DECEMBER 2016

# How Are Vermont's Young Children and Families?

HARNESSING THE POWER
OF VERMONT COMMUNITIES
TO IMPROVE CHILD
AND FAMILY WELL-BEING

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# PURPOSE STATEMENT

The purpose of the fouth edition of *How Are Vermont's Young Children and Families?* is to provide a factual depiction of the state of young child and family well-being in Vermont, 2016. We hope this report will be a useful tool for government leaders, service providers, parents and caregivers, educators, and other community members interested in improving neighborhoods and communities to better support a safe, healthy, and prosperous future for Vermont. The report is not meant to repeat data found in other places, rather it is meant to bring these sources together to be analyzed in a way that creates a more nuanced view of the state of young child and family well-being.

## FROM THE GOVERNOR

Welcome to the fourth edition of *How Are Vermont's Young Children and Families?* Produced annually by Vermont's early childhood advisory council, Building Bright Futures (BBF), the report serves as an important resource for Vermonters – focusing attention on the well-being of young children and families in our state. My hope is that this report will help to improve our shared understanding of how young Vermonters and their families are faring.

This year's report documents successes and challenges facing young children and their families in five different topic areas. There is also a chapter dedicated to BBF regional profiles.

As you will see, we have much to celebrate – from the initial implementation of universal pre-K, to increased early childhood immunization rates, to a steady decrease in the percent of Vermont families living in poverty. The report also highlights opportunities for improvement, including supporting families in crisis, increasing access to quality child care, and ensuring that Vermont's youngest children receive the recommended early childhood development screenings.

I hope that after reviewing the 2016 edition of this report that you will join with others in Vermont in prioritizing the needs of our youngest generation and ensuring that all of our children have a strong start in life and a chance to succeed.

Sincerely,

Peter Shumlin
Governor

## FROM THE EXECUTIVE DIRECTOR

It is an honor and a privilege to serve as executive director of Building Bright Futures. Building Bright Futures' vision is noble and, under Act 104 (33 V.S.A. § 4602), our charge is great.

Building Bright Futures is a 501(c)(3) non-profit charitable organization with a statewide network of 12 regional councils charged with improving the well-being of young children and families by improving the system that serves them. As the designated Vermont early childhood advisory council to the Governor, Administration, and Legislature, Building Bright Futures has the authority and duty to convene members of the child care community, medical community, education community, and other organizations, as well as state agencies serving young children, to ensure that families receive quality services in the most efficient and cost-effective manner.

Our charge includes monitoring the status of young children in Vermont and advising on the needs of the early care, health, and education system. The *How Are Vermont's Young Children and Families?* report provides a factual depiction of the state of young child and family well-being at a point in time, as well as progress on selected indicators and outcomes for the early care, health, and education system. This report is designed to be a useful tool for state and local government leaders, service providers, parents and caregivers, educators, and other community members interested in supporting a safe, healthy, and prosperous future for Vermont.

We look forward to continuing to build bright futures for all Vermont's young children together, based on the collective impact of a shared vision, shared data, and shared action.

Sincerely,

Sarah Squirrell

Sarah Squirrell
Executive Director

# Executive Summary

## How Are Vermont's Young Children & Families?

Welcome to the fourth edition of *How Are Vermont's Young Children and Families?*, prepared by Building Bright Futures. The December 2016 report brings together data and analysis from multiple sources to provide an overview of successes and challenges impacting Vermont's young children, their families, and their communities.

Additionally, this year's report features a new section on recommendations from Vermont's Blue Ribbon Commission on Financing High Quality, Affordable Child Care. Building Bright Futures was a member of the Commission and the last section of this year's edition provides an overview of the Commission's recommendations related to Vermont's early care and learning system.

## Chapter highlights

### Family and Social Relationships

This chapter discusses the importance of positive, nurturing interactions and relationships for young children's development.

**Key highlights include:**

- Information on how adverse experiences in early childhood can impact development. This information continues to be discussed in the following chapters.
- The importance of whole family support programs that address the needs of parents and children.

### Health & Development

This chapter focuses on successes Vermont has achieved in child and family health and current challenges facing young children and families.

**Key highlights include:**

- Vermont tied Massachusetts in having the lowest percent of uninsured children in the country.
- The percent of children under age 3 receiving full series of vaccines recommended by the Centers for Disease Control reached a record high of 76% in 2015.
- Vermont children and families continue to be impacted by substance use disorders, particularly opiate use.
- In 2014, only 25% of Vermont children in the CHAMP (Children's Health Advances Measured in Practice) network received all three recommended developmental screenings by age 3.

### Safety

This chapter focuses on issues related to child abuse and neglect and ways to build and support safe communities for children.

**Key highlights include:**

- Information on increases in the rate of children under age 9, and particularly under age 3, who are in the protective custody of the Vermont Department for Children and Families.
- Programs that serve families are important in reducing child abuse and neglect, including evidence-based home-visiting programs.

### Early Care and Learning

This chapter reviews issues impacting Vermont's early care and learning system.

**Key highlights include:**

- Vermont faces a child care challenge. Only 47% of infants and toddlers likely to need child care have access to regulated programs.

- About 7,300 age-eligible children attended publicly-funded pre-K programs during the 2015–2016 school year. This number is expected to increase in 2016–2017 with the full implementation of Act 166.
- Vermont adopted the new Ready for Kindergarten! Survey (R4K!S) for the 2015–2016 school year, consisting of 34 new and revised questions across five domains.

## Family Economic Well-being

This chapter shares information on whether families have adequate, sustainable financial resources to meet their basic needs.

**Key highlights include:**

- The percent of families living in poverty in the US and in Vermont has decreased since 2013.
- The average time that children under age 18 stay in publicly-funded homeless shelters in Vermont has increased to a record high of 39 days.
- This coincides with the cost of housing, as a share of family income, representing more than 30% of household income for 34.7% of families who own their own home and 50.5% of families who rent.
- Even with financial assistance, families in Vermont spend up to 37.8% of their income on child care.

## Regional Council Profiles

This report provides information on a dashboard comprised of five indicators for each of the 12 Building Bright Futures Regional Councils, building from datasets discussed earlier in the report.

**The five regional indicators evaluated include:**

- Population of children under age 9.
- The percent of regulated child care and early learning programs participating in the state's voluntary quality recognition and improvement system, known as STARS.
- Immunization rates for Vermont children between the ages of 19 months and 35 months
- The rate of children under age 9 in protective custody.
- The percent of children ready for kindergarten according to the new 2015–2016 Ready for kindergarten! Survey (R4K!S) in the primary supervisory unions or school districts in each region.

Regional profiles also feature an overview of the region and the current priorities of the region's Building Bright Futures Council.

## Additional Resources

Much of the information highlighted in this year's report is also available through Vermont Insights, a program of Building Bright Futures, at www.vermontinsights.org. Through Vermont Insights, users can continue to explore the evolving data behind these issues and learn about other topics related to young children, families, and communities in our state.

# Family & Social Relationships

## Young children learn about the world through their relationships

Young children learn about the world through their social interactions and relationships, primarily with their families and other caregivers.[1] Children's sense of, "who they are, what they can become, and how and why they are important to other people," depend upon the quality and stability of their relationships with others.[2] Babies whose needs are met through positive, nurturing interactions develop a bond of attachment with their families and caregivers in which they learn that the outside world is a welcoming place.[3] With this security, infants are more likely to explore and interact with their environment. This social learning sets the stage for children's development in other areas, including their cognitive development. How well Vermont children engage with their environment, and the quality of their experiences, depends largely on their social and family relationships.

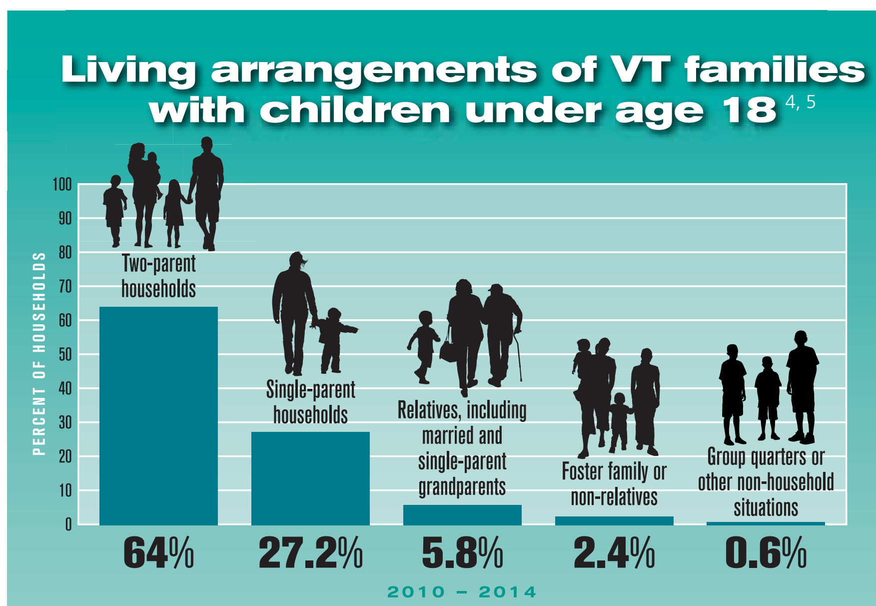



**Figure 1**

## Adverse Childhood Experiences (ACEs)

Unfortunately, some children experience adverse experiences during early childhood. Adverse experiences fall into three categories: family/household challenges (e.g., substance abuse, mental illness, separation), neglect, and abuse.[6]

The more adverse experiences in childhood, the greater the likelihood of health and development problems including developmental delays, heart disease, diabetes, substance abuse, and depression. Fortunately, research also indicates that nurturing relationships "with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response."[7] This is why strong, nurturing family and social relationships, particularly with parents and guardians, are critical for young children.

**Children with two or more Adverse Childhood Experiences** (ACEs) in Vermont and the US, 2011-2012 [8]

| Age group | Vermont | US |
|---|---|---|
| Birth to 5 years old | 13.8% | 12.5% |
| 6 to 11 years old | 26.3% | 24.4% |

**Figure 2**

# Comprehensive services received by Vermont children and families served by Head Start and Early Head Start, 2015[9,10]

| Type of comprehensive service | Number | Percent |
|---|---|---|
| **Children** | | |
| Continuous, accessible health care in a medical home | 1,719 | 99% |
| Up-to-date on a schedule of age-appropriate preventive and primary health care, according to the relevant state's Early and Periodic Screening, Diagnostic and Treatment schedule for well child care | 1,557 | 91% |
| Continuous, accessible health care in a dental home | 1,442 | 84% |
| Up-to-date on all age-appropriate immunizations | 1,134 | 66% |
| **Families** | | |
| Received at least one family service[11] | 1,160 | 73% |
| Parenting education | 914 | 57% |
| Health education | 853 | 53% |
| Emergency/crisis intervention such as meeting immediate needs for food, clothing, or shelter | 315 | 20% |
| Mental health services | 247 | 15% |
| Housing assistance such as subsidies, utilities, repairs, etc. | 223 | 14% |

**Figure 3**

## The context for social and family relationships

Raising children is one of the most rewarding and challenging jobs the world has to offer. The parents and guardians who care for Vermont's children, like parents and guardians around the world, rely upon a wide variety of supports. When those supports are strong, parents are most effective in promoting their children's healthy development. When life is particularly demanding or social supports are weak, parents are more prone to stress and depression, which can interfere with nurturing interactions with their children. For these reasons, two-generation strategies, those that address the well-being of both parents and children, are particularly important.[12]

## Two-generation programs

Vermont implements several programs that support young children and their families.

### Head Start and Early Head Start

Head Start and Early Head Start promote the school readiness of children from low-income families by providing them with comprehensive services. Head Start serves three- and four-year-olds and five-year-olds not age-eligible for kindergarten, and Early Head Start serves children under the age of three and pregnant women.[13] During federal fiscal year (FFY) 2016, the total federal Office of Head Start-funded enrollment in Vermont was 1,447 slots (Head Start: 1,014; Early Head Start: 365; Early Head Start-Child Care Partnership: 68) at seven Head Start programs, of which, four offer Early Head Start programs, and two offer Early Head Start-Child Care Partnerships.[14] This represents approximately 20% of all Vermont Head Start and Early Head Start age-eligible children below 100% of federal poverty level (FPL).[15,16]

### Children's Integrated Services (CIS)

Vermont's Department for Children and Families' Child Development Division (CDD), Children's Integrated Services (CIS) provides a range of services to pregnant and postpartum women, infants, and children 0-6, their families and specialized child care providers. In state fiscal year (SFY) 2015, CIS had contact with almost 5,000 individuals. Additionally, more than 80% of those who received services from CIS in SFY15 and the first half of SFY16 achieved one or more goals established through their coordinated services plan called OnePlan.[17,18]

### Strengthening Families™

Strengthening Families is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. CDD supports implementation of Strengthening Families with grants to high-quality early care and learning programs. In 2014, 43 programs were awarded grant funding.[19] Also, the Strengthening Families Demonstration Project provides intensive family services to families who have open family support cases with Vermont's Family Services Division who were assessed as being at "high or very high risk" of maltreating their children in the future. In the first 1½ years of this program, 7% of children with open cases entered state custody. Historically, this rate has been close to 30%.[20]

# Health & Development

The Vermont Early Childhood Action Plan's first goal is to give all children a healthy start through preventive and supportive services that ensure proper health and education for children and families.

## Areas where Vermont's young children are sustaining and thriving

**Access to Health Insurance**

The Annie E. Casey Foundation's "Kids Count Databook 2016" shows Vermont tied with Massachusetts with the lowest percent of uninsured children in the country.[21] The Foundation cites the US Census Bureau's 2014 American Community Survey data, which shows 97.8% of Vermont children under the age of 18 covered by some form of health insurance in 2014.[22]

**Low birthweight births**
in Vermont and the US, 2009-2013[23]

| Location | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Vermont | 6.75% | 6.16% | 6.67% | 6.18% | 6.72% |
| US | 8.16%[24] | 8.15%[25] | 8.10%[26] | 7.99%[27] | 8.02%[28] |

**Figure 4**

**Prenatal Care**

Women accessing prenatal care during their first 13 weeks of pregnancy have a lower risk of complications and their babies are less likely to be born underweight.

Reducing the risk of low birthweight is important: "low birth weight babies (weighing less than 2,500 grams/5.5 pounds) are more likely than babies with normal weight to have health problems as a newborn … [and] have a higher risk of chronic health conditions later in life."[29]

**Childhood Vaccinations**

Vermont has seen a steady increase in the number of children under age 3 completing vaccinations recommended by the Centers for Disease Control. In 2015, 76% of Vermont children 19–35 months old received the full series—the highest rate reported in Vermont.[30] The Healthy Vermonters 2020 goal is to have at least 80% of 19–35-month-old children receive all recommended vaccines.[31]

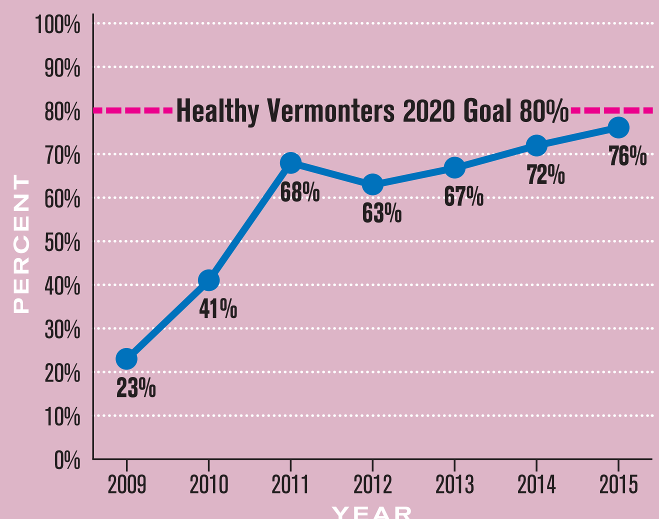



**Figure 5**

## Health and development challenges

### Opiates

The rate of Vermont newborns with opioid exposure increased significantly since 2008 with a diagnosis rate in 2012 five times higher than the national average. However, it is possible these numbers reflect a transparent, comprehensive, and nurturing system of care in Vermont. Vermont has one of the most comprehensive systems of care for adults seeking treatment for opioid dependence in the country. The University of Vermont found that among women delivering infants exposed to opioids in utero, 60% began treatment before conception and 95% began treatment by the time of delivery. In addition, 90% of the women kept custody of their children. Infants born to women in treatment do not have worse outcomes and there are no known negative long-term outcomes of in-utero opioid exposure. Also, most Vermont hospitals use the diagnosis code of **Neonatal Abstinence Syndrome (NAS)** when the infant has opioid exposure, while many US hospitals code only those infants who need treatment. In fact, at the University of Vermont, only 25% of infants with an opioid exposure diagnosis needed treatment.[35]

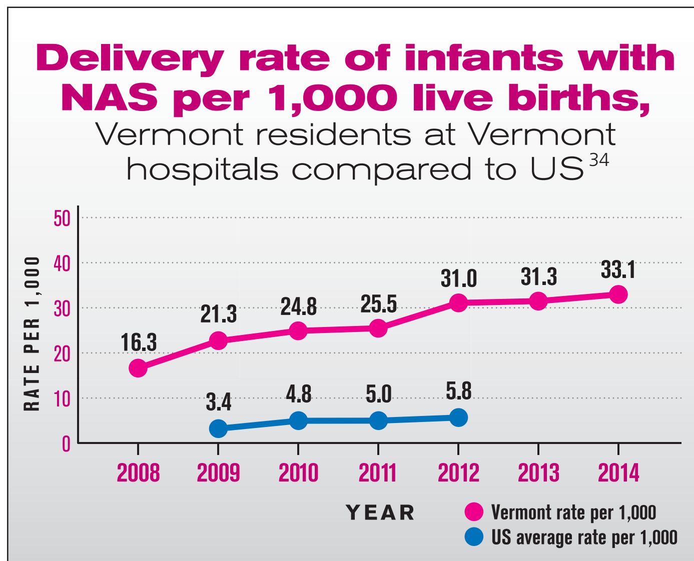
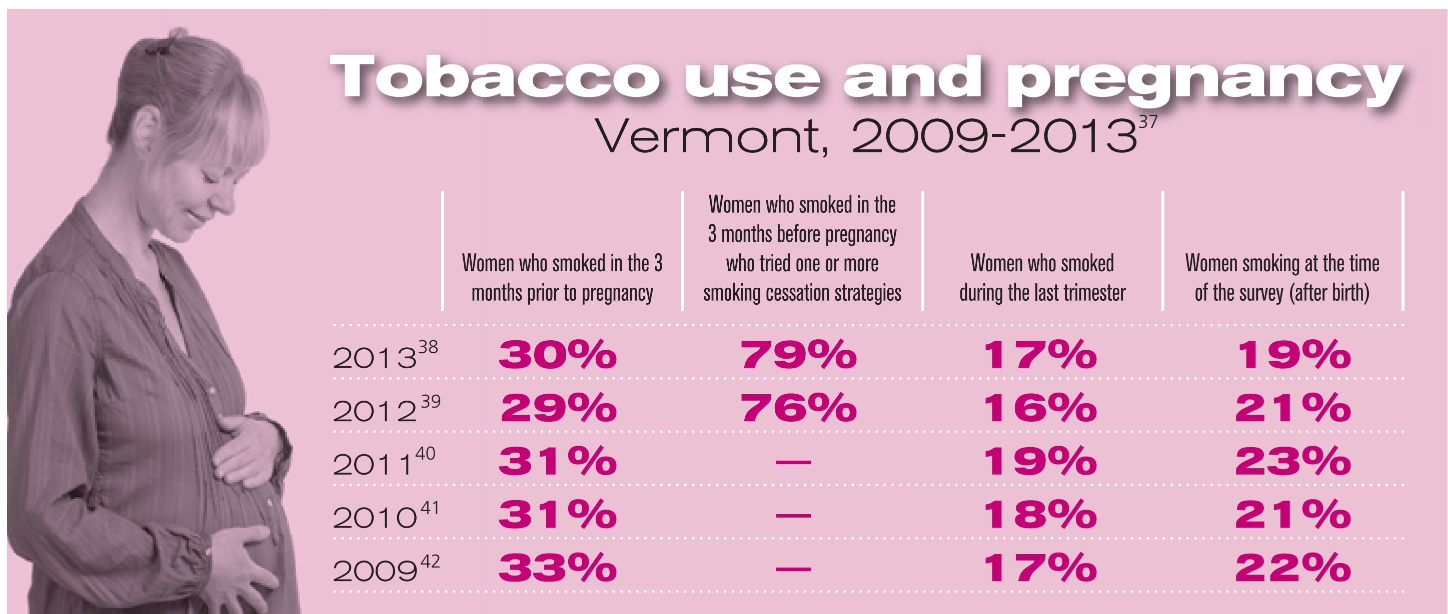



**Figure 6**

### Tobacco

Overall, the number of pregnant women smoking before and during pregnancy has decreased. This is good news for Vermont's young children and their families. According to the Vermont Department of Health, "smoking during pregnancy can have a negative impact on the health of women and children by increasing the risk of fertility problems and pregnancy complications … [and can] increase the risk of preterm birth, low birth weight, and sudden infant death syndrome—some of the leading causes of infant mortality."[36]



Tobacco use and pregnancy
Vermont, 2009-2013[37]

| | Women who smoked in the 3 months prior to pregnancy | Women who smoked in the 3 months before pregnancy who tried one or more smoking cessation strategies | Women who smoked during the last trimester | Women smoking at the time of the survey (after birth) |
|---|---|---|---|---|
| 2013[38] | 30% | 79% | 17% | 19% |
| 2012[39] | 29% | 76% | 16% | 21% |
| 2011[40] | 31% | — | 19% | 23% |
| 2010[41] | 31% | — | 18% | 21% |
| 2009[42] | 33% | — | 17% | 22% |

**Figure 7**

## Alcohol use and pregnancy
Vermont, 2009-2013[43]

| | Drank at least some alcohol in the 3 months prior to pregnancy | Of those who drank at least some alcohol in the 3 months prior to pregnancy, percent who had at least one binge (4 or more drinks in one sitting) | Drank during the last 3 months of pregnancy |
|---|---|---|---|
| 2013[44] | 68% | 18% | 13% |
| 2012[45] | 70% | 24% | 14% |
| 2011[46] | 67% | 30% | 13% |
| 2010[47] | 72% | 32% | 13% |
| 2009[48] | 71% | 30% | 13% |

**Figure 8**

**Alcohol**

Prenatal alcohol exposure is one of the leading preventable causes of birth defects. Reducing the percentage of pregnant women who drink alcohol is a goal of Healthy Vermonters 2020, the state's set of public health goals for the decade.[49] Overall, the number of women who used alcohol in the 3 months prior to pregnancy has been decreasing.

## Strengthening health and development supports

**Developmental Screening**

Development screenings help assess developmental progress of young children, improve early identification of risks and/or delays, and ensure that children and families are linked to appropriate resources and services. The American Academy of Pediatrics Bright Futures Guidelines set the schedule for these screenings for children under age three at 9, 18, and 24 or 30 months and as needed to address concerns.[50] A 2015 report found that 25% of Vermont children who received health services through a CHAMP (Children's Health Advances Measured in Practice) network practice in 2014 received all three recommended developmental screens by age 3.[51] To increase the number of children receiving screenings, Vermont Child Health Improvement Program (VCHIP) has several initiatives to engage families, health care providers, and early care and learning providers.

- The launch of HelpMeGrow, a statewide system helping identify at-risk children, linking those children and their families to services and supports. Through Vermont 2-1-1, HelpMeGrow received approximately 400 calls from its September 2015 launch through June 2016.[52]
- The training of 430+ early care and learning providers in developmental screening.[53]
- Staff engagement from over 44 pediatric and family health practices in efforts to increase Vermont developmental screening rates.[54]

**Nutrition**

More students today receive free and reduced-price school meals than during the Great Recession. This increase could also indicate the effectiveness of Vermont public initiatives to eliminate child hunger.

Children have been a priority in Vermont's effort to eliminate hunger. Vermont has expanded students' access:

- In 2008, by eliminating the cost to students of reduced-priced breakfasts
- In 2013, by eliminating the cost to students of reduced-priced lunches[55]
- In 2014, by adding the Community Eligibility Provision, allowing a school or group of schools with 40% or more of their students directly certified for free meals to offer breakfast and lunch at no charge to all students for a four-year period[56]

There has been a steady increase in children under age 18 enrolled in 3SquaresVT—a federal US Department of Agriculture program (formerly food stamps) designed to help stretch food dollars—from 17.3% in 2009 to 26.4% in 2015.[57] Each year represents the rolling average of data for three years. Parents may be eligible for 3SquaresVT if their gross household income is equal to or less than 185% of the FPL,[58] regardless of the resources they own, or if they receive the Vermont Earned Income Tax Credit.[59]

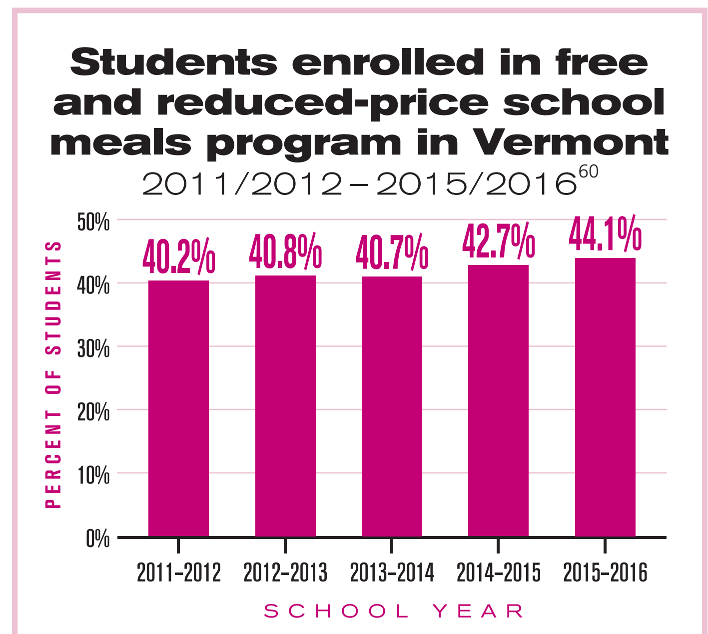



**Figure 9**

# Safety

Children need safe and secure environments in which to grow, learn, and develop. This chapter highlights information regarding the safety of Vermont's youngest children and their families, and ties to the Early Childhood Action Plan's goals of ensuring all Vermont children have a healthy start and that families and communities play a leading role in children's well-being.

## Creating safe communities for children

The safety and well-being of Vermont's children is a collective responsibility shared by all of Vermont's citizens, with families at the center. It is important to ensure parents and caregivers have the necessary skills and supports to raise their children in caring communities and stable home environments. Sometimes, though, children face unsafe situations, including abuse and neglect.

## Understanding child abuse and neglect

According to Vermont law, "An 'abused or neglected child' is a child whose physical health, psychological growth and development or welfare is harmed or is at substantial risk of harm by the acts or omissions of his or her parent or other person responsible for the child's welfare."[61] Child abuse and neglect put children at risk for cognitive delays, emotional difficulties, and challenging behaviors.[62] Health problems (e.g., alcoholism, depression, drug abuse, eating disorders, obesity, high-risk sexual behaviors, smoking, suicide, and certain chronic diseases) are more likely among adults who experienced abuse or neglect as children.[63]

## Children in protective custody

According to Vermont's Department for Children and Families, in 2015, "Vermonters called the state's Child Protection Line a record 19,434 times to report suspected child abuse or neglect."[64] When reports of abuse and neglect are received, Vermont's child protection system is activated to ensure children's safety and well-being. Trained social workers, acting in concert with public safety officials, respond to and investigate reports.

These reports highlight a range of complex and interlocking factors contributing to child abuse and neglect including substance abuse, domestic violence, economic insecurity, mental health challenges, and lack of affordable housing.

If children are found to be unsafe in their homes, they may be placed in protective custody (removed from their homes) with another family member, a foster family, or another protective care arrangement.

The rate of Vermont children under age 9, and particularly the rate of those under age 3, who at any given time are in protective custody has increased significantly from 2012 to 2014.

**Rate of Vermont children under age 9 (per 1,000) in protective custody**
2012–2014[65]

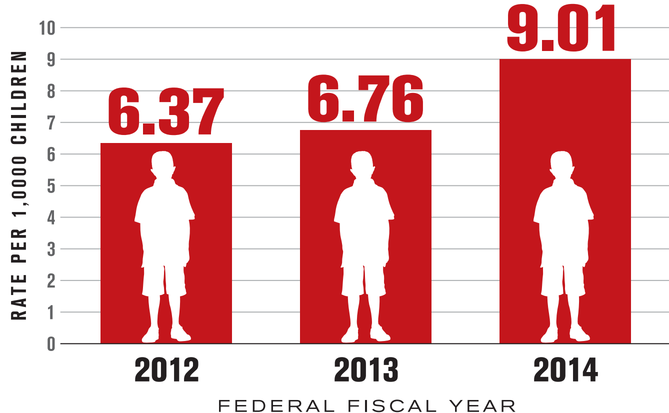



**Figure 10**



Citations, figures and tables available at http://buildingbrightfutures.org/initiatives/how-are-vermonts-young-children/

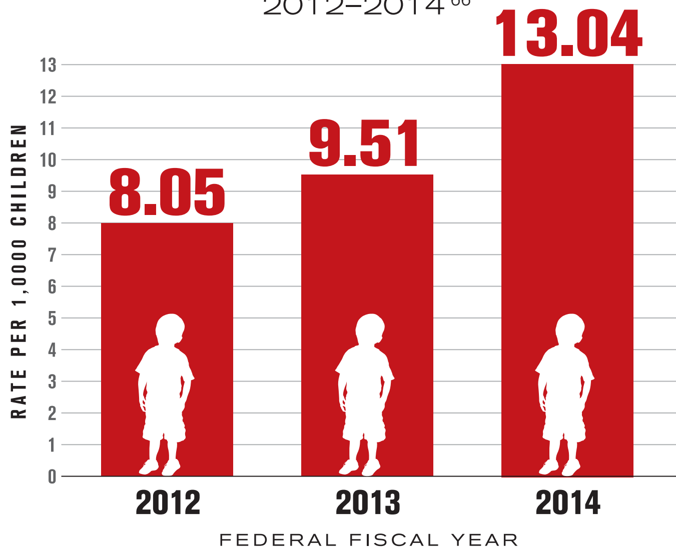



Figure 11

## Building safe communities

As outlined in the Family & Social Relationships chapter, supportive, nurturing relationships can help mitigate the impacts of adverse childhood experiences. To build and sustain safe and supportive communities for our children, Vermont has several community-based initiatives that support parent resilience and strengthen social connections and community supports to decrease incidents of child maltreatment.

One such program is Safe Kids/Safe Streets, a national 5-1/2-year demonstration project that improves community response to child and adolescent abuse and neglect. Vermont's Chittenden County is home to one of five Safe Kids/Safe Streets sites in the US that is working to achieve the program's goal through a variety of community-wide, cross-agency strategies.[67]

Nurse home-visiting is another important resource for families. The Vermont Department of Health's Maternal and Child Health Division (MCHD) and the Department for Children and Families' Child Development Division, Children's Integrated Services (CIS) offer home-visiting programs for Vermont's youngest children and their families from the prenatal period through age 6. These regular, voluntary visits help prevent child abuse and maltreatment, improve maternal and child health, reduce crime and domestic violence, and improve parent education and self-sufficiency.[68]

### Home visiting

In 2016, a range of evidence-based home-visiting programs were offered in areas of Vermont including:

- **Nurse Family Partnership (NFP):**
  Offered by MCHD, NFP offers nurse home-visiting for first-time, low income pregnant mothers and their infants. Since its 2012 inception, the program has served 500+ families.
- **Maternal Early Childhood Sustained Home Visiting (MECSH):**
  MECSH is a new program offered by CIS providing nurse home-visiting for at-risk pregnant women and their babies. Data on the number of families reached by the program will be available in the future.
- **Parents as Teachers® (PAT):**
  PAT is a new program offered by CIS and MCHD that serves families with young children. A trained family support worker based in one of Vermont's Parent Child Centers provides home-visiting services.[69] Data on the number of families reached by the program will be available in the future.
- **Early Head Start**
  Early Head Start: During the 2015–2016 school year, four community-based organizations provided home-visiting services to pregnant women and 268 infants and toddlers from low-income families.[70]

Additional resources designed to support children and families include those discussed in the Family & Social Relationships chapter—Head Start, Strengthening Families, and Children's Integrated Services—as well as others offered through organizations such as Prevent Child Abuse Vermont and Vermont Parent Child Centers. Together, these resources form a support network to help prevent child maltreatment and to address and mitigate the effects of child maltreatment if/when it occurs.

# Early Care & Learning

The Vermont Early Childhood Action Plan includes a goal that "all children and families have access to high-quality opportunities that meet their needs." This chapter provides information on how Vermont is doing to meet that goal in the areas of early care and learning.

## The need for high-quality early care and learning opportunities

In Vermont, 70.38% of children under 6 years old and 78.54% of children 6 to 17 years old have all available parents in the labor force.[71] This means that many families in the state have to balance the needs of their children with parent or caregiver work schedules. For families with young children, particularly children not yet enrolled in school, this balancing act may mean that a family must rely on other family members, friends, neighbors, or a child care provider to provide a safe, nurturing, and positive environment for young children for part of the day. These early care and learning settings play an important role in the learning and development of Vermont's young children.

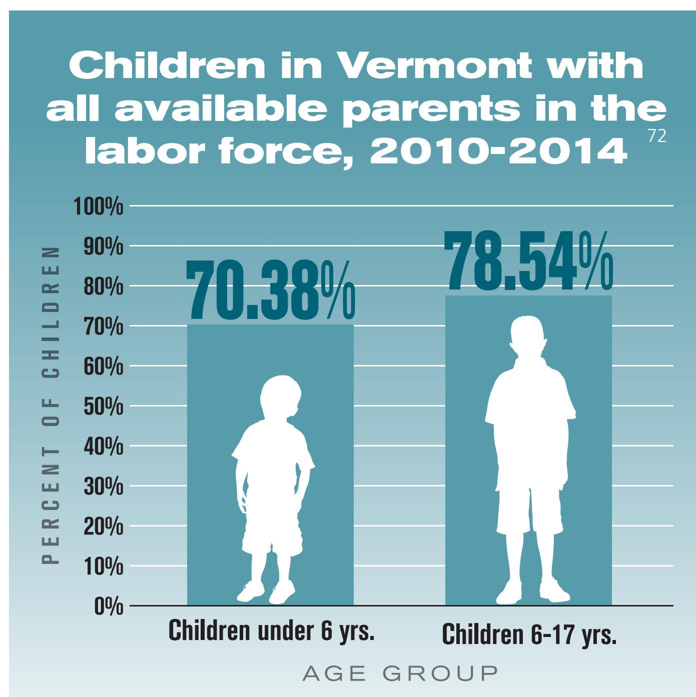



**Figure 12**

### Vermont's early care and learning system

While many families balance child care needs and work using family, friends, and neighbors, some families in Vermont use regulated (licensed or registered) early care and learning programs. As of June 2016, Vermont had 1,436 regulated child care and early learning programs.[73] These programs offer a range of care and learning programs ranging from daily child care, non-recurring care (such as child care at a ski resort), after-school care, and early education (such as preschool or prekindergarten [pre-K]). These programs can take place in a family child care home (sometimes known as home-based child care), a child care center (sometimes known as center-based care or early learning program), a Head Start/Early Head Start classroom, or a public school pre-K classroom.

### Lack of access for infants and toddlers

At this time, Vermont does not track enrollment data for all regulated programs. However, in May 2016, a study released by Let's Grow Kids and advised by the Department for Children and Families Child Development Division (CDD), Vermont Department of Health Maternal and Child Health Division, Vermont Birth to Five, and Building Bright Futures analyzed the supply of and demand for regulated early care and learning for infants and toddlers

in Vermont.[74] Using data from CDD and the Vermont Department of Health, the study found that nearly 47% of Vermont's infants and toddlers likely to need child care do not have access to regulated child care programs. Further, 79% of infants and toddlers likely to need care do not have access to high-quality, regulated early care and learning programs. The findings of this report demonstrate that Vermont still has work to do to ensure that all Vermont families have access to high-quality early care and learning opportunities for infants and toddlers.

**47% of Vermont's infants and toddlers likely to need child care do not have access to regulated child care programs.**

### Universal Pre-K

As of July 1, 2016, all 3- and 4-year-olds, and 5-year-olds not yet enrolled in kindergarten are eligible for publicly-funded pre-K for a minimum of 10 hours per week for 35 weeks a year.[75] This is an important step forward to make high-quality early education available to all Vermont children. Vermont's universal pre-K program recognizes the need for families to be able to select the best pre-K option for their children and gives families the option to enroll in a pre-K program operated by a public school in their community or region or to enroll in a pre-K program operated by a regulated child care or early learning provider who has been qualified by the state to participate in the universal pre-K program.

While all school districts in Vermont will participate in the state's universal pre-K program in the 2016–2017 school year, some school districts were early adopters for the 2015–2016 school year. According to the Vermont Agency of Education, in the 2015–2016 school year, about 7,300 children were funded through public education dollars at a pre-K program that was part of Vermont's universal pre-K system.[76] This number is expected to increase in 2016–2017 with the full implementation of the program.

## Supporting high-quality early care and learning opportunities

### Why quality matters

It is important for families that use regulated care and learning opportunities to have access to child care providers who understand and nurture children's learning and development through quality interactions, because the way children are treated by the adults in their lives shapes their development.[77]

### Kindergarten readiness

Quality early care and learning experiences help support the learning and social and emotional development of children and prepare them for success in kindergarten and beyond. Each fall since 2000, as new groups of children entered kindergarten, Vermont teachers have used a survey to better understand the developmental progress of each child in areas such as social and emotional development, communication, cognitive development, wellness, and learning. The survey is not a direct assessment of children; rather, it relies on the teacher's accumulated observational knowledge of the child from the first few weeks of kindergarten.[78]

**Kindergarten readiness in Vermont**
2015-2016 school year[79]

| | Percent of students surveyed | Percent ready |
|---|---|---|
| **Vermont** | **90.20%** | **81.79%** |
| Boys | 52.23% | 77.42% |
| Girls | 47.77% | 86.58% |

**Figure 13**

In the fall of 2015, after extensive expert review, a new Ready for Kindergarten! Survey (R4K!S) was adopted. The survey consists of 34 new and revised questions across five domains:

- Physical Development and Health
- Social and Emotional Development
- Approaches to Learning (e.g., enthusiasm for learning, persistence, curiosity)
- Communication
- Cognitive Development

Teachers rate each child's skills as "beginning," "practicing," or "performing independently" on 28 questions and judge if challenges such as hunger, illness, or fatigue inhibit the child's learning on the remaining six questions. Children are identified as ready if their total score places them within the "practicing" and "performing independently" range. In previous versions of the survey, a score of "beginning" on any single item disqualified a child from being identified as ready, without regard for the overall score.[80]

These changes in readiness criteria resulted in a substantially greater percentage of students identified as ready in the 2015–2016 school year than in previous years. The difference in the number and percent of students identified as ready is due entirely to the new method used to determine and define readiness, not to changes in the population of kindergarten students. Because the new R4K!S tool is different from surveys used previously, the results cannot be compared between the 2015–2016 school year and past findings. The 2015–2016 report is a new benchmark for understanding kindergarten readiness assessment findings.

## Supporting quality

In addition to providing a safe, nurturing, and loving environment, quality providers also appreciate that an early care and learning program is just one part of a child's daily life, and seek strategies that contribute to not only the healthy development of the child, but also to the nurturing and support of the child's family. Therefore, sustaining and developing the quality of early care and learning programs is important not only for Vermont's youngest children, but also their families.

Vermont is one of 39 states plus the District of Columbia with a quality rating and improvement system to support regulated early care and learning providers in sustaining and developing the quality of their programs.[81] In Vermont this is the **STep Ahead Recognition System (STARS).** STARS is a voluntary program that recognizes regulated providers for going above and beyond the standard early care and learning regulations. Programs that participate in STARS receive a quality recognition designation beginning at 1 star and ranging up to 5 stars. Programs with 4 or 5 stars or programs that have received national accreditation through groups such as the National Association for the Education of Young Children or the National Association of Family Child Care are recognized by many systems as high-quality programs.

Since 2009, Vermont has seen an important increase in the number of regulated providers who choose to participate in **STARS** and the number of programs with increasing quality recognition designations in **STARS**. This is great news for Vermont's youngest children and their families, and highlights the importance of supporting Vermont's early care and learning providers in the incredibly important work they do to nurture children and families.

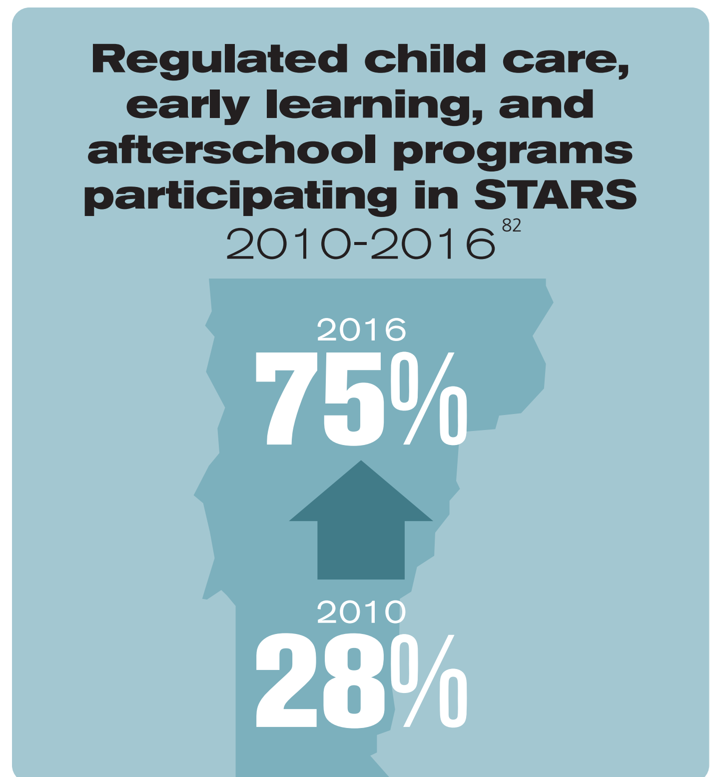



**Figure 14**

An important factor behind this increase is the work of many partner organizations that work directly with providers. Through close collaboration, often including mentoring, these partner organizations directly engage child care providers to improve program quality. These partners include Vermont Birth to Five, the Vermont Association for the Education of Young Children, the Vermont Community Loan Fund, and Vermont Child Care Providers Association.

These quality improvement initiatives have significantly impacted participation rates of programs in STARS.

# Family Economic Well-Being

Family economic well-being considers whether families have adequate, sustainable financial resources to meet their needs. This chapter considers indicators including poverty, homelessness, and the cost of meeting basic needs. While families with young children still face challenges to their economic well-being, Vermont is working to ensure the economic well-being of families through programs and policies like Reach-Up, 3Squares VT, WIC, the Child Care Financial Assistance Program (CCFAP), Early Head Start and Head Start, and Paid Sick Leave (effective January 2017).

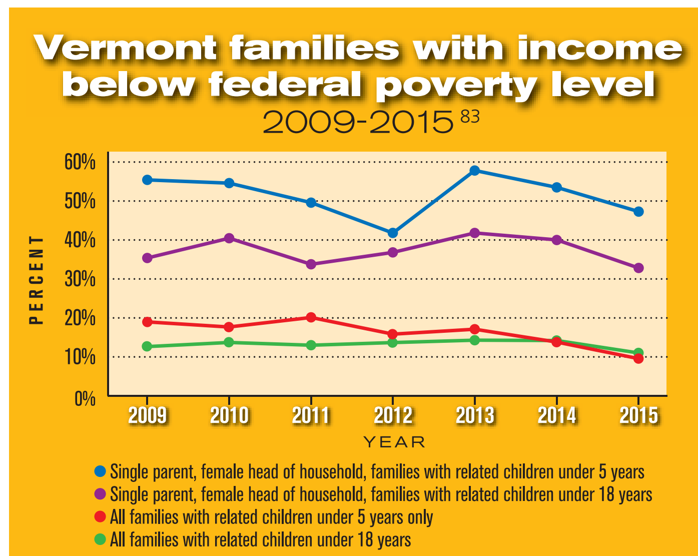



**Figure 15**

## Poverty in Vermont

Each year, the federal government releases information used to quantify at what income level a person or family is considered to live in poverty. Research shows that poverty is the single greatest threat to children's well-being.[84] Children who experience poverty in their early years are at higher risk for poor health, and poverty can negatively impact children's early development. However, states can address these negative impacts by ensuring that workers receive a livable wage, lower-income families have access to high-quality early care and learning, and families have access to health and other social support.[85] The good news is that the percent of families living in poverty in the US and Vermont has decreased.

The percent of Vermont families with children under the age of five who live in poverty showed a statistically significant decline from 19% in 2009 (the end of the Great Recession) to 9.6% in 2015, which coincides with an increase in median household income in Vermont. Additionally, while the percent of single parent, female head-of-household families who live in poverty is decreasing as well, it remains three times more than all families.

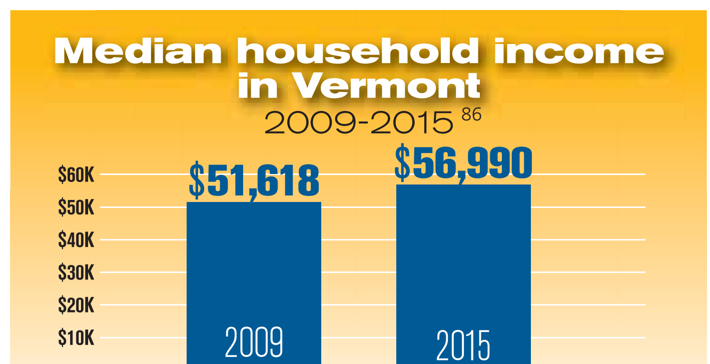



**Figure 16**

## Vermont's Basic Needs Budget

Even though a lower percent of Vermont families with young children live in poverty, many families face significant economic challenges affording basic needs such as food, transportation, housing, and child care.

Developed by Vermont's Joint Fiscal Office, Vermont's *Basic Needs Budget* estimates the level of income needed by an individual or family to afford basic needs in either urban

or rural Vermont. As shown in Figure 19, the basic needs budget for two working adults with two children in an urban area is almost equal to the median four-person family income in Vermont in 2015, $91,793. This demonstrates that a family would need to earn wages significantly higher than Vermont's current minimum wage of $9.60 an hour, well above the federal government's poverty threshhold.[87,88]

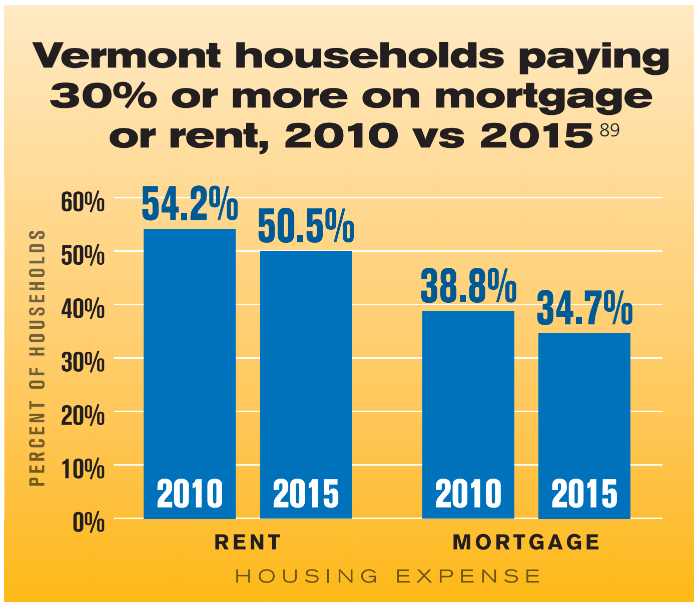



**Figure 17**

## Housing

The cost of housing, as a share of family income, has increased since the Great Recession. Households spending more than 30% of their monthly incomes on rent, mortgage payments, taxes, insurance, and/or related expenses have fewer financial resources to meet their children's other basic needs and make other investments in their children's development. According to the 2015 *Out of Reach Report*, the fair market rent in Vermont for a two-bedroom apartment is $1,075. In order to afford this level of rent and utilities—without paying more than 30% of income on housing—a household must earn more than $3,585 monthly or $43,017 annually.

Assuming a 40-hour work week, 52 weeks per year, this level of income translates to an hourly wage of $20.68 per hour. Consequently, a large number of Vermont families don't earn enough to afford a two-bedroom unit. If they can afford a unit, Vermont's low vacancy rates (sometimes as low as 1%), pose an additional housing challenge.[90]

For families who own, rather than rent, many Vermont households still pay more than 30% of their income on housing. As seen in Figure 17, since 2010, the percent of Vermont owners and renters spending more than 30% of their income remains high. There was a statistically significant decrease of 12% for household mortgages between 2010 and 2015. No significant change occurred between those years for household rent.

## Homelessness

When families can't afford housing, they may become homeless. For families experiencing homelessness, there are a number of publicly-funded emergency shelters that offer safe sleeping space. While the number of children under the age of 18 who are sheltered has been variable over the past few years, increasing slightly in SFY 2016, the average length of stay in SFY 2016 has been steadily increasing to a record high of 39 days. Additionally, according to Vermont's Office of Economic Opportunity, approximately 38% of children and 23% of families who used a publicly-funded shelter in SFY 2016, spent their stay at a domestic/sexual violence shelter.[91]

## Child care

The basic needs budget highlights child care as unaffordable for many Vermont families, even in two-parent households where both parents work.

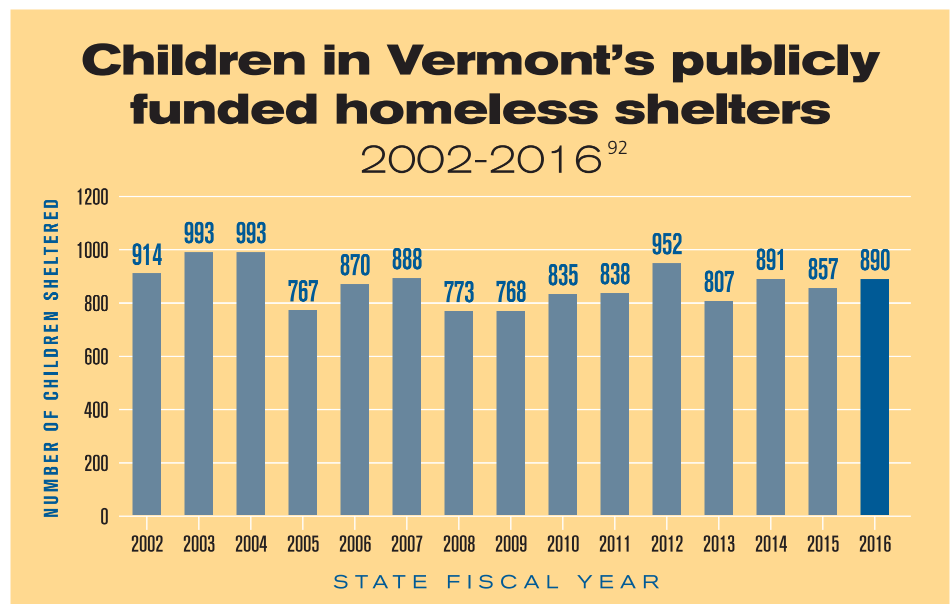



**Figure 18**



Citations, figures and tables available at http://buildingbrightfutures.org/initiatives/how-are-vermonts-young-children/

## 2014 Vermont Basic Needs Budget [93]

| Category | Two working parents with two children (rural) Cost estimates per month | Two working parents with two children (urban) Cost estimates per month |
|---|---|---|
| Food | $1,025 | $1,025 |
| Housing (including utilities) | $926 | $1,328 |
| Transportation | $1,174 | $955 |
| Child care | $1,128 | $1,258 |
| Personal & household expenses | $683 | $683 |
| Health & dental care | $559 | $559 |
| Insurance & savings | $338 | $357 |
| Taxes | $984 | $1,101 |
| **Monthly** | **$6,817** | **$7,266** |
| **Annual** | **$81,799** | **$87,181** |

**Figure 19**

Using information from the 2014 Child Care Market Rate Survey conducted by the DCF Child Development Division, the annual statewide median cost for a two-parent family with one infant and one preschooler in a full-time, center-based child care program was $20,280.[94] For many families, this cost can pose an economic challenge. However, Vermont's Child Care Financial Assistance Program (CCFAP) helps low- and moderate-income families afford quality child care programs, for their children who are between birth to 13 years old (or 19 years old in some cases), while parents work or attend school. CCFAP is also available for families with certain health needs and children who are currently in the care of the Department for Children and Families (DCF). In FY2015, CCFAP helped a total of 14,301 children access early care and learning and afterschool programs.[95]

For families enrolled in the program, CCFAP pays 10% to 100% of a tuition assistance rate set by the state, depending on a family's income and size. The family pays the remaining balance. The more a family earns, the less tuition assistance the family receives. CCFAP tuition assistance rates are set based on a program's level of recognition through the state's quality recognition and improvement system, known as STARS (STep Ahead Recognition System). The higher a program's STARS level, the higher the tuition assistance rate. However, over time, the state's tuition assistance rates have not kept pace with the cost of child care, leaving a gap between how much tuition assistance covers and the current market rates for child care programs. This gap creates economic challenges for families and for child care providers. Many providers cannot afford to lose the difference between CCFAP's tuition assistance rate and the provider's standard tuition, so providers may ask families to cover this difference. This means that families enrolled in CCFAP that qualify for 100% tuition assistance may still need to pay an additional co-pay to cover the difference between the CCFAP tuition assistance rate and the amount a provider charges for tuition.

For a family of four—two working adults and two children—this means that the share of a family's income directed toward child care can range from 4.5% (for families with incomes of 100% or less of poverty, receiving full child care financial assistance, and choosing a high-quality 4-star program) to 37.8% (for families with incomes of 200% of poverty receiving the minimum subsidy of 10% and choosing a high-quality 4-star program).[96,97]

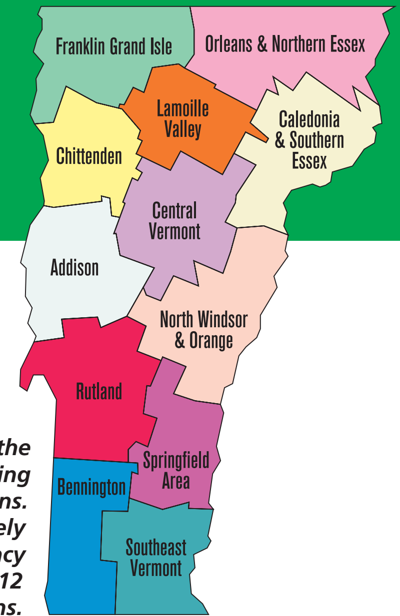
## Share of household income spent on child care costs, 2016 [98,99,100,101]

| | Household Income | | | |
|---|---|---|---|---|
| | **$24,300** | **$48,600** | **$72,900** | **$91,793*** |
| Income as a percentage of FPL | 100% | 200% | 300% | 378% |
| CCFAP tuition assistance eligibility | 100% | 10% | 10% | not eligible |
| Share of income directed for for child care with child care financial assistance and program used is 4-star | **4.5%** | **37.8%** | **25.2%** | --- |
| Share of income directed for child care with child care financial assistance and program used does not participate in STARS | 22.7% | 38.7% | 25.8% | --- |
| Share of income directed for child care without public child care financial assistance | 83.5% | 41.7% | 27.8% | 22.1% |

*State median income for a family of four

**Figure 20**

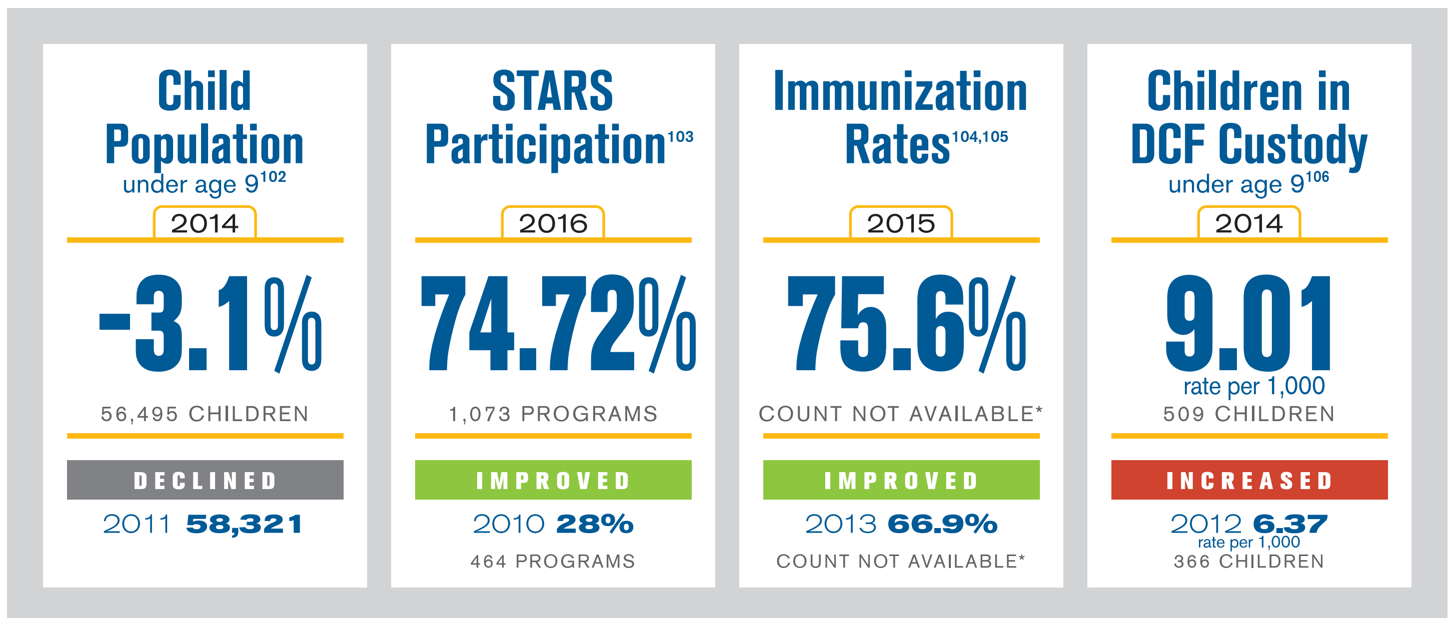
# Building Bright Futures Regional Council Profiles




## About the regions

The 12 Building Bright Futures regional councils harness the power of Vermont communities to impact child and family well-being. Staffed by a regional coordinator, each regional council works to address challenges faced by young children and families in their community. Statewide, nearly 250 individuals who represent a wide variety of perspectives participate in regional councils.

***The map outlines the boundaries of the 12 Building Bright Futures (BBF) regions. BBF regions are largely based on Vermont Agency of Human Services' (AHS) 12 service regions.***




## About the regional profiles

The pages that follow are snapshots of selected regional data that highlight how young children and their families are faring in each Building Bright Futures region.

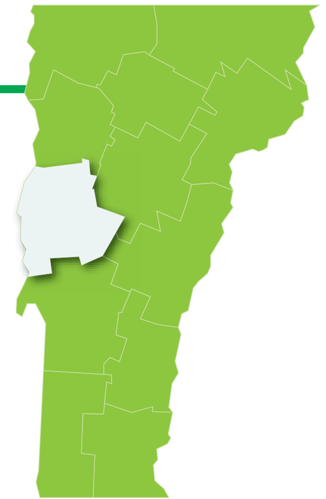
Indicators include child population (reported as percent change), the participation of regulated early care and learning programs in the state's STARS program, early childhood immunization rates, the number of young children in DCF protective custody, and the findings of the state's new "Ready 4 K!" Survey. *It is important to note that the statewide immunization information, noted above, is from a different source than the region-specific information reported on each region-specific page. Statewide information comes from the Centers for Disease Control (CDC) and the region-specific information comes from the Vermont Immunization Registry Program, as region-specific information is not available from the CDC. Additionally, the children in DCF custody information is point-in-time data from September 30, 2014. This means that on that date there were 9.01 children under age 9 in DCF custody per 1,000 children under age 9, which equated to 509 total children.

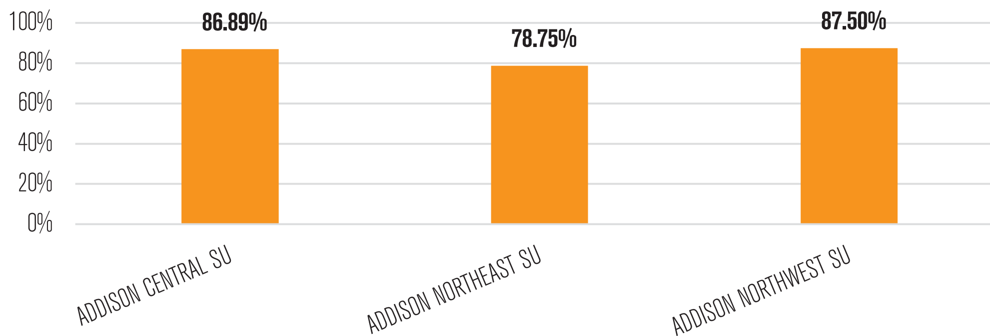
Additional information on all of the regional indicators can be found on Vermont Insights, www.vermontinsights.org, a program of Building Bright Futures. Full citations and data notes for each indicator can be found at: **http://buildingbrightfutures.org/initiatives/how-are-vermonts-young-children/**

### Kindergarten readiness in Vermont
2015-2016 school year[107]

| Percent of students surveyed | Percent ready |
|---|---|
| 90.20% | 81.79% |

## Addison Region






| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -5.0% | 80% | 70.1% | 8.3 rate per 1,000 |
| 3,011 CHILDREN | 72 PROGRAMS | 344 CHILDREN | 25 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **3,168** | 2010 **33.7%** | 2013 **64.3%** | 2012 **6.79** rate per 1,000 |
| | 35 PROGRAMS | 295 CHILDREN | 21 CHILDREN |

### About the region

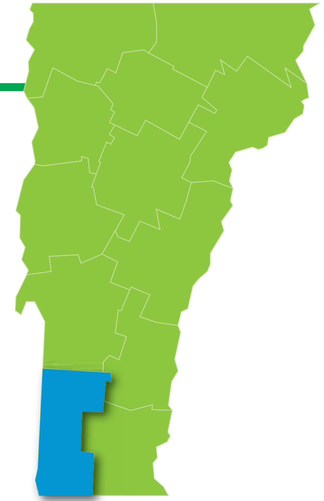
The Addison Building Bright Futures Region covers all of Addison County, the third largest county in Vermont. The largest town in the county is Middlebury. Major employers include Middlebury College, Porter Medical Center, and the Goodrich Corporation.

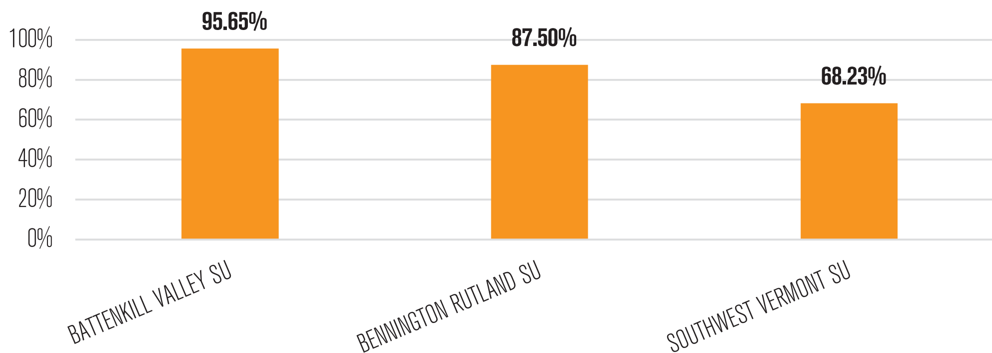
While home to affluent towns like Middlebury, many other communities in the region struggle with food insecurity; opioid and other substance abuse; lack of early care, education, and health supports for parents with young children; and a chronic shortage of high-quality infant care. Regional public and private partners have worked collaboratively to integrate their Building Bright Futures and Integrated Family Services infrastructures to create a continuum of care and services for Addison children and youth, birth to ages 22.

In 2016–2017, the regional council's priorities are:

- Increasing the availability of social, emotional, and other programs and services to promote family and child well-being while preventing adverse child experiences;
- Expanding the capacity of programs to provide high-quality infant care by working in partnership with local businesses and other stakeholders; and
- Increasing access to quality pre-natal and other health and wellness services for children and families to promote lifelong health.

## Bennington Region






| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -3.6% | 78.2% | 69.0% | 12.84 rate per 1,000 |
| 3,272 CHILDREN | 68 PROGRAMS | 373 CHILDREN | 42 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **3,393** | 2010 **27.1%** | 2013 **61.1%** | 2012 **7.17** rate per 1,000 |
| | 29 PROGRAMS | 330 CHILDREN | 24 CHILDREN |

### About the region

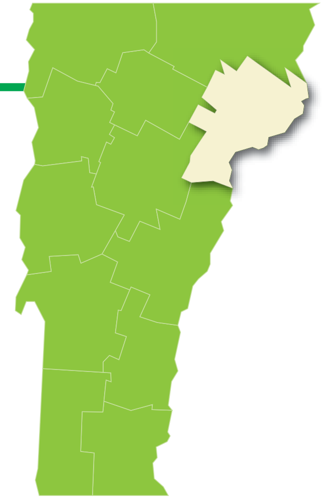
The Bennington Building Bright Futures (BBF) Region shares the same boundaries as Bennington County. The population centers are Bennington in the Southshire and Manchester in the Northshire. The county has three supervisory unions that serve all but two towns in the county.

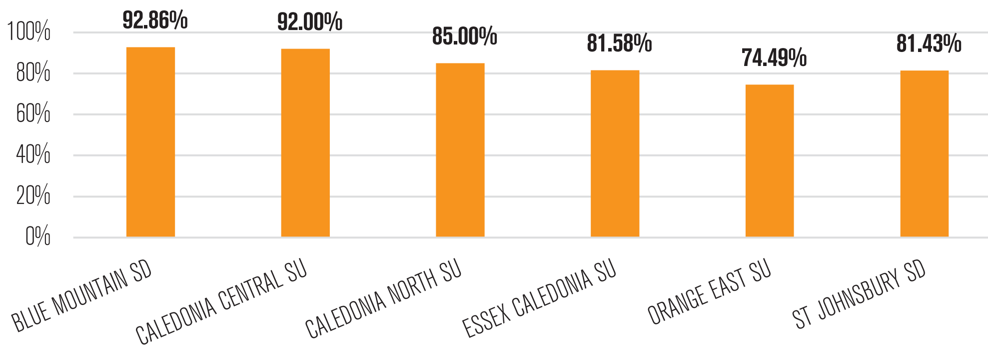
The Bennington BBF Region has a very active regional council that is representative of most community sectors. The work of this regional council is guided by an updated strategic plan that is focused on nine outcomes. Each outcome is overseen by a committee and has a professional development strand woven into it. The council actively supports community interventions and services to address each of these outcomes to combat high rates of adverse child experiences, to address high rates of opioid and other substance abuse, and to ensure children are ready for school.

For 2016–2017, the regional Action Plan outcomes with the highest priority are:

- Ensuring that children are ready for school in five developmental areas;
- Working to make Bennington a trauma-informed and trauma-sensitive region; and
- Working to ensure that children are born into and live in homes that are free of substance abuse.

# Caledonia & Southern Essex Region






| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -9.5% | 73.5% | 59.3% | 11.55 rate per 1,000 |
| 3,118 CHILDREN | 61 PROGRAMS | 290 CHILDREN | 36 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **3,444** | 2010 **21.2%** | 2013 **52.8%** | 2012 **6.77** rate per 1,000 |
| | 21 PROGRAMS | 262 CHILDREN | 23 CHILDREN |

## About the region

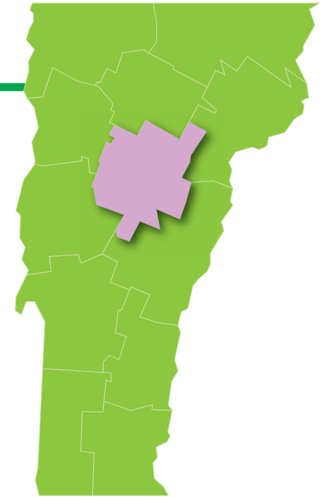
The Building Bright Futures Caledonia/ Southern Essex Region encompasses towns in three counties: Caledonia County, the southern portion of Essex County, and a small portion of upper Orange County. This area is part of the Northeast Kingdom and among the most sparsely populated in Vermont. A strong history of area logging and agriculture play an important role in the area's changing and struggling economy.

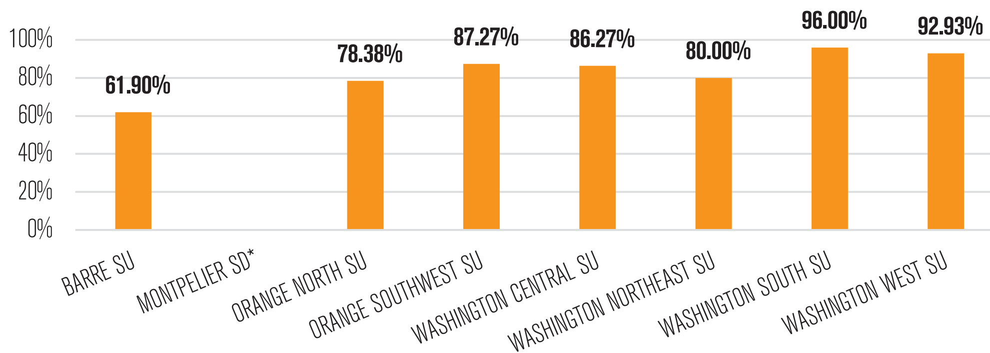
The Building Bright Futures Caledonia/Southern Essex Regional Council has a long and robust history of working together to address regional needs. In addition to high poverty rates, families struggle with homelessness, substance abuse, and other issues leading to higher involvement with Family Services Division. Lack of a transportation infrastructure is a barrier for families receiving services. These factors can also influence school readiness.

The regional council will be working together in 2016–2017 to address priority areas including:

- Poverty;
- Substance abuse;
- Housing; and
- School readiness.

# Central Vermont Region






| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -6.1% | 59.5% | 69.9% | 7.97 rate per 1,000 |
| 6,026 CHILDREN | 97 PROGRAMS | 652 CHILDREN | 48 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **6,420** | 2010 **16.4%** 32 PROGRAMS | 2013 **66%** 671 CHILDREN | 2012 **6.57** rate per 1,000 41 CHILDREN |

## About the region

The Central Vermont Building Bright Futures Region includes almost all of Washington County and a few towns in northern Orange County. Home to the state capital of Montpelier, the region also has seven supervisory unions and one school district. Major employers include Central Vermont Medical Center, National Life Group, and the State of Vermont.

The Central Vermont Building Bright Futures regional council consists of more than 25 active members with a strong core membership representing the early care, health, and education fields. The regional council is focusing its work on several community needs and strategies that were identified during its 2015 regional planning process, which included food insecurity, lack of access to postnatal services for young parents, and uneven quality and capacity of the area's child care system.

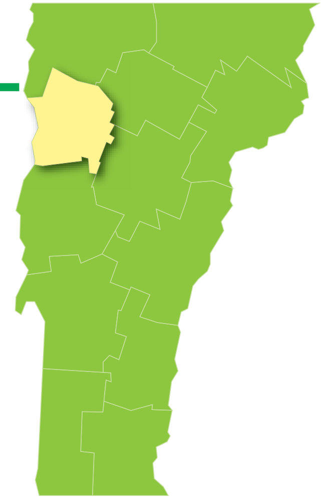
In 2016–2017, the regional council's priorities are:

- Promoting safe and healthy housing and access to nutritious food for young children and their families;
- Ensuring that families have access to postnatal supports by providing new parents with access to available resources; and
- Working collaboratively with partners to improve child care quality and capacity and to support a highly skilled workforce.

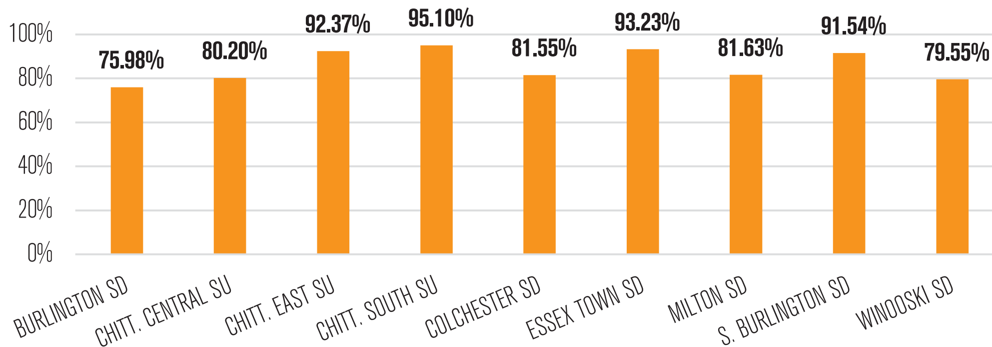


Citations, figures and tables available at http://buildingbrightfutures.org/initiatives/how-are-vermonts-young-children/

## Chittenden Region



### 2015-2016 R4K!S Percent of All Students Ready for Kindergarten




### Child Population
under age 9

2014

**-0.04%**

14,266 CHILDREN

DECLINED

2011 **14,271**

### STARS Participation

2016

**69.8%**

208 PROGRAMS

IMPROVED

2010 **28.8%**

97 PROGRAMS

### Immunization Rates

2015

**70.3%**

1,764 CHILDREN

IMPROVED

2013 **57.9%**

1,420 CHILDREN

### Children in DCF Custody
under age 9

2014

**5.33**

rate per 1,000

76 CHILDREN

INCREASED

2012 **3.97**

rate per 1,000

56 CHILDREN

## About the region

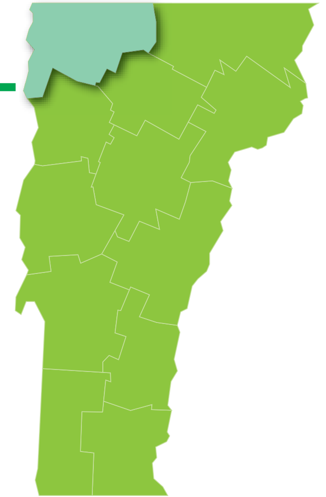
The Building Bright Futures Chittenden Region serves Chittenden County, which is the economic center for Vermont with 24% of the state's population. It encompasses 18 municipalities, including those in the greater Burlington area. The county is home to a mixture of rural and urban families, native-born long-time residents, and recent immigrants. Major employers include the University of Vermont, University of Vermont Medical Center, and GlobalFoundaries.

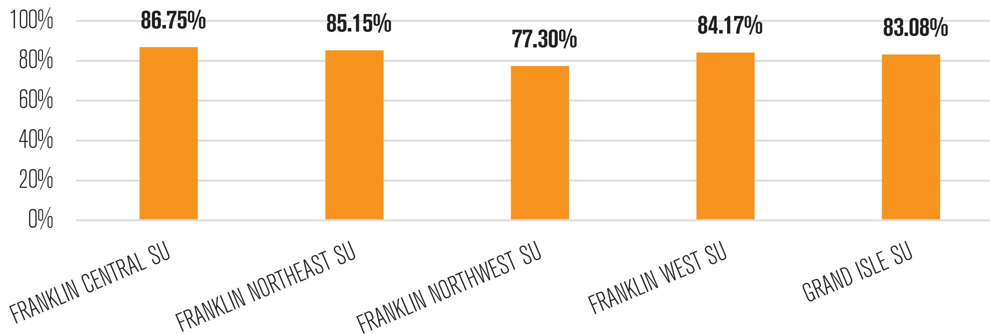
The BBF Chittenden Regional Council has been active since 1992, and has representatives from school districts, early childhood providers, mental health agencies, parents, and community based service providers of all kinds. The regional council believes young children's healthy social and emotional development is critical to school readiness and positive long-term social and health outcomes across the lifespan, and is working to address barriers that prevent this from happening in the region.

In 2016–2017, the regional council's priorities are:

- Reducing health disparities for children through earlier screening, identification and intervention for services;
- Improving school climate, cultural competence and language access; and
- Supporting family stability by reducing stressors such as drug addiction, underemployment, and lack of safe and affordable housing.

# Franklin Grand Isle Region






| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -2.1% | 81.1% | 67.1% | 12.12 rate per 1,000 |
| 5,939 CHILDREN | 142 PROGRAMS | 618 CHILDREN | 72 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **6,067** | 2010 **27.9%** | 2013 **61.3%** | 2012 **10.33** rate per 1,000 |
| | 56 PROGRAMS | 593 CHILDREN | 62 CHILDREN |

## About the region

The Building Bright Futures Franklin and Grand Isle Region is located in the northwestern corner of Vermont. This area is very rural and scenic, bordering Canada, Lake Champlain, and the Green Mountains, and encompasses the counties of Franklin and Grand Isle. The region holds nine percent of the state's population and is the third-most populated region in Vermont for children ages 0–8.

The Building Bright Futures Franklin Grand Isle regional council is comprised of over 20 members. For 2016–2017, the council is focused on integrating systems that support children and families to address families' basic human needs such as housing and food insecurity and to support prevention initiatives to combat violence as well as opioid and other substance abuse.

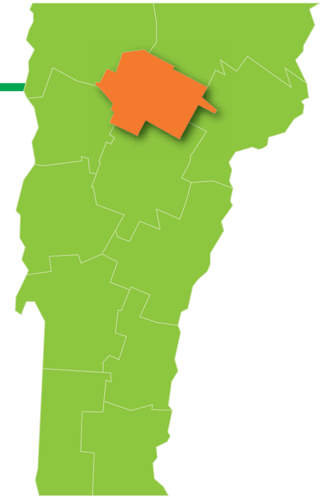
The top three priorities of the council are:

- Meeting the nutritional and housing needs of children and families;
- Creating safe and stable environments for children by leveraging the power of the regional network to build trauma informed communities; and
- Working with early care providers, school districts, and supervisory unions to provide children and families with access to high-quality learning opportunities.

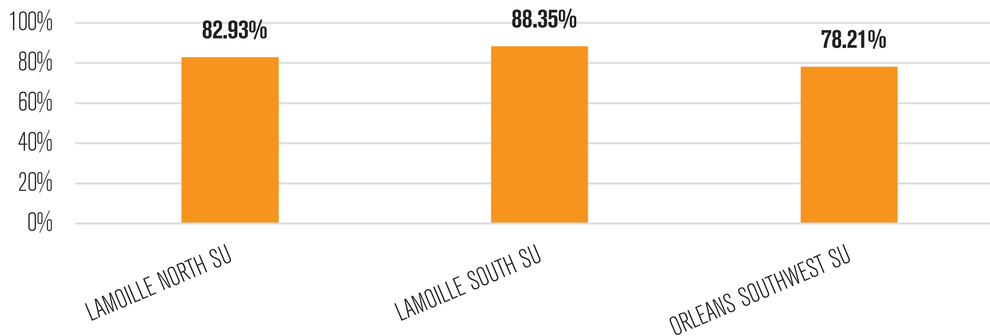


Citations, figures and tables available at http://buildingbrightfutures.org/initiatives/how-are-vermonts-young-children/

# Lamoille Valley Region



### 2015-2016 R4K!S Percent of All Students Ready for Kindergarten




| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| **-3.4%** | **75.9%** | **56.8%** | **6.11** rate per 1,000 |
| 3,109 CHILDREN | 63 PROGRAMS | 273 CHILDREN | 19 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **3,218** | 2010 **31.2%** | 2013 **45.8%** | 2012 **3.76** rate per 1,000 |
| | 29 PROGRAMS | 222 CHILDREN | 12 CHILDREN |

## About the region

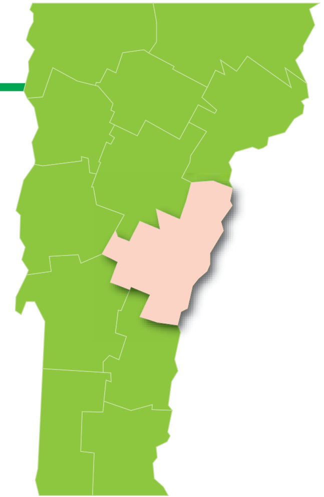
The Building Bright Futures Lamoille Valley Region includes 15 different towns that range from one of Vermont's wealthiest, to some of the state's poorest communities. The region encompasses three supervisory unions, and health services are delivered by two different regions focusing separately on mental health and physical health. Major employers include Community Health Services of Lamoille Valley, Copley Hospital, Stowe Mountain Resort, Lamoille South Supervisory Union, Manufacturing Solutions, and Concept 2.

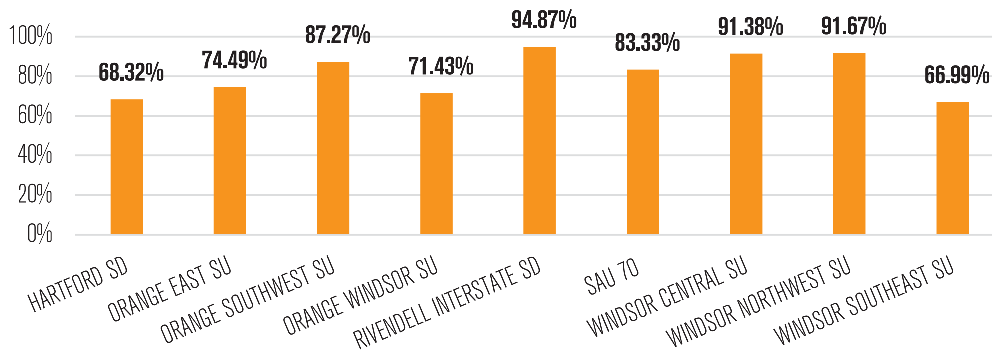
The Building Bright Futures Lamoille regional council includes representatives from all three supervisory unions, the Department of Health's Maternal Child Health team, the Parent Child Center, parents, child care providers, center owners, executive directors, and private businesses.

In 2016–2017, the Building Bright Futures Lamoille Valley Region's priorities are:

- Helping parents learn how to be a good parent and helping them find resources to support them in this process;
- Increasing the quality of early care and learning programs; and
- Addressing the inequity within our communities reflected by kindergarten readiness data.

## Northern Windsor & Orange Region






| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -3.6% | 86.73% | 57.1% | 11.27 rate per 1,000 |
| 4,169 CHILDREN | 85 PROGRAMS | 393 CHILDREN | 47 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **4,326** | 2010 **27.1%** 29 PROGRAMS | 2013† **34.6%** 229 CHILDREN | 2012 **4.25** rate per 1,000 18 CHILDREN |

### About the region

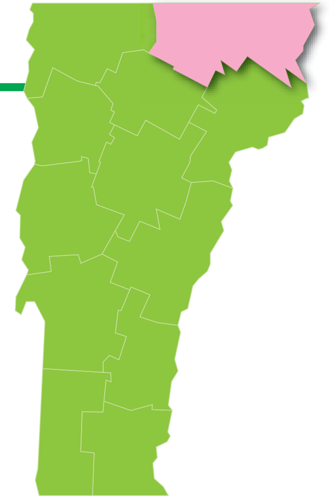
The Building Bright Futures Northern Windsor and Orange Region extends along the Connecticut River, stretching from the middle of Windsor County to the spine of the Green Mountains and into the southern tip of the Northeast Kingdom. Known colloquially as the "Upper Valley," the region's services, infrastructure, and workforce are largely shared with neighboring New Hampshire communities. Many major employers in the area are located just across the border in New Hampshire.

The Building Bright Futures Northern Windsor and Orange Regional Council is comprised of diverse sectors with over 30 active members representing the education, early care, and health systems of the region. Using its recently developed regional Action Plan, the regional council intends to remove barriers to address the lack of transportation, specialized care, and social-emotional wellness services for young families.

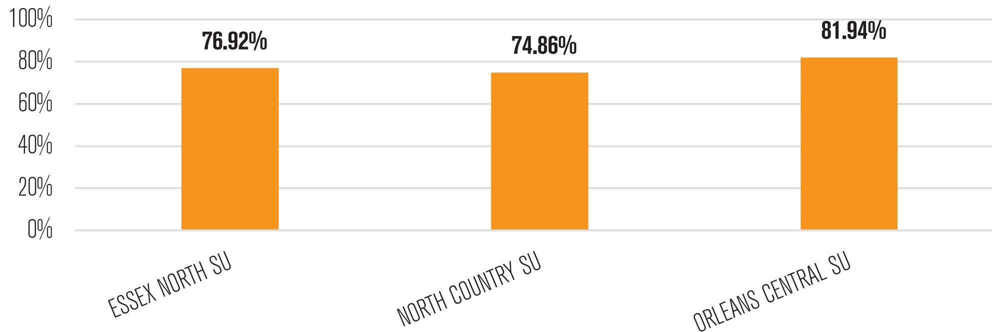
In 2016–2017, the regional council will focus strategically on these priorities:

- Ensuring families have access to safe, reliable, and affordable transportation;
- Ensuring caretakers of young children are adequately supported with specialized services and education; and
- Ensuring young children experience healthy social-emotional development.

## Orleans & Northern Essex Region



2015-2016 R4K!S Percent of All Students Ready for Kindergarten




| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -3.1% | 84% | 68.2% | 5.51 rate per 1,000 |
| 2,543 CHILDREN | 63 PROGRAMS | 272 CHILDREN | 14 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **2,625** | 2010 **33.33%** | 2013 **65.8%** | 2012 **5.07** rate per 1,000 |
| | 29 PROGRAMS | 296 CHILDREN | 13 CHILDREN |

### About the region

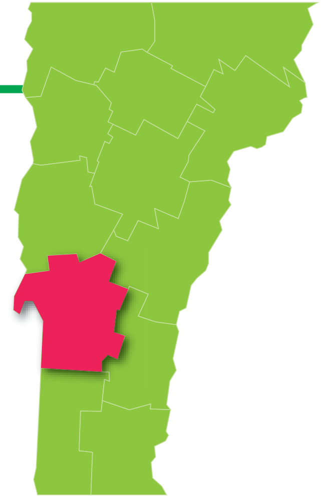
The Building Bright Futures Orleans and Northern Essex Region covers the northern half of the geographic area known as Vermont's Northeast Kingdom. The region is known for its natural resources and landscape. The region's population center is its only city, Newport, which houses one of the largest employers in the region, North Country Hospital, but much of the population lives in small towns and villages.

The Building Bright Futures Orleans and Northern Essex Regional Council includes representatives from the region's three supervisory unions, early childhood educators, as well as representatives from the health (including mental health) and non-profit sectors. The regional council is committed to building a community where young children and their families are celebrated and supported since the rural and sometimes isolated nature of the region can make accessing services, transportation, and employment difficult for its residents.

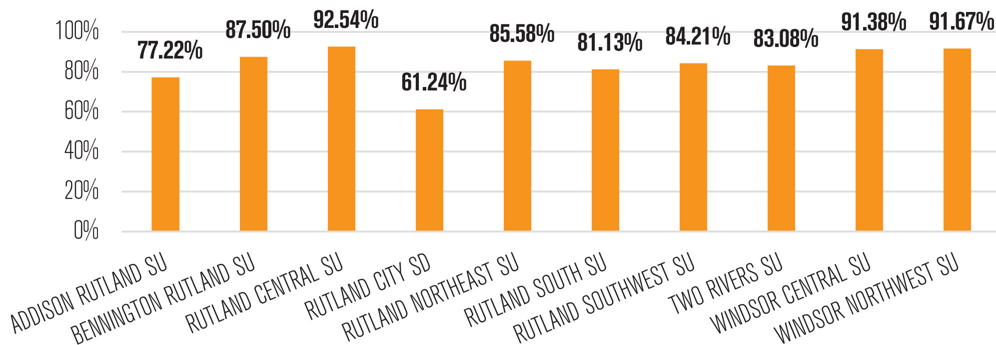
In 2016–2017, the regional council is focused on these priorities:

- Promoting the physical well-being of children and their families, as rates of obesity among children entering preschool has become an issue of concern;
- Enhancing caregiver's understanding of the social and emotional well-being of children; and
- Providing meaningful and useful information about child well-being for parents as well as providers in the local system of care.

# Rutland Region



## 2015-2016 R4K!S Percent of All Students Ready for Kindergarten




### Child Population
under age 9

2014

**-2.8%**

5,071 CHILDREN

DECLINED

2011 **5,216**

### STARS Participation

2016

**71.3%**

107 PROGRAMS

IMPROVED

2010 **26.2%**

44 PROGRAMS

### Immunization Rates

2015

**56.5%**

493 CHILDREN

IMPROVED

2013 **46.5%**

373 CHILDREN

### Children in DCF Custody
under age 9

2014

**10.25**
rate per 1,000

52 CHILDREN

INCREASED

2012 **6.38**
rate per 1,000
33 CHILDREN

## About the region

Located in southwestern Vermont, the Rutland Building Bright Futures (BBF) Region shares its boundaries with Rutland County, which is the second most populous region after Chittenden County. Rutland lags behind the nation and the state in household median income and its projected population growth is the second slowest in Vermont. Major employers in the area include Rutland Regional Medical Center, GE Aircraft Engines, and Killington Pico Ski Resort Partners.

The Rutland Building Bright Futures Regional Council has an active membership of 20 stakeholders representing early care, education, and health services. For 2016–2017, the council is developing initiatives to strengthen programs and resources to support the physical and emotional wellbeing of Rutland's young children and families.

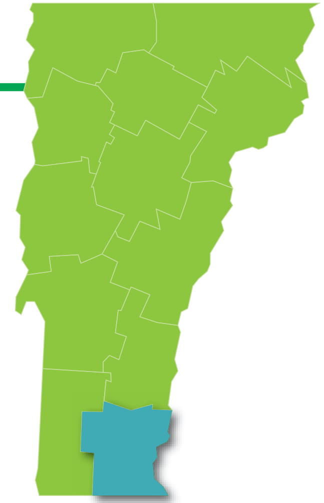
Three of the most important priorities the council has identified are:

- Collaborating with local partners to deliver early care mental health consultation programs to strengthen young children's social and emotional competence;
- Fostering alliances with the Rutland Promise Community and Help Me Grow, so families have access to age-appropriate information and guidance around their child's social and emotional development, including other community health resources; and
- Cultivating effective parent engagement programs combined with excellent learning supports in early care and learning programs.

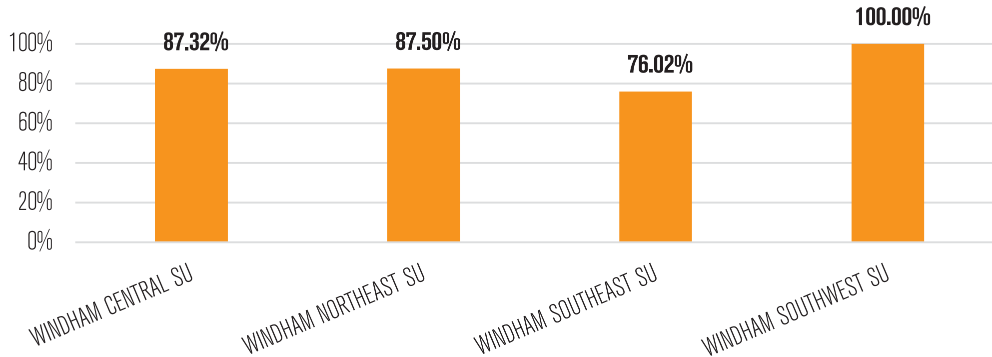


Citations, figures and tables available at http://buildingbrightfutures.org/initiatives/how-are-vermonts-young-children/

## Southeast Vermont Region



### 2015-2016 R4K!S Percent of All Students Ready for Kindergarten




| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -2.0% | 72.9% | 54.9% | 14.95 rate per 1,000 |
| 3,010 CHILDREN | 51 PROGRAMS | 279 CHILDREN | 45 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **3,071** | 2010 **46.1%** | 2013 **54.2%** | 2012 **10.87** rate per 1,000 |
| | 41 PROGRAMS | 254 CHILDREN | 33 CHILDREN |

### About the region

The Building Bright Futures Southeast Vermont Region covers most of Windham County, including 19 towns. It is bordered by the Connecticut River and New Hampshire to the east and Massachusetts to the south. Major employers include C&S Wholesale Grocers, Brattleboro Memorial Hospital, and the Brattleboro Retreat.

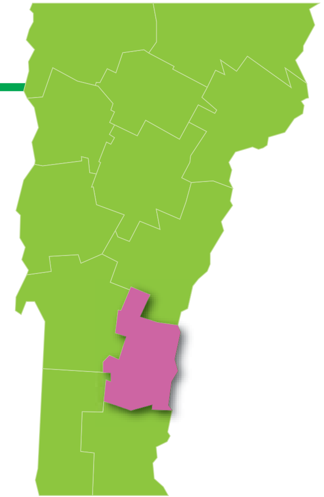
The Building Bright Futures Southeast Vermont Regional Council reflects our community. The regional system of early childhood supports has a deep history of collaborative, innovative approaches to serving all children and families.

The work of the regional council is focused on improving upon existing assets and to address the many challenges families face including: generational poverty, low wages, lack of timely mental health, medical and substance abuse services to meet increasing needs, and lack of basic needs such as affordable housing, food, and transportation.

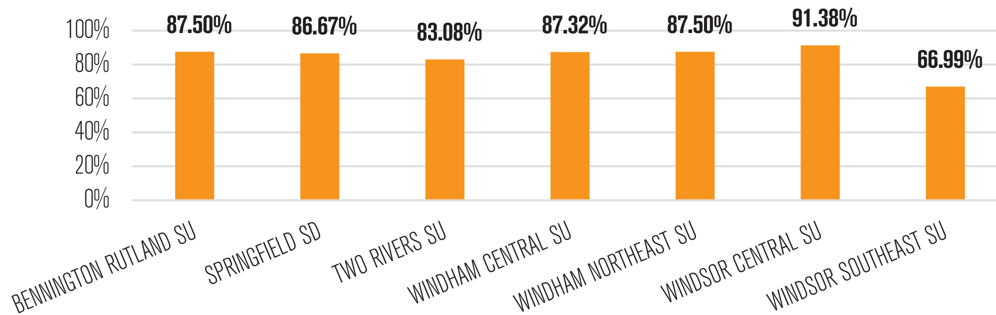
In 2016–2017, the regional council's priorities are:

- Ensuring schools and communities are ready for children and families by promoting the importance of family-centered workplace policies; and
- Identifying ways to streamline how families access supports and services to create an easily accessible regional early childhood system.

# Springfield Area Region



## 2015-2016 R4K!S Percent of All Students Ready for Kindergarten




| Child Population under age 9 | STARS Participation | Immunization Rates | Children in DCF Custody under age 9 |
|---|---|---|---|
| 2014 | 2016 | 2015 | 2014 |
| -4.5% | 87.5% | 57.9% | 11.14 rate per 1,000 |
| 2,961 CHILDREN | 56 PROGRAMS | 278 CHILDREN | 33 CHILDREN |
| DECLINED | IMPROVED | IMPROVED | INCREASED |
| 2011 **3,102** | 2010 **31.43%** | 2013† **32.8%** | 2012 **9.92** rate per 1,000 |
| | 22 PROGRAMS | 161 CHILDREN | 30 CHILDREN |

## About the region

The Springfield Area Building Bright Futures Region is composed of 12 towns in northern Windham and southern Windsor Counties. The region is rural in nature with greater concentrations of population located along the Connecticut River. Major employers include industry, health care, and other services.

The Springfield Area Building Bright Futures Regional Council has representation from a variety of different sectors including schools, public safety, child care providers, libraries, churches, a parent child center, and state agencies. The council determined the greatest need in this region is to ensure all children and families have the support they need to be socially and emotionally healthy.

The council's three priorities are:

- Providing education on developmentally appropriate behaviors using existing events, as well as traditional and non-traditional programs and approaches;
- Assisting to expand capacity for mental health services so all children and families who need services receive them in a timely manner; and
- Providing education around adverse childhood experiences to community and service providers to better understand the impact of trauma on one's life and what can be done to mitigate these effects.



Citations, figures and tables available at http://buildingbrightfutures.org/initiatives/how-are-vermonts-young-children/

# Recommendations for Vermont's Early Care and Learning System

Last year, the Vermont Legislature created the Blue Ribbon Commission on Financing High Quality, Affordable Child Care to investigate and make recommendations related to the early care and learning of Vermont children birth to five. Over the past year, the Commission's work has focused on three primary areas: defining the elements and costs of high-quality care, defining affordability, and defining financing options. This work directly relates to many topics noted in this year's *How Are Vermont's Young Children and Families?* report, particularly those noted in the Early Care & Learning and Family Economic Well-Being chapters. In its report, the Commission noted that, ***"Equitable early care and learning for all Vermont children ages birth to five is the most significant opportunity for the state for making systemic and dynamic improvements that will foster economic development, advance social and community well-being, and provide the greatest positive impact for future generations."***[108] As such, in its report, the Commission outlined immediate and longer-term recommendations to strengthen and grow Vermont's early care and learning system. A summary of its recommendations follows.

## RECOMMENDATION 1

### Make Annual Incremental Investments Immediately in High-Quality, Affordable Early Care and Learning

It is the recommendation of the Commission that the state immediately begin to make annual incremental investments to support high-quality, affordable early care and learning. To support the further development of quality and access in the state's early care and learning system, the Commission recommends the following strategies:

**1.** To improve financial access and stability, adjust Vermont's Child Care Financial Assistance Program (CCFAP) in the following way:

a. Set the 4-star rate at the 75th percentile of 2015 market rates and adjust accordingly the current tiered system methodology which incentivizes quality

b. Provide 100% benefit at the 200% federal poverty level (FPL)

c. Provide 50% benefit at the 300% FPL

d. Provide 0% benefit at the 350% FPL

The estimated cost per year for this benefit level is $90.8 million. The current budget for CCFAP in State Fiscal Year 2017 is $47.3 million. An additional $43.5 million would be needed to fund these changes.

**2.** To increase capacity and quality environments, establish a facilities fund to be maintained by the Vermont Community Loan Fund that includes, but is not solely funded by, the Building Bright Futures license plate revenue. Annual allocation should be at least $3 million to finance grants and loans.

**3.** Vermont's early care and learning professionals face a unique set of challenges, including significant disparity between their wages and benefits and those of other education professionals with similar qualifications. To make early care and learning a sustainable profession, providers need compensation that is aligned with their education, skills, and expertise. To support early childhood professionals and strengthen the early childhood workforce:

a. Establish a range of "Outstanding Early Childhood Professional" recognitions that are substantial enough to incentivize providers to enter and stay in the workforce;

b. Establish and fund a W.A.G.E.$® program that assures private sector programs can recruit and retain highly qualified staff;

c. Permanently establish an early childhood leadership institute or program to foster strong, ongoing, committed leaders in the early childhood system;

d. Establish pathways to credentials and licensure:

i. Locally enhanced higher education coursework and and accredited opportunities

ii. Portfolio development and assessment of prior learning

iii. Provider support through mentoring, coaching, teaching, and assisting;

e. Establish a scholarship fund robust enough to incentivize pursuing a degree in early childhood education. Link this to the T.E.A.C.H.® support already in place.

i. Scholarships for educational advancement toward degree attainment

ii. Incentives that promote social and emotional competence and literacy

iii. Supports for "relief time" for schooling and coursework

4. Educate employers about ways to support employees in affording quality early care and learning programs, such as offering a matching contribution fund that allows employees to dedicate pre-tax dollars to early care and learning programs. Consider developing an "Early Care and Learning for Businesses" handout.

## RECOMMENDATION 2

## Design and Implement Vermont's Future Early Care and Learning System for Children Birth to Five

The Commission recommends that the state's early childhood public/private partnership (Building Bright Futures) engage Vermont's early care and learning stakeholders, including members of Vermont's gubernatorial administration and Legislature, in a design process to develop and implement a comprehensive, inclusive, voluntary, high-quality, affordable early childhood system for all children birth to five based on the work of the Commission. More details on this proposal can be found in the detailed report.

## RECOMMENDATION 3

## Financing Mechanisms

The Commission discussed a range of potential mechanisms that could help to finance a future expanded high-quality, affordable early care and learning system in Vermont. The Commission recommended that the Vermont Legislature review and act on the following list of potential financing mechanisms to support Vermont's early care and learning system.

a. Reallocation of savings across all state agencies through operational efficiencies

b. Business and philanthropic community partnerships and incentives:

i. Public-Private Partnerships

ii. Pay for Success

iii. Philanthropic Investments

c. Early care and learning license plates

d. Endowment funds

e. Leveraging additional funding from Medicaid through the global commitment waiver

f. Exploring options for other revenue sources

## NEXT STEPS

As a member of the Commission and as the state's designated early childhood advisory group, Building Bright Futures recommends that the Governor and Legislature implement the Commission's immediate and longer-term recommendations in order to support Vermont's youngest children and their families.

## ACKNOWLEDGEMENTS

The 2016 *How Are Vermont's Young Children and Families?* report is truly a collaborative effort between Building Bright Futures (BBF) and key early childhood stakeholders, organizations, and agencies in Vermont.

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# Endnotes

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**2** National Scientific Council on the Developing Child. (2014). *Young Children Develop in an Environment of Relationships: Working Paper #1.* Retrieved from http://developingchild.harvard.edu/resources/wp1/.

**3** American Psychological Association. (n.d.). Parents and Caregivers are Essential to Children's Healthy Development. Retrieved from http://www.apa.org/pi/families/resources/parents-caregivers.aspx.

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**Figure 1: Living arrangements of VT families with children under age 18**

Data Notes

The following steps were used to calculate the percent of children in each type of living arrangement:

The percent of children living in two-parent households was calculated by dividing the number of children in married couples families (ACS Table B09002), by the total number of children under age 18 years (ACS Table B09001).

The percent of children living in single-parent households was calculated by dividing the number of children living with one parent families (ACS Table B09002) by the total number of children under age 18 years (ACS Table B09001).

The percent of children living with relatives, including grandparents was calculated by dividing the number of grandchildren (ACS Table B09018) by the total number of children under age 18 years (ACS Table B09001).

The percent of children living in foster, family or non-relatives was calculated by dividing the number of other child relatives and foster or other unrelated children (ACS Table B09018) by the total number of children under age 18 years (ACS Table B09001).

The percent of children living in group quarters or other non-household situations was calculated by dividing the number of children living group quarters and other non-household situations (see calculation below) by the total number of children under age 18 years (ACS Table B09001).

The number of children in non-household situations was calculated by subtracting the total number of children with relationships of head of household (ACS Table B09018) from the total number of children in households (ACS Table B09001). This value was then added to the children in group quarters (ACS Table B09001) and provided the total number of children in group quarters and other non-household situations.

**6** Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M.P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, 14(4), 245–258.

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**8** Data Resource Center for Child and Adolescent Health. (2011–2012). Browse by Survey & Topic: National Survey of Children's Health. Available from http://childhealthdata.org/browse.

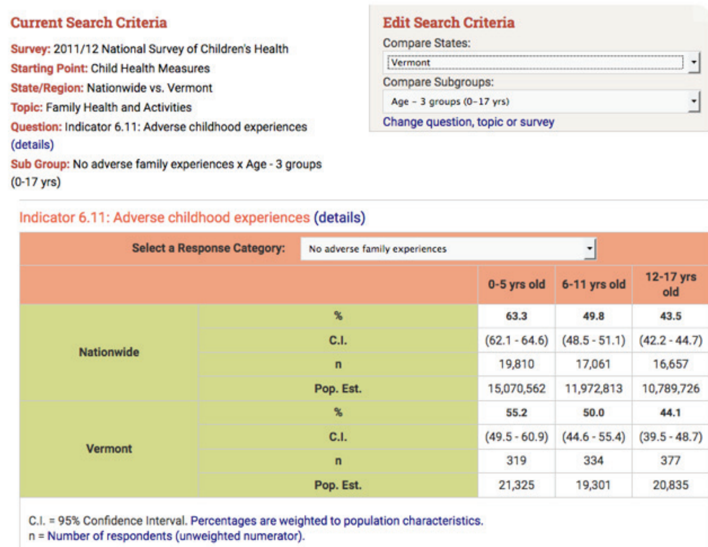
**Figure 2: Children with two or more Adverse Childhood Experiences (ACEs) in Vermont and the US, 2011–2012**

Data Notes

In the 2011/12 National Survey of Children's Health, Adverse Family Experiences were included to capture psychosocial risk factors affecting children. A modified version of the nine adverse childhood experiences list was developed for this survey: (1) socioeconomic hardship, (2) divorce/separation of parent, (3) death of parent, (4) parent served time in jail, (5) witness to domestic violence, (6) victim of neighborhood violence, (7) lived with someone who was mentally ill or suicidal, (8) lived with someone with alcohol/drug problem, (9) treated or judged unfairly due to race/ethnicity. These nine items were based initially on the BRFSS ACE Module, which includes items 2, 4, 5, 7, and 8. The additional four items were developed based on a review of life course stressors in children's lives by a Technical Expert Panel.

The survey is being conducted again by the Census Bureau in 2016, with initial data expected in 2017.

The following nationwide and Vermont table (screen shot) from http://childhealthdata.org/browse (November 14, 2016) includes the margins of error at the 95% confidence interval, the percentages weighted to the population characteristics, and the unweighted numerator.



Current Search Criteria

Survey: 2011/12 National Survey of Children's Health
Starting Point: Child Health Measures
State/Region: Nationwide vs. Vermont
Topic: Family Health and Activities
Question: Indicator 6.11: Adverse childhood experiences (details)
Sub Group: No adverse family experiences x Age - 3 groups (0-17 yrs)

Edit Search Criteria

Compare States: Vermont
Compare Subgroups: Age - 3 groups (0-17 yrs)
Change question, topic or survey

Indicator 6.11: Adverse childhood experiences (details)

Select a Response Category: No adverse family experiences

| | | 0-5 yrs old | 6-11 yrs old | 12-17 yrs old |
|---|---|---|---|---|
| Nationwide | % | 63.3 | 49.8 | 43.5 |
| | C.I. | (62.1 - 64.6) | (48.5 - 51.1) | (42.2 - 44.7) |
| | n | 19,810 | 17,061 | 16,657 |
| | Pop. Est. | 15,070,562 | 11,972,813 | 10,789,726 |
| Vermont | % | 55.2 | 50.0 | 44.1 |
| | C.I. | (49.5 - 60.9) | (44.6 - 55.4) | (39.5 - 48.7) |
| | n | 319 | 334 | 377 |
| | Pop. Est. | 21,325 | 19,301 | 20,835 |

C.I. = 95% Confidence Interval. Percentages are weighted to population characteristics.
n = Number of respondents (unweighted numerator).

**9** Office of Head Start. (2016). 2015–2016 H*ead Start Program Information Report.* Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/data/pir/2015-2016-pdf/2015-2016-pir-form.pdf.

**10** Vermont Health Start Collaboration Office. (2015). *US Office of Head Start, Vermont State Level Program Information Report (PIR): Summary Report; Health Services Report; Dental Services Report; Family Information Report.* Retrieved from https://eclkc.ohs.acf.hhs.gov/hslc/data/psr.

**Figure 3: Comprehensive services received by Vermont children and families served by Head Start and Early Head Start, 2015**

Data note:

Head Start and Early Head Start programs were asked to report on the number of families who received at least one of the family services: Emergency/crisis intervention such as meeting immediate needs for food, clothing, or shelter; Housing assistance such as subsidies, utilities, repairs, etc.; Mental health services; English as a Second Language training; Adult education such as GED programs and college selection; Job training;

Substance abuse prevention; Substance abuse treatment; Child abuse and neglect services; Domestic violence services; Child support assistance; Health education; Assistance to families of incarcerated individuals; Parenting education, and Relationship/marriage education.

**11** Ibid

**12** The Annie E. Casey Foundation. (2014). *Kids Count: 2014 Data Book, State Trends in Child Well-Being (25th Ed.).* Retrieved from http://www.aecf.org/m/resourcedoc/aecf-2014kidscountdatabook-2014.pdf.

**13** Vermont Head Start State Collaboration Office (VHSSCO). (2014). *2013 Vermont Head Start and Early Head Start Needs Assessment Report.* Retrieved from http://dcf.vermont.gov/sites/dcf/files/CDD/Reports/2013_Head_Start_Needs_Assessment.pdf.

**14** The federal OHS Region I Office supplied the VHSSCO with the enrollment figures on September 22, 2015.

**15** U.S. Census Bureau. (2014). *2010-2014 American Community Survey, Table B17024, Children Under 6-Years Old Living in Households Under the 100% Federal Poverty Level in Vermont.* Available from http://vermontinsights.org/5-years-old-and-under-living-below-100-percent-federal-poverty-level.

**16** Ibid

Data Note

This report provides the denominator estimate of 7,167 VT children under 6 years of age who are living at or below 100% FPL. The numerator is the number of children enrolled in Early Head Start or Head Start for the FFY 2016. 1,447 (October 1–September 30). The result as a percentage is:

20.60% = 1,447/7,167 x 100%

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**18** Vermont Agency of Human Services Department for Children and Families Child Development Division. (June 30, 2016). *Children's Integrated Services Semi-Annual Report July 1, 2015–December 31, 2015.* Waterbury, VT.

**19** Vermont Agency of Human Services Department for Children and Families Child Development Division. (2014). *List of Programs Awarded a Strengthening Families Child Care Grant.* Retrieved from http://dcf.vermont.gov/sites/dcf/files/CDD/Docs/2014_List_of_Strengthening_Families_Grantees.pdf.

**20** *Testimony to Legislative Panel on Child Protection.* (July 23, 2014). (Testimony of Vermont Agency of Human Services Department for Children and Families Commissioner Dave Yacovone).

**21** The Annie E. Casey Foundation. (2016). *Kids Count: Data Book, State Trends in Child Well-Being, p. 30.* Retrieved from http://www.aecf.org/m/resourcedoc/aecf-the2016kidscountdatabook-2016.pdf.

**22** US Census Bureau. (2014). *Table HI05, Health Insurance Coverage Status and Type of Coverage by State and Age for All People, American Community Survey.* Available from https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html

**23** Vermont Agency of Human Services Department of Health. (2009-2013). *Low Birth Weight (Less than 2,500 Grams/5.5 Pounds) Babies Born by Vermont Resident Mothers, by Geography and Year.* Available from http://vermontinsights.org/low-birth-weight-babies.

**Figure 4: Low birth weight births in Vermont and the U.S., 2009-2013**

Data Note:

Step 1: Go to http://vermontinsights.org/low-birth-weight-babies, table view

Step 2: Select geography = Vermont statewide

Step 3: Select years 2009–2013

Step 4: Select filter option

Step 5: Get Vermont results from table

Step 6: Go to http://www.cdc.gov/nchs/products/nvsr.htm for comparable US results

**24** Martin, J., Hamilton, B., Ventura, S., Osterman, M., , Wilson, E., Kirmeyer, S., & Mathews, T.J., Wilson, E.(2011). *Births: Final Data for 2009, 60*(1). Division of Vital Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_01.pdf.

**25** Martin, J., Hamilton, B., Ventura, S., Osterman, M., Wilson, E., & Mathews, T.J. (2012). *Births: Final Data for 2010, 61*(1). Division of Vital Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf

**26** Martin, J., Hamilton, B., Ventura, S., Osterman, M., & Mathews, T.J. (2013). *Births: Final Data for 2011, 62*(1). Division of Vital Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

**27** Martin, J., Hamilton, B., Osterman, M., Curtin, S., & Mathews, T.J. (2013). *Births: Final Data for 2012, 62*(9). Division of Vital Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf.

**28** Martin, J., Hamilton, B., Osterman, M., Curtin, S., & Mathews, T.J. (2015). *Births: Final Data for 2013, 64*(1). Division of Vital Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf.

**29** Vermont Agency of Human Services Department of Health. (2009-2013). *Low Birth Weight (Less than 2,500 Grams/5.5 Pounds) Babies Born by Vermont Resident* Mothers, by Geography and Year* [Narrative section]. Available from http://vermontinsights.org/low-birth-weight-babies.

**30** Centers for Disease Control and Prevention. (2016). ChildVaxView, *Vermont 2009-2015*. Retrieved from https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/.

**31** Vermont Agency of Human Services Department of Health. (2012). *State Assessment Plan: Healthy Vermonters 2020.* Retrieved from http://healthvermont.gov/hv2020/documents/hv2020_report_full_book.pdf.

**32** Centers for Disease Control and Prevention. (2016). *Vermont 2009-2015.* ChildVaxView. Retrieved from https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/.

**33** Center for Disease Control and Prevention. (2009 - 2015). *Vermont Children, Ages 19-35 Months, Receiving the Full Series of Recommended Vaccines (4:3:1:4:3:1:4)* [Narrative Section]. Available from http://vermontinsights.org/children-19-35-months-receiving-full-recommended-vaccine-series.

**Figure 5: Children in Vermont receiving full series of recommended vaccines, age 19-35 months, 2009-2015**

Data Notes

The Vermont Department of Health publishes the 4:3:1:4:3:1:4 full series of recommended vaccines in their annual Immunization report to the Legislature in January. This full series represents the following vaccines and doses:

- 4+ DTaP: 4 or more doses of diphtheria, tetanus and pertussis vaccine
- 3+ Polio: 3 or more doses of poliovirus vaccine
- 1+ MMR: 1 or more dose of a measles, mumps, rubella vaccine
- 4+ Hib: 4 or more doses of Haemophilus influenza type b vaccine
- 3+ HepB: 3 or more doses of hepatitis B vaccine
- 1+ Var: 1 or more doses of varicella vaccine
- 4+ PCV: 4 or more doses of pneumococcal conjugate vaccine

The National Immunization Survey (NIS) is a large, ongoing phone survey of immunization coverage among US pre-school children (19 through 35 months old).

The NIS provides current, household, population-based, state and local area estimates of vaccination coverage among children and teens using a standard survey methodology. The surveys collect data through telephone interviews with parents or guardians in all 50 states, the District of Columbia, and some US territories. Landline and cell phone numbers are randomly selected and called to enroll one or more age-eligible children or teens from the household. The parents and guardians of eligible children are asked during the interview for the names of their children's vaccination providers and permission to contact them. With this permission, a questionnaire is mailed to each child's vaccination provider(s) to collect the information on the types of vaccinations, number of doses, dates of administration, and other administrative data about the health care facility.

Margin of error (MOE) is a measure of the possible variation in the percent estimates. The following table includes the margin of error for the 2015 estimate:

| Percent 19–35 Months Vermont Children Receiving Full Series of Recommended Vaccines | | | | |
|---|---|---|---|---|
| Year | VT | Margin of Error | US | Margin of Error |
| 2015 | 76% | ± 5.9 | 72% | ± 1.4 |

To determine if these two values—2015 Vermont and US percent of 19–35 months children receiving full series of recommended vaccines—were statistically significant, the following formula was used:

$$\left|\frac{\hat{X}_1 - \hat{X}_2}{\sqrt{SE_1^2 + SE_2^2}}\right| > Z_{CL}$$

$\hat{x}_1$ (76%) and $\hat{x}_2$ (72%) are the percent estimates while SE1 and SE2 are the standard errors for each of the estimates. To calculate the standard error for each estimate, the MOE was divided by 1.960 (the value for 95% confidence interval).

$SE_1 = 5.9\%/1.960$

$SE_2 = 1.4\%/1.960$

The critical value ($Z_{CL}$) was set at 1.960 to determine if one can reject, with 95% confidence, the assumption that the differences in estimated percentages between the two values were due to sampling or some other measurement error. Plugging the values into the formula resolves to 1.0309, which is less than the critical value of 1.960. The above assumption can be accepted. Thus, the two values, VT and US percent of 19–35 months children receiving full series of recommended vaccines, was not statistically significant.

**34** Vermont Agency of Human Services Department of Health. (July 2016). *Neonates Exposed to Opioids in Vermont, Vermont Uniform Hospital Discharge Data Set.* Retrieved from http://healthvermont.gov/research/documents/opioids_neonate_exposure.pdf.

**Figure 6: Delivery rate of infants with NAS per 1,000 live births, Vermont residents at Vermont hospitals compared to US**

Data Notes

The data analysis used the Vermont Uniform Hospital Discharge Data Set (VUHDDS) and was limited to discharges of live born (diagnosis code of V3) Vermont residents at Vermont hospitals, excluding transfers. Opioid exposed infants were identified by any mention of ICD-9 CM diagnosis code 779.5 or 760.72. Live born infants weighing less than 1500 grams or missing birth weight were excluded from all analyses.

**35** Johnston, A. (Producer). (2015). Children born to opioid- dependent parents. [Presentation to: Joint Legislative Child Protection Oversight Committee]. Retrieved from http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/Child%20Protection%20Oversight/October%2020/W~Anne%20Johnston%20MD~Children%20born%20to%20opioid-dependent%20parents~10-20-2015.pdf.

**36** Vermont Agency of Human Services Department of Health. (1997-2013). *Pregnant Vermont residents who smoked during their pregnancy in Vermont by geography and year* [Narrative Section]. Available from http://www.vermontinsights.org/smoking-during-pregnancy.

**37** Vermont Agency of Human Services Department of Health. (2016). Vermont PRAMS Data Briefs. Retrieved from http://healthvermont.gov/research/PRAMS/PRAMSDataBriefs.aspx#top.

**38** Vermont Agency of Human Services Department of Health. (2016). *2013 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2013_PRAMS_overview.pdf.

**39** Vermont Agency of Human Services Department of Health. (2015). *2012 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2012PRAMSoverview.pdf.

**40** Vermont Agency of Human Services Department of Health. (2013). *Vermont PRAMS Data Brief: 2011 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2013-07-262011VermontPRAMSHighlights.pdf.

**41** Vermont Agency of Human Services Department of Health. (2012). *Vermont PRAMS Data Brief: 2010 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2012-08-24Highlights2010.pdf.

**42** Vermont Agency of Human Services Department of Health. (2011). *Vermont PRAMS Data Brief: 2009 Vermont PRAMS Facts.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2011-09-23FactSheet09.pdf.

**Figure 7: Tobacco use and pregnancy, Vermont 2009–2013**

Data Note:

Vermont PRAMS, the Pregnancy Risk Assessment Monitoring System, is a project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The data are collected via surveys mailed to a random sample of Vermont mothers 2–6 months after they have given birth. Vermont PRAMS began collecting data in 2001.

The data regarding women who smoked in their 3 months before pregnancy who tried one or more smoking cessation strategies were not collected by Vermont PRAMS before 2012.

**43** Vermont Agency of Human Services Department of Health. (2016). Vermont PRAMS Data Briefs. Retrieved from http://healthvermont.gov/research/PRAMS/PRAMSDataBriefs.aspx#top.

**44** Vermont Agency of Human Services Department of Health. (2016). *2013 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2013_PRAMS_overview.pdf.

**45** Vermont Agency of Human Services Department of Health. (2015). *2012 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2012PRAMSoverview.pdf.

**46** Vermont Agency of Human Services Department of Health. (2013). *Vermont PRAMS Data Brief: 2011 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2013-07-262011VermontPRAMSHighlights.pdf.

**47** Vermont Agency of Human Services Department of Health. (2012). *Vermont PRAMS Data Brief: 2010 Vermont PRAMS Highlights.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2012-08-24Highlights2010.pdf.

**48** Vermont Agency of Human Services Department of Health. (2011). *Vermont PRAMS Data Brief: 2009 Vermont PRAMS Facts.* Retrieved from http://healthvermont.gov/research/PRAMS/documents/2011-09-23FactSheet09.pdf.

**Figure 8: Alcohol use and pregnancy Vermont, 2009-2013**

**49** Vermont Agency of Human Services Department of Health. (2014). Health Department's '049' Campaign = Zero Alcohol for Nine Months of Pregnancy [Press release]. Retrieved from http://healthvermont.gov/news/2014/090814_049.aspx.

**50** Bright Futures/American Academy of Pediatrics. (2016). *Recommendations for Preventive Pediatric Health Care*. Retrieved from https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

**51** Barry, S.E., Karlsson, L.H., Richardson, S.V., Willis, R., & Pellegrino, C. (2015). *CHAMP 2014 Network Data Summary Report: 39 Practices.* Vermont Child Health Improvement Program (VCHIP), University of Vermont, College of Medicine. Retrieved from http://contentmanager.med.uvm.edu/docs/champnetworkreport2014/vchip-documents/champnetworkreport2014.pdf?sfvrsn=2.

**52** Help Me Grow Vermont. (2016). *Report Card (September 2015-June 2016).* Retrieved from http://cdn.buildingbrightfutures.org/wp-content/uploads/2016/07/HMG-report-card-Sept-1-Jun-30-2016-7-25-16.pdf.

**53** University of Vermont Larner College of Medicine. (2016). *Vermont Child Health Improvement Program, Universal Developmental Screening.* Retrieved from http://www.med.uvm.edu/vchip/universaldevelopmental.

**54** University of Vermont Larner College of Medicine. (2016). *Vermont Child Health Improvement Program, Child Health Advances Measured in Practice (CHAMP).* Retrieved from http://www.med.uvm.edu/vchip/champ.

**55** Hunger Free Vermont. (n.d.). *For Students Who Qualify for Reduced-Price Meals, Back-to-School Means Lunch at No Charge.* South Burlington, VT. Retrieved from http://www.hungerfreevt.org/images/stories/schoolmealsvt/pdf/Enrollment_Participation_and_Revenu/Elimination_of_Redu_Price/article_free_lunch_for_reduced_price_students.pdf.

**56** Vermont Agency of Education. (December 2014). *Child Nutrition Policy and Administration.* Retrieved from http://education.vermont.gov/student-support/nutrition/school-programs/community-eligibility-program.

**57** Kids Count Data Center, Annie E. Casey Foundation. (2008-2016). *Children Receiving 3SquaresVT (SNAP), Vermont.* Available from http://datacenter.kidscount.org/data/tables/8183-children-receiving-3squaresvtsnap?loc=47&loct=2#detailed/2/any/false/1491,1443,1218,1049,995/any/15680.

**58** Vermont Agency of Human Services Department for Children and Families. (October 2015). *Income Guidelines for 3SquaresVT (Oct 2015).* Retrieved from http://dcf.vermont.gov/benefits/3SquaresVT/income-guidelines.

**59** Vermont Agency of Human Services Department for Children and Families. (2016). 3SquaresVT. Retrieved from http://dcf.vermont.gov/benefits/3SquaresVT/.

**60** Kids Count Data Center, Annie E. Casey Foundation. (2011-2015). *Students enrolled in the free and reduced price school meals program.* Available from http://datacenter.kidscount.org/data/tables/8185-students-enrolled-in-thefree-reduced-price-school-meals-program?loc=47&loct=2#detailed/2/any/false/1539,1381,1246,1124,1021/any/16703.

**Figure 9: Students enrolled in free and reduced-price school meals program in Vermont, 2011/2012 – 2015/2016**

Data Notes

Data represents eligibility and enrollment in October of the school year shown. School years are indicated by the fall term of the school year, for example, 2013–2014 data is represented as 2013.

Percent of Vermont students enrolled in the free & reduced price school meals program is defined as the number public school children approved for free and reduced price school meals in public schools offering the National School Lunch Program, as percent of total public school student enrollment. Eligibility is based on household income. Children are eligible for free school lunches if their household income does not exceed 130% of the federal poverty threshold, and children are eligible for reduced-price lunch if their family income falls between 130%–185% of the federal poverty threshold. This data is inclusive of both categories. Beginning in the 2013 school year, meals in the reduced-price category are reimbursable to schools and are available at no-cost to students.

**61** Vermont Agency of Human Services Department of Health. (2016). Understanding Child Abuse in Vermont. Retrieved from http://healthvermont.gov/dvsv/ca_about.aspx.

**62** Child Welfare Information Gateway. (2013). *Long-Term Consequences of Child Abuse and Neglect.* Retrieved from https://www.childwelfare.gov/pubPDFs/long_term_consequences.pdf.

**63** Centers for Disease Control and Prevention. (2016). Child Abuse and Neglect: Consequences. Retrieved from http://www.cdc.gov/violenceprevention/childmaltreatment/consequences.html.

**64** Vermont Agency of Human Services Department for Children and Families. (2016). *Outcomes for Vermonters (January 2016).* Retrieved from http://dcf.vermont.gov/sites/dcf/files/DCF/budget/DCF-Outcomes.pdf.

**65** Vermont Agency of Human Services Department for Children and Families Family Services Division. (2012-2014). *Point-in-Time Rate of Children and Youth (per 1,000) in DCF Custody, by Geography and Year.* Available from http://vermontinsights.org/point-in-time-rate-children-in-dcf-custody.

**Figure 10: Rate of Vermont Children Under Age 9 (per 1,000 children) in Protective Custody, 2012–2014**

Data Notes

Rates for the number of children and youth in Vermont's Department for Children and Families' (DCF) custody were calculated using the following formula:

*[(Point-In-Time Count of Children Under Age 9 in DCF Custody statewide) / (Population Count for Children Under Age 9 in Vermont)] * 1,000*

Point-in-time counts represent all children and youth (unique counts) who are in DCF custody on the last day of the fiscal year (September 30th) from the DCF Adoption and Foster Care Analysis and Reporting System (AFCARS) dataset.

Tip: Select geography for Vermont AHS Districts at Vermont Insights, http://vermontinsights.org/point-in-time-rate-children-in-dcf-custody. This report will include already aggregated age groups for Vermont.

**66** Ibid

**Figure 11: Rate of Vermont Children Under 3 Years (per 1,000 children) in Protective Custody, 2012–2014.**

Data Notes:

Rates for the number of children and youth in Vermont's Department for Children and Families' (DCF) custody were calculated using the following formula:

[(Point-In-Time Count of Children Under 1 years + 2 years + 3 years of age in DCF Custody statewide) / (Population Count for Children Under 1 years + 2 years + 3 years of age in Vermont)] * 1,000

Point-in-time counts represent all children and youth (unique counts) that are in DCF custody on the last day of the fiscal year (September 30th) from the DCF Adoption and Foster Care Analysis and Reporting System (AFCARS) dataset.

Tip: Select geography for Vermont Statewide at Vermont Insights, http://vermontinsights.org/point-in-time-rate-children-in-dcf-custody. Download Under 1 years, 2 years, 3 years ages. This report will provide the counts for both the numerator and denominator for the formula noted above.

**67** Vermont Victim Assistance Academy. (n.d.). *VVAA Chapter 16: Child Victimization.* Retrieved from http://www.ccvs.state.vt.us/sites/default/files/resources/VVAA%20Ch%2016%20%20Child%20Victimization.pdf.

**68** Vermont Agency of Human Services, Department of Health Maternal and Child Health Division and Department for Children and Families Child Development Division. (2015). *Improving Outcomes for Vermont Children and Families through Evidence Based Home Visiting (EBHV) Programs.* Waterbury, VT.

**69** Ibid

**70** Vermont Head Start State Collaboration Office (VHSSCO). (2016).

**71** US Census Bureau. (2014). *2010-2014 American Community Survey, Table B23008, Children 5-Years Old and Under with all Parents in Labor Force.* Available from http://www.vermontinsights.org/5-years-old-and-under-all-parents-in-labor-force.

**72** Ibid

**Figure 12: Children in Vermont with all available in the labor force, 2012-2014**

**73** Vermont Agency of Human Services Department for Children and Families Child Development Division. (2016). *STep Ahead Recognition System (STARS) Monthly Report.* Available from http://vermontinsights.org/stars-monthly.

Data Notes

Step 1: Go to http://vermontinsights.org/stars-monthly, table view

Step 2: Select geography = Vermont statewide

Step 3: Select data range June 2016 to June 2016

Step 4: Select all license type

Step 5: Select all Star ratings

Step 6: Select filter option

Step 7: Result will be under table column "Provider Count (All)"

**74** Let's Grow Kids. (June 2016). Stalled at the Start: Vermont's Child Care Challenge; An Analysis of the Supply of and Demand for Regulated Infant and Toddler care in Vermont. Burlington, VT. Retrieved from http://www.letsgrowkids.org/sites/default/files/Stalled%20at%20the%20Start%20Report%20Updated%20June%202016_0.pdf.

**75** Vermont Agency of Education and Vermont Agency of Human Services Department for Children and Families Child Development Division. (2014). *Implementation Guidance of Act 166 of 2014.* Retrieved from http://cdn.buildingbrightfutures.org/wp-content/uploads/2014/12/AHS-and-AOE-Implementation-Guidance-on-Act-166-of-2014-Part-1-20141223.pdf.

**76** Murphy, R., & Riegel-Garrett, M. (June 20, 2016). Vermont State Board of Education Retreat June 20, 2016: Act 166. South Burlington, VT.

**77** Zero to Three. (2010). *Resources & Services: Parenting Resource - How to Choose Quality Child Care.* Retrieved from https://www.zerotothree.org/resources/84-how-to-choose-quality-child-care.

**78** Vermont Agency of Education. (2016). *Ready for Kindergarten! Survey: 2015-2016, Fast Facts.* Retrieved from http://education.vermont.gov/sites/aoe/files/documents/edu-early-education-ready-4-kindergarten-survey-fast-facts.pdf.

**79** Ibid

**Figure 13: Kindergarten readiness in Vermont 2015-2016 school year**

**80** Ibid

**81** Quality Rating and Improvement System (QRIS): National Learning Network. (2016). *Current Status of QRIS in States.* Retrieved from http://qrisnetwork.org/sites/all/files/maps/QRISMap.pdf.

**82** Vermont Agency of Human Services Department for Children and Families Child Development Division. (2016). *STep Ahead Recognition System (STARS) Monthly Report.*
Available from http://vermontinsights.org/stars-monthly.

**Figure 14: Regulated child care, early learning, and afterschool programs participating in STARS, 2010-2016**

Data Notes:

Step 1: Go to http://vermontinsights.org/stars-monthly, table view

Step 2: Select geography = Vermont statewide

Step 3: Select data range June 2009 to June 2009

Step 4: Select all license type

Step 5: Select Star ratings 1-5

Step 6: Select filter option

Step 7: Scroll through the table results to find the result = Provider Percent (Stars selected) which is equivalent to percent participation of all licensed and registered providers in STep Ahead Recognition System (STARS) monthly report.

**83** US Census Bureau. (2010-2015). *American Community Survey 1-Year Estimates, Selected Economic Characteristics, Table DP03.* Available from http://factfinder.census.gov/.

**Figure 15: Vermont Families with Income Below Federal Poverty Level, 2009-2015**

Data Notes:

Margin of error (MOE) is a measure of the possible variation in the percent estimates. The MOE, by year, for all families with related children under 5 years in Vermont is in the table below.

| Year | Vermont all families with related children under 5 years only | Margin of Error |
|---|---|---|
| 2015 | 9.6% | +/- 4.1% |
| 2009 | 19.0% | +/- 4.9 % |

To determine if there was a statistically significant difference in the downward trend for this poverty measure between 2009 and 2015, the following formula was used:

$$\left|\frac{\hat{X}_1 - \hat{X}_2}{\sqrt{SE_1^2 + SE_2^2}}\right| > Z_{CL}$$

$\hat{x}_1$ (9.6%) and $\hat{x}_2$ (19.0%) are the percent estimates while SE1 and SE2 are the standard errors for each of the estimates. To calculate the SE for each estimate, the MOE was divided by 1.960 (the value for 95% confidence interval).

$$SE_1 = 4.1\%/1.960$$

$$SE_2 = 4.9\%/1.960$$

The critical value ($Z_{CL}$) was set at 1.960 to determine if one can reject, with 95% confidence, the assumption that the differences in estimated percentages between the two years was due to sampling or some other measurement error. Plugging the values into the formula resolves to 2.420, which is greater than the critical value of 1.960. The above assumption can be rejected. Thus, the decrease in the percent of families in Vermont with related children under 5 years living in poverty between 2009 and 2015 was statistically significant.

**84** National Center for Children in Poverty. (2016). *Topics: Child Poverty.* Retrieved from http://www.nccp.org/topics/childpoverty.html.

**85** Ibid

**86** US Census Bureau. (2009 & 2015). *American Community Survey 1-Year Estimates, Selected Economic Characteristics, Table S0201.* Available from http://factfinder.census.gov/.

**Figure 16: Median Household Income in Vermont, 2009-2015**

Data Notes:

Household income includes the income of the householder and all other persons 15 years and older in the household, whether or not they are related to the householder. It is inflation adjusted.

The median household income is the amount which divides the income distribution into two equal groups, half having income above that amount, and half having income below that amount.

The percent change is the extent to which something gains or loses value. This measure is useful to help people understand changes in a value over time. The percent change formula:

Step 1: Calculate the change by subtracting the old value from the new value

Step 2: Divide that resulting number by the old value, resulting in a decimal value

Step 3: Convert the decimal value into a percentage by multiplying it by 100

**87** U.S. Census Bureau. (2015). *1 Year American Community Survey, Median Family Income in the Past 12 Months, Table B19119.* Available from http://factfinder.census.gov/.

**88** Vermont Legislative Joint Fiscal Office. (2015). *Basic Needs Budgets and the Livable Wage.* Retrieved from http://www.leg.state.vt.us/jfo/reports/2015%20Basic%20Needs%20Budget%20report%2001-15-2015.pdf.

**89** U.S. Census Bureau. (2010 & 2015). *1-Year American Community Survey, Selected Economic Characteristics, Table S0201.* Available from http://factfinder.census.gov/.

**Figure 17: Vermont Households Paying 30% or More on Mortgage or Rent, 2010 vs 2015**

Data Notes:

See data notes for **Figure 15: Vermont Families with Income Below Federal Poverty, 2009-2015**
for the definition of statistical terms and acronyms used in this section.

Percent of Vermont households paying 30% or more of their income on their mortgage

To determine if there was a statistically significant difference in the downward trend for the percent of Vermont Households Paying 30% or more of their income on their mortgage between 2010 and 2015, the following formula was used:

$$\left|\frac{\hat{X}_1 - \hat{X}_2}{\sqrt{SE_1^2 + SE_2^2}}\right| > Z_{CL}$$

$\hat{x}_1$ = 38.8% and $\hat{x}_2$ = 34.7%. To calculate the SE for each estimate, each percent's MOE was divided by 1.960.

$SE_1$ = 1.7%/1.960

$SE_2$ = 1.6%/1.960

$Z_{CL}$ was set at 1.960 to determine if one can reject, with 95% confidence, the assumption that the differences in estimated percentages between the two years were due to sampling or some other measurement error. The formula returned a value of 2.889, which is greater than the critical value of 1.960. The above assumption can be rejected. Thus, the decrease in the percent of Vermont households paying 30% or more of their income on their mortgage between 2010 and 2015 was statistically significant.

Percent of Vermont households paying 30% or more of their income on their rent

To determine if there was a statistically significant difference in the downward trend for the percent of Vermont households paying 30% or more of their income on rent between 2010 and 2015, the same formula as above was used.

$x_1$ = 54.2% and $x_2$ = 50.5%. To calculate the SE for each estimate, each percent's MOE was divided by 1.960.

$SE_1$ = 1.7%/1.960

$SE_2$ = 1.6%/1.960

$Z_{CL}$ was set at 1.960 to determine if one can reject, with 95% confidence, the assumption that the differences in estimated percentages between the two years was due to sampling or some other measurement error. The formula returned a value of 1.335, which is less than the critical value of 1.960. The above assumption cannot be rejected. Thus, the decrease in the percent of Vermont households paying 30% or more of their income on their mortgage between 2010 and 2015 was not statistically significant.

**90** Vermont Agency of Human Services Department of Housing and Community Development. (2015). *2015-2020 Vermont Housing Needs Assessment.* Retrieved from http://accd.vermont.gov/sites/accdnew/files/documents/Housing/H-Research-VTHousingNeedsAssessment.pdf.pdf.

**91** Vermont Agency of Human Services Department for Children and Families. (2016). *Housing Opportunity Grant Program (HOP) Vermont Annual Report - State Fiscal Year 2016.* Retrieved from http://dcf.vermont.gov/sites/dcf/files/OEO/Docs/HOP-Final-Report.pdf.

**92** Ibid

**Figure 18: Children in Vermont's publicly funded homeless shelters, 2002-2016**

**93** Vermont Legislative Joint Fiscal Office. (January 15, 2015). B*asic Needs Budgets and the Livable Wage.* Vermont Basic Needs Budget for a family of 4 (Ed.). Retrieved from http://www.leg.state.vt.us/jfo/reports/2015%20Basic%20Needs%20Budget%20report%2001-15-2015.pdf.

**Figure 19: 2014 Vermont Basic Needs Budget**

Data Notes:

A basic needs budget is a market-based analysis that accounts for estimated monthly living expenses in Vermont. This is the 11th edition of the Vermont Basic Needs Budgets and Livable Wage Report, submitted every 2 years to the state Legislature. The 12th edition will be released January 2017.

Two health and dental care expenses were used in the Basic Needs Budget report. The employer-sponsored health and dental coverage budget was used for this table.

**94** Vermont Agency of Human Services Department for Children and Families Child Development Division. (2014). *2014 Vermont Child Care Market Rate Survey.* Retrieved from http://dcf.vermont.gov/sites/dcf/files/CDD/Reports/Market_Rate_Survey_Report_2014.pdf.

**95** Vermont Agency of Human Services Department for Children and Families Child Development Division. (2016). *Outcomes for Vermonters.* Retrieved from http://dcf.vermont.gov/sites/dcf/files/DCF/budget/DCF-Outcomes.pdf.

**96** US Department of Health & Human Services. (2016). *US Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs.* Retrieved from https://aspe.hhs.gov/poverty-guidelines.

**97** Vermont Agency of Human Services Department for Children and Families Child Development Division. (August 21, 2016). *Child Care Financial Assistance Rate Schedule and Sliding Fee Scale.* Retrieved from http://dcf.vermont.gov/cdd/ccfap-policies.

**98** U.S. Census Bureau. (2015). *1-Year American Community Survey, Median Family Income in the past 12 months, Table B19119,* Available from http://factfinder.census.gov/.

**99** Vermont Agency of Human Services Department for Children and Families Child Development Division. (2014). *2014 Vermont Child Care Market Rate Survey.* Retrieved from http://dcf.vermont.gov/sites/dcf/files/CDD/Reports/Market_Rate_Survey_Report_2014.pdf.

**100** Vermont Agency of Human Services Department for Children and Families Child Development Division. (August 21, 2016). *Child Care Financial Assistance Rate Schedule and Sliding Fee Scale.* Retrieved from http://dcf.vermont.gov/cdd/ccfap-policies.

**101** US Department of Health & Human Services. (2016). *US Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs.* Retrieved from https://aspe.hhs.gov/poverty-guidelines.

**Figure 20: Share of household income spent on child care costs, 2016**

Data Notes:

Step 1: The family size was selected to be a family of four with two full-time working parents with an infant and preschooler attending child care full-time.

Step 2: Four income levels were selected for a family size of four: 100%, 200%, and 300% of the FPL and the state median income. For example:

The family at 100% of the FPL = $24,300

Step 3: The total annual cost of child care for the family was calculated using the 2014 (most recent) statewide median market rate survey results:

Total cost = $20, 280

($205/week for infant care + $185/week for preschool care) x 52 weeks/year

Step 4: The total annual child care financial assistance received for the family using the August 2016 Child Care Financial Assistance Child Care Provider Rate Schedule and the Child Care Financial Assistance Sliding Fee Scale was calculated for each of the income levels and two scenarios:

Scenario 1: family uses a center that does not participate in the STARS program and receives the base rate

Income at 100% of FPL or less ($24,300) receives 100% of financial assistance

Licensed center not participating in STARS:

Total subsidy = $14,760

($150.36 + $133.49) x 52 weeks/year

Scenario 2: family uses a center participating in STARS, has a 4-star rating, and receives a higher rate than the base rate

Income at 100% of FPL or less ($24,300) receives 100% of financial assistance, licensed center participating in STARS and has a 4-star rating:

Total subsidy = $19,188

($195.47 + $173.53) x 52 weeks/year

Step 5: The difference between the total subsidy and total child care cost for each of the income levels and two scenarios was calculated. For example:

Scenario 1: Difference between total cost and the total subsidy 100% of financial assistance, licensed center not participating in STARS:

Difference = $5,519.80 ($20, 280 - $14,760)

Scenario 2: Difference between total cost and the total subsidy 100% of financial assistance, licensed center participating in STARS and has a 4-star rating:

Difference = $1,092 ($20, 280 - $19,188)

Step 6: The family's percent share of income directed towards child care for each of the income levels and two scenarios was calculated. For example:

Scenario 1: Percent share for the family with income at 100% of FPL or less, licensed center not participating in STARS

Family's percent share = 22.7% [($5,519.80/$24,300) x 100%]

Scenario 2: Percent share for the family with income at 100% of FPL or less, licensed center participating in STARS and has a 4-star rating:

Family's percent share = 4.5% [($1,092/$24,300) x 100%]

**102** US Census Bureau and Vermont Department of Health. (2014). *Population Counts in Vermont by Geography, Year, and Age.* Available from http://vermontinsights.org/population-by-age.

**Regional Indicator: Child Population Under Age 9 Percent Change Between 2001 and 2014**

Data Notes:

The population counts for children under age nine were calculated using the following three steps. First, at the table view for http://vermontinsights.org/population-by-age, the variables geography equals Agency of Human Services districts, the year equals 2014, and the age groups—under 1 to 2, 3–5 and 6–8 years—were selected. Then, the table results were filtered and the total population counts for children eight years and under were found in the highlighted rows for each of the 12 AHS districts under column selected ages. The final step was then to map the AHS districts to BBF regions as follows:

| AHS district | BBF region |
|---|---|
| Middlebury | Addison |
| Bennington | Bennington |
| St. Johnsbury | Caledonia-Southern Essex |
| Barre | Central Vermont |
| Burlington | Chittenden |
| St. Albans | Franklin Grand Isle |
| Morrisville | Lamoille Valley |
| Hartford | Northern Windsor and Orange |
| Newport | Orleans and Northern Essex |
| Rutland | Rutland |
| Brattleboro | Southeast Vermont |
| Springfield | Springfield Area |

**103** Vermont Agency of Human Services Department for Children and Families Child Development Division. (2016). *STep Ahead Recognition System (STARS).* Available from http://vermontinsights.org/stars-monthly.

**Regional Indicator: STARS Participation Number and Percent Participation for 2010 and 2016**

Data Notes:

The following seven steps were followed to determine the percent change in participation in STARS between Year 2010 and Year 2016 for each BBF region.

Step 1: The http://vermontinsights.org/stars-monthly, table view was obtained

Step 2: The first AHS region, Middlebury was selected

Step 3: The date range Month YEAR to Month YEAR was selected

Step 4: All license type was selected

Step 5: The STARS level 1–5 was selected

Step 6: The filter option was selected

Step 7: The table results Provider Percent (stars selected) was identified which represented the percent participation of all licensed and registered providers in STARS

Steps 1–7 were repeated for the date range Month YEAR to Month YEAR

The percent change is the extent to which something gains or loses value.

This measure is useful to help people understand changes in a value over time. The percent change formula used was:

Step 1: Calculated the change by subtracting the old value from the new value

Step 2: Divided that resulting number by the old value, resulting in a decimal value

Step 3: Converted the decimal value into a percentage by multiplying it by 100

All AHS region results were then mapped to their respective BBF regions.

**104** Centers for Disease Control and Prevention. (2016). *Vermont 2009–2015.* ChildVaxView. Available from https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/.

**Statewide Indicator: Immunization Rates for 13-35 month olds between 2013 and 2015**

Data Notes:

Statewide information is from the CDC's ChildVax Information System. Region-specific information comes from the Vermont Immunization Registry Program and is detailed in the following citation.

**105** Center for Disease Control and Prevention. (2009 - 2015). *Vermont Children, Ages 19-35 Months, Receiving the Full Series of Recommended Vaccines (4:3:1:4:3:1:4)* [Narrative Section]. Available from http://vermontinsights.org/children-19-35-months-receiving-full-recommended-vaccine-series.

**Regional Indicator: Immunization Rates: Percent (and Count) of 19-35 month olds Immunized for 2013 and 2015**

Data Notes:

This vaccine coverage information reflects immunizations recorded in the Vermont Immunization Registry, and may not give a complete picture of vaccine coverage. Currently, about 80% of VT medical practices serving children enter or send data to the Registry.

Completed series means 4:3:1:4:3:1:4 series (DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine).

The number of children for the state level is provided by the Census. The county-level and district-level totals are from the Vermont Immunization Registry.

2013 and 2014 vaccine coverage information for White River Junction and Springfield AHS districts are underreported due to a significant portion of the population seeking care in New Hampshire. During this time period, Vermont Immunization Registry did not capture immunizations received outside of the state. In 2015, the Vermont Immunization Registry received immunization records for VT residents who seek care in New Hampshire at Dartmouth Hitchcock Medical Center and associated practices, but acknowledge that the registry may have incomplete records for those individuals who may otherwise seek care out of state.

**106** Vermont Agency of Human Services Department for Children and Families. (2014). *Point-In-Time Rate of Children and Youth (per 1,000) in the Vermont Department for Children and Families (DCF) Custody by Geography, Age, and Year.* Available from http://vermontinsights.org/point-in-time-rate-children-in-dcf-custody.

**Regional Indicator: Children in DCF Custody: Point-in-time rates (and counts) under age 9 (per 1,000) for 2012 and 2014**

Data Notes:

Rates for the number of children and youth in Vermont's Department for Children and Families' (DCF) custody were calculated using the following formula:

*[(Point-In-Time Count of Children 8 years and Under in DCF Custody AHS Region) / (Population Count for Children 8 Years and Under in AHS Region)] * 1,000*

Point-in-time counts represent all children and youth (unique counts) who are in DCF custody on the last day of the fiscal year (September 30) from the DCF Adoption and Foster Care Analysis and Reporting System (AFCARS) dataset.

Tip: Select geography for Vermont AHS Districts at Vermont Insights, http://vermontinsights.org/point-in-time-rate-children-in-dcf-custody. This report will include already aggregated age groups for Vermont.

**107** Vermont Agency of Education. (2016). *Ready For Kindergarten! Survey (R4K!S) 2015–2016: Report to Supervisory Unions/Supervisory Districts.* Retrieved from http://education.vermont.gov/sites/aoe/files/documents/edu-early-education-ready-for-kindergarten-report.pdf.

**Regional Indicator: 2015-2016 R4K! Survey Findings: Percent of all students ready for kindergarten**

Data Notes:

The data from the online pdf report was converted to an excel file. The BBF-Vermont Insights Program mapped each of the each SU/SD results to their respective BBF Region. Some SUs/SDs overlap BBF regions. In those instances, the SU/SD results were assigned to each of the overlapping regions. The following is a table of all results by region.

| BBF region | SU/SD | 2015–2016 R4K!S all students percent ready |
|---|---|---|
| Addison | Addison Central SU | 86.89% |
| Addison | Addison Northeast SU | 78.75% |
| Addison | Addison Northwest SU | 87.50% |
| Bennington | Battenkill Valley SU | 95.65% |
| Bennington | Southwest Vermont SU | 68.23% |
| Bennington | Bennington Rutland SU | 87.50% |
| Caledonia & Southern Essex | Blue Mountain SD | 92.86% |
| Caledonia & Southern Essex | Caledonia Central SU | 92.00% |
| Caledonia & Southern Essex | Caledonia North SU | 85.00% |
| Caledonia & Southern Essex | Essex Caledonia SU | 81.58% |
| Caledonia & Southern Essex | St Johnsbury SD | 81.43% |
| Caledonia & Southern Essex | Orange East SU | 74.49% |
| Central Vermont | Barre SU | 61.90% |
| Central Vermont | Montpelier SD | NO RESULTS – did not participate |
| Central Vermont | Orange North SU | 78.38% |
| Central Vermont | Washington Central SU | 86.27% |
| Central Vermont | Washington Northeast SU | 80.00% |
| Central Vermont | Washington South SU | 96.00% |
| Central Vermont | Washington West SU | 92.93% |
| Central Vermont | Orange Southwest SU | 87.27% |
| Chittenden | Burlington SD | 75.98% |
| Chittenden | Chittenden Central SU | 80.20% |
| Chittenden | Chittenden East SU | 92.37% |
| Chittenden | Chittenden South SU | 95.10% |
| Chittenden | Colchester SD | 81.55% |
| Chittenden | Essex Town SD | 93.23% |
| Chittenden | Milton SD | 81.63% |
| Chittenden | South Burlington SD | 91.54% |

| Chittenden | Winooski SD | 79.55% |
|---|---|---|
| Franklin & Grand Isle | Franklin Central SU | 86.75% |
| Franklin & Grand Isle | Franklin Northeast SU | 85.15% |
| Franklin & Grand Isle | Franklin Northwest SU | 77.30% |
| Franklin & Grand Isle | Franklin West SU | 84.17% |
| Franklin & Grand Isle | Grand Isle SU | 83.08% |
| Lamoille Valley | Lamoille North SU | 82.93% |
| Lamoille Valley | Lamoille South SU | 88.35% |
| Lamoille Valley | Orleans Southwest SU | 78.21% |
| Northern Windsor & Orange | Hartford SD | 68.32% |
| Northern Windsor & Orange | Orange East SU | 74.49% |
| Northern Windsor & Orange | Orange Southwest SU | 87.27% |
| Northern Windsor & Orange | Orange Windsor SU | 71.43% |
| Northern Windsor & Orange | Rivendell Interstate SD | 94.87% |
| Northern Windsor & Orange | Sau 70 | 83.33% |
| Northern Windsor & Orange | Windsor Central SU | 91.38% |
| Northern Windsor & Orange | Windsor Northwest SU | 91.67% |
| Northern Windsor & Orange | Windsor Southeast SU | 66.99% |
| Orleans & Northern Essex | Essex North SU | 76.92% |
| Orleans & Northern Essex | North Country SU | 74.86% |
| Orleans & Northern Essex | Orleans Central SU | 81.94% |
| Rutland | Addison Rutland SU | 77.22% |
| Rutland | Bennington Rutland SU | 87.50% |
| Rutland | Rutland Central SU | 92.54% |
| Rutland | Rutland City SD | 61.24% |
| Rutland | Rutland Northeast SU | 85.58% |
| Rutland | Rutland South SU | 81.13% |
| Rutland | Rutland Southwest SU | 84.21% |
| Rutland | Windsor Central SU | 91.38% |
| Rutland | Windsor Northwest SU | 91.67% |
| Rutland | Two Rivers SU | 83.08% |
| Southeast VT | Windham Southeast SU | 76.02% |
| Southeast VT | Windham Southwest SU | 100.00% |
| Southeast VT | Windham Central SU | 87.32% |
| Southeast VT | Windham Northeast SU | 87.50% |
| Springfield | Bennington Rutland SU | 87.50% |
| Springfield | Springfield SD | 86.67% |
| Springfield | Two Rivers SU | 83.08% |
| Springfield | Windham Central SU | 87.32% |
| Springfield | Windham Northeast SU | 87.50% |
| Springfield | Windsor Central SU | 91.38% |
| Springfield | Windsor Southeast SU | 66.99% |

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Vermont Insights is the go-to data hub for child, family, and community data in Vermont. Data is vetted from trusted sources, analyzed and organized in one comprehensive, publicly-available platform, providing a one-stop data shopping experience for data seekers.

By helping to raise the visibility of key issues affecting Vermont's children and families, Vermont Insights is making it easier for leaders, policymakers, families and communities to use data to make informed policy and program decisions.

Learn more about young children, families, and communities in Vermont at: **www.vermontinsights.org**

Vermont Insights is a program of Building Bright Futures and a partner of the Vermont State Data Center at the University of Vermont Center for Rural Studies.

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