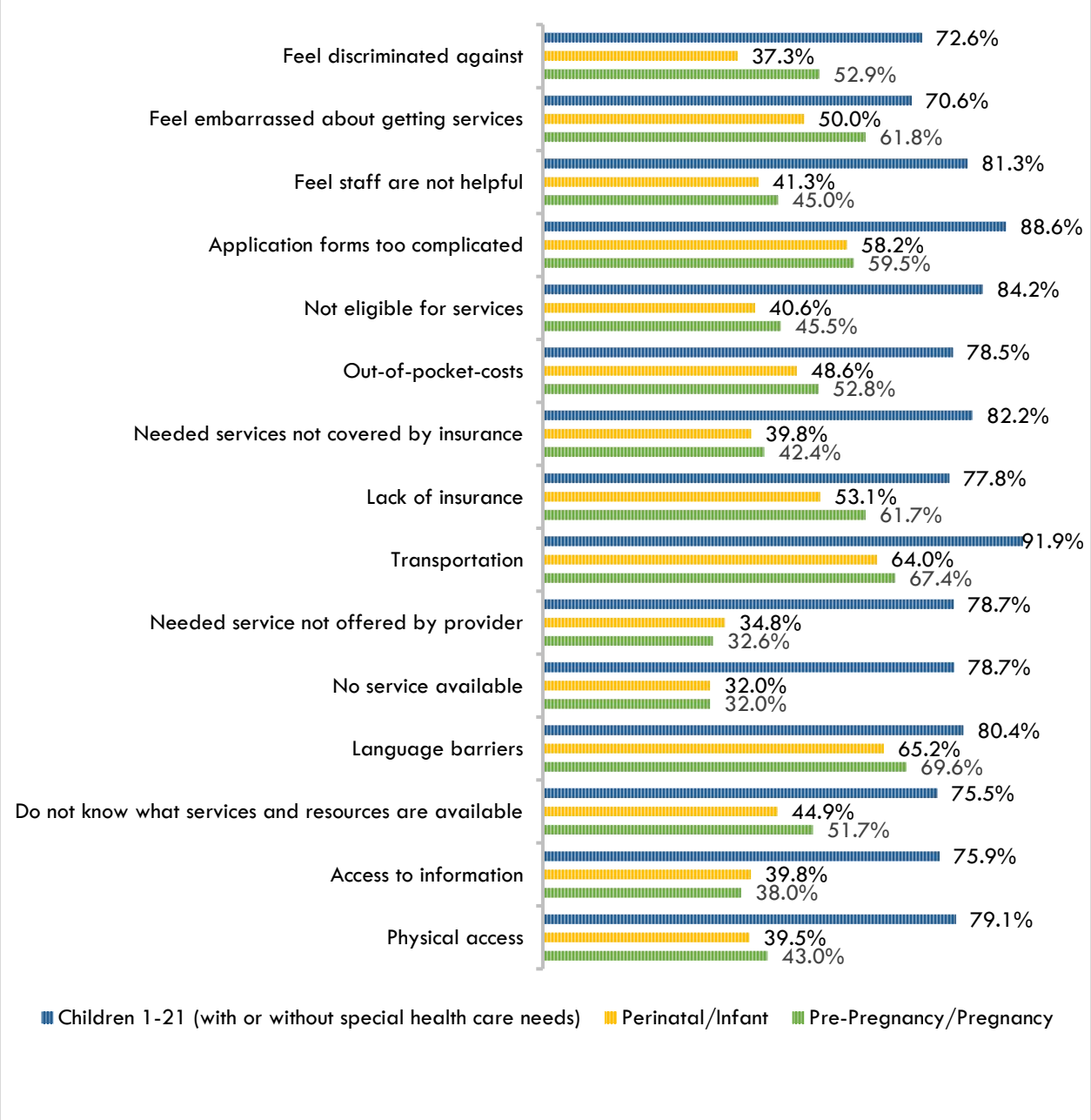
"Which barriers prevent you or your family from receiving services or resources?"

The *Access to Health and Wellness Survey* asked respondents to identify barriers that they or a family member had encountered, for three focus populations (pre-pregnancy/pregnancy, perinatal/infant, and children and youth under 21 including those with special health needs) (Fig. 5). Survey respondents identified the following barriers to care:

- For ***pre-pregnancy/ pregnancy-related care***, language barriers (69.6%), transportation (67.4%), feeling embarrassed (61.8%) and lack of insurance (61.7%) were the most commonly identified barriers. Respondents were the least likely to identify a lack of services as a barrier to their care (32.0%).
- For ***perinatal/infant care***, language barriers (65.2%), transportation (64.0%), and complicated application forms (58.2%) were the most commonly identified barriers. Respondents were the least likely to identify a lack of services available as a barrier to their care (32.0%).
- For ***children and youth under age 21, including those with special health needs,*** transportation (91.9%), complicated application forms (88.6%), and not eligible for services (84.2%) were the most commonly identified barriers. Respondents were the least likely to identify "embarrassed about getting services" (70.6%) and "feel discriminated against" (72.6%) as barriers to their care. The high percentage of respondents who identified even the lowest ranking barriers (with no barrier receiving less than 70%) suggests that all these issues are of concern for families with children under age 21.

In addition to the gaps and barriers identified through the survey, in focus groups nurse home visitors noted needs for more access to family support funds (small amounts to address immediate needs such as a minor car repair, a heating bill, or another unexpected expense) as a persistent need.

Figure 5. Perceived barriers to care by focus population, *Access to Health and Wellness* survey.



ii. Describe the extent to which home visiting services meet the needs of families in your state

Vermont's home visiting system is integrated through the Department for Children and Families (DCF) Children's Integrated Services (CIS) infrastructure. CIS is a unique compilation of nurse and family support home visiting, early intervention, early childhood mental health, and specialized childcare. CIS services are for at-risk pregnant and postpartum families, children from birth to age three who have disabilities or developmental delays, and children from birth to 5-years of age with social-emotional or behavioral challenges. MIECHV's home visiting is embedded into this system of care, The CIS system is designed to improve child and family outcomes by providing family-centric holistic services, effective service coordination, and flexible funding to address prevention, early intervention, health promotion and accountability. There are 13 CIS intake teams in Vermont hosted

by community organizations, made up of a variety of early childhood and family support staff including a CIS coordinator, specialized child care coordinator, early interventionist, early childhood mental health clinician, maternal and child health nurse and a family support worker. CIS teams have a coordinated intake to process to offer the optimal programs to address the identified needs, including early identification to coordinate multiple services across programs. Services include identifying and enrolling children in specialized childcare programs, supporting requests for childcare financial assistance, sharing positive parenting strategies, conducting nurse home visits with pregnant and postpartum women and caregivers, supporting young children and families who have experienced trauma, and providing developmental screenings and early intervention services (IDEA Part C). Services are primarily provided within a family's home or in a child's early care and learning program.

Home visiting services offered within CIS are branded as ***Strong Families Vermont*** and support pregnant people and new parents through home visits delivered by trained professionals using a continuum of services. Home visitors partner with each family to set goals and promote optimal development, health and wellbeing. Home visits also provide an opportunity for early screening and identification of potential challenges facing families, as well as connections to the broader array of Children's Integrated Services (CIS) and other local services and supports. The three-tiered system includes 1) Sustained Home Visiting; 2) Responsive Home Visits; and 3) Universal Home Visits.

1) Sustained Home Visiting

The **Strong Families Vermont Nurse Home Visiting Program**, internationally known as *Maternal Early Childhood Sustained Home Visiting Program Home-Visiting (MECSH)* is an evidenced-based nurse home visiting model. In 2012, Vermont began using MIECHV to implement Nurse Family Partnership (NFP), making it available to 12 of the state's 14 counties by 2017. During this period, Vermont learned a tremendous amount about how to meet and balance the needs of federal funding requirements, program expectations and fidelity, the uniqueness of local communities, and most importantly, Vermont families. Based on these considerations, Vermont's human services leaders decided to transition from NFP to MECSH on October 1, 2018. MECSH was selected because it addressed the state's priorities to have: 1) one nurse model across the state; 2) a model that can serve families in any pregnancy; and 3) a model that can be implemented in every region in the state. The MECSH model meets these criteria, allowing families to enroll at any time during pregnancy and up to six weeks postpartum, as well as supporting families and nurse home visitors to work together to determine when goals have been met. MECSH can be adapted to meet the unique needs and priorities of Vermont's families and systems.

Registered nurse home visitors from home health agencies and other community-based organizations deliver a long-term, structured, evidence-based home visiting program for families including at least 25 visits during pregnancy up to age two. The program improves maternal and child health and family economic self-sufficiency, promotes optimal child development, prevents child abuse and neglect, and coordinates referrals to community resources. *Strong Families* nurse home visitors support healthy decision making and effective parenting through a free, voluntary program that is structured and customized to meet the family's goals. Strong Families Vermont Nurse Home Visiting Program is Vermont's MIECHV-funded home visiting model.

The Strong Families Vermont Family Support Home Visiting Program is an evidence-based home visiting program which uses the national Parents as Teachers model and is implemented by Parent Child Centers and other community-service organizations that promotes the optimal early development, learning, and health of children by supporting and engaging their parents and

caregivers. Trained professionals from CIS partner agencies deliver this long-term, evidence-informed home visiting program for families through regular visits up to age five. The program strengthens the parent-child relationship, builds social connections, prevents child abuse and neglect, and promotes optimal child development and school readiness. Evidence shows that families engaging in PAT demonstrate improved child health and development; less child abuse and neglect; increased school readiness; and increased parent involvement in children's care and education.

> "We have a "let's figure out what we can do" approach when families are struggling—they can show up with kids and tell us what they need. 'I need tires, or food, or a place to cry or talk'. . . we are positioned to receive it all."
>
> ~ Strong Families Nurse Home Visitor

2) Responsive Home Visits

MCH collaborates with CIS teams, who work together to connect families with MCH nurses and/or Family Support Workers to provide regular home visits in response to time-limited needs. These visits support and strengthen families' health, wellbeing, parenting skills, social connections and ability to address stressors.

3) Universal Home Visits

Many communities in Vermont offer universal home visits through a range of community partners working together to ensure every family receives 1-3 visits during pregnancy and in the first months of parenting. These visits take many forms to provide a warm welcome and promote social connections, check in on the health and wellbeing of parents and baby, and share information about community resources to meet their needs.

Head Start and Early Head Start promote school readiness of young children from low-income families through local community-based organizations, and are federally funded and administered by the Office of Head Start, Administration for Children and Families, U.S. Department of Health and Human Services. *The Head Start home-based option* is a comprehensive program to meet the needs of preschool-aged children and their low-income families and increases the school readiness of the children served. *The Early Head Start home-based program* is a nationally recognized, evidence-based home visiting model and meets the needs of low-income pregnant people and families of infants and toddlers. The Early Head Start home visiting program has been shown to improve child cognitive development, reduce child behavioral problems, enhance family well-being, and increase parental participation in educational opportunities.

The **Home Visiting Alliance** is an advisory committee to the State of Vermont on how to effectively operationalize the continuum of Strong Families Vermont home visiting in accordance with the Vermont home visiting rule, standards, and manuals. The HVA's goals are to inform the ongoing design of Vermont's home visiting continuum; review programmatic data and make recommendations to DCF CDD, CIS and MCH staff regarding fidelity to models; and assure sustainability for home visiting programs by educating and informing administration leadership and legislature.

Strengths of The Home Visiting System: The quality of home visiting services available for eligible families, including those with newborns, young parents, low-income parents, and parents with a history of or risk for substance use, was identified as a strength by needs assessment stakeholders.

Home visiting providers stated that there is less stigma about receiving home visiting services than they found in the past, and that families generally respond positively to receiving home-based care. When MCH has had funding to provide portable cribs and other tangible infant care items for families, home visitors noted that these material supports are an effective incentive to voluntarily engage low-income families.

Focus group participants identified numerous strengths of Vermont's early childhood home visiting system and services, which were clustered into four main themes:

1. ***Focus on building relationships:*** Home visiting services may continue over weeks or months, with a single visit duration of 45 to 90 minutes. Nurse home visitors described the importance of building trust, establishing safety, and providing non-judgmental support as high priorities in the services they provide, and viewed this as one of the most important distinctions between home visiting and other types of care and support that families with infants and young children access.

2. ***Able to address basic needs:*** Nurse home visitors frequently stated that families have more complex needs than ever before, and for low-income families meeting basic needs such as stable housing and access to food are critical. Some home visitors stated that they may transport a client to an appointment, to the grocery store, or to pick up WIC supplies or needed medications when families lack transportation to do so. In this manner, nurses discussed that they frequently provide "social work" using a different set of skills than those used by nurses in hospital and other acute care settings.

3. ***Responsive and relevant to families' circumstances:*** Nurse home visitors generally agreed that within their role they have flexibility to focus on the issues and concerns that families identify, that they have strong familiarity with available services and supports to facilitate linkages, and their presence in the home makes it possible to provide a broad scope of support for multiple members of the family when needed. In many cases, nurse home visitors attributed their ability to be responsive to the roles of holistic, thoughtful supervisors who encouraged and supported them to provide quality care, even in complex circumstances. Nurse home visitors frequently described their work with fathers, including supporting their roles as co-parents and providing parenting education. Some focus group participants expressed a wish for more resources targeted towards engaging men in home visiting family supports.

4. ***Uses an effective, coordinated team approach:*** While there were differences from region to region, most home visitors found that coordination with other kinds of home visitors and opportunities to work as a team have strengthened their ability to provide support. Home visitors described teams that include representatives from DCF, early intervention, other home visiting programs, social workers, children with special health needs supports, and a variety of other practitioners. The composition and frequency of meeting for such teams varies from region to region, depending on what family services are locally available. Home visitors agreed that when cross-referrals and information sharing agreements are in place and working well, families receive a higher quality of care.

iii. Gaps in staffing, community resources, and other requirements for delivering evidence-based home visiting services

Focus group participants described a variety of staffing and resource needs to support high quality home visiting services.

Staffing/workforce needs: Staffing and workforce issues were among the most frequently discussed topics for focus group participants. According to a 2018 DCF Child Development Division Report,[24] approximately 350 individuals work in CIS roles, providing comprehensive health promotion, prevention, and early intervention services to pregnant and postpartum people, infants and children birth to age five (5) or age 13 for those receiving specialized child care services, their families, and child development providers. The largest service or administrative area is early intervention (29.2%), followed by early childhood family mental health (25.2%), administration (19.2%), CIS nursing (14.6%), family support (7.1%), and specialized childcare (4.6%). At the time of the report, there were 41 nurses employed in the Strong Families Vermont home visiting program.

Nurse home visitors and other MCH providers identified workforce shortages as a significant issue. Concerns related to this theme included high turnover, limited professional pathways for home visiting and public health nurses, need to protect staff from burnout, lower pay in public nursing settings when compared to hospital-based positions, and a desire for greater flexibility and autonomy within their roles. Many nurse home visitors stated that their roles require "too much paperwork," and that the time burden of administrative tasks detracts from their professional satisfaction.

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

Community resources: Gaps in available community resources to address basic needs, provide social services, and clinical supports are a significant concern in most regions of the state, and especially for low-income, rural Vermonters. Nurse home visitors and community members described limited availability of high quality early childhood care (especially for infants), few mental health providers when referrals are needed and a need for more mental health providers who are skilled in addressing postpartum depression and other maternal mental health conditions. Throughout the state, there is a need for family-centered, accessible substance use treatment designed for mothers of young children, and offered in settings and approaches that reduce stigma associated with seeking treatment.

Policies and practices to support home visiting: Home visiting nurses and home visiting nurse supervisors discussed a variety of opportunities to strengthen policies and practices to improve service delivery. Some home visiting program agencies have policies that prohibit the use of personal cell phones and/or do not provide staff with cell phones. Yet many home visiting clients, and especially young families, prefer contact via text messaging, making it difficult for nurses to connect with families in some cases. Likewise, some nurse home visitors felt they had easy access to information systems and databases that provide current, accurate client information across systems, while others expressed

[24] Vermont Department for Children and Families Child Development Division. 2018. Vermont Early Childhood and Afterschool Professionals Workforce Report. Vermont Agency on Human Services.

frustration about limitations in how information is available or exchanged based on policies and practices related to client information release forms. In many cases these obstacles were attributed to a partner agency's policies or practices, but the variation among providers suggests it may be beneficial to standardize client information exchange processes across the home visiting system.

Within the policies and practices theme, nurse home visitors frequently discussed the important role screening tools play in their professional practice. There was wide agreement that screening instruments and protocols (infant/child development, postpartum depression, substance use, intimate partner violence, and others) provide critical information to guide the care they provide. Focus group participants expressed concern that practitioners in other fields do not conduct or use screening tools with the same consistency or fidelity, or that the professional culture of nurse home visitors differs from that of other kinds of providers serving low-income, at-risk families, with different values around the use of screening tools.

Regional differences: MIECHV home visiting services are provided through subrecipient grant agreements with home health agencies, with significant differences in each agency's service area, relationships with other providers, human resource practices and policies, and numerous other variables. In addition, home visiting providers in eastern Vermont may need to interact with hospitals and social service systems in New Hampshire, and report that families with ties in both states may move back and forth, depending on family circumstances, job opportunities, and available benefits. These factors contribute to wide regional variations in home visiting service delivery. More rural/ remote home visiting providers described difficulty recruiting and retaining a well-trained workforce. The extent to which variations resources and practices from region to region is an area that would benefit from further analysis to understand how these variations impact MIECHV outcomes.

Table 18. Unduplicated MIECHV Participants, 2019[25]

	Participation Status		***Participant Race***							***Total***
Participants	*Newly Enrolled*	*Continuing*	*American Indian/ Alaska Native*	*Asian*	*Black or African American*	*Native Hawaiian/ Other Pacific Islander*	*White*	*More than one race*	*Unknown*	
Pregnant Women	197	24	2	14	4	0	199	4	8	221
Female Caregivers	80	147	1	4	1	1	200	5	15	227
Male Caregivers	0	0	0	0	0	0	0	0	0	0
All Adults	**277**	**171**	**3**	**8**	**5**	**1**	**399**	**9**	**23**	**448**
Female Children	96	66	1	4	0	0	126	1	30	162
Male Children	94	91	1	0	1	0	146	3	34	185
All Children	**190**	**157**	**2**	**4**	**1**	**0**	**272**	**4**	**64**	**347**

In 2019, Vermont's MIECHV program served 448 adults and 347 children (795 individuals), representing 448 unduplicated households. As detailed in Table 18, 89.1% of parents identified as white, as did 78.4% of children. "Unknown/ did not report" was the next largest category of racial identification (5% of adults and 18.4% of children). Individuals who identified as "more than one race" or Asian each comprised 1.5% of participants. The remaining 1.5% of adult and child

[25] Vermont Department of Health, MIECHV program data

participants identified as Black, African American, Native Hawaiian or Pacific Islander, American Indian or Alaskan. Approximately 2.2% of participants identified as Hispanic or Latino.

Among adult participants, 30.1% were never married; 20% were married; 37% were not married but living with a partner; 1.5% were separated, divorced, or widowed (Table 14). An additional 11.2% did not report their marital status. Nearly half (46.4%) were unemployed; 20% were employed full-time; and 13.6% were employed part-time. Nearly half (47.5%) had a high school diploma, GED or had not completed high school. Of those whose housing status was known, 5.6% were homeless, including those living in emergency or transitional housing, or sharing housing because of homelessness. Of those who were not homeless, 27% reside with a parent or family member, 6.8% reside in public housing; and 64% rent or own a home, condo, or apartment. More than half (57.5%) of households had an income at or below 200% of the federal poverty level (Table 20).

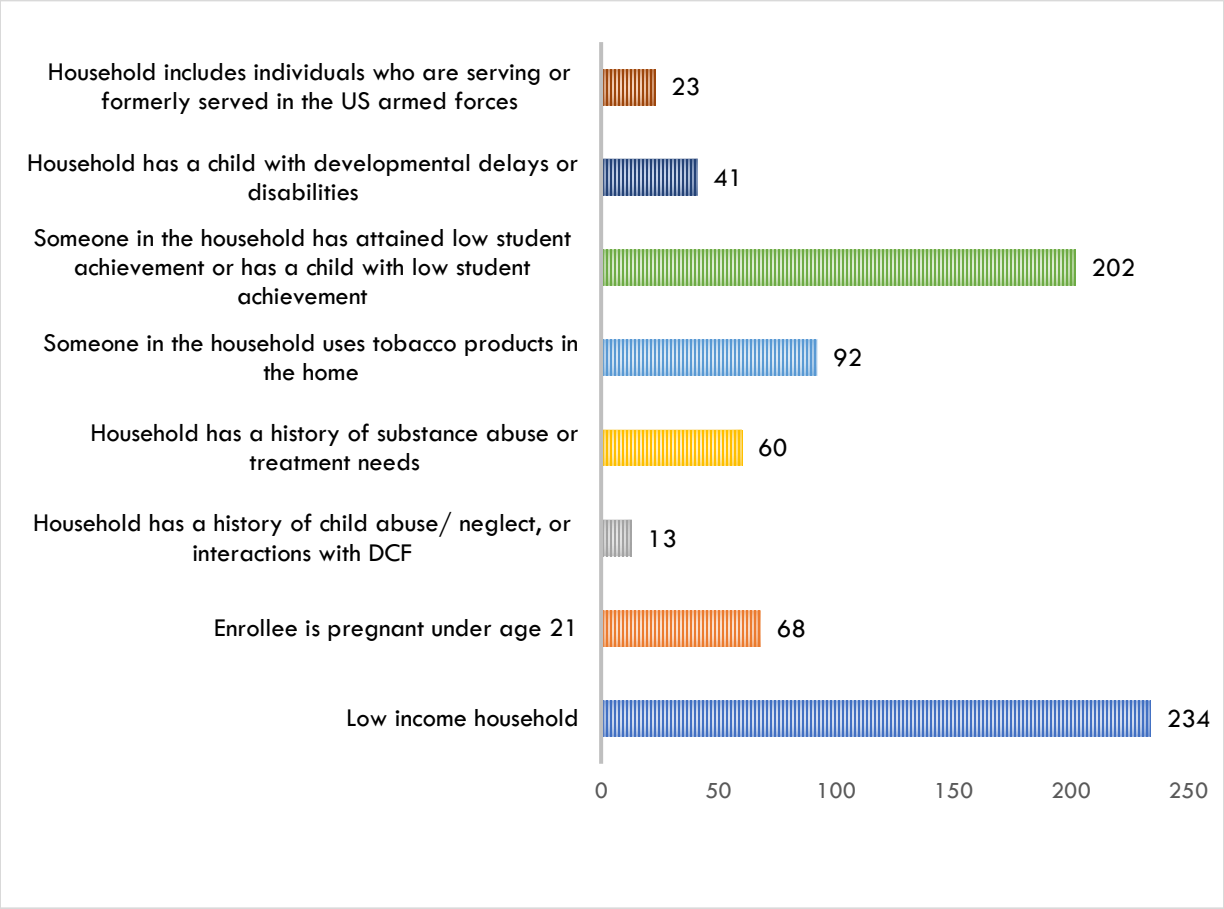
Table 19. Adult participants by marital status

Adult Participants	Never Married	Married	Not Married but Living with Partner	Separated/ Divorced/ Widowed	Unknown/ Did Not Report	Total
Pregnant Women	69	47	81	6	18	221
Female Caregivers	66	43	85	1	32	227
Male Caregivers	0	0	0	0	0	0
All Adults	**135**	**90**	**166**	**7**	**50**	**448**

Table 20. Household Income

Percent Federal Poverty	Number of Households	Percent
50% and Under	182	40.6%
51-100%	32	7.1%
101-133%	20	4.5%
134-200%	24	5.4%
201-300%	36	8%
>300%	13	2.9%
Unknown/Did no Report	141	31.5%
All Households	**448**	**100%**

Fig. 6. MIECHV priority population household characteristics, 2019 (n=448, multiple selections may apply)



Local early childhood systems coordination entities: Vermont's home visiting programs benefit from a statewide network of affiliated efforts that share a focus on ensuring the health, safety, and well-being of parents/caregivers and young children:

- **Building Bright Futures** serves both as the state's Early Childhood Advisory Council and the governance structure for the early childhood system.
- **Community Child Care Support & Referral Agencies** provide a variety of services including childcare referrals, childcare resource development and training support, and eligibility determination services for the Vermont Child Care Financial Assistance Program.
- **Head Start & State Collaboration Office:** Head Start and Early Head Start are federally funded child development programs which provide comprehensive development services for low-income children and social services for their families. In its 2018 Needs Assessment, Head Start and Early Head Start regions rated their level of involvement with VDH programs, including MIECHV, as having a high degree of coordination and collaboration.[26]
- **Help Me Grow Vermont (HMGVT)** is part of the national *Help Me Grow* program, which seeks to ensure all young children receive developmental screenings to support healthy development by engaging families, pediatricians, childcare providers, and others in the early childhood system.

[26] Swain, R. 2018. 2018 Vermont Head Start and Early Head Start Needs Assessment Report. Vermont Department for Children and Families Child Development Division.

- **Let's Grow Kids** is leading a movement for affordable access to high-quality childcare for all Vermont families who need it by 2025. LGK is strengthening the early care and education system to create immediate impact for families with children birth to five while simultaneously mobilizing Vermonters from all walks of life to call for policy change and public investment in child care to build a better Vermont for generations to come.
- **Parent Child Centers (PCCs):** DCF supports 15 PCCs (also known as family centers) throughout the state, which serve as a community resource for information and support for families with young children. PCCs provide parent education opportunities, playgroups, PAT home visits to families with young children who request or need home-based support, and center-based childcare programs. This programming builds on families' strengths while promoting wellbeing and healthy starts for children.
- **Specialized Child Care Coordinators** help childcare providers, social workers, families, and community partners with issues related to specialized childcare.
- **The Vermont Family Network (VFN)** is a statewide nonprofit organization dedicated to empowering and supporting families of children with special needs. By providing families with a strong start, lifting family voices for positive change, and advancing inclusive communities, the VFN seeks to ensure that every Vermont family can help their child reach their potential. As the Chittenden County Children's Integrated Services (CIS) Early Intervention program, VFN provides direct support services for eligible families of children birth to age three who have or are at-risk for developmental delays, including skilled family-to-family support, information and connection for families of children and youth with disabilities/special health care needs.
- **Building Flourishing Communities:** This proven public health model engages average Vermonters in discussion and action to address the factors that lead to poor health outcomes. BFC Master Trainers facilitate discussions in all regions of Vermont to increase awareness about how early, overwhelming and/or threatening events can lead to later poor health and well-being. The model is derived from evidence in neuroscience, epigenetics, the ACEs study, and research about the role of resilience. Trainers include staff from DCF/Family Services Division, VDH, the Department of Mental Health, DCF/Economic Services Division, ADAP, community mental health agencies, Parent Child Centers, public schools, United Ways, Building Bright Futures, physicians, restorative justice organizations, a mentoring organization and a domestic and sexual violence prevention program. Since its inception in 2017, the initiative has trained thousands of ECCE providers.

iv. Discuss optional considerations

The COVID-19 pandemic has illuminated gaps in systems of care for MIECHV populations. In the early phase of the pandemic when Vermont's "Stay Home, Stay Safe" order was in effect, it became apparent that home visiting services and populations were especially at a disadvantage. Many current home visiting families lacked internet access, up-to-date technology devices, or in some cases, cell phone coverage or cell phone data plans needed to participate in home visiting via telehealth. As other providers who refer clients to MIECHV adapted to changes in their services, home visiting programs reported fewer new referrals.

In places where there is limited access to primary care and/or obstetric services that feed into the home visiting system, home visitors are frequently called upon to fill in service gaps. The closure of the childbirth center at the Springfield Hospital in Springfield, Vermont in 2019 was identified by providers who participated in focus groups as a challenge for women in Southeast Vermont. Two hospitals with maternity services are located within a 45-minute drive from Springfield (and further from other Windham County towns). This closure follows the closure of the maternity ward at nearby

Alice Peck Day Memorial Hospital in Lebanon, New Hampshire in 2018. Women in this region may need to travel up to one hour for prenatal care.

> *"It is hard for families to engage in services from a stable place—substance use dictates everything else in their lives. This is their urgent need. Help is less available, they are less able to engage in help, and fearful about receiving any kind of help, including home-based services. We are seeing more NAS babies, more families with difficult substance use issues"*
>
> ~ Focus Group Participant

4) CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

A. RELATED TO THE NEEDS OF PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN WHO MAY BE ELIGIBLE FOR MIECHV SERVICES:

i. Describe range of treatment and counseling services

Home visitors routinely conduct substance use screening with home visiting clients. Clients who have a positive screening are referred to a designated agency or another clinical provider in their region for a full assessment to determine the level of care that is needed to address the issue/s identified through screening. Vermont's 16 "designated agencies" are private nonprofit agencies that partner with the Vermont Department of Mental Health to provide mental-health care, including substance use treatment services. Designated agencies offer care to Vermonters affected by developmental disabilities, mental health conditions, and substance use disorders.

Home visitors offer several essential supports for clients in homes where an SUD issue has been identified, including (1) care coordination from the point of referral and throughout treatment engagement; (2) working as part of a collaborative team with physicians, case managers, licensed alcohol and drug counselors (LADCs) and other providers to support clients' progress on treatment goals and adherence to treatment plans; (3) harm reduction education, including discussing health and safety risks during pregnancy and in the postpartum period; and (4) coaching, including using motivational interviewing, to build trust and support clients to access, follow-up on, and remain connected to SUD treatment services.

Vermont's Opioid Use Disorder Treatment System: "Hub and Spoke" is Vermont's system of Medication Assisted Treatment (MAT), supporting people in recovery from opioid use disorder. This framework efficiently deploys OUD expertise and helps expand access to opioid use disorder treatment for Vermonters.

Hubs: Nine regional Hubs offer intensive, daily support for patients with complex addictions. Hubs are Opioid Treatment Programs, with expanded services and strong connections to area Spokes. There are currently nine Hubs in Vermont. Each Hub is the source for its area's most intensive opioid use disorder treatment options, provided by highly experienced staff. Hubs offer the treatment intensity and staff expertise that some people require at the beginning of their recovery, at points during their recovery, or all throughout their recovery. Hubs provide all elements of MAT, including assessment, medication dispensing, and individual and group counseling. Additional Health Home supports are made available at Hubs through the Hub & Spoke staffing and payment model. These include case management, care coordination, management of transitions of care, family support services, health promotion, and referral to community services.

Spokes: An additional 75 local Spokes offer ongoing opioid use disorder (OUD) treatment fully integrated with general healthcare and wellness services. Spokes provide ongoing treatment in community settings. The Spokes are mostly primary care or family medicine practices, and include obstetrics and gynecology practices, specialty outpatient addictions programs, and practices specializing in chronic pain.

Nurse home visitors support clients who have a MAT treatment plan as part of their care team, and provide ongoing care coordination. LADCs who provide hub and spoke case management may have a case load of as many as 100 clients. Nurse home visitors provide essential, continuous support for the many needs and challenges vulnerable parents in MAT treatment encounter, and provide whole family supports.

ii. Describe gaps in the current level of treatment and counseling services available to home visiting service populations

Substance use and dependence during pregnancy is a significant problem in Vermont, where the rate of substance use during pregnancy (28.2 per 1,000 births) is four times higher than the U.S. rate (6.8 per 1,000 births). The incidence rate of infants born with a diagnosis of drug withdrawal syndrome peaked in 2014 at 35.3 per 1,000 live births in 2014, and was 29.5 in 2017.[27] The incidence remains more than double the 2007 rate of 12.8 cases per 1,000 live births, suggesting that substance use treatment intervention for pregnant women continues to be a high priority concern. Quality improvement data and national studies have shown that most women delivering an infant with neonatal abstinence syndrome (NAS) are on Medication-Assisted Treatment (MAT). Among women who delivered an infant with NAS, 81% were insured under Medicaid.[28]

Nurse home visitors stated that evidence of parental substance use is increasingly common during home visits. Home visitors noted that they may receive and follow different guidance pertaining to alcohol, marijuana, and substance use during pregnancy than the physicians who are providing prenatal care, or that standard guidance to abstain from substances during pregnancy may be subjectively offered, only when a physician perceives that a patient is especially at risk or has an identified SUD history. Likewise, home visitors stated that with Vermont's large focus on opioid use in the last five years, there has been less effort toward identifying and responding to alcohol use among pregnant and parenting women, despite its far higher prevalence in most regions of the state. Focus group participants expressed concern that most home visitors do not routinely carry Narcan.

Providers expressed concern that women who experience postpartum depression or another maternal mental health condition are vulnerable to SUD relapse and need a well-integrated, responsive approach to treatment. Focus group participants generally agreed that when a postpartum mother with SUD treatment needs is effectively linked to services, the system works well. At the same time providers stated that stress during the postpartum period can jeopardize SUD recovery, and that many families would benefit from more intensive support for a longer period during this time.

iii. Describe barriers to receipt of substance use disorder treatment and counseling services

[27] Vermont Uniform Hospital Discharge Data Set (VUHDDS) (2019). Data analysis was performed on the Vermont Uniform Hospital Discharge Data Set (VUHDDS) 2007-2017, as published in the *2019 How Are Vermont's Young Children and Families* report.

[28] Corr, TE, Schaefer, EW, and Paul, I.M. (2018). Growth during the first year in infants affected by neonatal abstinence syndrome. BMC Pediatrics, 18(1): 343.

Few consumers who participated in the assessment raised topics related to substance use. Nurse home visitors agreed that addressing substance use is difficult, largely because of the significant stigma women encounter. Providers stated that pregnant and parenting women may be reluctant to identify and seek care for substance use, and cited a fear of negative responses or judgement from physicians and other health care providers, having a history of negative encounters with child protective systems, or having "burned bridges" with the only treatment providers in their region due to relapse or family instability. Despite these concerns, nurse home visitors frequently noted that families have become more accepting of receiving home-based services, and that home visitors provide effective, judgement-free support. Specific barriers that participants identified included:

Few child and family-friendly SUD treatment services: A 2017 assessment conducted by the Building Bright Futures (BBF) Substance Use & Opiate Task Force identified important gaps for families[29]:

- Insufficient family-centered/multi-generational services available to meet the needs of the whole family in child and family-friendly practices and settings.
- Knowledge gaps among service and treatment delivery providers to meet the comprehensive needs of families with substance use issues and address the impact substance use on children.
- Lack of coordination and integration between the adult substance use treatment system, early childhood mental health, and the child welfare system.
- Differences in practice approach and perspectives, reflecting different guiding practices and principles and goals in early childhood and substance treatment systems (for example, a focus on adult treatment without sufficient focus on the impact on the family system including children).
- Lack of coordination and flexible funding and billing to allow service providers to provide support, care coordination and treatment to parents and children, and to use funds in a coordinated way.

> "I have lost family to the opioid epidemic. There needs to be more treatment options at the spokes of our hub and spoke system. People doing these drugs are driving hours on the road each day with their children. . . children are endangered."
>
> ~Survey respondent

Nurse home visitors who participated in focus groups reiterated these issues and concerns. Providers identified the lack of specialized services available for low-income pregnant women who need SUD treatment as a persistent challenge in many regions of the state. Only one residential SUD treatment program for pregnant and parenting women that enables mothers and infants or young children to remain together during treatment was identified. Providers stated that most emergency and transitional housing programs for women are not equipped to support pregnant or parenting women's SUD treatment in a family-centered manner, and that no such programs exist outside of Chittenden County. Some Hubs do not have practices in place to enable children to be present with parents who receive MAT and other treatment services.

Transportation barriers: For many low-income Vermonters, access to any kind of health, mental health, or substance use treatment is limited by a lack of transportation. Lack of a vehicle, vehicles that fail inspection or do not have winter tires, no or limited public transportation, private transportation services (including those for people with disabilities) that are not equipped to transport children

[29]Substance Use & Opiate Task Force. 2017. *Substance Use & Opiate Task Force Report and 2017 Recommendations*. Building Bright Futures.

together with parents, and the need to travel long distances to receive treatment services were identified as barriers to accessing treatment services.

Lack of MAT Spokes nearby: In several regions, home visitors stated that there are no MAT prescribers in their area and/or that prescribers in their county are too far away for clients to access. Likewise, focus group participants frequently discussed barriers related to parents' need to bring young children with them to MAT providers to receive treatment.

In the MAT system, there are cultural and structural constraints to integrating MAT with home visiting. However, in response to the COVID-19 pandemic, some MAT providers have begun to explore providing home-based MAT to patients who are COVID positive and/or under quarantine from a COVID exposure. This is an emerging area for Vermont MAT providers that is likely to continue to evolve as public health norms evolve in response to the pandemic, and which may create new opportunities for collaboration.

iv. Describe opportunities for collaboration with state and local partners

Children and Recovering Mothers (CHARM) Team: Vermont's collaborative approach to an inter-disciplinary and cross-agency teams to coordinate care for pregnant and parenting women with opioid use disorders and their infants to improve their health and safety outcomes. CHARM teams coordinate medical care, substance abuse treatment, child welfare, and social service supports, and are offered in most counties throughout the state (Table 21).

Table 21. Empaneled and non-empaneled support groups for pregnant and postpartum individuals with OUD and Opioid exposed newborns

County	Team Name and Contact Information	Individuals Served and Timeframe
Addison	***Non-empaneled team*** **-** County has a connected group of providers with a consent to share information to support pregnant and postpartum individuals with OUD.	• Pregnant and postpartum individuals • Followed for at least 6 weeks after delivery
Bennington	**Safe Arms –** High Risk OB team reviewing all pregnant individuals with SUD and opiate-exposed newborns	• Pregnant and postpartum individuals who are in recovery and/or at high risk • Follow for minimum of six weeks
Caledonia	**Supporting Mothers and Recovery Together (SMART)**	• Pregnant and postpartum individuals who are in recovery and/or high risk • Followed for up to two years
Chittenden	**Children and Recovering Mothers (ChARM)**	• Pregnant and postpartum individuals • Followed for up to one year
Franklin & Grand Isle	**Children and Recovering Mothers 2 (ChARM 2)**	• Pregnant and postpartum individuals with substance misuse related issues • Followed for up to one year
Essex & Orleans	**Antepartum Coordination Team (ACT)**	• Pregnant and postpartum individuals. • Serves high-risk individuals as well as individuals with OUD. • Followed up for up to one year after delivery
Lamoille	**Lamoille Valley Community Response Team (LVCRT)**	• Pregnant individuals who are stable and in treatment with MAT. Also willing to serve any high-risk pregnant individuals.
Orange	***Non-empaneled team*** **- Gifford Area Recovery Program (GARP)** Team	• Pregnant and postpartum individuals

		• Followed for up to 6 weeks after delivery, if further needs, transitioned to peds support. • Serves OUD and other high risk pregnant and postpartum individuals with housing instability, food insecurity, IPV, mental health concerns.
Rutland	**Coordinated Care for Families in Recovery**	• Pregnant and postpartum individuals • Followed for at least one year
Washington	**Central Vermont Community Response Team (CVCRT)**	• Pregnant and postpartum individuals with OUD and alcohol use disorder • Followed for at least a year
Windham	**Community Resource Team (CRT)**	• Pregnant and postpartum individuals with OUD and other high-risk pregnancies with housing instability, IPV, and other concerns.
Windsor	***No specific groups identified***	

CAPTA Workgroup: A 2017 workgroup was established to develop policies and procedures related to substance-exposed newborns in Vermont. The group includes representation from VDH, (ADAP and MCH), DCF, Child Development Division and Family Services Division, Vermont Children's Hospital Neonatology/Vermont Child Health Improvement Program/Improving Care for Opioid-exposed Newborns (ICON), Lund, and KidSafe Collaborative.

Improving Care for Opioid-exposed Newborns (ICON): A project of VCHIP, the ICON project partners with VDH and The University of Vermont Children's Hospital to improve health outcomes for opioid-exposed newborns. Improved health outcomes are achieved by provision of educational sessions on up-to-date recommendations and guidelines to health care professionals who provide care for opioid-dependent pregnant women and their infants. The project also maintains a maternal and newborn population-focused database for tracking process and outcome measures. These data are used to identify gaps in care and systems related resources; the project addresses these gaps through quality improvement initiatives, focused on enhanced care processes and systems' changes.

Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Project: Vermont's OMNI Learning Community team includes representatives from the Vermont Department of Health, Department of Vermont Health Access, Department for Children and Families, and Vermont Child Health Improvement Program, and works to improve Vermont's systems of postnatal identification and care for infants exposed to opioids in utero by developing and adopting standardized approaches for identifying substance exposed newborns at hospitals.

Vermont Helplink is a statewide, public resource to connect individuals to treatment and recovery resources. Helplink provides free, confidential, personalized phone and online services via AIRS-certified Helplink Specialists who are supported by clinicians.

v. Describe any current activities to strengthen the system of care for addressing substance use disorder

The nurse home visiting program administrator is MCH's liaison with ADAP, including disseminating information about available substance use treatment services to home visiting nurses, providing training for home visitors to access free materials via the Vermont Alcohol and Drug Information Clearinghouse, and supporting ADAP to review and implement screening tools with pregnant women.

In 2019, VDH contracted JSI Research and Training Institute, Inc. to evaluate the VDH Tobacco Control Program (VTCP), Alcohol and Drug Abuse Programs (ADAP) and MCH to better understand substance use during pregnancy.[30] The study examined alcohol, tobacco, marijuana, and opioid use. The evaluation examines pregnant women's knowledge, perceptions, experiences, and practices; needs to motivate them and support them to discontinue use during pregnancy; healthcare providers' knowledge, perceptions, experiences, and practices regarding substance use during pregnancy; and healthcare providers' needs for support to address substance use during pregnancy. Recommendations from the study include needs to:

- Educate providers and patients about the risks of harm from substance use during pregnancy. More information on marijuana will help.
- Help providers work with patients who need to make decisions in the face of uncertainty about the health impact of substance use during pregnancy.
- Improve screening guidelines for both substance use and mental health.
- Create messages that communicate ways to reduce use, avoid and/or abstain from substances during and after pregnancy.

Findings from the evaluation are being used to implement programmatic improvements, communication and outreach strategies, and planning efforts to strengthen Vermont's responses to substance use during pregnancy. The MIECHV program manager will support these efforts as plans are developed.

MIECHV has collaborated with ADAP to ensure that home visiting teams have current information and training about Vermont's SUD treatment resources, including periodically disseminating printed materials for home visitors to share with clients. In addition, the Nurse Home Visiting program administrator met with ADAP staff to review screening tools for home visiting populations that screen and/or assess substance use needs. The MECSH Steering Committee reviewed tools to consider future updates or adaptations of the screening tools.

The Substance Misuse Prevention Oversight and Advisory Council was established within VDH to improve the health outcomes of all Vermonters through a consolidated and holistic approach to substance misuse prevention. All categories of substances are addressed in this effort, including alcohol, cannabis, controlled substances such as opioids, cocaine and methamphetamines, and tobacco products, tobacco substitutes and substances containing nicotine. The Council provides advice to the Governor and General Assembly for improving prevention policies and programming throughout the State and to ensure that population prevention measures are at the forefront of all policy determinations.

5) COORDINATION WITH TITLE V MCH BLOCK GRANT, HEAD START, AND CAPTA NEEDS ASSESSMENTS

A. DESCRIBE HOW YOU COORDINATED WITH AND TOOK INTO ACCOUNT OTHER NEEDS ASSESSMENTS, AND AT A MINIMUM, THE NEEDS ASSESSMENTS REQUIRED BY TITLE V MCH BLOCK GRANT, HEAD START, AND CAPTA PROGRAMS

[30] JSI, Inc. (2019). Substance Use and Pregnancy: Vermont Healthcare Providers' and Patients' Knowledge, Perceptions, and Attitudes of Substance Use and Pregnancy Draft Report. Vermont Department of Health.

Vermont's MIECHV statewide needs assessment was conducted concurrently with Vermont's five-year needs assessment for the Title V MCH Block Grant program, as many states have done, in accordance with federal guidance from both programs. Data from this assessment have been used for both the Title V[31] and MIECHV needs assessment reports. The assessment team reviewed the 2018 Head Start and Early Head Start Needs Assessment report. Vermont has not conducted a recent needs assessment for the CAPTA program, but the most recent CAPTA annual report data were reviewed for this assessment.

In addition, Vermont received a Preschool Development Birth through Five (PDG B-5) planning grant, which included a requirement to conduct a needs assessment of the state's early childhood care sector. This funding was received by, and is administered through Building Bright Futures, described above. MCH is a member of the BBF Steering Committee and has coordinated MIECHV and Title V needs assessment strategies with the PDG B-5 assessment as much as is practical. The final PDG B-5 assessment report will become available in late 2020.

B. Discuss how findings or data from the Title V MCH Block Grant, Head Start, and CAPTA needs assessments informed your MIECHV needs assessment update

The Title V and MIECHV needs assessments were conducted jointly by Noonmark in coordination with key MCH and MIECHV staff. A single survey (Access to Health and Wellness) informed both assessments, and included survey items that comprehensively addressed Vermont's maternal and child health domains, including MIECHV consumer, potential consumer, and service provider groups. Focus groups with home visiting nurses and supervisors, and stakeholders from across Vermont's home visiting system were used to collect data specifically for the MIECHV assessment, which also informed the Title V needs assessment and its summary report. One significant area that was addressed in the Title V needs assessment that is not well addressed within the domains of the MIECHV Needs Assessment Update are concerns specific to maternal health, including prenatal visits, rates of breastfeeding and related issues, rates of cesarian sections and high risk births, and similar concerns. In many cases, these concerns for new parents extend to infants and young children. Likewise, indicators related to rates of WIC use and access, and related data sets that were included within the Title V assessment were outside of the scope of this needs assessment, which is limited in the domains it addresses. As previously stated, Vermont's small state population and very small county populations made it difficult to identify maternal health data sources that could be standardized for this assessment, because PRAMS data cannot be disaggregated for fewer than 500,000 population.

Both the Title V MCH needs assessment and Vermont's PDG B-5 needs assessment provided valuable data from a holistic perspective about how well Vermont's systems are serving women, infants, children, and young families. MCH conducts routine annual and long-range strategic planning which relies heavily on data from across its programs and services, as well as Vermont's public health and early childhood surveillance systems. As described above, and referenced throughout this needs assessment report, numerous reports from other statewide efforts to address health and wellness for families and children provided relevant information that informs MIECHV's strategies and activities. The MIECHV needs assessment team considered data from multiple sources, including

[31] Vermont's Title V Needs Assessment report is available for download at https://www.healthvermont.gov/sites/default/files/documents/pdf/cyf_Title%20V%20Needs%20Assessment.pdf

extant findings from other programs as well as new data from focus groups and survey. The conclusions drawn reflect the triangulation of these qualitative, quantitative, and externally sourced data. Given the scope of MCH's efforts and the complexity of Vermont's multi-agency integrated home visiting system, drawing upon multiple data sources provides an avenue to validate similar information from different points within the system.

C. Describe your efforts to convene stakeholders to review and contextualize results from various needs assessments in your state

The joint MIECHV and Title V needs assessment process has provided an opportunity to convene stakeholders to reflect on the current strengths, challenges, and opportunities that exist for home visitors. Data collection for this needs assessment concluded in February, 2020, coinciding with the beginning of the COVID-19 pandemic. For numerous reasons, including the urgency of the public health system's response and capacity required to do so, a need to maintain physical distance by reducing in-person convenings, and the agency-wide reprioritization of resources as many VDH staff were re-deployed to short and long term COVID-19 response roles limited the opportunity to convene stakeholders outside of MCH to reflect on these results.

The primary stakeholder group that will participate in future planning in response to this needs assessment will be coordinated through the Vermont Home Visiting Alliance (HVA). The HVA includes more than thirty members representing all of Vermont's strands of home visiting services, including home visiting services funded by MIECHV, as well as those supported through other funding mechanisms.

D. Describe processes established for ongoing communication with Title V MCH Block Grant, Head Start, and CAPTA representatives to ensure findings and data from respective needs assessments are shared on an ongoing basis

As described throughout the Needs Assessment Update Narrative, Vermont's small size engenders close collaboration among key stakeholders who support health and wellbeing for women, infants, children, and young families. As a small rural state, Vermont has proportionally small state government agencies. Committed staff at children and family-serving state agencies and nonprofit organizations collaborate to address the needs of Vermont children and families.

The MIECHV program manager is situated within the MCH and works very closely with other MCH staff and stakeholders. Vermont is served by a statewide network of local offices at the district level. MCH holds strong partnerships with the professional organizations that serve women of childbearing age, pregnant women, children, and families, through which it disseminates information:

- MCH has ties to the Vermont chapters of the AAP, AAFP, ACOG, AMA and the VT NP Association, and regularly provides updates and information such as needs assessment findings to these professional networks.
- Vermont MCH is a major sponsor of the VT Family Network's annual conference to educate health, human service, and educational providers, as well as a contributor to many professional conferences and forums each year. These forums provide in-person and electronic avenues to share findings and data.

- The Building Bright Futures *Early Childhood Interagency Coordinating Team* plays a critical role in identifying and eliminating barriers to collaboration, and addressing the priorities lead agencies and organizations identify. The Team's efforts result in a more cohesive voice of state government in Vermont's early childhood system by convening representatives of the state agencies represented on the Building Bright Futures State Council (Agency of Human Services, Education, Child Development Division, Vermont Department of Health Maternal and Child Health Division, Department of Commerce).
- The Vermont Interagency Coordinating Council is made up of parents of children receiving Children's Integrated Services (CIS), as well as representatives from legislature, Medicaid, Head Start, community providers and many more that have a desire to improve services for Vermont families. The Interagency Coordinating Council (ICC) advises the State of Vermont around programs relating to children and families with disabilities under the Individuals with Disabilities Education Act (IDEA) Part C. Vermont's unique approach to the ICC uses this group to advise and assist program practices and decisions for *all* of Vermont's Children's Integrated Services programs, in addition to Part C Early Intervention.

6) CONCLUSION

A. SUMMARIZE MAJOR FINDINGS OF THE STATEWIDE NEEDS ASSESSMENT UPDATE

1) Vermont's integrated home visiting system is working well at the leadership level; there is room to improve coordination at the direct service level. Along with workforce topics, integration and coordination issues were among the most frequently discussed themes by stakeholders within the home visiting system of care. These providers widely agree that an integrated system is desirable, beneficial for families, and has the potential to effectively meet the needs of the populations who may benefit most. For consumers, the fact that home visiting is held by several lead agencies (VDH, DCF) provides multiple on-ramps, which can facilitate broader access for at-risk families. At the leadership level, state agency partners spoke strongly of valuing the contributions and leadership of each partner, and identified frequent contact through a variety of regular, well-structured meetings and initiatives as being key to efforts to build a strong, highly integrated home visiting system. Leaders described the importance of "using a common language" and in many cases, described the ideal system with strikingly similar language.

Home visiting nurses and other service providers who refer families to home visiting and/or also serve home visiting populations (such as Parent Child Center staff, early childhood care providers, and providers who serve children with special needs) agree about the benefits of integration and coordination, but also identified numerous places where coordination could be strengthened. Focus group participants noted that regions with the most effective collaboration have built longstanding relationships with key individuals—when staff turnover among any of the partners occurs, and especially when a vacancy is prolonged, partners have difficulty maintaining communication/ information flow and coordination. In addition, direct service providers who are part of the home visiting care continuum hold their roles tightly and benefit from clarity about the roles of others and where each fits in the system of care; some identified confusion about roles as a challenge in service delivery. There are opportunities to look closely at how regional service delivery differs and to address inconsistencies, and potentially to improve opportunities for direct service staff to build fluency in the roles and shared values of an integrated system.

2) The nurse home visiting workforce is strongest when schedules, training, supervision, and systemic structures fully support their success. Home visiting nurses identified needs for flexible scheduling to better align with the needs of the families they serve. In addition, nurses described limited "social work" training within their nursing education, and expressed a need for more and different training and resources that reflects the scope of services they provide, and especially to address basic needs, poverty, trauma, and related topics. Home visiting nurses identified that they feel most equipped to do their work when systems, forms/paperwork, data access are all working well. Some noted that effective communication via shared records access is a critical mechanism for providing safe, high quality care.

3) Addressing basic needs and social determinants has a direct impact on family health, and Vermont's home visiting services are uniquely positioned to notice and address these concerns. Especially in light of the COVID-19 pandemic, the primacy of meeting basic needs as a cornerstone of public health was well founded throughout this assessment. While the home visiting nurse's job description is to provide traditional maternal and child care using nursing tools (breastfeeding support, nutrition and parenting education, well-baby support and screening, emotional support for new mothers), the vulnerability and multifaceted needs of families necessitates that home visiting nurses provide a much broader scope of care. To the extent that the health care system (and children's medical homes), are the point of access for families to address physical, emotional, developmental, and behavioral needs, integrating (and potentially shifting resources to) concerns such as affordable housing or accessible transportation may alleviate the resource gaps that eventually show up as unmet health needs and risks.

B. DESCRIBE DISSEMINATION OF THE STATEWIDE NEEDS ASSESSMENT UPDATE TO STAKEHOLDERS

The Nurse Home Visiting Program Administrator who oversees MIECHV programming will work with the MCH Division's communications specialist to design electronic and print needs assessment reports and summaries for dissemination to key stakeholders, including those who participated in needs assessment activities. At minimum, the needs assessment results will be shared with members of the Home Visiting Alliance, nurse home visitors and supervisors, representatives from CIS, DCF, other VDH divisions, and other partner entities. In addition, the MIECHV needs assessment report will be made available to the public via the MCH website, and through its provider portal.

7) NONPROFIT DOCUMENTATION (REQUIRED OF NONPROFIT AWARDEES ONLY)

a. Not applicable.

APPENDIX

VERMONT MCH TITLE V/ MIECHV FOCUS GROUP QUESTIONS

PATIENTS/CONSUMERS

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

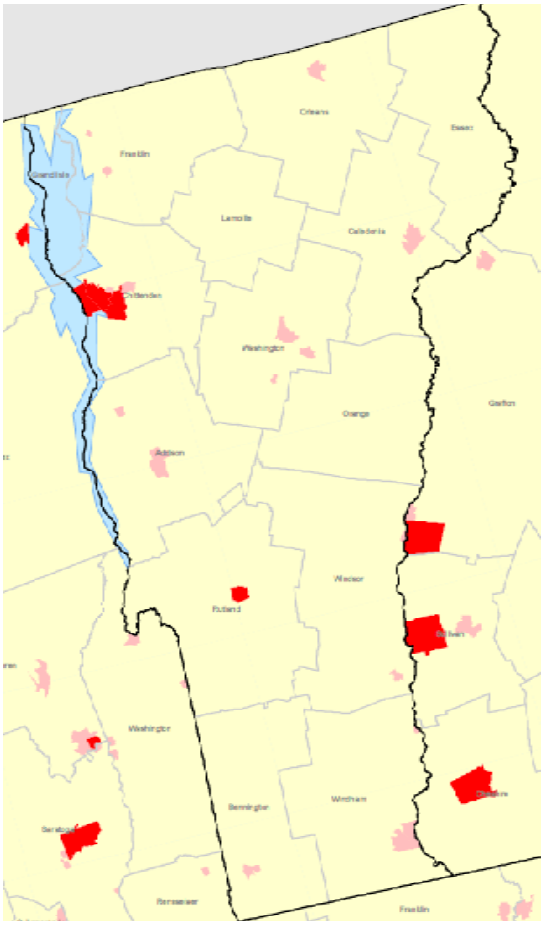
PROVIDERS

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

QUESTIONS FOR ALL:

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

Figure A1. Vermont's Rural status by county (U.S. Census Bureau)

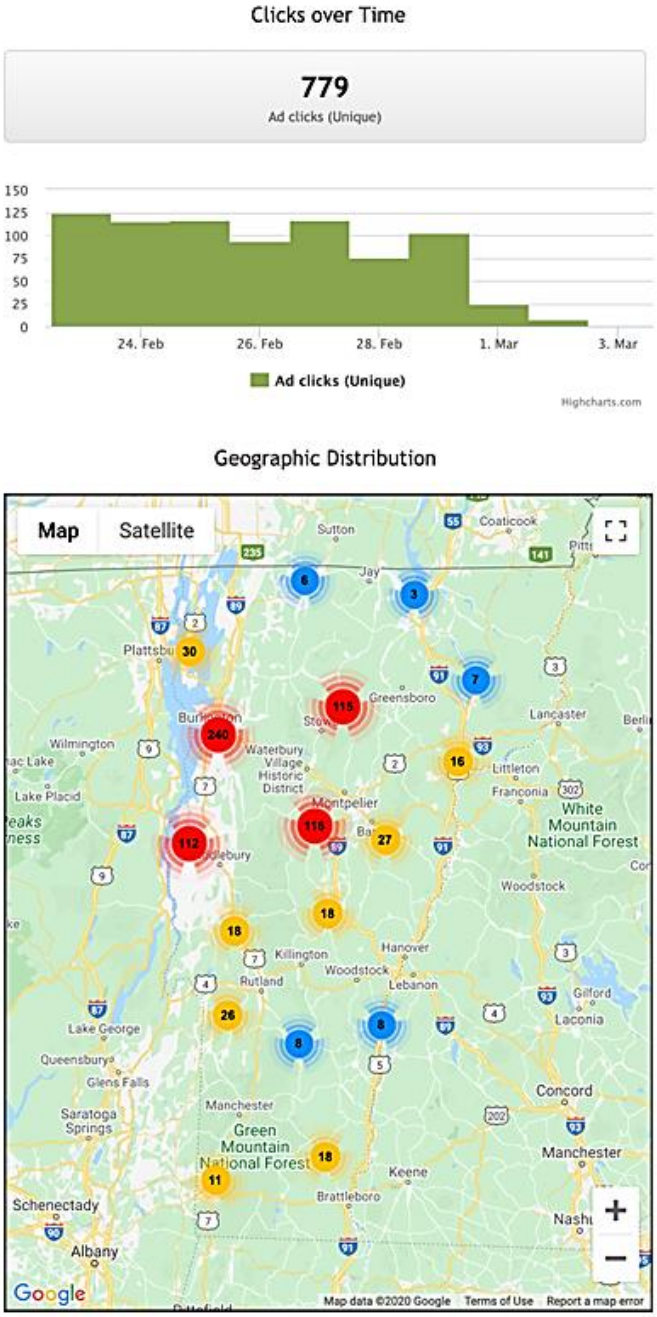


Areas in dark red are those with a population between 10,000 and 49,999 residents.

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

Unshaded areas have fewer than 2,500 residents

Figure A2. Front Porch Forum Survey Reach



VERMONT
DEPARTMENT OF HEALTH

Access to Health and Wellness Survey

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

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

Thank you

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

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

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

Did we miss some factors? enter here

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

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

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

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

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

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

Other (please specify)

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

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

Other (please specify)

VERMONT
DEPARTMENT OF HEALTH

Access to Health and Wellness Survey

Information About You

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

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

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

6. What county do you live in?

- ○ Franklin/Grand Isle
- ○ Orleans
- ○ Essex
- ○ Lamoille
- ○ Caledonia
- ○ Chittenden
- ○ Washington
- ○ Addison
- ○ Orange
- ○ Rutland
- ○ Windsor
- ○ Bennington
- ○ Windham

7. What is your age?

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

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

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

9. What best describes your sexual orientation?

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

10. What is your gender identity?

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

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

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

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

Name	
Email Address	
Phone Number	