



Vermont 2025 Title V Needs Assessment

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Division of Family and Child Health

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EXECUTIVE SUMMARY

As a recipient of federal Title V funds administered by the Health and Resources Services Administration (HRSA),¹ the Vermont Department of Health (VDH) Division of Family and Child Health (FCH) is required to apply for funding each year, to submit an Annual Report, and to complete a statewide, comprehensive needs assessment every five years. Vermont's previous Title V needs assessment was completed in 2020, prior to the onset of the COVID-19 pandemic. This needs assessment report aggregates information from VDH statewide data (surveillance) systems together with surveys and focus groups with parents/caregivers across Vermont, as well as providers such as pediatricians and primary care providers, early intervention specialists, school nurses, state agency staff, and numerous others. In all, more than 700 individuals contributed to this assessment, providing valuable information about health and wellness for infants, children, adolescents, young adults, and parents/caregivers.

“The dream is to have a fully, over-resourced system of care: education, medical services, mental health access– all of it– that touches every town and is accessible for every family based on their needs.”

By many measures, most Vermont children and families are healthy and well. VDH tracks national performance measures (NPMs) and state performance measures (SPMs) for each Title V domain through a variety of statewide data systems. Overall, Vermont performs better than the United States as a whole. These indicators demonstrate that Vermont appears to have areas of strength in birth practices and outcomes, breastfeeding, safe sleep practices, childhood and adolescent obesity rates, immunization, and access to/quality of health services. Because health and wellness is dynamic and multi-faceted, with many variations across Vermont's communities and settings, even in areas of strength, there are often opportunities to improve conditions. By reviewing statewide surveillance data alongside input from parents/caregivers and providers, this assessment sheds light on the true complexity of key measures across a wide range of health topics.

In engaging a large group of FCH constituents in this needs assessment, VDH has sought to understand the factors that support health and wellness for the populations FCH serves. While the assessment generally approached engagement from an asset-focused framework, participants were invited to raise any topic they found important to the extent to which systems are working to support health and wellbeing for families. In the post-pandemic context of this data collection, numerous factors external to FCH services and activities are at the forefront of families' thinking about health. Many of the core issues identified in this assessment were raised in the 2020 Title V needs assessment, but the level of concern about the most significant issues has changed substantially.

¹ Title V Maternal and Child Health (MCH) Services Block Grant website: <https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-services-block-grant>

Three core areas were identified by almost every parent/caregiver and provider who participated in the needs assessment:

1. **Mental Health and Substance Use:** The widespread demand for mental health services, especially for children and adolescents, is undeniable. Vermont’s systems of care for families are struggling to adapt to rising needs at multiple intervention points, leaving many families with challenges in accessing timely and appropriate care. While most topics generate a range of strengths and challenges, almost all of the hundreds of references to mental health and substance use reflected a high degree of frustration, dissatisfaction, or worry from both parents/caregivers and providers.
2. **Financial Stability:** Many families are struggling to afford basic needs, housing, and healthcare. Parents/caregivers frequently identified financial concerns as one of the most important things contributing to, or undermining health for themselves and their families. Providers of all kinds struggle to provide care within their regular scope without first addressing basic needs, and report that Vermont’s economic climate compounds workforce recruitment and retention challenges.
3. **Access to Care:** For all of FCH’s focus populations, there is a need for care located nearby, with reasonable wait times, easy scheduling, and sufficient availability of providers and specialists who provide high-quality care. For well-resourced families with access to transportation, most of these factors are working adequately. For families with more barriers, access to care challenges can be insurmountable, limiting their likelihood of receiving needed care.

“Children’s Medicaid in Vermont has been amazing with a number of health issues that have come up for my kiddos, letting me get them the care they need without worrying about how to pay for it.”

Within these topics, assessment participants identified system of care, workforce, and equity challenges as well as strengths. Importantly, the largest themes were identified by parents/caregivers and providers in every county and region, by parents/caregivers of children and adolescents of every age group, and by every participant demographic.

This Title V Needs Assessment Report is organized both thematically and by Title V domain to examine these issues and many others that contribute to health and well-being for infants, children, adolescents, young adults, and parents/caregivers.

Insights



Several important strengths, opportunities, and challenges emerged regarding influences and conditions of health and well-being for Vermont's infants, children, adolescents, young adults, and parents/caregivers.

Stress, mental health, financial stability and supportive connections are critically impacting health and well-being for all.

In all, data points on these four topics represent thousands of statements made by an overwhelming majority of both parents/caregivers and providers. As the most frequently identified topics by all stakeholder groups, these issues are truly cross-cutting. Individuals from every community of focus, region, age group, and population spoke about the way stress, mental health, and finances undermine their health and wellbeing. While these topics were all identified in the previous Title V needs assessment in 2020, their magnitude overshadows many other areas within the Title V population domains (e.g., these issues are of great concern to pregnant people, adolescents, families of children with special health needs, etc.). From an equity perspective, these issues appear to be a significant source of struggle for BIPOC, LGBTQ+, and Medicaid-eligible families, as well as those with children who have special health needs. Importantly, stress, mental health, and financial stability all touch on 'access to care' concerns driven by geography, availability of providers, health insurance status, and other factors. The challenges and frustrations that households and providers shared implicate social norms, economic and educational systems, and community integrity as critical factors shaping the lives of children and families.

The Division of Family and Child Health is meaningfully working to engage communities of focus in programs, services, and feedback loops.

One result of the needs assessment is a process finding: since the 2020 Title V Needs Assessment was conducted, VDH has broadly invested in strengthening its systems to engage communities, including those with greater health disparities. The addition of the Health Equity Team, and its work to build effective networks among FCH's core constituencies was supremely valuable in facilitating outreach to well-established networks, ensuring strong community engagement for the needs assessment survey and focus groups. As a result, the assessment engaged high percentages of LGBTQ+, BIPOC, and Medicaid eligible parents and caregivers, as well as parents/caregivers of children with special health needs. FCH gives thoughtful attention to cultural and linguistic accessibility, approaches to reaching and engaging communities that minimize or remove barriers (such as enabling individuals who identified a need for assistance to complete the survey by telephone), and examines and re-examines the ways the Division can work side-by-side with, and not simply "on behalf of" Vermonters. These practices were applied consistently by the staff team that supported the Title V Needs Assessment and will contribute to effective planning and programming in the future.

Vermont needs a system of care with strong connectivity across home, school/early care, and healthcare domains. System-of-care and access-to-care issues were frequently identified as both strengths and challenges by parents/caregivers and providers. “Education” or “school” were among the most frequently identified concerns by parents, even though these settings and systems are largely outside the traditional ‘health’ arena. Current systems to support family health and well-being work well in some places but are siloed in others. These regional differences can bolster or undermine the quality of care and access. Competing funding mandates across state agencies, state-driven payer models, and insurance obstacles were often cited as the cause of service fragmentation that impedes access to care for children and families.

Access to care is often determined by household financial circumstances. Across geographic regions, communities of focus, and other household characteristics, assessment participants shared a compelling narrative: Those with basic financial stability and access to health insurance could get most of the care they want and need much of the time. Those with basic needs gaps (especially transportation) and those without insurance or with inadequate insurance are more likely to struggle to meet their own and their families' health needs. Rural barriers and an insufficient supply of providers and specialists compound this problem, but families with adequate financial resources often have an easier time navigating around obstacles. This finding highlights the extent to which social determinants are a driving factor in understanding which Vermonters are and cannot get the healthcare, mental health care, dental care, and specialty care they need.

Parent/caregiver health is a point of concern for many, including providers. When asked what concerned them most for themselves, after “mental health” and “financial stability,” parents and caregivers most often identified physical health concerns, including managing chronic conditions, parenting with a disability, and getting their own healthcare needs met as a contributor to household stability and children’s health. Numerous providers also expressed concerns about how parents’ health affects the well-being of children in their care. The breadth of concerns facing parents suggests that, whether through public health, primary care, or collaboration with other state systems such as the Department for Children and Family Services, more efforts are needed to help parents manage their own well-being while caring for families.

Providers are working hard to meet the needs of Vermonters; however, the workforce is facing many challenges. The healthcare workforce serving Vermont families encounters many of the same challenges identified throughout the assessment. Stress and mental health are significant concerns among providers for themselves, their colleagues, and their staff/employees. While access to affordable housing has long been an important topic for families, providers report that the lack of affordable housing is a barrier to recruiting and retaining a skilled workforce. For those who deliver care, pressures driven by high demand for services, insufficient reimbursement rates, worker turnover, and serving high needs populations cannot remain untended. Vermont’s FCH workforce is a tremendous asset, and there is wide recognition that providers bring important skills and a

high degree of dedication to those they serve. Resourcing the workforce ultimately contributes to better health outcomes for all.

About the Division of Family & Child Health

The Vermont Department of Health (VDH) Division of Family and Child Health (FCH) works across the life course to encourage optimal health and positive outcomes for all Vermonters, under its vision and mission.

Our vision: Strong, healthy families power our world.

Our mission: We invest in people, relationships, communities and policies to build a healthier Vermont for future generations.

The FCH division supports programs that provide direct services to pregnant people, children and families and build healthy communities; provides leadership and guidance to professionals who work with children and families in a variety of settings including health care, early care and learning, schools, and human service organizations; responds to the needs of Vermont families by helping them connect to resources; improves access to quality health care and services; and ensures that policies and systems are developed to allow all Vermont residents to achieve optimal health. Collaboration with local and national partners encourages a collective impact resulting in long-term positive outcomes.

FCH's work is grounded in guiding principles, including strength-based approaches that promote protective factors and recognize that families have many strengths and the capacity to learn, grow and change; a two-generation framework that creates opportunities for, and addresses the needs of, children and the adults in their lives; partnering with state agencies, health care providers, human service organizations, and families to succeed at its vision; incorporating health equity into all aspects of the work to reach the people and communities most in need of support; and the value of family and community engagement in the success of FCH programs.

As an entity of VDH, FCH works to advance the State Health Improvement Plan, which is informed by the 2024 State Health Assessment (SHA).² The SHA identifies “communities of focus,” the populations within Vermont that experience high rates of health inequities. For FCH, communities of focus who most access FCH programs and services include indigenous people, people of color, people with disabilities, people who are unhoused, and LGBTQ+ Vermonters.

The Title V funds Vermont receives are applied across all of FCH's efforts, directly or indirectly serving thousands of Vermonters every year.

If you have questions about the content in this report, please contact Emily.j.smith@vermont.gov.

² Vermont State Health Improvement Plan and State Health Assessment
<https://www.healthvermont.gov/about/plans-reports/state-health-assessment-improvement-plan>

INTRODUCTION



Title V is one of the largest federal block grant programs, and a key source of support for promoting and improving the health and well-being of mothers, pregnant and birthing people, children, including children with special needs, and their families across the United States. In 2023, it was estimated that Title V supported services reached 94.6% of all pregnant people, 98.5% of infants, and 59.1% of children nationwide.³

The purpose of the federal Title V Maternal and Child Block Grant is to create federal/state partnerships in all U.S. states that support service systems for addressing current and emerging maternal and child health challenges, such as:

- Significantly reducing infant mortality
- Providing comprehensive care for women before, during, and after pregnancy and childbirth
- Providing preventive and primary care services for infants, children, and adolescents
- Providing comprehensive care for children and adolescents with special health care needs
- Immunizing all children
- Reducing adolescent pregnancy
- Putting into community practice national standards and guidelines for prenatal care, for healthy and safe childcare, and for the health supervision of infants, children, and adolescents
- Assuring access to care for all mothers and children
- Meeting the nutritional and developmental needs of mothers, children, and families.

Each state has discretion over what services and programs to support with Title V funding within the scope of its statutory purpose as set forth by Congress each year. Each state's funding allotment is determined by a formula that considers the proportion of low-income children relative to the total number of low-income children in the U.S.

This statewide family and child health needs assessment was conducted from June 2024 through February 2025 in accordance with Title V statutory mandates and FCH priorities, with a broad goal of ensuring that Vermont pregnant and birthing people, adolescents, children, children with special health needs, as well as all parents/caregivers and families have what they need to be healthy and well, in accordance with Vermont's State Health Improvement Plan⁴, which envisions that "All people in Vermont have a fair and just opportunity to be healthy and to live in healthy communities."

Health equity is the concept underlying a commitment to reducing health inequities – the systematic, avoidable differences in health that vary by levels of social advantage, with worse health occurring among the disadvantaged. The FCH Division works in many

³ Title V Maternal and Child Health (MCH) Services Block Grant website: <https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-services-block-grant>

⁴ Vermont Department of Health. 2024. Vermont State Health Assessment & Improvement Plan. <https://www.healthvermont.gov/about/plans-reports/state-health-assessment-improvement-plan#:~:text=The%20State%20Health%20Improvement%20Plan%20is%20a%20five-year,efforts%20of%20people%20and%20organizations%20across%20the%20state>

communities where systems and institutions have created injustice and oppression, and supports the work of cross-sectoral partners to promote a fair and just opportunity for all Vermont children and families to be healthy and live in thriving communities. FCH names racism and systems of oppression as contributors to poorer health outcomes and approaches all its work by acknowledging and addressing root causes of systemic inequities.

To this end, the Division of Family and Child Health commits to having community and family voice maximally represented in programming that affects/impacts them. The Division attempts to identify strategic opportunities for communities to meaningfully contribute their expertise and knowledge toward health improvement.

The assessment focused on understanding strengths and needs across Vermont for five federally identified population domains within Title V:

1. Women's and maternal health
2. Perinatal and infant health
3. Children's health
4. Adolescent health
5. Children and youth with special health needs

The words “maternal”, “women,” and “birthing people” are used together and occasionally interchangeably throughout this document. The Division of Family and Child Health recognizes all gender identities, including in the perinatal space. The division makes every effort to acknowledge and honor the wide range of gender identities and personal experiences of those who seek or access services. This approach aims to be inclusive, respectful, and sensitive to unique perspectives, including for all birthing people. A move toward inclusive language does not force any individual to stop using the language many people identify with; it simply creates more space for people of all identities, reflecting FCH's commitment to equity in all its forms.

Needs assessment results will inform future FCH efforts to improve health and access to care for pregnant people, infants, children, adolescents, and families.

If you need help accessing or understanding this information, contact emily.j.smith@vermont.gov.

METHODOLOGY



Key informant interviews: To begin the Vermont Title V Needs Assessment, the Noonmark consultant team met with 10 FCH Division leaders and interviewed six additional key informants from state agencies, who provided guidance on the needs assessment design, outreach plans, and data collection process.

Provider interviews and focus groups:

The Noonmark team worked with FCH and key informants to identify individuals and organizations working in settings that support FCH's programs and mission. The team conducted outreach to provider lists to identify individuals from each of the Title V domains who represent all geographic regions of Vermont, as well as those who represent or work closely with individuals from FCH communities of focus. A total of 88 providers and professionals, including staff members at VDH, state agencies, community-based organizations, primary care providers, pediatricians, and others participated in one-on-one and small group interviews or focus groups. The participants included numerous FCH staff members, as well as representatives from entities external to VDH serving all regions of Vermont, and all Title V domains, age groups, and sub-populations. Of these 88 participants, 17% were FCH/VDH staff and 83% were external to VDH.

NEEDS ASSESSMENT PARTICIPANTS

- 609 community survey respondents
- 43 community members in focus groups
- 88 providers and professionals focus groups + interviews

Community survey of parents/caregivers: A survey was disseminated to the public via a wide range of electronic distribution lists and social media channels. Survey outreach was supported by FCH staff members, who shared the survey with a diverse set of contacts, including agencies and programs that provide direct services to individuals in the populations the survey sought to engage. Noonmark consultants also disseminated the survey to statewide listservs, organizational contacts (including those participating in provider focus groups), and members of the public.

The survey used the SurveyMonkey platform and was open for responses from November 26, 2024, to January 10, 2025. A total of 1540 surveys were returned, of which 609 were ultimately deemed valid for analysis. Responses that were deemed invalid included surveys (1) where the respondent indicated they were not a member of an eligible population (e.g. non-parents who do not plan to become parents/caregivers, parents/caregivers of children over age 21); (2) where the respondent indicated a need for assistance completing the survey and was contacted to complete the survey using an alternate means (e.g. via phone with a researcher or VDH staff, with an interpreter); or (3) surveys suspected of having been completed by chatbot, duplicate surveys that appeared to be completed by a single individual, and/or surveys that were too incomplete to be deemed valid. All valid surveys were entered into a gift card drawing as an incentive to complete the survey.

Parents/caregivers who responded to the survey were asked to rate a variety of items related to health and wellbeing based on how much that area was challenging or easy for them to address. Options ranged from (1) "this is a struggle" to (6) "this is easy," on a 6-

point scale. Average scores were calculated for each item for the respondents themselves, as well as for how easy or challenging an item was rated for their child or children. Crosstabulation was used to examine responses for individuals who identified as Lesbian, Gay, Bisexual, Trans, Queer, and others (LGBTQ+); Black, Indigenous, People of Color (BIPOC); households with Medicaid eligibility; as well as parents/caregivers of children and youth with special health needs, and by children's age group. In the report sections describing each Title V domain, additional survey crosstabulations are provided for families with a child with special health needs, young children, school-age children, and adolescents. For additional survey information please see Appendix 2.

Community focus groups: Noonmark conducted five focus groups with community members who were: parents of children up to age 21, young adults, and/or people who planned to become parents. A total of 43 individuals participated in the Zoom-based groups facilitated by a member of the Noonmark team using a standard list of questions, see Appendix 3. Three groups were composed of individuals who were identified via the community survey, one group was an existing parent advisory body of a statewide organization, and one group was composed of BIPOC parents/caregivers. All community focus groups included representation from multiple counties throughout Vermont, including both urban and rural residents. All focus group participants received a gift card incentive.

Data analysis: Survey data was analyzed using SurveyMonkey and MS Excel to tabulate responses by survey item, calculate percentages and averages, and compare groups within the survey using crosstabulation. Qualitative data transcripts from each focus group session and from open-ended survey items were coded using NVivo. Single statements could be assigned up to three codes, leading to duplication across clusters and sub-themes. Codes were grouped into thematic clusters and subgroups for each data source (e.g., provider focus groups, surveys). Assessment data were reviewed, along with surveillance data from VDH and numerous other sources and compared with Title V national and state performance measures and outcomes.

Data was analyzed in February and March 2025. Assessment findings were interpreted within the context of the conditions under which they were originally collected in 2024 and early 2025. Patterns, behaviors, and responses identified in this assessment reflect the social, political, and cultural norms that shaped how individuals engaged with systems and institutions at the time they participated. Data interpretation was conducted within the sociopolitical landscape of early 2025. Given the rapid policy shifts with the change of Presidential administrations since January, and particularly the increasing vulnerability of marginalized populations under current federal policies, assessment themes are contextualized in light of shifting internal and external forces that influence FCH's programming. Future changes at the state and federal levels may amplify, alter, or challenge previous findings, underscoring the importance of dynamic and reflexive action that considers both historical stability and contemporary disruptions. This needs assessment report attempts to provide insights that will remain relevant, responsive, and ethically grounded.

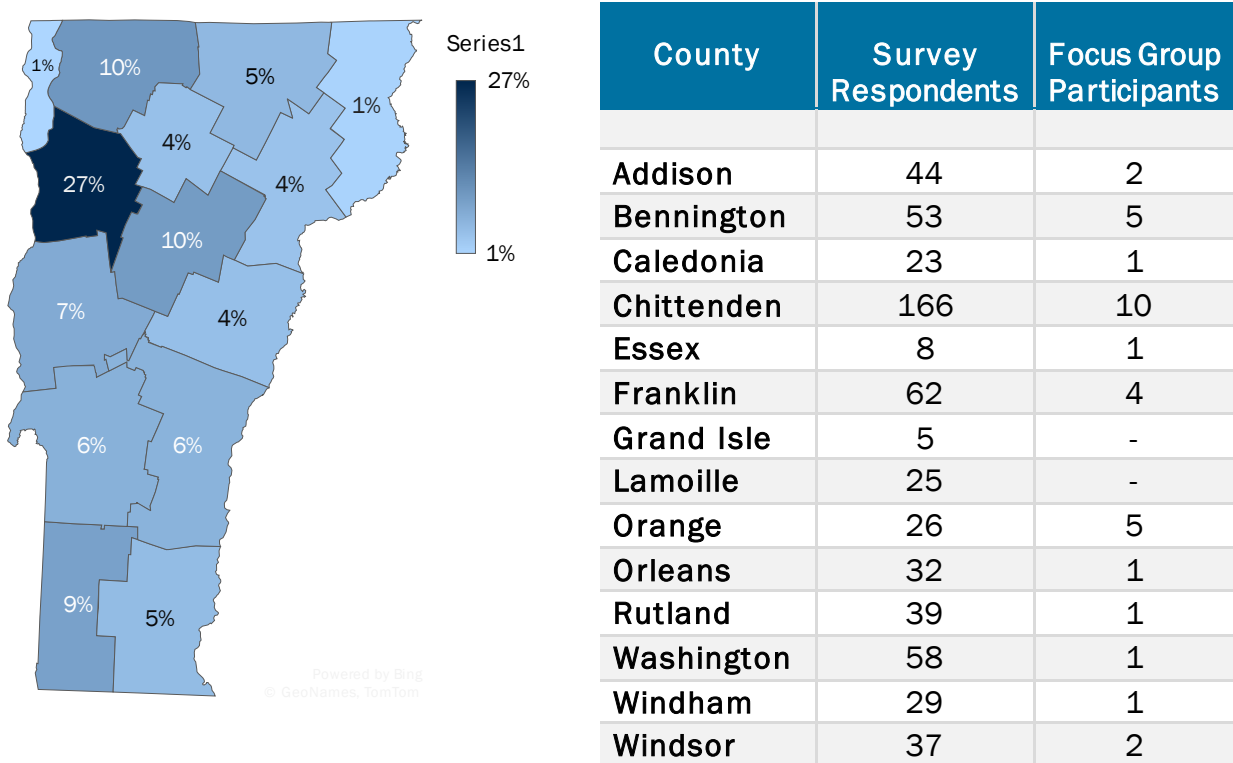
RESULTS



Through the provider and community engagement via surveys, interviews, and focus groups, more than 700 individuals contributed to the Title V Needs Assessment.

Geographic reach: The Title V Needs Assessment collected data from all stakeholder groups from all Vermont counties. The map and table below reflect the county of residence for parents/caregivers who identified their county through surveys or focus groups.

Chart 1. Community Survey and Focus Group Reach By County



Household composition: Parents/caregivers were invited to identify all age groups of children and young adults in their households (Table 2). Nearly all respondents (90%) had children who were under age 18. In addition, 16% were parents/caregivers of a young adult, 8% were currently pregnant or planning to become pregnant, 1% were themselves young adults aged 18 to 21.

Table 2. Survey respondents' family composition

Population	N	%
Infant (less than one year)	64	11%
Early childhood (1-3)	164	27%
Preschool (3-5)	168	28%
School age (6-11)	265	44%
Adolescents (12-17)	225	37%
Young adult (18-21)	99	16%
Currently pregnant or planning to become pregnant in the next 12 months	49	8%
Respondent was a young adult aged 18-21	7	1%

Note: Respondents may have reported ages for more than one child; percentages do not equal 100.

Respondent characteristics: Survey and focus group respondents were asked to identify personal and household characteristics related to race/ethnicity, LGBTQ+ identity, primary language, economic factors, disability status, and concerns about basic needs for themselves and their child/children. Respondents could choose multiple race/ethnicity responses. The largest group of respondents identified only as White (86%, self; 78%, child/children), with 13% of respondents identifying as Black, Indigenous, People of Color (BIPOC), and 21% of respondents identifying that their children are BIPOC. For each group, 1% of respondents selected “I prefer not to answer.” As shown in Table 3, respondents were similar to, or exceeded, the percentage of the Vermont population for each identity group.

Table 3. Community Survey Respondents' Race/Ethnicity

Race/Ethnicity	Self	Child/Children	Vermont Population Comparison
Abenaki or another Native American or Alaska Native	5%	5%	0.4%
Asian or Asian American, for example, Chinese, Asian Indian, Nepalese, or Vietnamese	1%	1%	2.1%
Black or African American	4%	8%	1.6%
Hispanic or Latino, Latina, or Latine, for example, Mexican, Venezuelan, or Brazilian	2%	6%	2.6%
Native Hawaiian or another Pacific Islander	1%	1%	-
White or European American (Only)	86%	78%	91.5%

Participants hold a wide range of identities, reflecting all FCH’s communities of focus (Table 4).

Table 4. Assessment Participant Characteristics

Participant Identities	Survey	Focus Groups
I am LGBTQIA+	15%	25%
One or more of my children is LGBTQIA+	13%	14%
I mainly speak a language other than English	13%	25%
My children mainly speak a language other than English	11%	29%
I am a person with a disability	12%	-
One or more of my children is a person with a disability	21%	-
People in my immediate family are newcomers to the United States (immigrants, asylees, refugees)	2%	11%

Survey respondents reflected the social determinant and economic equity concerns that are present in all Vermont communities. Individuals from communities of focus were more likely to report economic challenges for their households, reflecting the disproportionate burden unequitable systems have historically had on members of marginalized communities (Table 5):

- More than half (59%) said that “their household typically earns enough to meet monthly expenses.” Fewer respondents who are BIPOC (37%) or Medicaid eligible (36%) agreed with this statement.
- Nearly half of all respondent households were Medicaid-eligible (47%), including 72% of BIPOC respondents.
- 54 respondents (9%) indicated that they had been homeless in the last year, including 15% of BIPOC and Medicaid eligible respondents.
- About one in four (24%) survey respondents indicated they were concerned about their household’s food security. Rates of food insecurity were higher among BIPOC (35%), Medicaid eligible (37%) and households with a child with special health needs (30%).

Table 5. Basic Needs Characteristics of Survey Respondents

Item	All Respondents		BIPOC Respondents		Medicaid Eligible Respondents		Child with Special Health Needs	
	N	%	N	%	N	%	N	%
My immediate family typically earns enough to meet monthly expenses	356	59%	28	37%	103	36%	69	53%

I/members of my immediate family are eligible to receive Medicaid	284	47%	54	72%	284	100%	75	58%
I/members of my immediate family are/have been homeless within the last year	54	9%	11	15%	43	15%	13	10%
I/members of my immediate family are often worried whether food would run out before we could afford to buy more	149	24%	26	35%	105	37%	39	30%

Focus group participants: 34 of 43 focus group participants provided information about themselves and their households. All participants were parents/caregivers of children under age 18. Nearly all Vermont counties were represented by focus group participants (of those who shared information, Grand Isle and Lamoille Counties were not identified) (Table 1). Focus groups attempted to oversample from communities of focus to assure that their voices and experiences were well reflected in needs assessment data (Charts 2 and 3).

Chart 2. Race/Ethnicity of Focus Group Participants

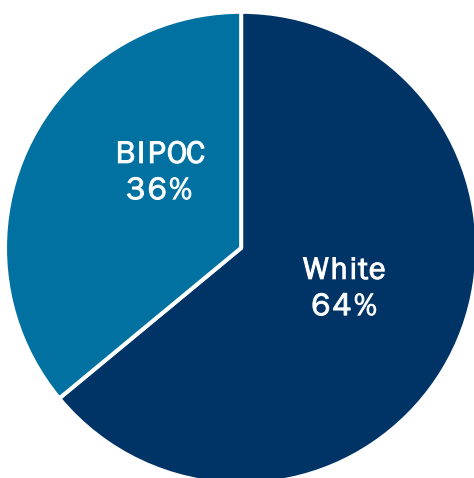
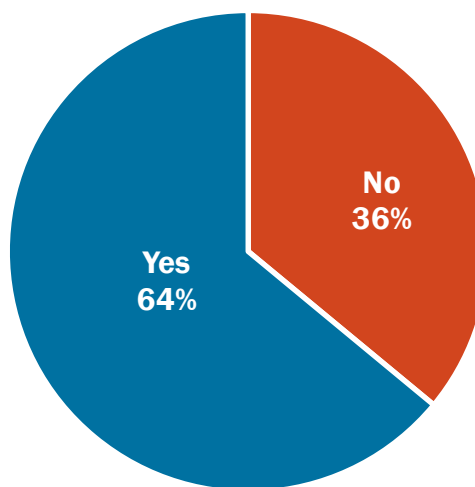


Chart 3. Most participants were eligible for Medicaid.



Survey Responses

Survey respondents were asked to rate health and wellness topics on a scale from (1) “This is a struggle” to (6) “This is easy.” Across all groups, respondents identified “keeping stress low” as their greatest struggle, and “staying safe” as the easiest item. For almost all ranked survey items, parents/caregivers ranked their level of ease or struggle more positively for their child/children than for themselves.

Most respondents reported that the easiest items were

1. “Staying safe from violence” (88%)
2. “Finding health care that is safe and accessible for my culture, language, and/or identity” (84%).

Across all groups (including BIPOC, Medicaid eligible, CSHN, LGBTQ+, as well as among child/adolescents by age group) “keeping stress low” was consistently identified as an area of struggle, with an average median ranking of 2.67 on the survey’s 6.0-point scale (See Appendix 2 for additional data). Maintaining mental health was the second most challenging topic, followed by “Finding connections in the community where I feel a sense of belonging.” The Charts below represent areas of greatest struggle by community of focus, as ranked by survey respondents for “self”.

Chart 4. Keeping Stress Low (Myself)

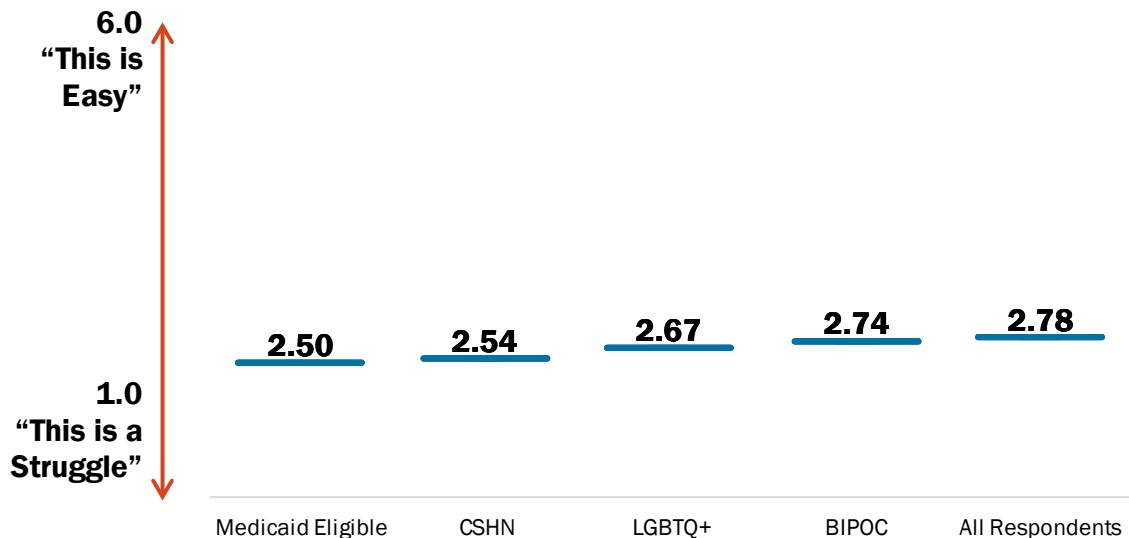


Chart 5. Maintaining mental health (Myself)

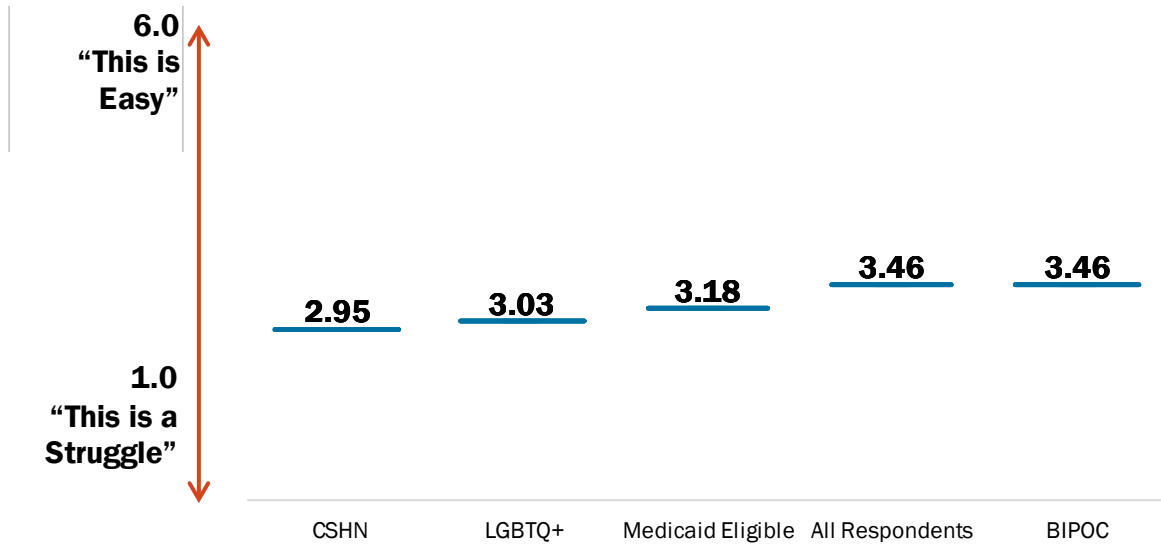
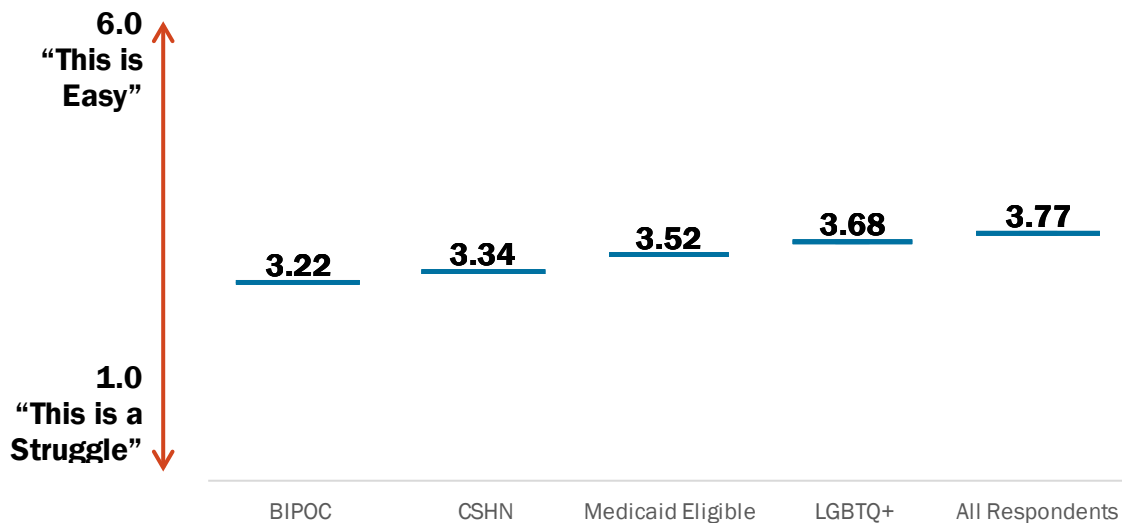


Chart 6. Finding connections in the community where I feel a sense of belonging (Myself)



Parents/caregivers from communities of focus most often ranked all three measures as a greater struggle than all respondents:

- Medicaid-eligible households ranked “Keeping stress low” as a greater struggle than other comparison groups.

- Parents of CSHN ranked “Maintaining mental health” as a greater struggle than other comparison groups.
- BIPOC parents/caregivers ranked “Finding connections in the community where I feel a sense of belonging” as a greater struggle than other comparison groups.

“Keeping stress low” was also the greatest area of struggle respondents identified for their child/children. Among all respondents, the next most challenging topics were maintaining mental health (3.46) and finding connections in the community (3.77). Notably, the survey did not include a ranking item on financial health or financial stress. Based on survey respondents’ open-ended responses, financial stability was an additional significant concern.

Open-ended survey responses: Community members who completed the survey were invited to respond to four open-ended questions. Responses were assigned up to three codes based on their main idea/s and grouped into themes and clusters of related themes. Codes and themes are not necessarily positive or negative—they are simply a catalog of topics that were raised most frequently. The most frequently expressed topics are organized into the following themes for respondents and their children (Table 6).

Table 6. Community Survey Respondents’ Top Three Concerns

Self	Child/Children
Mental health (including anxiety, depression, substance use, and stress)	Mental health (including anxiety, depression, substance use, and stress)
Financial concerns (including household income, financial security/stability, cost of living, cost of health care, and affordability)	Media/technology (including social media, screens, technology use, phones, and video games)
Personal health (including health conditions and healthcare)	School and education (quality of education, school safety, students’ learning and academic achievement)

For each open-ended survey question, the most common themes are presented in Table 7. As later sections of this report detail, there were few differences among communities of focus or geographic populations in how they responded—the most frequently identified topics were reported by respondents of all races/ethnicities, sexual and gender identities, household compositions, and regions of Vermont.

Table 7. Community Survey Open-ended Question Coding Summary

Question	Most frequent codes/ Major themes (frequency)
1. What are the top two areas you are most concerned about for yourself?	<ul style="list-style-type: none"> • Mental health (210+) • Financial stability, affordability, income (200) • Health and health conditions (70+) • Housing (45+) • Stress (45+)
2. What are the top two areas you are most concerned	<ul style="list-style-type: none"> • Mental health (160+) • Social media, screens, technology use (110)

about for your child/children?	<ul style="list-style-type: none"> • Education & school (100) • Community connections, belonging, relationships & friendships (80) • Safety & violence (80)
3. If you or a member of your family had a positive healthcare experience, what worked well? What made a difference or made it possible to get the care needed?	<ul style="list-style-type: none"> • Care was accessible (timely, able to find a provider) (90+) • Provider/s were responsive (80+) • Provider/s listened (50+) • Health insurance (including Medicaid) covered care (40) • Provider/s were welcoming or non-judgmental (40)
4. If you or a member of your family had a negative healthcare experience or have been unable to get needed care, what prevented you from finding or receiving care? What would have made a difference or made it possible to get the care needed?	<ul style="list-style-type: none"> • Unable to access needed care (90+) <ul style="list-style-type: none"> ◦ Lack of providers or specialists (40+) • Provider was dismissive or didn't help (35+) • Poor quality of care (misdiagnosed, didn't receive needed care) (35+) • Health insurance barriers (didn't cover care, uninsured, unable to afford) (35+) • Cost of care was a barrier (30+)

Parent/caregiver Focus Groups: Focus groups were used to engage parents/caregivers in exploring health and wellness topics illuminated by the survey and provider data in greater depth. Across all focus group questions, several topics were frequently mentioned by participants, closely aligning with the most common topics and concerns identified in other assessment data sources. Additional coding is presented with the thematic summary section that follows, and in Appendix 1.

Top 5 Domains from Focus Group Participants

Domains	Count
Access to care (wait times, provider availability, location, hours)	~85
Financial concerns	~50
Basic needs (housing, transportation, food)	+40
Mental health, substance use disorders (SUDs), Stress	+35
Social well-being, relationships, community belonging	~30

Provider Focus Group Analysis

Providers differed from parents/caregivers in their thinking about health and wellbeing for FCH populations because they were most often working within systems and could speak to areas of strength and challenge. In addition, most had a direct connection to one or two

specific Title V domains and spoke narrowly to those areas. For example, while parents/caregivers could speak to their own unique circumstances, providers are positioned to reflect on how parents/caregivers are faring as a population. One parent of a child with special health needs or an infant with difficult sleep patterns may describe feeling personally exhausted, but these concerns can be viewed as broader issues when dozens of providers report observing that “parents are exhausted.”

Key themes identified by providers

1. Integration of FCH with other systems and providers
2. System of care issues and costs
3. School settings
4. Mental health (all age groups)
5. Supporting parents
6. Basic needs & social determinants
7. Workforce needs, including staffing issues and professional development

Beyond single themes, many of the ideas shared by providers integrated multiple issues and topics that do not fit solely into the key themes listed above. Among providers, there was wide agreement that:

- **The FCH Division is effective within the scope of programs and services it provides,** attracts talented professionals who care about children and families, and succeeds in prioritizing strong collaboration with other divisions, state agencies, and statewide and community-based organizations.
- **People working in systems serving children and families are extremely dedicated to their roles, but staffing shortages and a lack of providers negatively impact children and families** across numerous categories of providers and Title V domains. Vermont’s lack of affordable housing and low compensation in some fields were frequently cited as obstacles to recruiting and retaining workers.
- **The system of care is complex and places a significant burden on parents and families.** Well-resourced families with ‘typical’ care needs are able to get most needs met most of the time—but less well-resourced families and those with specialized care needs encounter numerous obstacles.
- **Children, adolescents, and families have increasingly complex needs** and often with greater acuity than even a few years ago, placing new and changing demands on providers and care systems.
- **Vermont needs a system of care with strong connectivity across home, school/early care, and healthcare domains**—the current system works well in some places, is siloed in some places, and has differences from region to region that can undermine the quality of care and access. Competing funding mandates, payer models, and insurance obstacles were often cited as the cause of service fragmentation.
- **Providers find it difficult to address health and well-being needs separately from basic needs**—when housing or food are insecure, health and well-being are secondary concerns for many Vermont families.

THEMATIC ANALYSIS



Several overarching themes emerged from the data collection with strong agreement between community members and care providers. The most frequently identified themes are overwhelmingly cross-cutting, touching on all FCH populations, age groups, and regions of Vermont.

Mental Health & Substance Use

Across all data from community members and care providers, “mental health” was the most commonly identified concern. More than one-third of all community survey respondents identified it as a top concern for themselves or their children. This is closely linked to the high percentage of community survey respondents (73%) who identified “keeping stress low” as a struggle sometimes, usually, or always.

While rising mental health concerns were identified as one of the top themes in the 2020 Title V needs assessment,⁵ There was an enormous shift in the centrality of these concerns for both parents/caregivers and providers. The prior needs assessment data collection was completed just prior to the onset of the COVID-19 pandemic. Since that time, there is evidence that mental health concerns for parents, children, adolescents, and young adults have grown more widespread and more acute,⁶ and that accessing care has become more challenging.

Responses from parents/caregivers mirror input from providers, who described mental health concerns among the populations they serve, as well as workforce gaps and provider shortages throughout the state.

In 2021-2022, Vermont adults aged 18 and older reported substantially higher rates of any mental illness and serious mental illness within the last year than the U.S. and New England regional average.⁷ Among adults, 10.3% of Vermonters reported experiencing a major depressive disorder in the past year, compared to only 8.6%

“My daughter has been struggling with anxiety and it has been preventing her from attending school. I believe her pediatrician, school counselor, and teacher were all dedicated and compassionate enough to pursue support for my daughter. I also know that it took me asking for help, frequently, in order for her to get support.”

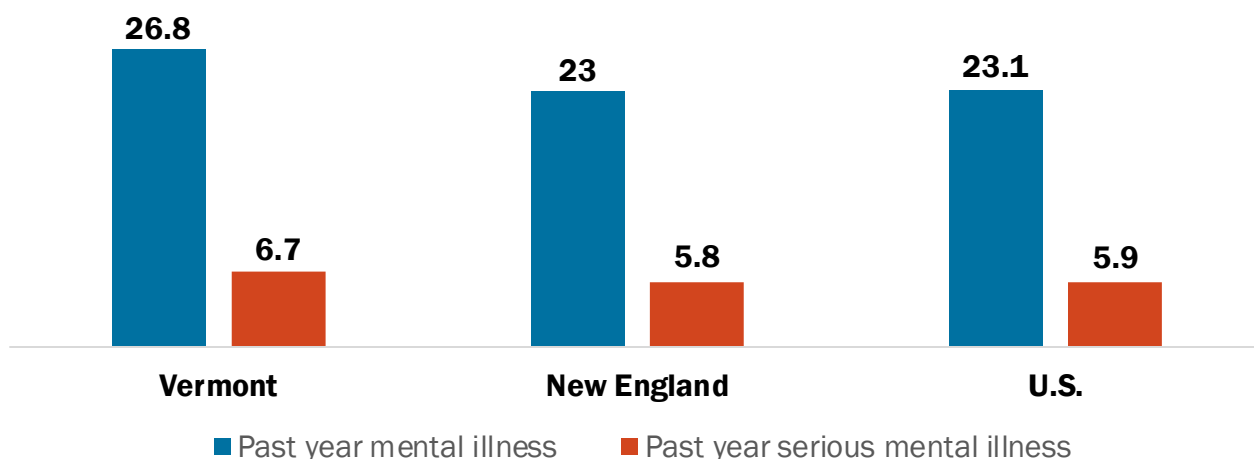
⁵ Vermont Department of Health, Maternal And Child Health Division. Title V Five-Year Needs Assessment. 2020. https://www.healthvermont.gov/sites/default/files/documents/pdf/cyf_TitleV%20Needs%20Assessment.pdf

⁶ Gramlich, J. 2023. Mental health and the pandemic: What U.S. surveys have found. Pew Research Center. <https://www.pewresearch.org/short-reads/2023/03/02/mental-health-and-the-pandemic-what-u-s-surveys-have-found>.

⁷ Substance Abuse and Mental Health Services Administration. (2024). Behavioral Health Barometer, Region 1, Volume 7: Indicators as Measured in the 2021-2022 National Surveys on Drug Use and Health (SAMHSA Publication No. PEP24-07-007). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

nationally.⁸ There is a persistent need for services for both adults and children with serious mental illness across the state.

Chart 7. Rates of Mental Illness and Serious Mental Illness, ages 18 and older, National Surveys on Drug Use and Health



Suicide Risk: In 2024, Vermont’s rate of suicide per 100,000 residents dropped from 20.4 (2021-2023) to 16.1. While this indicator has significantly improved, Vermonters remain at greater risk of suicide than the U.S. rate (14.2 per 100,000).⁹ Vermonters who identify as male or White, and those ages 25 and older have rates of suicide that exceed the state rate overall. Suicide rates in Essex (50.1) and Caledonia (32.7) Counties significantly exceed the state rate. For Vermonters age 15 to 24, the 2024 suicide death rate was 11.4 per 100,000 residents.¹⁰

The rate of suicide-related emergency department visits among Vermont children and young adults appears to be declining. For children ages 0 to 14, the current rate (2025) of suicide related emergency department visits is 140.5 per 10,000 population in 2025, down from 194.7 from 2022-2024. For adolescents and young adults ages 15 to 24, the current rate (2025) of suicide related emergency department visits is 456.2 per 10,000 population in 2025, down from 605.6 from 2022-2024. Adolescents and young adults continue to be one of the highest risk groups for emergency department visits related to suicide, with rates that far exceed the average for all age groups statewide, which is currently 223.4 per 10,000 population.¹¹

Of particular concern to the Family and Child Health Division are the mental health and substance use risks encountered by pregnant people during the prenatal and perinatal period. More than 90% of perinatal deaths in Vermont occurred among people with at least

⁸ Ibid.

⁹ Centers for Disease Control and Prevention. n.d. Suicide Prevention. Suicide Trends Interactive Chart. <https://www.cdc.gov/suicide/facts/data.html>

¹⁰ Vermont Department of Health. N.d. Suicide Surveillance Dashboard. <https://www.healthvermont.gov/stats/surveillance-reporting-topic/suicide-data>

¹¹ Ibid.

one diagnosed mental health disorder.¹² From 2012 to 2023, 10% of perinatal deaths were suicides. From 2012 to 2023, nearly half (45%) of maternal deaths were caused by accidental overdose. Of all maternal deaths during this period, 59% involved substance use, even if overdose was not the cause of death.

Substance use and Substance Use

Disorders (SUDs): Within the mental health domain, substance use is an area of concern for parents/caregivers including pregnant people, as well as adolescents and young adults. According to the National Substance Use and Mental Health Survey¹³ in 2021:

- The percentage of Vermonters aged 12 and older who had used an illicit drug in the previous month was higher than the U.S. and New England averages, driven by very high rates of cannabis use in Vermont.
- In 2021-2022, 32.9% of Vermonters over age 12 reported marijuana use compared to only 20.5% nationally.
- A significantly higher percentage of Vermonters ages 12 and older reported using hallucinogens (4.2% vs. 2.9%) and cocaine (2.8% vs. 1.8%) than the national average.
- Vermont had the highest rate of substance use disorders (SUDs) in New England, at a rate significantly higher than the national average, with 21.8% of individuals ages 12 and over reporting SUD in the past year (Chart 8).¹⁴
- While Vermonters' past year opioid use disorder (OUD) rate is similar to the rate in the U.S. and region, it is an important concern for families, as well as for health and social service providers who support them.

“We see injuries to children that happen because of parent substance misuse, and not having adequate resources to support families. There is funding allocated to the opioid crisis. . . but not enough attention to the baby who died in an unsafe sleep environment while their parents were abusing substances, youth overdoses, etc.”

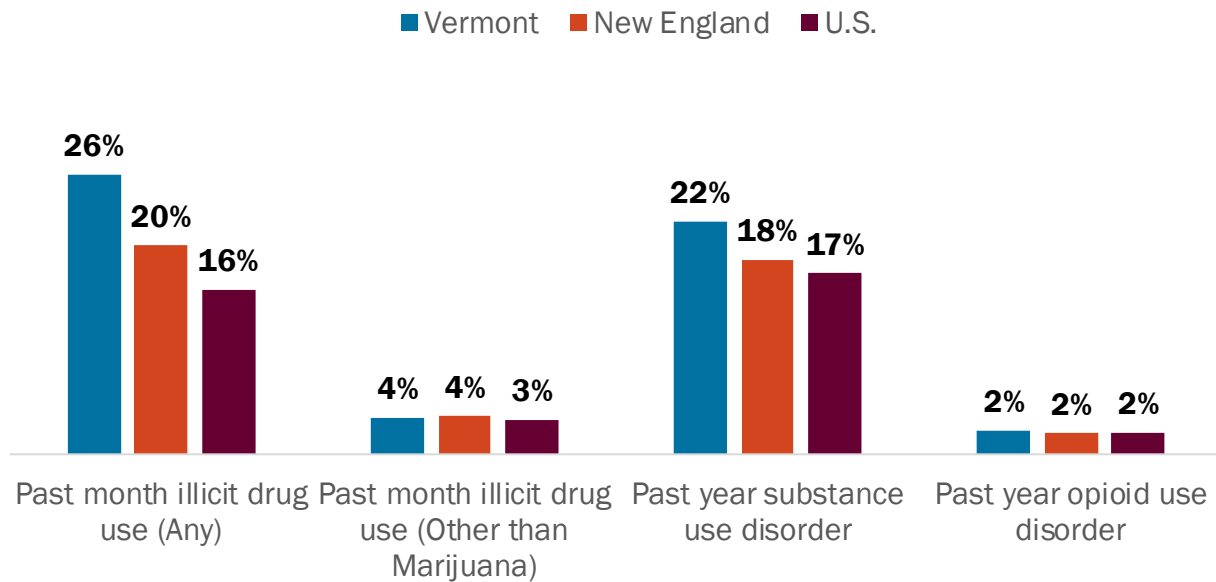
¹² Vermont Department of Health. 2025. Maternal Mortality Review Panel Annual Report 2025 Report to the Legislature. <https://legislature.vermont.gov/Documents/2026/Workgroups/House%20Human%20Services/Reports%20and%20Resources/W~Vermont%20Department%20of%20Health~Maternal%20Mortality%20Review%20Panel%202025%20Annual%20Report~1-17-2025.pdf>

¹³ Substance Abuse and Mental Health Services Administration. (2024). Behavioral Health Barometer, Region 1, Volume 7:

Indicators as Measured in the 2021-2022 National Surveys on Drug Use and Health (SAMHSA Publication No. PEP24-07-007). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/sites/default/files/reports/rpt45295/2022-nsduh-barometer-region-1.pdf>

¹⁴ Ibid.

Chart 8. Key Substance Use Indicators of Vermonters 12 years and older by State and Region National Surveys on Drug Use and Health



Notably, few parents/caregivers identified SUDs as a top concern in the community survey or focus groups, but substance use was a more frequent topic among providers. Both providers and community members have strong feelings and differing viewpoints. The purpose of this section of the report is to highlight those. These comments are not reflective of VDH/FCHs stance on public health issues.

Behavioral health workforce: Mental health and substance use issues must be examined in light of the availability of providers across the state. Vermont’s behavioral health workforce includes professionals with a range of clinical backgrounds and specializations (Table 9). Vermont has a mental health provider ratio of 180 residents per provider, compared to a U.S. ratio of 3 40:1.¹⁵ Windham County has the most providers with a ratio of 120:1, and Essex and Grand Isle counties have the lowest ratio, with a ratio of 1500:1.

According to data from the Vermont Department of Health’s April 2024 census of licensees¹⁶, there were 1,017 active licensed clinical mental health counselors (MHCs) in Vermont in January 2023, representing 658.6 full-time equivalents (FTEs). The distribution of these counselors varied widely across counties while Washington County had the highest FTE ratio of 150.8 per 100,000 population, Essex County had the lowest at just 16.7 FTEs per 100,000. Notably, Vermont saw a 20% increase in MHC FTEs from 2021 to 2023.

¹⁵ University of Wisconsin Population Health Institute. 2025. County Health Rankings and Roadmaps: Mental Health Providers. <https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/mental-health-providers?year=2024&tab=1>

¹⁶ Vermont Department of Health. 2024. Health Care Workforce Census, Mental Health Counselors, 2023. <https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-mhc23.pdf>

In addition, several trends characterize Vermont’s MHC workforce:

- The workforce is aging: the median age among MHCs was 51, with 30.7% of active counselors aged 60 or older.
- Access via public insurance remains limited: 71.3% of active MHCs reported accepting new Medicaid clients, while only 16.8% accepted new Medicare clients in 2023.
- The vast majority of counselors identify as female (76.7%) and White (91.8%).

Table 9. Active behavioral health professionals in Vermont

Profession	Number active in VT	Full Time Equivalents
Alcohol and Drug Counselors	382	222.4
Clinical Social Workers	1072	859.9
Marriage and Family Therapists	76	48.3
Mental Health Counselors	1017	658.6
Psychiatrists	170	121.0
Psychoanalysts	21	8.0
Psychologists	518	373.2
Psychotherapists	747	530.5

According to a February 2025 workforce report from the health department¹⁷, the number of psychologists in Vermont dropped from 378.1 in 2018 to 343.8 in 2024. Caledonia, Essex, Grand Isle, and Orleans counties have fewer than 20.0 FTE psychologists per 100,000 population. In addition, several trends shape Vermont’s psychological workforce:

- The workforce is gaining-- the median age is 59 at the master’s level and 61 at the doctoral level. More than half of active psychologists who are age 60 and older.
- Limited access for people with Medicaid and Medicare, ranging from 57% to 80% accepting Medicaid, and 23% to 54% accepting Medicare when comparing master’s level and doctoral level psychologists.
- Most active psychologists identify as female (64%) and White (90%).

While most Vermont counties have an average provider ratio at or above the national average, providers are frequently based only in one city or town within a county and inaccessible to those in outlying areas, may have a narrow population focus (e.g. serving only adults), or may not offer the level of care that families need. Likewise, because Vermont has higher than average rates of mental health and substance use concerns, there is a need

¹⁷ Vermont Department of Health. 2025. Health Care Workforce Census, Psychologists Master’s and Doctoral, 2024. <https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-psych24.pdf>

for more specialized providers. All of these factors contribute to the challenges Vermonters identify in accessing mental health services, which can result in other adverse outcomes including more emergency room visits for mental health concerns, delaying care and thus increasing the level of severity of mental health needs, or foregoing care resulting in other negative outcomes for families and communities such as public safety concerns, DCF involvement, and needing a higher level of care to manage mental health conditions.

“There are talented people who are ready and willing to do this work and it is challenging – finances, housing...difficulty staffing teams [is] leading to staff with too much on their plates – burnout is real.”

Financial Stability

Financial stability for families appears to have shifted significantly in the last five years and was the second most frequently raised thematic cluster by parents/caregivers. Issues identified included a wide range of concerns about income/earning enough money, cost of living and affordability in Vermont, financial stability in the present and future, and difficulty meeting basic needs. Basic needs concerns (housing and food security, access to transportation, Medicaid access) were a focus of the 2020 Title V Needs Assessment and remain a significant concern for many. In addition, community respondents described concerns related specifically to the cost of healthcare, the ability to afford needed care in light of other household needs, and relatedly, financial challenges related to health insurance, such as difficulty managing co-pays, being unable to afford care even with health insurance, and foregoing needed care when costs were too high.

“I don’t think families needs have changed as much as it’s just even harder to meet the needs because of the financial burden that they present.”

“...housing is actually worse than food insecurity. We have huge numbers of citizens who are unhoused and it gets worse all the time.”

The 2024 Vermont Livable Wage is \$19.53 per hour in urban areas and \$17.68 in rural areas.⁷ The state’s Basic Needs budget estimates

monthly costs for food, housing, transportation, health care and other essentials range from \$3,042 for a single individual with no children living in a rural area to \$7,704 for a household with two adults and two children. Household expenses plus federal and state taxes range from \$44,346 (single earner without children, rural) to \$97,664 (two earners, two children, urban).

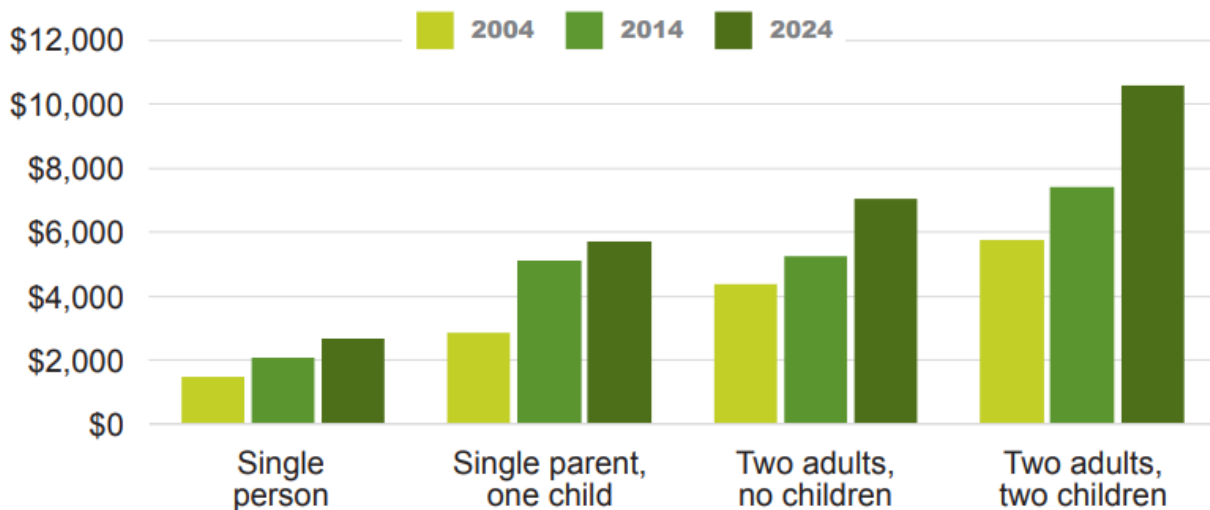
Based on these calculations, most households would need to earn between 300% and 400% above the federal poverty guidelines for their family composition to manage a basic needs budget.

Vermonters have encountered rising costs in a number of areas, including housing and property taxes, as well as health insurance. According to the Public Assets Institute’s *State*

of *Working Vermont 2024* report, healthcare costs have risen sharply in the last two decades.¹⁸ The same report details numerous economic factors, including the impact of wage growth, inflation, housing costs, 3SquaresVT benefits and other metrics related to cost of living and affordability. Public Assets Institute concludes that in 2024 more than half of single adults in Vermont (with and without children) are unable to meet basic needs.

Healthcare costs: Among the identified concerns, healthcare and health insurance affordability were specifically cited as critical issues. Vermont consistently has among the lowest rates of uninsured individuals in the U.S., and the Dr. Dynosaur Medicaid program was frequently cited as being a top factor in families’ ability to meet children’s health needs. Despite widespread coverage, out-of-pocket costs have risen rapidly in recent years and are unaffordable for many middle and low-income households.

Chart 9. Vermonters’ out-of-pocket health care costs, Vermont Joint Fiscal Office



Source: [SWVT2024.1.pdf](#)

In focus groups and open-ended survey responses, parents who described positive or negative healthcare experiences frequently cited health insurance coverage as an important factor in whether they could access needed care. **In 2020-2021, 74.0% of children ages 0-17 in Vermont were adequately insured, compared to 68.2% of children nationally.**

¹⁸ Public Assets Institute. 2025. State of Working Vermont. <https://publicassets.org/wp-content/uploads/2025/01/SWVT2024.pdf>

For providers, payment systems, including insurance-driven reimbursement rates, were identified as one driver of systemic quality-of-care concerns. Issues identified include insufficient staffing to meet community needs given the costs of providing care, challenges in delivering the scope of services families seek, and other limitations that frustrate both providers and the communities they serve.

“The cost of healthcare is unreasonable for our family, and prevents us from accessing emergency care...It is cheaper for us to only pay for services we need and hope nothing catastrophic happens.”

Access to Care

Access to healthcare was the third-most frequently identified topic among Title V needs assessment participants. According to Vermont Department of Health data, roughly 95% of Vermonters reported that they could obtain needed care; more Vermonters reported that children and infants were unable to obtain needed care than nationally. **In 2020–2021, 5.1% of children ages 0–17 in Vermont could not obtain needed health care, compared to 3.1% of children nationally.**

Access to care topics covered most healthcare roles/settings, including primary care, specialist care, dental care, and mental health care. The access to care theme group includes a wide range of topics, including:

- Location of care (distance, travel time, geographic access and barriers)
- Lack of providers or specialists
- Ease of scheduling, getting to see a provider in a timely manner, and long wait times for appointments
- Finding responsive providers for specific needs (*other than health specialties) (e.g., gender affirming care, routine dental care for children with special health needs, etc.)
- Telehealth, when available, has closed access to care gaps for some
- Ability to find a provider who accepts Medicaid/insurance
- Having transportation to get to care
- Navigating insurance rules and processes related to accessing care
- Choosing a primary care provider/pediatrician vs. urgent care or an emergency department based on accessibility factors
- Needing care to be free of stigma

Care experiences: Parents/caregivers discussed a wide range of positive and negative healthcare encounters. After specific components of access, the greatest attribute of positive or negative care experiences was provider responsiveness or dismissiveness.

Individuals who had positive encounters reported that the provider made an effort to address their needs, listened well, treated them with respect, and enabled them to address their concerns. Individuals who had negative encounters reported that the provider was not helpful, did not listen or was judgmental, did not enable them to resolve the issue, or led to needing to seek other care from a different provider.

Broadly, nearly all individuals who had positive experiences described having adequate health insurance coverage that removed cost barriers, no difficulty finding a provider and getting an appointment, and providers who were responsive, non-judgmental, listened to their concerns, and provided quality care. Individuals with negative experiences uniformly described being unable to find a provider with timely availability, lacking adequate health insurance or the ability to afford care, and encountering providers who did not listen to concerns or reinforced feelings of stigma about the needed care.

Among providers, themes around access to care were a lack of providers or specific resources, and barriers linked to basic needs gaps for those they serve. Vermont provides relatively strong health coverage and access to pediatric care compared with other states, but families and providers still face significant barriers to navigating insurance systems, limited-service capacity, and referral gaps. At the same time, workforce shortages, administrative burdens, and complex social circumstances such as poverty, housing instability, and language barriers make it difficult for many families to engage with services and for providers to meet community needs. In all cases, providers expressed an interest in working across systems to remove barriers to care as a high priority. Some providers acknowledged that Vermont’s systems of care serve families more effectively than those in other states and noted Vermont’s strong, positive health outcomes across many measures.

“The cost of healthcare is unreasonable for our family, and prevents us from accessing emergency care...It is cheaper for us to only pay for services we need and hope nothing catastrophic happens.”

Access to dental care: Many assessment participants identified difficulty accessing dental care. Concerns included difficulty finding a nearby dentist, lack of dental insurance, inability to find a dentist accepting Medicaid, and long appointment wait times. According to VDH data¹⁹, in 2021 the overall number of dentists in Vermont was the highest since 2007, at 393. From 2021 to 2023, the number of dentists dropped to 296, the lowest level since 2009. While most Vermont dentists accepted new patients (92%), only 41% accepted new Medicaid patients. On average, new patients experience longer wait times, with 6.6 weeks for adults and 5.3 weeks for children. Parents of children with special health needs especially identified difficulty finding basic dental care for their child/children. Most dentists are general practitioners, with only 3.5% specializing in pediatric dentistry. Some providers described “dental deserts” and wished for more school-based dental services; however, Vermont has no Medicaid dental cap during pregnancy, highlighting a notable strength.

¹⁹ Vermont Department of Health. 2025. 2023 Census of Dentists, Statistical Report. <https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-dent23-detail.pdf>

Other major themes

Beyond mental health, financial stability, and access to care, assessment participants identified many Title V domain-specific topics, which are detailed in the next section. Two additional areas were identified, which are genuinely cross-cutting in nature. Neither rose to the volume of discussion as the three major themes, but each is uniquely and highly relevant to FCH programming and the populations it serves:

Social connections (including community connections and interpersonal relationships): Among parents/caregivers, 44% identified finding community connections as a struggle, with higher rates of struggle among BIPOC parents/caregivers, and parents/caregivers of children with special health needs. In qualitative responses, “social connections” was the 4th top concern parents/caregivers had for children after mental health, social media/screens, and education/school theme clusters. FCH routinely tracks measures of connectedness for middle and high school students via the Vermont Youth Risk Behavior Survey (see Adolescent Health domain below) but does not have a consistent data source to track social connectedness for parents/caregivers or children and youth across the age span.

“We need to engage dads and challenge the narrative around fathers’ needs – mental health, violence prevention, gender equality.”

As shown in the survey data (Chart 5 and Appendix 2), all respondents from communities of focus ranked social connections as a greater struggle than survey respondents overall, with BIPOC parents/caregivers especially identifying finding connections as an area of struggle.

As the statements below demonstrate, Vermont parents seek social connections from a wide range of sources, including family members, classmates, social and faith organizations, other parents, and the larger community.

Parent/caregiver well-being: As identified in the survey index, most parents report a high degree of stress, and many struggle to find supportive connections in the community. The third largest code cluster for parents/caregivers was parent health/healthcare. These topics included concerns about a long list of chronic conditions, as well as parents’ own mental health and/or substance use concerns. Among the top concerns parents/caregivers identified, a small but surprising number remarked that they worry about the future and that their or their children’s happiness is among their top concerns. The combination of poor mental health and financial stress, when added to health concerns, vulnerability associated with marginalized identities, and access to care barriers places many parents in an impossible situation. Many parents/caregivers spoke of delaying or foregoing care for themselves. Providers frequently remarked that parents’ needs are not addressed, which often impacts children’s health and well-being. The breadth of concerns facing parents suggests that, whether through public health, primary care, or collaboration with other state systems such as the Department for Children and Family Services and/or the Agency of Education, more efforts are needed to help parents manage their own well-being while caring for families.

TITLE V DOMAIN ANALYSIS

Women’s Health and Maternal Health

The Title V Needs Assessment collected information on maternal and women’s health from multiple perspectives. Among survey respondents, 64 individuals identified as the parent/caregiver of an infant and 49 identified that they were currently pregnant or planning to become pregnant within the next year. In addition, focus groups with providers included OB/GYNs, nurse-midwives, and home-visiting program staff. Community members’ concerns mirrored those evident across all groups in the assessment, primarily mental health, stress, and finances.

Several survey respondents identified positive birthing experiences as examples of a time they had a positive care encounter. Few community members identified reproductive health care issues as priority concerns in surveys or focus groups.

“My prenatal/postnatal care was very positive. I had a lot of issues with my first pregnancy, and the doctors and nurses took exceptional care of me. I am very grateful for that experience”

Since the 2020 Title V needs assessment, Planned Parenthood of Northern New England has closed clinics in Bennington, Hyde Park, Middlebury, Newport, St. Johnsbury, and St. Albans. Additionally, since these data were collected, the Copley Hospital Birth Center closed its doors, leaving a critical gap in perinatal care and birthing services in Lamoille County and surrounding rural communities, requiring many pregnant individuals to travel to neighboring counties, such as Chittenden or Washington, for hospital-based delivery services. In these communities, telehealth is now providing access to care for sexual and reproductive health concerns without requiring in-person visits; however, this is not a sufficient replacement for the loss of in-person services. Providers identified concerns about the impact of clinic closures for these communities, but parents/caregivers did not raise this issue. Several providers also identified concerns related to the nexus of pregnancy and substance use/substance use disorders and pregnancy and mental health (including post-partum mental health) as times when available care and resources may not match the urgency for individuals and families.

Amidst these challenges, home visiting programs provide an important opportunity to support families early in a child’s life and help address needs within the comfort of the home environment. Participants emphasized the need to better integrate home visiting and perinatal services, especially for migrant and agricultural worker families, and highlighted the importance of improving language access, translation services, and understanding the birthing experiences of refugee and immigrant families.

Mental health during pregnancy: Parents/caregivers especially identified issues related to mental health during pregnancy, as well as in response to infertility and/or the

loss of a pregnancy. This finding aligns with recent statewide surveillance data, which found:²⁰

- 24% of people report feeling depressed before their pregnancy, but only 18% receive care for depression before getting pregnant.
- 23% of people feel depressed during pregnancy.
- Vermonters under 25, or enrolled in Medicaid, or without a high school diploma, are significantly more likely to experience depression while pregnant (see [PRAMS report](#) for comparisons).
- 13% of Vermont mothers experience postpartum depression symptoms.

Perinatal Mood and Anxiety Disorders (PMAD) are an ongoing concern. One in four pregnant or postnatal Vermonters experience a PMAD, and fewer than half received treatment.²¹

Pregnancy & Substance Use: While few assessment participants raised issues surrounding substance use during pregnancy, this is an area where indicators continue to fall short of targets:

- ***Cigarette Use & Cessation:*** One in 10 people smoke during pregnancy. Vermonters under 25, enrolled in Medicaid, or without a high school diploma are significantly more likely to smoke while pregnant. Most (76%) Vermonters who smoke during pregnancy received advice from a health care provider to quit smoking; 44% of people who smoke prior to pregnancy quit during pregnancy.
- ***Alcohol & Substance Use:*** 70% of people report drinking in the months before getting pregnant and 18% report binge drinking. About 12% of people drink during pregnancy. Cannabis use before pregnancy increased from 13% in 2016 to 20% in 2022. Vermonters under 25, enrolled in Medicaid, or without a high school diploma are significantly more likely to use cannabis during pregnancy. During pregnancy, 10% of pregnant people report using cannabis.

Maternal and Women’s Health Key Indicators

Compared to the U.S. rates, Vermont has statistically significant lower rates of low-birth-weight deliveries, pre-term births, early term births, infant mortality, and births by teens ages 15 through 19. Vermont has a somewhat higher percentage of women who experience postpartum depressive symptoms than the national average. **In 2022, 12.9% of women in Vermont experienced postpartum depressive symptoms following a recent live birth, compared to 12.0% of women nationally.**

²⁰ Vermont Department of Health. 2024. Pregnancy Risk Assessment Monitoring System Phase 8 Report. https://www.healthvermont.gov/sites/default/files/document/hsi-prams-phase-8-report_6.pdf

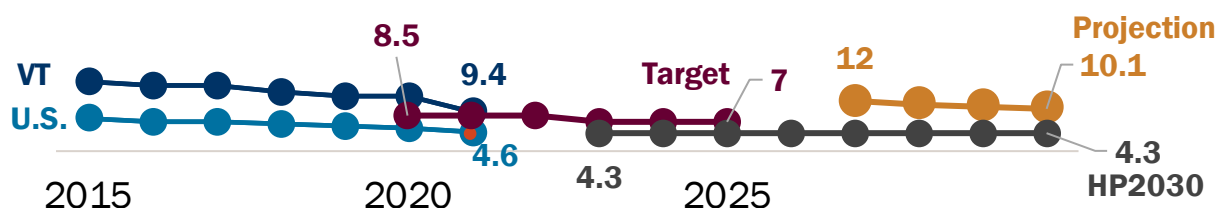
²¹ Platt, I. et al. 2023. Estimating the Costs of Untreated Perinatal Mood and Anxiety Disorders in Vermont. Mathematica, Inc. <https://legislature.vermont.gov/Documents/2026/Workgroups/Senate%20Government%20Operations/Bills/S.53/Witness%20Documents/S.53~Martine%20Larocque%20Gulick~Vermont%20PMAD%20Issue%20Brief~2-19-2025.pdf>

FCH tracks the following National and State Title V Performance Measures (PM) for Women’s and Maternal Health:

1. NPM: % of women who smoke during pregnancy
2. State PM: % of women advised by a HCW to abstain from alcohol during pregnancy

In 2022, 12.4% of women in Vermont reported drinking alcohol in the last three months of pregnancy, compared to 7.8% of women nationally.

Chart 10. PM-14.1: Women who smoke during pregnancy, 2009-2021 NVSS



Summary

- Needs assessment participants who were pregnant and/or parents of infants were most concerned about mental health, stress, and finances.
- Vermont has lower rates of low-birth-weight deliveries, pre-term births, early term births, infant mortality, and births by teens compared to the U.S.
- Positive birthing experiences and praise for home visiting services were identified by both parents/caregivers and providers.
- Vermont has a higher percentage of people experiencing postpartum depressive symptoms than the national average. Perinatal Mood and Anxiety Disorders (PMAD) affect one in four pregnant or postnatal Vermonters, with fewer than half receiving treatment; 13% experience postpartum depression symptoms. These findings suggest a need for screening and intervention resources, particularly given the broader assessment findings on mental health care concerns and access.
- Substance use during pregnancy remains a concern, with above-average rates of pregnant people using alcohol (12%), cannabis (10%), tobacco (10%), or other substances during pregnancy.

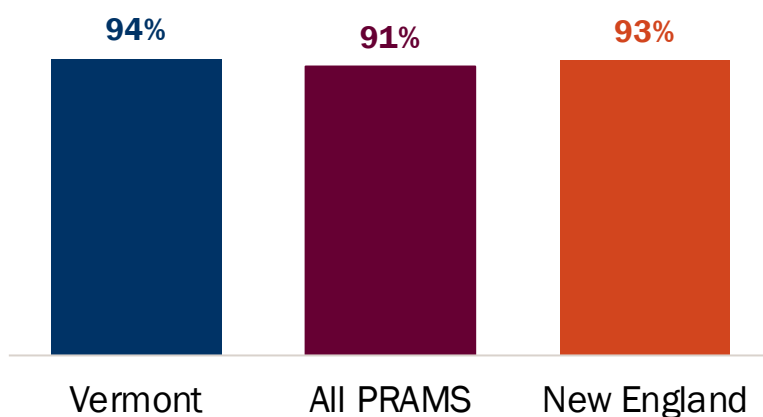
Perinatal and Infant Health

Across many measures, most Vermont newborns and infants have a healthy start. Vermont's pre-term birth rate (7.7%) is lower than the national average (10.1%) and has improved in the last two years. The state's infant mortality rate (4.9 per 1,000 live births) is lower than the U.S. average (5.6), but has increased significantly in the last five years, from a rate of 2.8 in 2019.²²

Among those who had a baby in 2022, most (87%) birthing parents received adequate prenatal care, and nearly all (93.7%) had a postpartum visit, a Title V Universal Performance Measure (Chart 11). Of birthing parents, 82.7% had a visit with a health care provider in the year before pregnancy. Of births in 2022, 70% of pregnancies were intended, surpassing the Healthy Vermonters 2030 goal of 65%.²³ In 2023, most (75.8%) Vermont children received recommended immunizations by age 2, compared to 66% in the United States.²⁴ There is a wide range in immunization rates by county, from 82.5% in Addison County to 45.5% in Essex County.

Chart 11. Percentage of postpartum visits of 2022 births.

PRAMS



Providers identified a number of strong and effective initiatives and partnerships that are supporting collaboration toward strong perinatal and infant health outcomes in Vermont including Vermont's Perinatal Quality Collaborative (PQC-VT), Perinatal Cares (previously Screening, Treatment, & Access for Mothers & Perinatal Partners (STAMPP)), Support Delivered, Developmental Understanding and Legal Collaboration for Everyone (DULCE), a variety of Home Visiting programs, Children's Integrated Services (CIS) programming, among many other critical initiatives. Some providers identified difficulty making inroads to address perinatal risks such as safe sleep, basic needs challenges, and parents' substance use and

²² Centers for Disease Control and Prevention, National Center for Health Statistics. 2025. Natality data, 2013-2023.

²³ Vermont Department of Health. 2024. Pregnancy Risk Assessment Monitoring System Phase 8 Report. https://www.healthvermont.gov/sites/default/files/document/hsi-prams-phase-8-report_6.pdf.

²⁴ Vermont Department of Health. 2024. Immunization Registry. <https://www.healthvermont.gov/stats/registries/immunization-registry>

mental health concerns. Both providers and parents/caregivers seek more resources for, and recognition of men’s parenting roles, and related support and education needs. For households with young children, childcare costs and the availability of childcare providers were among the most commonly identified concerns.

Newborns Exposed to Opioids: Neonatal Abstinence Syndrome (NAS) is a very specific medical diagnosis, but it represents only a subset of the much larger population of infants and children whose health and well-being are impacted by parental substance use. While not specifically identified by needs assessment participants, rates of NAS in Vermont continue to be a bellwether indicator for parental and infant health in the larger context of substance use issues facing Vermont households. Several providers noted that infants and children suffer from the high rates of SUDs among Vermont adults. Of significant concern, Vermont’s rate of infants born with a clinical diagnosis of neonatal abstinence syndrome has remained nearly three times the U.S. average. **In 2022, the rate of infants born with neonatal abstinence syndrome in Vermont was 15.5 per 1,000 delivery hospitalizations, compared to 6.2 per 1,000 nationally.** While this represents fewer than 100 infants born in Vermont, the long-term health and system implications for the infant, family, and community are substantial and preventable. Notably, this indicator has trended in a positive direction, with the 2022 rate of Vermont newborns diagnosed with neonatal abstinence syndrome at less than half the 2013 rate.²⁵

Perinatal and Infant Health Key Indicators

Compared to the U.S. rates, Vermont has statistically significant higher rates of infants who are breastfed through the first six months, infants who are ever breastfed, infants placed on their backs to sleep, and infants sleeping without soft or loose objects. At 3.2 deaths per 1,000 live births Vermont’s infant mortality rate is significantly lower than the national average (5.4).

Summary

- Vermont’s high rates of prenatal care and low rates of pre-term births and infant mortality generally reflect positive health outcomes for newborns and birthing parents.
- Providers identified several strong initiatives supporting perinatal health outcomes in Vermont, including the Perinatal Quality Collaborative, Perinatal Cares, Support Delivered, DULCE, among many other strong partnerships and programs.
- Challenges remain in addressing perinatal risks such as safe sleep, basic needs, and parents’ substance use and mental health concerns.
- Both providers and parents/caregivers seek more resources and recognition for male-identifying parenting roles and related support and education needs.
- Childcare costs and availability are significant concerns for households with young children.

²⁵ Vermont Department of Health. 2024. Newborns Exposed to Opioids in Vermont. https://www.healthvermont.gov/sites/default/files/document/hsi-nas-in-vermont_0.pdf

Children’s Health

In addition to mental health and family financial concerns, the most identified topics by both parents/caregivers and providers were:

1. Schools and education
2. Social media/screens/technology
3. Social connections and belonging
4. Safety and violence, including in school settings

Survey responses were cross-tabulated for groups of parents with infants or children under age 3, preschool children (age 3-5), and school-age children (age 6-11). Responses were generally similar to the responses by all survey respondents, with parents/caregivers identifying “keeping stress low,” “maintaining mental health,” and “finding connections in the community as the areas of greatest challenge for both themselves and their child/children. The areas that were identified as the easiest to manage included “finding healthcare that is safe and accessible,” and “staying safe from violence” (Table 10).

Table 10. Lowest Ranked Survey Items by Child’s Age Group

Minimum = 1.0 (“This is a struggle”), Maximum= 6.0 (“This is easy”)	All Respondents		Infants/ Children up to age 3		Preschool Children (age 3-5)		School-age Children (age 6-12)	
	Self	Child	Self	Child	Self	Child	Self	Child
Keeping stress low	2.78	4.13	2.79	4.72	2.92	4.38	2.85	4.16
Maintaining mental health (freedom from anxiety, depression)	3.46	4.26	3.47	5.09	3.24	4.88	3.51	4.39
Finding connections in the community where I/they feel a sense of belonging	3.77	4.35	3.67	4.77	3.75	4.57	3.86	4.62

Schools and education: Approximately 100 parents/caregivers identified school or education as one of their top two concerns for their child/children. Concerns identified included school quality, prioritizing learning and education, opportunities for enrichment activities for school-aged children, and school safety. In the 2020 Title V Needs Assessment, schools were discussed related to children with special health needs, transitions from early intervention, and other areas where health needs and educational settings necessarily come together. This finding represents a significant shift which likely reflects changing perceptions about the role of schools in communities following the COVID-19 pandemic. It is notable that for many of the parents/ caregivers who listed school/education-related topics as one of their top concerns, they expressed concerns not about traditional aspects of health, but

about basic educational needs such as “Is my child learning?” and “Is my child safe at school?”

Providers also frequently identified school collaboration, including discussion about the value of school nurses, opportunities to strengthen collaboration between healthcare and educational systems, and recognition that school workforces are experiencing many of the same shortages and constraints found in the healthcare sector.

Social media/screens/technology:

More than 100 parents/caregivers identified concerns about social media and screens as top concern, with some raising concerns about the impacts of screen time on mental health and social relationships. Within this cluster, parents were concerned about video games, social media use, and the connection between screen time and physical activity.

As noted in the thematic analysis, social wellbeing, including community belonging and positive peer relationships, were frequently identified. Having friendships and community connections that are positive, support a sense of belonging, and give children social skills were specifically noted. Relatedly, more than a dozen parents/caregivers identified concerns about bullying as one of their top concerns (see Adolescent Health Domain). While most parents of school-aged children and adolescents did not identify safety as a concern in the ranked item responses, many parents used open-ended responses to identify concerns about safety in school and in the community, including safety in households where domestic violence had occurred, in communities with increased substance use in public places, and identity-safety related to a child’s LGBTQ+ or BIPOC identity.

Providers identified concerns about the connection between basic needs challenges and rising rates of school absences (and wished for more resources to address these challenges); a need to examine silos separating health, social service, and education systems to better meet the needs of vulnerable children and families; and numerous benefits of effective care teams/care coordination in both primary care and educational settings to help ensure that children’s needs are met.

Children’s Health Key Indicators

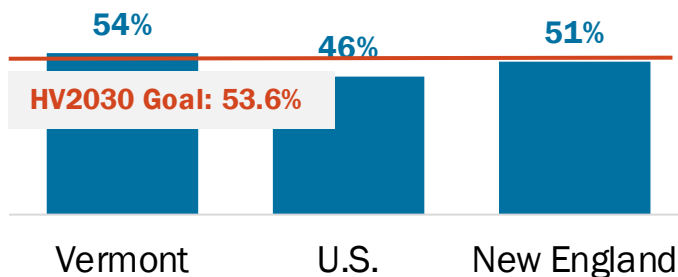
According to data from the National Survey of Children’s Health (NSCH), 92.3% of Vermont children are in “good or very good health” compared to 89.9% nationally (2022). The percentage of Vermont children and adolescents who are obese or very obese is significantly lower than the national average (11.6% vs. 18.1%). **In 2021–2022, 92.3% of children in Vermont were reported to be in excellent or very good health, compared to 89.9% of children nationally.**

“We need more established structure for provider engagement with schools. It would be wonderful if every school had a physician as part of school team that could be there for everything from coordination of care to helping inform policy or practices.”

Having a medical home is an identified universal performance measure for Title V. For all children ages 0-17, the Vermont and New England medical home rates (53.9% and 51.2%, respectively) significantly exceed the US rate (46.1%) (Chart 12). This indicator corresponds to needs assessment input about families' access to primary care including pediatricians. Overwhelmingly, families that have a medical home reported satisfaction with their providers' care.

“Our children's pediatrician is wonderful. Someone is always available to take a call even for a simple question 24/7. While we aren't in need of this service as much now that our children are older, it was so valuable as a new parent.”

Chart 12. NPM 11. Percentage of children having a medical home, 2021-2022, (NSCH)



Summary

- In the lives of their children, parents/caregivers are concerned about social media, screens, and technology; social connections and belonging; and safety.
- Parents/caregivers overwhelmingly listed school or education as a top concern, focusing on school quality, prioritizing learning and education, opportunities for enrichment activities, and school safety. Providers emphasized the importance of school collaboration, including the role of school nurses and the need for better integration between healthcare and educational systems.
- Social media and screens, and especially their impact on mental health and social relationships, are an emerging concern for many parents/caregivers.
- Providers noted the connection between basic needs challenges and rising rates of school absences, advocating for more resources to address social determinants that undermine both health and educational success.

Adolescent Health

Parents/caregivers overwhelmingly identified stress, mental health, and social media/technology as top concerns for adolescents. They pointed to a lack of community connections and decreasing numbers of mental health providers in the state, coupled with increased concerns around substance use, including vaping. Parents/caregivers are concerned about adolescents’ safety when in school, bullying, as well as the quality and consistency of sexual health education they’re receiving. Survey responses highlighted challenges related to supporting adolescents to gain a sense of belonging in community, including positive, healthy peer influences, and relationships with the broader community that promote healthy activities and connections.

Of the 609 individuals who responded to the community health needs assessment survey, 224 (36.8%) indicated that they were parents/caregivers of adolescents ages 12 to 17. In responses about themselves the two groups had few differences. In considering responses for their child/children, parents/caregivers of adolescents indicated slightly greater struggle for children “keeping stress low,” “maintaining mental health,” and “starting difficult conversations” (Table 11). Interestingly, parents/caregivers of adolescents were more likely to indicate that “hope for the future” and “getting good information” were easier for their child/children.

Table 11. Survey Responses from Parents/Caregivers of Adolescents Compared to All Respondents

Minimum = 1.0 (“This is a struggle”), Maximum= 6.0 (“This is easy”)	All Respondents		Parents/Caregivers of Adolescents	
	Self	Child	Self	Child
Keeping stress low	2.78	4.13	2.75	3.81
Starting difficult conversations about health and wellness	4.29	4.33	4.23	3.99
Maintaining mental health (freedom from anxiety, depression, etc.)	3.46	4.26	3.43	4.01
Finding connections in the community where I/they feel a sense of belonging	3.77	4.35	3.81	4.24
Hope about a bright future	4.04	4.45	4.11	4.76
Getting good information and/or finding resources to understand how to stay healthy or become healthier	4.79	5.07	4.87	5.14

Issues identified by providers included social media and its impact on mental health, mental health more broadly, substance use including vaping, sexual health education quality and consistency, and collaboration challenges when school and healthcare providers must share information and work as a team. Two State Performance Measures illustrate how needs related to mental health and connection are impacting Vermont adolescents:

Chart 13. The rate of Vermont adolescents who feel they matter to people in their community is below the target.

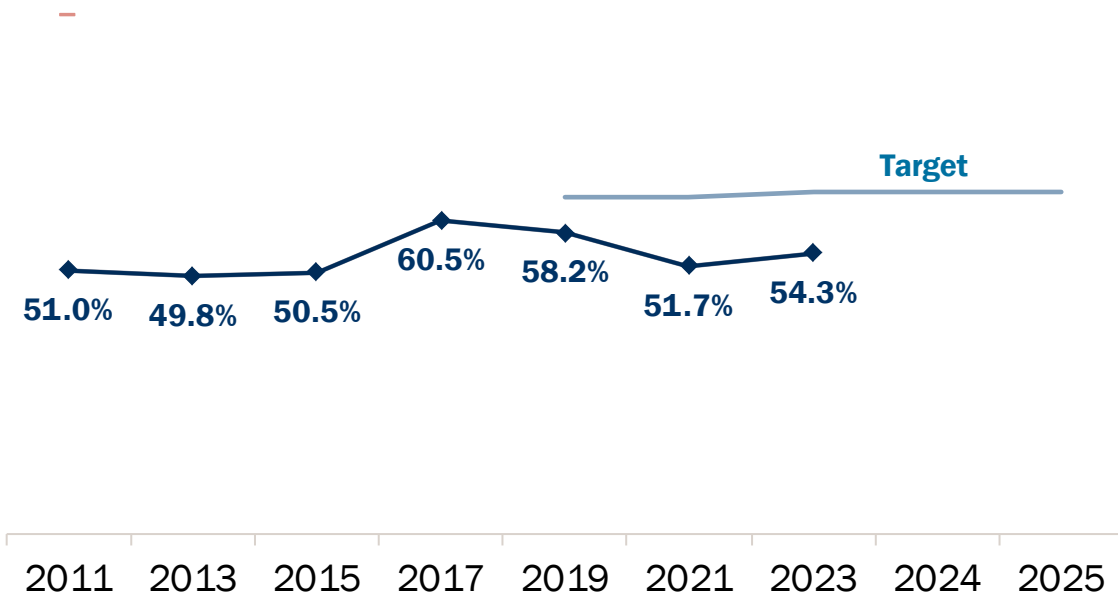
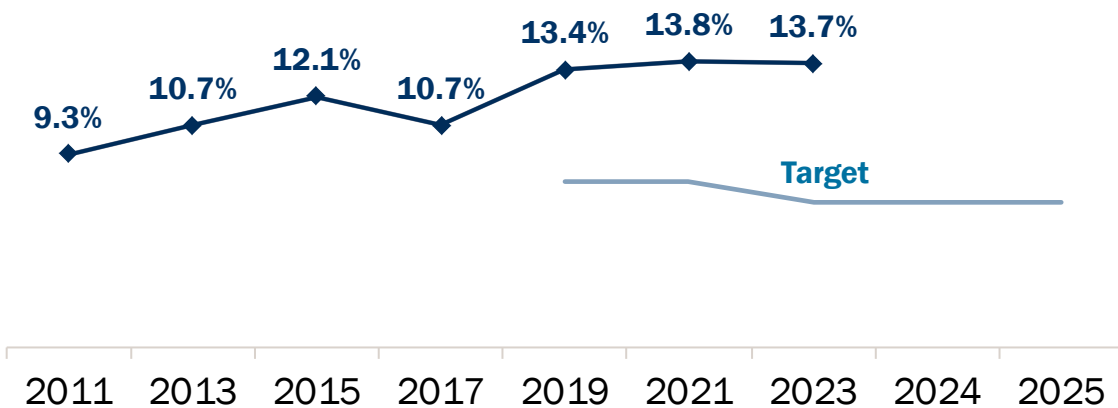


Chart 14. The rate of Vermont adolescents who plan to attempt suicide is higher than the target.



Adolescent Health Key Indicators

According to data from the National Survey of Children’s Health (NSCH), Vermont has a lower rate of students in grades 9 through 12 who are obese or very obese (13.6% compared to 16.3% in the U.S.); higher rate of children who receive an annual influenza vaccine (70.9% compared to 57.4%); and higher percentage of children ages 13 through 17 who have had at least one dose of the HPV vaccine (88.0% compared to 76.0%). Vermont’s teen birth rate is less than half the U.S. average (5.8 per 1,000 population, compared to 13.6).

“In general youth are seeking that 3rd space area, how do we build that up to have safe healthy positive activities for youth?”

Bullying: While not a new issue, the number of parents identifying bullying as a top concern was greater than in the prior needs assessment. Vermont's rate of those who bully others, and the rate of adolescents ages 12-17 who are bullied, significantly exceeded the US rate in 2018-21 and New England's rate in 2020-21. The links between bullying and mental health, as well as school safety, make this a particular concern. Parents/caregivers identified bullying as one of their top concerns for their child/children.

Chart 15. PM-9: Adolescents ages 12-17 who bully others, 2018-2021, YRBS

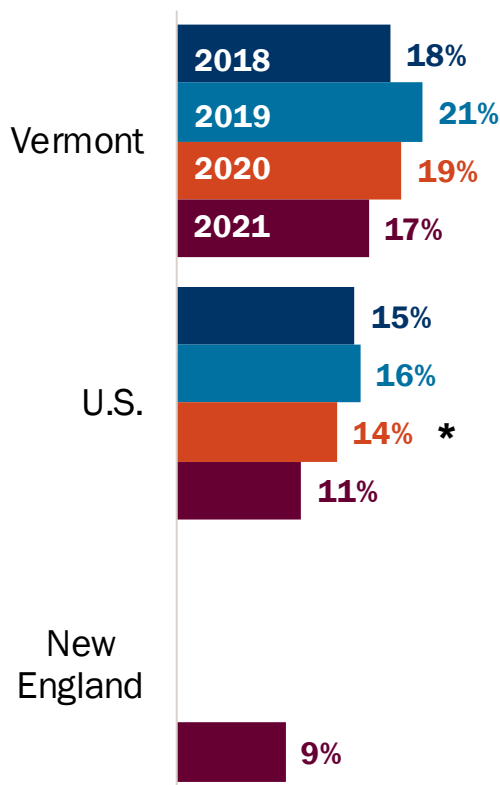
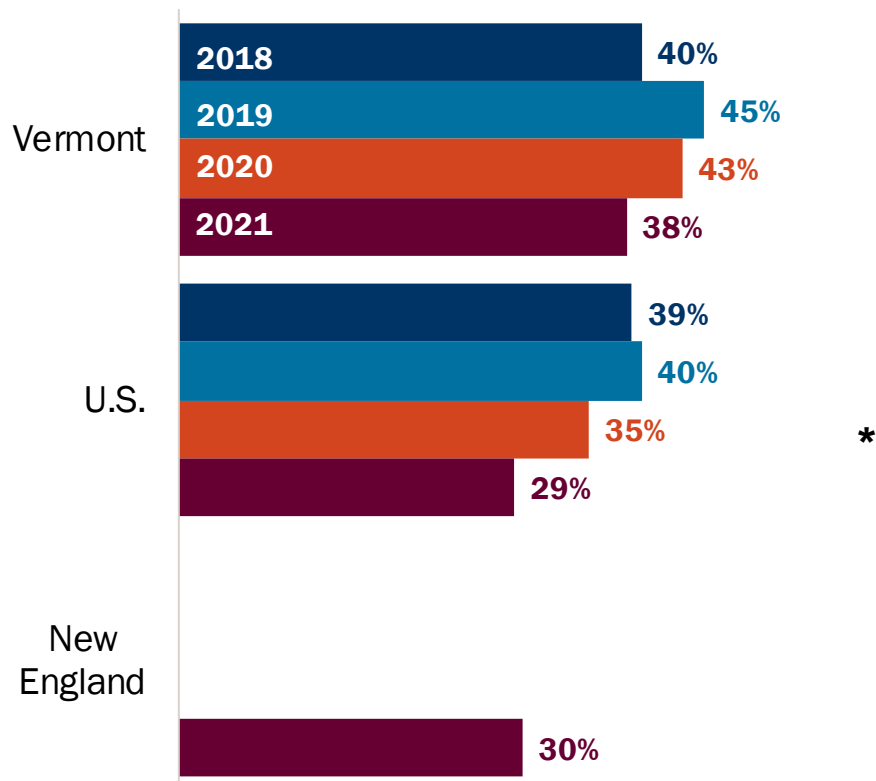


Chart 15a. Adolescents aged 12-17 have been bullied, YRBS



Summary

- Parents/caregivers identified stress, mental health, and social media/technology as top concerns for adolescents, with additional concerns about substance use (including vaping), safety in school, bullying, and the quality and consistency of sexual health education.
- Supporting adolescents to gain a sense of belonging in the community, including through positive peer influences and relationships, is a significant concern among parents/caregivers.
- Issues identified by providers included the impact of social media on mental health, substance use, sexual health education quality, and collaboration challenges between school and healthcare providers.
- Meeting the needs of LGBTQIA youth, including providing gender affirming primary care, access to mental health providers, and the quality of care in rural communities were of particular concern among households with LGBTQIA+ members.

Children with Special Health Needs (CSHN)

Parents/caregivers of children with special health needs reported ongoing challenges in accessing basic and specialist care, challenges related to care coordination and integration, as well as positives resulting from effective care coordination when it is working well. Working across siloed systems continues to be a perplexing issue for both parents of CSHN and providers, who struggle when a child ages out of one level of service or when their circumstances necessitate working with multiple kinds of providers for ongoing care.

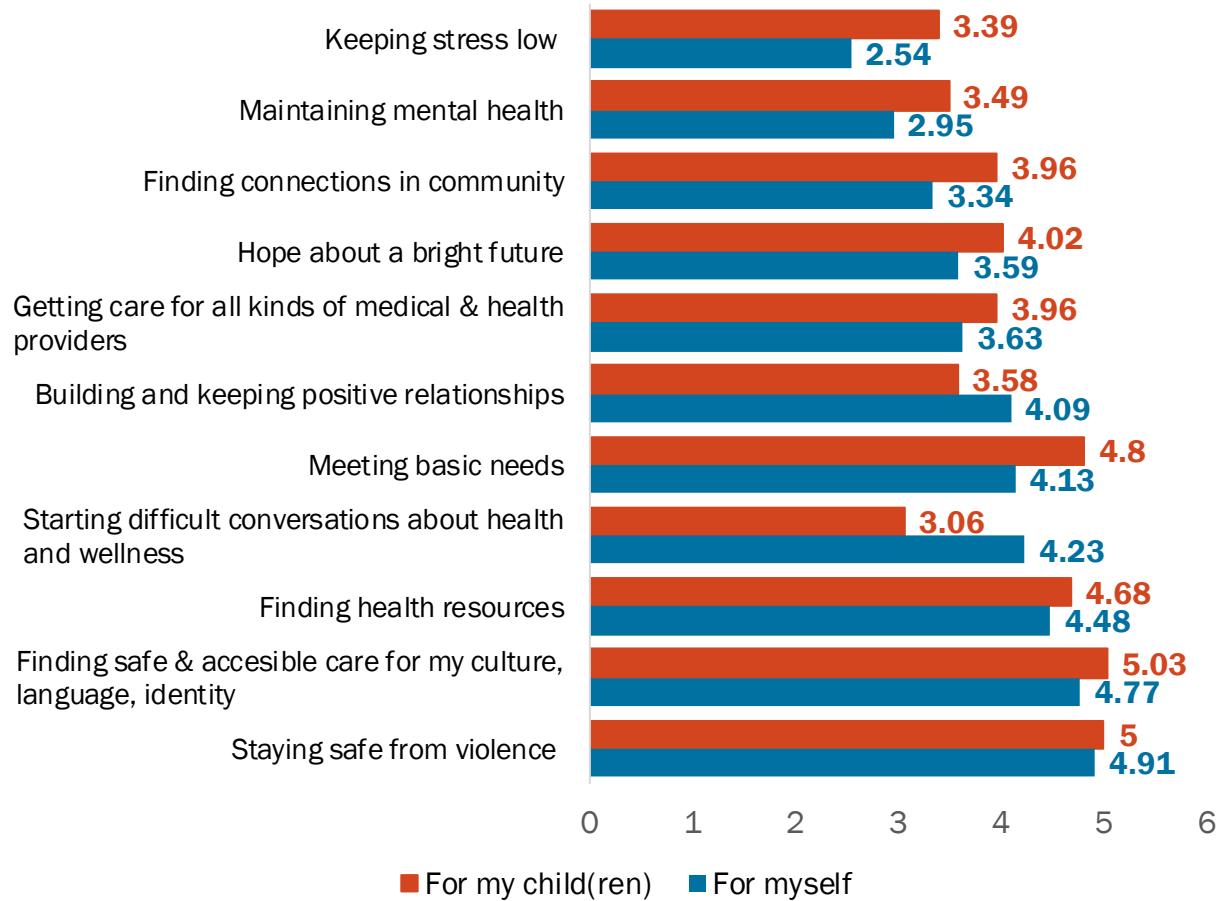
Even with many providers concentrated in Chittenden County, families report long wait times, with many traveling to Dartmouth or as far as Boston to receive timely care. Parents/caregivers of CSHN bear the significant burden of care coordination and must navigate multiple healthcare systems to ensure that all providers have access to their child/children's medical information and that appointments and medications are appropriately cross-referenced. Many identified Medicaid coverage as critical for enabling access to care at the level and frequency required for children with complex needs. Autism and ASD were frequently identified by parents/caregivers of CSHN as well as many providers, who identified a need for greater support behavioral health support, and roles for schools and school systems in ensuring educational needs are being identified, tracked, and met with fidelity.

Survey responses from parents/caregivers of CSHN differed more from all respondents than other subgroups, both for "self" and "child/children." On average, parents/caregivers of CSHN identified a lower ranking (greater struggle or less easy) for every item, both for themselves and their child/children (Chart 14). For their children, more than 50% of CSHN parents/caregivers identified "finding connections in the community," and "building and keeping positive relationships" as always, usually, or somewhat a struggle.

"It makes a huge difference to have a medical social worker, if those team workers can meet with the school, it's magical."

Chart 16. Survey Responses by Parents of CSHN

Minimum = 1.0 (“This is a struggle”), Maximum= 6.0 (“This is easy”)

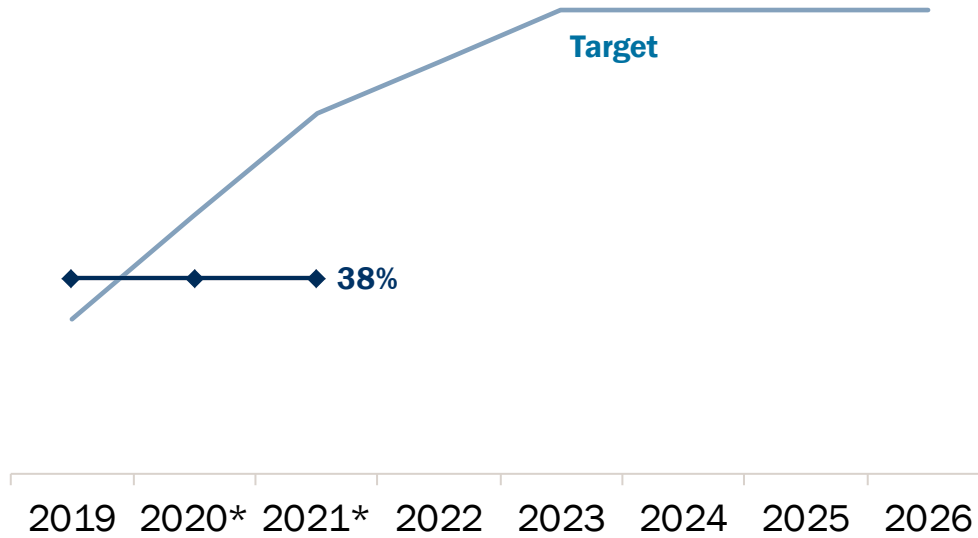


Children with Special Health Needs Key Indicators

For children with special health needs, the transition to adult primary and specialty care is especially important. Continuity in access to care is critical to maintaining health and well-being. **In 2021–2022, 28.3% of adolescents ages 12–17 in Vermont received services to prepare for the transition to adult health care, compared to 17.8% of adolescents nationally.**²⁶

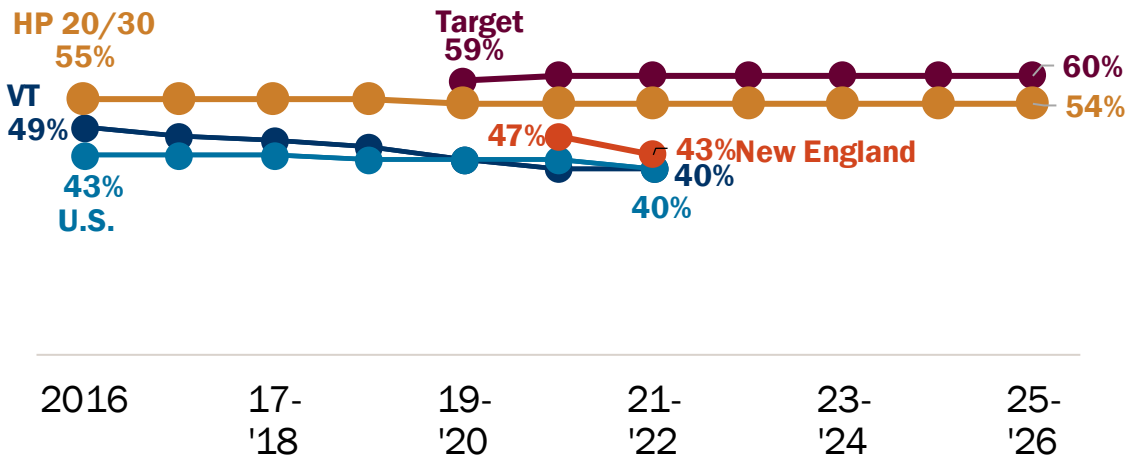
²⁶ National Survey of Children’s Health (NSCH), 2021–2022, U.S. Census Bureau; Maternal and Child Health Bureau, HRSA.

Chart 17. The percentage of CSHN who have had a transition planning meeting prior to their 18th birthday



As identified under Children’s Health (Chart 12), connection to a medical home is a universal Title V performance measure. Vermont’s rate (40.6%) is roughly the same as the U.S. rate (40.7%) but falls below the New England rate (43.6%) and is significantly lower than the target of 60%. Parents/caregivers of CSHN identified numerous challenges in accessing care, and many struggle to find specialists. Similarly, as shown in Chart 18 and Appendix Table A.6, parents/caregivers of CSHN had the lowest ranking for “Getting care from all kinds of medical and health providers” of any community of focus or assessment population, both for themselves and for their child/children.

Chart 18. Percent of children with special needs, ages 0-17, who have a medical home



Summary

- Parents/caregivers of children and youth with special health needs face ongoing challenges in accessing basic and specialist care. Parents/caregivers bear the burden (and stress) of care coordination, navigating multiple healthcare systems to ensure all providers have access to their child’s medical information.
- Compared to other communities of focus and parents and children/youth overall, parents/caregivers of CSHN report greater struggle in numerous aspects of health and wellbeing, and particularly in finding community connections and building positive relationships.
- Families who rely on specialists and multi-specialty teams often experience long wait times and may need to travel to Dartmouth or Boston for timely care.
- Autism and ASD continue to be the most frequently identified specific special health need. Parents and providers both wish for greater behavioral health support and coordination with schools to ensure educational needs are met.

Effective care coordination, including the involvement of medical social workers, makes a significant difference for CHSN families. Care coordination and integration when transitioning between different levels of service or working with multiple providers is especially challenging.

Cross-Cutting & Systems Domain

In addition to the cross-cutting topics identified in the thematic discussion above, a variety of cross-cutting topics related to equity, inclusion, and cultural/linguistic access in health and wellness were identified by needs assessment participants. Additionally, interpersonal violence continues to be a high priority topic across all the populations FCH serves.

Equity, Inclusion, and Access

In general, topics related to bias, equity, and access about communities of focus, including LGBTQ+ people, English learners, and BIPOC were raised most by providers who are not for the most part members of these populations. Responses from communities of focus were mostly the same as those from all parents/caregivers who participated in the assessment, with mental health, stress, financial concerns, access to care, and needs for community connections identified as their most significant needs.

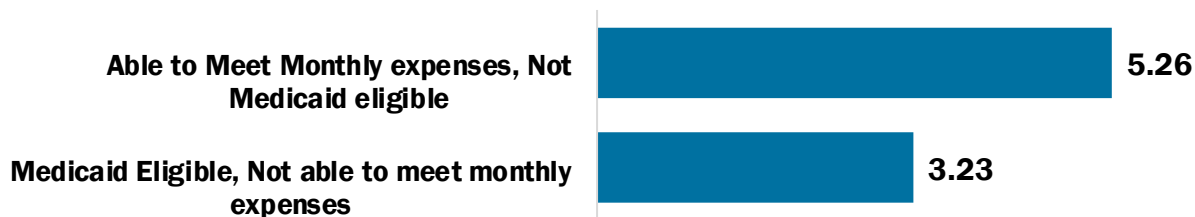
Notably, on average, BIPOC survey respondents ranked meeting basic needs, building positive relationships, finding culturally/linguistically accessible care, and connecting to the community as a greater struggle for themselves than all respondents. This finding is reflective of the social determinants of health that drive equity gaps for many individuals in FCH communities of focus, and systemic gaps that impose obstacles for parents and families from focus populations. (See Appendix Tables A.1. and A.2 for additional data).

Table 12. BIPOC Survey Respondents Compared To All Respondents

Minimum = 1.0 (“This is a struggle”), Maximum = 6.0 (“This is easy”)	All	BIPOC	Change ▲
Meeting basic needs (housing, food, transportation)	4.31	3.57	-0.74
Building and keeping positive relationships with family and/or friends	4.45	3.77	-0.68
Finding health care that is safe and accessible for my culture, language, and/or identity	4.96	4.40	-0.56
Finding connections in the community where I/they feel a sense of belonging	3.77	3.22	-0.55

There is a substantial gap in respondents’ reported ability to meet basic needs for housing, food, transportation and other essentials. About 58% of respondents stated that they are typically able to meet monthly expenses. When survey respondents are separated into those who selected that they are Medicaid eligible and not able to meet monthly expenses compared to those who are not Medicaid eligible but are able to meet monthly expenses, there is a nearly 2-point difference in their ranking of meeting basic needs (Chart 19).

Chart 19. Meeting Basic Needs By Household Income Categories



Survey responses highlighted the disproportionate impacts on marginalized communities of basic needs challenges and access to care that is sensitive and/or competent with regard to identities, including culture, race/ethnicity, gender, and sexuality. Numerous community resources (e.g. Dad Guild, The Family Room, HireAbility, Reach Up, VT Family Network, Vermont I-Team) were identified as critical in addressing their family’s healthcare concerns.

Providers expressed valuing opportunities to listen to, engage with, and elevate the voices of those with lived experience, and also noted the time and effort required to reach and create inclusive spaces for vulnerable populations across identity markers (language, citizenship, gender identity, etc.). Challenges identified included effectively connecting with populations such as migrants and unhoused families, with interest in using partnerships and other intentional efforts to connect with harder-to-reach populations where they are. Gender- and family-inclusive language across all sectors, culturally appropriate materials, and accessible translation/interpretation services were identified as needs in some areas and strengths in others.

“Emergency mental health care is available but was executed poorly for my child. Better training for LGBTQ issues would have made a difference.”

Interpersonal Violence

Domestic and family violence are a significant public health problem in Vermont and elsewhere, but very few needs assessment participants raised these topics beyond identifying concerns about bullying among parents of school-aged children.

According to the 2023 Vermont Youth Risk Behavior Survey (YRBS):

- 23% of students ever had someone do sexual things to them that they did not want. Female, BIPOC and LGBTQ students are all significantly more likely to report experiencing sexual harm.
- Among all students who dated during the past year, 9% experienced physical violence. Female, BIPOC and LGBTQ+ students are all significantly more likely than others to experience violence in a dating relationship.

According to 2021 Vermont Behavioral Risk Factor Surveillance System (BRFSS) data:

- 16% of adults reported having ever been made to take part in any non-consensual sexual activity.
- Women, LGBTQ+, and adults living with a disability are significantly more likely to report having ever been made to take part in any non-consensual sexual activity (women 24% vs. 8%, LGBTQ 37% vs. 13%, people with disabilities 23% vs. 13%).
- In 2023, 24% of homicides in Vermont were linked to domestic violence.

A handful of focus group participants named that they had experienced domestic violence and spoke to how their experiences impacted access to healthcare, increased basic needs insecurity, and for those in rural communities, compounded access to care barriers for themselves and their child/children.

Summary

- BIPOC respondents identified the same top three struggles as all needs assessment participants, and also ranked meeting basic needs, building positive relationships, finding culturally/linguistically accessible care, and connecting to the community as greater struggles compared to all respondents, reflecting the disproportionate impact of historic inequities in systems of care.
- Topics related to bias, equity, and access were mainly raised by providers, especially concerning LGBTQ+ people, English learners, and BIPOC Vermonters.
- Basic needs challenges are a significant obstacle for roughly 4 in 10 households, and directly undermine access to healthcare.
- Providers value opportunities to listen to, engage with, and elevate the voices of those with lived experience, noting the time and effort required to reach and create inclusive spaces for vulnerable populations.
- Domestic and family violence are significant public health problems, but few parents/caregivers or providers outside of the FCH staff identified these issues as top concerns.

“I’ve been trying to apply for EBT and Medicaid...Applying for Reach Up you have to list the partner for DCF office. As a domestic abuse survivor, it’s not safe, I have to put my and my son’s life in jeopardy to get assistance, even though he has no link to the father.”

SUMMARY OF FINDINGS

Overall, the 2025 Title V Needs Assessment identified that Vermont's systems of care for family and child health are broadly meeting many of the most critical health and wellbeing needs for families across the state. Even recognizing all that is currently working well, there are opportunities to strengthen systems of care, reach more Vermonters, and improve health outcomes. Insights from this assessment are provided to support future programmatic and systemic improvements, both within VDH, and through close collaboration with providers of all kinds:

Stress, mental health, financial stability and supportive connections are critically impacting health and well-being for all. In all, data points on these four topics represent thousands of statements made by an overwhelming majority of both parents/caregivers and providers. As the most frequently identified topics by all stakeholder groups, these issues are truly cross-cutting. Individuals from every community of focus, region, age group, and population spoke about the way stress, mental health and finances undermine their health and wellbeing. While these topics were all identified in the previous Title V needs assessment in 2020, their magnitude overshadows many other areas within the Title V population domains (e.g. these issues are of great concern to pregnant people, adolescents, families of children with special health needs, etc.). From an equity perspective, these issues appear to be a significant source of struggle for BIPOC, LGBTQ+ and Medicaid eligible families, as well as those with children who have special health needs. Importantly, stress, mental health, and financial stability all touch upon 'access to care' concerns driven by geography, availability of providers, health insurance status, and other factors. The challenges and frustrations households and providers shared implicate social norms, economic and educational systems, and community integrity as critical factors that shape the lives of children and families.

The Division of Family and Child Health is meaningfully working to engage communities of focus in programs, services, and feedback loops. One result of the needs assessment is a process finding: since the 2020 Title V Needs Assessment was conducted, VDH has broadly invested in strengthening its systems to engage communities, including those with greater health disparities. The addition of the Health Equity Team, and its work to build effective networks among FCH's core constituencies was supremely valuable in facilitating outreach to well-established networks, ensuring strong community engagement for the needs assessment survey and focus groups. As a result, the assessment engaged high percentages of LGBTQ+, BIPOC, and Medicaid-eligible parents and caregivers, as well as parents/caregivers of children with special health needs. FCH gives thoughtful attention to cultural and linguistic accessibility, approaches to reaching and engaging communities that minimize or remove barriers (such as enabling individuals who identified a need for assistance to complete the survey by telephone), and examining and re-examining the ways the Division can work side-by-side with, and not simply "on behalf of" Vermonters. These practices were applied consistently by the staff team that supported the Title V Needs Assessment and will contribute to effective planning and programming in the future.

Vermont needs a system of care with strong connectivity across home, school/early care, and healthcare domains.

System of care and access to care issues were frequently named as both strengths and challenges by parents/caregivers and providers. “Education” or “school” were among the most frequently identified concerns by parents, even though these settings and systems are largely outside the traditional ‘health’ arena. Current systems to support family health and well-being work well in some places and are siloed in some places. These regional differences can bolster or undermine the quality of care and access. Competing funding mandates across state agencies, state-driven payer models, and insurance obstacles were often cited as the cause of service fragmentation that impedes access to care for children and families.

Access to care is often determined by household financial circumstances.

Across geographic regions, communities of focus, and other household characteristics, assessment participants shared a compelling narrative: Those with basic financial stability and access to health insurance could get most of the care they want and need much of the time. Those with basic needs gaps (especially transportation) and those without insurance or with inadequate insurance are more likely to struggle to meet their own and their families' health needs. Rural barriers and an insufficient supply of providers and specialists compounds this problem, but families with adequate financial resources often had an easier time navigating around obstacles. This finding highlights the extent to which social determinants are a driving factor in understanding which Vermonters are and are not able to get the healthcare, mental health care, dental care, and specialty care they need.

Maintaining parent/caregiver health and wellbeing is important and challenging.

When asked what concerned them most for themselves, after “mental health” and “financial stability,” parents and caregivers most often identified physical health concerns, including managing chronic conditions, parenting with a disability, and getting their own healthcare needs met as a contributor to household stability and children’s health. Numerous providers also expressed concerns about how parents’ health affects the well-being of children in their care. The breadth of concerns facing parents suggests that whether through public health, primary care, or collaboration with other state systems such as the Department for Children and Family Services, more efforts are needed to help parents manage their own well-being while caring for families.

More support is needed for those that serve children and families.

The healthcare workforce that serves Vermont families encounters many of the same challenges that were identified throughout the assessment. Stress and mental health are significant concerns among providers for themselves, their colleagues, and their staff/employees. While access to affordable housing has long been an important topic for families, providers report that lack of affordable housing is a barrier to recruiting and retaining a skilled workforce. For those who deliver care, pressures driven by high demand for services, insufficient reimbursement rates, worker turnover, and serving high needs populations cannot remain untended. Vermont’s FCH workforce is a tremendous asset, and there is wide

recognition that providers bring important skills and a high degree of dedication to those they serve. Resourcing the workforce ultimately contributes to better health outcomes for all.

Appendix

Appendix 1. Code Summary

Code clusters and thematic groups from qualitative data analysis are summarized below. The largest code groups are denoted in **bold**. The number following each code group is the approximate number of instances in that group.

CLUSTER	PROVIDER CODES	COMMUNITY MEMBERS- FOCUS GROUP CODES	COMMUNITY MEMBERS- OPEN-ENDED SURVEY CODES
1. Title V Domains & FCH Practice Areas	Adolescent Health (25+)	Child health (~10)	Adolescent Health (25+)
	Child health (35+)	Child health- childcare, school, education (10+)	Child health (20+)
	Early childhood (20+)	CSHN (20+)	Early childhood (20+)
	Schools (50+)	CSHN- Care Coordination (10+)	Schools (100+)
	CSHN (30+)	Maternal, perinatal, infant health (~10)	CSHN (55+)
	Maternal health (20+)	Family health & Family Concerns (~10)	Maternal health (~10)
	Perinatal/infant health (<20)	Parent health, parenting (10+)	Perinatal/infant health (<10)
	Home Visiting (20+)		Parents/Parenting (15+)
	Parents (25+)		Family health (<10)
	Family health (<20)		
2. Strengths, Needs, Challenges, and Opportunities		Basic Needs (10+)	Basic Needs (40+)
		Transportation (10+)	Transportation (15+)
		Housing (10+)	Housing (50+)
	FCH strengths (75+)	Food, nutrition, food security (10+)	Food, nutrition, food security (10+)
	Systemic challenges (90+)	Social well-being, relationships, and community belonging (30+)	Social well-being, relationships, and community belonging (100+)
	Opportunities (35+)	Affordability/cost of living (20)	Affordability/cost of living (120+)
	Basic needs (35+)	Health insurance/cost of care (25+)	Health insurance/cost of care (70+)
	Transportation (<20)	Income (10+)	Income (40+)
	Housing (50+)		

3. Equity & Access	Equity & Access (65+) LGBTQ+ (including gender-affirming) (<20) Lived Experience (<20) New American/Migrant/ELL (<20) SDOH (25+)	Bias & Equity (10+)	Bias & Equity (30+)
4. Healthcare Domains	Primary care (<20) Mental health (40+) SUD (20+) Dental care (<20) Prevention (<20) Public Health (20+)	Primary care (30) Mental health and SUD (30) Dental care (15+) Telehealth (5+)	Primary care (30+) Mental health and SUD (210+) Dental care (40+) Telehealth (10)
5. System of Care	System of care (75+) Administration (<20) Capacity (20+) Integration (90+) Payment model (40+) Funding (20+) Regional differences (<20) Outreach & Community Engagement (25+) Partnerships (20+) Technology (<20) Data (25+) Telehealth (<20)	Provider communication, listening, quality and responsiveness (15) Access to care (35+) Access to care-challenges (25+) Access to care-successes (20) Effective self/parent advocacy (5)	Access care (90+) Unable to access care (90+) Insurance barriers (35+) Dismissive provider/provider did not help (35+) Responsive provider (80+)
6. FCH Workforce	Workforce (100+) Lack of Providers (20+) Training (25+) Turnover (<20)		Lack of providers/specialists (40+)
7. Emergent Issues	Emergent Issues (60+) Nutrition (<20)	Safety (4) Exercise (5)	Social media/screens/technology (110)

	Safety & Violence (<20) Social media (<20) Autism (20+)		Safety and violence (80) Schools/education (100) Stress (45+)
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Appendix 2. Community Health Survey Rankings

Table A.1. Survey responses by Communities of Focus—Respondents’ ranking “For Myself”

<i>Minimum = 1.0 (“This is a struggle”), Maximum = 6.0 (“This is easy”)</i>	All Respondents	BIPOC	Medicaid Eligible	LGBTQ+	CSHN	Median
Staying safe from violence (at school, at home, in the community)	5.10	4.74	5.10	4.96	4.91	4.96
Finding health care that is safe and accessible for my culture, language, and/or identity	4.96	4.40	4.86	4.62	4.77	4.77
Getting good information and/or finding resources to understand how to stay healthy or become healthier	4.79	4.42	4.65	4.83	4.48	4.65
Building and keeping positive relationships with family and/or friends	4.45	3.77	4.23	4.29	4.09	4.23
Meeting basic needs (housing, food, transportation)	4.31	3.57	3.75	3.81	4.13	3.81
Starting difficult conversations about health and wellness	4.29	4.31	4.21	3.73	4.23	4.23
Hope about a bright future	4.04	4.00	3.85	3.66	3.59	3.85
Getting care from all kinds of medical and health providers	3.98	3.77	3.88	3.93	3.63	3.88
Finding connections in the community where I/they feel a sense of belonging	3.77	3.22	3.52	3.68	3.34	3.52
Maintaining mental health (freedom from anxiety, depression, etc.)	3.46	3.46	3.18	3.03	2.95	3.18
Keeping stress low	2.78	2.74	2.50	2.67	2.54	2.67
Aggregate Average	4.18	3.85	3.98	3.93	3.88	3.93

Table A.2. Survey responses by Communities of Focus—Respondents’ ranking “For My Child/Children”

<i>Minimum = 1.0 (“This is a struggle”), Maximum= 6.0 (“This is easy”)</i>	All Respondents	BIPOC	Medicaid Eligible	LGBTQ+	CSHN	Median
Keeping stress low	4.13	4.06	4.06	4.26	3.39	4.06
Maintaining mental health (freedom from anxiety, depression, etc.)	4.26	4.34	4.14	4.39	3.49	4.26
Starting difficult conversations about health and wellness	4.33	4.53	4.21	3.49	3.06	4.21
Finding connections in the community where I/they feel a sense of belonging	4.35	4.26	4.11	4.55	3.96	4.26
Hope about a bright future	4.45	4.69	4.77	4.9	4.02	4.69
Building and keeping positive relationships with family and/or friends	4.45	4.21	4.32	4.66	3.58	4.32
Getting care from all kinds of medical and health providers	4.62	4.46	4.64	5.14	3.96	4.62
Getting good information and/or finding resources to understand how to stay healthy or become healthier	5.07	4.77	4.93	5.34	4.68	4.93
Meeting basic needs (housing, food, transportation)	5.12	4.43	4.83	4.95	4.80	4.83
Staying safe from violence (at school, at home, in the community)	5.24	5.06	5.26	5.49	5.00	5.24
Finding health care that is safe and accessible for my culture, language, and/or identity	5.29	4.97	5.31	5.44	5.03	5.29
Aggregate Average	4.66	4.53	4.60	4.78	4.09	4.60

Table A.3. Community Survey Index by Child Age Group

Minimum = 1.0 (“This is a struggle”), Maximum = 6.0 (“This is easy”)	All Respondents		Infants/Children up to age 3		Preschool Children (age 3-5)		School-age Children (age 6-12)	
	<i>Self</i>	<i>Child</i>	<i>Self</i>	<i>Child</i>	<i>Self</i>	<i>Child</i>	<i>Self</i>	<i>Child</i>
Keeping stress low	2.78	4.13	2.79	4.72	2.92	4.38	2.85	4.16
Maintaining mental health (freedom from anxiety, depression)	3.46	4.26	3.47	5.09	3.24	4.88	3.51	4.39
Finding connections in the community where I/they feel a sense of belonging	3.77	4.35	3.67	4.77	3.75	4.57	3.86	4.62
Getting care from all kinds of medical and health providers	3.98	4.62	4.08	4.87	4.02	4.68	4.08	4.77
Hope about a bright future	4.04	4.45	4.23	5.13	4.17	5.10	4.07	4.96
Starting difficult conversations about health and wellness	4.29	4.33	4.48	4.97	4.35	4.70	4.12	4.07
Meeting basic needs (housing, food, transportation)	4.31	5.12	4.24	5.20	4.34	5.00	4.37	5.22
Building and keeping positive relationships with family and/or friends	4.45	4.45	4.61	5.05	4.39	4.89	4.51	4.75
Getting good information and/or finding resources to understand how to stay healthy or become healthier	4.79	5.07	4.86	5.25	4.83	5.26	4.80	5.27
Finding health care that is safe and accessible for my culture, language, and/or identity	4.96	5.29	5.00	5.59	5.03	5.42	5.11	5.46

Staying safe from violence (at school, at home, in the community)	5.10	5.24	5.26	5.39	5.13	5.26	5.18	5.29
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Table A.4. Survey items compared by household economic circumstances, “for myself”

For Myself	Medicaid Eligible, Not able to meet monthly expenses	Able to Meet Monthly expenses, Not Medicaid eligible	Difference
Meeting basic needs (housing, food, transportation)	3.23	5.26	2.02
Finding connections in the community where I/they feel a sense of belonging	3.22	4.15	0.94
Keeping stress low	2.30	3.20	0.90
Maintaining mental health (freedom from anxiety, depression, etc)	3.00	3.86	0.86
Building and keeping positive relationships with family and/or friends	4.00	4.79	0.79
Getting good information and/or finding resources to understand how to stay healthy or become healthier	4.45	5.12	0.67
Hope about a bright future	3.71	4.37	0.66
Getting care from all kinds of medical and health providers	3.67	4.20	0.53
Finding health care that is safe and accessible for my culture, language, and/or identity	4.72	5.18	0.45
Starting difficult conversations about health and wellness	4.12	4.51	0.39
Staying safe from violence (at school, at home, in the community)	5.10	5.19	0.09

Table A.5. Survey items compared by household economic circumstances, “for my child/children”

For my child/children	Medicaid Eligible, Not able to meet monthly expenses	Able to Meet Monthly expenses, Not Medicaid eligible	Difference
Meeting basic needs (housing, food, transportation)	4.53	5.46	0.93
Finding connections in the community where I/they feel a sense of belonging	4.17	4.57	0.40
Building and keeping positive relationships with family and/or friends	4.51	4.71	0.20
Getting good information and/or finding resources to understand how to stay healthy or become healthier	5.07	5.24	0.17
Starting difficult conversations about health and wellness	4.38	4.51	0.13
Maintaining mental health (freedom from anxiety, depression, etc.)	4.25	4.34	0.10
Keeping stress low	4.14	4.19	0.05
Hope about a bright future	4.85	4.83	-0.02
Getting care from all kinds of medical and health providers	4.72	4.64	-0.08
Staying safe from violence (at school, at home, in the community)	5.31	5.20	-0.11
Finding health care that is safe and accessible for my culture, language, and/or identity	5.44	5.32	-0.13

Table A.6. Survey Responses from Parents/Caregivers of CSHN

Minimum = 1.0 (“This is a struggle”), Maximum= 6.0 (“This is easy”)	All Respondents		Households with CSHN	
	<i>Self</i>	<i>Child</i>	<i>Self</i>	<i>Child</i>
Keeping stress low	2.78	4.13	2.54	3.39
Maintaining mental health (freedom from anxiety, depression, etc.)	3.46	4.26	2.95	3.49
Finding connections in the community where I/they feel a sense of belonging	3.77	4.35	3.34	3.06
Getting care from all kinds of medical and health providers	3.98	4.62	3.63	3.96
Hope about a bright future	4.04	4.45	3.59	4.02
Starting difficult conversations about health and wellness	4.29	4.33	4.23	3.82
Meeting basic needs (housing, food, transportation)	4.31	5.12	4.13	4.80
Building and keeping positive relationships with family and/or friends	4.45	4.45	4.09	3.58
Getting good information and/or finding resources to understand how to stay healthy or become healthier	4.79	5.07	4.48	4.68
Finding health care that is safe and accessible for my culture, language, and/or identity	4.96	5.29	4.77	5.03
Staying safe from violence (at school, at home, in the community)	5.10	5.24	4.91	5.00

Appendix 3. Selected National Performance Measures, State Performance Measures and Evidence-based/Evidence-informed Strategy Measures

Vermont's selected National Performance Measures (NPMs)

- ✓ NPM 4A - Percent of infants who are ever breastfed
- ✓ NPM 4B - Percent of infants breastfed exclusively through 6 months
- ✓ NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
- ✓ NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
- ✓ NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- ✓ NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs
- ✓ NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health
- ✓ NPM 14.1 - Percent of women who smoke during pregnancy

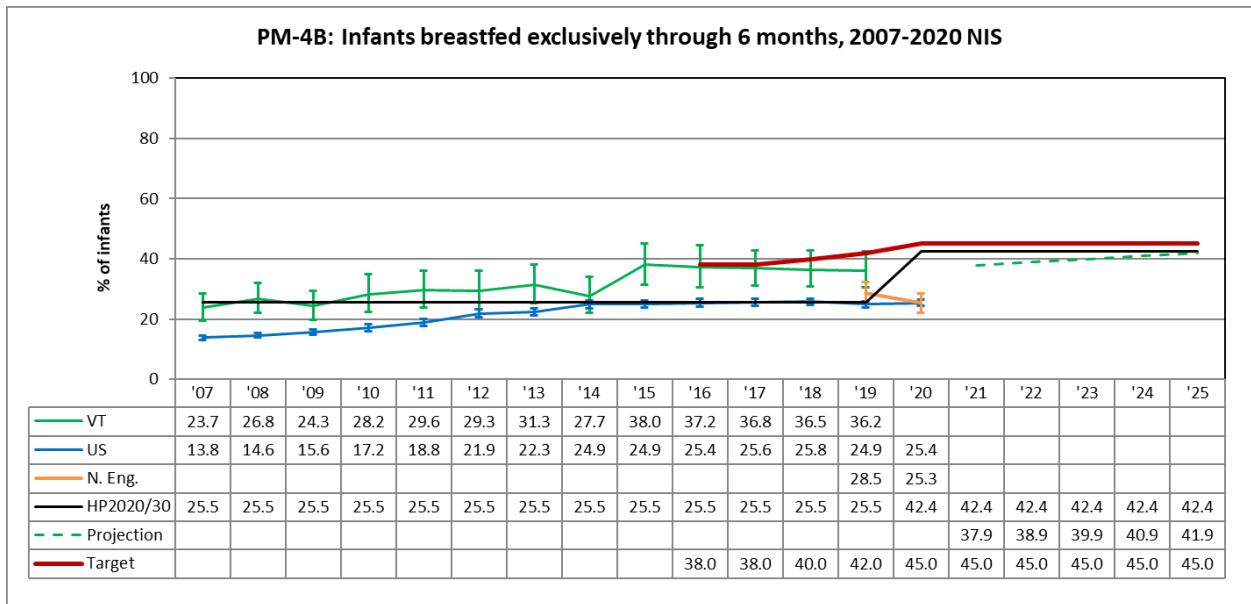
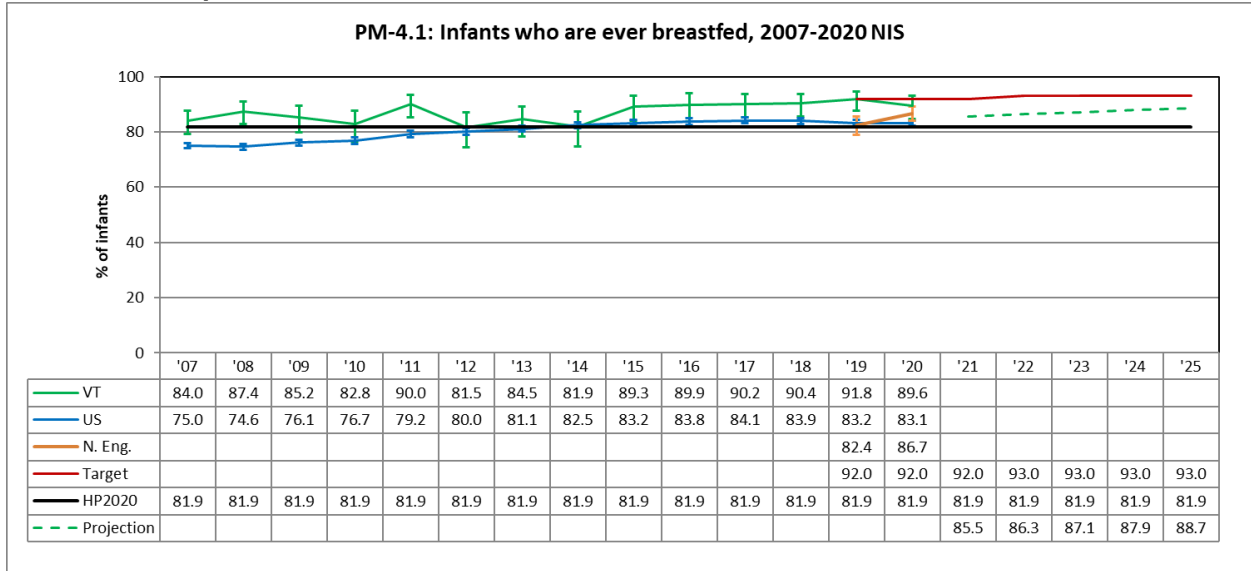
Vermont's selected State Performance Measures (SPMs)

- ✓ SPM 1 - % of children 6 months to 5 years who meet all 4 flourishing items
- ✓ SPM 2 - % of adolescents that feel they matter to people in their community
- ✓ SPM 3 - Percent of Women advised by a healthcare worker to abstain from alcohol during pregnancy
- ✓ SPM 4 - Percent of high school students who made a plan to attempt suicide in the past 12 months
- ✓ SPM 5 - Percent of MCH programs that partner with family members, youth, and/or community members

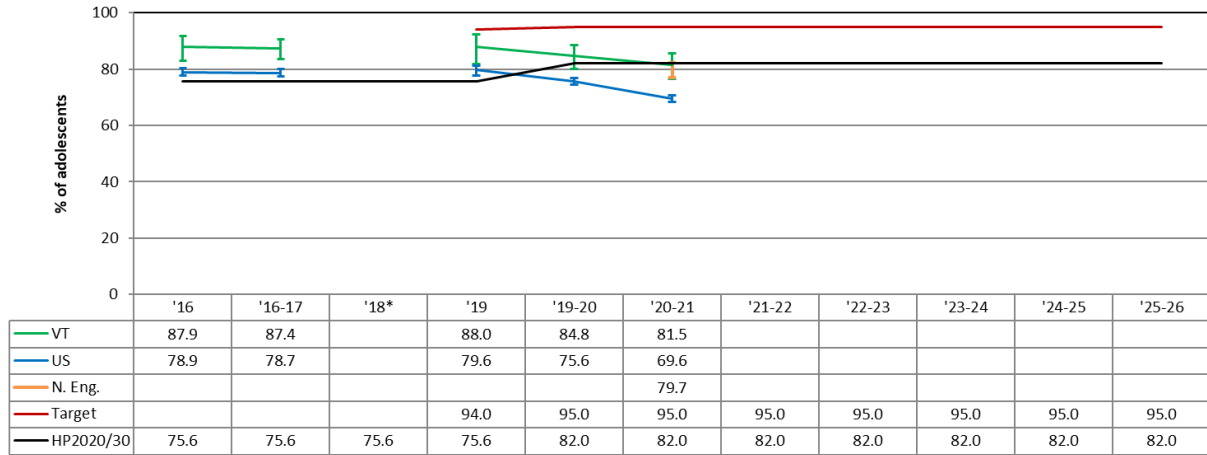
Vermont's selected Evidence-Based/Evidence-Informed Strategy Measures (ESMs)

- ✓ ESM 4.1 - % of 10 Step compliant or designated Baby-friendly hospitals
- ✓ ESM 6.1 - Number of providers trained in developmental surveillance and screening
- ✓ ESM 8.1.1 - Number of classrooms or schools that sign on to 3-4-50, including a commitment to daily recess
- ✓ ESM 10.1 - Number of public schools implementing the PATCH [Providers and Teens Communicating for Health] for Teens curriculum as part of their Health Education Curriculum
- ✓ ESM 12.2 - # of families, transition-aged youth, and providers who participated in transition-focused trainings using established/high-quality/best- practice transition resources
- ✓ ESM 13.2.1 - # of students participating in Vermont's 802Smiles Network of School Dental Health Programs receiving oral health services
- ✓ ESM 14.1.1 - % of pregnant smokers who register with the QuitLine or QuitOnline

Select NPM/SPM Data

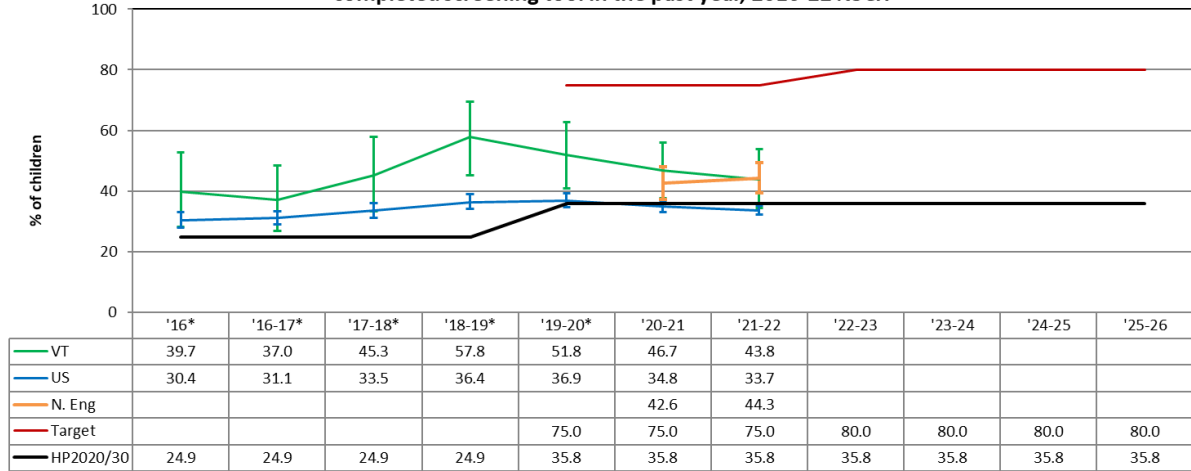


PM-10: Adolescents ages 12-17 with a preventive medical visit in the past year, 2016-21 NSCH

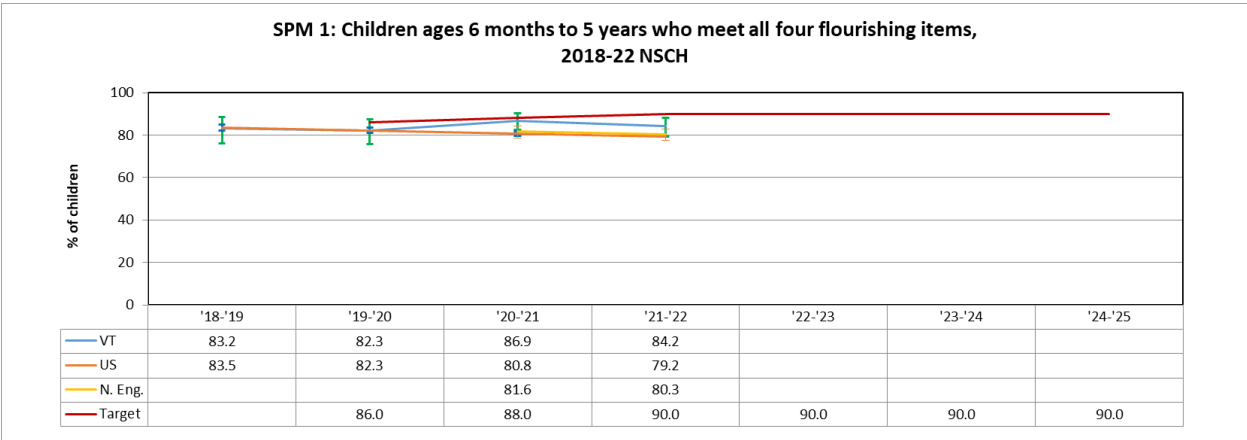
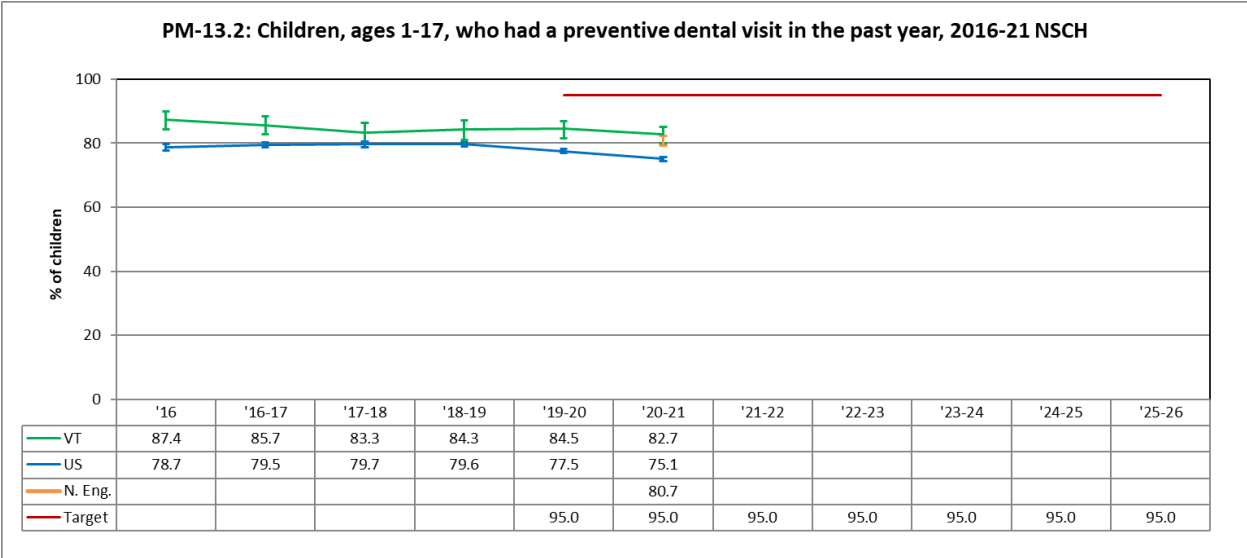
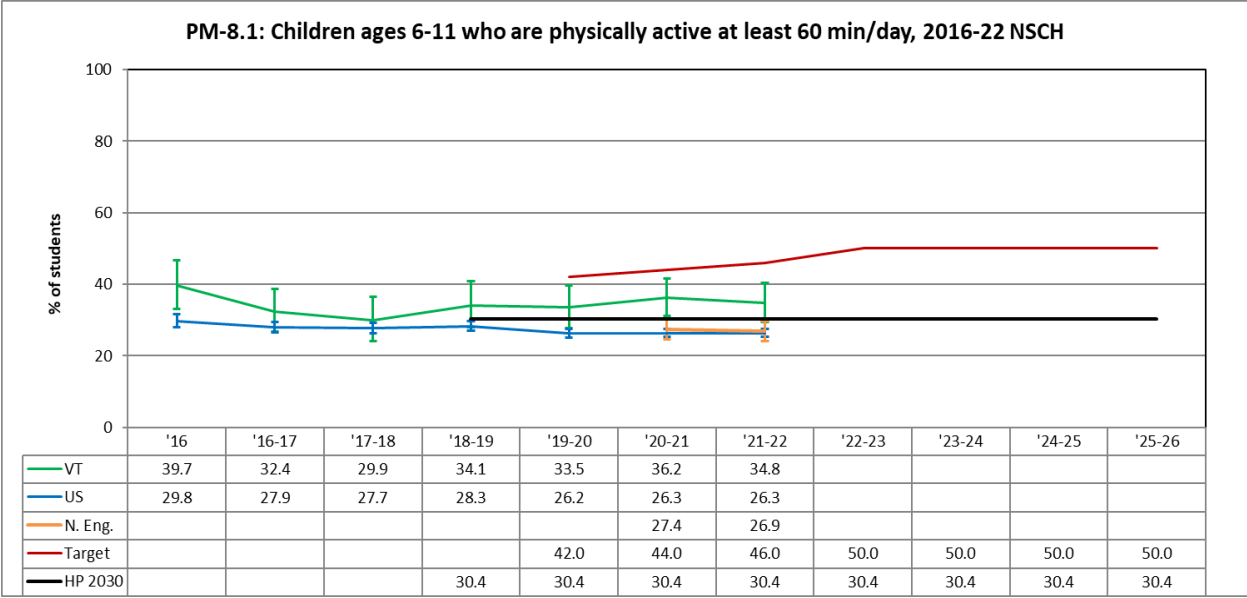


* The question asked in 2018 was incompatible with other years and is not reported.

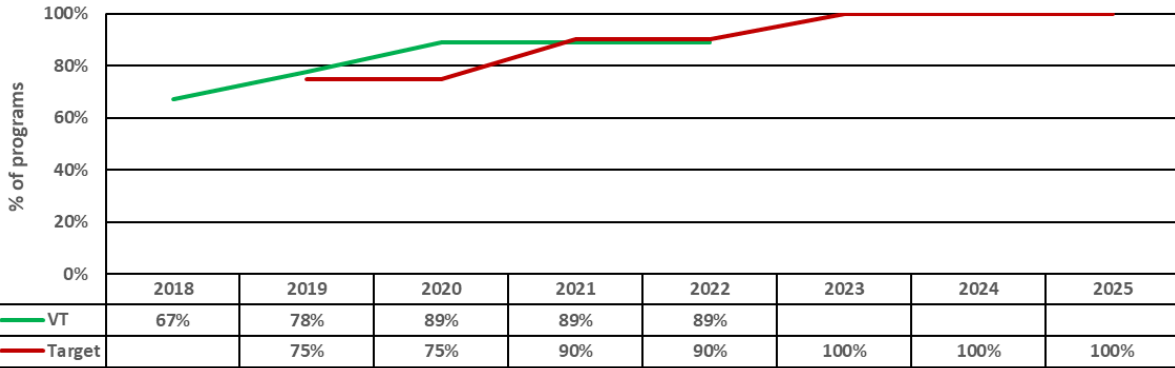
PM-6: Children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year, 2016-22 NSCH



* Due to small VT sample size, interpret with caution.



**SPM 5: MCH Programs with Family/Youth/Community Partnerships,
2018-22 Program Data**



Appendix 3 Interview and Focus Group Questions

Interview and Focus Group Questions for Providers/Professionals

1. FCH works on a wide range of issues related to health for families, including for infants, children, and teens. What in your work or lived experience connects you to this work?
2. When you think about Vermont's ability to meet the needs of [children/families/parents/adolescents/infants], what are some things that are working very well? What work are you doing that you are the proudest of?
3. What are the top 3 things you need to provide effective care for the population/s you serve? What would enable you to be more successful in meeting your clients/patients' needs?
4. What is the most urgent unmet need that your patients/clients bring to you? What topics or issues arise for people you serve that are the most under-resourced?
5. What are the ways that the care you provide is integrated with other services and providers? How well is it working?
6. How well equipped is the workforce that deals with family/ maternal/ infant/ children's health issues? What are the resources that help you do your job? What gets in the way of your ability to be an effective provider?
7. What are you doing within your practice that meets the needs of priority populations (e.g., people of color, the LGBTQ+ community, people with disabilities, and people with low socio-economic status)? What culturally responsive actions have you taken?
8. What new or emerging health issues come up for people you serve?
9. What questions do clients/patients ask that you don't know how to answer?
10. What gaps do you see in the resources that are available for the populations you serve?
11. What priority populations do you interact with most in your role? What obstacles do underserved Vermonters encounter in accessing care or being healthy?
12. What haven't I asked that is important to these topics?

Interview and Focus Group Questions for Community Members, Service Users, Parents

1. Where do you go when you need healthcare? How well has it met your needs?
2. Basic needs include things like housing, heat, food, and income. Which basic needs areas could be improved to help your family be healthier? How? (Or alternate question: What is your most urgent unmet need today that contributes to your health?)
3. Describe your best experience dealing with a health issue.
4. Describe a time when it was difficult to address a health issue. If you had a concern about mental health for yourself or a family member, what would you do to get help?
5. Who do you talk to about your health or the health of someone in your family?
6. What are your top 3 most pressing health and wellness concerns?
7. What gets in the way of your ability to meet your/your family's health needs?
8. Community means different things to different people and can include your neighborhood, your child's school, a faith group, or organizations you visit. What are the ways you tap into your community to be healthy?
9. What contributes most (positively?) to your or your family's health and well-being?

If you have ever been pregnant:

1. What care did you receive and how did it go? Describe your experience.
2. As a new parent, did you receive any care? How did it go? Describe your experience.

If you have a child with special health needs:

1. What care did/do you/they receive and how is it going?
2. Describe your experience.
3. Are there ways health care systems, providers, or community supports could work better for you or your child/family? How so?

Specifically for parents of teens/adolescents:

1. What conversations do you have with your teens about sex and sexual health?
 - a. Probe: When you talk to your son/daughter/teen what do you say to them about sex?
2. What barriers do you face to talking to your teen about sex/sexual health?
 - a. Probe: What makes it hard to have conversations with your teen?
3. What resources would help you talk to your teen about sex/sexual health?
 - a. Probe: What would make it easier to have conversations about sex and sexual health? (e.g., scripts on what to say, practice having the conversation, more accurate information about risks, etc.)