# Community Health Needs Assessment

## Chittenden and Grand Isle Counties, Vermont

2022

## STEERING COMMITTEE MEMBERS

























# TABLE OF CONTENTS



## KEY

● Endnote Reference | ● Secondary Data Source Reference

# Leadership Message

**Stephen Leffler, MD**
President and COO,
UVM Medical Center

Our last Community Health Needs Assessment was completed in 2019. It has only been three years, but it feels like a lifetime ago. We have gained important insights. So much has transpired that informs how the 2022 CHNA was conducted.

First, and most obviously, the COVID-19 pandemic began in the winter of 2020. Over the last two years, we have learned a great deal about this virus – how to prevent it, and how to treat it. To keep our communities healthy and safe, we forged new approaches and partnerships that have extended beyond the immediate crisis, meaning we've also learned how to better promote the overall health of the communities we serve.

The past few years have also been a time of social upheaval – starting with the horrific murder of George Floyd in the late spring of 2020. As with many areas within our society, this was a time of reckoning for the medical field as we recognized elements within our health care system that allowed ignorance and bias to drive decision-making and often outcomes. There was a clear need to address these systemic inequities both for the communities we serve and for our employees as well.

It was clear to us that the 2022 CHNA process for Chittenden and Grand Isle counties needed to focus on health equity as a key lens for telling the story of health in our community.

And so for this year's CHNA, we brought new partners to the table to gather diverse perspectives and insights and lessons learned from our pandemic response work and about inequities within our health system more broadly. These partnerships are crucial as Community Health Needs Assessments are ultimately about guiding and supporting meaningful collective action to improve the health and wellbeing of our community.

Our community benefit team – working in concert with new and existing partners – more than doubled the number of survey responses we received in 2018. This comprehensive report is the result of that collaborative process – incorporating the many important perspectives and experiences of community members, especially those in underrepresented and structurally marginalized groups.

As in previous CHNA's, we plan to use this document to guide our programming and investments over the next three years. Investments will build upon the important progress of our partners, and key assets that exist in our community, leveraging strategic investments, such as the UVM Medical Center Community Health Investment Fund.

To everybody who participated in this process, thank you. We look forward to continued engagement and advancement of these community-driven health priorities with all of our partners – new and old. Working together, we can address health inequities and the other areas of focus identified within our 2022 CHNA.

# Acknowledgments and Special Contributions

The 2022 Community Health Needs Assessment was guided by our Steering Committee—representing over 25 community partners, including: community-based organizations, local and regional institutions, hospital departments, and state agencies.

## STEERING COMMITTEE MEMBERS

**Alicia Jacobs**
University of Vermont Medical Center, Department of Family Medicine

**Ali Dieng**
Building Bright Futures

**Amanda Biggs**
Building Bright Futures

**Cara Feldman-Hunt**
The University of Vermont Integrative Health

**Cathy Davis**
Lake Champlain Chamber of Commerce

**Dana Ward**
Vermont Department of Health, Burlington District Office

**Debbie Ingram**
Vermont Interfaith Action

**Heather Danis**
Vermont Department of Health, Burlington District Office

**Jane Helmstetter**
Vermont Agency of Human Services

**Joanne Crawford**
Abenaki Nation of Missisquoi

**Sara Haimowitz**
Center for Health & Learning

**Kate Purcell**
University of Vermont Medical Center Patient and Family Centered Care Advisor

**Katy Davis**
Hunger Free Vermont

**Karen Vastine**
University of Vermont Health Network, Office of Government and Community Relations

**Kim Anderson**
Community Health Centers of Burlington

**Lindsay Morse**
University of Vermont Health Network, Care Management

**Margaret Bozik**
Champlain Housing Trust

**Maria McClellan**
University of Vermont Health Network, Office of Government and Community Relations

**Marielle Matthews**
City of Burlington, Racial Equity, Inclusion, & Belonging Office

**Matthew MacNeil**
Howard Center

**Melanie Needle**
Chittenden County Regional Planning Commission

**Melissa Southwick**
SASH at Cathedral Square

**Mike Bensel**
Pride Center of Vermont

**Mike Ohler**
Champlain Housing Trust

**Neerusha Phuyal**
Winooski High School

**Nyla Ruiz**
City of Burlington, Racial Equity, Inclusion, & Belonging Office

**Olivia Moseley**
U.S. Committee for Refugees and Immigrants (USCRI) Vermont

**Penrose Jackson**
Community Member, Vermont Public Health Institute

**Raquel Aronhime**
United Way of Northwest VT; Mercy Connections

**Robin S. Way**
Champlain Islanders Developing Essential Resources

**Robyn Freedner-Maguire**
Patient and Family Centered Care Advisor/ Mental Health First BTV

**Sarah Twichell**
University of Vermont Children's Hospital

**Sean McMannon**
Champlain Valley Superintendents Association, Winooski School District

**Steven Berbeco**
United Way of Northwest Vermont

**Susie Posner Jones**
University of Vermont Health Network, Philanthropy

**Thato Ratsebe**
Association of Africans Living in Vermont

**Virginie Diambou**
Champlain Valley Office of Economic Opportunity

Three Work Groups met to design and review research activities—from collecting secondary data to designing the community prioritization sessions.

## SECONDARY DATA WORK GROUP

**Dean Pallozzi**
UVM Medical Center, Data Management Office

**Heather Danis**
Vermont Department of Health Burlington Office

**Joanne Crawford**
Abenaki Nation of Missisquoi

**Julie Kaplan**
Community Health Centers of Burlington

**Marielle Mathews**
City of Burlington, Department of Innovation and Technology

**Melanie Needle**
Chittenden County Regional Planning Commission

**Rebecca Sardaro**
Abenaki Nation of Missisquoi

**Sarah Twichell**
UVM Children's Hospital, Department of Pediatrics

**Sean McMannon**
Champlain Valley Superintendents Association, Winooski School District

**Susie Posner Jones**
UVM Health Network, Philanthropy

## KEY INFORMANT INTERVIEWS & COMMUNITY SURVEY WORK GROUP

**Kim Anderson**
Community Health Centers of Burlington

**Ali Dieng**
Building Bright Futures

**Cara Feldman-Hunt**
UVM Integrative Health, UVM Medical Center

**Matthew MacNeil**
Howard Center

**Kate Purcell**
Patient and Family Centered Care

**Sara Haimowitz**
The Center for Health and Learning

**Olivia Moseley**
U.S. Committee for Refugees and Immigrants (USCRI) Vermont

**Robin S. Way**
Champlain Islanders Developing Essential Resources

**Penrose Jackson**
Community Member, Vermont Public Health Institute

**Randy Lanier**
UVM Medical Center, Paramedicine

**Yvonne Zietlow**
UVM Health Network, Population Health & Wellness

## COMMUNITY PRIORITIZATION & FOCUS GROUPS WORK GROUP

**Debbie Ingram**
Vermont Interfaith Action

**Mike Ohler**
Champlain Housing Trust

**Nyla Ruiz**
City of Burlington, Racial Equity, Inclusion, & Belonging Office

**Raquel Aronhime**
United Way of Northwest Vermont

**Robyn Freedner-Maguire**
Mental Health First BTV

**Maria McClellan**
UVM Medical Center, Government & Community Relations

**Cathy Davis**
Lake Champlain Chamber

**Alicia Jacobs**
UVM Medical Center, Department of Family Medicine

**Melissa Southwick**
SASH at Cathedral Square

**Jane Helmstetter**
Agency of Human Services

## SPECIAL ACKNOWLEDGMENTS & APPRECIATIONS

Association of Africans Living in Vermont

U.S. Committee for Refugees and Immigrants Vermont

Miriam Berkson, UVM Medical Center Community Health Improvement CHNA Outreach and Engagement Intern

Mark Hughes, Wilda White and the Vermont Racial Justice Alliance Wellness Committee

Don Stevens, Chief, Nulhegan Band of the Coosuk - Abenaki Nation, and Diane Stevens

Health Disparities and Cultural Competence Committee

Vermont New American Advisory Council

April Mentzer, Support and Services at Home (SASH)

Emily Taylor, Champlain Housing Trust

Steven Kostell, UVM Department of Community Development & Applied Economics

Dean Pallozzi, UVM Health Network, Data Management Office

Peter McConville, City and Lake Semester, Burlington High School

Aden Haji, Spectrum Multicultural Youth Program

Emily Anderson, Bridging Program, Champlain Community Services

Sydney Hinckley, Multilingual Learners Program Assistant and Parent University Manager, Burlington School District

Elizabeth Gilman, Vermont 211, United Ways of Vermont

Lynette Reep and Sandy Pucillo, UVM Medical Center Language Access Services Team

Geri Ann Higgins, UVM Medical Center Communications & Engagement Strategies Liaison

The Larner College of Medicine, Public Health Project Team: 'Improving the Accessibility and Efficacy of the UVMMC CHNA to Populations Experiencing Homelessness'

## THE 2022 CHNA PROJECT TEAM

### THE UNIVERSITY OF VERMONT MEDICAL CENTER, COMMUNITY BENEFITS:

Erin Armstrong

Marcela Bradova

Justin Graham

Kristin Fontaine

Christina Keating

Molly Lawrence

Thomas Moore

Sr. Pat McKittrick

### THE CENTER FOR RURAL STUDIES AT THE UNIVERSITY OF VERMONT:

Kerry Daigle

Kelly Hamshaw

Michael Moser

# 2022 CHNA Executive Summary

## THE 2022 COMMUNITY HEALTH NEEDS ASSESSMENT

A Community Health Needs Assessment (CHNA) is a process that non-profit hospitals complete every three years in partnership with community-based organizations to learn more about the significant health needs in the greater community. These valuable insights inform strategic investment and guide community programming to improve the identified priorities.

The UVM Medical Center (UVMMC) and 37 members of the 2022 CHNA Steering Committee collaborated on the 2022 CHNA for its designated Health Service Area of Chittenden and Grand Isle Counties.

### THE 2022 CHNA GOALS WERE:

1. To conduct an inclusive and high-quality assessment, through the lens of racial and health equity, of community health needs and assets in Chittenden and Grand Isle Counties.
2. To partner with diverse stakeholders resulting in: a) consensus of priority needs to address, b) shared buy-in for implementation strategies, c) support of complimentary community initiatives and assessments.

## DATA GATHERING AND COMMUNITY HEALTH PRIORITIES

The 2022 CHNA process was the most inclusive and robust yet in our history of completing this assessment. We collected data through interviews, surveys, and focus groups held in our local community in addition to reviewing health indicators available for the two counties.

- **KEY INFORMANT INTERVIEWS:** 32 community leaders interviewed
- **SECONDARY DATA:** 70+ health indicators
- **COMMUNITY SURVEY:** Offered in 12 languages with 3,771 survey responses [nearly twice last cycle's response rate]
- **FOCUS GROUPS:** 5 sessions held with populations of focus

### COMMUNITY HEALTH PRIORITIES SESSIONS:

- Two virtual sessions were held in January 2022 to engage community leaders and champions in prioritizing six health priorities that emerged from the data gathering phase.
- 140 participants from 57 different organizations and agencies participated and provided ratings by three criteria: Impact, Community Readiness, and Equity.

### THE TOP 3 COMMUNITY HEALTH PRIORITIES, IN ALPHABETICAL ORDER,:

- **Cultural Humility and Inclusive Health Care**
- **Housing**
- **Mental Health and Wellbeing**

## COMMUNITY HEALTH PRIORITIES AND KEY FINDINGS

| **Accessible and Coordinated Care:**<br>Improving access to coordinated care that meets all people's health needs while addressing complexities in the system. | **Cultural Humility and Inclusive Health Care:**<br>Access to inclusive, high-quality health care in settings where all community members feel safe, respected, and understood. | **Food Access and Security:**<br>Families and individuals experience food security when they have reliable access to healthy, culturally appropriate foods. |
|---|---|---|
| • 46% of Community Survey respondents want increased coordination of care between providers<br>• The region has seen a decline in the number of primary care providers, from 2010 to 2018<br>• There is a need for affordable care options outside of the "9-5" weekday hours | • Community leaders spoke to the importance of respecting how cultural, religious, and spiritual beliefs guide health and wellbeing<br>• 2 out of 3 Community Survey respondents who have lived in the U.S. for less than one year do not feel their cultural identity is respected by health care providers | • 1 in 10 Community Survey respondents shared that they cannot access the foods they want to eat<br>• However, only 1 in 3 Community Survey respondents who reported living in the United States for less than one year reported being able to access foods they want to eat |
| **Housing:**<br>Having safe, healthy, and affordable housing that meets the needs of all families and individuals in our community, while promoting equitable access. | **Mental Health and Wellbeing:**<br>Supporting the mental health and wellbeing of all community members by offering timely services and promoting social connections. | **Workforce Development:**<br>Supporting people to gain knowledge and skills that allow greater employment, financial stability, and opportunity. |
| • 1 in 6 households experience severe housing problems such as being overcrowded, having incomplete plumbing or kitchen facilities<br>• 62% of Community Survey respondents said increasing affordable housing units will improve health and wellbeing<br>• There are racial disparities in homeownership rates | • 65% of Community Survey respondents said increasing mental health services would strengthen health and wellbeing<br>• Increased number of adults experiencing mentally unhealthy days<br>• Increased number of 9th-12th grade students feeling sad or hopeless<br>• COVID-19 pandemic has led to increased social isolation | • 71% of Community Survey respondents believe increasing jobs that pay a livable wage is important<br>• More than 50% of Community Survey respondents reported that affordable childcare is not available<br>• There are disparities in median income reported by race and ethnicity and sex |

## NEXT STEPS: MOVING FROM ASSESSMENT TO ACTION

- The CHNA will advance to the UVMMC Board for adoption and ratification of the health priorities to focus on. The CHNA report will be made available publicly.
- The CHNA findings will inform the development of the 2023-2025 Community Health Improvement Plan (CHIP) that UVMMC will develop in collaboration with key partners.

**The CHIP process will:**

- Facilitate inclusive community engagement to generate solutions that builds upon strengths and addresses inequities
- Communicate shared goals, strategies, and resources to make measurable improvements

**To learn more about Community Health Improvement or the 2022 CHNA/CHIP process, please visit:**

www.UVMHealth.org/medcenter/about-uvm-medical-center/the-community/needs-assessment

**CONTACT:**

**Molly Lawrence, MPH**
Community Health Needs Assessment Project Manager
Molly.Lawrence@UVMHealth.org

# About this Report

## WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT?

The Affordable Care Act requires all non-profit hospitals to identify "significant health needs" in their communities every three years through an assessment process. The IRS guidance for conducting a Community Health Needs Assessment (CHNA) for Charitable Hospital Organizations, as outlined in Section 501(r)(3), describes a significant health need as, "requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community, such as particular neighborhoods or populations experiencing health disparities."

To understand community priorities, hospitals and their partners draw on health and demographic data from a variety of sources, as well as seek community-wide input through activities such as surveys, interviews, and focus groups.

These findings inform a formal prioritization process to identify the significant health needs to be addressed by the corresponding Implementation Strategy. Hospitals and partners then work together to identify actions for addressing these priorities in the greater community.[1]

### COMMUNITY HEALTH NEEDS ASSESSMENT HISTORICAL TIMELINE

**2013 PRIORITIES:**

- Access to Food and Good Nutrition
- Dental Health
- Mental Health
- Removing Barriers to Care
- Senior Issues

**2016 PRIORITIES:**

- Access to Healthy Food
- Affordable Housing
- Chronic Conditions
- Early Childhood and Family Supports
- Economic Opportunities
- Healthy Aging
- Mental Health
- Oral Health and Health Care
- Sexually Transmitted Infections
- Teen Births
- Substance Abuse

**2019 PRIORITIES:**

- Affordable Housing
- Childhood and Family Health
- Cancer
- Disease Prevention
- Mental Health
- Substance Use Disorder

**2022 PRIORITIES:**

- Accessible and Coordinated Care
- Cultural Humility and Inclusive Health Care
- Food Access and Security
- Housing
- Mental Health and Wellbeing
- Workforce Development

## COMMUNITY HEALTH IMPROVEMENT

The University of Vermont Medical Center's (UVMMC) Community Health Improvement (CHI) Department is responsible for implementing and advancing activities that improve the health and wellbeing of those who live and work in our community. This is done in a variety of ways and requires strong partnerships.

The most important tool used to guide this work is the Community Health Needs Assessment (CHNA). UVMMC has led health assessments since the 1980s as a way to facilitate meaningful investment in community health improvement. While UVMMC serves patients from all counties and its neighboring states, for the purposes of the CHNA, the designated Health Service Area (HSA) is limited to Chittenden and Grand Isle Counties. Every three years, UVMMC leads a CHNA, providing an opportunity for community members to join the conversation around how to best strengthen the health of the community.

CHI is a process to identify and address the health needs of communities. Because working together has a greater impact on health and economic vitality than working alone, CHI brings together health care, public health, and other stakeholders to consider high-priority actions to improve community health.[2]


Photo compliments of the Champlain Community Services Bridging Program

## ABOUT THE 2022 CHNA

The 2022 CHNA seeks to tell a robust story of health and wellbeing, with a focus on advancing health and racial equity. Understanding the importance of using data to inform and measure progress, the following vision was adopted:

> The 2022 CHNA process will guide measurable community health improvements in Chittenden and Grand Isle Counties.

The Project Team felt it was important to use a strengths-based approach to develop goals to support the vision and guide the process. The 2022 CHNA goals were:

1. To conduct an inclusive and high-quality assessment, through the lens of racial and health equity, of community health needs and assets in Chittenden and Grand Isle counties.
2. To partner with diverse stakeholders resulting in: a) consensus of priority needs to address; b) shared buy-in for implementation strategies; c) support of complimentary community initiatives and assessments.

The 2022 CHNA Project Team was a partnership between members from UVMMC and consultants from the Center for Rural Studies at the University of Vermont (CRS). The 2022 CHNA process was overseen by a 37-member Steering Committee, representing over 25 key organizational partners and community members during the 11 month-long assessment process conducted between May 2021 and March 2022. Efforts were made to create an inclusive, cross-sector Steering Committee with representatives from backgrounds including: health care, public health, education, community development, social services, community-based organizations, and members of the community. The Steering Committee played an integral role in shaping and informing each step of the assessment process. Three Work Groups were created to focus on specific data gathering activities for the assessment.

This report contains findings from secondary data sources, a community survey that generated over 3,700 responses, key informant interviews, and focus group conversations. The findings provide valuable insights into the health and wellbeing of our community. Our hope is that this assessment will promote rich dialogue and guide strategic investments to advance health equity.

### USE THIS REPORT TO:

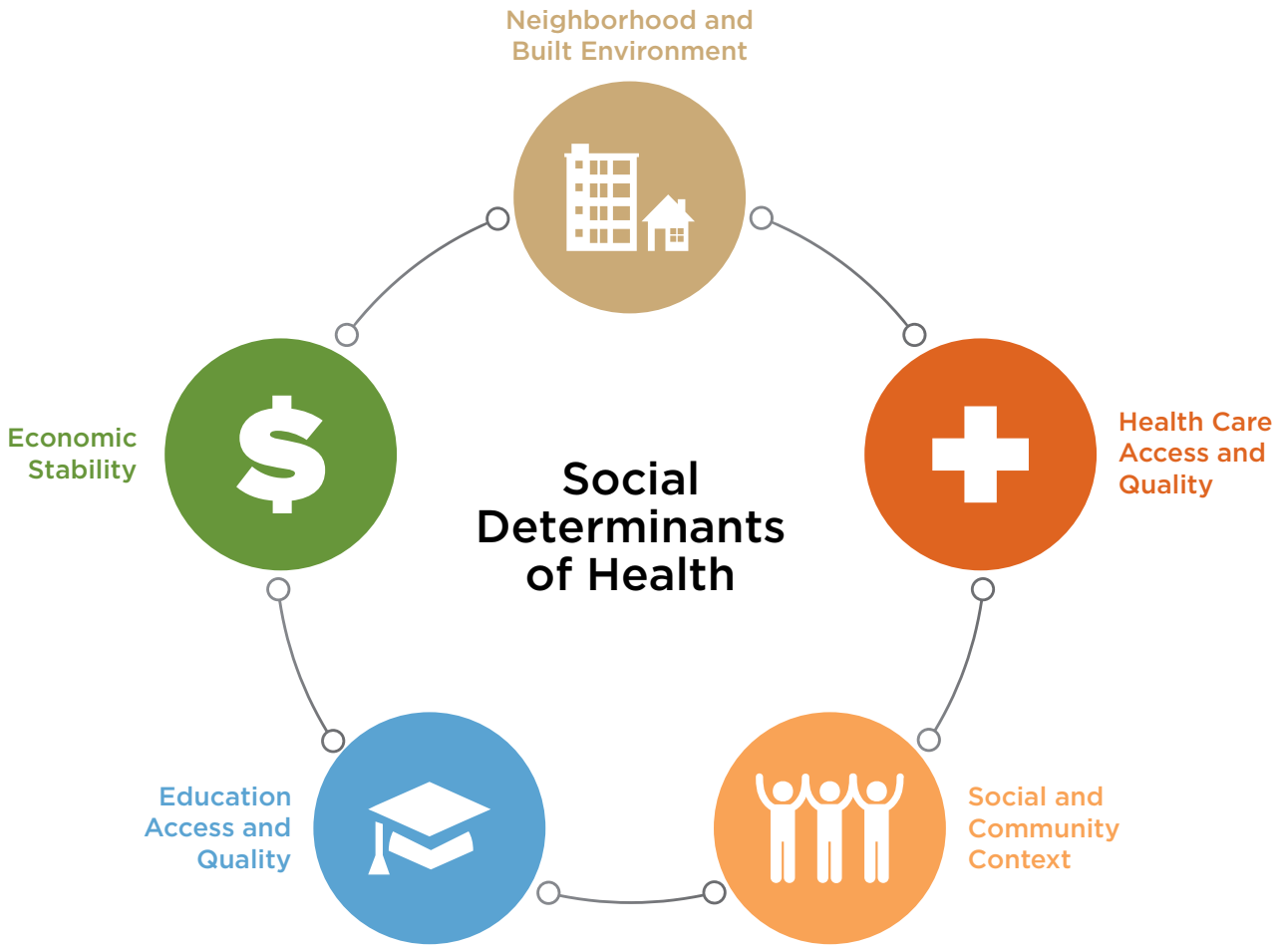
- **Learn about health and wellbeing in our community**
- **Inform decisions about organizational strategic planning or community programming**
- **Access data about health and wellbeing specific to our community**
- **Indicate where community priorities align with proposed projects for grant applications**
- **Identify opportunities for further exploration and continued conversations between partners**

## COMMUNITY ENGAGEMENT PROCESS

A primary goal for the 2022 CHNA was to center the experiences and priorities of community members most impacted by historical and persistent racial, economic, and health inequities. We focused on collaborating with a diverse range of community partners, creating new connections, listening and learning about the experiences, environments, and systems that influence the health of people in our community. We introduced new engagement processes, such as compensating community member participants to recognize their time and valuable contributions, and made our broadest engagement tool, our Community Survey, available in twelve languages. New data collection methods were adopted to tell a richer, more inclusive story of health in our community. We are grateful to everyone who engaged in this collaborative process and offered their time, expertise, and valuable perspectives. We strive to honor your stories and recognize that "change only happens at the speed of trust."

## GUIDING CONCEPTS FOR THE 2022 CHNA

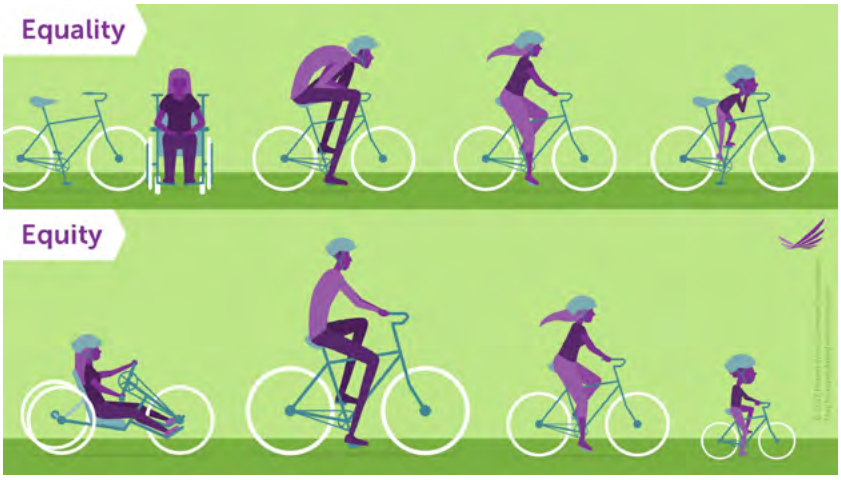
The 2022 CHNA process was guided by two foundational concepts: the Social Determinants of Health (SDoH) and Health Equity. The U.S. Department of Health and Human Services' Healthy People 2030 defines the social determinants of health as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."



To achieve health equity, it is essential to examine the foundational drivers of health -- the social, environmental, economic, and cultural context and conditions that shape health status.

"Health equity exists when all people have a fair and just opportunity to be healthy – especially those who have experienced socioeconomic disadvantage, historical injustice, and other available system inequities that are associated with social categories of race, gender, ethnicity, social position, sexual orientation and disability."

**-VERMONT DEPARTMENT OF HEALTH**




(Robert Wood Johnson Foundation, 2017)

Racism and Economic Instability are widely recognized as root causes driving health disparities. Health disparities are defined as

"a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

**-HEALTHY PEOPLE 2020 ADVISORY COMMITTEE**

Measuring health disparities across groups is important to the work of advancing health and racial equity.

**THE IMPORTANCE OF LANGUAGE:**

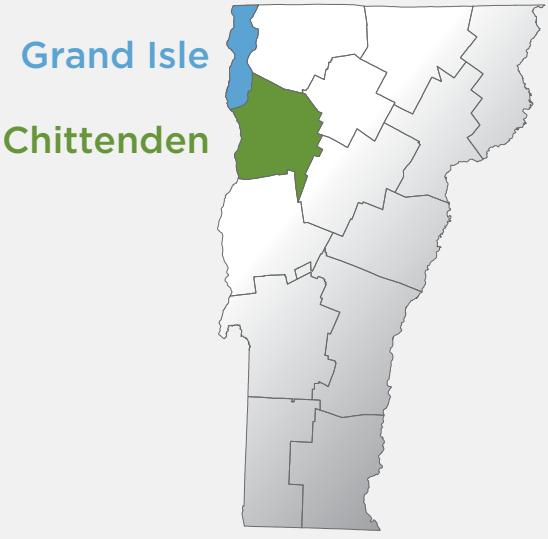
- We recognize how impactful language is and that terminology varies between communities – and evolves over time.
- After consultation with diverse partners, we have adopted shared language that you will see reflected throughout the report.
- Our hope is to identify and communicate common experiences among communities in an effort to build on strengths and address inequities.
- We recognize this work is iterative and limitations may not allow everyone to feel comfortable with the chosen terms.
- Although shared language is essential in assessing and communicating population-level health findings, using person-centered language, and language that people use to describe themselves (self-identification) is the best approach.
- You will see that secondary data sources (including county-level, state and federal data cited within this report) do not always reflect this adopted language. This is a reflection of systemic and racist structures in our society, and shows the need for collecting better data to identify and address health disparities across race, ethnicities, and cultures.

# About Our Community

## Introduction

The UVM Medical Center (UVMMC) serves patients from a broad geographic region. For the purpose of this assessment, the hospital's defined community consists of Chittenden and Grand Isle Counties[3]. This community will be referred to as the Health Service Area (HSA)[4].

This section provides a snapshot of the demographic and socio-economic characteristics of the community using available data from the United States Census Bureau's American Community Survey. The indicators will be provided for the Health Service Area along with the State of Vermont as whole for comparison. Many of these indicators are featured in later sections of this report with additional levels of disaggregation (separation into parts).




**HEALTH SERVICE AREA TOTAL POPULATION:**

**175,616 residents**

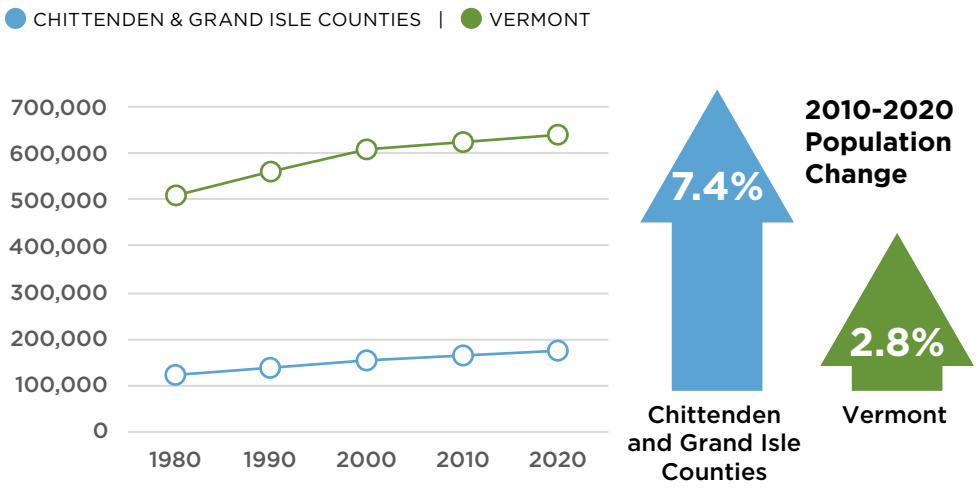
SOURCE: Secondary Data[1]

| CHITTENDEN COUNTY | GRAND ISLE COUNTY |
|---|---|
| Largest county in Vermont with 25% of the state's population | Second least populated county in Vermont, with approximately 7,200 residents |
| Fastest population growth rate in the state: 7.8% | Third fastest population growth rate in the state: 4.6% |
| Vermont's most racially and ethnically diverse county | Third least racially and ethnically diverse county in Vermont |
| 19 municipalities spanning a mix of urban, suburban, and rural communities | 5 municipalities situated on two islands in Lake Champlain and a peninsula along the Canadian border |
| Economic center for northwestern Vermont | Agriculture, second homes, and tourism are key economic drivers |

## POPULATION DEMOGRAPHICS

Chittenden and Grand Isle Counties, like the State of Vermont as a whole, have been increasing in population since 1980 and earlier. However, this region has seen a higher rate of population growth in comparison to the rest of the state between 2010 and 2020. Chittenden County, Vermont's most populous county, is home to 168,323 residents while Grand Isle County has 7,293 residents.

### POPULATION BY DECADE



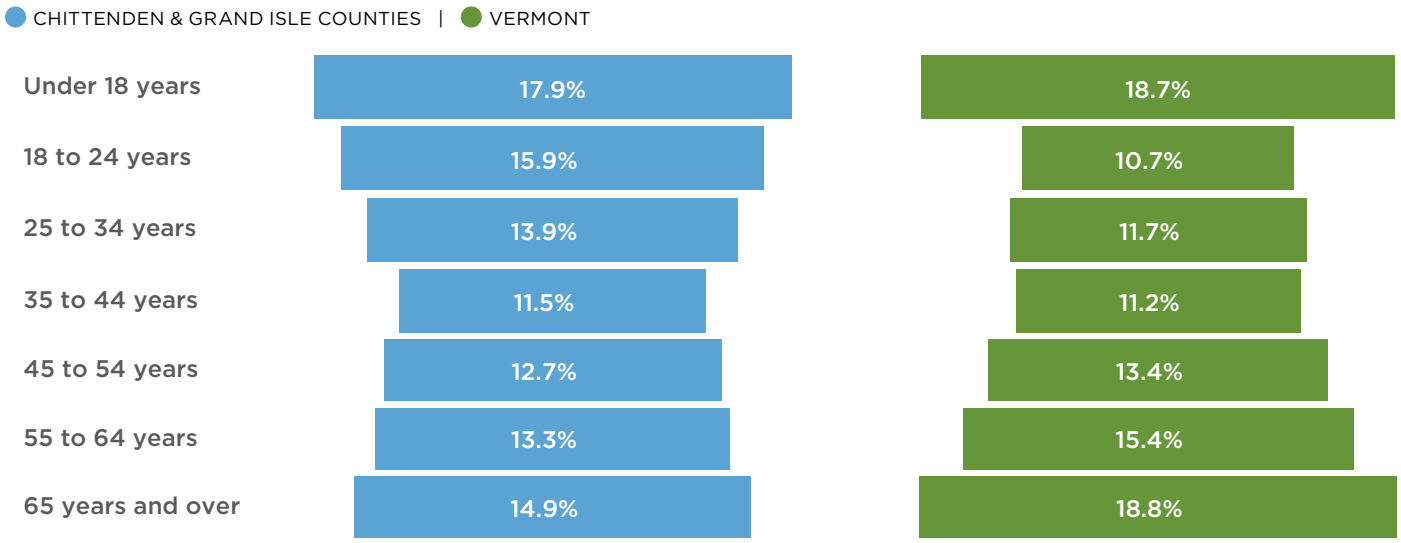

SOURCE: Secondary Data[1, 2]

### DEMOGRAPHIC HIGHLIGHTS

- The Health Service Area population is growing at a faster rate than the state of Vermont.
- Chittenden County continues to be the most racially and ethnically diverse county in Vermont.
- The median age for Chittenden County residents is lower than both that of Grand Isle County residents and the state of Vermont.
- 1 in 8 residents in Chittenden and Grand Isle Counties are below the federal poverty level.
- Median household incomes have increased across the Health Service Area yet disparities remain by race and ethnicity and sex.
- The overall high school graduation rate is 94% yet disparities are evident by race and ethnicity.

The median age of Chittenden County residents (36.5 years) is lower than the median age of Grand Isle County residents (48.2 years) by more than 10 years. The statewide median age was 42.9 years. Together, the residents of Chittenden and Grand Isle Counties are younger compared to the state of Vermont overall.

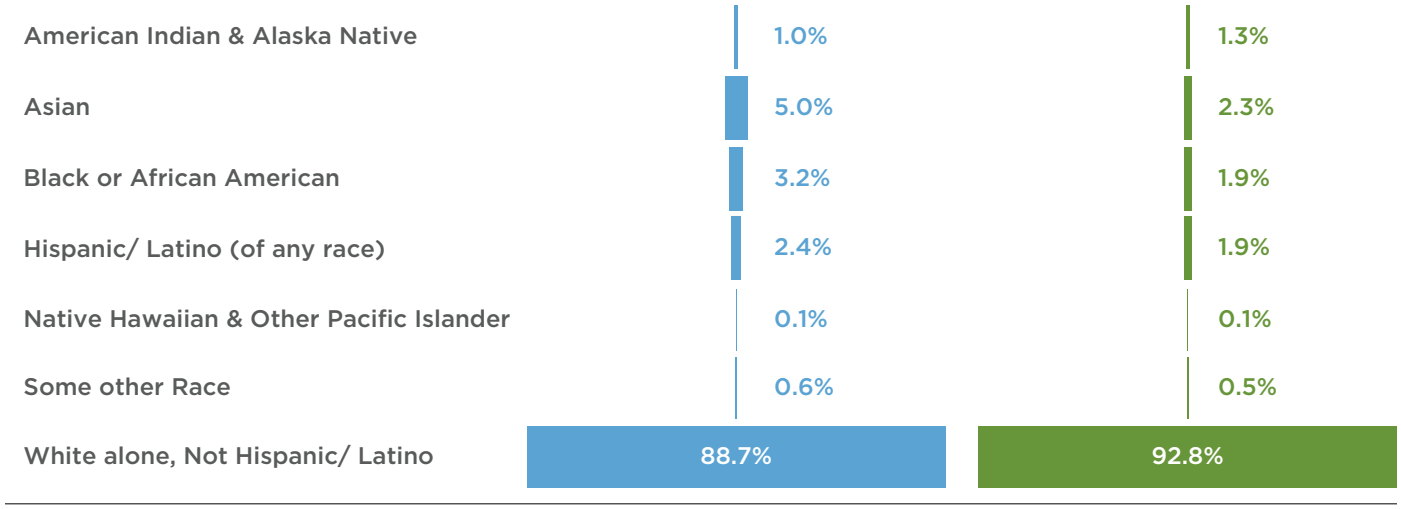
### AGE BREAKDOWN FOR CHITTENDEN AND GRAND ISLE COUNTIES AND VERMONT[4]




SOURCE: Secondary Data[2]

Chittenden County is the most racially and ethnically diverse of Vermont's fourteen counties and is home to a larger percentage of "limited English-speaking households." A "limited English-speaking household" is one in which no member 14 years and over speaks only English "very well." Slightly more than 3% of households in the region are households with limited English-speaking, increasing from 3.0% from 2009-2014 to 3.4% in 2015-2019.[3]

### POPULATION BY RACE AND ETHNICITY[5]




SOURCE: Secondary Data[4]

Median household income has increased in both Chittenden County and Grand Isle County more than the statewide median between the two reporting periods.

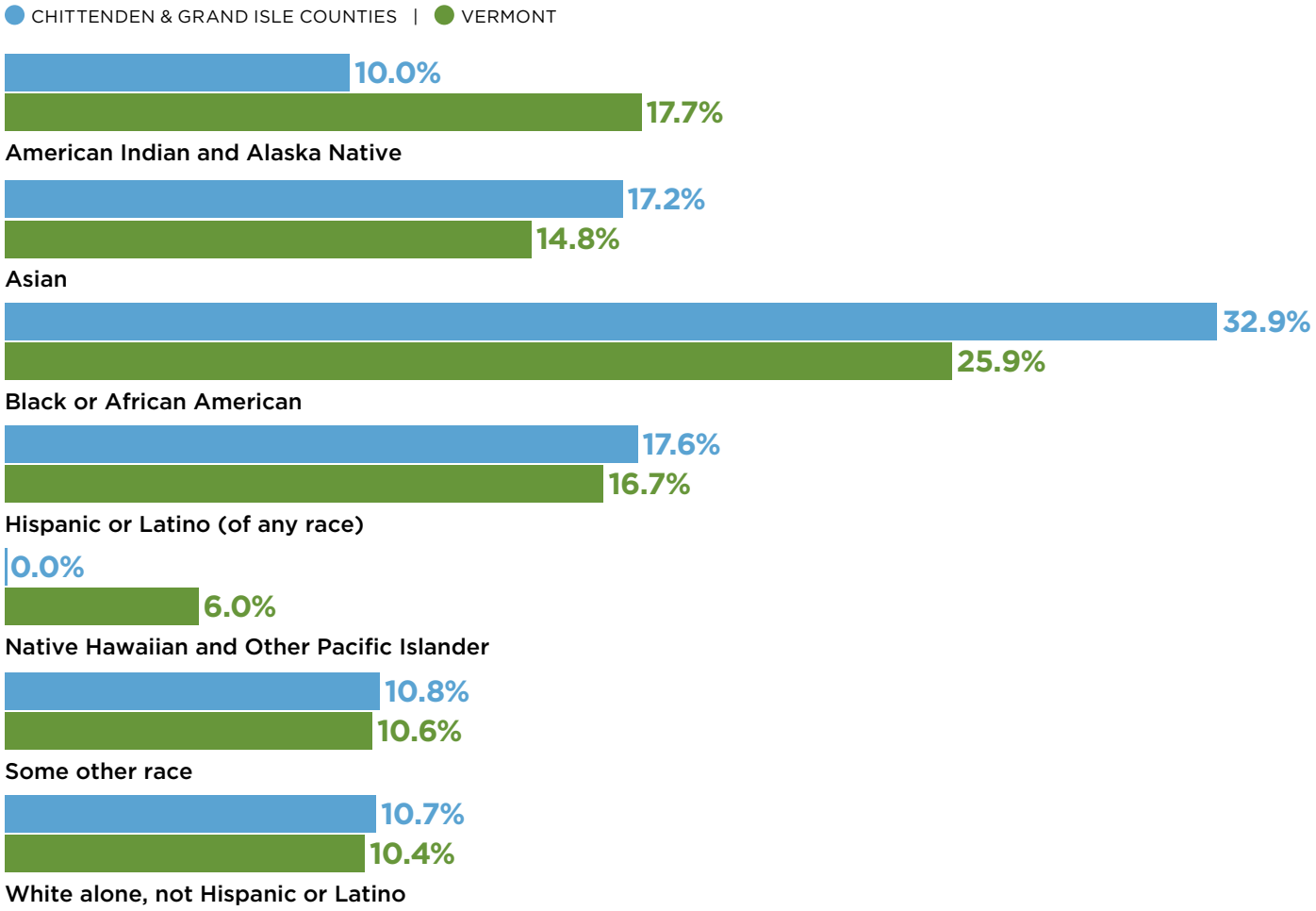
**MEDIAN HOUSEHOLD INCOME**

| | 2010-2014 | 2015-2019 | DIFFERENCE ($) |
|---|---|---|---|
| Chittenden County | $64,243 | $73,647 | $12,308 ↑ |
| Grand Isle County | $61,338 | $71,587 | $10,249 ↑ |
| Vermont | $54,447 | $61,973 | $7,526 ↑ |

SOURCE: Secondary Data[5]

While median incomes for both counties are higher than the state of Vermont as a whole, 1 in 8 residents in Chittenden and Grand Isle Counties are below the federal poverty level. This is a slightly higher rate than the state.

**FEDERAL POVERTY STATUS BY HOUSEHOLD RACE AND ETHNICITY, 2015-2019**




SOURCE: Secondary Data[6]

**Additional information includes:**

**12.6%**
of those under 18 years of age are below the federal poverty line

**29.3%**
of those with less than a high school diploma are below the federal poverty line

**12.8%**
of females versus 11.0% of males are below the federal poverty line

SOURCE: Secondary Data[6]

Examining poverty status by race and ethnicity shows significant income disparities between different groups in the community. For example, 1 in 3 Black or African American households are below the federal poverty status compared to 1 in 10 white, non-Hispanic/Latino/x households within Chittenden and Grand Isle Counties.

The U.S. Census Bureau estimates approximately 11% of Chittenden and Grand Isle County residents have a cognitive or physical disability. While data was not available for Grand Isle, Chittenden County residents with a disability are more likely to be considered to have "poverty status" by federal guidelines compared to residents without a disability.

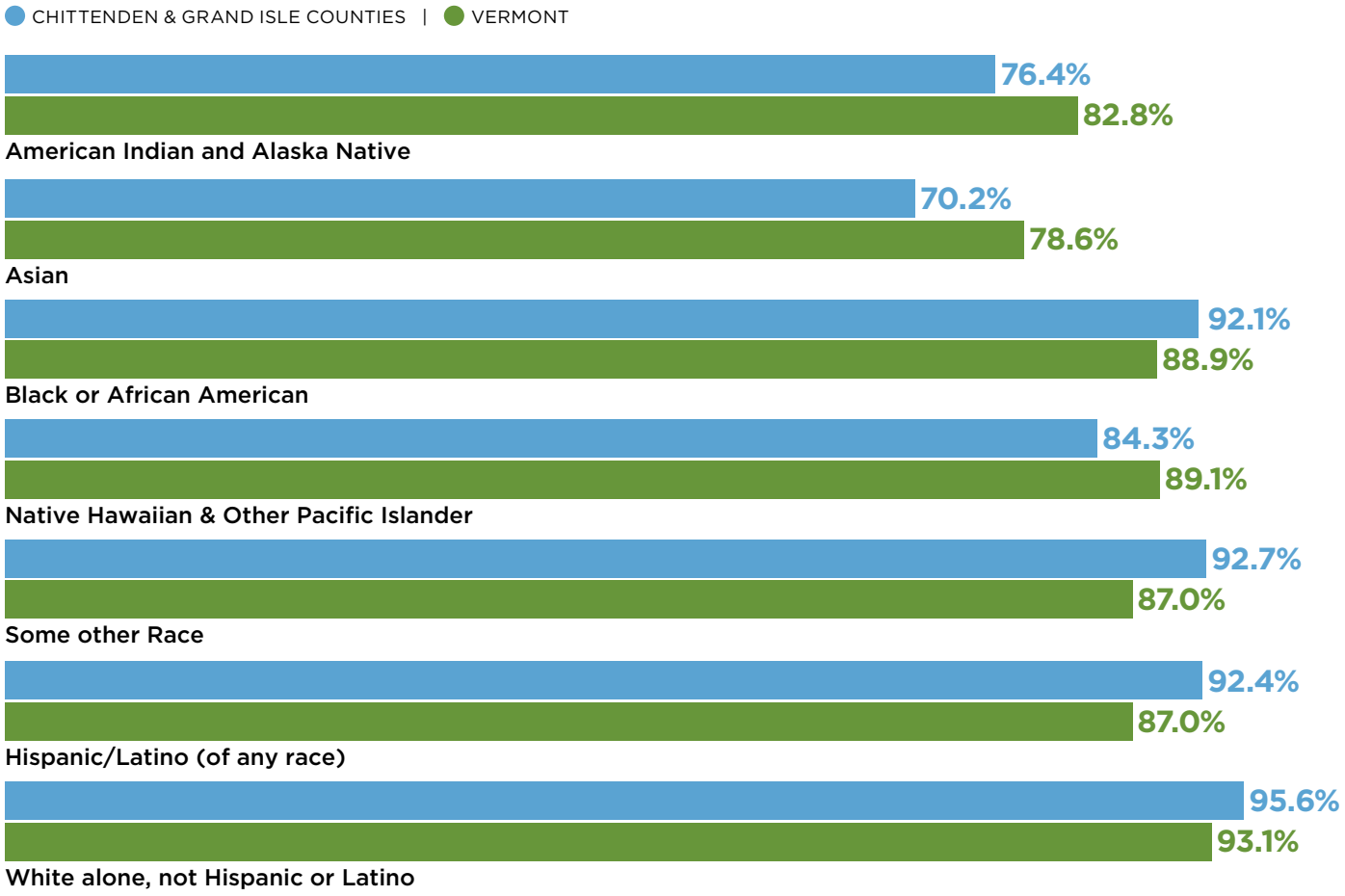
**POPULATION AGE 16 AND OVER FOR WHOM POVERTY STATUS IS DETERMINED -WITH AND WITHOUT A COGNITIVE OR PHYSICAL DISABILITY**

| 2015-2019 | WITH A COGNITIVE OR PHYSICAL DISABILITY | WITHOUT A COGNITIVE OR PHYSICAL DISABILITY |
|---|---|---|
| Vermont | 19.0 | 8.9 |
| Chittenden County | 21.2 | 10.6 |
| Grand Isle County | NA | NA |

SOURCE: Secondary Data[7]

Over 94% of area residents aged 25 or older have completed their high school degrees or higher levels of education. In a similar trend to the state, the American Community Survey estimates slightly more females than males have at least a high school degree. High school graduation rates are lower for American Indian & Alaska Native, and Asian residents in Chittenden and Grand Isle Counties compared to the rest of the state.

### HIGH SCHOOL GRADUATION OR HIGHER - 2015-2019 ACS




SOURCE: Secondary Data[8]

## POPULATIONS OF FOCUS

The CHNA process is an opportunity to learn and reflect on the health and wellbeing of the community. Using a health equity lens, the data gathering and community engagement activities provided insights into the unique experiences and perspectives of populations who have been historically under or unrepresented in previous assessments. It is important to focus on the groups most burdened by inequities to ensure that the goal of health equity is advanced and disparities are addressed. Working with existing secondary data and gathering our own primary data, we have sought to provide disaggregation for these populations of focus throughout the priority findings.

- Black, Native American, and People of Color
- People who are non-binary, genderqueer, fluid, and transgender
- People with Limited English Proficiency (LEP)
- People with disabilities
- People who are LGBTQ+
- Older adults over 65 years of age
- Refugees & newly immigrated individuals
- People experiencing poverty or lower socio-economic status
- Youth

## KEY HEALTH AND WELLBEING INDICATORS

The Secondary Data Work Group developed a secondary data matrix of community health indicators. The Work Group reviewed more than 70 leading population-level health indicators from a variety of secondary data sources.

These sources ranged from internal data from the UVMMC and the Community Health Centers of Burlington, to the Vermont Department of Health and the United States Census Bureau. This table provides these data over time for the region organized by the Department of Health and Human Services' Healthy People 2030 social determinants of health domains.

| Positive, Increasing | Positive, Decreasing | Positive, No Change | Negative, Increasing | Negative, Decreasing | Neutral, Increasing | Neutral, Decreasing | Neutral, No Change |
|---|---|---|---|---|---|---|---|

| INDICATOR | PREVIOUS REPORTING PERIOD | CURRENT REPORTING PERIOD | TREND |
|---|---|---|---|
| **Domain: Health Care Access** | | | |
| Adults who cannot obtain care or delay care | 7% | 6.5% | ↓ |
| Dentists per 100,000 | 40 | 43 | ↑ |
| Insured | 95% | 97% | ↑ |
| Mental health professionals per 100,000 | n/a | 423 | n/a |
| Primary Care Physicians per 100,000 | 90 | 81 | ↓ |
| **Domain: Health Outcomes** | | | |
| Adult Diabetes prevalence | 6% | 6% | ● |
| Adults Binge Drink | 21% | 22% | ↑ |
| Adults over 20 years who are obese | 21% | 25% | ↑ |
| Adults who smoke cigarettes | 14% | 12% | ↓ |
| Adults with a Depressive Disorder | 24% | 22% | ↓ |
| Adults with Asthma | 9% | 9% | ● |

SOURCE: Secondary Data

| INDICATOR | PREVIOUS REPORTING PERIOD | CURRENT REPORTING PERIOD | TREND |
|---|---|---|---|
| Adults with COPD | 3% | 4% | ↑ |
| Adults with Poor Mental Health | 11% | 15% | ↑ |
| Adults with Poor Physical Health | 8% | 9% | ↑ |
| Arthritis | 49% | 44% | ↓ |
| Hypertension | 24% | 25% | ↑ |
| Opioid Related Deaths per 100,000 | 10 | 13 | ↑ |
| Suicide rate per 100,000 | 12% | 12% | ● |
| Youth in HS Marijuana Use | 23% | 21% | ↓ |
| **Domain: Health Care Utilization** | | | |
| Adults ages 50-75 receiving colorectal screening | 73% | 76% | ↑ |
| Adults ages 65 and older receiving flu shot in the last year | 65% | 63% | ↓ |
| Blood cholesterol checked in last 5 years | 77% | 81% | ↑ |
| Children receiving blood lead test in first three years of life | 1,566 | 1,637 | ↑ |
| Children receiving recommended vaccines | 68% | 77% | ↑ |
| Children who received a developmental screening in first three years of life | 65% | 80% | ↑ |
| Women ages 21-65 receiving Cervical Cancer Screening | 93% | 87% | ↓ |
| Women ages 50-74 with mammogram in last 2 years | 83% | 79% | ↓ |

SOURCE: Secondary Data

| INDICATOR | PREVIOUS REPORTING PERIOD | CURRENT REPORTING PERIOD | TREND |
|---|---|---|---|
| **Domain: Education Access & Quality** | | | |
| Educational Attainment (High School Graduate or Higher) | 94% | 94% | ● |
| Kindergarten Readiness | 91% | 87% | ↓ |
| Third Grade Reading Level | 54% | 56% | ↑ |
| **Domain: Financial Stability** | | | |
| Households receiving food stamps/SNAP benefits | 11.7% | 8.4% | ↓ |
| Housing cost burden (Households paying 35% or more of household income) | 29% | 27% | ↓ |
| Population below Federal Poverty Level | 11.1% | 11.9% | ↑ |
| Unemployment rate | 4.5% | 2.6% | ↓ |
| **Domain: Neighborhood & Built Environment** | | | |
| Days with particulate matter over the standard (air pollution) | 0% | 0% | ● |
| Housing units built before 1940 as percent of total units | 20% | 18% | ↓ |
| Low access to a grocery store for low-income residents | 12% | 10% | ↓ |
| Rental unit vacancy rate | 6.5% | 2.8% | ↓ |
| Renter-occupied as percent of all occupied housing units | 28% | 27% | ↓ |

**SOURCE:** Secondary Data

| INDICATOR | PREVIOUS REPORTING PERIOD | CURRENT REPORTING PERIOD | TREND |
|---|---|---|---|
| **Domain: Social & Community Context** | | | |
| High school students bullied in past 30 days | 19% | 18% | ↓ |
| Households with children | 26% | 23% | ↓ |
| Limited English-speaking households | 3% | 3.3% | ↑ |
| Middle school students bullied in past 30 days | 23% | 18% | ↓ |
| Seniors living alone | 37% | 38% | ↑ |
| Single-parent households | 28% | 28% | ● |
| Teen pregnancy rate per 1,000 | 19.3 | 7.40 | ↓ |

**SOURCE:** Secondary Data

Note: The data sources and timeframes of reporting periods vary by indicator. For more information, please see pages 86-87 in the Appendix.

## COVID-19 IMPACTS

The COVID-19 pandemic has impacted all aspects of life for Vermonters, including the residents of Chittenden and Grand Isle counties. Many people experienced job loss or disruption, first time or increased food insecurity, increased anxiety and depression, and prolonged treatment of chronic health conditions. The Vermont Department of Health reported increased substance use and increased opioid-related fatalities in Chittenden County, from 17 opioid-related fatal overdoes in 2019 to 38 fatal overdoes in 2021.

Between March 2020 and May 2022, there have been more 36,000 reported cases of COVID-19 in Chittenden and Grand Isle Counties. Of the 654 Vermont deaths attributed to COVID-19 during the same time period, nearly 28% of those were in Chittenden and Grand Isle Counties.

| LOCATION | CUMULATIVE COVID-19 CASES SINCE MARCH 2020 | COVID-19 DEATHS |
|---|---|---|
| Chittenden County | 34,882 | 177 |
| Grand Isle County | 1,140 | 5 |
| State of Vermont | 129,464 | 654 |

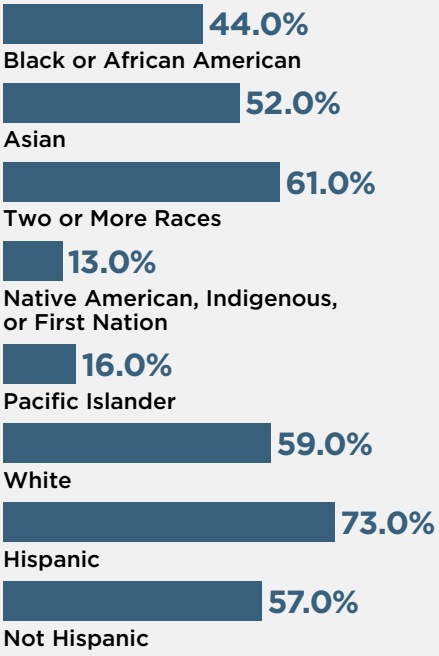
Note: data as published by the Vermont Department of Health through May 16, 2022

SOURCE: Secondary Data[9]

The State of Vermont has fared better than other areas of the country with COVID-19 vaccination rates. However, the most current vaccination data available from the Vermont Department of Health in March 2022 does show differences in vaccination rates by race and ethnicity.

The pandemic also highlighted the community's collective strength, resilience, and goodwill through supporting each other, the development of new programs and the allocation of additional funding to address urgent and emergent needs. As COVID-19 evolves, there is a heightened acknowledgment to critically examine persistent systemic inequities in an inclusive, culturally humble way.

### VERMONTERS AGED 5+ WITH UP TO DATE COVID-19 VACCINATIONS




SOURCE: Secondary Data[10]

- **Native American, Indigenous, or First Nation Vermonters have the lowest rate of up to date vaccinations while Vermonters of two or more races have the highest rate.**
- **Black Vermonters have a lower rate of up to date vaccinations compared to white Vermonters and Asian Vermonters.**
- **Hispanic Vermonters have a higher rate of up to date vaccinations compared to non-Hispanic Vermonters.**

# Data Gathering and Community Engagement

## Overview

Data gathering and community engagement for the 2022 CHNA began in May 2021. This multi-phased assessment, overseen by the CHNA Steering Committee, was conducted through the lens of health and racial equity. Data for this assessment was gathered through four methods: a community-wide survey, focus groups, key informant interviews, and existing population data sets.

The Center for Rural Studies at the University of Vermont led the data gathering and analysis activities. CRS and the UVMMC Community Benefits Team facilitated community meetings and coordinated the Steering Committee and Work Groups.

WORK GROUPS COLLABORATED ON:

- **Defining frameworks for data collection that centered the social determinants of health domains and health equity**
- **Identifying key informant interviewees**
- **Conducting key informant interviews**
- **Recruited focus group participants**
- **Promoting the community survey**
- **Informing the selection of population-level health indicators**

# Engaging the Community in the Data Gathering Process

Data collection for the 2022 CHNA required a collaborative effort among the Steering Committee and key community partners to hear from as many voices as possible. No single method in the data gathering process can fully capture community strengths, disparities, and significant health needs. Therefore, a mixed methods approach was used to collect data in a variety of ways. Centering findings from the qualitative data collection allowed us to examine important factors. In particular, it brings focus and context to the experiences of populations that previously were not included and had been lost in the white dominant narrative. This approach creates a more accurate picture of the overall health and wellbeing in Chittenden and Grand Isle Counties.

## KEY INFORMANT INTERVIEWS:

Key informants were intentionally selected from all areas of the social determinants of health domains. We emphasized the experience of those impacted by historic and persistent inequities. Interviews were conducted by Work Group members and key themes were analyzed by CRS researchers. Thirty-two key informants participated in the interview process. Due to COVID-19, most interviews were conducted virtually by Work Group members. The key informants worked in a number of community settings: school districts, health care services, economic development organizations, town elected positions, and faith communities.

## SECONDARY DATA:

The Secondary Data Work Group identified and selected existing community indicators from across broad domains of community health and wellbeing. The process was based on evidence-based, community health indicators research and publications. Community health indicators from past CHNAs were reviewed and then organized by the Social Determinants of Health domains by the U.S. Department of Health and Human Services' Healthy People 2030 initiative, with the exception of the Health Care Access and Quality domain. This domain was divided into three categories: Health Outcomes, Health Care Utilization, and Health Care Access. The Work Group then selected indicators most relevant to the 2022 CHNA using criteria that included factors such as: data availability, ability to analyze over time, timeliness, relevance to the community, and ability to disaggregate by selected population characteristics.

**DATA COLLECTION ACTIVITIES AT A GLANCE:**

### Key Informant Interviews:
**July 2021**

**32** interviews with community leaders and champions

### Secondary Data:
**August 2021**

**70+** population-level health and wellbeing indicators

### Community Survey:
**September 2021**

**3,771** community member responses

### Focus Groups:
**November 2021**

**5** focus groups

### Community Health Priorities Sessions:
**January 2022**

**140** participants from **57** organizations and agencies

**DATA SOURCES INCLUDED:**

- UVM Medical Center
- Community Health Centers of Burlington
- The Vermont Department of Health's Healthy Vermonters 2020 Data Explorer
- University of Wisconsin Population Health Institute's County Health Rankings data aggregation portals
- U.S. Census Bureau

To address data gaps from these sources, several Community Survey questions were designed to collect data that was unavailable from existing sources.

## COMMUNITY SURVEY:

The Community Survey aimed to examine social and environmental conditions that contribute to people's health and wellbeing.

The Community Survey was the most wide-reaching opportunity to hear from community members ages 16 and older about their perspectives and experiences. Incentives were offered to randomly selected survey respondents to increase participation. Trusted community leaders helped to promote the online survey. One-on-one support was provided by interpreters from the Association of Africans Living in Vermont and the U.S. Committee for Refugees and Immigrants-Vermont, to reach community members using their primary languages. Incentives were provided to respondents who completed the survey with interpreters in recognition of the additional time necessary to complete the survey.

The 2022 Community Survey was the first CHNA survey to be offered in multiple languages.

**With the assistance of the UVMMC Language Access Services Team and consultants, the survey was offered in the following languages:**

- Arabic
- American Sign Language
- Burmese
- English
- French
- Kirundi
- Maay Maay (spoken)
- Nepali
- Somali
- Spanish
- Swahili
- Vietnamese

## FOCUS GROUPS:

Focus groups were held to gain a deeper understanding of the experiences of certain groups who face unique challenges to achieving health and wellbeing. Focus group data provides stories and examples of how participants experience health challenges, what existing solutions can be leveraged, and what barriers need to be addressed. The Work Group informed the selection of the focus groups and reviewed the questions used during the sessions. While each of the focus groups represent distinct populations, overlapping and repeating themes helped generate ideas that benefit the greater community.

**The five focus groups included were:**

- Older adult residents at an assisted living facility
- Parents and caregivers of children with mental health challenges and disabilities
- Abenaki community members
- Individuals with housing insecurity experiences
- High School-aged youth

# Data Limitations

While efforts were made to gather the most inclusive, relevant, timely, and reliable data to tell the story of health and wellbeing in the community, it is important to recognize that each method for gathering data has limitations. This section describes the limitations and identifies gaps that were encountered as part of this process.

## SECONDARY DATA:

The most recent public data that can be reviewed for this purpose is from 2019. Time lags between data collection and reporting periods are a common challenge with large secondary data sets. For this CHNA cycle, secondary data is further limited because it does not reflect the changing social and economic conditions due to the COVID-19 pandemic. In addition, many population data sets, such as the American Community Survey conducted by the U.S. Census Bureau, do not collect demographic information in a way that is fully inclusive of the diverse community members of Chittenden and Grand Isle County. Therefore, information cannot be broken down in a way that accurately reflects our population, or not at all.

## COMMUNITY SURVEY:

The Community Survey was promoted through Steering Committee members' organizations and networks to reach as many people as possible. A convenience sampling method was used so that any interested community member 16 years or older could participate. While the survey enabled over 3,700 residents to share their perspectives and experiences related to health and wellbeing, the results are not considered to be fully representative of the whole health service area due to this sampling strategy. However, the community survey provides valuable information beyond what is available from secondary data sources.

## KEY INFORMANT INTERVIEWS AND FOCUS GROUPS:

Key Informant Interview participants were selected for their knowledge of health needs in Chittenden and Grand Isle Counties. Focus group participants were recruited with the assistance of key community partners and members of the Steering Committee. Three of the five groups were held in person due to a combination of technological limitations and participant comfort levels. It is important to note that qualitative research should always be considered as representative only of the participants included in the sample and not the whole community.

# Analyzing Findings and Selecting Health Priorities

Data collected from each of the four methods was analyzed to identify emerging health priorities within the community. Findings were selected based on the "threshold descriptions" for each method as shown below.

| DATA GATHERING METHOD | THRESHOLD DESCRIPTION |
|---|---|
| Community Survey | Most selected action to improve the community, per SDoH domain, OR more than 20% disagree with the statement about their community |
| Key Informant Interviews | Top five needs based on content analysis of key informant interviews |
| Focus Groups | Emerging findings based on analysis within and across focus groups |

These three data gathering methods produced 16 unique emerging health priorities. To select the three emerging health priorities identified in this report, the CHNA Project Team facilitated three stages of discussion and voting. This process is described in the following steps:

## STEP 1: PROJECT TEAM REVIEW

The CHNA Project Team first met to analyze the preliminary emerging health priorities. The goal of this process was to combine closely related findings. The result was a list of 10 emerging health priorities.

## STEP 2: STEERING COMMITTEE VOTING

The list of 10 emerging health priorities was then brought to the Steering Committee for their feedback. The project team discussed the findings and methods for selection. Steering Committee members were then asked to rate the findings based on ability to impact health equity. All Steering Committee members were given the chance to rate priorities from 1 to 4, with 1 being the least ability to impact health equity and 4 being the greatest ability.

| THE SIX TOP PRIORITIES WERE IDENTIFIED AS (IN ALPHABETICAL ORDER): |
|---|
| Accessible and coordinated care |
| Cultural humility and inclusive health care |
| Food access and security |
| Housing |
| Mental health and wellbeing |
| Workforce development |

## STEP 3: COMMUNITY HEALTH PRIORITIES SESSIONS:

Finally, the Project Team hosted two virtual sessions in January 2022 to gather additional feedback to confirm the six emerging priorities. Over 500 community members from a range of organizations, community groups, and agencies were invited to participate. Over 140 community members participated across the two virtual sessions—exceeding the participation of those in previous CHNA prioritization sessions.

### ATTENDEES REPRESENTED SECTORS SUCH AS:

- housing
- transportation
- health care
- faith-based organizations
- early education
- secondary and post-secondary education
- local and state government
- hunger and food access
- community centers
- other multi-program hubs

Many attendees represented a range of members and advocates from identities including but not limited to LGBTQ+, veterans, Black, Indigenous, and People of Color; refugees, immigrants and English language learners; and those with physical and cognitive disabilities.

**During the priority sessions, CHNA data findings were presented for each of the six priorities. Immediately after the presentation, participants spent time in breakout rooms, with 5-7 participants, reflecting and discussing the following questions:**

- Drawing on your experiences, which of these emerging health priorities resonate most strongly with you?
- What community assets relate to these emerging health needs?

Once the small group discussions were completed, participants were asked to rate the six priorities using three criteria via an electronic survey. The exact wording of the three criteria used during the voting is show below:

| CRITERIA |
| --- |
| **[IMPACT]** We can make a difference. Investing in this area has the potential for powerful, measurable improvements for health and wellbeing in our community. |
| **[COMMUNITY READINESS]** Working together can help make the greatest impact. We have the capacity as a community to address this need. Some resources and networks may already exist, and assets could be built upon to address this priority. |
| **[EQUITY]** Equity exists when all people have a fair chance to be healthy. Many systems in our society make it harder for those of a certain race, gender, ethnicity, social position, sexual orientation, and disability status, to attain their highest level of health. |

Following these sessions, CRS researchers analyzed the quantitative and qualitative findings.

**THREE HEALTH PRIORITIES EMERGED FROM THE SIX PRIORITIES PRESENTED:**

- Cultural Humility and Inclusive Health Care
- Housing
- Mental Health and Wellbeing

The top three health priority findings were then presented to the Steering Committee. Steering Committee members then had the opportunity to consider the following questions for each of the three priorities:

- What is working well currently?
- Where can our community focus resources to make meaningful health improvements?
- Who should be at the table? Consider inclusion of community stakeholders and groups who have not been engaged to date and how they can contribute moving forward.

These conversations validated the three top community health priorities, which are presented in greater detail within Section 4.

# Community Health Priorities

## Overview

This section presents the key findings from the 2022 Community Health Needs Assessment organized by the six community health priorities that emerged from the assessment process. Each community health priority features qualitative and quantitative findings that offer valuable context and community insights.

**THE SIX COMMUNITY HEALTH PRIORITIES, IN ALPHABETICAL ORDER, ARE:**

- **Accessible and Coordinated Care**
- **Cultural Humility and Inclusive Health Care**
- **Food Access and Security**
- **Housing**
- **Mental Health and Wellbeing**
- **Workforce Development**

PRIORITY

# Accessible and Coordinated Care

## INTRODUCTION

The ability to access coordinated care for all Chittenden and Grand Isle County residents is important for supporting community health and wellbeing.

COVID-19 posed extreme challenges for accessing care in a variety of settings and significantly strained the health care workforce. It also highlighted the pre-existing challenges and once again demonstrated the difference in outcomes between races and ethnicities. The pandemic inspired creative approaches to care delivery that can inform future efforts—especially for meeting the needs of groups who face systemic barriers to care.

> "Accessing primary care providers is really difficult for people working third shifts for example. We need more affordable and accessible care outside of the 9-5, Monday to Friday."
>
> **-COMMUNITY LEADER**

SOURCE: Key Informant Interview

## ACCESSIBLE AND COORDINATED CARE AT A GLANCE

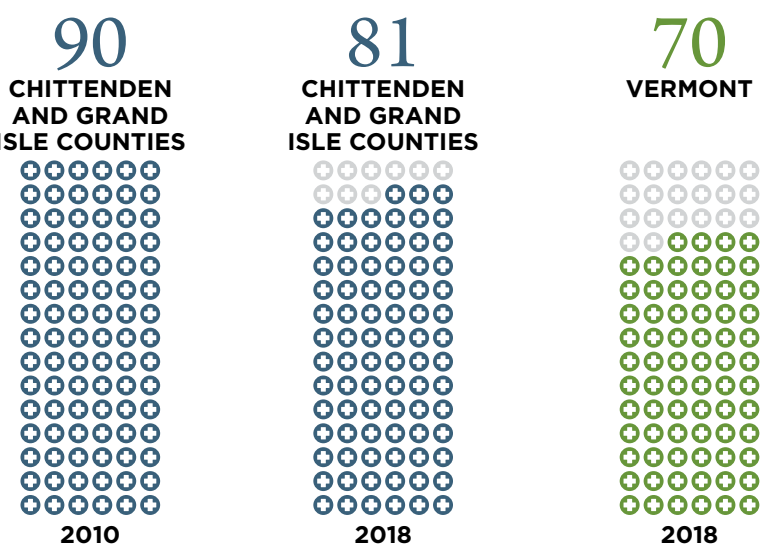
There are many factors that impact coordinated and accessible care. The lack of availability of primary care providers, multiple hospital systems with different Electronic Health Record systems, the complexities of the health care systems and more. There is a lack of availability of providers that reflect the population racially and culturally which impacts those seeking help. This section details key themes that emerged from the data gathering process.

**These include:**

- challenges accessing reliable transportation to health care services
- demand for care coordination between providers
- stress related to provider wait times
- the need to increase access to care outside of typical business hours
- challenges related to accessing telehealth
- increasing access to substance misuse recovery support resources

Additional challenges include systemic issues with the health care system. Many challenges were further heightened by the COVID-19 pandemic. The health care workforce has been strained and community members continue to encounter significant delays in care.

### DECLINING PRIMARY CARE PHYSICIANS




SOURCE: Secondary Data[11]

**46.1%**

**of the Community Survey respondents chose "increased coordination of care between providers" as a top action for promoting health and wellbeing in the community.**

SOURCE: Community Survey

**6.5%**

**percent of adults report delaying or not being able to access care at all.**

SOURCE: Secondary Data

**45%**

**of Community Survey respondents would like to see more primary care services.**

SOURCE: Community Survey

## HEALTH INSURANCE

The percentage of people with health insurance coverage has increased from 95% (2010-2014) to 97% (2015-2019) within the Health Service Area. However, there are differences in coverage by race and ethnicity. For example, 15% of American Indian and Alaska Native are uninsured which exceeds the statewide percentage of 13%. Those who are uninsured or underinsured have limited options for where and when they seek health care. Health insurance rates and services covered vary by plans making more comprehensive coverage costly and out of reach for some.

SOURCE: Secondary Data[12]

## NAVIGATING COMPLEX HEALTH CARE SYSTEMS

Community leaders shared concerns about the complexities of the health care system and how people access services. One community leader shared the need to, "look at the entire system from a whole-person perspective—not just the specific, direct health services needed." Another community leader called for increased coordination between health care institutions and community-based groups for transitions of care. This would allow community members to return home from more intensive in-patient settings with appropriate levels of support and services.

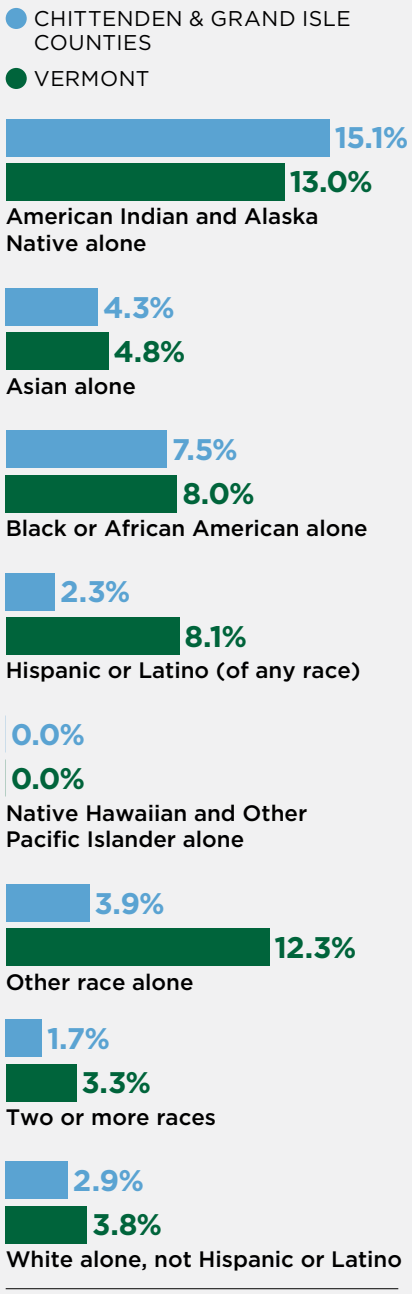
Community leaders also discussed the turnover rate of primary care providers as a challenge. This was noted as being especially difficult for patients with chronic health conditions and a history of trauma – making it hard to establish trusting, long-lasting relationships with care providers. One focus group participant shared his experience of significant delays between receiving a cancer diagnosis and waiting two months to have a follow-up appointment to determine a treatment plan. Another participant described her disheartening experience of paying into a dental insurance plan for over a year before realizing that no dental providers in the area accepted her insurance.

"Having affordable dental or eye care for low-income seniors is obscene. I know how to call around and get some help but many people do not. I tell everyone I know to use 211."

**-COMMUNITY SURVEY RESPONDENT**

SOURCE: Community Survey

### PERCENT UNINSURED BY RACE AND ETHNICITY 2015-2019




SOURCE: Secondary Data[13]

Participants from a focus group held with older adults shared the difficulty of tracking referrals from their primary care providers to specialists and making sure that medical records are being shared. Multiple participants shared that printed materials designed for those with poor eyesight or a health care resource directory geared toward older adults would be helpful. Gaps in medical record sharing between primary care providers, the hospital system, and dental providers causes frustration. Using technology and managing various passwords for internet-based support is a significant challenge. Additionally, limited access to reliable internet and technology was identified by some focus group participants with lower incomes as a challenge to accessing health care and navigating community services. They shared experiences that illustrated the difficulty they face when trying to connect to community services, complete applications, or forms necessary for assistance. With a fixed number of minutes on cell phone plans, long wait times on hold were also identified as a significant concern. As one community leader summarized,

> "Access to health care is based on availability of the resources instead of what the community needs. We need to build our systems to meet the needs of the community."
>
> **-KEY INFORMANT INTERVIEW**

SOURCE: Key Informant Interview

## TRANSPORTATION CHALLENGES

Community leaders and residents alike identified the lack of transportation as a key challenge in accessing health care services. Transportation challenges can vary across the community. A community leader noted that transportation to preferred providers for LGBTQ+ community members is a challenge, stating "yes, there are many issues in our community and many services to help, but if people can't get to them, they're useless." Several leaders identified limited public transportation options with routes and schedules while others noted that there are simply no public transportation options in many outlying rural areas. One leader described "Public transportation makes it complicated; people may choose to just work instead. It could just take too long to get to the appointment and miss work. They may not have WiFi, may not have a car, and may not have the flexibility at work." This example illustrates how barriers can add up and make accessing health and wellbeing resources more difficult for certain groups of community members.

> "Not everyone works at a desk job where they can call their primary care office or other medical providers and be put on hold for 25 minutes or longer. Or go through the complexity of four layers of push button selections to speak with the proper department—imagine if it is not even your first language."
>
> **-KEY INFORMANT INTERVIEW**

SOURCE: Key Informant Interview

## IMPORTANCE OF COMMUNITY-BASED CARE DELIVERY APPROACHES

Given the significant transportation challenges raised by focus group members, it was not surprising to learn that residents greatly appreciated options for services in their community—serving people where they are and at times outside the "9 to 5" weekday hours. Several community leaders mentioned that a lack of after-hours care, challenges of long wait times, and fear of costs has led people to seek assistance from the Emergency Department when issues become urgent.

There are examples of this approach already being used in the community. For example, one focus group participant shared, "The Safe Harbor Clinic comes here once a month. I think [it] would be beneficial to have someone come once a week, not a necessarily a doctor, but someone who could check vitals, like my blood pressure is weird, little things that could be checked without having to make an appointment and figuring out how to get there." A community leader noted that by drawing on lessons learned from delivering important health services, such as pop-up vaccines clinics, progress can be made especially for people without paid sick time or flexible work hours. Working with community partners to provide access to care outside of traditional settings was identified as a key opportunity for improvement. Others noted that some organizations lack the support and investment from the community to be able to expand services they already offer or launch new efforts.

> "BIPOC [led] organizations should lead in organizing and offering health services as these organizations have the community connections, trust, and knowledge—they're just lacking the financial capital and the seats at the table."
>
> **-COMMUNITY LEADER**

SOURCE: Key Informant Interview

PRIORITY

# Cultural Humility and Inclusive Health Care

## INTRODUCTION

Everyone deserves respect and dignity when accessing health care.

The following definition for Cultural Humility has been adopted for this process: "a lifelong commitment to self-evaluation and critique, to addressing the power imbalances in the physician-patient dynamic and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (p. 123 in Tervalon & Murray-Garcia, 1998).

It is critical to provide access to inclusive, high-quality health care in settings where all community members feel safe, respected, and understood.

### A BARRIER TO HEALTH & WELLBEING

Community leaders discussed a lack of culturally competent care in different ways:

- **Lack of language accessibility services at all points of care for community members with limited English proficiency**
- **Lack of diversity within the professional health care workforce**
- **Community members not feeling safe or understand in health care setting due to institutional racism (systems that reinforce racial inequality)**

## CULTURAL HUMILITY & INCLUSIVE HEALTH CARE AT A GLANCE

Investing in and promoting cultural humility and inclusive health care can improve health for groups that have been impacted by historical and persistent inequities. Many groups expressed a need for greater understanding and respect from health care providers, including Abenaki, older adults, people who have recently moved to the United States as refugees or immigrants, and individuals of a variety of gender identities and sexual orientations. Increasing cultural humility training for care providers, encouraging more dignity for older adults in care settings, improving language access services, and cultivating a more diverse health care workforce emerged as key strategies for providing more inclusive health care.

"A healthy community is one where all people have access to quality health care – where they have the information they need to make informed choices. They have access to experts who provide clear info to whomever is asking the questions – where information is communicated in language that is digestible and accessible to everyone."

**-COMMUNITY LEADER**

SOURCE: Key Informant Interview

Several key informants spoke of mistrust in local health care systems from groups of community members that have been structurally marginalized while others noted how many health care professionals default to a "western perspective" (one that reinforces white-dominant culture) with Indigenous patients or patients who are refugees or immigrants.

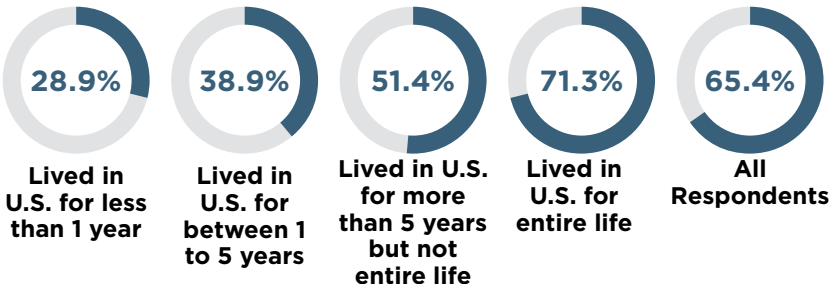
## RECOGNITION & RESPECT IN HEALTH CARE SETTINGS

Stories from focus groups and key advisor interviews point to a need for health care providers that represent and understand the many cultures, races, and ethnicities represented in the community. The need for more diversity among the health care workforce was discussed, as well as more cultural competency training for current providers to foster deeper appreciation for a greater breadth of patient experiences and perspectives.

The Community Survey asked respondents to rate their level of agreement with the statement, "health care providers respect my identity" from strongly agree to strongly disagree. Overall, 65.4% of respondents reported strong agreement. When broken down by race and ethnicity, gender, and sexual identity, it is clear that there are differences in levels of respect felt by respondents.

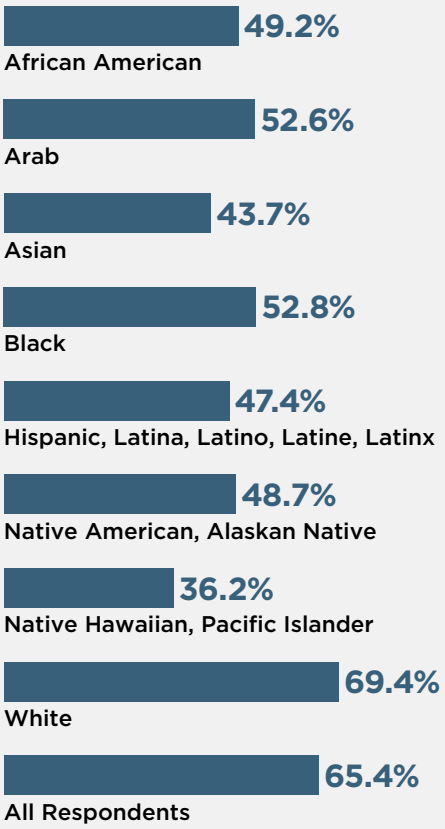
When responses are broken down by length of time lived in the United States, those who have lived in the United States for 5 years or less, are less likely to feel that health care providers respect their cultural identities. For those who have lived in the U.S. for less than 1 year, only 1 in 3 individuals feel their cultural identity is respected by health care providers.

### RESPONDENTS FEELING THAT "HEALTH CARE PROVIDERS RESPECT MY CULTURAL IDENTITY" BY AMOUNT OF TIME LIVED IN THE UNITED STATES




SOURCE: Community Survey

### COMMUNITY SURVEY RESPONDENTS FEELING THAT "HEALTH CARE PROVIDERS RESPECT MY CULTURAL IDENTITY"




SOURCE: Community Survey

> "BIPOC people don't feel safe, especially Black and Latino people, in health care settings—they are subjected to bias and discrimination at all levels of service provision."
>
> **-COMMUNITY LEADER**

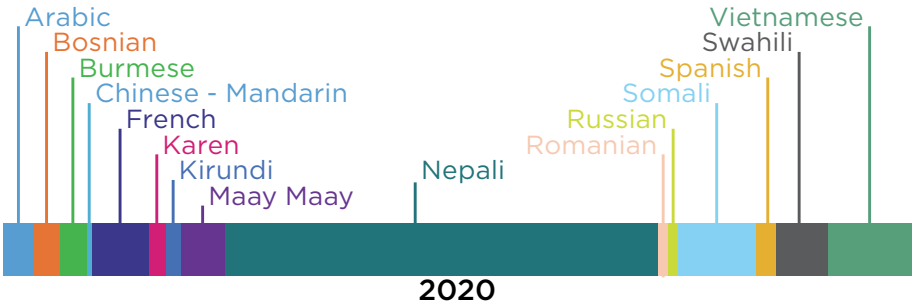
SOURCE: Key Informant Interview

## LANGUAGE ACCESS

The Community Survey asked community members to rate their level of agreement with the statement: "My language needs are met by health care providers." Approximately 68% of all respondents strongly agreed with this statement. However, community members who have lived in the United States for less than five years are more likely to experience challenges with language access.

Language access data are currently collected by the Community Health Center of Burlington (CHCB) and UVMMC. Total numbers and percentage breakdowns of health services encounters where English was not the primary language and where interpretation services were requested are provided below. These numbers do not reflect instances where a family member was present and interpreted during the visit (note: this is commonly observed across health care settings but is not considered best practice).

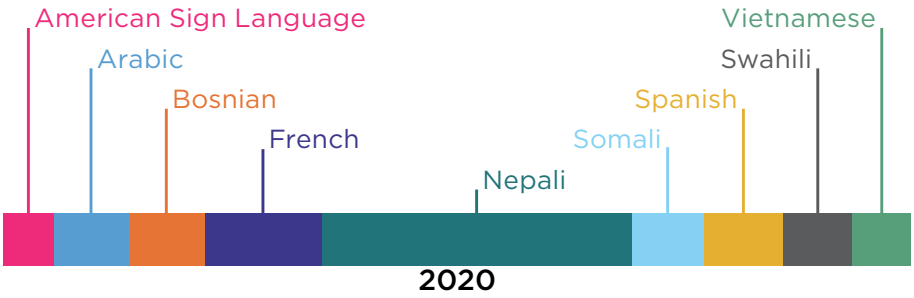
### INTERPRETATION LANGUAGES REQUESTED AT COMMUNITY HEALTH CENTERS OF BURLINGTON HEALTH CARE VISITS




*Does not match to total interpreter requests due to data collection.

SOURCE: Secondary Data[14]

### LANGUAGES FOR PATIENT VISITS AT UVMMC OTHER THAN ENGLISH

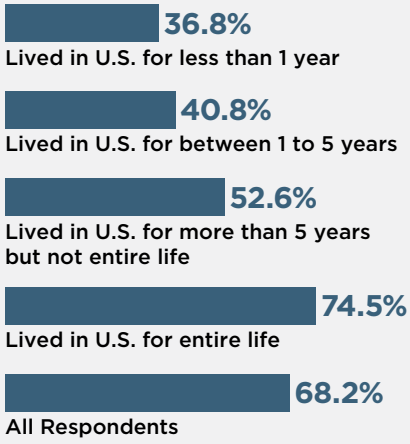



SOURCE: Secondary Data[15]

UVMMC patient language data in 2020 show that the majority of patients (98.5%) spoke English of a total 1,053,386 total patient visits. Of languages that were not English, Nepali, French, and Spanish were the most frequent.

### COMMUNITY SURVEY RESPONDENTS WITH LANGUAGE NEEDS BEING MET BY AMOUNT OF TIME LIVED IN UNITED STATES

PERCENT OF RESPONDENTS WHO STRONGLY AGREED




SOURCE: Community Survey

### RECOGNIZING THE CONNECTION BETWEEN CULTURE AND HEALTH

Multiple community leaders spoke to the importance of respecting how cultural, religious, and spiritual beliefs guide health and wellbeing. For example, a local religious leader shared their experience in providing information to community members about COVID-19 vaccines and religious beliefs and practices. They described how COVID-19 prevention practices were well-aligned with religious practices to promote healthy behaviors. "Community based resources" were repeatedly mentioned as a source of support for physical and mental health during a focus group held with Abenaki community members. Specifically, having a shared space to be together, sing, and perform ceremonies, played a substantial role in the mental well-being of Abenaki participants. The Vermont Indigenous Heritage Center (VIHC) was identified by focus group participants as a valuable resource. As one participant put it, "if I know I can go there and I can be with people who understand... that's the program to help me." A shared cultural space, like VIHC, is a model that can be replicated in other communities where all members can feel safe, supported, and understood. For example, a community leader working with refugees and individuals who have recently immigrated to the United States called for creating, "social spaces where people feel like they belong, where they can connect with others, and create neighbor-to-neighbor opportunities for helping each other."

### LACK OF CULTURAL UNDERSTANDING BY HEALTH CARE PROVIDERS

Abenaki community members spoke of negative experiences where the western health care system does not understand or reflect their culture during a focus group session. One participant shared the experience of talking to his doctor about his skin cancer concerns. Despite knowing others diagnosed with skin cancer in his community, his doctor told him, "Abenaki don't have problems with skin cancer." The doctor's lack of cultural understanding and shared concern affected both the physical and emotional well-being of the participant. For her, it was less about a specific health need and more about another focus group member shared feeling that health care providers don't understand her or how her culture influences her health care decisions and needs. She was particularly frustrated by doctors' lack of understanding of Abenaki culture when trying to navigate a wellness plan for her elderly mother. She says, "very seldom do I see any doctors expressing interest in who she really is and they just start working with what they see on a piece of paper." Her mother's health record doesn't capture the whole picture of her health needs.

#### NEED FOR INCREASED DATA

- **Cultural humility and inclusive health care is an area that has limited secondary data points available at the time this assessment was conducted.**
- **Not enough population-level data has been collected across sources to comprehensively identify needs or track initiatives related to this priority.**
- **This assessment seeks to draw attention to the need for increased data and to collect baseline information to understand perspectives on inclusivity and belonging.**
- **UVMMC is currently conducting a system-wide gap analysis of needs to further identify and address inequities.**

### GENDER IDENTITY

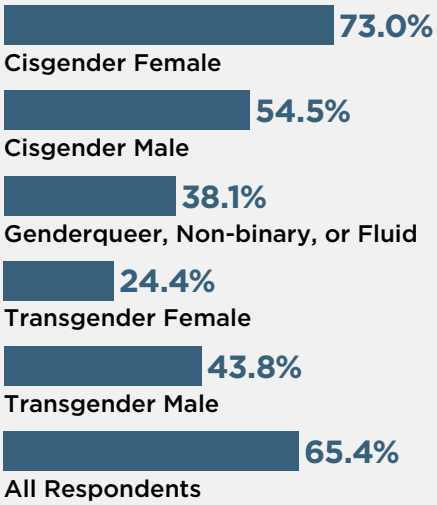
The Community Survey asked respondents to rate their level of agreement with the statement, "health care providers respect my gender identity" from strongly agree to strongly disagree. Overall, 65.4% of respondents reported strong agreement. Respondents who are genderqueer, non-binary, gender fluid, or as transgender female or transgender male, overall reported a lower level of agreement.

### SEXUAL ORIENTATION

The Community Survey asked respondents to rate their level of agreement with the statement, "health care providers respect my sexual orientation" from strongly agree to strongly disagree. Overall, 69.2% of respondents reported strong agreement. Lower levels of respect experienced during interactions with health care providers were reported by asexual, queer, gay and lesbian respondents.

RESPONDENTS FEELING THAT HEALTH CARE PROVIDERS RESPECT MY CULTURAL IDENTITY BY GENDER IDENTITY

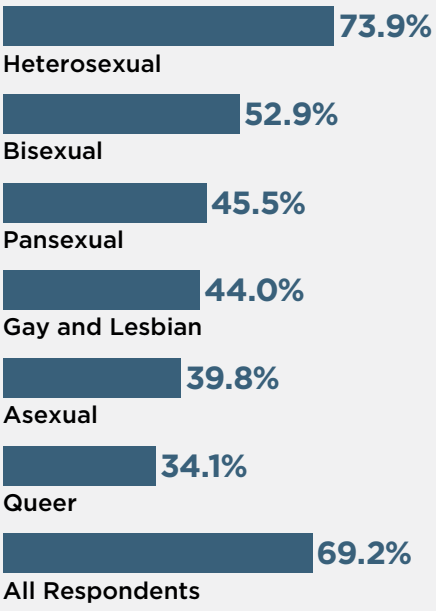
PERCENT OF RESPONDENTS WHO STRONGLY AGREED




SOURCE: Community Survey

RESPONDENTS FEELING THAT HEALTH CARE PROVIDERS RESPECT MY CULTURAL IDENTITY BY SEXUAL ORIENTATION

PERCENT OF RESPONDENTS WHO STRONGLY AGREED




SOURCE: Community Survey

## INDEPENDENT LIVING SUPPORTS FOR ADOLESCENTS WITH DISABILITIES AND MENTAL HEALTH CHALLENGES AS THEY TRANSITION TO ADULTHOOD

A focus group was held with parents and caregivers of children with mental health challenges and disabilities. Participants shared their desire to ensure the safety and independence for their children when they were no longer available as caregivers. To do so, parents highlighted the need for more supportive living options for children and young adults with disabilities. One participant, whose son was in his early 20s, had direct experience with navigating the transition to early adulthood:

> "I have nothing against all the wonderful services that hopefully are in place [for early childhood], but these kids grow up and those needs change, but they still exist, as we folks are aging, and it doesn't behoove us to think that forever these children will live with us and we will take care of them."
>
> **-FOCUS GROUP PARTICIPANT**

SOURCE: Focus Group

Other parents echoed the need for more supportive programs that will enable their children to succeed if they have to or want to live independently. "Our children are going to be the next adults trying to live on their own," one parent remarked, continuing "if we can't prepare them because the funding isn't available to do that, that is just not acceptable." This quote reflects the recognition that funding for these initiatives is limited or not available.

### THE NEED TO BE HEARD BY HEALTH CARE PROVIDERS

A focus group with older adult community members reported a range of experiences with accessing health care and provider interactions. Several reported experiences where they felt medical providers did not fully listen to their health concerns or priorities. One participant shared, "what matters most to me is being heard by my health care providers. And I mean really heard. Not someone saying, 'this is what I want you to do' but rather someone that asks, 'is this what would you like?' To really hear me and not try to just tell me what do to because they're the doctor." Another participant shared that while she felt her family and physician were currently in alignment about her health needs and quality of life, she had concerns about that changing if she had a health crisis.

> "I haven't hit a crisis point yet to really know whether or I am going to be heard. Many people don't understand how difficult it is to communicate or be heard when you're in your 80s—until you're in your 80s."
>
> **-FOCUS GROUP PARTICIPANT**

SOURCE: Focus Group

A recommendation from the focus group participants was to increase provider training about geriatric care, with specific emphasis on listening and treating patients with dignity. Participants described instances of not having their questions answered or concerns addressed, which led them to believe their providers felt their health was not important given their age.

PRIORITY

# Food Access and Security

## INTRODUCTION

Families and individuals experience food security when they have reliable access to healthy, culturally appropriate foods. The ability to purchase food is influenced by finances and the overall cost of living. Some other barriers include lack of transportation, health and mobility issues that make it challenging to cook or shop, and limited availability of foods that meet cultural or dietary needs.

This section discusses key community needs and opportunities to improve food security within Chittenden and Grand Isle Counties.

### WHAT COMMUNITY LEADERS SHARED:

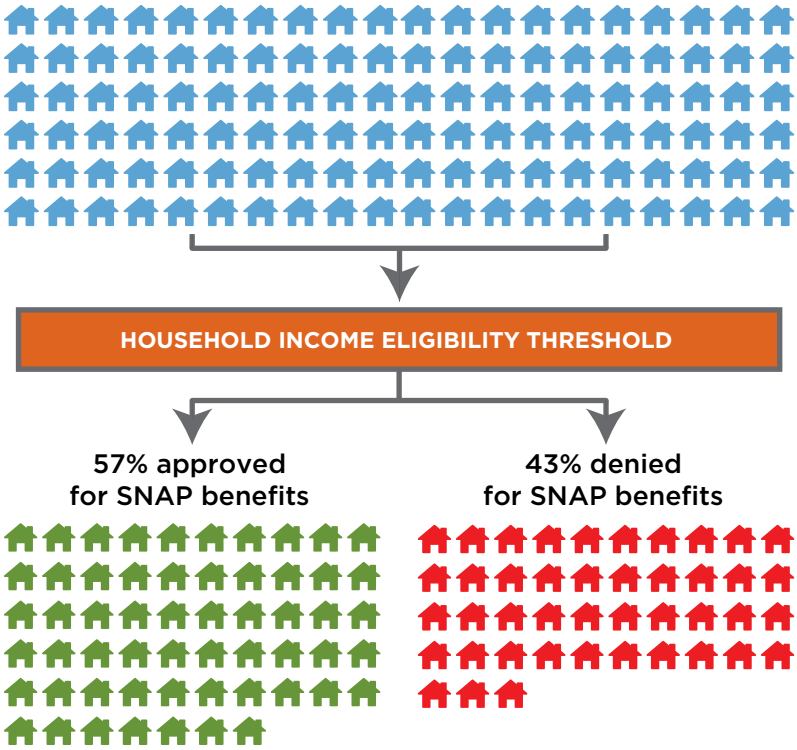
- **Transportation is a barrier for residents to get the food they need**
- **Stigma can impact individuals' participation in food assistance programs**
- **Need for expanded home delivery meal services**
- **Current free school meals need to incorporate higher quality, more nutritious foods**
- **Community gardens are an important asset to household food security**

SOURCE: Key Informant Interviews

## FOOD ACCESS AND SECURITY AT A GLANCE

The Supplemental Nutrition Assistance Program (SNAP), often referred to as Food Stamps, is a federal food program that serves households that meet eligibility requirements based on income or age (this program is called 3SquaresVT in Vermont). Although enrollment in 3SquaresVT is one way to measure the state of food security, data from 2019 demonstrates that almost half of Vermonters who are considered food insecure have incomes above the eligibility threshold (Feeding America, 2019).

**Food Insecure Households in Need of SNAP Benefits**




This data was not available for Grand Isle County.

SOURCE: Secondary Data[16]

This finding indicates that there are additional community members experiencing food insecurity beyond those who are eligible for federal food assistance – emphasizing a need for additional resources to address food security.

# 1 in 3

**Vermonters have experienced food insecurity since March 2020**

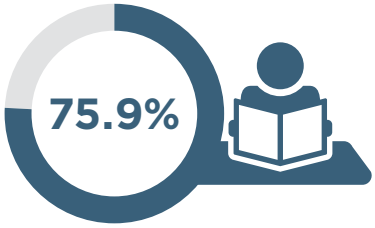
Food insecurity in Vermont is at an all-time high since the start of COVID-19 (McCarthy et al., 2021).

This number has increased from the estimated 1 in 10 Vermonters experiencing food security in 2019 (Feeding America, 2019).

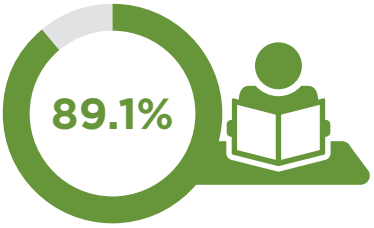
### YOUTH & FOOD SECURITY

Youth are particularly vulnerable to the impacts of food insecurity. Households with children were more than twice as likely to experience food insecurity since the onset of the pandemic (McCarthy et al., 2021). Fortunately, due to federal funding, all school aged children in Vermont were eligible for meals at no-cost during most of the COVID-19 pandemic. Prior to this, youth who are eligible to receive free or reduced lunch (FRL) are generally found to perform lower on the Kindergarten Readiness Index, demonstrating a connection between access to healthy and adequate foods, income status, and educational outcomes.

#### FREE AND REDUCED LUNCH ELIGIBILITY AND KINDERGARTEN READINESS




**Students who do qualify for Free and Reduced Lunch are considered "kindergarten ready"**




**Students who do not qualify for Free and Reduced Lunch are considered "kindergarten ready"**

SOURCE: Secondary Data[17]

### OVERCOMING TRANSPORTATION CHALLENGES

Transportation was a key challenge for focus group members living in one housing community—even with a grocery store relatively nearby. Several members shared how difficult it was to get back and forth from their home to grocery stores and other community resources. Residents shared that despite attempts to get a bus stop located closer than the half-mile walk, they weren't sure if their attempts had been heard. Participants did report using the Special Services Transportation Agency (SSTA) for getting to medical appointments, but this was not a resource available for grocery store trips.

## KEY THEMES

Several emerging themes across data collection methods pointed to challenges with food security in the community. Access to food was the most pressing concern among community members.

**THIS INCLUDES DIFFICULTY WITH:**

- accessing food without reliable transportation
- accessing preferred and culturally appropriate foods
- accessing food for older adults

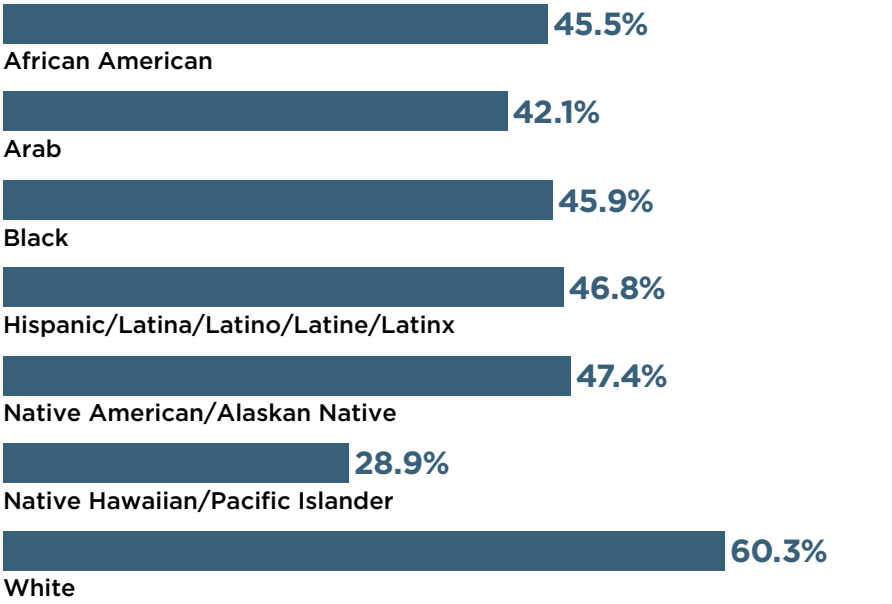
> Being able to walk and go grocery shopping and stuff would be most helpful. You know, most of us don't have cars and it's hard to get around here. The older I get, the more hard it is to be able to do anything."
>
> **-FOCUS GROUP PARTICIPANT**

SOURCE: Focus Group

## ACCESSING PREFERRED AND CULTURALLY APPROPRIATE FOODS

The CHNA Community Survey asked residents two questions about their ability to access foods they want to eat and their support for increasing places to buy healthy foods.

### I CAN GET THE FOOD I WANT TO EAT IN MY COMMUNITY




SOURCE: Community Survey

The importance of accessing traditional foods was mentioned multiple times during a focus group discussion with members of the Abenaki community. One participant described that many health issues prevalent in the Abenaki community occur because they have "gone a long way from what [they] used to eat."

> "I didn't even realize for ten years of my whole life why I was so sick. It's because I'm allergic to half of the foods that are part of our [dominant culture] food system and once a nutritionist told me that, I've started eating foods that are closer to us [Abenaki] and it's changed my life."
>
> **-FOCUS GROUP PARTICIPANT**

SOURCE: Focus Group

Previously in the discussion, members explained that Abenaki evolved to have a very specific diet, one that does not align with the Western diet.

### COMMUNITY SURVEY FINDINGS

**1 in 10**

**respondents "cannot get the foods they want to eat"**

- Nearly 67% of respondents reporting household incomes of $125,000 or more can get the foods they want to eat.
- This is compared to 57% of those earning less than $25,000 or 55% of those earning between $25,000 to $27,000.

**1 in 3**

**respondents would like to "increase places to buy healthy foods"**

- When broken down by race, less than half of residents identifying as African American, Black, Hispanic/Latinx, Arab, Native American/ Alaskan Native, or Native Hawaiian/Pacific Islander strongly agreed that they can get the foods they want to eat.
- Participants identifying as white most frequently reported getting the foods they wanted to eat.

SOURCE: Community Survey

The Community Survey also found a gap in the availability of preferred foods for refugees and immigrants. About 58% of all respondents can access the foods they want to eat. It found that community members who have not lived in the United States for their whole lives were less likely to agree that they can get the foods they want to eat.

### MEALS FOR OLDER ADULTS

Having healthy, nutritious meals is an important driver of health for focus group participants at a residential center for older adults. Participants shared examples of how they stretch their budgets to integrate healthy foods in their diets. Some use the on-site garden space at [their housing community] to grow their own produce and freeze it for use later in the year. Others shared that they pay for meals prepared on-site while others get meals delivered through Meals on Wheels. One focus group participant, who had long enjoyed preparing her own healthy meals for much of her life, described the challenges she encountered with trying to continue her healthy habits in her late 80s:

> "...I found that I was laying on the couch, worrying about [what to eat] and not eating at all. So, I finally ended up using Meals on Wheels because I realized I was losing weight and it wasn't good for me."
>
> **-FOCUS GROUP PARTICIPANT**

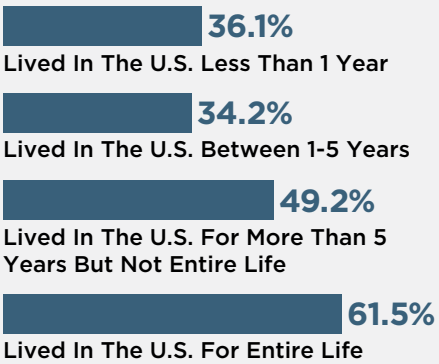
SOURCE: Focus Group

The relative proximity to City Market, a community-owned grocery store, was also highlighted as an asset for the community in terms of access to fresh and healthy foods. Some shared they were able to take advantage of the free grocery delivery service offered during the pandemic. It was also noted that the public bus can be used to access groceries, but that it limits how much one can purchase for any given trip.

**64%**

**of immigrants and refugees cannot get the foods they want to eat**

PERCENT OF COMMUNITY SURVEY RESPONDENTS WHO CAN ACCESS FOODS THEY WANT TO EAT




SOURCE: Community Survey

PRIORITY

# Housing

## INTRODUCTION

Having access to safe and affordable housing is an important factor impacting health and wellbeing for all community members. As one community leader shared, "If you don't have housing, it is extremely difficult to do other proactive things that support a healthy life." This section highlights a variety of housing-related issues in Chittenden and Grand Isle counties—from affordability and availability to quality and safety.

**Nearly 62% of community survey respondents** said that increasing affordable housing units will strengthen the physical environment of their community.

**SOURCE:** Community Survey

## HOUSING AT A GLANCE

Housing costs are a key concern in Chittenden and Grand Isle counties. If a person pays more than 30% of their monthly income for all of their housing-related experiences, they are living in housing that is unaffordable for them. The term "cost-burdened" is used to describe this relationship between housing costs and income.

Lower income households are more likely to live in housing that is unaffordable relative to their income—particularly households earning less than $35,000 per year in our community.

### SURVEY RESPONDENTS WHO...

- are genderqueer, non-binary, fluid, transgender-female or transgender-male
- reported living in the United States for less than 5 years

### ...WERE MORE LIKELY TO REPORT NOT HAVING AFFORDABLE HOUSING THAT MEETS THEIR NEEDS

### COST BURDENED RENTER AND HOMEOWNER HOUSEHOLDS

CHITTENDEN & GRAND ISLE COUNTIES | VERMONT

| YEARS (4 YEAR) | COST BURDENED RENTER HOUSEHOLDS | | COST BURDENED HOMEOWNER HOUSEHOLDS | |
|---|---|---|---|---|
| 2015—2019 | 45.3% | 40.7% | 19.0% | 25.0% |
| 2009—2013 | 44.8% | 41.5% | 25.0% | 27.3% |

SOURCE: Secondary Data[18]

Housing wage data provides a snapshot of what an individual would need to earn per hour to afford a rental unit at HUD's calculated Fair Market Rent for the area.

- Housing wage for 1-bedroom rental unit at Fair Market Rent in 2022: $22.37 per hour
- Housing wage for 2-bedroom rental unit at Fair Market Rent in 2022: $28.85 per hour
- Vermont minimum wage in 2022: $11.75 per hour

SOURCE: Secondary Data[19]

### SPOTLIGHT ON RENTER HOUSEHOLDS

**Approximately 1 in 4 housing units are renter-occupied**

**Renters are more likely to be cost-burdened by their housing costs compared to homeowners**

### COST-BURDENED HOUSEHOLDS BY INCOME

CHITTENDEN & GRAND ISLE COUNTIES

VERMONT

| INCOME | COST BURDENED HOUSEHOLDS | |
|---|---|---|
| Less than $20,000 | 10.2% | 11.0% |
| $20,000 TO $34,999 | 8.8% | 9.4% |
| $35,000 TO $49,999 | 6.2% | 5.4% |
| $50,000 TO $74,999 | 6.1% | 4.7% |

SOURCE: Secondary Data[18]

## HOUSING AVAILABILITY

- Housing vacancy rates are decreasing over time in Chittenden and Grand Isle counties while construction of new homes is slow. These trends have led to increased demand for housing resulting in higher prices and fewer available options to choose from.
- Community leaders identified the lack available rental units that can meet the needs of larger, multi-generational families. Several community leaders specifically noted this challenge impacts families who have moved to the area as refugees and immigrants.

"Housing is an integral part of health. I know of cases where 2-bedroom apartments have 10-person families living there."

-COMMUNITY LEADER

SOURCE: Key Informant Interview

### AVAILABLE RENTAL UNITS OVER TIME

CHITTENDEN COUNTY | GRAND ISLE COUNTY | VERMONT

| | | | |
|---|---|---|---|
| 2015—2019 | 2.0% ↓ | 3.5% ↓ | 4.2% ↓ |
| 2006—2010 | 3.2% | 4.1% | 5.7% |

SOURCE: Secondary Data[20]

### AVAILABLE HOMES FOR SALE OVER TIME

CHITTENDEN COUNTY | GRAND ISLE COUNTY | VERMONT

| | | | |
|---|---|---|---|
| 2015—2019 | 0.8% ↓ | 3.1% ↑ | 1.7% ↑ |
| 2006—2010 | 1.0% | 2.1% | 1.4% |

SOURCE: Secondary Data[20]

## HOUSING AND RACE & ETHNICITY

- **Homeownership is a key strategy to build generational wealth in the United States**
- **Structural racism has led to racial disparities in homeownership rates**
- **White households are much more likely to own their homes (65.5%) while Black or African American households are much more likely to rent their homes (82.5%)**

AMERICAN INDIAN AND ALASKA NATIVE
61.0% RENT | 39.0% OWN

ASIAN
52.6% RENT | 47.4% OWN

BLACK OR AFRICAN AMERICAN
82.5% RENT | 17.5% OWN

HISPANIC OR LATINO ORIGIN
59.5% RENT | 40.5% OWN

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER
38.9% RENT | 61.1% OWN

SOME OTHER RACE
70.1% RENT | 29.9% OWN

TWO OR MORE RACES
46.5% RENT | 53.5% OWN

WHITE ALONE, NOT HISPANIC OR LATINO
34.5% RENT | 65.5% OWN

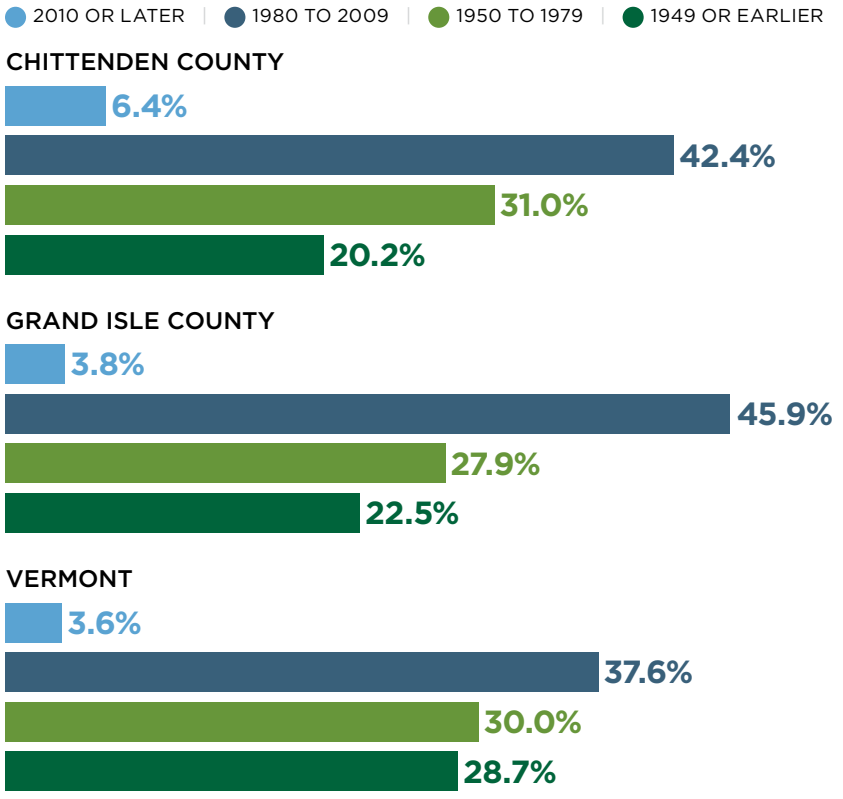
SOURCE: Secondary Data[21]

## HOUSING QUALITY

As housing demand and costs increase, it is also important to consider the quality and safety conditions of available housing in the community. A community leader cited that many lower income residents, especially those who rent, are at higher risk of health issues related to their housing. For example, older units that may not be properly weatherized—leaving residents vulnerable to leaky drafts, mold, and high energy bills. Because of low vacancy rates, renters don't have many options to consider.

Age of housing units is a key indicator often used to describe quality of the housing stock. This graph displays housing units by the year they were constructed. Health and safety issues, such as lead paint or asbestos, can be found in housing units that pre-date the 1980s.

### AGE OF HOUSING STOCK




SOURCE: Secondary Data[22]

# 1 in 6

**households experience severe housing problems**

SOURCE: Secondary Data[23]

**A HOUSING UNIT IS CONSIDERED TO HAVE "SEVERE HOUSING PROBLEMS" IF IT HAS ONE OR MORE OF THE FOLLOWING ISSUES:**

- **Lacks complete kitchen facilities**
- **Lacks complete plumbing facilities**
- **Is overcrowded; or**
- **Household is paying more than 50% of their income for their housing costs**

"There is a lack of affordable, safe housing. There isn't decent housing for families or multi-generational households. Small apartments aren't adequate. New builds are not affordable—all contributes to stress and depression."

**-COMMUNITY LEADER**

SOURCE: Key Informant Interview

## HOMELESSNESS

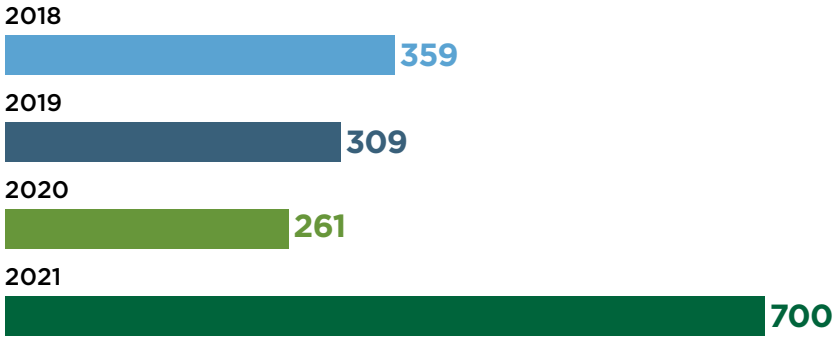
Homelessness is a serious issue that impacts health and wellbeing in the community. A community leader stated that being housed is a basic requirement for health and safety and reflected, "if you are housed successfully for a few years, chances are that your access to health, mental health services, and better quality of life will increase."

The Chittenden County Homeless Alliance conducts the Annual Point In Time (PIT) Count each January. This measure counts the number of individuals and families who do not have permanent housing. This includes those in shelters, transitional housing, hotel rooms, and living in unsheltered locations. The PIT Count has also been conducted in Grand Isle County but no individuals experiencing homelessness have been identified.

It is important to note that the PIT Count is likely to undercount rates of homelessness in the community as people may have unstable, temporary housing with family or friends at the time of the count. However, this measure provides a standardized process for comparing on a year-to-year basis.

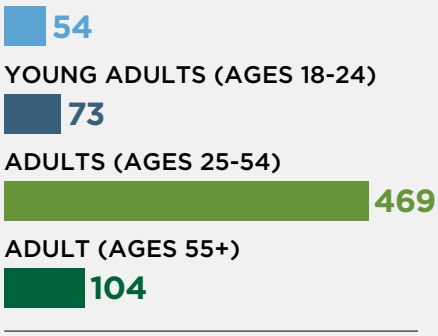
The number of individuals experiencing homelessness increased during the COVID-19 pandemic after several years of declining. Of the 700 individuals experiencing homelessness counted in January 2021, 509 people were being housed at a publicly funded hotel.

### PEOPLE EXPERIENCING HOMELESSNESS IN CHITTENDEN COUNTY BY YEAR




SOURCE: Secondary Data[24]

### INDIVIDUALS EXPERIENCING HOMELESSNESS BY AGE GROUP




SOURCE: Secondary Data[24]

**165**

**Number of households experiencing chronic homelessness**

**111**

**Number of households currently fleeing domestic violence**

**22**

**Number of veterans experiencing homelessness**

SOURCE: Secondary Data[24]

PRIORITY

# Mental Health and Wellbeing

## INTRODUCTION

Mental health and wellbeing are critical for a healthy community.

Mental health was identified as a top health priority in previous CHNAs completed in 2016 and 2019. The COVID-19 pandemic has amplified the importance of mental health and wellbeing within the health care system and the community. Social isolation and anxiety due to the COVID-19 pandemic have raised concerns about mental health and wellbeing. This section details key themes and secondary data that provide insight into trends, gaps in services, and opportunities for action.

As one community leader described, a healthy community is a place,

> "where each individual member of the community and circle feels that this is a place for them that allows them to thrive and succeed. It's not just physical health – it's also mental health, belonging, a sense of community and home. Someone in the community without medical problems but feels alone – that is not a healthy feeling. Feeling like you have a place and voice in your community."
>
> **-COMMUNITY LEADER**

SOURCE: Key Informant Interview

## MENTAL HEALTH & WELLBEING AT A GLANCE

For the Chittenden and Grand Isle County region, there are many key secondary data indicators that show the need for continued work in this area:

- Increased number of adults experiencing mentally unhealthy days in the past 30 days from 3.6 days in 2018 to 4.1 days in 2021.
- Increased number of 9-12 grade students reporting feeling so sad or hopeless every day for two weeks or more in a row during the past 12 months that they stopped doing some usual activities, from 22% to 27%.
- 1 in 5 adults have a depressive disorder.
- Opioid-related deaths are increasing from 10 deaths per 100,000 residents in 2012 to 13 per 100,000 in 2016.

SOURCE: Secondary Data[25, 26, 27, 28]

UVMMC reports the number of psychiatric encounters in the Emergency Department each year. It is important to highlight that COVID-19 protocols and the cyberattack UVMMC experienced in October 2020 likely affected the decrease in the number of these encounters in 2020. The length of stay of encounters was also longer due to unavailable inpatient beds in the state. There has been long-term pressure on psychiatric services at UVMMC due to the state psychiatric hospital's closure, including 54 in-patient beds, in 2011 due to Tropical Storm Irene.

The table below presents the total number and percentage of mental health patients for UVMMC, the State of Vermont, and the United States. Mental health patients have consistently been a larger percentage of patients at UVMMC relative to the State of Vermont and the United States in general. The percentage increased from 11.5% to 13.3% between 2019 to 2020, adding continued pressure on existing services and that number will likely rise in the 2021 and 2022 data.

### NUMBER/PERCENT OF MENTAL HEALTH PATIENTS: 2020 & 2019 UNIFORM DATA SYSTEM

| | UVMMC | | VERMONT | | U.S. | |
|---|---|---|---|---|---|---|
| Year | Number | Percent of all patients | Number | Percent of all patients | Number | Percent of all patients |
| 2020 | 3,662 | 13.3% | 14,005 | 8.2% | 2,512,287 | 8.8% |
| 2019 | 3,459 | 11.5% | 14,553 | 7.8% | 2,581,706 | 8.7% |

SOURCE: Secondary Data[30]

### EMERGENCY DEPARTMENT PSYCHIATRIC ENCOUNTERS AT UVMMC

**1121**
**2018**

**1165**
**2019**

**896**
**2020**

SOURCE: Secondary Data[29]

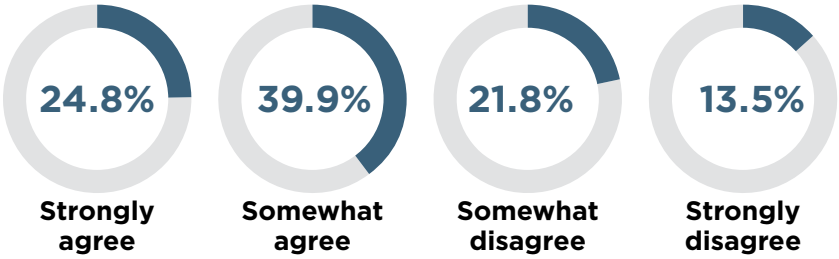
**65%**
**of community survey respondents prioritized increasing mental health services as one way to strengthen health in their community.**

SOURCE: Community Survey

## AVAILABILITY OF MENTAL HEALTH SERVICES

Community leaders identified the continued need for accessing mental health services as a top concern for the community. Community Survey respondents were asked to rate their level of agreement or disagreement with the statement: "Mental health resources are available."

### COMMUNITY SURVEY RESPONDENTS' LEVEL OF AGREEMENT WITH: "MENTAL HEALTH RESOURCES ARE AVAILABLE IN MY COMMUNITY"




SOURCE: Community Survey

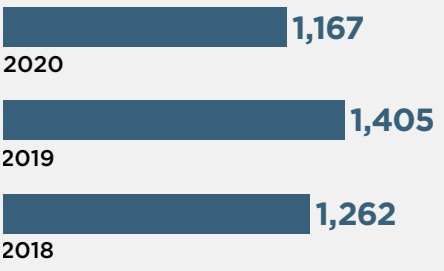
- Respondents who reported living in the United States for less than one year were less likely to report mental health resources as being available compared to fellow residents with longer lengths of time spent living in the United States.
- Respondents who reported their sexual orientation as Gay/Lesbian, Queer, Bisexual, or Pansexual were less likely to report mental health resources as being available compared to respondents who reported their sexual orientation as Heterosexual or Asexual.

The focus group with parents and caregivers of children with mental health challenges shared their experiences in navigating the mental health care system. Their experiences included a variety of settings—home, school, social services and the UVMMC Emergency Department. "Health" to these families meant children and their families are safe, both physically and emotionally, and that families have "the ability to keep moving forward in a positive and meaningful way." Overwhelmingly, focus group participants felt the current mental health care system in Vermont is not able to adequately support the needs of their children with mental health challenges.

### SPOTLIGHT ON SUBSTANCE USE

- **Substance use continues to be a pressing issue in our community—especially due to the social isolation resulting from COVID-19.**
- **1 in 4 Community Survey respondents did NOT agree with the statement: "Substance use treatment resources are available in my community."**
- **Community Leaders highlighted concerns about:**
  - The connection between substance use, mental health, and suicide
  - The need for more resources for those struggling with drug and alcohol use
  - The cascading impacts on children's health and wellbeing from substance use within their families—especially opiate overdoses

### UVMMC EMERGENCY DEPARTMENT SUBSTANCE USE PATIENT ENCOUNTERS FOR CHITTENDEN AND GRAND ISLE COUNTY RESIDENTS




SOURCE: Secondary Data[31]

### CRISIS RESPONSE

Parents and caregivers of children with mental health challenges found it difficult to get help during times of crisis. Participants described having "horrendous experiences at the emergency room." Families spent hours, days, and even weeks trying to get the services their child needed. One participant emphasized "it's not a criticism of the people that are working there, it's a criticism of the system itself: it is broken. Our state is in a mental health crisis, and we need better care for our children." One participant suggested a designated floor that can care for children, so they are not shuffled from bed to bed in the Emergency Department. Others expressed frustration that they were unable to access services that might be available in other states, due to health insurance coverage. Outside of the Emergency Department, other participants felt that community resources did not have the capacity to serve their needs.

> "The whole system is completely overwhelmed, right from where you are trying to get a therapist or get immediate help, and I don't know how to fix that, but I just know that being helpless when your child is in need is a terrible place to be."
>
> **-FOCUS GROUP PARTICIPANT**

SOURCE: Focus Group

### AVAILABILITY OF MENTAL HEALTH PROVIDERS

Finding ongoing support for mental health challenges was also a significant challenge for parents and caregivers. Participants discussed a feeling of desperation and hopelessness over an inability to get their child in to see a therapist.

> "I have cried so many times within the past month, I have called so many people, I have several calls into the social worker through our doctor's office, because I was told by another therapist that that's the only way I'm going to get them in to somebody, but I can't get that person to call me back, and I think that's the most frustrating thing right now."
>
> **-FOCUS GROUP PARTICIPANT**

SOURCE: Focus Group

Another participant described that they have been waiting on five different wait lists over the last five months to find her son a new therapist after his current one moved away.

### RESPITE FOR CAREGIVERS

Parent and caregivers in the focus group discussed their need for more support. They felt that their family's overall health and wellbeing is not possible unless they get the care they need. As one parent described, "their [child's] struggles become our struggles and we create this loop that is anxiety producing for everybody." She explained that health and wellbeing to her is about having the capacity and awareness to respond with kindness, instead of being "reactive."

Having adequate respite is critical to a caregiver's personal health and their ability to support their child's needs. Additional staff that are trained in dealing with children with mental health issues are needed to provide these benefits to parents and caregivers.

## YOUTH MENTAL HEALTH & WELLBEING CONCERNS

Qualitative findings revealed concerns about the mental health and wellbeing of youth. Community leaders spoke to the challenges of providing social-emotional support and mental health services to youth through the educational system during the pandemic. One community leader shared that the mental health workforce within the school system is struggling to keep up with students' needs as more students seek support services and positions are left vacant. Parents and caregivers in one focus group expressed frustration that their wealth of knowledge and lived experience with supporting children with mental health challenges and disabilities is not being drawn from to improve mental health support in schools.

### YOUTH EXPERIENCES AT SCHOOL

Youth shared varying perspectives about mental health resources in their school. Some students shared that they felt supported by their guidance counselors and the student support center at school. Others shared a different perspective, feeling like they were bounced between multiple guidance counselors or that their guidance counselors were not available for the support they needed. Students also mentioned that they wished the school would check in with them more often or asked them if they were getting the help they need. Some participants mentioned their school has a wellbeing check form that can be completed. Students report they don't feel like it is helpful because they can't be honest and don't trust where the information is going. Another student gave a different perspective: "if people are coming up to me and constantly asking me if I'm okay and checking in with me, I'm going to shut them down, and want to be left alone."

### SUPPORTING A RANGE OF NEEDS IN SCHOOLS

Schools were frequently discussed as a setting that greatly impacted children's mental health and wellbeing. Experiences varied greatly depending on the individual staff and amount of interaction with students. When children had positive experiences in school, they were attributed to well-trained, kind, and compassionate staff. Parents discussed the impact that even just one individual could have on their child's learning experience. Participants also discussed the difficulty in accessing the appropriate school resources or convincing schools to give them the support they needed. One parent shared that they often provide support to other parents seeking support for their children. They said, "I often found myself behind the scenes having to tell parents what to say in order to get an IEP," and that "when it comes to those sorts of things, it truly comes down to the way that things are worded."

Multiple focus group members discussed how their child did much better when schools switched to remote learning for the 2020-2021 school year. One participant said it was "like a light was switched." Her child was more included, achieved more schoolwork, and joined more extracurricular activities than ever before. This led her to the realization that her child's time in school was spent "just learning how to tolerate being in school." This parent described it as a "gut punch" when the school told her everyone must return for in person learning for the 2021-2022 school year and then she made the decision to home-school her child.

### SUPPORTING YOUTH MENTAL HEALTH CONVERSATIONS

Students have questions about how to evaluate their mental health status. One participant was confused when she went to the doctor and her record showed her depression level as "normal." She felt unsure about this because she was struggling. She felt that her need for mental health support wasn't validated because her responses didn't raise any major flags. Others felt like they didn't want to be honest in mental health screenings because others had a harder time than they did or because they didn't feel comfortable being honest. They described that "I wish [instead of check boxes and a scale] there was an opportunity to explain it yourself, like a box to write in and explain it." Many youth focus group participants reported that they wish to feel less restricted by social norms. They wished for easier conversations about mental health and more comfort accessing the resources they need. Without stigma around mental health, youth would be more comfortable sharing about their mental health challenges.

## IMPORTANCE OF SOCIAL CONNECTIONS FOR MENTAL HEALTH & WELLBEING

All focus groups spoke to the importance of social connections for supporting mental health and wellbeing.

- Youth participants discussed how being isolated in their homes early in the pandemic caused them to consider mental health as part of their overall physical health.
- Older adults and residents who experience housing insecurity also experience isolation from not being able to participate in external community events, which can help create build community cohesion.
- Abenaki community members and parents and caregivers of children with mental health challenges and disabilities described the importance of connecting with others who have similar lived experiences as a positive influence on their mental health and wellbeing.

### THE IMPORTANCE OF CULTURE

Multiple Abenaki focus group members shared that they suffered from anxiety, with one experiencing frequent panic attacks. They were not able to find relief through their primary care or therapists. The Vermont Indigenous Heritage Center (VIHC) was the only place that could provide relief. “VIHC is my health care regimen” one member remarked, with others nodding around the screen. She continued to say, “if I know I can go there and I can be with people who understand and I don’t have to feel anxious, or nervous, or deal with a million questions, that’s the program to help me.”

### ISOLATION AMONG OLDER ADULTS

The COVID-19 pandemic resulted in significant changes for all participants—not only in terms of being unable to participate in community events or have outside visitors, but also being able to connect with each other. One member shared, “for me, my biggest challenge with my health is struggling with social isolation and maintaining and nurturing the relationships that I do have and I regard a few here in the building as my brothers and sisters. To be able to ask for help can be difficult but at this point in my life I need to ask for help and I want to help others—it helps me stay connected.”

### BUILDING COMMUNITY

Residents of a local affordable housing community, older adults and families with children, expressed a need for building social connections within their community as a critical way to improve mental health and wellbeing for their neighbors. One participant described the current social dynamics as being challenging because people keep to themselves in order to “avoid drama” which leads to even greater social isolation. Several focus group members shared that there had been several recent deaths in a relatively short period of time and it was difficult to process their grief. Having more support available on site to build community would be welcomed. Residents shared potential ideas for promoting positive social connections, such as creating common gathering areas and sharing community meals.

### SOCIAL MEDIA AS A CHALLENGE TO MENTAL HEALTH

Youth participants agreed about the negative impacts of social media on their health. From reinforcing unhealthy body images, to spending too much time on their phones, and decreasing their productivity on schoolwork, social media felt challenging during COVID. One student reported he "deleted and redownloaded Tik-Tok and Instagram like 8 times," demonstrating that they understand the impact of social media and were trying to monitor their own use. Participants explained that deleting social media was difficult because it is a main way that they stay connected to their friends and peers. One participant explained, "I decided I was spending way too much time on Snapchat and I wasn't getting work done and I was just in my room, not really connecting with my family. So, I decided to delete it, but then, I don't have people's numbers...so I had to redownload it so I was able to talk to people."

### SUPPORTING PARENTS AND CAREGIVERS OF CHILDREN WITH MENTAL HEALTH CHALLENGES AND DISABILITIES

Parents and caregivers discussed the benefits of connecting with others who share similar experiences. A participant noted that "finding other parents where you don't have to explain, you just say it and everyone's heads nod, that personally has been really saving in many ways throughout this process." Others shared this thought and discussed how hard it is to "take your own temperature" and honor your own needs. One focus group participant said she would make a point of asking others how they were doing and what they liked to do for fun, explaining that "if we don't take time to talk about ourselves and to validate each other and actually connect with what may give us joy, then what do we have to give to our loved ones?"

PRIORITY

# Workforce Development

## INTRODUCTION

Economic opportunity and financial stability are important factors impacting health and wellbeing. Workforce development opportunities help people gain knowledge and skills that allow greater employment opportunities, as well as support their ability to remain in the workforce. Increasing workforce development can help individuals improve financial stability for themselves and their families while meeting the demands of the labor force and supporting the local economy.

### COMMUNITY LEADER QUOTE SPOTLIGHT:

> "It's important to recognize that a single adult earning $15/hour doesn't qualify for anything. And you can't afford to live here with the high cost of living."
>
> **-COMMUNITY LEADER**

SOURCE: Key Informant Interview

## WORKFORCE DEVELOPMENT AT A GLANCE

Workforce development emerged as a top need from the Community Survey findings. This section provides an overview of the needs highlighted: to increase jobs that pay a livable wage, provide access to training for higher paying jobs, and better sustain the workforce by increasing access to childcare and transportation.

**Community leaders cited the connection between income, cost of living, and health in different ways:**

- "We need a basic income so people can flourish in their community."
- "Cost is a barrier. If you're lower working class, but doing well enough to not get assistance, then families will put things off related to health because of pressing needs."
- "A lack of a living wage means both parents have to work full-time to survive. It means that one works all day and the other works all night. This causes huge amounts of stress for the parents and children because families can't survive with just one parent working."

SOURCE: Key Informant Interviews

## ECONOMIC STABILITY

This section highlights median income and unemployment rates, both key contributors to the local economy. Put simply, economies thrive when jobs are filled, people are paid well, goods and services are being produced and purchased. This data shows us some key opportunities to improve this cycle in our community. It is noted that data that is inclusive of all genders, races and ethnicities, is not available from major secondary sources at this time. It is important to recognize that this data has several limitations.

"We have a lack of jobs that are accessible to many people—that give purpose and meaning and pay a living wage."

**-COMMUNITY LEADER**

SOURCE: Key Informant Interview

### COMMUNITY SURVEY FINDINGS:

**71%**

**selected "increasing jobs that pay a livable wage" as a top action to strengthen peoples' finances in the community**

**67%**

**selected "strengthening of job training programs" as a top action to strengthen education in the community**

**52%**

**disagree that affordable childcare is available in the community**

SOURCE: Community Survey

## MEDIAN INCOME

Median incomes[6] in the Health Service Area are slightly higher than the state median. The cost of living in Chittenden and Grand Isle counties is higher than many other regions in the state. For example, the Vermont Department of Taxes reported median home sale prices in Chittenden and Grand Isle Counties as, respectively, 43% and 15% higher than the state median for 2021.

Median income levels are also not consistent across genders or race and ethnicity demonstrating some of the economic inequities that exist. **The median income for Black or African American households is less than half of the median income reported for White, not Hispanic or Latino households.**

### MEDIAN HOUSEHOLD INCOME BY RACE & ETHNICITY 2015-2019

| RACE & ETHNICITY | CHITTENDEN COUNTY | GRAND ISLE COUNTY | VERMONT |
|---|---|---|---|
| Black or African American alone | $37,004 | n/a | $39,400 |
| American Indian and Alaska Native alone | $41,835 | n/a | $41,959 |
| Asian alone | $57,532 | n/a | $59,241 |
| Hispanic or Latino (any race) | $53,008 | $79,803 | $47,701 |
| Native Hawaiian and Other Pacific Islander alone | n/a | n/a | $42,125 |
| Some other race alone | $68,390 | n/a | $67,551 |
| Two or more races | $38,942 | $66,335 | $45,288 |
| White alone, not Hispanic or Latino | $76,501 | $71,418 | $62,770 |

SOURCE: Secondary Data[32]

*Several data categories are suppressed for reliability reasons due to low population numbers and high margins of error.

The gap in earnings has decreased over time for the state and for Chittenden County. Grand Isle County has not had the same experience. Women in both Chittenden and Grand Isle Counties earn less than $.80 on the dollar than men. **In Grand Isle County women earn about $.70 for every dollar earned by men.** Once again, it is important to note the historical lack of inclusive gender identifiers for data collected by the U.S. Census Bureau.

### MEDIAN INCOME BY SEX FOR POPULATION AGE 25 OR OLDER

| COUNTY | MALE | FEMALE | RATIO OF FEMALE TO MALE EARNINGS |
|---|---|---|---|
| Chittenden | 53,518 | 41,641 | 77.8% |
| Grand Isle | 50,824 | 35,824 | 70.5% |
| Vermont | 45,066 | 35,481 | 78.7% |

SOURCE: Secondary Data[32]

## UNEMPLOYMENT

The Vermont unemployment data from the U.S. Census Bureau reflects unemployment before the start of the COVID-19 pandemic. Unemployment data is not reliable at the county levels by race and ethnicity. Unemployment rates were falling compared to the previous reporting period, with overall unemployment rate at 3.6%. However, this rate was higher for Black or African American community members, Hispanic or Latino community members, American Indian/Alaska Native community members, and community members of two or more races.

### UNEMPLOYMENT BY RACE AND ETHNICITY FOR THE STATE OF VERMONT 2015-2019

| RACE AND ETHNICITY | VERMONT |
|---|---|
| Black or African American alone | 4.4% |
| American Indian and Alaska Native alone | 4.4% |
| Asian alone | 3.2% |
| Hispanic or Latino (any race) | 5.4% |
| Native Hawaiian and Other Pacific Islander alone | n/a |
| Some other race alone | 10.4% |
| Two or more races | 5.6% |
| White alone, not Hispanic or Latino | 3.5% |
| Total Population | 3.6% |

SOURCE: Secondary Data[33]

The U.S. Census Bureau provides data about workforce participation and employment for individuals with cognitive and physically disabilities. An individual is considered to have a disability on the American Community Survey if they indicate difficulties with: hearing, vision, cognitive, ambulatory, self-care, and independent living.

### LABOR FORCE PARTICIPATION RATE BY DISABILITY STATUS

#### CHITTENDEN COUNTY

Total population with disability

**10,457**


% Employed


% Unemployed


% Not in labor force

#### GRAND ISLE COUNTY

Total population with disability

**346**


% Employed


% Unemployed

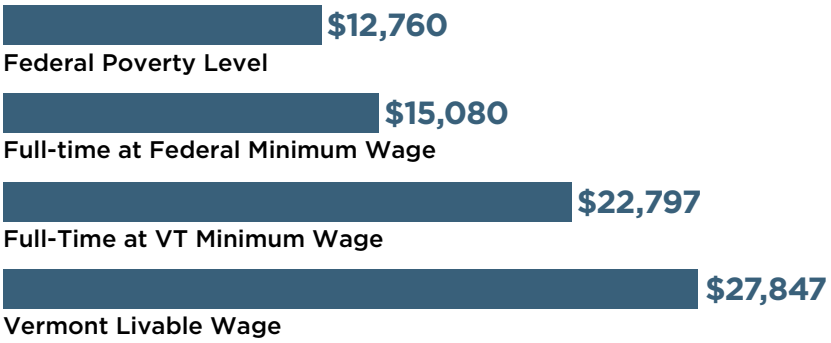

% Not in labor force

SOURCE: Secondary Data[33]

## COST OF LIVING AND LIVABLE WAGE

Based on 2020 data used to calculate a basic needs budget for Vermont households, the cost of living in **Vermont is estimated to be more than two times higher than the federal poverty level, which is often used to determine eligibility for federal assistance programs.** This leaves many residents working at or near the state's minimum wage without enough income to meet their basic needs or a safety net to close the gap.

### 2020 WAGE RATE COMPARISONS FROM THE VERMONT LEGISLATIVE JOINT FISCAL OFFICE




SOURCE: Secondary Data[34]

# 1 in 6

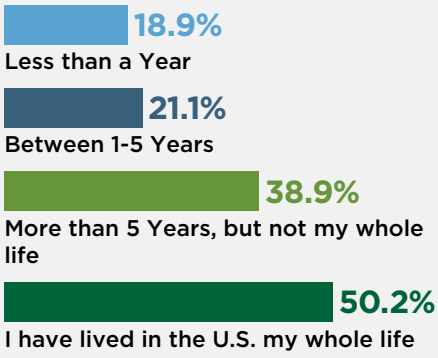
community members via the CHNA Community Survey expressed that they have at least some difficulties affording their basic needs.

**A closer look at this survey data showed that the following groups were more likely to report some difficulty in meeting their basic needs relative to total respondents overall:**

- Households with children under age 5
- Black, African American, and Arab community members
- Community members who have lived in the United States for less than 5 years

SOURCE: Community Survey

### COMMUNITY MEMBERS WHO STRONGLY AGREE THEY HAVE ENOUGH MONEY TO PAY FOR THEIR BASIC NEEDS BASED ON TIME SPENT LIVING IN THE U.S.




SOURCE: Community Survey

## REDUCING BARRIERS TO WORK

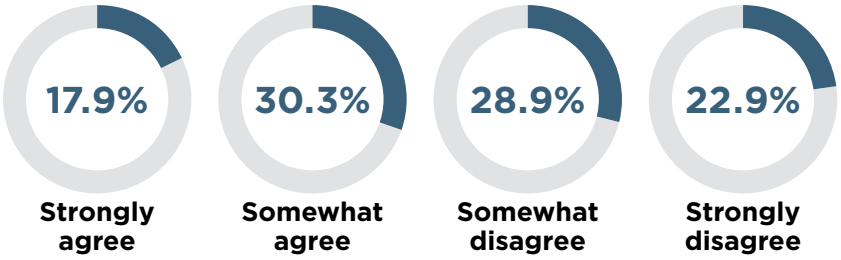
**There are a variety of factors that affect an individual's ability to thrive in the workforce, including:**

- Having stable and affordable housing
- Access to affordable childcare and transportation
  - When people with young children do not have access to affordable childcare, they may leave the workforce altogether with impacts on the local economy and face greater economic instability.
  - In a largely rural state like Vermont, individuals and families depend on personal vehicles to get to the places they need to go, including work. Not having a reliable personal vehicle can be a significant barrier.

## AFFORDABLE CHILDCARE

Community leaders mentioned quality, affordable childcare as an important factor that supports overall community health and wellbeing. Several communities called for more early childhood education programs and expanded childcare opportunities. The CHNA Community Survey found that many community members do not believe that affordable childcare is available in their community, with 52% of all respondents either strongly or somewhat disagreeing with that statement.

### COMMUNITY SURVEY RESPONDENTS' LEVEL OF AGREEMENT WITH: "AFFORDABLE CHILDCARE IS AVAILABLE"

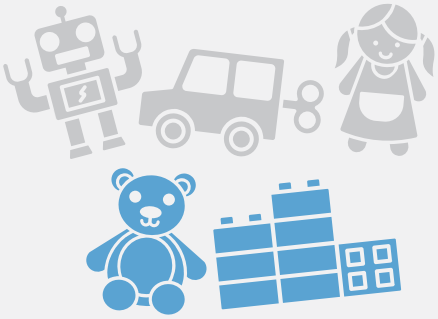



SOURCE: Community Survey

- Respondents who identified as Cisgender Female and Genderqueer, non-binary, or fluid were less likely to agree to that affordable childcare is available relative to all survey respondents.
- Those who have lived in the United States for fewer than five years are less likely to agree that affordable childcare is available relative to all survey respondents.

# 3 in 5

**of Vermont's youngest children (from birth to age 5) did not have access to the care (early childhood education) they needed prior to the COVID-19 pandemic (Let's Grow Kids, 2022).**



SOURCE: Secondary Data[35]

## AFFORDABLE TRANSPORTATION

The CHNA Community Survey found that many community members do not have affordable and reliable transportation options. A focus group with people who experienced housing insecurity highlighted a lack of transportation as a barrier to maintaining a steady job. In a rural state like Vermont, there are limited public transit options.

The Community Survey found that nearly 1 in 5 respondents feel that they don't have affordable transportation options.

- Respondents who are LGBTQ+ experience more barriers to accessing affordable transportation
- Those who have lived in the United States for less than five years experienced more barriers to affordable transportation
- Respondents who are genderqueer, non-binary, fluid, transgender female or transgender male experience more barriers to accessing affordable transportation

Over **2,700 workers in Chittenden and Grand Isle Counties do not have a private vehicle available to them**. There are a few places within these two counties where workers may be able to access their workplaces, services, and community amenities without a private vehicle. However, for most residents of Chittenden and Grand Isle Counties, especially in more rural areas, a vehicle is required to get to the places people need to be.

### WORKERS WITH NO VEHICLE AVAILABLE

| | NUMBER | PERCENT OF ALL WORKERS |
|---|---|---|
| Chittenden and Grand Isle Counties | 2,721 | 3.0% |
| Vermont | 7,112 | 2.3% |

SOURCE: Secondary Data[36]

# 1 in 5

**Do not have affordable transportation options**

SOURCE: Community Survey

Grand Isle County workers have the highest rate of a long commute (defined as 30 minutes or more by the U.S. Census Bureau). Chittenden County is among those with the lowest rate. Lengthy commute times to workplaces are also connected to housing affordability trends in the area. More affordable housing options are located further away from areas of employment.

The American Community Survey estimates that only 2.7% of workers within the two counties utilize public transportation. While this rate is higher compared to the state, the majority of public transportation users clearly reside in Chittenden County. Grand Isle County workers have markedly lower rates of public transportation usage highlighting the impact of rural and urban settings on access to transportation infrastructure. Several community leaders noted that the rural nature of communities beyond the greater Burlington area makes public transportation challenging given limited routes and infrequent schedules.

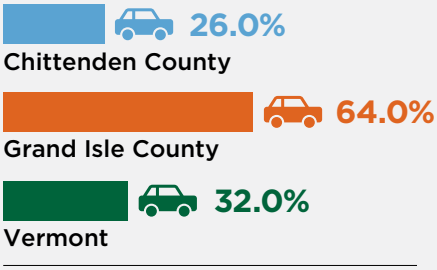
**WORKERS UTILIZING PUBLIC TRANSPORTATION**

| LOCATION | TOTAL WORKERS | WORKERS USING PUBLIC TRANSPORTATION | PERCENT |
|---|---|---|---|
| Chittenden County | **90,442** | **2,539** | **2.8%** |
| Grand Isle County | **3,565** | **17** | **0.5%** |
| Chittenden and Grand Isle Counties | **94,007** | **2,556** | **2.7%** |
| Vermont | **322,189** | **4,124** | **1.3%** |

SOURCE: Secondary Data[38]

# 2 in 3

**people in Grand Isle County have a long commute alone.**




SOURCE: Secondary Data[37]

# Moving from Assessment to Action

This section outlines opportunities for action identified by CHNA Steering Committee members, Community Health Priorities Session attendees, and individuals involved in our primary data gathering activities. An important next step will be to further engage in dialogue with community groups and champions to generate shared solutions. Advancing these priorities requires addressing as a community the underlying drivers of health, including: racism, economic instability, prejudice and poverty.

## COMMUNITY LEADERS, CHAMPIONS, AND MEMBERS SHARED THE FOLLOWING KEY INSIGHTS:

- The six emergent health priorities are interconnected
- Health and wellbeing should be broadly defined
- The COVID-19 pandemic has increased awareness about persistent health disparities to be addressed in the community
- Build upon community partnerships to co-develop innovative service delivery models
- The need to balance investment in addressing urgent community needs, while advocating for systems-level changes that target the root causes of health disparities

The table on pages 75 and 76 serves to generate additional community conversation and work towards shared solutions.

## DRIVERS OF HEALTH DISPARITIES

Making improvements across these six health priorities involves addressing the upstream root causes of community health outcomes. Racism and Economic Instability emerged in our assessment findings as key drivers of health disparities. Throughout the data gathering activities, community leaders spoke to the importance of dismantling these systems to achieve a vision of a stronger, more resilient community where everyone has the opportunity to thrive.

"It would be to our benefit to approach this work from a racial equity perspective because there can be no health equity or equity more broadly without racial equity."

**-COMMUNITY LEADER**

| HEALTH PRIORITY | POPULATIONS OF FOCUS | OPPORTUNITIES FOR ACTION IDENTIFIED BY THE COMMUNITY |
|---|---|---|
| **Accessible and Coordinated Care** | People who are LGBTQ+<br>Older adults<br>People with disabilities<br>People experiencing poverty<br>Youth, Families | • Expand access beyond traditional hours of 9-5<br>• Reduce wait times: primary and specialty care, dental care, and mental health<br>• Expand Medicaid coverage for older Vermonters<br>• Utilize primary care visits to address the social determinants of health<br>• Improve coordination of care at medical homes<br>• Expand co-location of services and wrap around services, especially in rural areas<br>• Increase access to language services and use of plain language in care delivery<br>• Increase healthy aging and cognitive decline resources and supports<br>• Expand treatment options for people experiencing mental health crises<br>• Address barriers to communicate with providers and access digital services, such as telehealth appointments and MyChart<br>• Increase school-based clinics for health and mental health services<br>• Expand respite care options for families and caregivers<br>• Ensure continuity of care for individuals with chronic health conditions |
| **Cultural Humility and Inclusive Health Care** | Black, Native American, and People of Color<br>People who are LGBTQ+<br>Older adults<br>People with disabilities<br>Refugees and newly immigrated individuals | • Establish trusting relationships with historically marginalized communities<br>• Build on success of BIPOC vaccine clinic and New American Clinic models<br>• Increase data collection to measure and address health disparities<br>• Invest in language access services, including medically trained interpreters<br>• Diversify all levels of workforce, including adding more multi-lingual social workers<br>• Develop peer education programs to complement individual provider training<br>• Support non-traditional points of entry for all health care related services<br>• Increase provider competencies to better serve diverse populations |
| **Food Access and Security** | Infants and families<br>Native Americans<br>Older adults<br>People experiencing poverty<br>Refugees and newly immigrated individuals<br>People living in rural communities<br>Youth | • Increase food access and meal delivery programs for older Vermonters<br>• Increase access to culturally appropriate foods<br>• Implement universal food security screening and referral processes<br>• Support universal breakfast and lunch for school-aged children<br>• Increase availability of healthy meals for children in all settings<br>• Increase access to local growers and programs that redirect surplus food to those in need and reduce food waste |

| HEALTH PRIORITY | POPULATIONS OF FOCUS | OPPORTUNITIES FOR ACTION IDENTIFIED BY THE COMMUNITY |
|---|---|---|
| **Housing** | College students<br>Multi-generational families<br>People experiencing homelessness<br>People with disabilities<br>Refugees and newly immigrated individuals<br>Workforce, Health care Workforce | • Accommodate larger families in affordable housing units<br>• Increase affordable housing requirements for new building units<br>• Scale up home sharing, home swap, co-living housing programs<br>• Work with colleges to increase and incentivize campus housing<br>• Work within defined 'growth zones' to create supportive housing<br>• Promote cultural humility trainings for housing service providers<br>• Decrease the gap in livable wages and housing affordability<br>• Support energy efficiency and healthy home initiatives for older homes<br>• Expand wrap-around services for people in transitional housing |
| **Mental Health and Wellbeing** | Black, Native American, and People of Color<br>Families, new parents<br>Older adults<br>People experiencing poverty<br>People living in rural communities<br>People who are non-binary, genderqueer, fluid, and transgender<br>Youth | • Integrate mental health services into all pediatric and primary care clinics<br>• Grow mental health workforce, including BIPOC mental health providers and counseling services<br>• Build resiliency, including peer-to-peer, at-home and community center programming<br>• Advocate for universal insurance coverage of mental health services<br>• Scale up Mental Health First Aid for educators, community members<br>• Expand access hours and address long wait times<br>• Expand low-barrier treatment for substance use disorder<br>• Conduct universal youth depression screenings<br>• Increase transportation options to services and community resources<br>• Support cultural centers and community gathering spaces<br>• Engage youth to understand their needs and increase resources available for them |
| **Workforce Development** | Black, Native American, and People of Color<br>Early Childcare<br>Eldercare<br>Health care<br>People experiencing mental health challenges<br>Refugees and newly immigrated individuals | • Address wage gaps in education and helping professions<br>• Diversify workforce, especially in health care settings<br>• Accept and honor prior job training and skills of newly immigrated individuals and refugees<br>• Address cost and housing stock limitations that are a barrier to workforce recruitment and retention<br>• Increase investment in Black, Indigenous, Native American, and People of Color-serving organizations that address the social determinants of health<br>• Create a well-trained workforce prepared to meet the needs of a diverse community |

# Next Steps

## MOVING FROM ASSESSMENT TO ACTION

The 2022 Community Health Needs Assessment process has offered a robust opportunity to hear from diverse community members, leaders, and organizations about the strengths, assets, and most pressing needs and opportunities impacting the health and wellbeing of our community. Findings, data and other information from the CHNA can be used by community partners to drive strategy, guide investments and inform decisions.

We will continue to engage in the assessment findings and develop a Community Health Improvement Plan (CHIP) in collaboration with key partners.

- The CHIP will outline shared goals and a framework for addressing the community-driven health priorities.
- The top priorities advancing for UVMMC Board approval are:
  - **Cultural Humility and Inclusive Health Care**
  - **Housing**
  - **Mental Health and Wellbeing**
- Equitable community engagement practices will be adopted to identify strategies that target known disparities and build upon existing strengths and assets.
- The adopted CHIP outlines the allocated resources and key partnerships to address the top priorities for the next three calendar years, 2023-2025.
- Annual progress will be reported annually and publicly available here: Community Health Needs Assessment (UVMHealth.org)

To learn more about the community health needs assessment, request a presentation of key findings, or learn about opportunities to get involved, please contact:


**Molly Lawrence, MPH**

Community Health Needs Assessment Project Manager

Molly.Lawrence@UVMHealth.org

**The University of Vermont Medical Center**

**COMMUNITY HEALTH IMPROVEMENT**

128 LAKESIDE AVENUE, SUITE 106
BURLINGTON, VT 05401

# References


FEEDING AMERICA. (2019). MAP THE MEAL GAP.
https://map.feedingamerica.org/county/2019/overall/vermont

HEALTHY PEOPLE 2020, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (N.D.). *DISPARITIES*.
https://www.healthypeople.gov/2020/about/foundation-healthmeasures/Disparities#:~:text=Healthy%20People%202020%20defines%20a,%2C%20and%2For%20environmental%20disadvantage.

HEALTHY PEOPLE 2030, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (N.D.). *SOCIAL DETERMINANTS OF HEALTH*.
https://health.gov/healthypeople/objectives-and-data/social-determinants-health

HEALTHY PEOPLE 2030 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (N.D.), *HEALTH EQUITY IN HEALTHY PEOPLE 2030*.
https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

LET'S GROW KIDS. (2022). *VERMONT'S CHILD CARE CRISIS AND WHY IT MATTERS*.
https://letsgrowkids.org/

MCCARTHY, ASHLEY C.; BERTMANN, FARRYL; BELARMINO, EMILY H.; AND NILES, MEREDITH T., "FOOD SECURITY IMPACTS OF THE COVID-19 PANDEMIC: FOLLOWING A GROUP OF VERMONTERS DURING THE FIRST YEAR" (2021). COLLEGE OF AGRICULTURE AND LIFE SCIENCES FACULTY PUBLICATIONS. 186.
https://scholarworks.uvm.edu/calsfac/186

ROBERT WOOD JOHNSON FOUNDATION. (2017). VISUALIZING HEALTH EQUITY: ONE SIZE DOES NOT FIT ALL INFOGRAPHIC.
https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html

TERVALON, M., & MURRAY-GARCIA, J. (1998). CULTURAL HUMILITY VERSUS CULTURAL COMPETENCE: A CRITICAL DISTINCTION IN DEFINING PHYSICIAN TRAINING OUTCOMES IN MULTICULTURAL EDUCATION. JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED, 9(2), 117-125.

VERMONT DEPARTMENT OF HEALTH. (N.D.) *HEALTH EQUITY*.
https://www.healthvermont.gov/about-us/our-vision-mission/health-equity

# Endnotes

1 Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3) | Internal Revenue Service (irs.gov). Retrieved from: https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3#:~:text=Section%20501%20%28r%29%20%283%29%20%28A%29%20requires%20a%20hospital,%28r%29%20%283%29%20%28B%29%20provides%20that%20the%20CHNA%20must%3A.

2 Community Health Improvement Navigator - CDC (https://www.cdc.gov/chinav/index.html#:~:text=Community%20health%20improvement%20%28CHI%29%20is%20a%20process%20to,to%20consider%20high-priority%20actions%20to%20improve%20community%20health.)

3 Grand Isle County is also part of the Northwestern Medical Center's designated health service area.

4 Data is presented for the Health Service Area within this report where it is possible. This allows for consideration of both Chittenden and Grand Isle Counties in comparison over time or to the state as a whole.

5 The source for population-level Race and Ethnicity data in the U.S. is the U.S. Census Bureau. The Census Bureau utilizes vetted & standardized categories of race and ethnicity. At the time of this reporting, the concept of ethnicity refers only to whether a person self-identifies as being of Latino/x or Hispanic background or not. The Census Bureau presents most population data for the following top five (by populations in the U.S.) race groupings- African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, and White. Ethnicity and race are overlapping concepts, where individuals may self-identify as being of any number of race categories AND of being of Latino/x or not Latino/x ethnicity.

6 Median income is the exact middle of all incomes in a defined area: half of households will be higher and half will be lower than the median annual income amount.

# Appendix

## IRS COMPLIANCE REQUIREMENTS

The Internal Revenue Service (IRS) has specific requirements that must be included within Community Health Needs Assessments. This table outlines where each Schedule H (Form 990) requirement can be found within the report.

| REQUIREMENT | REPORT SECTION | PAGE NUMBERS |
|---|---|---|
| **Part V Section B Line 3a**<br>*A definition of the Community Served by the hospital facility* | **Section 2:**<br>About Our Community | Page 16 |
| **Part V Section B Line 3b**<br>*Demographics of the Community* | **Section 2:**<br>About Our Community | Pages 16-21 |
| **Part V Section B Line 3c**<br>*Existing Health Care Facilities and Resources (within the community that are available to respond to the health needs/priorities of the community)* | Appendix: Existing Health Care Facilities and Resources | Pages 102-107 |
| **Part V Section B Line 3d**<br>*How Data was Obtained* | **Section 3:**<br>Data Gathering and Community Engagement | Pages 28-34 |
| **Part V Section B Line 3c**<br>*The Significant Health Needs/Priorities of the Community* | **Section 4:**<br>Community Health Priorities | Pages 35-73 |
| **Part V Section B Line 3f**<br>*Primary and Chronic Disease Needs and Other Health Issues of Uninsured Persons, Low-Income Persons, and Minority Populations* | **Section 2:**<br>About Our Community | Pages 21-36 |
| | **Section 4:**<br>Community Health Priorities | Pages 35-73 |
| **Part V Section B Line 3g**<br>*Process for identifying and prioritizing community health needs/priorities and services to meet the community health needs/priorities* | **Section 3:**<br>Data Gathering and Community Engagement | Pages 28-34 |
| **Part V Section B Line 3h**<br>*Process for consulting with persons representing the community's interests* | **Section 1:**<br>About this Report | Pages 13-14 |
| | **Section 3:**<br>Data Gathering and Community Engagement | Pages 28-34 |
| **Part V Section B Line 3i**<br>*Impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA.* | Appendix: 2020-2022 Implementation Strategy Updates | Pages 108-115 |

## KEY INFORMANT INTERVIEW GUIDE

1. Can you briefly describe the communities and/or organizations that you belong to?
2. What is your vision of a healthy community?
3. What assets support a healthy life in your community?
4. From your perspective, what are the top three most pressing health needs in your community?
5. What barriers for achieving optimal health and wellbeing exist in your community?
6. Which populations in your community lack access to resources that support health and wellbeing?
7. What structural changes (i.e. supports, policies) are needed to improve the health of all community members?
8. Is your organization or community group currently pursuing any work to promote health equity? [If yes] Can you tell me more about what your organization is pursuing?
9. Is there anything else related to the health and wellbeing of your community that you'd like to share with us?

## KEY INFORMANT INTERVIEWEES

**Alex Yin, PhD**
Winooski School Board

**Andrea Green, MD**
UVM Children's Hospital, Pediatric New American Program

**Andrew Julow**
Lake Champlain Islands Economic Development Corporation

**Annie Cooper**
Essex Junction Recreation Advocate

**Anore Horton**
Hunger Free Vermont

**Bonnie Johnson-Aten**
Edmunds Elementary School

**Charlie Baker**
Chittenden County Regional Planning Commission

**Cyrus Patten, EdD**
Champlain College & Praxis Health Systems

**Steve Grant, MD**
University of Vermont Health Network Medical Group

**Emily Alger**
South Hero Land Trust

**Heather Stein**
Community Health Centers of Burlington

**Helen Labun**
Bi-State Primary Care Association

**Islam Hassan**
Islamic Society of Vermont

**Jane Catton**
Age Well

**Jay Nichols**
Vermont Principals' Association

**Jeff Benay**
Abenaki Nation of Missisquoi's Title VI Indian Education Parent Advisory Committee

**Jesse Bridges**
United Way of Northwest Vermont

**Jessie Baker**
City of South Burlington

**Kyle Dodson**
Greater Burlington YMCA

**Marybeth Pinard, Ellen Kane, and Irene Manion**
Catholic Charities of Vermont

**Michael Monte**
Champlain Housing Trust

**Paul Costello**
Vermont Council on Rural Development

**Paul Dragon**
Champlain Valley Office of Economic Opportunity

**Phet Keomanyvanh**
City of Burlington Community Economic Development Office

**Robert Ostermeyer**
Franklin- Grand Isle Community Action Agency

**Scott Strenio and Christine Ryan**
Department of Vermont Health Access/Vermont Medicaid

**Seth Leonard**
Vermont Housing Finance Agency

**Stephen Broer**
Northwestern Counseling and Support Services

**Taylor Small**
Pride Center and State Representative (Winooski)

**Trevor Hanbridge**
Howard Center

**Weiwei Wang**
Vermont Professionals of Color Network and Vermont Health Equity Initiative

**Yasamin Gordon**
City of Winooski

## SECONDARY DATA SOURCES LISTING

| | INDICATOR NAME | DATA SOURCE | YEARS |
|---|---|---|---|
| 1 | Total Population | U.S. Census Bureau, American Community Survey, Table DP05, ACS Demographic and Housing Estimates | 2015-2019<br>2010-2014 |
| 2 | Age of Population | U.S. Census Bureau, American Community Survey, Table S0101, Age and Sex | 2015-2019 |
| 3 | Limited English-Speaking Households | U.S. Census Bureau, American Community Survey, Table S1602, Limited English-Speaking Households | 2015-2019<br>2010-2014 |
| 4 | Population by Race and Ethnicity | U.S. Census Bureau, American Community Survey, Table DP05, ACS Demographic and Housing Estimates | 2015-2019 |
| 5 | Median Household Income | U.S. Census Bureau, American Community Survey, Table S1903, Median Income in the Past 12 Months | 2015-2019<br>2010-2014 |
| 6 | Federal Poverty Status | U.S. Census Bureau, American Community Survey, Table S1701, Poverty Status in the Past 12 Months | 2015-2019 |
| 7 | Population with Disability Status | U.S. Census Bureau, American Community Survey, Table S1810, Disability Characteristics | 2015-2019 |
| 8 | Educational Attainment | U.S. Census Bureau, American Community Survey, Table S1501, Educational Attainment | 2015-2019 |
| 9 | COVID-19 Case Counts | COVID-19 in Vermont Case Dashboard | 2022 |
| 10 | COVID-19 Vaccination Data | Vermont Department of Health COVID-19 Vaccine Dashboard | 2022 |
| 11 | Availability of Primary Care Physicians | Vermont Health care Provider Census | 2010, 2018 |
| 12 | Health Insurance | U.S. Census Bureau, American Community Survey, Table S2701, Selected Characteristics of Health Insurance Coverage in the United States | 2015-2019<br>2010-2014 |
| 13 | Percent Uninsured | U.S. Census Bureau, American Community Survey, Table S2702, Selected Characteristics of the Uninsured in the United States | 2015-2019 |
| 14 | Interpretation Languages Requested at CHCB | Community Health Center of Burlington, Patient Data | 2020 |

| | INDICATOR NAME | DATA SOURCE | YEARS |
|---|---|---|---|
| 15 | UVMMC Patient Visits by Language Not English | UVM Medical Center Patient Data | 2020 |
| 16 | SNAP Eligibility | Feeding America Map the Meal Gap, Food Insecurity in Chittenden County | 2017 |
| 17 | Kindergarten Readiness | Vermont Agency of Education, Ready for Kindergarten! Survey (R4K!S) Report. | 2020-2021 |
| 18 | Cost-burdened Households | U.S. Census Bureau, American Community Survey, Table S2503, Financial Characteristics | 2015-2019, 2009-2013 |
| 19 | Housing Wage Data | Vermont Housing Finance Agency, HousingData.org, National Low Income Housing Coalition | 2022 |
| 20 | Available Rental Units | U.S. Census Bureau, American Community Survey, Table DP04, Selected Housing Characteristics | 2015-2019, 2006-2010 |
| 21 | Homeownership Rates | U.S. Census Bureau, American Community Survey, Table S2502, Demographic Characteristics of Occupied Housing Units | 2015-2019 |
| 22 | Age of Housing Stock | U.S. Census Bureau, American Community Survey, Table DP04, Selected Housing Characteristics | 2015-2019 |
| 23 | Households with Severe Housing Problems | County Health Rankings Vermont | 2018, 2021 |
| 24 | Homelessness | Vermont's Annual Statewide Count of Those Experiencing Homelessness, Vermont Coalition to End Homelessness | 2018, 2019, 2020, 2021 |
| 25 | Adults Experiencing Mentally Unhealthy Days | County Health Rankings Vermont | 2018, 2021 |
| 26 | Students Reported Feeling Sad | Vermont Youth Risk Behavior Survey | 2017, 2019 |
| 27 | Adults with Depressive Disorder | County Health Rankings | 2018, 2021 |
| 28 | Opioid-related Deaths | Vermont Department of Health Vital Statistics | 2012, 2016 |
| 29 | Emergency Department Psychiatric Encounters – UVMMC | UVM Medical Center Patient Data | 2018, 2019, 2020 |

| | INDICATOR NAME | DATA SOURCE | YEARS |
|---|---|---|---|
| 30 | Mental Health Patient Counts | UVM Medical Center Patient Data | 2019, 2020 |
| 31 | UVMMC Emergency Department Substance Use Patient Encounters | UVM Medical Center Patient Data | 2018, 2019, 2020 |
| 32 | Median Household Income | U.S. Census Bureau, American Community Survey, Table S1903, Median Income in the Past 12 Months | 2015-2019, 2010-2014 |
| 32 | Unemployment | U.S. Census Bureau, American Community Survey, Table S2301, Employment Status | 2015-2019, 2010-2014 |
| 33 | Labor Force Participation Rate by Disability Status | U.S. Census Bureau, American Community Survey, Table C18120, Employment Status by Disability Status | 2015-2019 |
| 34 | Vermont Wage Rates | Vermont Legislative Joint Fiscal Office, Vermont Basic Needs Budgets and Livable Wage, 2021 Report | 2020 |
| 35 | Children who do not have the care they need | Let's Grow Kids | 2022 |
| 36 | Workers with No Vehicle | U.S. Census Bureau, American Community Survey, Table S0802, Means of Transportation to Work by Selected Characteristics | 2015-2019 |
| 37 | Drivers with Long Commute, Driving Alone | U.S. Census Bureau, American Community Survey, Table DP03, Selected Economic Characteristics | 2015-2019 |
| 38 | Workers Utilizing Public Transportation | U.S. Census Bureau, American Community Survey, Table DP03, Selected Economic Characteristics | 2015-2019 |

## KEY HEALTH AND WELLBEING INDICATORS SOURCE LISTING

| DATA SOURCE | INDICATORS | YEARS |
|---|---|---|
| Vermont Vital Statistics | Opioid Related Deaths per 100,000 | 2012, 2016 |
| | Suicide rate per 100,000 | 2009-2011, 2013-2015 |
| VT Health Care Workforce Census | Dentists per 100,000 | 2009, 2017 |
| | Mental Health Professionals per 100,000 | 2016-2017 |
| | Primary Care Physicians per 100,000 | 2010, 2018 |
| U.S. Census Bureau, American Community Survey | Insured | 2015-2019 |
| | Educational Attainment | 2010-2014 |
| | Households receiving food stamps/SNAP benefits | |
| | Housing cost burden | |
| | Population below Federal Poverty Level | |
| | Unemployment Rate | |
| | Housing Units built before 1940 | |
| | Low access to grocery stores for low-income residents | |
| | Rental unit vacancy rate | |
| | Renter-occupied as percent of all occupied housing units | |
| | Households with children | |
| | Limited English-speaking households | |
| | Seniors living alone | |
| | Single-parent households | |
| Vermont Youth Risk Behavior Survey | Youth in HS Marijuana Use | 2011, 2015 |
| | High school students bullied in past 30 days | 2017, 2019 |
| | Middle school students bullied in past 30 days | |

| DATA SOURCE | INDICATORS | YEARS |
|---|---|---|
| Vermont Behavioral Risk Factor Surveillance System (BRFSS) | Adults who cannot obtain care or delay care<br>Adults Binge Drink<br>Adults over 20 years who are obese<br>Adults who smoke cigarettes<br>Adults with a Depressive Disorder<br>Adults with COPD<br>Adults with Asthma<br>Adults with Poor Mental Health<br>Adults with Poor Physical Health<br>Arthritis<br>Hypertension<br>Adults 50-75 receiving colorectal screening<br>Adults ages 65 and older receiving flu shot in the last year<br>Blood cholesterol checked in the last 5 years<br>Women ages 21-65 receiving Cervical Cancer Screening<br>Women ages 50-74 with mammogram in the last 2 years | 2012-2013, 2017-2018 |
| Screening in Primary Care Survey | Children who received a developmental screening in the first three years of life | 2013, 2018 |
| US EPA Air Trends | Days with particulate matter over the standard | 2017-2019, 2018-2020 |
| Vermont Agency of Education | Kindergarten Readiness<br>Third Grade Reading Level | 2020, 2021 |
| Vermont Department of Health | Teen pregnancy rate per 1,000 | 2014 ,2016 |
| | Adult diabetes prevalence | 2012-2013, 2015-2016 |
| | Children receiving recommended vaccines | 2011, 2016 |
| | Children receiving a blood lead test in first three years of life | 2014, 2016 |

## COMMUNITY SURVEY QUESTIONS

### 2022 UVMMC CHNA SURVEY

Welcome to the Community Health Survey for Chittenden and Grand Isle Counties.

For language interpretation, call: 802-847-8899.

For the American Sign Language video link- click here.

This survey is being conducted for the University of Vermont Medical Center's Community Health Needs Assessment (CHNA) in collaboration with over 25 community partners on the CHNA Steering Committee. The results will be used to better understand and respond to top community health needs in Chittenden and Grand Isle Counties. Survey results will be made available by March 2022.

If you are 16 years of age or older, and currently live in Chittenden or Grand Isle County you may take this survey.

**Survey Information**

The survey takes about 10 minutes to complete. You may choose to answer or not answer any of the questions. You may choose to stop the survey any time. This survey is anonymous. Individual responses are not reported.

**Random Prize Drawing Information**

There is a random prize drawing for four $50 gift cards that will be awarded at random to people who complete the survey and choose to enter. At the end of the survey, you may choose to enter by including an email address or phone number. We only use this information for the prize drawing. If you are one of the people who are randomly selected, we will contact you about your prize.

The survey is being administered by the University of Vermont's Center for Rural Studies. If you have questions or need assistance, email: Michael.Moser@uvm.edu.

Thank you for your interest in this survey.

**PLEASE SELECT YOUR AGE CATEGORY.**

- ○ Under 16 years of age
- ○ 16 to 18 years
- ○ 19 to 24 years
- ○ 25 to 34 years
- ○ 35 to 44 years
- ○ 45 to 54 years
- ○ 55 to 64 years
- ○ 65 to 74 years
- ○ 75 years and over
- ○ Refuse

**PLEASE SELECT THE NAME OF THE CITY OR TOWN WHERE YOU CURRENTLY LIVE.**

Select

For the purpose of this survey, we ask that you think about your community as the place where you currently live, most of the time.

**PLEASE TELL US YOUR LEVEL OF AGREEMENT OR DISAGREEMENT WITH THESE HUMAN WELLBEING STATEMENTS: IN MY COMMUNITY...**

| | STRONGLY AGREE | SOMEWHAT AGREE | SOMEWHAT DISAGREE | STRONGLY DISAGREE | NO ANSWER |
|---|---|---|---|---|---|
| I trust my neighbors | ○ | ○ | ○ | ○ | ○ |
| I feel safe | ○ | ○ | ○ | ○ | ○ |
| Local government leaders work for people of all backgrounds | ○ | ○ | ○ | ○ | ○ |
| I can participate in cultural or arts events that reflect diverse backgrounds and interests | ○ | ○ | ○ | ○ | ○ |
| I feel a sense of belonging | ○ | ○ | ○ | ○ | ○ |
| I feel accepted for my beliefs or religion | ○ | ○ | ○ | ○ | ○ |
| I feel accepted for my gender or sexual identity | ○ | ○ | ○ | ○ | ○ |
| I feel accepted for my culture | ○ | ○ | ○ | ○ | ○ |
| Some other factor? | ○ | ○ | ○ | ○ | ○ |

**PLEASE TELL US YOUR LEVEL OF AGREEMENT OR DISAGREEMENT WITH THESE PHYSICAL PLACE STATEMENTS: IN MY COMMUNITY...**

| | STRONGLY AGREE | SOMEWHAT AGREE | SOMEWHAT DISAGREE | STRONGLY DISAGREE | NO ANSWER |
|---|---|---|---|---|---|
| I can get the foods I want to eat | ○ | ○ | ○ | ○ | ○ |
| I can access health care services that meet my needs | ○ | ○ | ○ | ○ | ○ |
| I have affordable transportation options | ○ | ○ | ○ | ○ | ○ |
| I have access to reliable internet service | ○ | ○ | ○ | ○ | ○ |
| I have access to public spaces, parks and recreation areas | ○ | ○ | ○ | ○ | ○ |
| I have access to housing that is affordable for my needs | ○ | ○ | ○ | ○ | ○ |
| I have access to safe and healthy housing | ○ | ○ | ○ | ○ | ○ |
| Sidewalks and buildings are easy to use and accessible for all | ○ | ○ | ○ | ○ | ○ |
| I have access to places of worship that meet my beliefs | ○ | ○ | ○ | ○ | ○ |
| Impacts of climate change are being addressed | ○ | ○ | ○ | ○ | ○ |
| Some other factor? | ○ | ○ | ○ | ○ | ○ |

**PLEASE TELL US YOUR LEVEL OF AGREEMENT OR DISAGREEMENT WITH THESE COMMUNITY RESOURCE STATEMENTS: IN MY COMMUNITY...**

| | STRONGLY AGREE | SOMEWHAT AGREE | SOMEWHAT DISAGREE | STRONGLY DISAGREE | NO ANSWER |
|---|---|---|---|---|---|
| Health care providers respect my cultural identity | ○ | ○ | ○ | ○ | ○ |
| Health care providers respect my gender identity | ○ | ○ | ○ | ○ | ○ |
| Health care providers respect my sexual identity | ○ | ○ | ○ | ○ | ○ |
| My language needs are met by health care providers (interpreters available, documents translated) | ○ | ○ | ○ | ○ | ○ |
| I have enough money to pay for the basic things I need | ○ | ○ | ○ | ○ | ○ |
| High-quality educational opportunities are available | ○ | ○ | ○ | ○ | ○ |
| Affordable childcare is available | ○ | ○ | ○ | ○ | ○ |
| Healthy aging resources are available | ○ | ○ | ○ | ○ | ○ |
| Substance use treatment resources are available | ○ | ○ | ○ | ○ | ○ |
| Mental health resources are available | ○ | ○ | ○ | ○ | ○ |
| Some other factor? | ○ | ○ | ○ | ○ | ○ |

## HAVE YOU OR SOMEONE YOU LIVE WITH BEEN DIAGNOSED WITH CANCER WITHIN THE PAST THREE YEARS, WHILE LIVING IN THIS COMMUNITY?

○ Yes

○ No

**PLEASE SELECT THE OPTION THAT BEST REPRESENTS YOUR EXPERIENCE WITH THE FOLLOWING CANCER CARE SERVICES.**

| | MISSING OR LACKING | WORKING WELL | I DON'T KNOW |
|---|---|---|---|
| Access to Cancer Health Care Providers (Timely appointments, Appointments with specialists) | ○ | ○ | ○ |
| Access to Cancer Support Health Care providers (nutritionists, stress relief, mental health counseling, alternative providers) | ○ | ○ | ○ |
| Access to information about cancer (screening services & resources) | ○ | ○ | ○ |
| In home services (caregiver respite, nursing care) | ○ | ○ | ○ |
| Opportunities for health promotion (tobacco cessation, exercise, substance abuse counseling) | ○ | ○ | ○ |
| Financial assistance programs, affordable medications, housing costs, travel costs associated with diagnosis, understanding of insurance coverage | ○ | ○ | ○ |
| Opportunities to participate in community support groups, exercise, recreation programs | ○ | ○ | ○ |
| Access to symptom relief (pain, nausea, etc. with medications, prescriptions or alternative therapies) | ○ | ○ | ○ |
| Information about genetic testing or clinical trials | ○ | ○ | ○ |
| Information about advanced care planning and hospice services | ○ | ○ | ○ |
| Some other service? | ○ | ○ | ○ |

**SELECT THE TOP THREE ACTIONS TO STRENGTHEN THE PHYSICAL ENVIRONMENT FOR YOUR COMMUNITY.**

☐ Increase places to buy healthy food

☐ Increase safety for walkers and bikers

☐ Increase public transportation

☐ Increase safety in public spaces

☐ Increase places for community activities and recreation

☐ Increase affordable housing units

☐ Some other action?_____

**SELECT THE TOP THREE ACTIONS TO STRENGTHEN THE SOCIAL ENVIRONMENT FOR YOUR COMMUNITY.**

☐ Increase anti-racism work

☐ Increase arts and culture events

☐ Increase programs for youth and young families

☐ Increase programs for elders and older adults

☐ Increase connections between community members

☐ Increase resources to prevent bullying

☐ Some other action?_____

**SELECT THE TOP THREE ACTIONS TO STRENGTHEN THE SOCIAL ENVIRONMENT FOR YOUR COMMUNITY.**

☐ Strengthen early childhood education

☐ Strengthen elementary education

☐ Strengthen middle school education

☐ Strengthen high school education

☐ Strengthen education opportunities after high school

☐ Strengthen job training programs

☐ Some other action?_____

**SELECT THE TOP THREE ACTIONS TO STRENGTHEN PEOPLE'S FINANCES FOR YOUR COMMUNITY.**

- ☐ Increase affordable food options
- ☐ Increase affordable housing
- ☐ Increase emergency housing services
- ☐ Increase workforce training
- ☐ Increase jobs that pay a living wage
- ☐ Increase financial literacy trainings
- ☐ Some other action?_____

**SELECT THE TOP THREE ACTIONS TO STRENGTHEN HEALTH CARE FOR YOUR COMMUNITY.**

- ☐ Increase primary care services
- ☐ Increase mental health services
- ☐ Increase substance use disorder treatment services
- ☐ Increase preventative screenings and services
- ☐ Increase cultural competency in health care
- ☐ Increase coordination of care between health care providers
- ☐ Some other action?_____

These last questions are about you and the people that you live with.

Please remember, this survey is anonymous. We do not know who you are. You may choose not to answer any question you do not want to.

After responding, you may choose to click a link to a separate form where you can provide contact information if you want to be included in the prize drawing.

Thank you!

**OVERALL, HOW SATISFIED ARE YOU WITH YOUR LIFE THESE DAYS? ON A SCALE FROM 0 TO 10 WITH 0 BEING LEAST SATISFIED AND 10 BEING MOST SATISFIED.**

| LESS SATISFIED | | | | | MORE SATISFIED | | | | | NO ANSWER |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ○ |

**OVERALL SATISFACTION**

**OVERALL, HOW MUCH HAS COVID IMPACTED YOUR PERSONAL WELLBEING? ON A SCALE FROM 0 TO 10 WITH 0 BEING LEAST IMPACT AND 10 BEING MOST IMPACT.**

| LESS IMPACT | | | | | MORE IMPACT | | | | | NO ANSWER |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ○ |

**OVERALL IMPACT**

**INCLUDING YOURSELF, HOW MANY PEOPLE DO YOU LIVE WITH?**

(enter a number) _____

**HOW MANY PEOPLE DO YOU LIVE WITH THAT ARE UNDER AGE 18?**

(enter a number) _____

**HOW MANY PEOPLE DO YOU LIVE WITH THAT ARE UNDER AGE 5?**

(enter a number) _____

**HOW MANY PEOPLE DO YOU LIVE WITH THAT ARE OVER AGE 65?**

(enter a number) _____

**DO YOU CURRENTLY HAVE HEALTH INSURANCE?**

○ Yes
○ No
○ No Answer

**DO YOU CURRENTLY HAVE DENTAL INSURANCE?**

○ Yes
○ No
○ No Answer

**DO YOU OR SOMEONE YOU LIVE WITH HAVE A CHRONIC HEALTH CONDITION?**

○ Yes
○ No
○ No Answer

**DO YOU OR SOMEONE YOU LIVE WITH HAVE A DISABILITY?**

○ Yes
○ No
○ No Answer

**WHAT IS THE HIGHEST LEVEL OF EDUCATION YOU'VE COMPLETED?**

- ○ Less than High School (no diploma, certificate)
- ○ High School graduate or equivalent
- ○ Some College or University, but no degree
- ○ College, University, or Technical degree
- ○ Advanced or Graduate degree
- ○ No answer

**WHAT IS YOUR EMPLOYMENT STATUS?**

- ○ Employed full-time
- ○ Employed part-time
- ○ Self-employed
- ○ Homemaker
- ○ Full-time student
- ○ Not employed and looking for work
- ○ Not employed and not looking for work
- ○ Retired
- ○ No Answer

**PLEASE CHOOSE THE STATEMENT THAT BEST DESCRIBES YOUR CURRENT HOUSING SITUATION.**

- ○ Rented by me and/or someone in my household
- ○ Owned by me and/or someone in my household
- ○ At a shelter outside
- ○ At transitional or emergency housing
- ○ A situation not listed here_____
- ○ No Answer

**HOW IMPORTANT ARE RELIGIOUS OR SPIRITUAL BELIEFS TO HOW YOU MAKE HEALTH DECISIONS?**

| VERY IMPORTANT | SOMEWHAT IMPORTANT | NOT AT ALL IMPORTANT | NO ANSWER |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

**HOW IMPORTANT ARE PERSONAL OR CULTURAL BELIEFS TO HOW YOU MAKE HEALTH DECISIONS?**

| VERY IMPORTANT | SOMEWHAT IMPORTANT | NOT AT ALL IMPORTANT | NO ANSWER |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

**HOW LONG HAVE YOU LIVED IN THE UNITED STATES?**

○ Less than a year

○ Between 1-5 years

○ More than 5 years, but not my entire life

○ I have lived in the United States my entire life

○ No Answer

**SELECT THE OPTION THAT BEST DESCRIBES YOUR GENDER IDENTITY. WE LIST THE MOST COMMON IDENTITIES WHILE RECOGNIZING THIS IS NOT A COMPLETE LIST.**

○ Cisgender female (gender identity matches sex assigned at birth)

○ Cisgender male (gender identity matches sex assigned at birth)

○ Genderqueer, non-binary, or fluid

○ Transgender female

○ Transgender male

○ A gender not listed here_____

○ No Answer

**SELECT THE OPTION THAT BEST DESCRIBES YOUR SEXUAL ORIENTATION. WE LIST THE MOST COMMON IDENTITIES WHILE RECOGNIZING THIS IS NOT A COMPLETE LIST.**

○ Heterosexual/Straight

○ Pansexual

○ Gay/Lesbian

○ Queer

○ Asexual

○ Bisexual

○ A sexual orientation not listed here_____

○ No Answer

**PLEASE SELECT ALL OF THE IDENTITIES THAT YOU USE TO DESCRIBE YOURSELF. THIS IS A MODIFIED LIST OF THE MOST COMMON GOVERNMENT CATEGORIES. WE RECOGNIZE THIS IS NOT A COMPLETE LIST.**

☐ Asian
☐ African American
☐ Black
☐ White
☐ Hispanic/Latino/Latine/Latinx
☐ Arab
☐ Native American or Alaskan Native
☐ Native Hawaiian or Pacific Islander
☐ Another identification not listed here _____

**WHAT IS YOUR RELIGIOUS OR SPIRITUAL AFFILIATION?**

○ Please write it here _____
○ I do not have one
○ No Answer

**ABOUT HOW MUCH DID YOU EARN WORKING LAST YEAR?**

○ Less than $25,000
○ $25,000-$50,000
○ $50,000-$75,000
○ $75,000-$100,000
○ $100,000-$125,000
○ $125,000-$150,000
○ More than $150,000
○ No Answer

**IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT COMMUNITY HEALTH AND WELLBEING?**

_____

_____

_____

After submitting your survey by clicking on the arrow at the right below, you can choose to click a link to enter the random prize drawing to possibly be selected to win one of four $50 gift cards.

## FOCUS GROUP QUESTIONS

1. What does health mean to you?
2. What resources (programs, services, people) help to support your health and wellbeing?
   a. Why are these working?
   b. How could they be improved?
3. What challenges do you face in having good health and wellbeing? What makes it difficult to maintain or improve your health?
4. What other resources could address these challenges to your health?
5. If you had a magic wand, what would you change to improve health in your community?
6. Is there anything else related to the health and wellbeing of your community that you'd like to share with us?

# DATA GATHERING METHODS NOTES

The 2022 CHNA data gathering process used a collaborative approach to conducting a mixed methods assessment of health and wellbeing priorities for Chittenden and Grand Isle Counties. This page outlines some key information and standard limitations associated with the data gathering methods.

## KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

- Selection of participants for the Key Informant Interviews was informed by the Work Group who worked across the Social Determinants of Health domains.
- Key Informant Interviewee perspectives provided valuable insights into health wellbeing across the community yet cannot be generalized as perspectives representing the whole community.
- This assessment included five focus groups. The Work Group informed the selection of these groups after a review of the Key Informant Interviews and Community Survey results.

Similar to the Key Informant Interviews, the findings from the focus groups cannot be generalized to the whole community.

## SECONDARY DATA

- The years of available data vary considerably due to the various sources and data availability.
- Most indicator data are derived from samples which may not be fully representative.
- All data contain a Margin of Error and can be found at the original source (see Secondary Data Sources Listing).
- Data sampled from smaller populations are often subject to larger relative shifts over time than data from larger populations.
- Data sampled from smaller populations (Grand Isle County) are more likely to be suppressed and not available to the public (n/a).
- Self-reported secondary data indicators are subjective and can be less accurate.
- Focusing on trends over time does mitigate some data inaccuracy.

## COMMUNITY SURVEY

- The Community Survey was a collaborative and iterative process that incorporated feedback from the CHNA Steering Committee and Work Group.
- The survey was designed using the Social Determinants of Health (SDoH) domains and utilized health equity as a guiding principle.
- Efforts were made to make the survey language as accessible and inclusive as possible.
- Question development was also informed by gaps in existing population health data that were identified through the efforts of the Secondary Data Work Group.
- The survey was made public on September 15, 2021 and was live for four weeks, until October 15, 2021. A total of 3,771 completed surveys were collected using a convenience sample.
- Great effort was made to ensure that organizations operating within the Chittenden and Grand Isle communities were actively engaged in promotion and outreach for the survey.

- While the survey was conducted primarily online, multiple outreach modes were employed. This included:
  - placement of printed surveys, palm cards and posters with QR codes in public spaces and specific events
  - distribution of paper surveys and QR code information at specific events and within local organizations
  - one-to-one survey taking support and interpretation services provided to community members with limited English proficiency and in American Sign Language. About 5.5% of total survey responses were completed in a language that was not English indicating that the outreach efforts were successful as the U.S. Census Bureau estimates that about 7.5% of households in the region speak a language other than English at home.
  - The very large number of completed responses means that the survey achieved a confidence level of 95% and a confidence interval (Margin of Error) of +/-1.6%. This means that if this study were conducted 100 times, 95 of those times, the results provided below would fall within a margin of +/-1.6% of what was found in this effort. This is a commonly accepted threshold for applied social science research of this type.

## EXISTING HEALTH CARE FACILITIES AND RESOURCES

The IRS requires that Community Health Needs Assessments identify important health care facilities and resources available within the community to address the health priorities. Many identified in this list have been engaged in the 2022 CHNA process or were highlighted by community members. It is important to note that this list is not exhaustive; there are many additional groups, organizations, schools, and municipalities working to improve health and wellbeing across our community.

| COMMUNITY ORGANIZATIONS | ORGANIZATION WEBSITE |
|---|---|
| Abenaki Nation of Missisquoi | https://www.abenakination.com/ |
| Age Well | https://www.agewellvt.org/ |
| Agency of Education | https://education.vermont.gov/ |
| Agency of Human Services | https://humanservices.vermont.gov |
| Alcoholics Anonymous (Area 70) | https://aavt.org/ |
| American Foundation for Suicide Prevention (AFSP Vermont) | https://afsp.org/chapter/vermont |
| American Red Cross of Northern New England | https://www.redcross.org/local/me-nh-vt.html |
| ANEW Place | https://www.anewplacevt.org/ |
| Association of Africans Living in Vermont | https://www.aalv-vt.org/ |
| Boys and Girls Club of Burlington | https://www.bandgclub.org/ |
| Building Bright Futures | https://buildingbrightfutures.org/ |
| Burlington Community Justice Center | https://www.burlingtoncjc.org/ |
| Burlington Housing Authority | https://burlingtonhousing.org/ |
| Burlington Partnership for a Healthy Community | http://www.burlingtonpartnership.org |
| Cathedral Square | https://cathedralsquare.org/ |
| Center for Health and Learning | https://healthandlearning.org/ |
| Centerpoint | https://centerpointservices.org/ |
| Champlain Community Services | https://ccs-vt.org/bridging/ |
| Champlain Housing Trust | https://www.getahome.org/ |
| Champlain Islanders Developing Essential Resources | https://cidervt.org/ |
| Champlain Valley Head Start | https://champlainvalleyheadstart.org/ |
| Champlain Valley Office for Economic Opportunity (CVOEO) | https://www.cvoeo.org/ |

| COMMUNITY ORGANIZATIONS | ORGANIZATION WEBSITE |
|---|---|
| Champlain Valley Superintendents Association | https://www.cvsdvt.org/ |
| Chittenden Accountable Community for Health (CACH) | https://www.cachvt.org/ |
| Chittenden County Network for Children, Youth, and Families | No website found |
| Chittenden County Homeless Alliance | https://helpingtohousevt.org/localcontinuaofcare/chittenden/ |
| Chittenden County Partnership | No website found |
| Chittenden County Regional Planning Commission | https://www.ccrpcvt.org/ |
| Clemmons Family Farm, Inc. | https://www.clemmonsfamilyfarm.org/ |
| Committee on Temporary Shelter (COTS) | https://cotsonline.org/ |
| Community Health Centers of Burlington | https://www.chcb.org/ |
| Community Health Investment Fund | www.UVMHealth.org/medcenter/about-uvm-medical-center/the-community/grants |
| Community of Vermont Elders | https://www.vermontelders.org/ |
| Disabilities, Aging and Independent Living | https://dail.vermont.gov/ |
| DREAM | https://www.dreamprogram.org/ |
| Efficiency Vermont | https://www.efficiencyvermont.com/services/renovation-construction/weatherization |
| Eleanor M. Luse Center for Communication: Speech, Language, and Hearing | https://www.uvm.edu/cnhs/luse_center |
| Essex Community Health Initiatives and Programs for Students (Essex CHIPS) | https://www.essexchips.org/ |
| Evolution House | https://soberhousedirectory.com/property/evolution-house/ |
| Feeding Chittenden | https://feedingchittenden.org/ |
| First Step Recovery | https://soberhousedirectory.com/property/first-step-recovery-vermont/ |
| Food Not Bombs (Burlington) | https://www.foodnotbombs.net/vermont.html |
| Give Way to Freedom | https://givewaytofreedom.org/ |
| Greater Burlington YMCA | https://www.gbymca.org/ |
| Help Me Grow Vermont | https://www.helpmegrowvt.org/ |

| COMMUNITY ORGANIZATIONS | ORGANIZATION WEBSITE |
|---|---|
| Helping and Nurturing Diverse Seniors (HANDS) | www.handsvt.org |
| HomeShare Vermont | https://www.homesharevermont.org |
| Hope Works | https://hopeworksvt.org |
| Howard Center | https://howardcenter.org/ |
| Hunger Council of Chittenden County | https://hungerfreevt.org/hunger-council-of-chittenden-county |
| Hunger Council of Franklin and Grand Isle Counties | https://www.hungerfreevt.org/hunger-council-of-franklin-grand-isle-counties |
| Hunger Free Vermont | https://www.hungerfreevt.org/ |
| Inner Space | www.innerspace.org |
| Intervale Center | https://www.intervale.org/ |
| KidSafe Collaborative | https://www.kidsafevt.org/ |
| King Street Center | https://kingstreetcenter.org |
| Lake Champlain Regional Chamber of Commerce | https://www.bbavt.org/members/lake-champlain-regional-chamber-of-commerce/ |
| Let's Grow Kids | https://letsgrowkids.org/ |
| Lund | https://lundvt.org |
| Mental Health First BTV | https://www.facebook.com/mentalhealthfirstBTV/ |
| Mercy Connections | https://mercyconnections.org/ |
| Military Kids Vermont | https://www.facebook.com/MKVermont |
| Milton Community Youth Coalition | https://miltonyouth.org |
| Missionary Sisters of Our Lady of Africa | No website found |
| National Alliance on Mental Health (Vermont) | https://namivt.org |
| Northeastern Family Institute Vermont | https://www.nfivermont.org |
| Northwest Regional Prevention Network | https://unitedwaynwvt.org/prevention-center-of-excellence |
| Northwestern Counseling and Support Services | www.ncssinc.org |
| Northwestern Medical Center | https://www.northwesternmedicalcenter.org |
| Office of Racial Equity Inclusion and Belonging (City of Burlington) | https://www.burlingtonvt.gov/CityCouncil/RacialEquityInclusionBelonging |

| COMMUNITY ORGANIZATIONS | ORGANIZATION WEBSITE |
|---|---|
| Office of the Health Care Advocate | https://vtlawhelp.org/health |
| OneCare Vermont | https://www.onecarevt.org/ |
| Outright Vermont | https://www.outrightvt.org/ |
| Parent University (Burlington School District) | https://www.bsdvt.org/our-schools/parent-university/ |
| Pathways Vermont | https://www.pathwaysvermont.org |
| Peace and Justice Center | www.pjcvt.org |
| PenArts Communications | https://penartscommunications.com/ |
| Pine Forest Children's Center | https://www.thepineforest.org/ |
| Planned Parenthood of Northern New England | https://www.plannedparenthood.org/planned-parenthood-northern-new-england |
| Prevent Child Abuse Vermont | https://www.pcact.org |
| Pride Center of Vermont | https://www.pridecentervt.org/ |
| Rebuilding Together (Greater Burlington) | https://www.rebuildingtogetherburlington.org |
| Refugee and Immigrant Service Provider Network (RISPNet) | https://www.rispnet.com |
| Safe Kids Vermont | https://www.safekids.org/coalition/safe-kids-vermont |
| Sarah Holbrook Community Center | https://sarahholbrookcc.org |
| Somali Bantu Community Association of Vermont | https://www.somalibantuvermont.org |
| South Hero Land Trust | https://www.shlt.org/ |
| Special Olympics Vermont | https://www.specialolympicsvermont.org |
| Spectrum Youth and Family Services | https://www.spectrumvt.org |
| Steps to End Domestic Violence | https://www.stepsvt.org |
| Support and Services at Home (SASH) | https://sashvt.org |
| Supportive Services for Veterans and Families at the University of Vermont | https://ssvf-uvm.com |
| Janet S. Munt Family Room | https://www.thefamilyroomvt.org/ |
| The Nulhegan Band of the Cooksuk Abenaki Nation | https://abenakitribe.org/ |
| The University of Vermont Medical Center | www.UVMHealth.org/medcenter |
| Turning Point Center of Chittenden County | https://turningpointcentervt.org |

| COMMUNITY ORGANIZATIONS | ORGANIZATION WEBSITE |
|---|---|
| U.S. Committee for Refugees and Immigrants | https://refugees.org/ |
| United Way of Northwest Vermont | https://unitedwaynwvt.org/ |
| University of Vermont Center for Rural Studies | https://www.uvm.edu/crs |
| University of Vermont Extension | https://www.uvm.edu/extension |
| University of Vermont Home Health and Hospice | www.uvmhomehealth.org |
| University of Vermont Integrative Health | https://www.uvm.edu/cnhs/integrativehealth |
| University of Vermont Larner College of Medicine | http://www.med.uvm.edu/ |
| University of Vermont's Children's Hospital | www.UVMHealth.org/childrens-hospital |
| Vermont 2-1-1 | https://vermont211.org |
| Vermont Afterschool | https://vermontafterschool.org/ |
| Vermont Blueprint for Health | https://blueprintforhealth.vermont.gov/ |
| Vermont Business Roundtable | https://vtroundtable.org/ |
| Vermont Businesses for Social Responsibility | www.vbsr.org |
| Vermont Cares | https://vtcares.org/ |
| Vermont Catholic Charities | https://vermontcatholic.org/ministries-programs/catholic-charities |
| Vermont Center for Independent Living | https://vcil.org/ |
| Vermont Child Health Improvement Program (VCHIP) | http://www.med.uvm.edu/vchip |
| Vermont Commission on Women | https://women.vermont.gov |
| Vermont Department for Children and Families | https://dcf.vermont.gov |
| Vermont Department of Health | https://www.healthvermont.gov/ |
| Vermont Family Network | https://vermontfamilynetwork.org |
| Vermont Foodbank | https://www.vtfoodbank.org |
| Vermont Foundation of Recovery | http://www.vfor.org |
| Vermont Garden Network | www.vtgardens.org |
| Vermont Health Equity Initiative | https://www.vermonthealthequity.org |
| Vermont Housing Finance Agency | https://www.vhfa.org |
| Vermont Indigenous Heritage Center | https://ethanallenhomestead.org/history/abenaki-heritage/ |

| COMMUNITY ORGANIZATIONS | ORGANIZATION WEBSITE |
|---|---|
| Vermont Interfaith Action | https://viavt.org/ |
| Vermont Landlord Association | https://www.vtlandlord.com |
| Vermont Legal Aid | https://www.vtlegalaid.org/ |
| Vermont Mental Health Counselors Association | https://www.vtmhca.org |
| Vermont National Guard | https://vt.public.ng.mil |
| Vermont Network Against Domestic and Sexual Violence | https://www.vtnetwork.org |
| Vermont New American Advisory Council | https://www.vnaac.org/ |
| Vermont Office of Veterans Affairs | https://veterans.vermont.gov/office-veterans-affairs |
| Vermont Partnership for Fairness and Diversity | https://vermontpartnership.org |
| Vermont Professionals of Color Network | https://vtpoc.net |
| Vermont Psychological Association | https://vermontpsych.org |
| Vermont Public Health Association | https://vtpha.org/ |
| Vermont Public Health Institute | https://vtphi.org/ |
| Vermont Racial Justice Alliance | https://www.vtracialjusticealliance.org/ |
| Vermont Roman Catholic Diocese | https://vermontcatholic.org/ |
| Vermont State Housing Authority | https://vsha.org |
| Vermont Suicide Prevention Coalition | https://vtspc.org/coalition |
| Vermont Works for Women | https://www.vtworksforwomen.org/ |
| Vermonters for Criminal Justice Reform | https://vcjr.org |
| Winooski Housing Authority | www.winooskihousing.org |
| Winooski Partnership for Prevention | https://winooskiprevention.org/ |

## CALENDAR YEAR 2021: WORK TO DATE

# Implementation Strategy
# Priority Focus: Mental Health

*Board approved 12/9/2019*

**GOAL: Expand access to high-quality, comprehensive mental health resources to improve the health and well-being of our patients, their families, and community members in Chittenden and Grand Isle Counties**

### OBJECTIVE # 1

**To create a Collaborative Care Model for mental health care within UVM Medical Center medical homes**

***Target Population:*** Patients of UVM Medical Center

***Strategy:***

Implement The University of Vermont Health Network's Mental Health Strategic Plan for Primary Care Integration within UVM Medical Center: Embed Psychiatrists, Mental Health Clinicians, and Care Managers in Adult Primary Care, and Pediatric Primary Care Practices.

***2021 progress against identified measures:***

% of UVM Medical Center Primary and Pediatric Primary Care Practices where model is implemented

- Model in place in five of the 10 sites (50%)
- 32,853 patients covered

% of patients who had 30 day follow up after discharge from the Emergency Department for alcohol and other substance use dependence* (plan for pulling this data is being developed)

% of patients who had 30 day follow up after discharge from the Emergency Department for mental health* (plan for pulling this data is being developed)

% screened for clinical depression and have a follow up plan*

- New patients and patients with appointments for physicals undergo behavioral health screening, which includes screening for depression. For every screening completed, a follow-up plan is documented in the patient's chart. Current metrics for this are:
  - South Burlington Family Medicine: 47% of patients have been screened.
  - Adult Primary Care South Burlington: 47% of patients have been screened.
  - Colchester Family Medicine: 47% of patients have been screened.
  - UPEDS Burlington: 59% of patients have been screened.
  - UPEDS Williston: 67% of patients have been screened.

% readmitted to inpatient psychiatry program due to clinical depression* (plan for pulling this data is being developed.)

**Of the practices that have implemented the model*

5

## OBJECTIVE # 1 CONT.

*Key Partners:*

Community-based organizations in Chittenden and Grand Isle Counties

University of Washington, Psychiatry & Behavioral Sciences Division of Population Health

6

## OBJECTIVE # 2

**Screen youth, ages 12 to 24, who utilize the Emergency Department, using a comprehensive approach to assess the severity of and/or risk of substance use and mental health symptoms**

***Target Population***: Youth ages 12-24 who utilize the Emergency Department at the UVM Medical Center

***Strategy:***

The Emergency Department Social Workers will screen youth using the Youth Screening, Brief Intervention and Referral to Treatment (Y-SBIRT) model which is a set of tools to assess the severity of substance use and mental health symptoms, identify the appropriate level of treatment and provide brief intervention if needed.

***2021 progress against identified measures:***

*The YSBIRTS pilot program in the Emergency Department concluded in March 2020. Following the conclusion of this pilot program, additional organizational strategies to address the youth mental health priority were implemented at various levels within the organization and community. These included:*

- Providing education on best practices for suicide risk assessment and management in primary care to providers at UVM Medical Center, UVM Children's Hospital and local community organizations.
- Providing Psychological First Aid (PFA) training to staff and regional community partners to support colleagues and community members dealing with ongoing COVID-19 related stress.
- Hosting a national conference on "Primary Care Mental Health Integration," with interdisciplinary attendance from around the region and country.
- Joining the state's legislative task force on mental health integration and engaging with key partners to enhance our mental health care system for all Vermonters.
- Providing opportunities for education and training in primary care mental health treatment through the psychology pre-doctoral internship program, and developing a new fellowship service line in primary care mental health treatment.
- Refining tools in our electronic medical record to promote measurement-based care and efficient access to mental health support.

***Key Partners:***

Spectrum Youth & Family Services

Howard Center

7

## OBJECTIVE # 3

**Assess gaps in service delivery and identify opportunities for alignment with community partners around strategic resource allocation to best address prevention, early intervention and access to mental health services for all populations**

***Target Population***: Patients of UVM Medical Center, community members of Chittenden and Grand Isle Counties

***Strategies:***

1. The Chittenden Accountable Community for Health (CACH) will identify and implement evidence based initiatives addressing the identified priority focus of suicide prevention, in alignment with their goal of achieving population health through collaboration.

2. The Community Health Investment Fund (CHIF) will invest annually in community initiatives that further the 2020-2022 priority area of mental health.

3. Via the Child and Adolescent Psychiatry & Psychology Consult Program (CAPPCON), improve coordination and interdisciplinary communication between the Emergency Department, inpatient pediatrics, pediatric medical homes, and community-based mental health providers to better serve children and families who may require mental health care.

***2021 progress against identified measures:***

1. CACH identified initiatives for all three Action Teams. These initiatives were implemented throughout 2021. An overview of the actions taken by each Action Team can be found below:

**Screening and Intervention Action Team (SIAT)**

- **Initiative:** The Action Team worked with participating patient-centered medical homes and primary care practices on a quality improvement initiative to expand or establish suicide screening programs and develop suicide-safer pathways to care that are rooted in research and best practices.
    - Worked with two primary care practices, Community Health Centers of Burlington and Champlain Center for Natural Medicine, to expand and improve suicide screenings, workflows and referral networks. This included establishing a partnership between each practice and a designated mental health agency, Howard Center.
    - Facilitated the delivery of suicide care training by clinical experts from Howard Center to Champlain Center for Natural Medicine staff.
    - Supported each UVM Medical Center practice in identifying data measures and establishing workflows for collecting data to monitor the effectiveness of suicide screening, safety plan development and referrals.
    - Began work with a third adult primary care practice, UVM Medical Center – South Burlington.

8

## OBJECTIVE # 3 CONT.

*2021 progress against identified measures:*

- **SIAT (cont'd):**
    - Began work with UVM Medical Center's Quality Improvement team and Information Technology staff responsible for EPIC, a cloud-based electronic health records system. The goal of this collaborative effort is to ensure that all screenings, safety plans and related pathway-to-care information are available and utilized in EPIC. Information Technology staff will work with the UVM Medical Center South Burlington Adult Primary Care Practice to ensure that information is documented, utilized and shared digitally. This will lead to best practice in patient care.

**Reducing Stigma Action Team**

- **Initiative:** The team will evaluate and quantify the level of suicide-related stigma across Chittenden County by utilizing an evidence-based tool. Based on this data, it will develop and implement initiatives to decrease the level of suicide-related stigma across specific demographic populations.
    - Began an in-depth and detailed analysis of the 465 responses gathered from the survey by an Action Team member who is a doctorate-level research and statistical analyst. This analysis will serve as the baseline and foundation for targeted interventions that address suicide-related stigma in Chittenden County.
    - Submitted a second application to the Institutional Review Board to distribute the survey to the Vermont Air National Guard due to a lack of male responses. The application was approved.
    - Distributed the suicide-related stigma survey to the Vermont Air National Guard, where individuals who identify as male predominate. The responses are currently being submitted.

**Social Connectedness Action Team**

- **Initiative:** The team will carry out an evidence-based pilot project to address loneliness across the community.
    - Established a connection with Dr. Renee Pepin, whose research and evidence-based interventions related to loneliness have proven effective for older adults.
    - Solidified arrangement with Support and Services at Home (SASH) to implement pilot project at one SASH location.
    - Obtained baseline data related to loneliness to support the evaluation of the initiative's effectiveness.
    - Solidified arrangement with the UVM College of Nursing and Health Sciences Integrative Health program to identify and recruit Behavioral Activation Coaches for the pilot project. Students from the Integrative Health program will receive training and provide direct services to program participants while also earning experience hours towards Board Certification.

9

## OBJECTIVE # 3 CONT.

2. *% of CHIF funding invested annually in community-based mental health programs*

The Community Health Investment Committee (CHIC) is responsible for disbursing the Community Health Investment Fund (CHIF) by providing grants across four categories. In 2021, 13 of 19 grants were provided by CHIC to community-based mental health programs. This is an increase of nearly 10% from 68% in 2020.

COVID-19 and the acknowledgement of racism as a public health emergency continued to guide the efforts of the CHIC in two primary ways over the course of 2021:

A. Emerging Need grants: One-time investments for either start-up or emergency bridge funding were strategically provided to bolster critical community organizations' resiliency in the face of the COVID-19 pandemic and acknowledge racism as a public health emergency.

VT Professionals of Color Network, Outreach, $39,112.50

Funding was provided to Vermont Health Equity Initiative (VHEI) for outreach efforts that shared COVID-19 information with the community in the period before children under the age of 12 were allowed to receive the vaccines, and for education about the COVID-19 Delta variant when it became a national public concern.

While more than 88% of Vermont's population is vaccinated, there is still vaccination hesitancy in the BIPOC community. In order to address this, VHEI used the support it received to bolster its primary outreach methods, which include the VHEI website (www.vermonthealthequity.org) and social media platforms (Instagram and Facebook), and to maintain a staff person dedicated to the management of outreach communications.

ANEW Place, Transitional Housing, $12,000

Due to changes to the State of Vermont's emergency housing program that began in July, the need for affordable housing was greater than ever. Staffing to address this need was crucial. CHIC provided ANEW Place $12,000 to support annual employment costs for the Transitional Housing Director at Independence Place.

Greater Burlington YMCA, On-site Professional Mental Health Services, $25,000

The funding supported access to emotional and mental health support for community members served by the YMCA, and for YMCA staff. Funds were also used to provide on-site professional mental health services for families and children with social, emotional and behavioral challenges, as well as resources and strategies for teachers to use in the classroom.

Pathways Vermont, Rapid Re-housing, $15,000

Pathways received funding for its newly expanded statewide rapid re-housing services. The support helped the organization address some of UVM Medical Center's priority areas, including mental health and family health, by providing housing and services to Vermonters experiencing homelessness during COVID-19.

10

## OBJECTIVE # 3 CONT.

**B.** Focus on racial equity and historically excluded communities: In order to ensure equitable access to grant application opportunities, the committee took inventory of all communication pathways by which community organizations could come to find out about them. On this basis, efforts were made to ensure that specific BIPOC organizations, smaller organizations and groups who have not historically applied for a CHIC grant were informed of grant opportunities and encouraged to apply.

- The committee continued to modify applications and reporting to assess its success in addressing racial equity and health disparities through grant-funded activities. This work included examining and updating "letter of intent" forms and grant applications to incorporate the following language, which serves as a foundation for all CHIC activities:

"In an effort to address systemic harm that disproportionately affects historically excluded communities, the Community Health Investment Committee (CHIC) will identify, support and collaborate with specific nonprofits and other partner organizations who incorporate diversity, equity, and inclusion efforts into their work, their leadership and as part of their mission. Organizations that incorporate diversity, equity, and inclusion efforts into their work and as part of their mission are more effective in engaging and serving excluded communities and people across different cultures, backgrounds and abilities. Further, CHIC aims to support organizations that promote a culture that demonstrates practices of diversity, equity and inclusion. Applications are encouraged from organizations that have established such practices or are currently working to embed such practices."

**3a.** # of consults conducted by the Child and Adolescent Psychiatry & Psychology Consult Program (CAPPCON)

- The CAPPCON team continued to treat high volumes of children and adolescents experiencing mental health emergencies in the Emergency Department and inpatient pediatric units.

**Inpatient Pediatrics**

- The team treated 140 children, whose diagnoses ranged from behavioral dysregulation to eating disorder conditions, in inpatient pediatrics units in 2021. CAPPCON leadership worked with the inpatient pediatrics leadership team to refine clinical pathways for eating disorder treatment and de-escalation. Leadership also participated in the quality improvement review process to improve the quality and safety of care delivered to children admitted to UVM Children's Hospital.

**Emergency Department**

- The CAPPCON team treated over 235 children in the Emergency Department in 2021. This represents an increase of 111% from 2020. The CAPPCON team developed, tested and implemented a pilot program aimed at reducing the number of children boarding in the Emergency Department. This unique clinical pathway prevented 16 children from boarding in the Emergency Department while they awaited placement.

11

## OBJECTIVE # 3 CONT.

**3b.** Improved provider satisfaction with care provided to this population (mechanism for data collection is forthcoming).

**3c.** Improved patient satisfaction with care provided to this population (mechanism for data collection is forthcoming).

*Additional highlights:*

**System Improvement:**

- CAPPCON leadership has been instrumental in developing clinical pathways, training care teams and building capacity to mitigate the effects of the workforce shortages that are affecting the mental health care system.
- Leadership also authored a job description for a case manager position dedicated to the CAPPCON team that will holistically address individual patient needs as well as system-wide needs.
- The co-directors of CAPPCON helped to develop "Trauma Informed Teams" in the Emergency Department.

***Key Partners:***

Community-Based Organizations in Chittenden and Grand Isle Counties

Community Health Investment Committee (CHIC), Chittenden Accountable Community for Health (CACH) members and member organizations

12

## ABOUT OUR CONSULTANTS

*UVMMC Community Health Improvement selected the Center for Rural Studies at the University of Vermont (CRS) as local consultants to support the development of the 2022 CHNA. Research Specialists Kerry Daigle, Kelly Hamshaw, and Michael Moser led research activities and provided facilitation support throughout the assessment process.*

The Center for Rural Studies (CRS) at the University of Vermont (UVM) is a nonprofit, fee-for-service research organization that addresses social, economic, and resource-based problems of rural people and communities. Based in the UVM College of Agriculture and Life Sciences, CRS provides consulting and research services in Vermont, the United States, and abroad. The research areas are divided into five main areas: Agriculture, Human Services and Education, Program Evaluation, Rural Community and Economic Development, and Vermont Community Data. The mission of CRS is to promote the dissemination of information through teaching, consulting, research, and community outreach. Primary emphasis is placed upon activities that contribute to the search for solutions and alternatives to rural problems and related issues. Bringing decades of experience to its work, CRS recognizes that answers to critical and timely questions often lie within a community or organization.

For questions about the Center for Rural Studies at the University of Vermont, please contact Director Jane Kolodinsky at Jane.Kolodinsky@uvm.edu.