Report to The Vermont Legislature

Agency of Human Services Strategic Framework

2020 Report to the Legislature

In Accordance with Act 72, Sec. E.300.8, An act relating to making appropriations for the support of government.

Submitted to: House Committee on Appropriations
House Committee on Corrections and Institutions
House Committee on Government Operations
House Committee on Health Care
House Committee on Human Services
House Committee on Judiciary

Senate Committee on Appropriations
Senate Committee on Government Operations
Senate Committee on Health and Welfare
Senate Committee on Institutions
Senate Committee on Judiciary

Submitted by: Michael K. Smith, Secretary, Agency of Human Services

Report Date: January 15, 2020

BACKGROUND AND OVERVIEW

Act 72 of 2019, an act relating to making appropriations for the support of government, included language that required the Agency of Human Services to identify emerging trends and develop a strategic plan for addressing the most challenging issues the Agency anticipates Vermont will face within the next five to 10 years:

(b) The Agency of Human Services shall analyze and determine:

(1)(A) projected changes in the demographics of the State;

(B) increasing or emerging trends that affect or are likely to affect human services needs in the State, including social risks to be addressed; and

(C) anticipated demands on the budgets of the Agency and its departments;

(2) whether current targeted investments are successfully achieving their anticipated outcomes and, if not, why not;

(3) the appropriate programmatic, policy, and organizational reconfigurations necessary to achieve the Agency's strategic plan; and

(4) such other issues as the Agency determines are relevant to developing and achieving the Agency's strategic plan.

The legislative language aligns with Governor Scott's State Strategic Plan that was developed in 2018 for FY2019–FY2023 and established a common vision for all state agencies: to ensure that Vermont's economy is growing faster than the costs of living; our state is measurably more affordable each year for families and businesses; and we are meeting our obligation to protect the most vulnerable.

REPORT APPROACH

Framework to Guide Decision-Making

The Agency of Human Services has designed a five-year strategic framework that establishes the ongoing ability to:

- Engage in longer-term planning, thinking ahead about the challenges facing Vermont and Vermonters, anticipate implications for how our organization and services are defined
- Establish goals and strategies to guide decisions in our day-to-day work as well as systemwide reform efforts to effectively address dynamic and changing conditions across the state
- Make informed decisions regarding the extent to which specific policy, program, organizational, and system change proposals advance identified goals and strategies
- Communicate a comprehensive, actionable, and cohesive vision as one agency

This strategic framework is different from a strategic plan. It is not project nor initiative specific. Rather, our approach is to develop a strategic framework that will guide decision-making across the entire organizational system.

Detailed plans surface in the form of legislative proposals, technology proposals, facility proposals, contracts, grants, and reform designs from all across the organization at different moments in time. We want all staff and decision-makers to understand what are the common goals that we need any new plan or project to advance, and to ensure they do that.

This strategic framework approach is designed to give leaders at every level of the organization a guide in preparing, prioritizing, and shaping policy, program innovation, and projects to ensure they align with the Agency's vision.

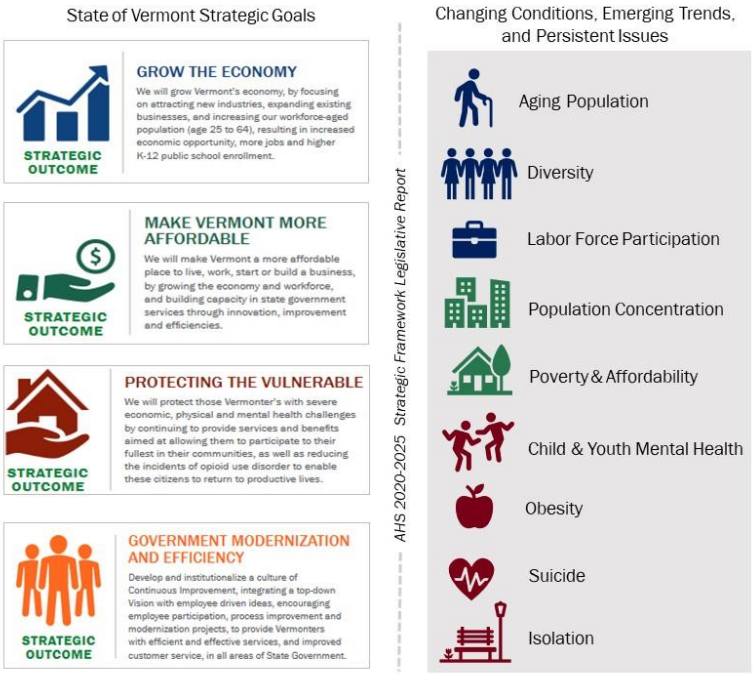
DEVELOPMENT PROCESS

The development process included engaging with over 300 staff, representing all six departments, from all twelve districts across the state. Leadership from every division of each department contributed information and insight that is the foundation of this plan. Reports and analyses published in the last two years were instrumental in weaving together the challenges faced by different parts of the Agency of Human Services system and connecting them with recommendations for change.

CHANGING DEMOGRAHPICS, EMERGING TRENDS, AND PERSISTENT ISSUES

The Agency of Human Services analyzed "projected changes in the demographics of the State; [and] increasing or emerging trends that affect or are likely to affect human services needs in the State, including social risks to be addressed."

Synthesizing data from national and international research, Vermont data and published reports, as well as internal stakeholder analyses and consideration of potential impacts to the health and human services system, the following changing demographics, emerging trends, and persistent issues surfaced as our focus, aligned with the Governor's Strategic Priorities:



The following section of the report outlines an overview of the conditions, trends, and issues as well as key facts related to each.

Aging Population

Vermont is among the oldest states in the nation, second only to Maine. And, like the country, Vermont is getting older – a trend driven by the aging of the baby boom generation. With the lowest birth rate of any state, Vermont's few new babies can't slow down the aging of the state's population.

Key Facts:

- Vermont has the second-oldest median age of any state. Only Maine is older (United State Census Bureau 2019).
- Vermont has the lowest birth rate of any state (Centers for Disease Control and Prevention 2018).

- Recent single-year-of-age projections by Vermont's Joint Fiscal Office show there will be more than twice the number of Vermonters age 76-83 in 2030 as in 2015. To look at it another way, in 2030, there will be 127,586 Vermonters age 70 or older – 57,000 more than there were in 2015 (Vermont Legislative Joint Fiscal Office 2019).

Diversity

The racial and ethnic makeup of the Vermont population has shifted since 2000, with growth in the number and proportion of people who are Black or African American, Asian, two or more races, and who are Hispanic or Latino. These changes are large relative to the previous size of each sub-population – for instance, the number of people who are Black or African American and living in Vermont more than doubled between 2000 and 2017. At the same time, this change and other changes in Vermont's racial and ethnic makeup have been small relative to Vermont's overall population. The same is true of the growth in Vermont's foreign-born population.

Members of each of these groups will interact with the Agency of Human Services in very different ways. Rather than considering how increasing diversity will impact human services needs overall, it may be more useful to think about the needs of specific populations, one at a time.

Key Facts:

- The 2017 American Community Survey 5-year estimate showed Vermont's total population was 624,636. Of that total, 94.5% of people were white only, 1.3% were black or African-American only, 0.3% were American Indian or Alaska Native only, 1.5% were Asian only, 0% were Native Hawaiian or other Pacific Islander only, 0.4% were a single other race, and 1.9% were two more races. 1.8% of Vermont's population were Hispanic or Latino (identifying as any race). Comparisons to the American Community Survey 2012 5-year estimate and the 2000 Census are given in Table 1 below.

Table 1: Population by Race and Ethnicity

Vermont Population, by Race and Ethnicity			
	American Community Survey 5-Year Estimates		Census
	2017	2012	2000
Total Population	624,636	625,498	608,827
White only	94.5%	95.3%	96.8%
Black or African American only	1.3%	0.9%	0.5%
American Indian or Alaska Native only	0.3%	0.3%	0.4%
Asian only	1.5%	1.3%	0.9%
Native Hawaiian and Other Pacific Islander only	0%	0%	0%
Some other race only	0.4%	0.3%	0.2%
Two or more races	1.9%	1.9%	1.2%
Hispanic or Latino (of any race)	1.8%	1.5%	0.9%

- The proportion of Vermont's population that is foreign born has grown over time. In 1990 the proportion was 3.1%, in 2000, 3.8%, and in 2017 4.5% (Migration Policy Institute 2019).

- Some immigrants to Vermont are refugees and many are not. Since 1994, 6,340 refugees, representing 29 countries, have arrived in Vermont (Vermont Department of Health 2018).

- Vermont's foreign-born population is more racially and ethnically diverse than its native-born population. In 2017 this population was 57.3% white only, 8.2% black or African American only, 0.6% American Indian and Alaska Native, 30.6% Asian, 0% Native Hawaiian and other Pacific Islander, 1.8% some other race, 1.4% two or more races, and 9.5% Hispanic or Latino of any race (Migration Policy Institute 2019).

- By region of origin, Vermont's foreign-born population includes 15,702 people from Europe and Canada, 9,466 people from South and East Asia, 2,311 people from Sub-Saharan Africa, and 1,601 people from South America. (Radford and Noe-Bustamante 2019) Another sources looks at the top countries of origin for immigrants living in Vermont, which were: Bosnia-Herzegovina (8.1%), Mexico (6.2%), Germany (5.1%), and Nepal (4.5%) (American Immigration Council 2017).

- In 2016, 40,788 people in Vermont (6.7% of the population) were native-born Americans who had at least one immigrant parent (American Immigration Council 2017).

- Most immigrants (89.5%) report speaking English "well" or "very well." Immigrants living in Vermont are as likely as native-born Vermont residents to have a college degree or more (36.9%) but are also more likely to have less than a high-school diploma (15.1% vs. 8.0%) (American Immigration Council 2017).

Population Concentration

More Vermonters are choosing to live in its most populous area. Vermont's one metropolitan area has Burlington (including South Burlington) as its principal city and includes Chittenden, Franklin, and Grand Isle Counties. Chittenden County has grown 12.3% since 2000 and the neighboring counties of Franklin and Lamoille have also grown. All other counties have remained about the same or have lost population (Brighton, Kleppner and Trenholm 2019). This makes Vermont's most rural counties even more sparsely populated.

The counties that added population – Chittenden, Franklin, and Lamoille – are also Vermont's youngest counties. Migration and births are making Vermont's youngest counties even younger relative to the state's median age. Meanwhile, Vermont's oldest counties are getting even older (Vermont Legislative Joint Fiscal Office 2018).

Key Facts

- From 2000 to 2018, Chittenden County, Franklin County, and Lamoille County each grew more than 8%. The populations of Addison County, Caledonia County, Grand Isle

County, Orange County, Orleans County, and Washington County have remained about the same size. Bennington County, Rutland County, Windham County, and Windsor County have each lost more than 3% of their population (Brighton, Kleppner and Trenholm 2019).

- Vermont's older counties are getting older and its younger counties are getting younger: every Vermont county (except Washington County) with a median age older than the state average in 2008-2012 was even older in 2012-2016. Every count with a median age below the state average in 2008-2012 was further below the state average in 2012-2016 (Vermont Legislative Joint Fiscal Office 2018).

Labor Force Participation

The proportion of Vermonters participating in the labor force is the lowest it has been since 1980. Labor force participation counts both people who are employed and people who are unemployed (meaning they do not have a job, have actively looked for a job in the past four weeks, and are currently available for work). People who are not included in the labor force include people who are retired, people who choose not to work, people who are unable to work, and people who want to work but who have not looked in the past four weeks.

Labor force participation is expected to continue declining in Vermont, as more baby boomers retire. A low labor force participation rate can impact the overall health of the economy. It also makes it difficult for businesses, non-profits, and the state to find staff, impacting their ability to provide necessary services for individuals and communities.

Key Facts:

- Labor force participation in Vermont was at 65.1% in October 2019. This is the lowest rate since 1980 (U.S. Bureau of Labor Statistics 2019).

- Vermont's unemployment rate is very low, at 2.2% in October 2019. An alternative unemployment rate, the U-6 measure, which includes people who indicate they want and are available for work and have looked in the recent past ("marginally attached workers") and people who want and are available for full-time work but are currently working part-time was 5.3% measured over a year ending in the 3rd quarter of 2019 (Vermont Department of Labor 2019).

- National labor force participation among the prime working age population (25 to 54) declined two percentage points between the end of the 2007-2009 recession and 2015, from 83% to 81%. The Congressional Budget office projects the labor force participation rate for this population will remain about the same between 2018 and 2027 (Congress of the United States Congressional Budget Office 2017).

- Seventy-four percent of prime working-age (25-54) women participated in the United States labor force in 2017 – the same percentage as in 1990. Meanwhile, prime working-age men's participation in the labor force declined five percentage points, from 93% to 88% (Congress of the United States Congressional Budget Office 2017). Prime working-

age men's participation in the labor force in Vermont has stayed relatively stable.

- In October 2019, prime working-age Vermonters participated in the labor force at the following rates (these are twelve-month moving averages from the U.S. Census): Women, 25-34 79.1%; Women 35-44 81.3%; Women 45-54 83.3%; Men 25-34 90.7%; Men 35-44 91.3%; Men 45-54 89.5%.

Poverty & Affordability

More than one in ten Vermonters live in poverty. For one person, the federal poverty threshold is $12,490. For a family of three, the poverty threshold is $21,330.

Poverty is more common in some parts of Vermont than others. Rates are lowest, around 8%, in Grand Isle, Addison, and Franklin counties and highest, around 15%, in Essex, Caledonia, and Orleans counties.

14.5% of children in Vermont live in poverty, and 16.5% of children under age five. "Deep poverty" means living in a household with income below 50% of the poverty threshold. For a family of three, this means up to $10,665 a year. For families with little or no other income, the Reach Up program provides income up to just below this threshold. In 2018, 4.7% of Vermont residents lived in deep poverty, a proportion about the same as in 2017 and significantly lower than in 2016 (U.S. Census Bureau 2019) (U.S. Census Bureau 2018). In 2018, 6% of children in Vermont lived in deep poverty – that's 7,000 children (Annie E. Casey Foundation 2019).

Many Vermonters who interact with Agency of Human Services programs are living in poverty, but others have resources above the federal poverty threshold. For example, adults with household income up to 138% of the federal poverty threshold qualify for Medicaid, while children in households with income up 317% of the federal poverty threshold qualify for Dr. Dynasaur. 3SquaresVT (called SNAP nationally and formerly known as food stamps) is available to households making less than 185% of the federal poverty threshold and to some people whose income is higher and who are over age 60 or have a disability. LIHEAP fuel assistance is also available to people making less than 185% of the federal poverty threshold. In general (excluding Dr. Dynasaur), benefits levels tend to decline for households between 100% and 200% of the poverty threshold (Minimum Wage and Benefits Cliff Study Committee 2017). The "benefits cliff" describes the sudden loss of benefits resulting from increased income, a phenomenon that can disincentivize people at certain income levels from earning more. Vermont has made changes that mitigate the effects of the benefits cliff, but has not completely removed it (The University of Vermont Legislative Research Service 2017).

Key Facts:

- The percentage of Vermonters in poverty in 2018 was 11%, measured by the American Community Survey (United States Census Bureau 2019). Since 2015 Vermont's poverty rate has varied within a fairy narrow range, from a low of 10.4% to a high of 11.3%. (Federal Reserve Bank of St. Louis 2019).

- Poverty thresholds are based on income, not including non-cash benefits like Medicaid, food stamps, or public housing. (United States Census Bureau 2019) The thresholds vary by household size and composition. In 2019 the poverty threshold for one person was $12,490. For a family of three living together it was $21,330. For a family of four living together the threshold was $25,750 (U.S. HHS Office of the Assistant Secretary for Planning and Evaluation 2019).

- Rates of poverty are lowest in Grand Isle (8.2%), Addison (8.3%), and Franklin (8.9%) counties and highest in Essex (14.6%), Caledonia (15%), and Orleans (15.2%) counties (U.S. Census Bureau 2019).

- The rate of people in poverty in Vermont was the same in 2018 as it was in 1996. This rate was more than in the years 1997 – 2008, and less than in the years 2009 – 2014.

- Women are more likely than men to live in poverty. Single women without children have a poverty rate of 11.4%, more than three times higher than single men without children (3.5%).

- Single parents are much more likely than married parents to be in poverty, and more women than men are solely responsible for the care of minor children. Single female householders with minor children have a poverty rate of 36.7%, compared to 16% for their male counterparts. The rate is even higher for women with children under five are at home, 47.1% (Change the Story 2019).

- Thirty-eight percent of Vermont children under age six live in households at less than 200% of the poverty level. In two counties, Essex and Orleans, this rate is above 50% (Vermont Insights 2019).

- Of children who were persistently poor, meaning they spent more than half their lives from birth to age 17 in poverty, only 34% are consistently working or in school from ages twenty-five to thirty. And less than half (45%) are never poor between the ages of twenty-five and thirty (Ratcliffe and Cancian Kalish 2017).

- Social sciences research shows that children who grow up in poverty experience negative psychological and social consequences throughout their lives. In childhood the effects include more antisocial conduct, such as aggression and bullying, and more feelings of helplessness. Children living in poverty have more chronic physiological stress and more short-term spatial memory deficits than children who are not in poverty. A recent study suggests many of these effects continue into adulthood, with adults who grew up in poverty showing worse short-term memory, more helplessness behaviors, greater (self-rated) tendency to argue or be impatient, and more physiological wear and tear from cumulative exposure to stressors as measured by blood pressure, stress hormones, and body mass index (Evans 2016).

- The 2019 Point in Time Count of homelessness in Vermont found that 1,089 Vermonters are literally homeless, a decrease of 15.5% from 2018. The number of unsheltered people was 114, a decrease of 39% from the previous year. 251 children eighteen and under

were part of the homeless population, the same proportion as in previous years. Eight percent of the homeless population is Black or African American and 4% is Hispanic or Latino, compared with 1.3% and 1.8% of Vermont's overall population respectively. (Vermont Coalition to End Homelessness & Chittenden County Homeless Alliance 2019).

- A single parent living with their children in Vermont must make $39.10 per hour (in urban areas) or $32.19 in rural areas to meet their family's basic needs (Vermont Legislative Join Fiscal Office 2019).
- In Vermont, 38,592 households and 67,195 individuals received 3SquaresVT as of August 2019. People are eligible for 3SquaresVT at 185% of the poverty level.
- Thirty percent of Vermont homeowners and 51% of Vermont renters pay more than 30% of their wages for housing; 12% of owners and 25% of renters pay more than 50% citation.
- The percentage of Vermont households spending more than 35% of their income on housing costs increased sharply from 21.4% in 2000 to 29.5% for the period 2007-2011, then decreased slightly to 28.3% for the period 2012-2016. Vermont has had a consistently higher percentage of households spending more than 35% than the United States overall (Vermont State Data Center / Center for Rural Studies 2018).
- Child care is among the basic needs many Vermonters struggle to afford. It is the largest expense category in the basic needs budget for some household types. The average weekly out of pocket cost of center-based child care for a preschooler is $46.31 for people who receive Child Care Financial Assistance and are at 100% of the federal poverty level, and $219.96 for people who have no help paying. The average weekly cost for home-based child care is $37.77 for people who have help paying and $158.92 for people who have no help paying. This is unaffordable for many families. The high cost of child care keeps some parents, especially mothers, out of the workforce (Schochet 2019).
- Forty percent of Vermonters say they would have a problem meeting an unexpected $1,000 expense (VPR & Vermont PBS 2019).
- Net out-migration from the state is highest among Vermonter taxpayers who make between $25,000 and $75,000 a year and are between the ages of 45 and 64. The rate of out-migration for this group, as a percentage of total taxpayers, is the forth worst in the country (Vermont Legislative Joint Fiscal Office 2019).

Child & Youth Mental Health

Young people in Vermont are experiencing more depression and anxiety than in the past. These young people are suffering now and are at risk for poor mental and physical health, unemployment, and other difficult life circumstances in the future. They are also at greater risk of dying by suicide than their peers.

In Vermont, depression prevalence has increased among high schoolers over five years, so that a quarter now report having experienced a depressive episode in the past year.

Rates of anxiety-related emergency department visits by pediatric patients are increasing in Vermont.

In addition to the documented increases in mental illness among Vermont adolescents, there is emerging evidence that children and adolescents who interact with state services have more acute needs than in the past. While the population under age eighteen has been decreasing, more children are engaging with specialized child care services and more require residential care (DCF, DAIL, and DMH). The fastest growing group of children in DCF custody is ages birth to five.

Key Facts:

- In 2017, 25% of Vermont high schoolers reported having had a period of two or more weeks in the past year where they felt so sad or hopeless almost every day that they stopped doing some of their usual activities, an increase from 2015 (24%) and from ten years ago (21% in 2007). 19% of middle schoolers reported the same experience, this rate has not changed significantly in the past five years (Vermont Department of Health 2018).
    - In both middle school and high school, rates are significantly higher for students of color than for white, non-Hispanic students. Rates are about twice as high for female students as for male students. Compared with heterosexual students, rates are nearly three times higher for LGB middle schoolers and nearly four times higher for LGBT high schoolers (note that the middle school YRBS asked students if they were lesbian, gay, or bisexual (LGB) while the high school YRBS asked students if they were lesbian, gay, bisexual, or transgender (LGBT))
- The rate of emergency department visits by Vermont pediatric patients for anxiety disorders nearly doubled between 2009 and 2017, from 3.7 per 1000 to 7.2 per 1000. Rates of visits for mood disorders also grew, from 6.1 per 1000 in 2009 to 8.4 per 1000 in 2017 (Vermont Department of Health and Vermont Department of Mental Health 2019).
- Across ages, the length of stay in Emergency Departments for mental illness has increased at a much greater rate than the number of visits. Based on discussions with stakeholders, The Department of Mental Health reports that wait times in Emergency Departments for mental health-related visits are a "significant access to care concern and an unresolved issue for Vermonters of all ages" (Department of Mental Health 2019).
- Vermont data shows that females have more pediatric Emergency Department claims for anxiety and mood disorders and for suicide and self-inflicted injury. Males have almost twice the number of pediatric Emergency Department claims for attention deficit, conduct, and disruptive behavior disorders as females (Vermont Department of Health and Vermont Department of Mental Health 2019).

- Nationally, the rate of 18-25 year-olds with serious mental illness, including anxiety and depression, grew significantly every year from 2008 through 2017. In 2017, 7.5% of 18-25 year-olds had a serious mental illness. More than half (57.4%) received treatment, while 42.6% had no treatment (McCance-Katz 2018).

- Between 2005 and 2014, the percentage of adolescents in the United States who had experienced a diagnosed major depressive episode in the last twelve months increased from 8.7% to 11.3% (Mojtabai, Olfson and Han 2016).

- As of 2011-2012, current anxiety was more common than current depression among children ages 6-17 in the United States (4.7% vs. 2.7%). The same study showed that national prevalence of current anxiety in children grew significantly from 2007 – 2011/2012 (Bitsko, et al. 2018).

- An estimated 31.9% of adolescents 13-18 years old have experienced any anxiety disorder during their lifetime and 8.3% have severe impairment (National Institute of Mental Health n.d.).

- The number of children engaging with specialized childcare services increased from 1332 in state fiscal year 2014 to 2159 in state fiscal year 2017, a 62% increase (State Interagency Team 2020). Specialized childcare serves three populations – children and families with open cases with the Family Services Division of DCF, families experiencing significant stress, and children with special physical, medical, behavioral, or development needs.

- The number of children in residential care (DCF, DAIL, DMH) increased from 252 in 2014 to 385 in 2018, a 53% increase (State Interagency Team 2020).

- There is emerging evidence from the Success Beyond Six program that children's mental health needs are more complex and acute today than they have been in the past. While there are fewer children in Vermont, the number of students Success Beyond Six serves has stayed about the same. The cost of serving that same number of students has increased significantly, for reasons including student need.

- In 2019, 498 children ages 0-5 were in DCF custody, compared to 222 in 2010. The total number of children and youth ages 0-17 in DCF custody was 1,282 in 2019 compared to 898 in 2010 (State Interagency Team 2020). The biggest increases in children ages 0-5 in DCF custody occurred between 2013 and 2014 (288 – 397) and between 2014 and 2015 (397 – 547). The children who entered custody during those years – and the many others whose families experienced similar stressors that did not lead to DCF involvement – will be entering elementary school or are in elementary school now (Department of Mental Health 2020).

- The National Survey of Children's Health (NSCH) indicates that nearly one in six children in Vermont experience three or more types of adversity (Department of Mental Health 2020). The most common types of adversity experienced by Vermont children are divorce of a parent or guardian (25%), living in a household where it is hard to cover the

basics, like food or housing (22%), living with someone with an alcohol or drug problem (13%), and living with someone who is severely depressed, mentally ill, or suicidal (10%) (State Interagency Team 2020). The more adverse experiences a child has, the greater their risk for a range of negative health and life outcomes, including poor mental health (U.S. Department of Health and Human Services 2019).

Obesity

Obesity is a major public health problem in every state in the nation, at every age. The increase in obesity over time in Vermont is dramatic: in 1990, one in 10 adults was obese. In 2018, the rate was approaching one in three. The growth in obesity among adults has slowed a bit in recent years, but obesity rates among 10-17 year-olds jumped 3% in just two years. Rates of obesity among high-schoolers have not changed much, so it's likely the increase is concentrated among children in the middle grades.

Childhood obesity puts young people at risk for high blood pressure, type 2 diabetes, heart disease, and asthma. And young people who are obese are five times more likely to be obese as adults, leading to serious health conditions throughout their lives.

Key Facts:

- Obese children and adolescents are five times more likely to be obese as adults, compared to children and adolescents who are not obese (Simmonds, et al. 2015).
- High childhood BMI is associated with an increase in adult diabetes, coronary heart disease, and a range of cancers (Llewellyn, et al. 2015).
- Well over a quarter of Vermont adults have obesity – 27.5%. Vermont is less obese, among adults, than all but seven states and the District of Columbia.
- The National Survey of Children's Health, in which parents or caregivers are asked to report their child's weight and height, found that obesity in 10-17 year-olds in Vermont rose from 11.8% in 2016 to 13.0% in 2017 to 15.1% in 2018 (Robert Wood Johnson Foundation 2019).
- Rates of obesity among 2-4 year-old WIC participants in Vermont have grown gradually, from 12.5% in 2000 to 14.5% in 2016 (Robert Wood Johnson Foundation 2019).
- Obesity varies somewhat by race and ethnicity in Vermont. People who identify as Asian/Pacific Islander are much less likely to be obese or overweight that the state average and people who are Native American/Alaska Native more likely to be obese (Vermont Department of Health 2018). Compared with race and ethnicity, socioeconomic status is a better predictor of obesity.

Suicide

Death by suicide is a devasting event for families and communities, and it is happening more and more frequently in Vermont. Rates of suicide deaths in the United States are growing, and rates

in Vermont are growing faster. The people in Vermont who are most vulnerable to suicide are men, especially older men, and they tend to use firearms to take their lives.

There are also sub-populations that are at greater risk of suicide, and may require targeted suicide-prevention strategies. These populations include veterans, who die from suicide at much higher rates than the general population. LGBT youth are also vulnerable, demonstrated by the one-third of LGBT high-school students who have made a suicide plan in the past year.

Key Facts:

- From 2005-2017 the U.S. rate of death by suicide increased 31%, while the Vermont rate increased 45% (Delany 2019).
- Most suicide deaths in Vermont are of older Vermonters. Men are four times more likely than women to die by suicide in Vermont. Firearms are the most common means, involved in 59% of deaths by suicide (Delany, Current Suicide Data in Vermont 2018).
- Twenty-five veterans died by suicide in Vermont in 2016. Ten veterans died by suicide in Vermont in 2017. This was a rate of 25.6 deaths per 100,000 veterans. Vermont veterans die by suicide at about the same rate as veterans nationally, and at a much higher rate than the general population (U.S. Department of Veterans Affairs 2017).
- One-third of LGBT high-schoolers made a suicide plan in the past twelve months, compared with 8% of heterosexual students (Vermont Department of Health 2018).
- In 2009, 1 in 1000 emergency department claims for Vermont pediatric patients had a primary diagnosis code of suicide and intentional self-inflicted injury. In 2017, the rate was 10 in 1000 (Vermont Department of Health and Vermont Department of Mental Health 2019).
- A 2019 article in JAMA Psychiatry found that "children of parents who use opioids may be at increased risk for suicide attempts" and "parental use of opioids was associated with a doubling of the risk of a suicide attempt by their offspring." The article suggests this association may be contributing to the time trend in adolescent suicidality (Brent, Hur and Gibbons 2019).

Isolation

Many people in Vermont are experiencing loneliness and isolation right now. The story of who is most vulnerable to loneliness is a complicated one.

Many studies show an inverse relationship between age and loneliness (Mullen, et al. 2019) (Kaiser Family Foundation 2018). However older people who *are* lonely and isolated may be especially vulnerable to compounding of that isolation through factors like retirement, death of a partner, hearing loss, living alone, and limited access to transportation. Older people who are isolated may also be more vulnerable to health problems and difficulty recovering from health events.

It's also easy to assume that rural life leads to greater isolation, but both national and Vermont data better support the opposite conclusion – that there is a richness in rural community life that leads to feelings of connectedness and wellbeing.

The populations most likely to be facing loneliness and isolation in Vermont today are adults 18-44, people who live in the more densely populated parts of the state, and people without a college education (VPR & Vermont PBS 2019). Loneliness can interact dangerously with mental health problems and substance use disorder in these populations. It is a risk factor in suicides and the other "deaths of despair" that are contributing to the recent increase in midlife mortality (Woolf and Schoomaker 2019). That increase is happening nationwide, and Vermont shows a larger increase than all but four other states.

Key Facts:

- Loneliness is more common among people with lower health status and loneliness is associated with use of health care, including primary care, emergency department or urgent care, and hospitalization (Mullen, et al. 2019).
- People with stronger social relationships were shown to have a 50% greater likelihood of survival compared with people with weaker social relationships in one meta-analytic review. This same review showed that social relationships were as influential on risk of death as smoking and alcohol consumption, and more influential than physical inactivity and obesity (Holt-Lunstad, Smith and Layton 2010).
- Reports of loneliness and social isolation are highest among people with one or fewer confidants, who have a mental health condition, who have a debilitating condition, who have lower income, who are single, divorced, separated, or widowed, or who have experienced three or more negative life events (Kaiser Family Foundation 2018).
- Loneliness is inversely associated with age and less common in people who are married and employed (Mullen, et al. 2019).
- In a recent survey of Vermont residents, 16% say they often or always feel isolated. Rates are highest among 18-44 year-olds, a full quarter of whom say they often or always feel isolated. People with a high school education or less are more likely to report often or always feeling isolated (23%) than people with some education beyond high school but no 4-year degree (13%) or people with a 4-year degree or higher (10%) (VPR & Vermont PBS 2019).

ANTICIPATED IMPACTS FOR THE HEALTH AND HUMAN SERVICES SYSTEM

The Agency of Human Services strives to improve the health and well-being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves.

What follows is a high-level analysis of current and anticipated impacts for the health and human services system across the changing demographics, emerging trends, and persistent challenges facing Vermonters explored in the previous section of this report. There are several interrelated

questions that the health and human services system will need to answer in order to be effective in our response to these changing conditions.

Anticipated Impacts and Critical Questions

- **Access to Appropriate Services**
    - How do we increase access to prevention, early intervention, and stabilization services at home and in the community and reduce use of emergency or higher-intensity, acute services?
    - How can we best ensure that people are supported and empowered through transitions into and out of services and different levels of care?

      (*Aging, Child and Youth Mental Health, Obesity, Suicide, Poverty & Affordability*)

- **Equitable Access to Basic Needs and Opportunities**
    - How do we support the individuals and families we work with across the health and human services system to reliably access basic needs and build financial security?
    - How can we support statewide efforts to grow the economy, increase wages and availability of employer benefits, and support parents earning income and providing care to children or parents?
    - How do we confront racial and other disparities (gender, age, ability, sexual orientation, class) in health outcomes?
    - How do we best understand and address policies or practices across our system that contribute to inequities in accessing care, justice, and opportunities for well-being?
    - How do we reduce the stigma associated with services and programming for mental health, financial assistance, benefits like food and fuel support, health conditions, and trauma to ensure that people access support for which they are eligible?

      (*Aging, Diversity, Labor Force Participation, Child and Youth Mental Health, Obesity, Suicide, Poverty & Affordability*)

- **Person-Centered, Trauma-Informed, and Resilience-Focused Approaches**
    - How can we shift the policies, practices, culture, and facilities that characterize our system of care to be trauma-informed?
    - How can we ensure that families are empowered to lead case planning efforts and have a voice in critical decisions?
    - How can we ensure that staff across the health and human services system are prepared to engage clients, community members, and deliver services in culturally competent ways?

- How can we ensure widespread application of strengths-based, multi-generational, and person-centered approaches to providing benefits and care?
- How can we be prepared to facilitate the participation of natural and community supports in case planning and through transitions in and out of periods of service engagement?

(*Aging, Diversity, Child and Youth Mental Health, Obesity, Suicide, Poverty & Affordability*)

- **Statewide Health Care and Caregiver Workforce**
  - How do we recruit and retain health care providers and support family caregivers that can support complex health and mental health needs to people across the lifespan?
  - How do we adequately support and retain a workforce that can provide holistic services, not just specialized services?
  - How can we support and retain a workforce that can deliver services and provide care to people at home?
  - How do we ensure training and professional development to support service and care providers to coordinate with others across the health and human services system?

(*Aging, Population Concentration, Diversity, Labor Force Participation, Child and Youth Mental Health, Obesity, Suicide, Poverty & Affordability, Isolation*)

- **Service System Capacity**
  - How do we ensure that providers in communities have capacity to deliver high quality services for people managing complex needs across the lifespan?
  - How do we ensure that our partners are supported by reliable financial and operational systems that reduce risk, ensure high quality, and increase opportunities for innovation?

(*Aging, Diversity, Child and Youth Mental Health, Obesity, Suicide, Poverty & Affordability*)

FACTORS FOR SUCCESS

As the Agency of Human Services continues to confront and innovate in response to the anticipated impacts and critical questions explored in the previous section, we will draw from principles of practice that we have understood from across the departments and districts to be effective.

Principles of Practice:

- Services should be strengths-based to meet people where they are (e.g., trauma-informed, culturally competent)

- Programs should be flexible to overcome obstacles that may present challenges to program engagement (e.g., transportation, child care, work or school hours)
- Case and care planning should be person-led and person-centered across the system of care, empowering individuals and families to set and adjust their goals
- Services and supports should be holistic, addressing needs in the context of individuals' and families' lives, and integrated to more efficiently administer benefits and supports
- Providers should be supported to collaborate across organizations in communities and utilize team-based approaches

These principles of practice can be applied across the health and human services system and advanced through local and central decisions made by the Agency of Human Services, and underpin the goals and strategies that are outlined in the section that follows.

GOALS AND STRATEGIES FOR THE HEALTH AND HUMAN SERVICES SYSTEM

Governor Scott set out three major priorities for the State of Vermont[1] and added an additional priority relative to efficient government

1. **Growing the Vermont economy**
   We will grow Vermont's economy, by focusing on attracting new industries, expanding existing businesses, and increasing our workforce-aged population (age 25 to 64), resulting in increased economic opportunity, more jobs and higher K-12 public school enrollment.
2. **Making Vermont more affordable**
   We will make Vermont a more affordable place to live, work, start or build a business, by growing the economy and workforce, and building capacity in state government services through innovation, improvement and efficiencies.
3. **Protecting the most vulnerable**
   We will protect those Vermonters with severe economic, physical and mental health challenges by continuing to provide services and benefits aimed at allowing them to participate to their fullest in their communities, as well as reducing the incidents of opioid use disorder to enable these citizens to return to productive lives.
4. **Modernize State Government.**
   Develop and institutionalize a culture of Continuous Improvement, integrating a top-down Vision with employee driven ideas, encouraging employee participation, process improvement and modernization projects, to provide Vermonters with efficient and effective services, and improved customer service, in all areas of Government.

As the Agency of Human Services analyzed changing conditions, trends, and persistent issues facing Vermont and synthesized the insights gathered from staff to understand goals and strategies that were emerging. The goals and strategies presented in this report are in direct alignment with the goals and strategies we had presented to Governor Scott in 2018.

[1] https://strategicplan.vermont.gov/

The following goals will guide AHS to "respond effectively to dynamic and changing societal needs" identified in this framework over the next five years. Each goal builds on the work done in 2018, with additional review of trends, discussion with each department and more than 300 staff in AHS districts across the state. Using these goals and strategies as guidance, AHS will evaluate and advance projects and initiatives across the organization that accomplish a shared vision.

The Agency of Human Services' three goals are:

Goal 1: **Deliver Effective & Coordinated Services**

Goal 2: **Leverage Resources & Data Across Our System**

Goal 3: **Encourage Systems Innovation & Continuous Improvement**

To work towards accomplishing each goal, strategies are outlined below that span the health and human services system:

Goal 1: Deliver Effective & Coordinated Services

Strategy 1.1: Ensure access to appropriate levels of care

- person and family-centered
- in the home and community
- in the least restrictive settings possible

Strategy 1.2: Improve flow across systems of care

- to facilitate smooth and supported transitions to different levels of care

Strategy 1.3: Coordinate care across programs and services

- to reduce duplication of efforts by participating individuals and families
- to maximize supports and benefits toward individuals' and families' goals

Strategy 1.4: Increase flexibility of services

- to meet individuals and families where they are and in a culturally competent way
- to support their goals holistically in the context of their lives and support systems

Goal 2: Leverage Resources & Data Across our System

Strategy 2.1: Share data and information

- through use of technology, clear policy, and common-sense procedures within the Agency of Human Services and with our partner organizations

Strategy 2.2: Harmonize program designs

- to reduce complexity and facilitate cross-program coordination
- to be able to use shared resources like technology and tools where it benefits clients and staff

Strategy 2.3: Increase use of shared resources

- to reduce duplicative spending (e.g., technology and data systems; facility operations and maintenance)
- to expand use of tools that work (e.g., forms, assessments)
- to create consistency and alignment across programs to clients and partners

Goal 3: Encourage Systems Innovation & Continuous Improvement

Strategy 3.1: Expand efforts to build workforce wellness and resilience

- to increase employee well-being and engagement, and retention
- to increase opportunities for professional development and career advancement

Strategy 3.1: Enhance processes for feedback across our system

- to learn and share about what works, challenges, and ideas for innovation
- to share accountability for results and be able to take action to improve

Strategy 3.2: Encourage collaborative continuous improvement

- with clients, staff, and partners to empower those with lived experience to influence change
- across the agency, community, and state to make a broader impact
- to reward critical thinking, creativity, and initiative to accomplish our mission

Strategy 3.3: Increase communication, transparency, and outreach

- so that that people understand our programs, services, and organization
- to ensure public awareness about changes, requirements, and new opportunities to increase multi-disciplinary dialogue, community, and connection across the service system

On the following page is a graphic visualization of the significant components of this strategic framework.

State of Vermont Strategic Goals

GROW THE ECONOMY

We will grow Vermont's economy, by focusing on attracting new industries, expanding existing businesses, and increasing our workforce-aged population (age 25 to 64), resulting in increased economic opportunity, more jobs and higher K-12 public school enrollment.

STRATEGIC OUTCOME

MAKE VERMONT MORE AFFORDABLE

We will make Vermont a more affordable place to live, work, start or build a business, by growing the economy and workforce, and building capacity in state government services through innovation, improvement and efficiencies.

STRATEGIC OUTCOME

PROTECTING THE VULNERABLE

We will protect those Vermonter's with severe economic, physical and mental health challenges by continuing to provide services and benefits aimed at allowing them to participate to their fullest in their communities, as well as reducing the incidents of opioid use disorder to enable these citizens to return to productive lives.

STRATEGIC OUTCOME

GOVERNMENT MODERNIZATION AND EFFICIENCY

Develop and institutionalize a culture of Continuous Improvement, integrating a top-down Vision with employee driven ideas, encouraging employee participation, process improvement and modernization projects, to provide Vermonters with efficient and effective services, and improved customer service, in all areas of State Government.

STRATEGIC OUTCOME

Changing Conditions, Emerging Trends, and Persistent Issues

- Aging Population
- Diversity
- Labor Force Participation
- Population Concentration
- Poverty & Affordability
- Child & Youth Mental Health
- Obesity
- Suicide
- Isolation

Impacts for Health & Human Services System

Across these changing conditions is an increasing need to focus system reforms on:

- Access to appropriate services
- Equitable access to basic needs and opportunities
- Person-centered, trauma-informed, and resilience-focused approaches
- Statewide health care and caregiver workforce
- Service system capacity

Factors for Success

- Strengths-based approaches that meet people where they are
- Program flexibility to increase engagement
- Person-led and person-centered care and case planning
- Holistic support and integrated services across sites and programs
- Provider collaboration and team-based approaches

2020-2025 Strategic Framework Goals

- Deliver Effective and Coordinated Services
- Leverage Data & Resources Across our System
- Encourage Systems Innovation & Continuous Improvement

GOALS, STRATEGIES, AND OPPORTUNITIES

For each of the goals and strategies named in this plan, there are associated opportunities – innovative ideas, and in some cases current practice, that arose from interviews with Agency of Human Services employees across the state, representing all six departments and twelve district offices.

Many of the opportunities identified would contribute to accomplishing more than one goal, and are included in multiple strategies below.

Over the next five years, Agency of Human Services leadership and staff in different divisions and units will be able to reference, interpret, and build on these opportunities in the context of their work and decision-making.

Recommendations for applying the strategic plan and associated procedures are described in the "Applying the Strategic Plan" section of this report.

Goal 1: **Deliver Effective & Coordinated Services**

Strategy 1.1	*Opportunities*
Ensure access to appropriate levels of care	• Develop and utilize common applications for services across program areas • Utilize person and family-led approaches to care/case planning • Utilize common assessments and screens • Maximize centralized intake and referral systems • Expand peer support and navigation programming • Amplify outreach and education efforts about available services, including cross-program "orientation" or informational sessions • Expand use of home visiting and home-based services • Expand early intervention and pre-crisis supports • Increase staff training to support people experiencing a crisis • Expand use of technology for distance interaction (e.g., telehealth, Skype) • Increase capacity for community-based crisis stabilization • Increase flexibility of services through non-categorical funding • Shift payment models to be value-based from fee-for-service • Encourage community innovation of local service systems • Improve more restrictive settings to be trauma-informed

Strategy 1.2	*Opportunities*
Improve flow across systems of care	• Strengthen relationships between service providers • Amplify outreach and education efforts about available services • Expand peer support and navigation programming • Enable data and information sharing across organizations • Encourage co-location of services and providers • Incent collaboration and shared accountability through grants • Maximize centralized referral and bed board systems • Review and recommend policy changes to prevent "cliffs" • Follow-up visits following transitions from care • Automatic re-enrollment or application for services upon reentering community from acute or restrictive environments • Encourage community volunteer supports where appropriate

Strategy 1.3	*Opportunities*
Coordinate care across programs and services	• Expand use of user-friendly online applications for all benefits • Transition to an integrated technology system for determining eligibility and enrolling individuals and families for multiple benefits at once • Develop relationships across program areas and organizations • Facilitate job shadows, site visits, and walk-throughs of partner programs and organizations for staff • Expand use of multi-disciplinary team-based care/case management approaches including natural supports • Increase capacity for non-categorical case coordinators to support individuals' and families' holistic case plans and teams • Increase capacity for system-wide navigators who can support individuals and families assess options and resources • Increase training, assistance, and implementation support for more coordinated processes • Utilize common assessments and screens • Utilize coordinated case/care plans to align actions and requirements to accomplish clients' goals • Enable data and information sharing across organizations • Encourage co-location of services and providers • Explore use of common scheduling tools for cross-program teams

	• Incent collaboration and shared accountability through grants

Strategy 1.4	*Opportunities*
Increase flexibility of services	• Increase involvement of natural supports for holistic case planning
	• Encourage co-location of services to reduce transportation burden
	• Coordinate case planning to align requirements for all program participation with person and family-centered goals
	• Increase use of neutral community site locations for visits and meetings, leveraging partnership and capacity building
	• Explore alternative operating hours and shift arrangements that increase flexibility for staff and clients
	• Expand use of technology for distance interaction (e.g., telehealth, Skype)
	• Expand the tools available to support staff doing home and community visits to process forms and communicate remotely
	• Explore options to increase flexible transportation for clients
	• Increase availability of discretionary funds and on-hand supplies
	• Increase flexibility of services through non-categorical funding
	• Shift payment models to be value-based from fee-for-service

Goal 2: **Leverage Resources & Data Across our System**

Strategy 2.1	*Opportunities*
Share data and information	• Increase training for staff and partners to appropriately share and protect client information
	• Utilize common information release forms to encourage coordinated case planning across AHS and community partner programs
	• Increase access to health and human services population trends and program data
	• Expand efforts to educate the public, partners, and policymakers about available data sources
	• Ensure use of consistent data management practices across the agency (data governance)

	• Develop and promote use of common data sharing agreements and simplified procedures for data matching and analysis across the system • Ensure new technology systems or applications enable data sharing and matching capabilities • Ensure new technology systems or applications collect, store, and manage data aligned with data policies • Utilize contract and grant agreements to outline expectations around data sharing and data management

Strategy 2.2	*Opportunities*
Harmonize program designs	• Increase continuous improvement and business process analysis training for staff and partners • Support continuous improvement projects that reduce complexity of important business processes to benefit clients, staff, and partners • Standardize business processes across programs to create consistency and efficiency for clients, staff, and partners • Utilize client, partner, and staff feedback to understand where there is opportunity to consolidate programmatic efforts in communities • Leverage grant agreements to support and facilitate consolidation of services in communities that would increase capacity and benefit clients

Strategy 2.3	*Opportunities*
Increase use of shared resources	• Increase use of common and holistic tools (applications, assessments, screenings, case plans) that facilitate multiple program objectives • Leverage partnerships to learn about, promote use of, or consolidate community-based offerings and opportunities for clients (e.g., classes) • Increase use of multi-disciplinary approaches to deliver integrated or coordinated services to individuals and families • Leverage staff in other program areas and community partners to identify opportunities, risks, and resources to holistically support clients and more efficiently problem-solve with clients • Increase opportunities to co-locate services or create multi-purpose spaces in buildings and facilities leased or owned by AHS • Expand use of technology systems and applications that are working to meet the needs of clients, staff, and partners to other program areas

	• Ensure that new technology systems and applications meet programmatic and administrative needs across programs and can be scaled for broad use • Transition outdated or specialized technology systems and applications to enterprise platforms where appropriate

Goal 3: **Encourage Systems Innovation & Continuous Improvement**

Strategy 3.1	*Opportunities*
Expand efforts to build workforce wellness and resilience	• Support staff relationship development and community-building • Assess trauma prevention and resilience development needs across the departments for AHS staff and clients • Evaluate workplace policies using a trauma-informed, resilience, and family-friendly lens • Promote participation in wellness activities and use of employee benefits • Proactively promote opportunities for professional development and skill-development to employees across the state • Establish pathways between professional development opportunities and career advancement • Leverage professional development opportunities and trainings across agencies and departments

Strategy 3.2	*Opportunities*
Enhance processes for feedback across our system	• Ensure that mechanisms are in place for individuals and families to evaluate their experience of care and customer service • Strengthen options available to staff and clients for reporting misconduct • Develop mechanisms for cross-program dialogue between the AHS and department central offices and each of the district offices • Ensure that partners receiving grants can participate in substantive dialogue regarding current or future grant programs and agreements • Encourage multi-sector local and statewide discussions about promising innovation and opportunities to learn and share • Encourage regular cross-program and cross-agency dialogue • Expand use of technology and processes that promote agency-wide communication and dialogue

Strategy 3.3	*Opportunities*
Encourage collaborative continuous improvement	• Expand training in continuous improvement, collective impact, and Results Based Accountability for staff and partners • Increase client participation in continuous improvement activities • Encourage collaborative improvement projects in district offices that reduce complexity of processes to benefit clients, staff, and partners • Encourage collaborative proposals and applications for funding • Explore the development of an innovation fund to resource innovative programs, services, or initiatives across programs and funding streams • Implement collaborative practices to manage and monitor grants • Share training and workshop opportunities to maximize networking and multi-organization problem-solving and idea generation in the community • Shift payment models to be value-based from fee-for-service, and reward networks of partners for improvements in quality and outcomes

Strategy 3.4	*Opportunities*
Increase communication, transparency, and outreach	• Amplify outreach and education efforts about available services, including cross-program "orientation" or informational sessions • Expand use of technology and processes that promote agency-wide communication and dialogue • Expand use of technology and processes that promote community-wide communication and dialogue across organizations • Increase access to health and human services population trends and program data • Expand efforts to educate the public, partners, and policymakers about available data sources • Amplify outreach and education efforts about available services, including cross-program "orientation" or informational sessions

This section presents strategies and opportunities to achieve the agency's three core goals. Together with the identified trends and anticipated impacts detailed in previous sections, gives us a tool for testing the alignment of any new plan or proposal.

Detailed plans surface in the form of legislative proposals, technology proposals, facility proposals, contracts, grants, and reform designs from across the organization at different moments in time. We want all staff and decision-makers to understand what are the common goals that we need any new plan or project to advance, and to ensure they do that.

APPLYING THE STRATEGIC FRAMEWORK TO DECISION-MAKING

This strategic framework is designed so that leaders at every level of the organization may use it to prioritize and shape policy and programs to align with the common vision. It will facilitate strategic decisions about resources required to effectively serve Vermonters as conditions in the State change.

Below is a description for how this document will be used at various levels of the Agency:

Secretary and Central Office

The Agency of Human Services developed a policy governance team in 2017 with the goal of creating a centralized decision-making body. At the time the Agency was the only State entity with a formal process to review, understand and make decisions within a formal process. The role of the Policy Governance Team is to determine how resources are used and to provide implementation support for large scale projects. The Policy Governance Team currently includes the Secretary, Deputy Secretary, Commissioners, other AHS leaders and the Secretary of the Agency of Digital Services. This guide will help ensure Policy Governance is asking the right questions about new projects and maintains a shared sense of priorities when making tough budgetary decisions.

District, Department Leadership and Staff

The governance structure is a powerful vehicle for alignment across the Agency's many departments and is particularly beneficial in making decisions that impact more than one department. However, we fully understand that no matter what we do to prepare and plan for all kinds challenges and demands, there are unanticipated decisions that must be made every day by every person at the agency. Most of these decisions must be made quickly. Importantly, this guide will support leaders and staff at every level as they act on behalf of the Agency. This guide will ensure that at every turn, we are moving in lock step toward protecting vulnerable Vermonters.

Partners

AHS relies on an extensive network of community partners, professional and academic experts and consumer advisory boards to accomplish its mission. AHS values integrity and transparency with our partners and we look forward to sharing this guide with them and getting their feedback. As we work to improve our grants management process, we will work with our funded partners to ensure the values and practice principles outlined in this document are integrated into our grant-making, technical assistance and grant monitoring guidelines.

We look forward to learning from our partners and working with them to determine how the Agency can incorporate their voices into our decision-making processes regularly.

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