Vermont Agency of Human Services

Opportunities and Pressures, Accomplishments, and Caseload Data

Cynthia D. LaWare
Secretary
February 2006

State of Vermont
Agency of Human Services

February 2006

Dear Legislator:

I am pleased to present to you the 2006 annual report of the Agency of Human Services. As you will see, the breadth and depth of this agency is enormous. We touch the most vulnerable Vermonters in extraordinary ways. Whether protecting a young child from abuse, helping a family access child care, supporting youth and adults through addiction and into recovery or reaching out to elder Vermonters in need of at-home or nursing home assistance, our agency provides support to needy Vermonters across an entire lifespan.

As you read this report, you will be struck by the complexity of our programs, driven largely by federal requirements. Through our recent reorganization, we are striving to provide holistic service to our customers, modifying our programs to ensure they are as responsive and accessible as possible.

Over the past year, we have worked tirelessly to save Medicaid. We have negotiated a first-in-the-nation agreement with the federal government, called Global Commitment. This agreement will not solve all our problems, but the flexibility it provides will enable us to leverage state and federal dollars to maximize health benefits for those we serve. We must, however, not lose sight of the enormous responsibility we have to create a sustainable system of health care for Vermont's most vulnerable.

Another area of concern this year has been the growing number of women in our correctional system. We can and must do more to reverse this trend. Incarcerated mothers and their children need our help to become stable and healthy families. We have challenged our human services networks, under the direction of our Field Directors, to come together to assure fewer women go to prison. Their locally driven plans are just emerging, and we are confident we will see promising results as these strategic efforts unfold across the state. We also know that a root cause driving this increase is substance abuse. Through the Governor's commitment to the DETER program, we will continue to expand the provision of services essential to aggressively confronting this issue.

As I look to the year ahead, I am convinced that we must continue to focus on transitioning our organization. This will ensure that we achieve our goal of providing holistic customer service, built upon strength-based relationships with our clients, as they work to improve their lives and the lives of their families. And, our key initiatives must include bending the curve on substance abuse, supporting youth in transition, developing transitional housing options, reducing the number of incarcerated women and replacing the current State Hospital.

As you review the important information contained in this report, please feel free to contact me or any one of our Commissioners. We are excited about the good work we are doing, and look forward to discussing the opportunities and challenges which lie ahead.

It is an honor to serve Vermont as Secretary of Human Services. Our dedicated staff, in conjunction with our outstanding community partners, do extraordinary work. It is a privilege to work with them, as together, we serve the needs of the most vulnerable among us.

Sincerely,

Cynthia D. LaWare, Secretary

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Office of the Secretary

"Our agency has the widest reach in state government and, I believe, the most important mission: to improve the conditions and well-being of Vermonters today and tomorrow and protect those among us who are unable to protect themselves. Whether protecting a young child from abuse, helping a family access child care, supporting youth and adults through addition and into recovery, reaching out to elder Vermonters in need of at-home or nursing home assistance, or supporting victims and offenders, we serve them with compassion, dedication, and professionalism. I have been privileged to serve as Deputy Secretary of AHS for the last year and as Secretary, I look forward to continuing to work with our dedicated staff, our outstanding community partners and our strong advocate community as together we serve the needs of the most vulnerable among us.

~ Cynthia D. LaWare, Secretary

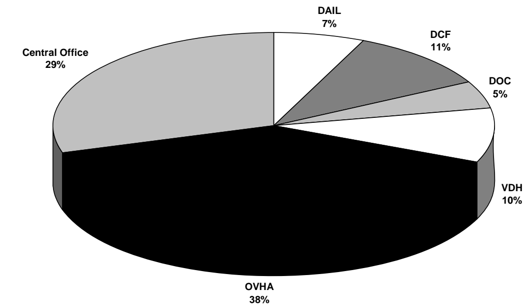
Number of Positions: **105**

Funding

General Fund	$ 143,491,933
Global Commitment Fund	196,285,564
Federal/Other	$ 433,179,668
Total	**$ 772,957,165**

AHS works as one agency, in partnership with communities, to provide effective services that are delivered respectfully, easy to access, well coordinated, and aimed at promoting well-being and intervening before crisis.

FY 2007 Governor's Recommend	DAIL	DCF	DOC	VDH	OVHA	Central Office	TOTALS
Positions	297	915	1,171	871	88	105	3,447
General Fund	16,889,632	81,384,282	108,757,963	27,391,384	0	143,491,933	377,915,194
Global Commitment Fund	129,441,301	52,993,288	2,750,144	158,577,405	758,103,799	196,285,564	1,298,151,501
Federal/Other Funds	26,080,245	144,580,937	7,770,435	66,328,007	258,521,347	433,179,668	936,460,639
Total Funds	172,411,178	278,958,507	119,278,542	252,296,796	1,016,625,146	772,957,165	2,612,527,334

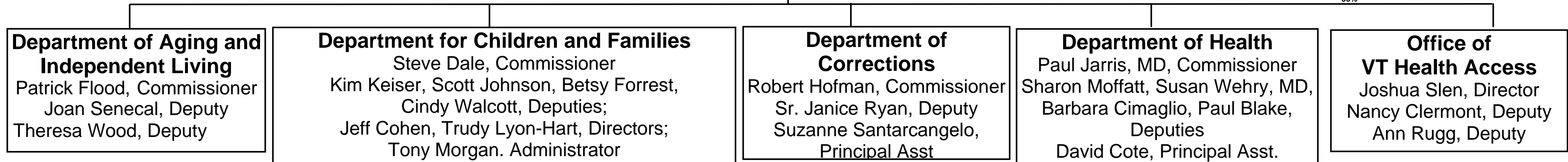


Agency of Human Services

February 2006

The mission of the Agency is to improve the conditions of well-being of Vermonters today and tomorrow and protect those who cannot protect themselves.

Secretary of Human Services
Cynthia LaWare, Secretary
Steve Gold, Deputy Secretary



Department of Aging and Independent Living
Patrick Flood, Commissioner
Joan Senecal, Deputy
Theresa Wood, Deputy

- Assists older Vermonters and people with disabilities to live as independently as possible.
- Provides support to families of children with disabilities.
- Helps adults with disabilities find and maintain meaningful employment.
- Protects elders and adults with disabilities from abuse, neglect, and exploitation.
- Provides public guardianship to elders and people with developmental disabilities.
- Licenses health care and long-term care services providers.

Department for Children and Families
Steve Dale, Commissioner
Kim Keiser, Scott Johnson, Betsy Forrest, Cindy Walcott, Deputies;
Jeff Cohen, Trudy Lyon-Hart, Directors;
Tony Morgan. Administrator

- Promotes safety, permanency and wellbeing for children living at home or in alternative care settings.
- Provides parentage, child support, medical support and protective services
- Seeks to break the cycle of abuse, neglect, and delinquency.
- Provides leadership and program coordination for quality early childhood services in VT.
- Determines eligibility for disability claims for Social Security.
- Provides assistance to address basic needs of those unable to provide for themselves.
- Establishes eligibility for health care coverage to over 140,000 Vermonters.
- Assists families with employment, crisis, nutrition, and housing.
- Serves more than 75,000 families - about 150,000 people.
- Increases the self-sufficiency of Vermonters.
- Strengthens communities by providing training, technical assistance and resource development.
- Provides program and grants management for community-based organizations.
- Connects communities with resources to eliminate the causes and symptoms of poverty.

Department of Corrections
Robert Hofman, Commissioner
Sr. Janice Ryan, Deputy
Suzanne Santarcangelo, Principal Asst

- Manages offender risk in partnership with communities.
- Operates correctional facilities for the disciplined preparation of offenders to become productive citizens.
- Supervises offenders serving sentences in the community and reintegrates offenders after release.
- Helps communities with Reparative Boards & Community Restorative Justice Centers.

Department of Health
Paul Jarris, MD, Commissioner
Sharon Moffatt, Susan Wehry, MD, Barbara Cimaglio, Paul Blake, Deputies
David Cote, Principal Asst.

- Leads state and communities in developing systematic approaches to health promotion, safety and disease prevention.
- Investigates disease outbreaks and prevents spread of infectious disease.
- Protects against health threats in air, water, food and housing.
- Promotes healthy behaviors and activities.
- Prepares for and responds to medical emergencies, disasters and disease terrorism threats.
- Provides mental health and substance abuse treatment services through community agencies.
- Operates the state psychiatric hospital.
- Mobilizes communities to action on local health issues.
- Monitors health trends.
- Provides leadership and resources for prevention of youth substance abuse.
- Ensures access to quality medical and mental health care and substance abuse treatment.

Office of VT Health Access
Joshua Slen, Director
Nancy Clermont, Deputy
Ann Rugg, Deputy

- Assists beneficiaries in accessing clinically appropriate health services
- Administers Vermont's public health insurance system efficiently and effectively
- Collaborates with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries
- Manages operations and technical support for the health care delivery system for 24% of Vermont citizens

	DAIL	DCF	DOC	DOH	OVHA	Central Office	TOTALS
Positions	297	915	1,171	871	88	105	3,447
State Funds	16,889,632	81,384,282	108,757,963	27,391,384	0	143,491,933	377,915,194
Other Funds	155,521,546	197,574,225	10,520,579	224,905,412	1,016,625,146	629,465,232	2,234,612,140
Total Funds	172,411,178	278,958,507	119,278,542	252,296,796	1,016,625,146	772,957,165	2,612,527,334

Department for Children and Families

"The creation of DCF allows us to look holistically at Vermont's children and families. Although we are a collection of many individual programs, our commitment is to be much more than the sum of the parts. We will strive to be totally focused on those we serve and their success, integrating and altering programs as necessary to be effective."

~ Stephen R. Dale, Commissioner

Number of Positions: 915

Funding

General Fund	$ 81,384,282
Global Commitment Fund	$ 52,993,288
Federal/Other	$ 144,580,937
Total	**$ 278,958,507**

The Department for Children and Families exists to promote the social, emotional, physical, and economic well-being and the safety of Vermont's children, youth, and families. We work within the context of an integrated Agency of Human Services and in close partnership with schools, community leaders, businesses, private service providers, and those we serve.

Year	FY '05	FY '06 Est.	FY '07 Gov Rec.
General Fund	105,940,763	107,544,257	81,384,282
Federal/Other	164,934,080	166,970,163	197,574,225
Total	**270,874,843**	**274,514,420**	**278,958,507**

DCF - Child Development Division

The Mission of the Child Development Division (CDD) is to improve the well-being of Vermont's Children. We do this in partnership with families, communities, schools, providers and State and Federal agencies to ensure access to high quality, economically viable, child development services.

The Division provides services to children – from pre-birth to adolescence – and their families through a continuum of child development and family support services which include primary prevention, early intervention and specialized therapeutic services.

OPPORTUNITIES

- **Improving the quality of child care:** The CDD continually seeks to improve the overall quality of care for Vermont's children by working in partnership with the provider community and families utilizing child care services. The Step Ahead Recognition System (STARS) was designed and implemented as a way to define specific levels of quality that exceed basic licensing requirements and to expand ways to award providers for achieving higher levels of program quality. It is a Vermont specific model that, when fully implemented, will result in a higher quality and more stable child care system where providers meet progressive performance standards and parents are informed consumers.
- **Enhancing the Professional Development of the Child Development Workforce:** The Northern Lights Career Development Center is affiliated with the State College System and serves as the entity that develops and aligns professional development opportunities for the various disciplines that comprise the Child Development System in Vermont. Through the work of the center, professional development opportunities will be enhanced and directly connected to a comprehensive career lattice with established articulation agreements between the various institutions of higher education in Vermont. This will positively impact our ability to recruit and retain qualified staff for the diverse programs within the Child Development System.
- **Enhancing CDD's use of E-Government to improve the quality customer service:** The CDD implemented a new web-based child care information management system known as Bright Futures in March, 2005. This system allows for on-line management of accounts with the CDD for child care providers and families seeking or already enrolled in services. Applications for the subsidy program, licensure and grant opportunities are now accessible through this system. While designed originally as a child care management system, the web design will allow for additions to the system over time to accommodate the other child development programs now in the division including, the Family, Infant and Toddler Program; Healthy Babies, Kids and Families; and Early Childhood Mental Health Programs.
- **Creating a full continuum of early intervention services for young children:** Through the integration of three early intervention programs for preschool age children into a single service delivery model, the CDD will establish a more holistic approach for ensuring children who are at risk and their families receive the support they need without overwhelming them with multiple agencies and service providers. The division is working with the existing service providers, community and state partners to develop a service delivery model that will utilize designated early intervention teams and a primary interventionist model in each of the 12 AHS regions.

- **Establishing a structure to formally address early childhood funding and policy issues:** Establishing the Building Bright Futures Policy and Governance Council will ensure that the state outcomes for families with young children are achieved by aligning early childhood policy, planning and resources while promoting collective accountability and responsibility for the early childhood care, health and education system at the state and local level.

PRESSURES

- **Recruitment and retention of qualified child care staff:**
  - A lack of qualified candidates and non-competitive salaries continue to be the main reasons for an unstable and inadequate child care workforce.
  - The limited higher-education opportunities in Vermont for early interventionists and allied health specialists, such as speech therapists, are creating a serious shortage of therapists and early childhood special educators throughout the state.
- **Access to services:**
  - The demand for regulated child care continues to exceed the supply of care. Specialized child care programs, capable of serving children with challenging behaviors, are available in only a few communities.
- **Ensuring access to appropriate services for children with special needs**:
  - The number of children who require specialized accommodations to succeed in community child care programs is growing. Vermont has struggled to respond to this.
- **Ensuring the safety of children in child care settings:**
  - Due to the large caseloads for each of Vermont's 7 child care licensers, the capacity to routinely inspect and monitor all regulated and certified providers is significantly diminished. This is putting the children who attend these programs on a daily basis at greater risk of harm.
- **Ensuring access to appropriate child care options for families eligible for the child care subsidy program:**
  - The state child care subsidy rates are far below market rates for most care statewide. This is having an adverse impact on access to care for families receiving the subsidy and on the financial stability of providers.
  - The child care subsidy fee scale has not been adjusted for federal poverty guidelines since 1999. This limits access to the full benefit eligible families could be receiving.

Statewide Average Weekly Rate for Full Time Care by Age and Program

			State Subsidy Rates	
	Licensed	**Registered**	**Licensed**	**Registered**
Infants	$143.20	$106.54	$120.00	$99.00
Toddlers	$135.96	$101.17	$119.00	$98.00
Preschool	$126.86	$98.77	$106.00	$85.00
School-Age	$108.83	$87.72	$106.00	$85.00

ACCOMPLISHMENTS

- **The Bright Futures Information System:** implemented in March, 2005. Internal and external users, including community based agency staff and child care providers, have been trained on the new system and a help desk has been established. Child care providers who serve children in the subsidy program are now being paid every two weeks.
- **The Children's Services Unit:** developed the design of the integrated services model for early intervention services and has begun meeting with local agencies and community councils to refine an implementation plan and timeline to move the three programs into a single service delivery approach (i.e., list of programs on page 4).
- **The Building Bright Futures Facilities Fund:** enhances financing sources to expand or improve child care facilities. It is a partnership between the Vermont Community Loan Fund (VCLF) and the CDD. In SFY' 2005, the State's investment of $155,738 enabled the VCLF to leverage other funds resulting in $1.8 million for renovations and expansions to child care facilities statewide. Sixty-one (61) new child care placements also were created.
- **Vermont has 114 Nationally Accredited child care programs:** Based on per capita population statistics, Vermont is now ranked number 1 in the nation for nationally accredited programs. We also have more accredited school age programs than any other state.

Child Care Caseloads:

- The regulated child care system annually serves 38,000 children, from birth to 13 years old.
- The Child Development Division regulates 685 licensed centers, 1305 registered homes and 1534 certified legally exempt providers. These programs employ over 5,000 people as part of the child care industry.
- About one-third of Vermont's children in regulated programs are receiving care for eight to nine hours a day.
- Over 5,600 Vermont families receive consumer education and referral services from local child care Resource and Referral agencies every year.

Child Care Subsidy Program

Fiscal Year	2002	2003	2004	2005	2006
Subsidy Population	4,979 FTE	5,002 FTE	5,366 FTE	7720 *	7734 *
$$$$	$24,921,294	$24,921,294	$26,5000,345	$33,000,320	$33,926,275

* The CDD converted from FTE to actual number of enrolled children in 2005

- The early intervention programs within the Child Development Division (Family, Infant and Toddler Program; Healthy Babies, Kids and Families; and Early Childhood Mental Health) served over 5,000 children in SFY' 05 and provided 1568 mental health consultations to early childhood programs.

DCF - Economic Services Division

The Division administers assistance that meets the basic needs of Vermonters who are unable to provide for themselves and their children. These programs promote the well-being of families and individuals by taking on many roles, including that of employment coach, health insurance provider, and crisis manager, and by helping people who have significant barriers to find employment.

OPPORTUNITIES

- **Medical Support from Noncustodial Parents:** Pursuing medical support from noncustodial parents whose children are on one of our health care programs is a mandate to the Office of Child Support (OCS) in collaboration with Economic Services. It is also an opportunity to increase parents' personal responsibility to support their children. Economic Services is working with OCS on a phased-in implementation that began this fall with the cases in our centralized Health Access Eligibility Unit. Statewide implementation will be reached by the end of SFY06. Medicaid savings will be an additional outcome of this initiative as more children become covered by private insurance and leave the Medicaid program totally or use Medicaid as a secondary, rather than primary, insurance.
- **Imaging Health Care Program Applications:** The Health Access Eligibility Unit has more than 100 file cabinets that contain applications and documentation from thousands of Vermonters applying for health care program benefits. We are exploring using imaging technology to eliminate the physical filing of thousands of sheets of paper, to enhance staff's efficiency in making health care program eligibility decisions, and to make this confidential information more secure. If this initiative is implemented successfully, we would look toward expanding use of this technology to our other centrally administered programs (for example, fuel and Lifeline) and possibly to our twelve district offices.
- **Improving Program Integrity:** Economic Services has for many years matched data for the Reach Up, Food Stamp, and Medicaid programs against Vermont's wage data base, but the Vermont database does not contain wage data from other states. The federal Administration for Children and Families (ACF) administers a National Database of New Hires (NDNH) that contains wage data from all 50 states. Although previously this database was not available to states, this past summer, for the first time, states were given the option to access NDNH to determine whether Reach Up participants have unreported earnings. Economic Services signed an agreement with ACF and began to run matches against the NDNH in September. At the present time, the authority to match against the NDNH does not extend to other programs administered by Economic Services, but once information obtained through the match is independently verified, it can also be used for these other programs. In addition, federal law may be changed to allow NDNH to be used to verify income reported for other federally-funded programs.
- **Document Management:** An RFP for a document management system within Economic Services was recently issued; the RFP also asks for bids to include an additional cost proposal for the Department of Corrections and for an entire executive branch option for all those who use the rule-making process. A design document for the system was created via a prior RFP. As rule-making and procedure writing processes increasingly move towards an electronic, paperless environment, administrative, staff, and cost efficiencies are gained. Some of the features contemplated include electronic public comment and filing processes, on-line rule and procedure access at all terminals throughout the workforce including on-line search capabilities, and fully integrated content across all written media including training materials. Implementation bids are to be reviewed in early calendar year 2006 with work starting soon thereafter. A target date for testing is early 2007.

PRESSURES

- **TANF Reauthorization:** On December 21, 2005, Congress passed budget reconciliation legislation that reauthorized the Temporary Assistance for Needy Families (TANF) Block Grant for five years. Congress had been debating changes to TANF since 2002 when the program first came up for reauthorization.

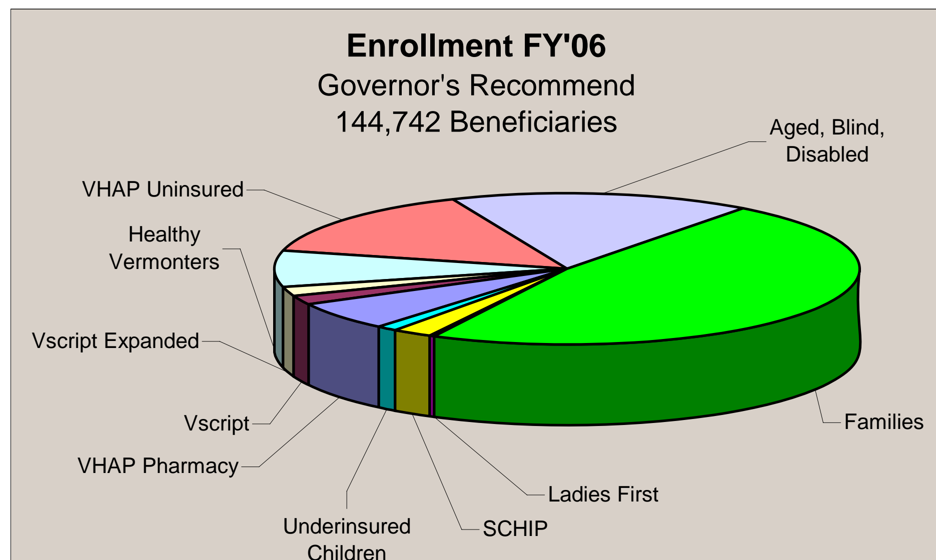
  Because the TANF reauthorization legislation passed as this report was going to print, its overall effects are still being analyzed; however, some impacts are clear. This legislation requires states to meet much higher work participation rates in 2007 or face fiscal penalties. According to the Congressional Budget Office, states can be expected to try to meet the requirements by applying a combination of approaches including funding more work activities, imposing tighter up-front requirements, and adopting stricter sanctioning policies. Though it is expected that states may need to create additional work placements for participants, they must do so with a level-funded TANF block grant.

  The legislation, in effect, increases the work participation rates, particularly for two-parent families. Under current law, states are required to meet a 90 percent work participation rate for two-parent families. Vermont has been able to meet this requirement due to receipt of a significant caseload reduction credit applied against the rate. The credit was based upon the state's reduction in its caseload since 1995. The bill changes the caseload reduction credit calculation by using 2005 instead of 1995 as the base year from which to determine the reduction. This will significantly reduce the credit.

  The new law restricts states' flexibility to set policies in state-funded programs, undoing a basic tenet of the 1996 welfare law. In Vermont, this change may jeopardize the sustainability of the postsecondary education program and other separate state initiatives that are part of Vermont's TANF program. In addition, the legislation applies the work participation rate to families in separate state programs as well as those receiving TANF assistance. These changes are likely to affect Vermont's ability to meet its participation rates. To avoid fiscal penalties, As soon as the new federal regulations are available, Vermont must immediately evaluate its options under the new law and determine ways to increase participation in countable work activities.

- **Long-term-care (LTC) Medicaid administration:** Staff throughout the division has dedicated significant effort over the last year to handle the complex financial situations of many LTC applicants and have done so with increased accuracy, consistency, and timeliness, and yet challenges remain. The additional resources that have been focused on training, supervision, and access to legal assistance must continue. Legal analysis of federal rules and estate planning vehicles has yielded program savings through increased cost sharing by individuals or estate recovery receipts; however, new estate planning techniques continue to emerge that need to be addressed. Furthermore, data collection, analysis, and reporting capabilities have to be developed to better monitor outcomes and for quality assurance purposes. As the Vermont population ages and application numbers increase, so also do pressures on the eligibility workforce charged with handling them.

- **Medicare Modernization Act (MMA):** The Economic Services Division worked diligently to prepare for the January 1, 2006 implementation of the MMA, which has a significant impact on Medicare beneficiaries who also receive benefits through Medicaid, VHAP- Pharmacy, VScript and VScript Expanded programs. IT development work was completed and in place, and extensive outreach and education was delivered. Fortunately, a rule also was put in place to hold individuals harmless. Once it became clear that the new federal systems were not working, ESD worked hand-in-hand with OVHA to reinstate the old mechanisms to ensure that Vermonters received their prescriptions as quickly and easily as possible.
- **Stretching the heating dollar:** Federal funding from the Low-Income Home Energy Assistance Program (LIHEAP) is not intended to meet the total cost of heating, but rather to provide supplemental assistance to households. Because there is no forward funding for this program, the actual federal appropriation level is unknown until the federal government approves a budget. For the past several years, this has happened well after the state seasonal and crisis assistance programs have begun issuing benefits. For the 2004/2005 heating season, 19,327 Vermont families received seasonal assistance and approximately 5,700 households accessed help through the Crisis Fuel program to avert a heating emergency. The rising cost of fuel is always a concern and this year the Office of Home Heating Fuel Assistance has received approximately 27,000 applications – an increase of 3,000 over last year at this time.



ACCOMPLISHMENTS

More than one in five Vermonters is covered by a state health program. Over the past five years, health care programs have expanded with higher income eligibility limits and new cost-sharing initiatives, such as premiums.

Program	% Poverty Level	Monthly income for 1	Program
Traditional Medicaid – in Chittenden County	N/A	$908	Dr. Dynasaur for pregnant women
Traditional Medicaid – outside Chittenden County	N/A	$841	VScript Expanded (pharmacy)
VHAP for uninsured and VHAP-Pharmacy	150%	$1,232	Working people with disabilities
VScript (pharmacy)	175%	$1,437	Dr. Dynasaur for children under 18 -and- Healthy Vermonters (pharmacy – any age)
VHAP for uninsured parents & caretakers; Transitional Medicaid for families leaving welfare	185%	$1,519	Healthy Vermonters (pharmacy – aged / disabled)

DCF – Family Services Division

The mission of the Family Services Division is to protect children and strengthen families, in partnership with families and communities. We strive to ensure that: Children are safe from abuse; children have enduring relationships with healthy, nurturing families; children are successful in family, school and community; and youth adjudicated delinquents are free from criminal behavior.

The Division works in partnership with the DCF Field Services Division, the Agency of Human Services and its partners to achieve these outcomes for children and families.

OPPORTUNITIES

- In partnership with the University of Vermont Social Work Department, Family Services is developing a new social work practice framework that emphasizes family engagement strategies, as well as a focus on minimizing risk and increasing protective factors.
- The Child Safety Unit is fully staffed and is focusing on quality and consistency of practice in intake, report acceptance, assessment of safety and risk and substantiation decisions.
- The division has implemented a comprehensive assessment process for all children entering custody. Our goal is to improve the quality of planning for children and their families, thereby improving outcomes.
- Division staff are working together to focus on the need for permanent connections for all children leaving our care and supervision, in the form of one or more meaningful relationships with adults. Staff around the state has volunteered to work in creative ways to achieve this goal. The department will co-sponsor a conference in the spring on permanency for youth, which will act as a “call to action”.

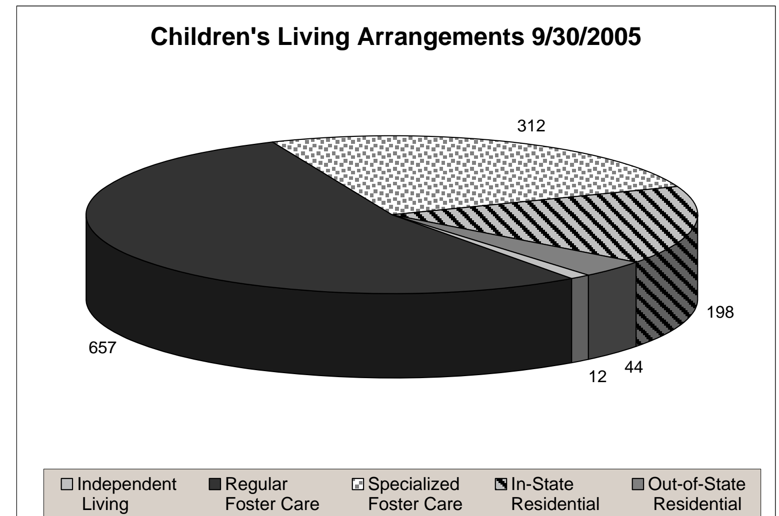
PRESSURES

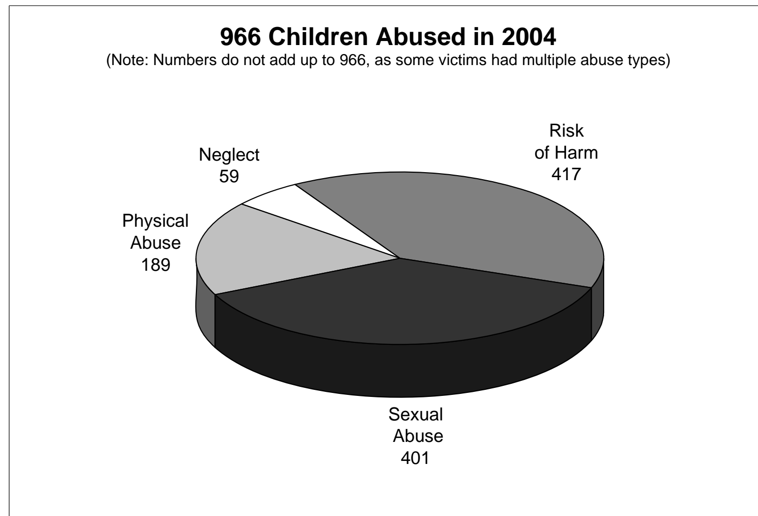
- Increases in substance abuse and domestic violence in Vermont negatively affect children, youth and families–and precipitate DCF intervention. Often, these families’ circumstances result in neglect or risk-of-harm substantiations.
- Implementation of child abuse registry checks for employees who will care for children or vulnerable adults has resulted in as many as 100 checks per week, generating increased work for staff.
- Children and youth committed to the care and custody of the state are increasingly in need of significant and on-going mental health and substance abuse treatment. This continues to place pressure on the substitute care budget, as more children require residential care and specialized foster care.
- The custody population continues to age: over 60% of children in custody are 12 and older.
- IV-E eligibility and receipts continue to decline, as federal law has “frozen" income standards at 1996 ANFC income limits.
- Social work practice and on-going staff development will need to be better geared toward assuring defined outcomes for children and families.
- Assuring adequate numbers of families who have the necessary skills to nurture children with complex behaviors and needs will continue to be a challenge.
- Currently, we provide supports to over 1400 adopted children with special needs. These children, often adopted at an older age, continue to need supportive services after adoption. Resources have not kept pace with this need.

ACCOMPLISHMENTS

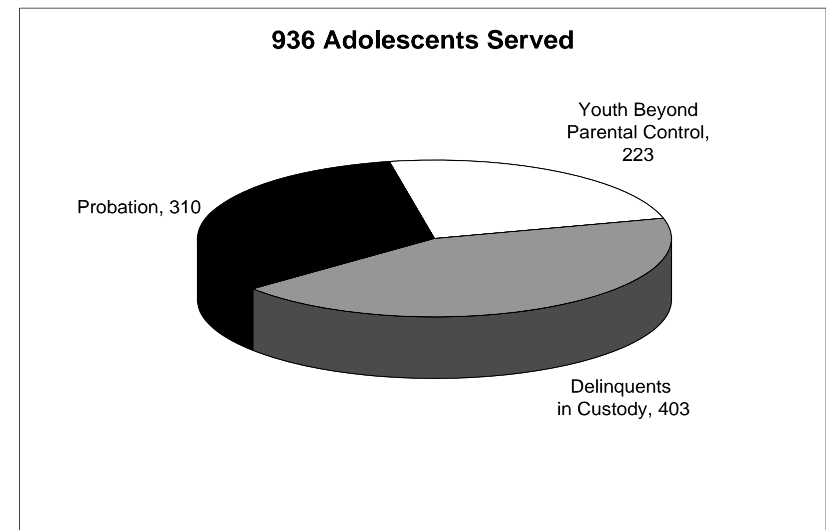
- We have established a partnership with the Vermont Student Assistance Corporation to ensure that young adults formerly in custody receive the benefits for higher education offered in 2004 by Emily's Bill. Currently 68 youth formerly in custody receive financial supports for college through VSAC.
- A partnership with the Vermont Department of Health and VCHIP has focused on early assessment of health needs. The project will expand to all 12 districts in 2006.
- Child Safety Unit staff completed a series of training for members of the clergy to familiarize them with their responsibility to report suspected child abuse.
- Our ongoing partnerships with Vermont communities of faith result in the provision of concrete supports for children and families, as well as less tangible benefits such as mentoring opportunities.
- In partnership with the University of Vermont Social Work Department, Family Services is developing a new social work practice framework that emphasizeS family engagement strategies, as well as a focus on risk and protective factors.
- A very successful Youth Summit was held at the Statehouse on December 10, 2005. Over 90 youth in DCF custody and young adults formerly in custody gathered to provide input about how to make the system more responsive to the needs of adolescents in custody, especially as they transition to adulthood.
- As of January 2006, Family Services policy will severely restrict the use of shackling during transports. New transportation options have been developed to meet the need.

On any given day, about 1,260 children and youth are living in out-of-home care provided by the division. On September 30, 2005, there were 826 in foster family care; 131 with relatives (kinship care); 21 in independent living programs; 255 in residential programs, including 44 in specialized, out of state programs; 30 placed at Woodside (including short-term detention and long-term treatment).





In 2004, DCF substantiated that 189 children were physically abused, 59 were neglected, 401 were sexually abused and 417 were at risk of serious harm.



On 9/30/2005, 936 adolescents were being served due to their delinquency or behavior issues.

Created through the 2004 reorganization of the Agency of Human Services, the Field Services Division maximizes the effectiveness of human services in each region of the state. The Division's scope covers the entire Agency of Human Services, including services provided through state-operated entities as well as those operated by private "designated" agencies.

The mission of the Field Services Division assures that our human service system is effective and works for all Vermonters.

- **History/Mandate:** For the past 35 years, human services in Vermont – as in all other states – have been organized around particular human problems. There have been Departments, Divisions, Offices and Units, dedicated to specific issues, such as economic problems, substance abuse, mental health, public health, child abuse, corrections, physical disabilities, developmental disabilities, and aging. In many of these areas, Vermont's programs have been exceptional and among the best in the country. Despite all of this good work, there are various indicators that demonstrate our continued need to move beyond our programmatic silos to meet the multifaceted needs of Vermonters.

  In May, 2004 our legislature authorized the Agency of Human Services to reorganize pursuant to the plan the Agency submitted to the Legislature. Eighteen months of statewide inquiry produced a large body of information indicating, that despite specific programs that have been excellent, the Agency still faced significant issues around customer service, access and navigation, flexible programs, and service coordination. The inquiry also identified that we must become better at focusing on the early identification and prevention of problems facing Vermonters.

  AHS Field Directors have been established in every district of the state to unify human services and to build a system focused on excellent customer service, the holistic needs of individuals and families, strength-based relationships, and improving results for Vermonters.

- **Major Programs/Activities:** AHS has dramatically changed the structure, leadership and authority of our teams in the 12 human-service districts across Vermont. Each AHS district team is now led by a Field Service Director, who works with local state managers, private sector managers, community partnerships, education, the broader community, and with those we serve to develop and implement specific strategies to achieve the goals of the reorganization.

  Field directors are charged with:
  - <u>Managing a consolidated district budget</u>, with flexible funding authority, and overseeing a district global budget of all agency expenditures, including grants and contracts,
  - <u>Holding team members and local providers accountable</u> for service standards and teamwork focused on client outcomes and prevention,
  - <u>Building excellent relationships</u> with community partners, including schools, law enforcement agencies and non-profit housing developers,
  - <u>Leading staff and partners</u>, in conjunction with the regional partnership, to drive positive trends in the region, and
  - <u>Delivering coordinated services</u> to individuals and families that are timely, flexible and seamless across all programs and agencies.

OPPORTUNITIES

AHS Field Directors work with state departments and divisions, private agencies, community partnerships, education, business, and especially, consumer groups, to design and implement innovations that improve performance related to the ten outcomes of the Agency of Human Services, and that make specific progress around the ten themes of the 2004 Reorganization of the Agency of Human Services:

- **Respectful Service:** Creating a pervasive customer-friendly culture.
- **Access to Services:** Creating a clear and welcoming presence in the community and assuring that people who connect with the agency are guided to the assistance they need. Creating technology that supports easy access.
- **Prevention:** Working together with communities to promote healthy individuals and families.
- **Preventing Crises:** Intervening as early as possible to reduce the need for more intensive services.
- **Effective Service Coordination:** Assuring that individuals and families served by AHS programs have a service coordinator and well-coordinated interventions and supports.
- **Flexible Funding to address gaps in services:** Working to respond to need and to avoid "silo thinking" that creates barriers.
- **Collaboration with Key Partners:** Building on existing partnerships and promoting broader relationships.
- **Support through Transition:** Building smooth bridges between programs defined by age, disability, or situation (e.g. pre-school to school, adolescence to adulthood, school to work, prison to community, hospital to community, etc.)
- **Continuous Improvement and Accountability:** Promoting a significant consumer voice in the process. Assuring tracking and addressing performance indicators related to our success.
- **Information Systems:** Establishing improved information systems to support a more effective and efficient system.

ACCOMPLISHMENTS

- **District Leadership Teams:** The District Leadership Teams are comprised of local leaders, both state and private, engaged in community-wide planning and assessment to support the Field Director in implementing the agenda of the Agency of Human Services and improved outcomes.
- **Regional Advisory Councils:** The Advisory Councils are made up of current and past service participants who advise, support and guide the Field Director in the development and implementation of strategies to improve the functioning of the Agency of Human Services and its outcomes.
- **Service Coordinators:** The Service Coordinators ensure that individuals or families with complex needs have a holistic, effective and well coordinated service delivery package that eliminates service duplications and identifies a lead case manager.
- **Direct Service Dollars:** The Direct Service Dollars are designed to temporarily assist individuals and families in need when gaps in the system are identified that cannot be met with any other categorical resource.
- **Peer Navigators:** The Peer Navigators were developed through a statewide collaboration with family organizations and a federal 360 Grant to offer service participants the support of someone who has experienced the system first-hand. Peer Navigators assist individuals and families to access and navigate the health, education and human service system.
- **Incarcerated Women's Initiative:** This initiative is being led by the Field Directors to turn the curve on the number of women entering the criminal justice system, reducing female incarceration rates, and ensuring appropriate community supports are in place to prevent recidivism.

The mission of the Office of Child Support is to improve the financial condition of children by obtaining child support obligations and payments, while avoiding and reducing public assistance, social services, and health care expenditures.

OPPORTUNITIES

- **Enhancing the Office of Child Support's use of E-government to further improve the quality of customer service:** The Office of Child Support is constantly enhancing its web site to improve the quality of customer service. This interactive site provides instant input and retrieval of individual case data. Parents can use their Personal Identification Number (PIN) to access case information such as payments, disbursements, scheduled court hearing dates, and other account information. Parents can also report information such as a change of address or employer. Users can order applications or publications, request help by e-mail, and view the parent handbook, among other features. Employers are able to input information critical to the collection of child support. Customer comment cards, available on the website, indicate that customers are very pleased with the interactive nature of the website and the ability to use the Internet to get case information. Recent updates increased employer interactive functions, including electronic notification of wage withholding, health insurance and employment verification forms available for employers to complete via the Internet as well as a web-based "wizard" to assist employers in completing health insurance enrollment forms.
- **Enhancing OCS' ability to collect medical support for children and reduce Medicaid costs through collaboration between the Office of Child Support, the Economic Services Division, and the Office of Vermont Health Access:** In SFY 2005, the Department for Children and Families (DCF), through the Office of Child Support (OCS) and the Economic Services Division (ESD), joined with the Office of Vermont Health Access (OVHA) to implement a comprehensive program for the establishment and enforcement of medical support. Benefits of this collaborative effort will be more flexible coverage for children through private health insurance and modest Medicaid cost recoveries to offset costs. Crucial to the initiative's success was the addition of key staff to OCS/ESD/OVHA in SFY 2006.

  In September the Office of Child Support was awarded a Section 1115 grant by the federal Office of Child Support Enforcement under Funding Priority 4: "Use of Specific Collaboration Protocols with Other Agencies". The project is called "PROJECT UNIMED: A Unified Approach to Medical Support through Intra-Agency Collaboration and Data Exchange" To build upon the collaborative work between these divisions.

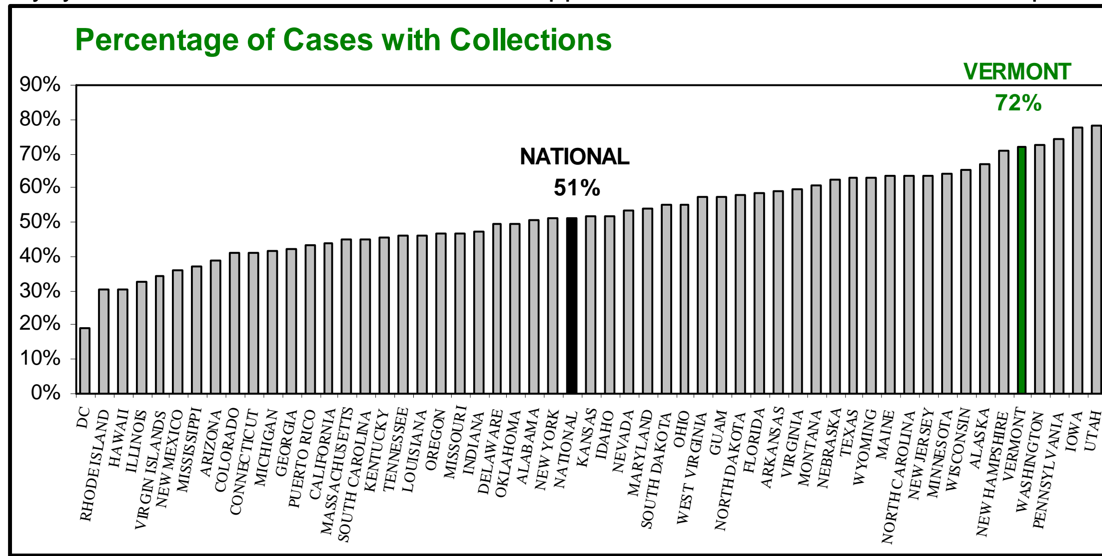
  PROJECT UNIMED objectives include:
  - Developing best practice communication/process models between Vermont's:
    - Office of Child Support (OCS) – Child/Medical Support
    - Economic Services Division (ESD) – TANF
    - Office of Vermont Health Access (OVHA) – Medicaid
  - Standardizing interagency interfaces for timely/accurate data exchange;
  - Increasing and expediting establishment of parentage and medical support;
  - Reducing Medicaid expenditures by increasing child enrollment in private health insurance plans; and
  - Collecting, analyzing, and providing data on project effectiveness, medical support impacts, and best practices for medical support enforcement and federal data reporting.

PRESSURES

- **Reduced resources may have an adverse impact on Vermont's families and on public assistance recovery efforts:** Any reduction in staff has a concomitant reduction in collections. Reductions in child support collections affect fragile families who rely on child support to sustain them. Without child support they are more likely to need public assistance.
- **Maintaining collection activities is important in order to meet and exceed benchmarks that form the basis for federal incentive funds:** The Office of Child Support receives state and federal funds. Federal incentive funds are based on the state's performance. Vermont earns incentive funds annually for meeting or exceeding federal performance indicator benchmarks. The long-term effect of budget reductions could adversely affect program performance and reduce the level of these incentive funds.
- **Continually rising caseloads with fixed or declining resources will continue to put pressure on the Office of Child Support's ability to provide services:** Title IV-D of the Social Security Act requires states to have child support programs. In Vermont, The Office of Child Support is the sole organization responsible for the child support program, and child support is the only program within the Office. It is mandated under federal law and state statute to perform the complete array of existing services regardless of budgetary circumstances. All applicants for services must be accepted. With rising caseloads and the possibility of reduced resources, collections and the federal funding based on performance incentives may be in jeopardy.

ACCOMPLISHMENTS

The Office is a top performer, nationally. The Office manages the child support program under Title IV-D of the Social Security Act by enforcing ordered child support obligations, establishing child support, medical support, parentage orders and locating missing non-custodial parents. For many years Vermont's Office of Child Support has ranked as one of the top ten programs in the nation for cases with collections, far outperforming the national average. In FFY 2004 Vermont collected child support on 72% of its cases, compared to the national average of 51%.



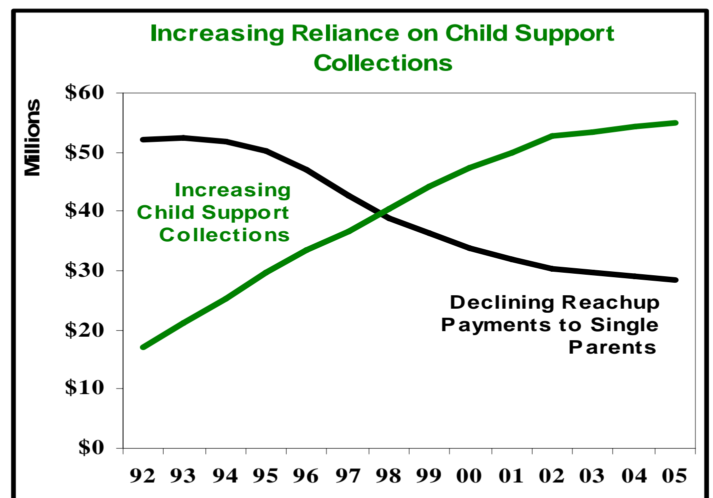
In addition, last year the Office of Child Support:

- Collected many millions in support payments ($54,889,953 in SFY 2005).
- Handled approximately 24,625 cases.
- Scheduled 7,970 court appearances by legal staff.
- Entered 6,022 new and modified court orders on the computer system.
- Averaged 821 cases per child support specialist.
- Processed 448,068 payments.

Child Support Enforcement is a complicated process with many actions required to move cases along. Filing court actions, appearing in court, recording the terms of court orders, processing employer wage withholding notices and payments are only a few. Other steps such as finding employer addresses in order to initiate wage withholding, sending out notices, contacting customers by telephone and/letter, and documenting actions, must also be taken.

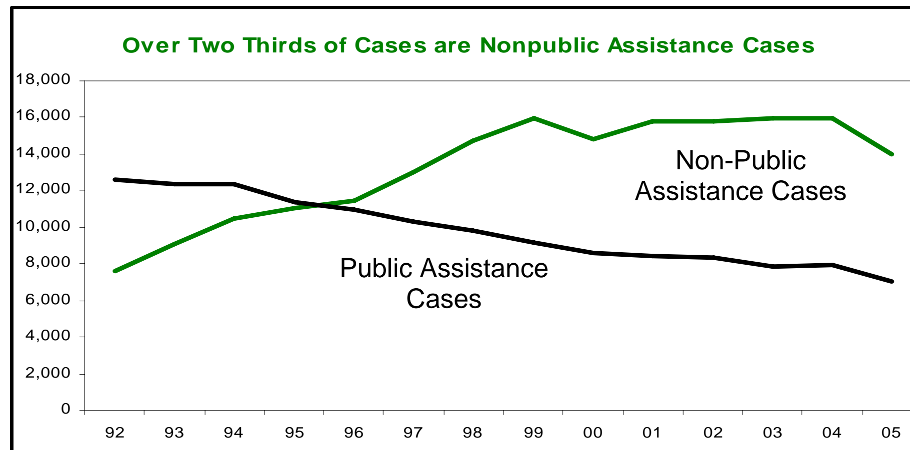
Increasing Importance of Child Support to Families

Welfare reform in Vermont has generated an increased reliance on child support payments as a method for sustaining low-income families. Caseload trends have moved increasingly from public assistance cases to non-public assistance cases. Vermont now collects and disburses more child support than public assistance payments made each year to single parent households. With the advent of time limits for cash assistance (ReachUp) and the increasing fragility of the safety net, child support payments are a crucial way for parents to sustain their families.



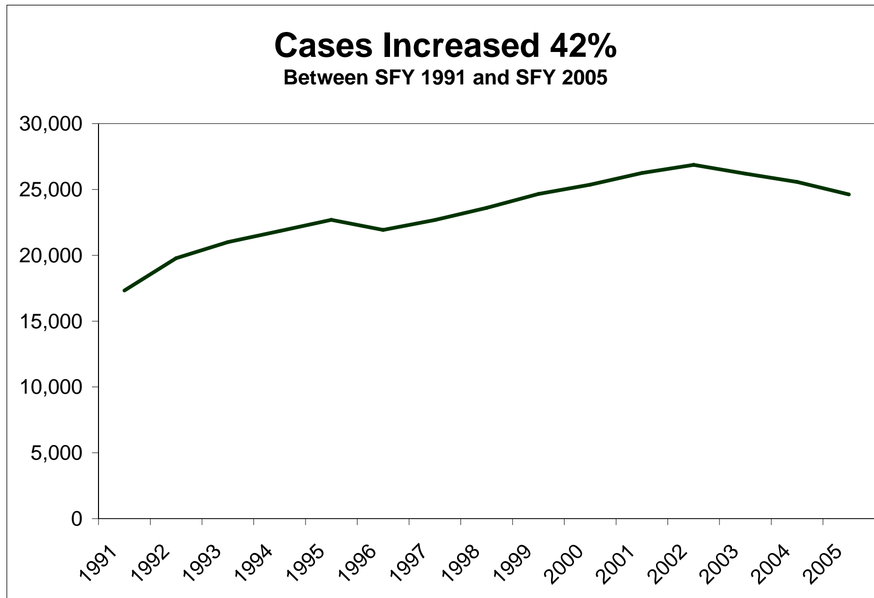
DCF – Office of Child Support

In state fiscal year 2005, 13,962 Office of Child Support cases were non-public assistance cases and 7,054 were public assistance cases. Seventy percent (70%) of the total is non-public assistance cases. During hard economic times collections are critical. Child support payments often make the difference between families remaining independent and self-supporting or needing to apply for state financial assistance. Child support collections are a cost avoidance for states in their challenge to reduce enrollments in public assistance programs.



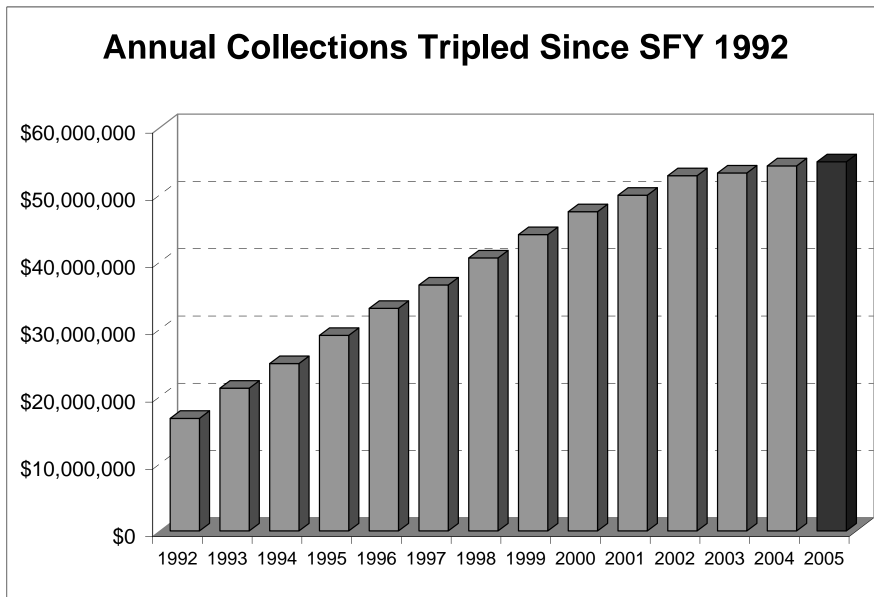
- The State of Vermont's Office of Child Support was named as one of 100 Top Information/Technology (IT) Visionaries for 2003 by "InfoWorld" Magazine, San Francisco, California. The designation was awarded for OCS' child support Business Intelligence (BI) System, a global organizational management component to OCS' Decision Support System (DSS).
- In August of 2001, the Office of Child Support was honored as a finalist for the Outstanding Program Achievement Award given by the National Child Support Enforcement Association to a state or county program for consistently providing effective services to its constituency and community.
- For several years Vermont's Office of Child Support has worked with the Vermont Council for Quality to improve quality and services by adopting a strategic plan and adhering to the Malcolm Baldrige Performance Excellence Criteria. In May of 2001, the Office of Child Support was honored with the U.S. Senate Productivity Award, an award presented by the Vermont Council for Quality, for achieving the largest demonstrated productivity gain over the previous year. It was the first time this award was given to a governmental agency.
- An Achievement Level Recognition Award was given to the Office of Child Support by the Vermont Council for Quality in 2004 in recognition of its organization performance excellence. This was a result of the fourth organizational survey and site visit conducted by the Vermont Council for Quality examiners.

Historical caseload and cost data



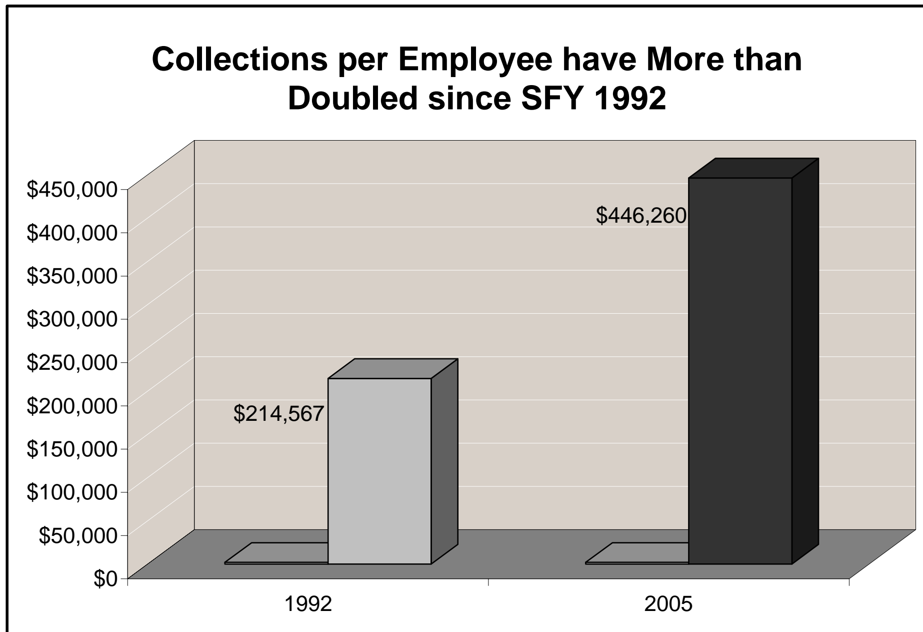
Growth in Cases

Vermont's out of wedlock birth rate increased greatly from 13.9% in 1981 to 30% in 2003. There were 2,495 divorces in Vermont in 2003 (1,273 of these involving children under 18 years old). The number of cases served by the Office of Child Support continues to grow at a rapid pace rising 42% since 1991. OCS currently has over 24,500 cases.



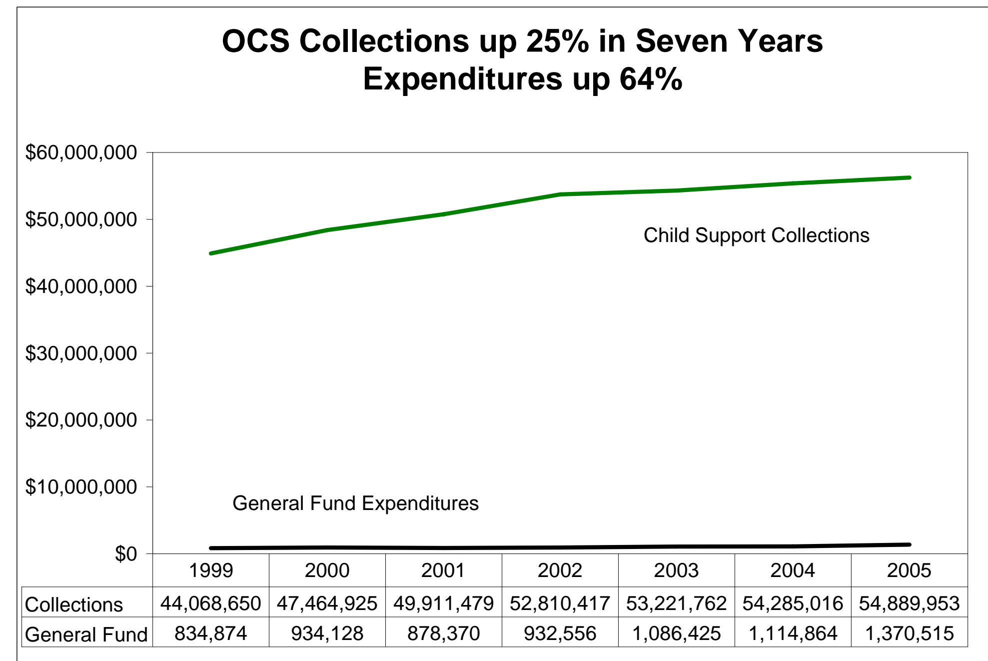
Growth in Collections

Since its creation as a separate entity in 1990, the Office of Child Support has achieved continual and phenomenal growth in collections. Annual collections have increased by 328% since 1992 to $54,889,953 in state fiscal year 2005. Total collections in the last 14 years are $558,790,401.



<u>Growth in Collections per Employee</u>

In 1992, the amount collected per employee was $214,567. By 2005, that amount had risen to $446,260. Much of this growth can be attributed to prudent application of new legislation and automation. Mandatory wage withholding laws were enacted in the early 1990's and automated systems were developed, which monitor and initiate case processing actions.



	1999	2000	2001	2002	2003	2004	2005
Collections	44,068,650	47,464,925	49,911,479	52,810,417	53,221,762	54,285,016	54,889,953
General Fund	834,874	934,128	878,370	932,556	1,086,425	1,114,864	1,370,515

In state fiscal year 2005 the Office of Child Support program had $1.37 million appropriated from the general fund. This investment generated almost $55 million in child support collections that supported families or recovered public assistance expenditures.

During the last seven year period from 1999 through 2005, the state's $7.15 million in appropriations has reaped almost $357 million dollars in child support collected for Vermonters.

DCF – Office of Disability Determination Services

The Office of Disability Determination Services (DDS) mission is to provide applicants with accurate decisions, as quickly as possible, as governed by Social Security federal statutes, regulations, and policy, with full and fair consideration of each applicant's situation, and respect and concern for the individual's well-being and legal rights.

DDS serves Vermonters who apply for disability benefits under the Social Security, Supplemental Security Income (SSI), and Medicaid programs.

OPPORTUNITIES

- DDS continues its collaboration with the Social Security Administration to enhance service to Vermonters with disabilities and to ensure stewardship of disability programs and public funds.
- DDS continues to take advantage of opportunities to collaborate with other agencies to improve service to Vermonters with disabilities. Examples of areas of collaboration include the Interagency Council on Homelessness, the Work Incentive Advisory Panel, Reach-Up counselors, and expedited disability claim processing for pre-release Correctional clients.
- The New England Region will be the first to roll out Social Security's new disability process. The proposed regulations were published in the Federal Register in August 2005, and the final rules are expected in December 2005. The New England DDS's may have opportunities to shape the process as they pioneer its implementation.

PRESSURES

- The transition to electronic claims and business processes is slowing DDS case-processing time and decreasing productivity. Factors include ergonomic issues, and the additional time it takes adjudicators and doctors to review large documents on the screen instead of in paper. Another factor is the necessity of maintaining dual processes (paper and electronic) since SSA has not yet converted all case types into electronic format. The conversion of paper evidence into electronic format adds excessive mail time as substantially all evidentiary material must be sent to SSA's national scanning contractor in Kentucky. The DDS has requested that SSA consider opening a branch scanning office in New England, or provide the DDS with equipment and funding to perform the bulk of our own scanning. Absent these potential solutions, the problem will continue until more Vermont healthcare sources develop electronic record transmission capability.
- DDS has serious concerns about the impact of the proposed new regulations for disability process improvement. Depending on details yet to be determined, the changes could mean slower case processing for Vermonters, especially of appeals.

    1. The proposed regulations would remove the reconsideration step from the state's jurisdiction. The DDS now allows 15-20% of reconsiderations; these claims take 50-60 days on average. Common reasons for reversing the initial denial include new evidence, new impairments, and worsening of impairment severity. Federal decisions at the next appeal level take over 400 days. With the removal of the DDS reconsideration step, medically eligible claimants may have to wait much longer for benefits granted by a federal decision.

2. For certain initial claims, the proposed regulations set extremely stringent, untested performance requirements. Failure to meet these requirements results in removal of a state's authority to make the determinations. The DDS is concerned that if either Social Security or a private contractor to Social Security outside the state assumed the workload, the service to Vermonters might suffer. Strong commitment to our citizens, attention to individual claims, and good relationships with the state's health care facilities are critical to high-quality disability determination service.
3. As yet unpublished qualifications for medical consultants have the potential to disqualify the DDS's internal consultant resources, forcing reliance on a national consultant pool, over which the DDS would have no control of turn-around time and quality. In addition, the DDS might lose the valuable training and consultation resource that on-site doctors provide for our adjudicators.

We hope that these concerns will not materialize; however, it is incumbent upon the DDS to prepare to meet new challenges and make every effort to shape the new process to provide the best possible service for Vermonters.

ACCOMPLISHMENTS

- In federal FY 2005, Vermont applicants for Social Security Disability and SSI received a DDS medical determination on average 30 days faster than the nation as a whole.
- The Vermont DDS continued to make early, accurate SSI allowance predictions that provide expedited benefit checks to SSI applicants prior to a final decision. For FY 2005, DDS provided early benefits to 83.8% of eligible SSI applicants (compared to only 21.4% nationally).

During federal FY 2005, the DDS was ranked 3rd in the nation for initial performance accuracy, while having the fastest initial case processing time and one of the lowest medical costs per case.

CASELOAD AND COST DATA

DDS serves the public by making prompt, program-accurate, cost-efficient decisions of medical eligibility for disability benefits under Social Security and SSI. In addition, a small part of the DDS workload (4.5% in FFY 2005) involves determination of medical eligibility for Medicaid. The full cost of federal claims processing is borne by the federal government.

The drop in the processed workload in 2005 is largely due to the decision of Social Security to decrease DDS reviews of continuing eligibility on a national basis. Increased costs reflect the technical and resource demands of the transition to electronic case processing in the second half of the federal fiscal year.

Federal Fiscal Year	2002	2003	2004	2005	2006 (projected)
Processed Claims (SSA & Medicaid)	5939	7184	8478	7301	7850
$$$ (SSA & Medicaid)	$3,090,941	$3,058,649	$3,149,262	$3,422,823	$3,950,000

DCF - Office of Economic Opportunity

The Office seeks to increase the self-sufficiency of Vermonters and strengthen Vermont communities by providing training and technical assistance, resource identification and development, and program and grants management for community-based organizations. The Office connects communities to resources within government and the private sector to eliminate the causes and symptoms of poverty.

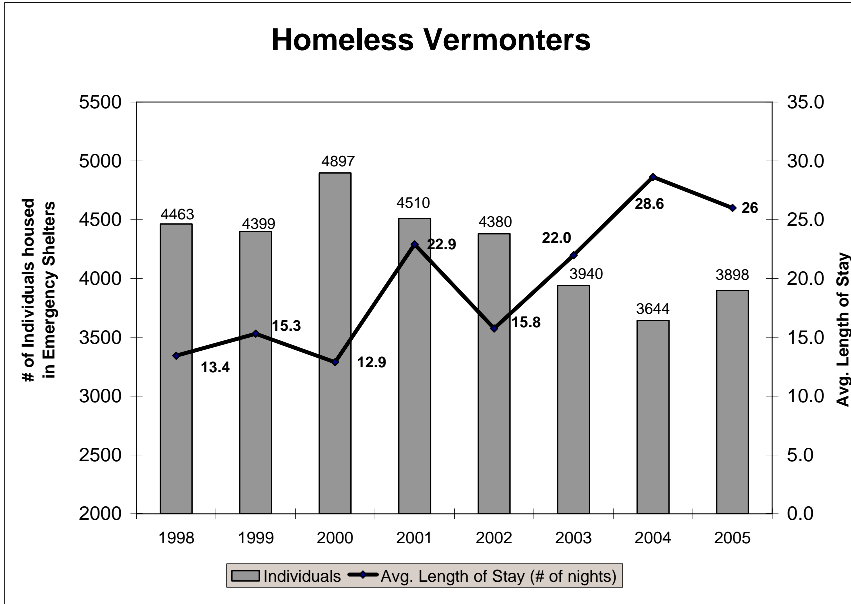
OPPORTUNITIES

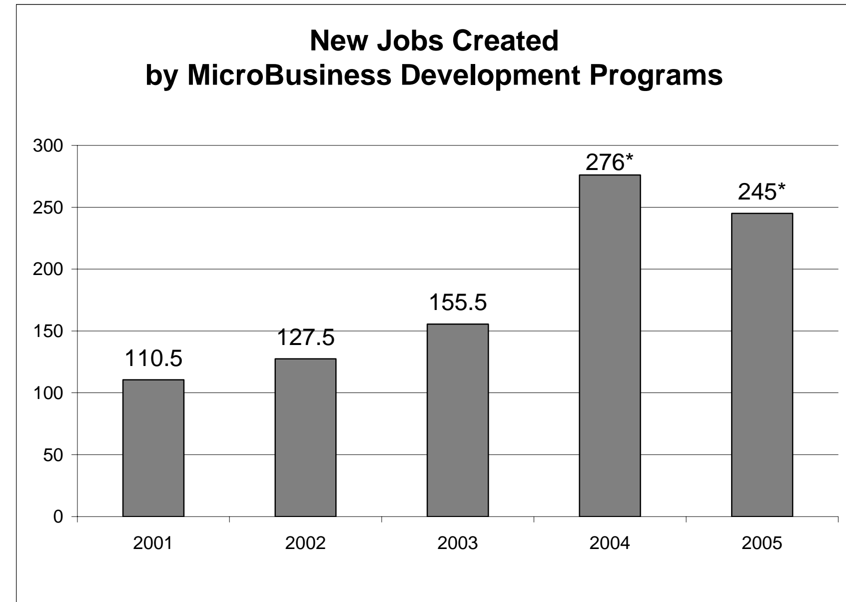
- The Office of Economic Opportunity continues to establish strong **partnerships** with a variety of organizations and works closely with the Department of Economic Development and Vermont Economic Development Authority (VEDA) **to help create new job opportunities** for low-income Vermonters through accessing the Vermont Job Start Loan Program. In addition, OEO works closely with numerous housing organizations to increase the availability of affordable housing throughout Vermont.
- Innovative programs such as Individual Development Accounts have demonstrated positive outcomes for low-income working Vermonters, enabling them to acquire assets that help move them out of poverty through education, starting a small business or achieving home ownership.
- Organizations receiving grants are required to use **Results Oriented Management and Accountability (ROMA)**, and other performance management tools to enhance the effectiveness of services provided to low-income Vermonters. These organizations are becoming increasingly sophisticated in their ability to use outcomes-based approaches to gauge effectiveness and improve service delivery.
- **The Weatherization Trust Fund** was reauthorized until June 30, 2008. Increases in funding from the U.S. Department of Energy and successful leveraging activities have stimulated an aggressive ramp-up in weatherization activities statewide. Vermont's weatherization program continues to lead the nation in instituting innovative and cost-effective methods for improving energy efficiency for low-income peoples' homes.

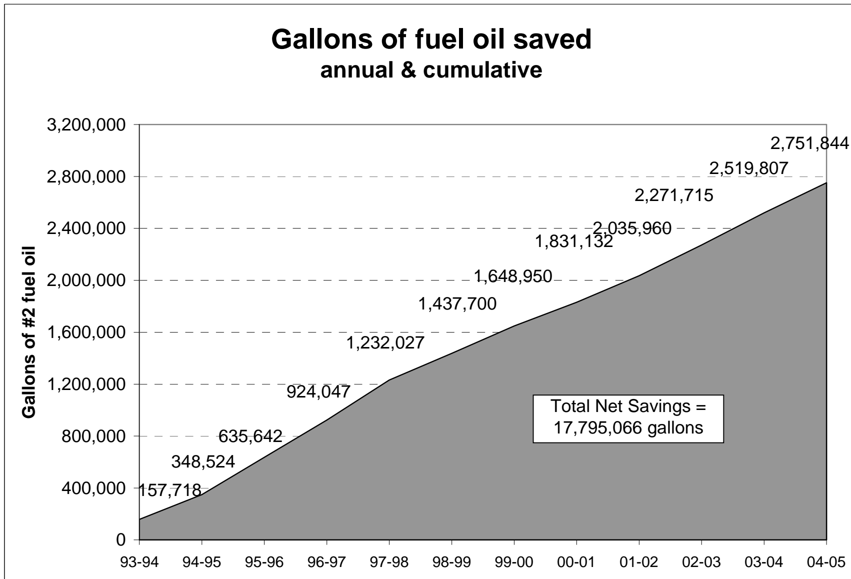
PRESSURES

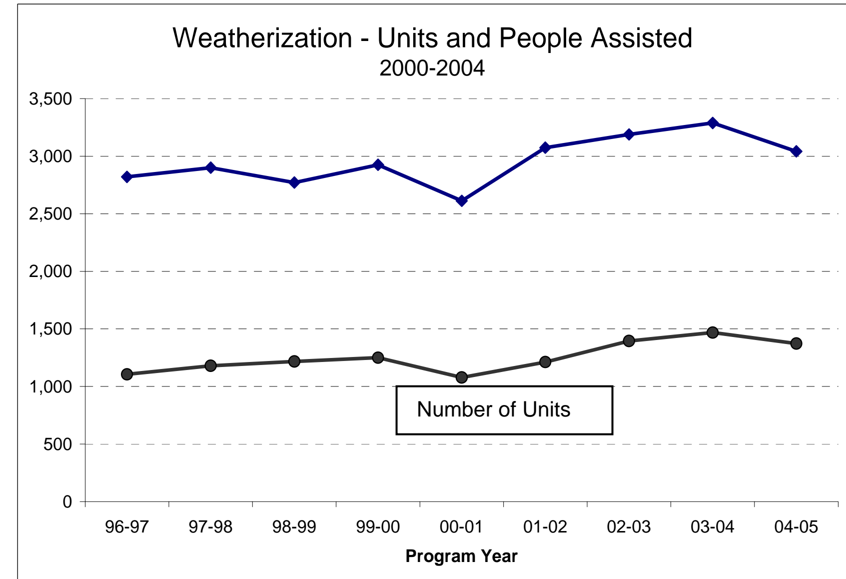
- **Homelessness plagues many Vermonters:** Families with children are found in increasing numbers in homeless shelters. Homeless shelters, Community Action Agencies and other service providers struggle to find decent housing – at any price – for the large number of working, but homeless, families. Living in shelters and being homeless has a negative effect on children. As shelters reach capacity, more and more Vermonters are turned away, ultimately living on the streets or on someone’s couch. **Transitional housing with supportive services** can alleviate some of this pressure.
- Rising **housing** costs are a huge burden. Many Vermont families pay 50 - 75% of their monthly income just to have a place in which to live. As housing costs continue to rise, more and more working Vermonters are caught in this housing 'squeeze.
- **Poverty** is a nagging problem in Vermont. During the '90s, the number of Vermonters at or below the federal poverty level (currently $19,350 for a family of four) rose by 3.6%. We counted 48,483 people in poverty in the 2000 census, creating constant pressure on our emergency service delivery system.

The federal **Community Services Block Grant (CSBG)** was reauthorized in 2003. This grant provides the 'core' funding for Vermont's five Community Action Agencies and is key to providing a host of anti-poverty services to more than 40,000 Vermonters each year, using new and innovative strategies that help people lift themselves out of poverty.









Department of Corrections

"Corrections employees work tirelessly 24 hours a day, 365 days a year, to protect Vermonters and successfully reintegrate offenders into our communities.

~ Rob Hofmann, Commissioner

Number of Positions: 1,171

Funding

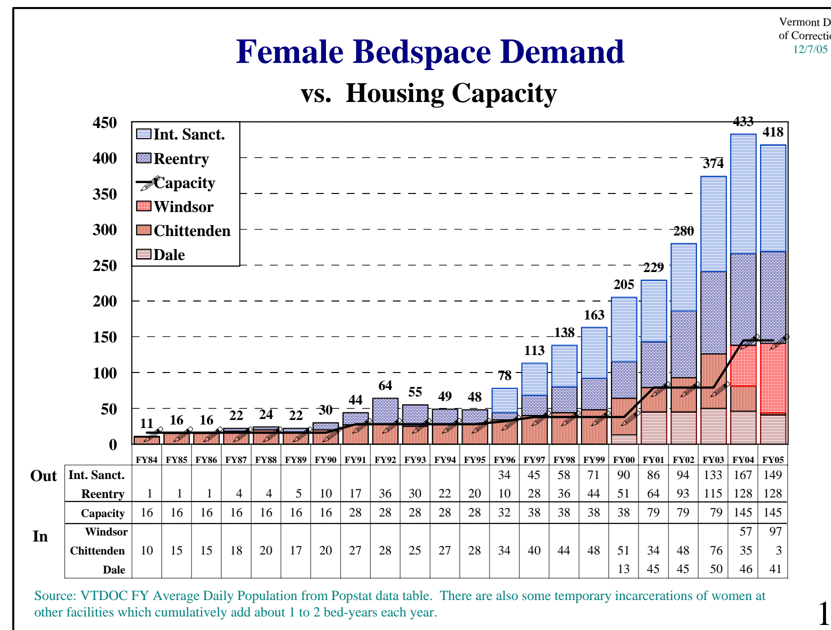
General Fund	$ 108,757,963
Global Commitment Fund	2,750,144
Federal/Other	$ 7,770,465
Total	**$ 119,278,542**

The Department of Corrections supports safe communities by preventing crime, repairing the harm done by crimes, addressing the needs of crime victims, ensuring accountability for criminal acts and managing the risk posed by offenders. The Department manages offender risk, operates correctional facilities for the disciplined preparation of offenders to become productive citizens, and supervises offenders serving sentences in the community. The Department helps communities with Reparative Boards and Community Restorative Justice Centers to address victims' needs and provides opportunities for offenders to make amends for the harm done to the community.

Year	FY '05	FY '06 Est.	FY '07 Gov Rec.
General Fund	94,906,767	103,005,423	108,757,963
Federal/Other	8,662,390	8,375,644	10,520,579
Total	**103,569,157**	**111,381,067**	**119,278,542**

PRESSURES

Prison Overcrowding: Women The criminal justice system responds to social issues as well as public safety. This is particularly true with women offenders, who are generally less violent than male inmates, but pose a risk to themselves or their children's welfare. As communities are becoming more concerned about issues such as mental health and substance abuse, they increasingly seek a criminal justice response. In Vermont the women's prison population has been growing faster than any other segment, at more than twice the rate of men. There are approximately 160 women in prison, up from fewer than 40 five years ago. In 2003, the Southeast Correctional facility in Windsor was converted from a men's to a women's facility in response to this pressure. The number of women on intermediate sanctions or conditional reentry has dipped slightly in the past year, and the number of women in prison has recently stabilized; however, in recent months the numbers have climbed and have reached or exceeded capacity.



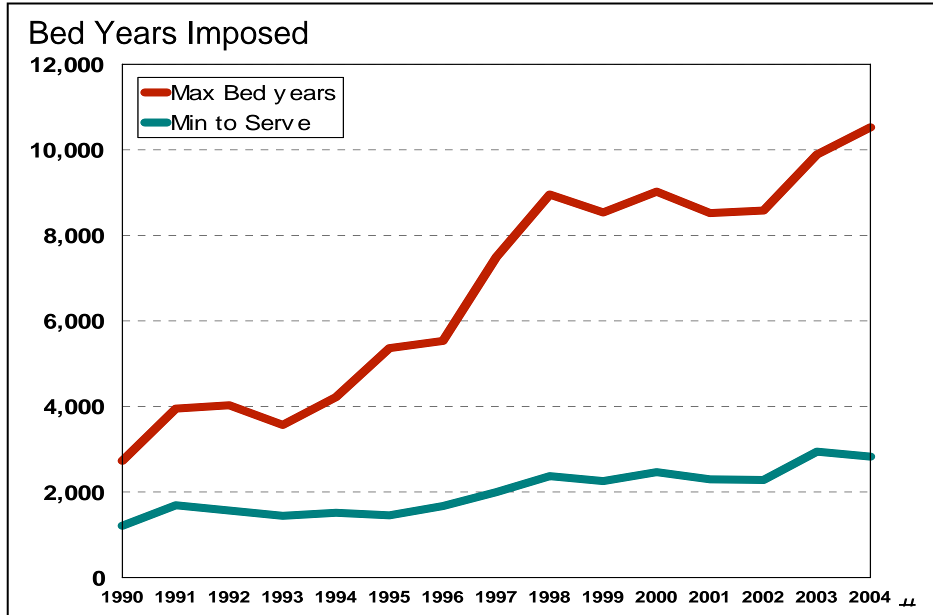
		FY84	FY85	FY86	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05
Out	Int. Sanct.													34	45	58	71	90	86	94	133	167	149
	Reentry	1	1	1	4	4	5	10	17	36	30	22	20	10	28	36	44	51	64	93	115	128	128
	Capacity	16	16	16	16	16	16	16	28	28	28	28	28	32	38	38	38	38	79	79	79	145	145
In	Windsor																					57	97
	Chittenden	10	15	15	18	20	17	20	27	28	25	27	28	34	40	44	48	51	34	48	76	35	3
	Dale																	13	45	45	50	46	41

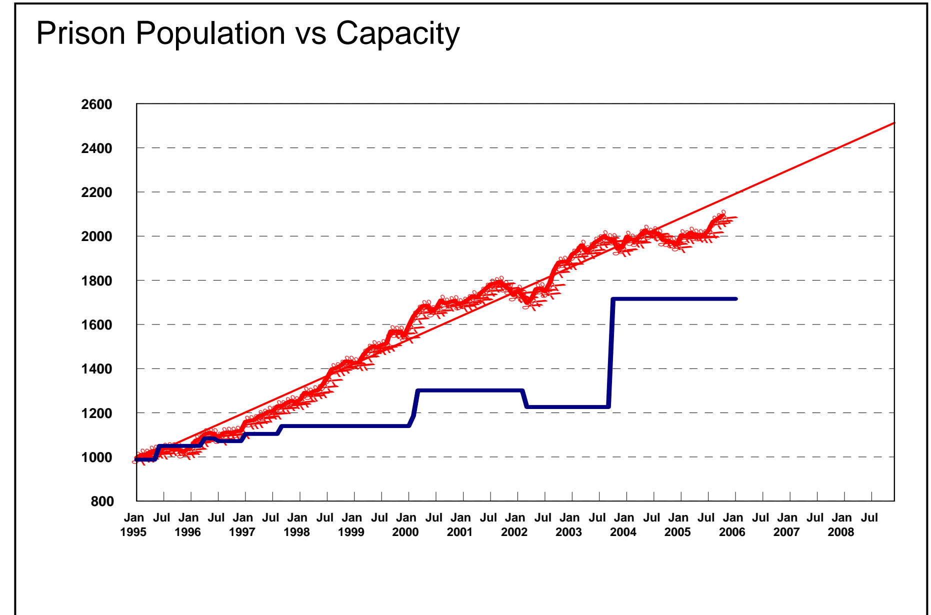
Source: VTDOC FY Average Daily Population from Popstat data table. There are also some temporary incarcerations of women at other facilities which cumulatively add about 1 to 2 bed-years each year.

In 2005, Secretary of Human Services Mike Smith identified that reducing the growth in women's incarceration was to be a major objective for the newly restructured Agency of Human Services. All AHS field sites have developed and are implementing comprehensive plans to build partnerships to increase the availability of community-based interventions for this growing population. Issues confronting women reentering the community include housing, employability, substance abuse treatment, and mental health services, and cross traditional department and agency lines.

The Governor's Commission on Prison Overcrowding, in its report dated August 19, 2004, stated plainly the crisis facing the Vermont Department of Corrections:

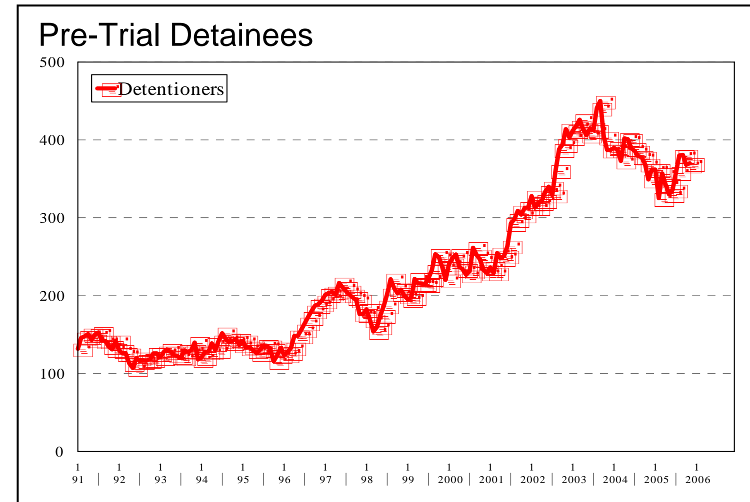
> **"Corrections in Vermont is in serious, if not dire, circumstances. If the current growth of incarceration continues unabated, Vermont will need to build the equivalent of three more Springfield facilities within 6 years at a construction cost of about $32 million per prison. This would require a total capital expenditure on the order of $100 million, not including substantial operating costs.**
>
> **"Virtually all of the many serious problems being exhibited, including some inmate deaths in 2004, are a function of critical, chronic, and recently exploding increases in the populations of its facilities, programs, and capacities."**





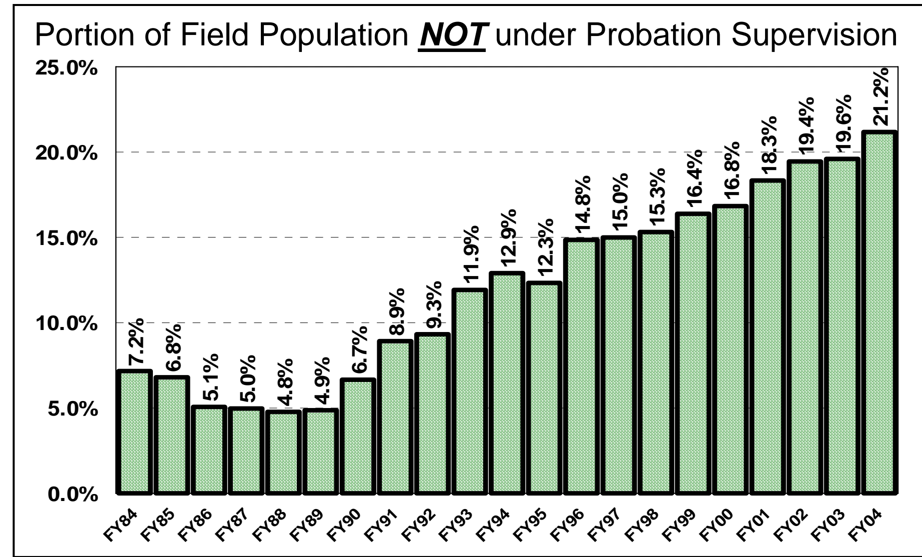
Prison Overcrowding: Sentencing For the past fifteen years there has been an increasing demand for prison space. While the core demand for incarceration has been the number of felons convicted and sentenced to prison terms, felony sentencing practices have remained essentially stable. There are about twice as many felons who were sent to prison in 2005 compared to 1990. However, sentencing of misdemeanants and motor vehicle misdemeanants shows a very different pattern. The average maximum sentence imposed for a misdemeanor or motor vehicle offense in 2005 is ***five times*** longer than in 1990. That, coupled with an doubling since 1990 of the number of sentences imposed, has increased the number of bed years "reserved" by the courts from 496 years to 5,304 bed years in FY2005, more than a tenfold increase.

The population in jail detained waiting trial has continued flat, with the cooperation of the Vermont District Courts, State prosecutors, and the bar, working to reduce the length of stay prior to resolution. However, the sentenced population has continued to increase.

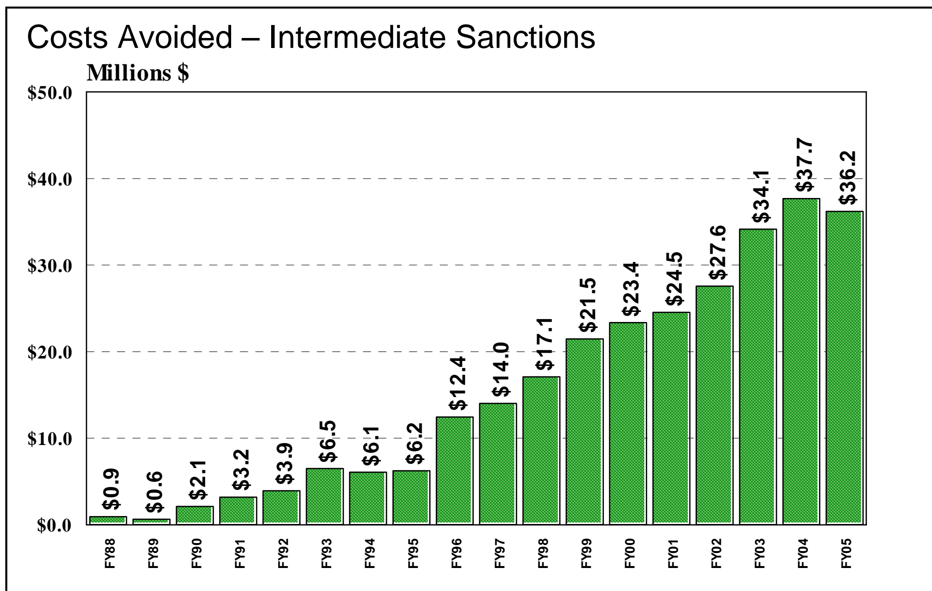


OPPORTUNITIES

Overcrowding in Community Corrections: Corrections' biggest cost center is prison space. However, the vast majority (12,400 of a total of 14,500) of the offenders in custody are under supervision in the community. Increasingly, offenders are placed in the community on sanctions other than Probation with an expectation that Corrections will provide treatment services and accountability for this population, the majority of whom pose low risk of re-offense. The ability of Corrections to manage offenders being released from incarceration becomes increasingly difficult in the face of the expectations for supervision and monitoring behavior for these low risk offenders.

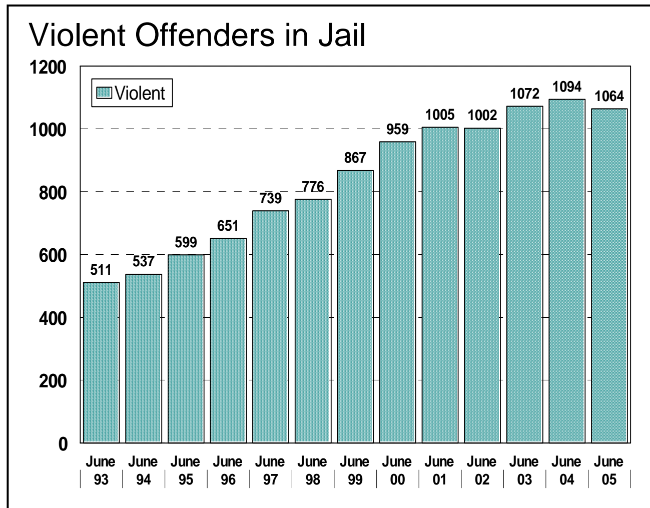


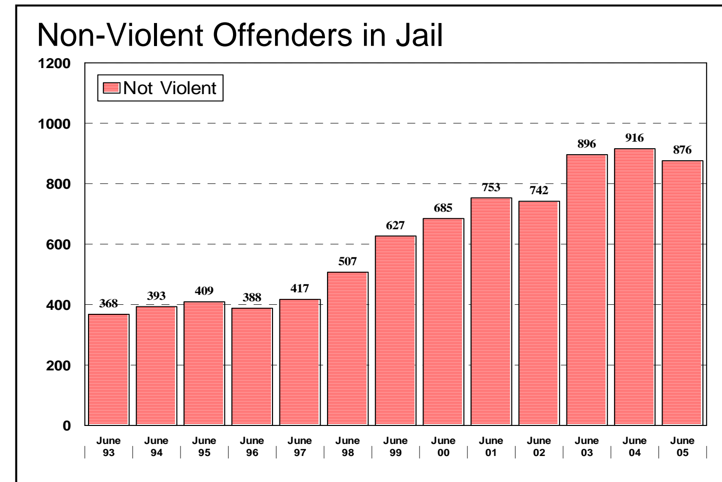
With more than 20% of the field population (some 2500 individuals) being supervised in the community under intermediate sanctions, parole, or on conditional reentry following incarceration, the field staffing levels are the same as five years ago. This has led to a saturation of community-based alternative programs, as well as intensive supervision caseloads. There are two general outcomes of this saturation: first, an increasing challenge to field personnel to take on more caseload; and second, a reduction in the time available per case, leading to staff reducing community involvement in cases, collateral contact, and collaborative community supervision with non-governmental controls.



The increase in the use of intermediate sanctions, and the increased numbers of offenders on conditional reentry after serving prison sentences has had significant impact on reducing costs of Corrections, diverting large numbers of offenders from incarceration at a fraction of the cost of prison. If all of the offenders on intermediate sanctions were housed in prison, the costs would approximate an additional $26 million. In fiscal year 2005, there was an average of 1,882 sentenced offenders in the community, nearly as many as the 1,992 average population in prison. In other words, technically, 48.5% of the sentenced population was not in prison.

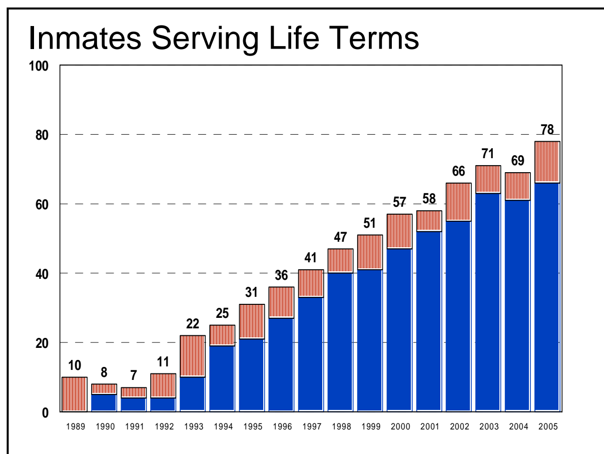
Maintaining these people in the community is not simply a criminal justice and supervision issue. The complexity of needs presented by many of them requires the coordinated efforts of the array of human and community services, particularly with regard to housing, mental health, substance abuse, and employment opportunities. To a large degree, the restructuring of the Agency of Human Services, with returning inmates as a priority population, will allow the targeting of resources to this group.

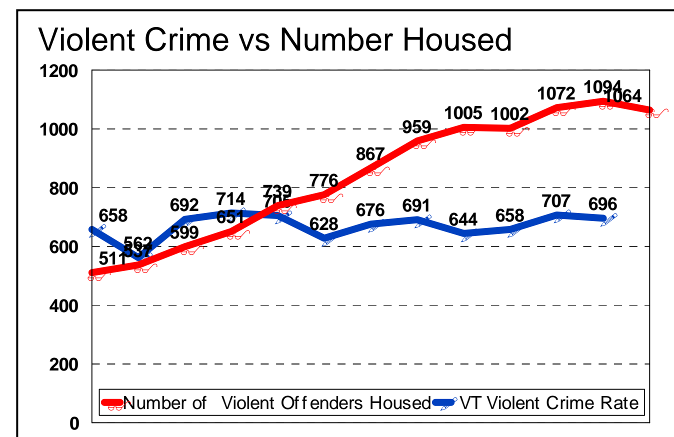




Public Values: According to market research conducted from 1994-2001, Vermonters believe prisons are for those who are dangerous to society. They also believe prisons should rehabilitate and have programs specifically for youthful offenders. For non-violent offenders they believe prison is counter-productive. They believe non-violent offenders should be accountable and acknowledge responsibility for their crime to the community and to their victims. Vermonters also believe offenders should make amends and repair damage where the damage can be repaired. Perhaps most important, Vermonters want to participate in justice, helping individual offenders and in decisions on admission to the system and release from it. Finally, Vermonters expect quality of service, at an affordable price.

PRESSURES



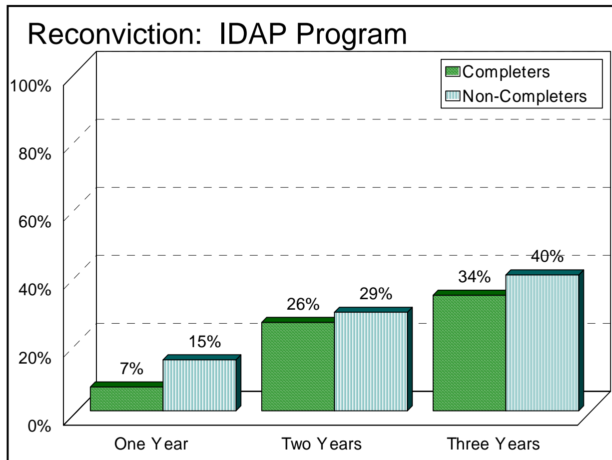


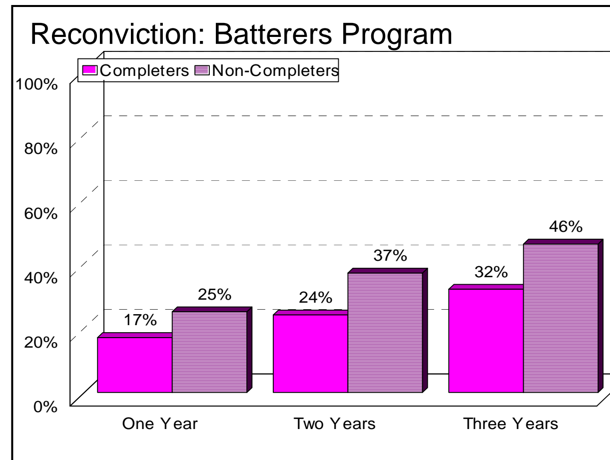
Safety: Safety from violence is the fundamental expectation of the Vermont justice system. Prison space should, therefore, be reserved for violent and repeat offenders. . To measure safety as an outcome we first measure the number of violent and high-risk offenders that are incarcerated. As sentences for serious offenses have increased, the length of stay has increased. The number of offenders in June 05 in the graphs above reflected a drop in demand. However, since that time, they numbers have increased. The average time served by violent felons housed in prison has more than doubled in the past ten years. This is consequence of specific sentencing, not a shift in sentencing practice. The number of felony sentences doubled in the past fifteen years, but the average minimum and maximum terms were relatively unchanged. The number of violent offenders housed has increased, but violent crime has been stable.

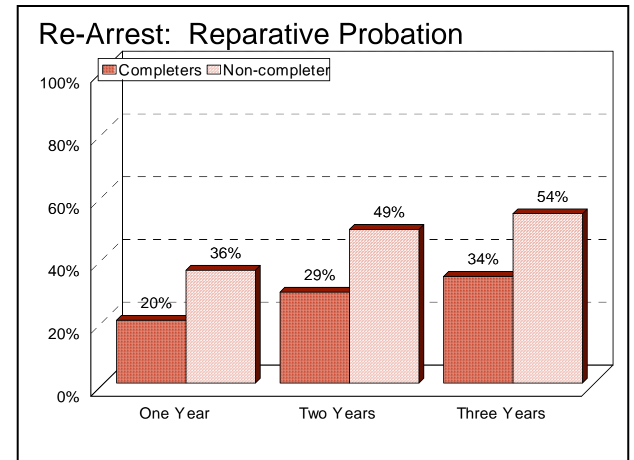
The number and severity of offense of the prison population has continued to increase, as sentences for both violent and non-violent offenders have increased. Both the incarceration rate and the length of stay have increased. The result is that the numbers in the incarcerated population of inmates who have committed violent crimes has increased, despite the ongoing reduction in the incidence of violent crime itself.

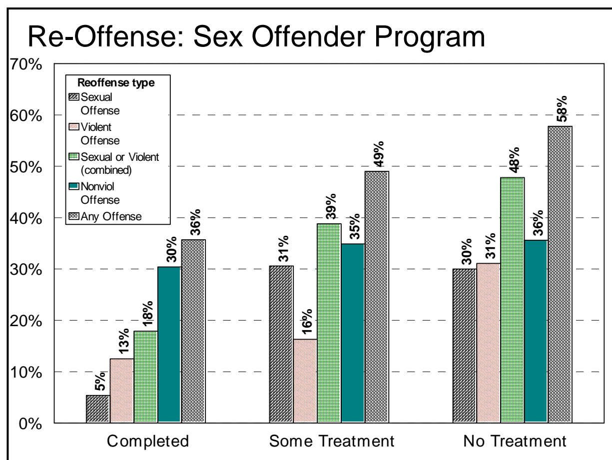
ACCOMPLISHMENTS

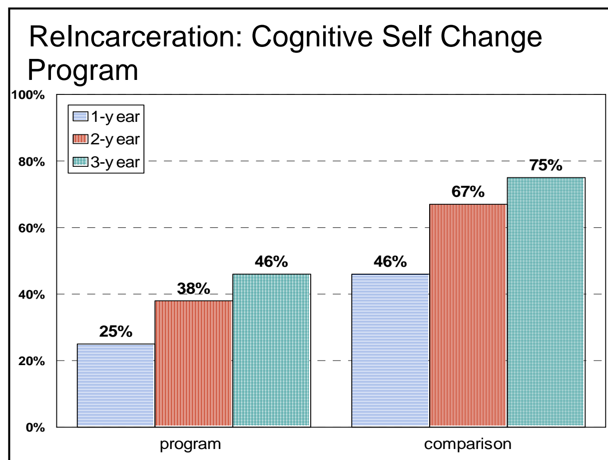
Treatment: Vermonters overwhelmingly expect treatment programs for offenders. They don't expect treatment to work every time, but they do expect it will be provided by the Department. Treatment programs costs are substantially less that the avoided costs of re-incarceration. The Cognitive Self Change program produces a 38% reduction (comparing the rates of completers vs. non-completers) in reincarceration; the Sex Offender Program produces an 83% reduction in repeat sexual offending; the Intensive Substance Abuse Program produces a 22% reduction in reconviction; the Intensive Domestic Abuse Program produces a 15% reduction in reconviction, the Batterer's Intervention Program produces a 30% reduction in reconviction, and the reparative probation program produces a 37% reduction in re-arrest (a different measure, but more significant).

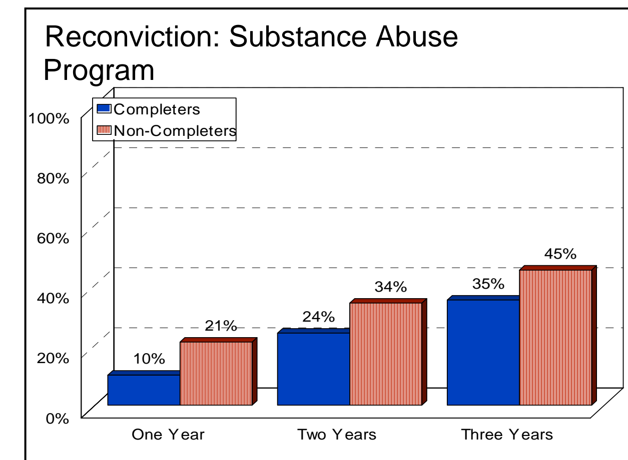




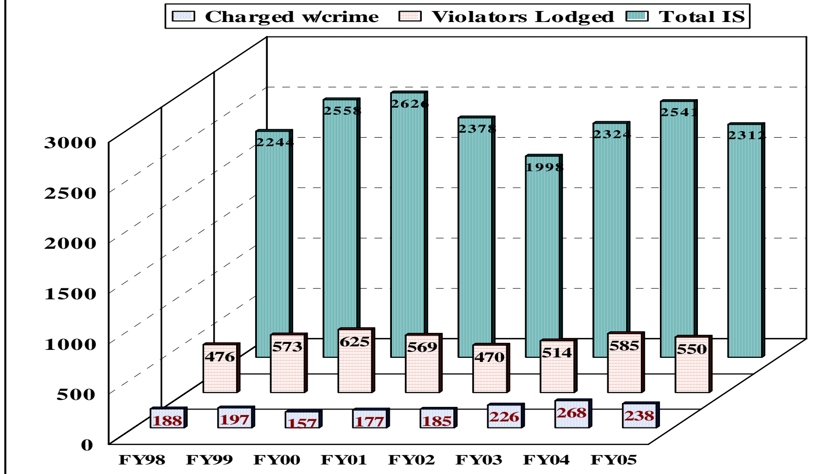








Accountability: Violations and New Charges -- **Intermediate Sanctions**

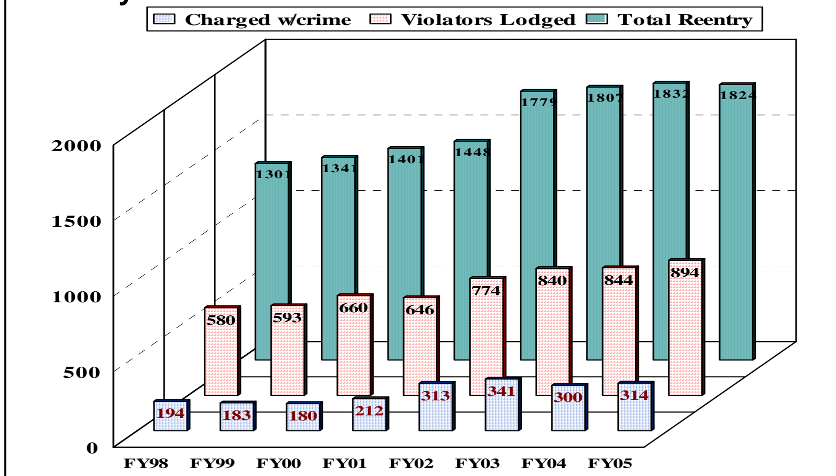


Accountability

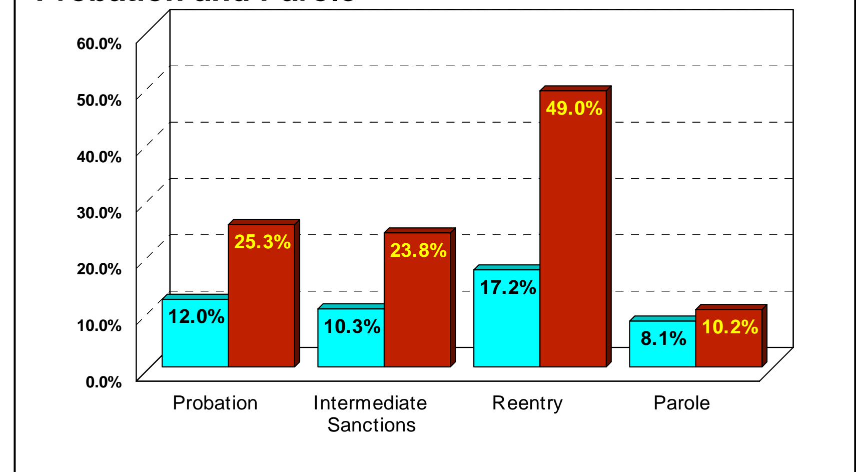
In 1995, sentencing options were implemented to give judges alternative sanctions to incarceration. Judges could focus on reserving the most expensive resource (prison beds) for higher risk, violent, and repeating offenders. The Department holds offenders on conditional re-entry to a high level of accountability. Half of such offenders are brought back to jail for a short duration, while the other half do not violate their conditions. Very low rates of new charges or new convictions (the front bars in the graphs) are strong evidence of success. Intermediate sanctions are reserved for those who pose a lesser risk and who are also held to a high level of accountability. Offenders on parole have succeeded in re-entry and the results are positive. Offenders on probation receive less supervision and commit new crimes at a higher rate than those on parole or intermediate sanctions.

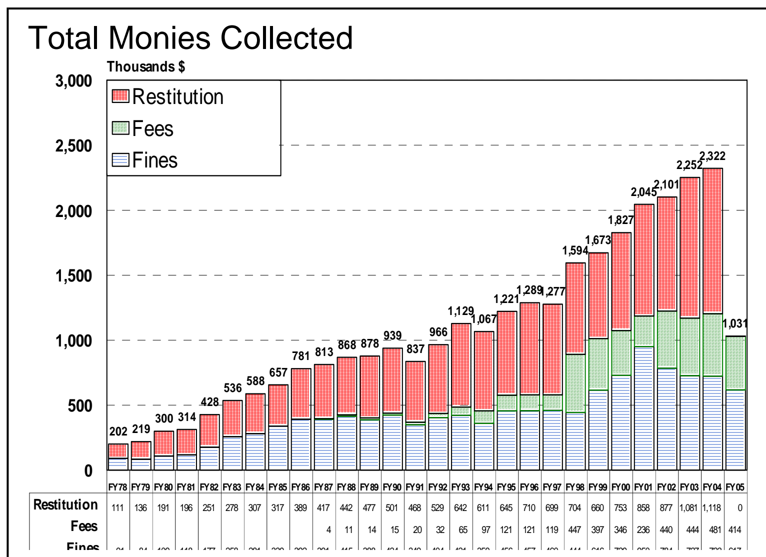
Accountability is not only achieved through avoiding conviction for a new offense. In fact, it is the fundamental job of corrections to hold offenders accountable for their behavior *before* it escalates to a level of crime. Intermediate sanctions and conditional reentry are extremely successful in support of this strategy. An offender is found in violation of a condition of release, is brought back to prison for a graduated sanction, short of total revocation. This works. The offenders on these intermediate levels re-offend at levels comparable to those levels in the open community.

Accountability: Violations and New Charges -- **Conditional Reentry**



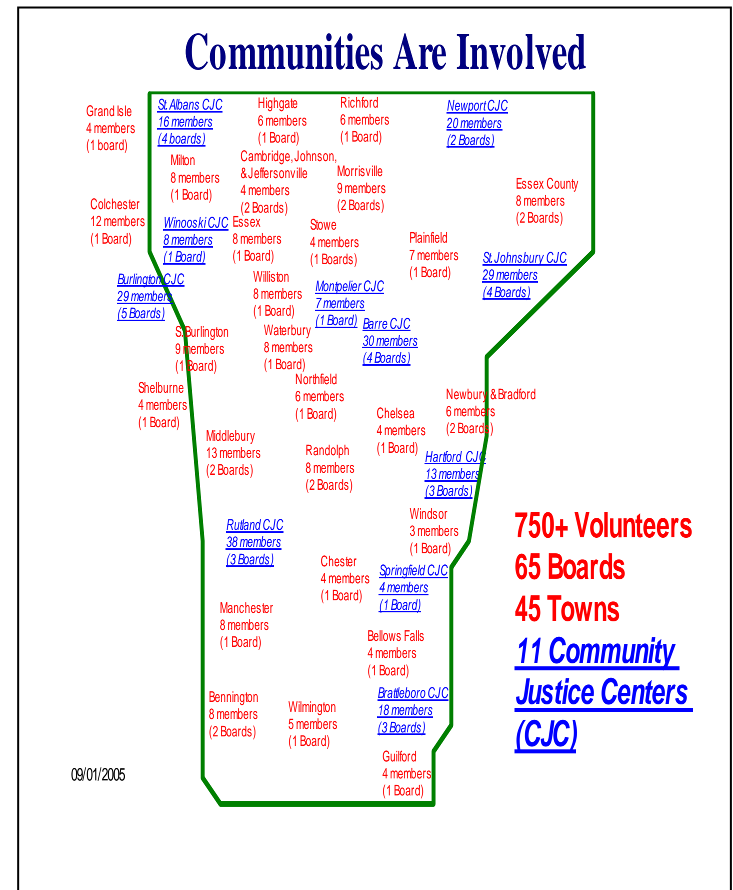
Accountability: Violations and New Charges – **Probation and Parole**





Reparation:
Vermonters expect offenders to make amends. Repairing damage and adding value to communities is done through contributions of service to volunteer and non-profit organizations, by working in a correctional work program inside a facility, and by apologizing to their victims. Vermonters want good to come from the response to crime and restitution made to victims. In the graph at the left, the drop in collections for restitution is positive. The entire collection process for restitution was transferred last year to the Office of Crime Victims Services, resulting in victims receiving immediate payments, rather than waiting for the offender to earn the money and pay it back.

Involvement. Vermont citizens amazed the Department with their desire to become involved in the system. Nearly 1,500 Vermonters volunteer in some capacity in the corrections system. More than 400 Vermonters have been reparative board members since the program began. In 2004, some 1,537 cases were given Reparative Probation, and dealt with by community boards. In addition, there are 11 Community Justice Centers in operation. These Centers manage a large number of crimes which would otherwise need to be dealt with in the community, without courts, corrections, or attorneys.



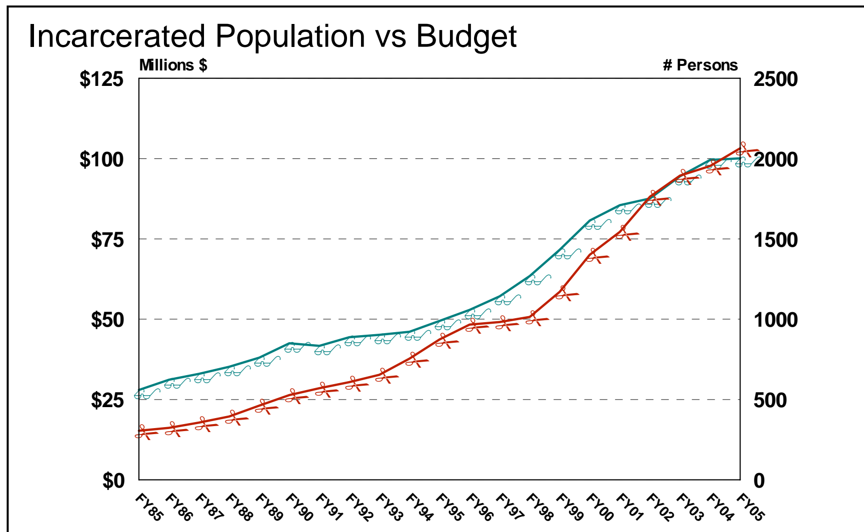
This approach uses the strengths of a community as the centerpiece and allows for informal community peer pressure to reinforce, and sometimes replace formal, expensive systems of criminal justice. Community partnerships have been strengthened recently by creating Restorative Community Justice Centers. Through these Centers, Municipalities can expand their community involvement by intervening early in conflict and disputes to divert resolution away from the adversarial, expensive, criminal justice process.

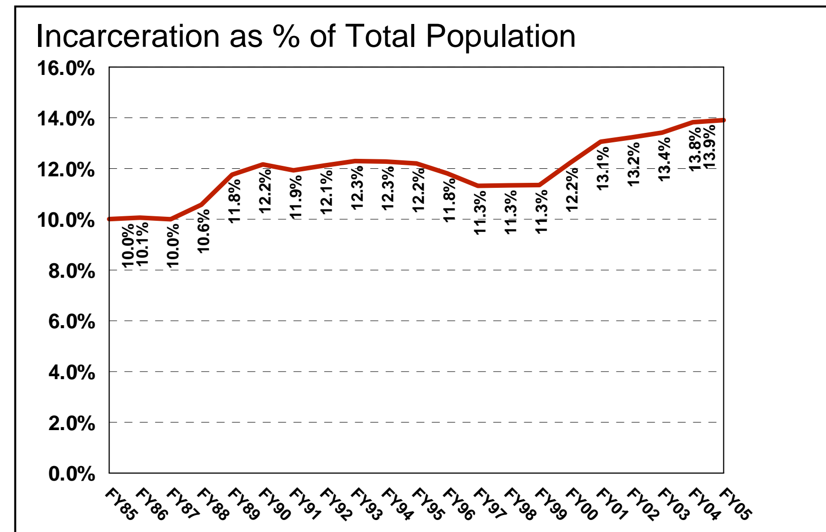
Quality: As more of the sentenced population has been placed in the community under intensive supervision, and despite the level of accountability and risk control that has been applied, cost reduction has been significant in comparison to the costs that would have been incurred by incarceration. The use of intermediate sanctions and conditional re-entry is effective in avoiding significant costs. They are an important part of why Vermont has maintained a relatively low cost to the taxpayer in spite of the seemingly significant increase in the Department's budget year after year.

CASELOAD AND COST DATA

Cost: The Department's budget has increased faster than most state agencies' for more than ten years. The total budget has increased more than 150% from $44 million in FY199 to $119 million in FY2007.

Total Caseload:
Since FY1995, the total number of individuals under the supervision of the Department of Corrections has increased 63%, from 8,107 to 14,088. The incarcerated population has more than doubled from 989 in 1995 to nearly 2,100 in 2005. The number of offenders on intermediate sanctions and furlough re-entry has increased five-fold, from 330 to 1,573. More than 44% of the sentenced population is **not** in prison.

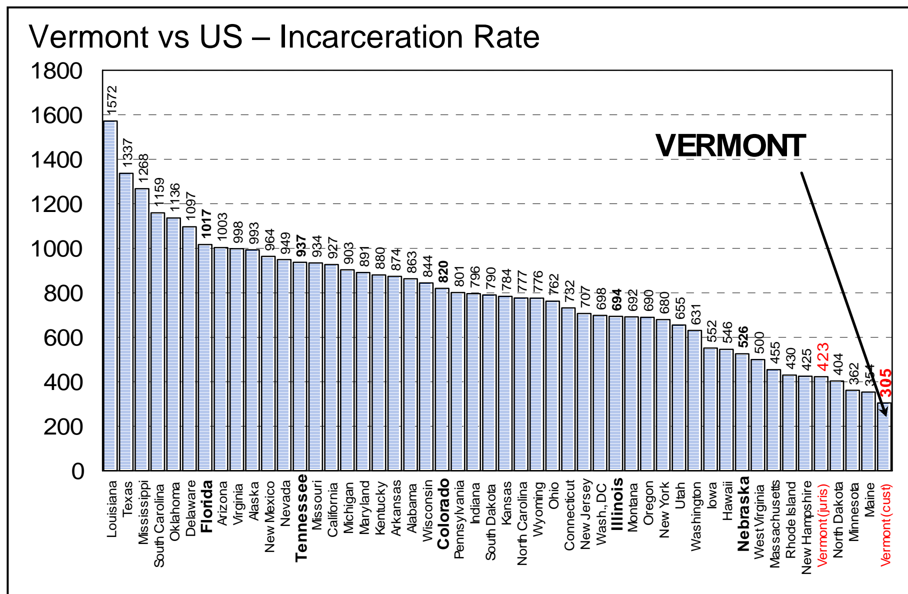


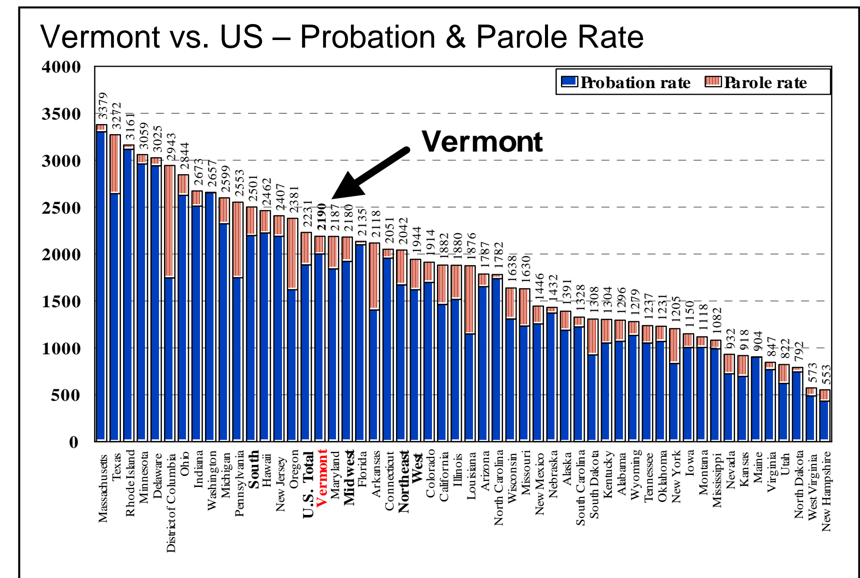


Incarceration:
Facilities are by far the largest cost item in the Department's budget. The caseload has increased far beyond Vermont's prison capacity. As a result of the increases in population, we contract to house over 400 inmates in out-of-state beds, primarily in Kentucky under a contract with the Corrections Corporation of America. This has enabled us to avoid construction of significant new bed space, or major legislative or judiciary changes to reduce demand. The department, with the support of the governor and the legislature, has embraced the recommendations in the report of the Governors Commission on Prison Overcrowding, and has implemented major changes to include the use of electronic monitoring, transitional housing, reintegration furlough, and other measures to reduce detention, hold down sentencing, and attempt to reform the system of corrections in Vermont. As the commission report stated, it took a long time for the Department of Corrections to get into the level of problems it faces, and it will take several years for the Department of Corrections to resolve the complex issues they currently face.

Vermont has one of the lowest crime rates in the nation, and the incarceration rate is the lowest. However, we also have, paradoxically, one of the higher rates of Probation & Parole in the nation. This rate translates into the very large number of citizens under the supervision of the State. While this is a form of social control that is relatively benign, it places a large population at risk of incarceration and provides the pool from which incarceration is drawn. Incarceration is increasing as a portion of that total.

The graphs below illustrate the two rates. The Incarceration rate shows the ranking of Vermont comparing instate housed populations. However, this is not comparable to the other states, since many of them also house population in out of state or private facilities. The probation and parole graph does not show the numbers on Conditional Reentry for Vermont, as very few States have such a program.





"The mission of the Department of Disabilities, Aging, and Independent Living is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence."

- Patrick Flood, Commissioner

Department of Disabilities, Aging, and Independent Living

Number of Positions: 297

Funding:

General Fund	$ 16,889,639
Global Commitment Fund	129,441,301
Federal/Other	$26,080,245
Total	**$172,411,178**

The Department assists older Vermonters and people with disabilities to live as independently as possible. It provides support to families of children with disabilities to help maintain them in their home. It helps adults with disabilities find and maintain meaningful employment and it ensures quality of care and life for individuals receiving health care and/or long-term care services from licensed or certified health care providers. The Department also protects vulnerable adults from abuse, neglect, and exploitation; and provides public guardianship to elders and people with developmental disabilities.

Year	FY '05	FY '06 Est.	FY '07 Gov. Rec.
General Fund	55,730,552	60,399,406	16,889,632
Federal/Other	93,921,787	94,679,594	155,521,546
Total	**149,652,310**	**155,079,000**	**172,411,178**

OPPORTUNITIES

The recent reorganization of the Department brings almost all of Vermont's core home and community-based services together. While this change includes some challenges, it presents us with major new opportunities to:

- View the needs of Vermonters across all disabilities and ages, rather than through the more narrow lens of individual programs;
- Develop a comprehensive, individualized approach to meeting needs across programs and funding sources;
- Improve transition planning for youth who are "aging out" of children's services;
- Increase opportunities for people to manage services and supports for themselves or their families: Consumers and families have more opportunity for increased control and management of their own services. The Department supports consumers by contracting with an intermediary service organization to provide assistance with employer responsibilities such as payroll, taxes and insurance. The development of a *Guide for People Self/Family Managing Medicaid-funded Services* provides additional guidance to consumers, families and service providers; and
- Improve our efforts to ensure the quality of home and community-based services. Through a Real Choices Quality Assurance/Quality Improvement Systems Grant from the Centers for Medicare and Medicaid Services (CMS), the Department will develop a comprehensive quality management system in all four Home and Community-Based Services Waivers using the CMS quality framework. The goal is to effect enduring systems change that fulfills Vermont's commitment to ensure the health and well-being of elders and individuals with physical and intellectual disabilities receiving Waiver services within Vermont's community-based long-term case system.

The Department continues to advance alternatives to nursing home placement (under Act 160, of the 1996 Legislative session). To promote this we need to:

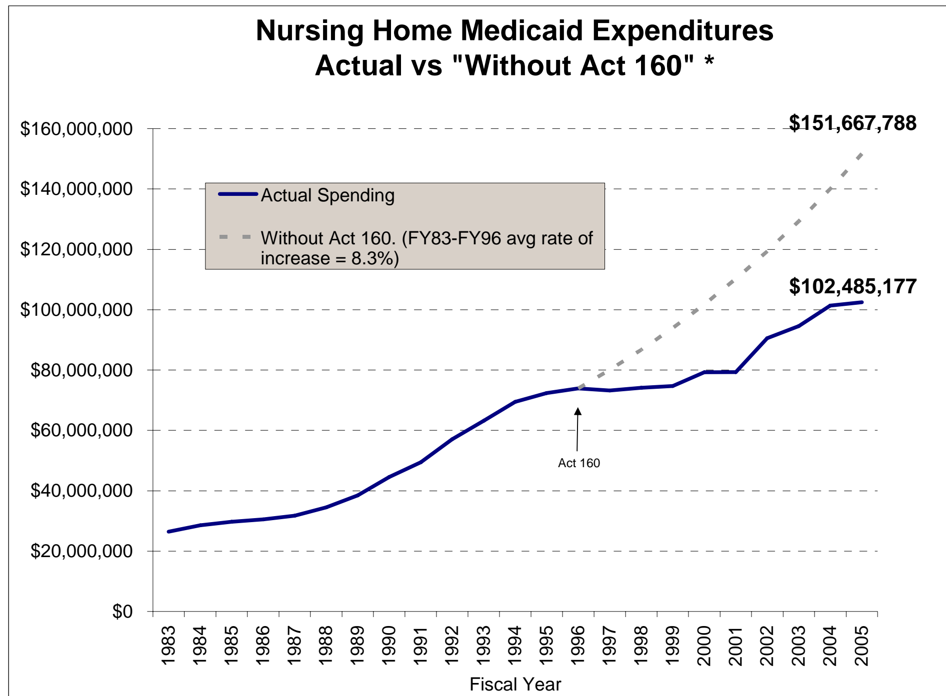
- Expand the system of home based services for elders and adults with disabilities by implementing the new 1115 Choices for Care Waiver, with equal entitlement to either home based or nursing home care.
- Maintain a healthy Area Agency on Aging network. These agencies face continuing financial challenges as the demand for services and the cost of providing those services continue to increase, while federal funding decreases or remains flat. Our efforts to build a strong community-based system of care cannot succeed without these Agencies.
- Continue to develop new housing/service models (e.g. adult family care) and expand programs to make individual homes accessible.
- Expand efforts to attract and retain more people to work as caregivers. Improvements in working conditions are as crucial as adequate wages and benefits.
- Expand adult day services to serve more people in more sites.
- Develop a complete system of care for younger adults with disabilities.
- Expand our public information and outreach to ensure that consumers and their families know how and where to find information about the care options available. Vermont has obtained a three year grant form the federal government to create "Aging and Disability Resource Centers" to develop model approaches to providing information and assistance to elders and adults with disabilities.
- Increase intervention and prevention services to address the steady increase in Adult Protective Services reported cases.
- Develop and implement the Governor's "Healthy Aging Initiative" to help prevent unnecessary and premature physical and health problems among older Vermonters.
- In the face of budget pressures, maintain a federal grant that provides long standing services related to assistive technology and technical assistance for people who need assistive devices due to disability.

PRESSURES

- The Department expects fewer nursing beds will be needed in the future, even though the rate of decreased utilization has slowed. Managing the demand as homes downsize or close will be a challenge. At the same time, we may need to increase funding to some nursing homes to ensure an adequate level of service is available in all parts of the state.
- Community-based alternatives to institutionalization need to be expanded and enhanced.
- Transportation and housing needs continue to increase for elders and other adults with disabilities. Meeting these increasing needs will be difficult in our rural state since the costs are rising while federal transportation funding remains stable and federal housing subsidies shrink.
- The Department will be challenged to assist more people with disabilities to find work in a flat economy. Vocational Rehabilitation caseloads have risen over 40% in the past years. Without additional capacity to serve this growth, consumers may be placed on waiting lists for the first time in the program's history.
- Although the rate of disability among older people is decreasing, both the rate of disability and life span are increasing for younger people with disabilities. A recent grant from the National Governors' Association Center for Best Practices will help us to better organize and support healthy aging and disease prevention programs.
- There are increasing caseload demands for individuals of all ages with developmental disabilities. This is due to many factors including abuse, neglect and exploitation; personal and public safety; long term supports needed after high school graduation; loss or aging of caregivers; homelessness; institutionalization; youth leaving the custody of the Department for Children and Families at age 18; and individuals who formerly would have been placed in nursing facilities.
- Budgetary pressures have forced the Department to set priorities for eligibility as well as restrict access to services for children and adults under the Developmental Services System of Care Plan since December 2001. It is estimated that approximately 40 children with developmental disabilities per year still require a higher intensity of services that could be provided through Medicaid waiver funding at a cost of 1.1 million dollars. The most critical needs of children include avoiding institutionalization, including residential school placement, and maintaining the child within the family.
- The Department keeps an Applicant List of people who are not eligible for developmental services funding, but who still seek services. If the 168 people who applied for services since FY '02 but have not received funding were funded, it would cost $2,746,593. Services requested include service coordination, community and work supports, clinical interventions, home supports and family supports.
- Adult Protective Services has experienced a continuing increase in the number of reports of abuse, neglect and exploitation of vulnerable adults. The Department convened a task force that has studied how to better address the issues of abuse. We want to study innovative ways of responding to abuse allegations, as well as developing prevention strategies.

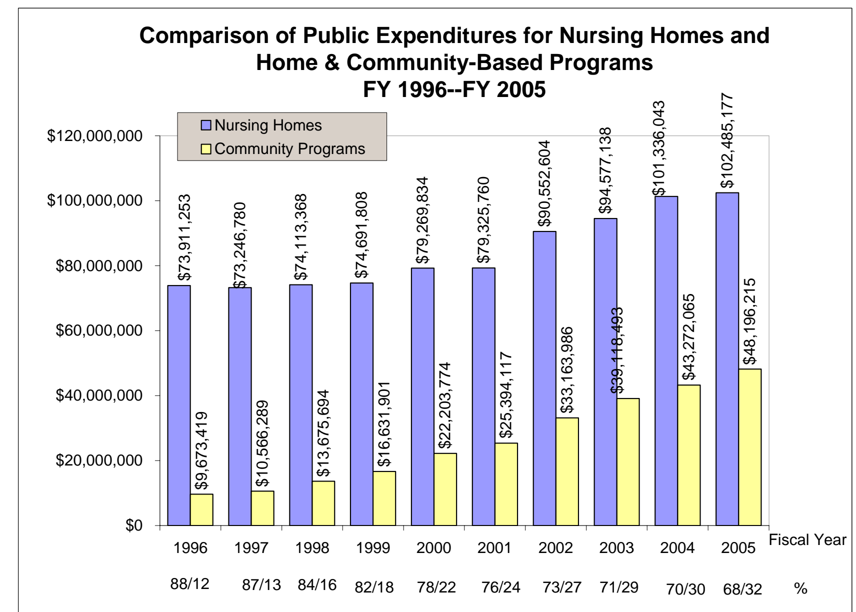
ACCOMPLISHMENTS

Over the past decade, the number of people utilizing nursing homes has declined in proportion to the number of people served by Medicaid Waivers. Limits on funding for home and community-based services, coupled with an entitlement for nursing home care remains a challenge as we continue to try to find ways to grow and support home and community-based services.



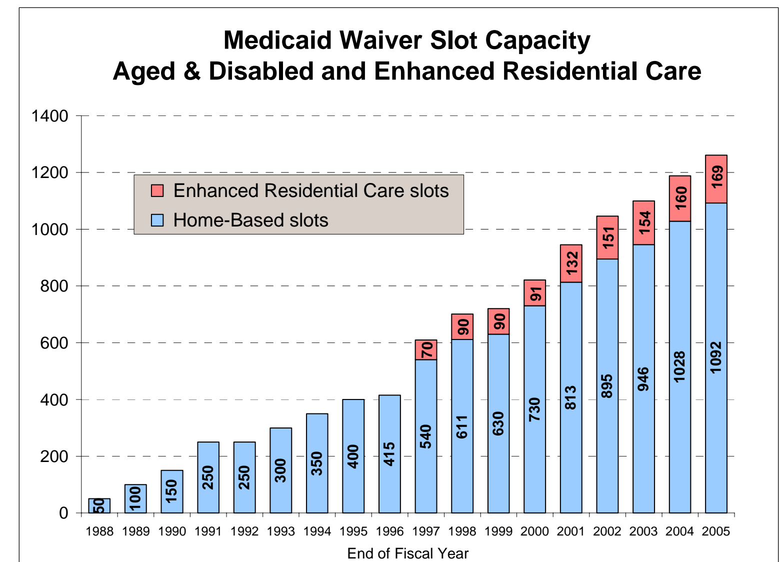
Nearly $50 million in nursing home costs have been avoided since 1996. Those dollars have been used to bolster home and community-based services. Act 160 has been a significant success. (Act 160, enacted in 1996, required the State to take saved dollars from reduced Medicaid nursing home utilization and shift those funds to home-based care.)

The Department continues its commitment to quality care in nursing homes. Nursing home expenditures continue to grow even as the number of people in nursing homes declines. However, home-based services occupy an increasing proportion of total public long-term care expenditures, having risen to 32% in Fiscal Year 2005.



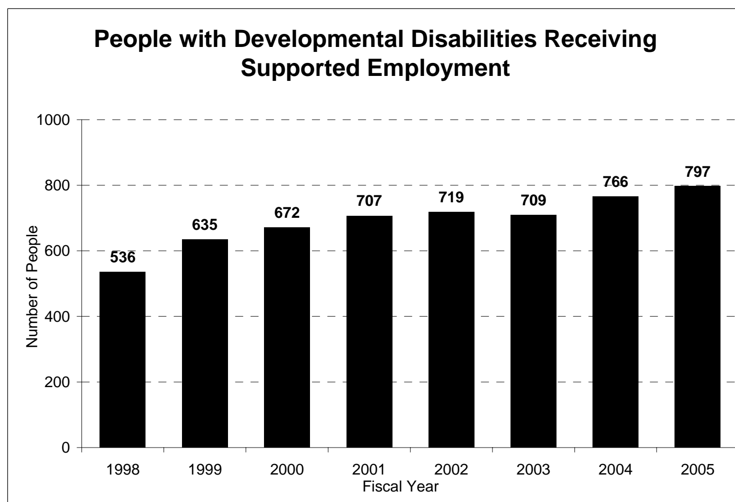
Vermont starts innovative Choices for Care Waiver to provide more access to home based care.
In October of 2005, the federal government approved a ground-breaking Waiver for long term care services in Vermont. Under the terms of this Waiver, Vermont will provide an entitlement to home based care. Until this Waiver, only nursing home care was an entitlement; people desiring home based services had to wait in line for limited resources. Now, Vermonters can choose either home based care or nursing home care.

Vermont has experienced a steady growth of utilization of home-based services. We expect that will continue under this Waiver, along with incrementally declining use of nursing homes. We will still require nursing home care, and need to make sure that care remains available and high quality for the persons who need it.



Housing with supportive services is crucial as an alternative to nursing home care; it can prevent unnecessary institutionalization.

- $800,000 has been invested in cost-effective service coordination and gap-filling services in congregate senior housing.
- Residential care homes have improved their capacity to serve people with higher levels of need. There are currently about 165 people in residential care homes that are nursing home eligible. Our Enhanced Residential Care program is serving these residents.
- Licensed assisted living is now an option in Burlington, Rutland, Norwich and Windsor. Other assisted living residences are in the planning phase.

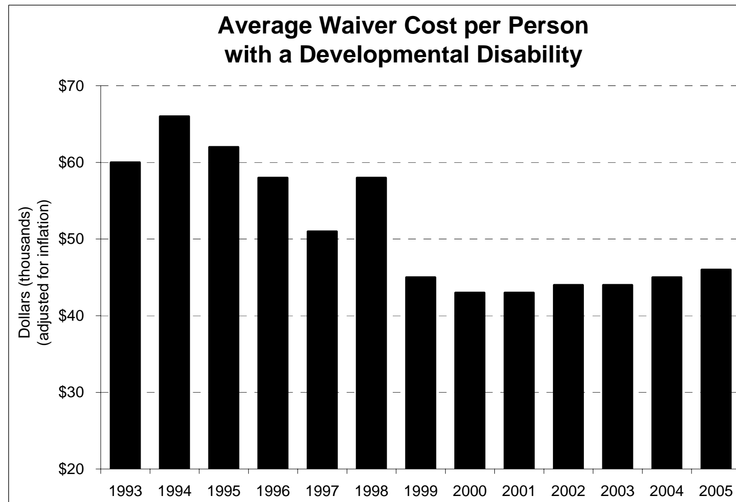


Supported Employment to Work

Vermont continues to be ranked 1st in the nation for people with developmental disabilities who receive supported employment services. In FY ’04, service providers helped 37% of working age adults with developmental disabilities to work. In FY ’05, an estimated $1,090,296 was saved in public benefits due to people working.

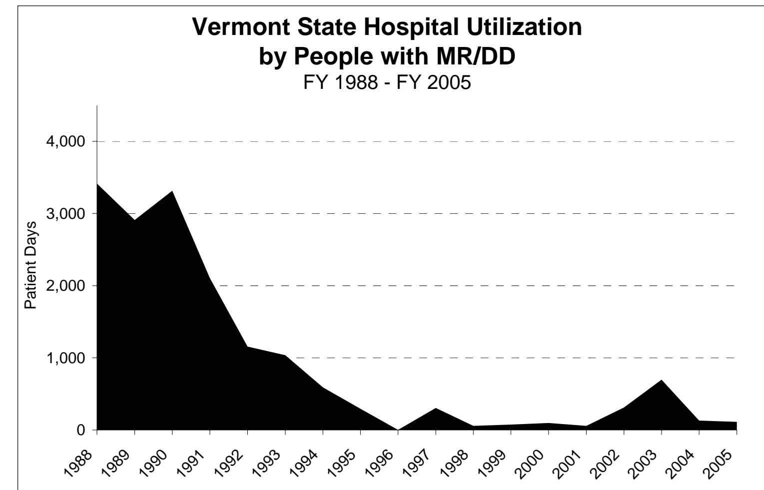
Green Mountain Self-Advocates Grow

A network of 16 peer support groups have formed a strong foundation for the statewide self-advocacy organization that provides public education and awareness, peer mentoring, support and direct action. Green Mountain Self-Advocacy, with funding through the federal Real Choices Systems Change Grant, is providing education to peers and service provider board members on best practices for including people with disabilities on agency boards.



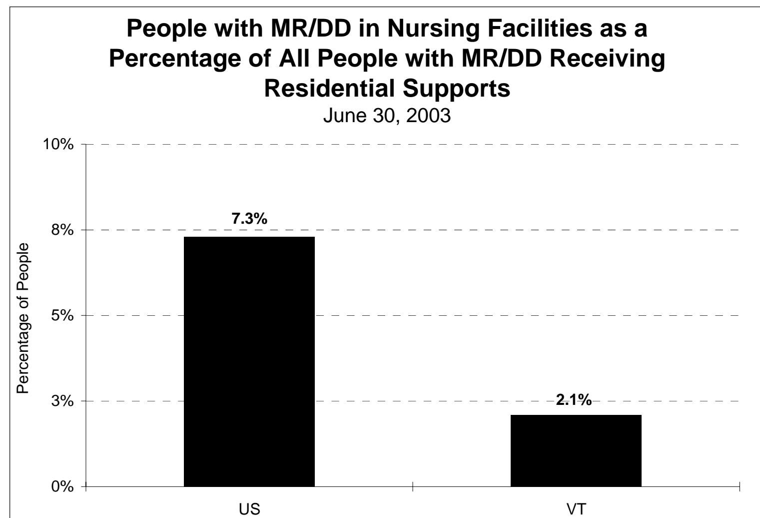
Federal Medicaid Waiver Costs Stabilize

Since the Brandon Training School closed in FY '94, the average cost of waiver services per person served have declined. Average waiver costs have remained relatively stable for the last five years.



Crisis Services Successful

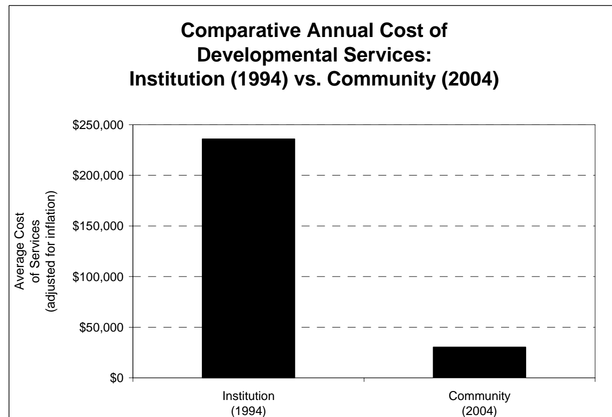
Since VT's Crisis Intervention Network was formed in 1991, Vermont State Hospital utilization by people with developmental disabilities has dropped dramatically. Last year, the Network created a second statewide crisis bed along with increased regional clinical and crisis capacity.



People with Mental Retardation/ Developmental Disabilities in Nursing Facilities as a Percentage of All People with MR/DD Receiving Residential Supports

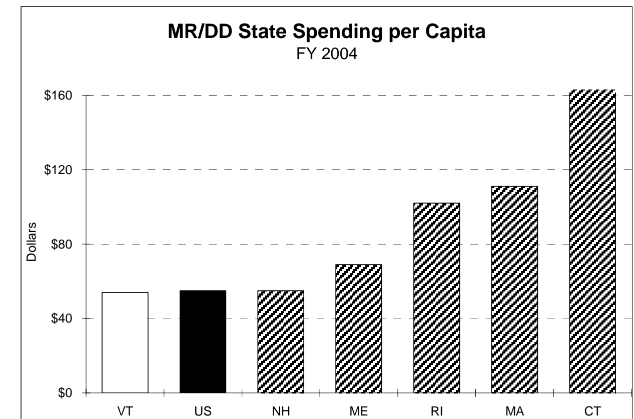
The number of people in Vermont with MR/DD in nursing facilities compared to all residential services for people with developmental disabilities in Vermont is 2.1%, well below the national average of (7.3%).

CASELOAD AND COST DATA



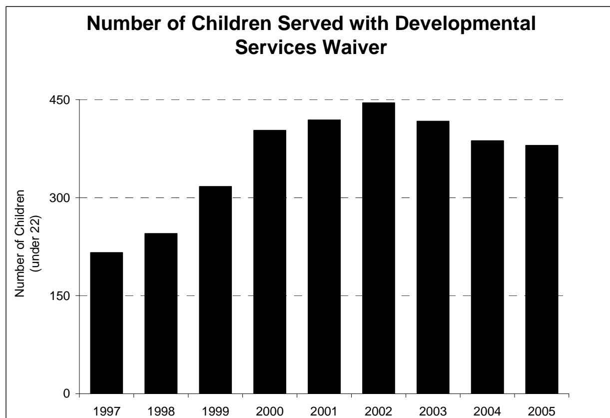
Community Services More Cost Effective than Institutionalization

In the last two full years of Brandon Training School, it cost an average of $235,934/year for each person served (adjusted for inflation). In FY '04, it cost $30,386 per person (in current dollars). Approximately 9 families can be supported with intensive in-home support, or 210 families can be supported with respite support, for the same amount of money.



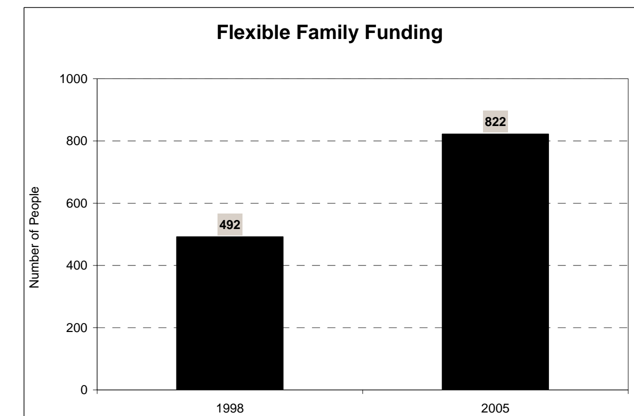
MR/DD State Spending per Capita Remains Low

Vermont utilizes a hig her percentage of federal funds (68%) than the national average (58%). In addition, Vermont spends less in state funds per capita than any New England state and slightly less than the national average.



Number of Youth Served on Medicaid Waiver Declining

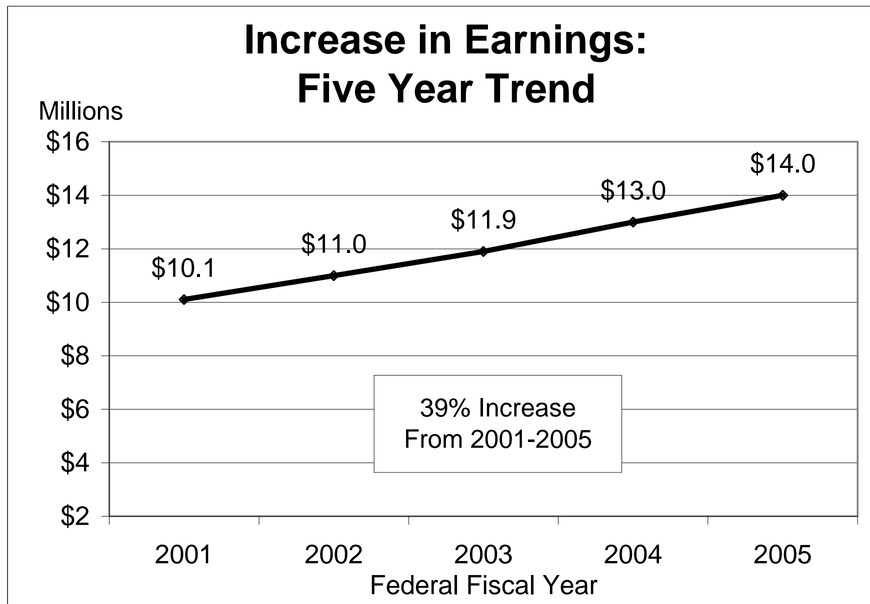
The number of children receiving Medicaid waiver services continues to steadily decline as a result of the change in funding priorities severely limiting access to waiver services for children living with family.

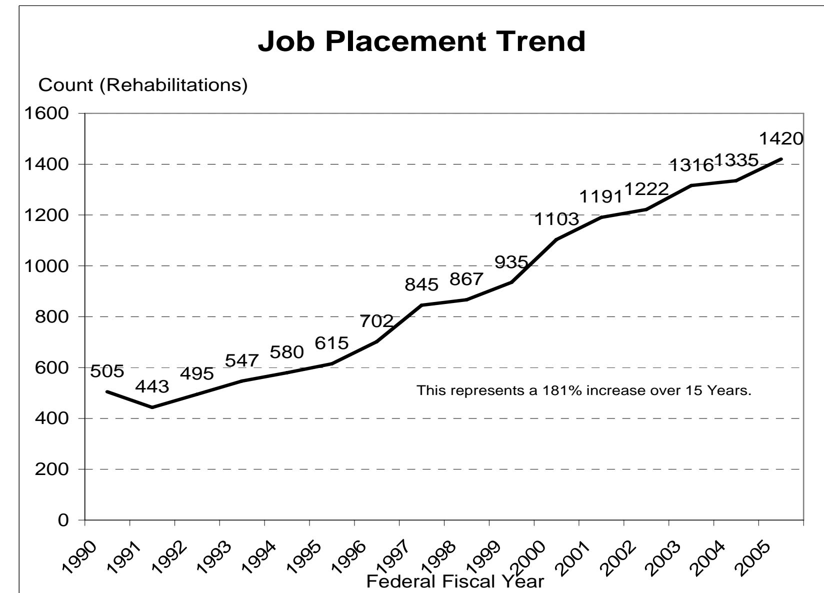


Respite/Flexible Family Funding

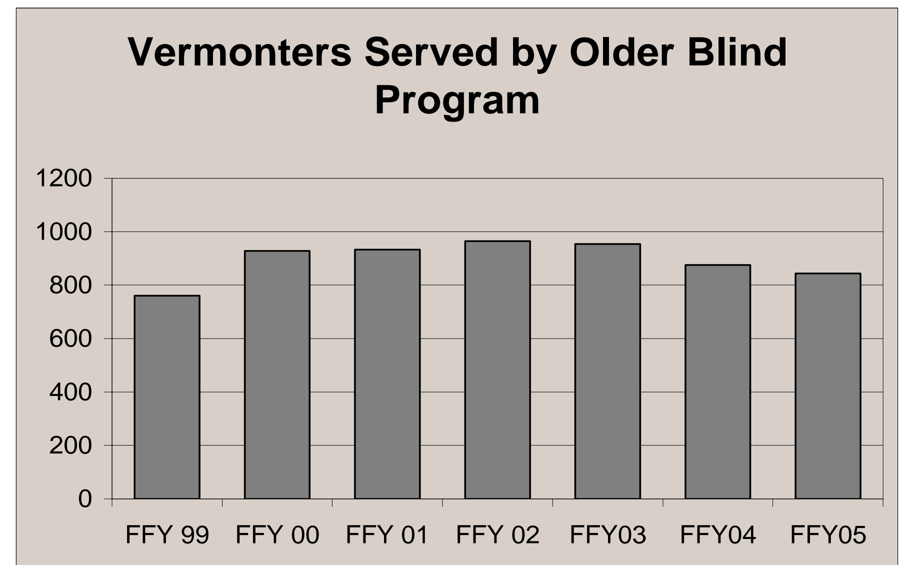
Flexible Family Funding, a unique family respite option, is a low cost program that offers a highly valued benefit to families of young and adult children. These funds, used at the discretion of the family, help provide care and support and avoid the need for more intensive and costly out-of-home services. The number of families who have benefited from this respite program has increased over the past couple of years.

Since 1995, Vocational Rehabilitation has increased employment placements for people with significant disabilities by 102%. Employment earnings have increased 3 9% since 2001.





The Older Blind Program will experience a higher demand for services as the population ages. New technology can help blind and visually impaired persons remain independent and participate in their communities. Providing sufficient funding will be an issue. The Vermont Association for the Blind and Visually Impaired is the sub-recipient of the Older Blind Grant which is a combination of State and Federal funds. This program provides specialized low vision and independent living services to blind and visually impaired individuals over the age of 55. These services include: outreach and peer counseling; low vision evaluations by trained optometrists; provision of optometric and/or low vision aids; rehabilitation teaching; orientation and mobility; and training opportunities to enable optometrists to continue their education in the provision of specialized diagnostic and prescriptive low vision services.



Department of Health

"Everyone benefits from the work of the Health Department, and that's our goal: Vermonters living healthy lives in healthy communities."
~ Paul Jarris, Commissioner

Number of Positions: 871

Funding:

General Fund	$ 27,391,384
Global Commitment Fund	158,577,405
Federal/Other	$ 66,328,007
Total	**$ 252,296,796**

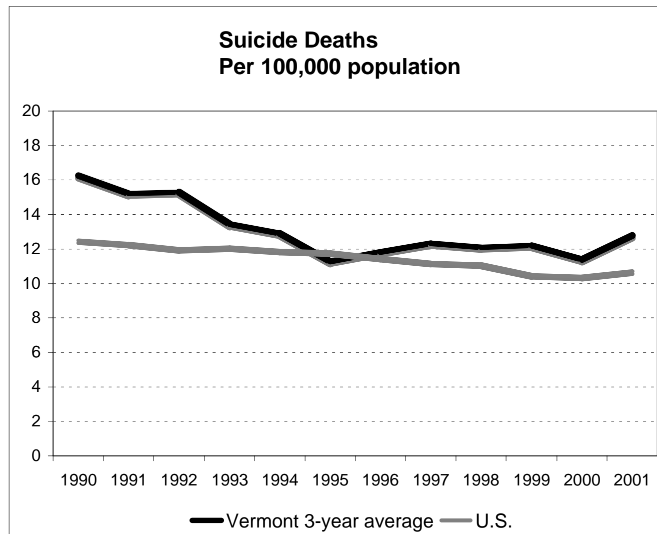
We will have the nation's premier system of public health, enabling Vermonters to lead lives in healthy communities. We will lead our state and communities in the development of systematic approaches to health promotion, safety and disease prevention. We will continuously assess, vigorously pursue and document measurable improvements to the health and safety of Vermont's population. We will succeed through excellence in individual achievement, organizational competence and teamwork within and outside of the Department of Health.

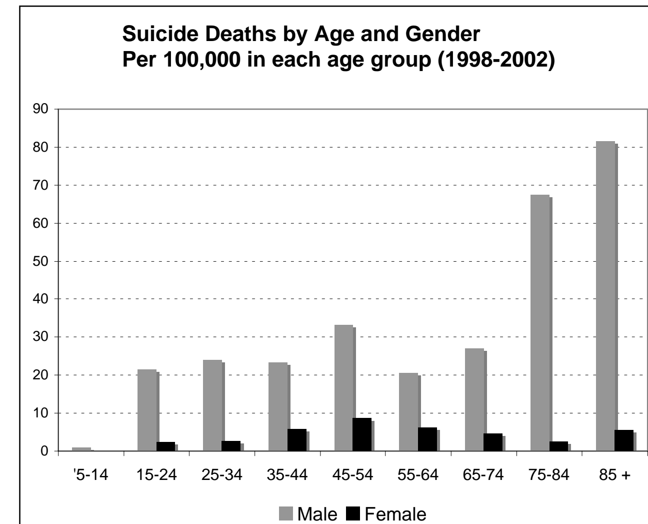
Year	FY '05	FY '06 Est.	FY '07 Gov Rec.
General Fund	$ 57,150,541	$ 28,384,671	27,391,384
Federal/Other	$ 158,029,787	$ 189,195,085	224,905,412
Total	$ 215,180,328	$ 217,579,756	**252,296,796**

OPPORTUNITIES

- **Vermont Blueprint for Health:** One of the nation's premier initiatives for improving health is being undertaken by the Department of Health and partner organizations from the public and private sectors. The Vermont Blueprint for Health aims to fundamentally change the way health care is delivered and how Vermonters living with life-long illnesses such as diabetes, asthma and cardiovascular disease care for themselves. The Blueprint is helping health care providers reorient their practices to provide proactive planned care to people with chronic conditions. This includes information systems, office practice redesign strategies, enhanced access to referral opportunities in the community, and a reexamination of the reimbursement structure. "Healthier Living with Chronic Conditions" is one of several opportunities for people with chronic conditions to begin to take charge of their own health; this workshop, which will be available statewide by the end of the year, helps people make a lifelong commitment to participating in their own care, dealing with symptoms, taking medications, and changing behaviors. Communities, both geographic and social, are being asked to support providers and patients. Through expansion of the Blueprint, we have the opportunity to align this framework across physical health, mental health and substance abuse.
- **Closer alignment of the State's mental health and substance abuse treatment:** Mental health and substance abuse services maintain an overlapping treatment network, use complementary treatment approaches, serve many of the same Vermonters and have similar need for prevention. The realignment will enable us to move toward a seamless system that is responsive to Vermonters' needs. For providers, we are working toward one consistent approach with regard to contracting, fiscal oversight, monitoring, quality improvement, credentialing, paperwork and training, and a closer connection with primary care. A new Co-occurring State Incentive grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is intended to strengthen infrastructure for integrated treatment of people with dual diagnoses of mental illness and substance abuse, allow expansion of co-occurring treatment more broadly in the service system, and support better integration of mental health and substance abuse information.
- **Substance Abuse Prevention Incentive Grant:** The State of Vermont successfully competed for and was awarded a grant of $2.3 million per year for up to five years from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). The grant is designed to health states and communities identify needs, and build infrastructure for effective, sustainable substance abuse prevention services.
- **Reducing Obesity:** Through the Governor's Fit & Healthy Kids program and a new capacity building from the federal Centers for Disease Control and Prevention (CDC), the department is tooling up to prevent obesity. The obesity prevention grant funds states to coordinate nutrition and physical activities, develop a state plan for preventing obesity and related chronic disease, and implement or enhance activities that have been proven effective. These activities will also be linked to the Vermont Blueprint for Health, as obesity is a primary risk factor for many chronic diseases.

- **The Vermont Suicide Prevention Platform:** Suicide is the eighth leading cause of death in Vermont and the eleventh in the United States. More people die from suicide than homicide in this country. On average, 78 Vermonters die by suicide each year and 14 are victims of a homicide. The Department of Health suicide prevention team worked in conjunction with an advocacy group, Vermonters for Suicide Prevention, to develop the Vermont Suicide Prevention Platform. The goals of the Suicide Prevention Platform include (1) reducing the rates of suicide attempts and other suicidal behaviors, (2) preventing suicide deaths across the life span, (3) reducing the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends, and (4) improving the mental health of Vermonters through early intervention, crisis treatment, and continuing care.

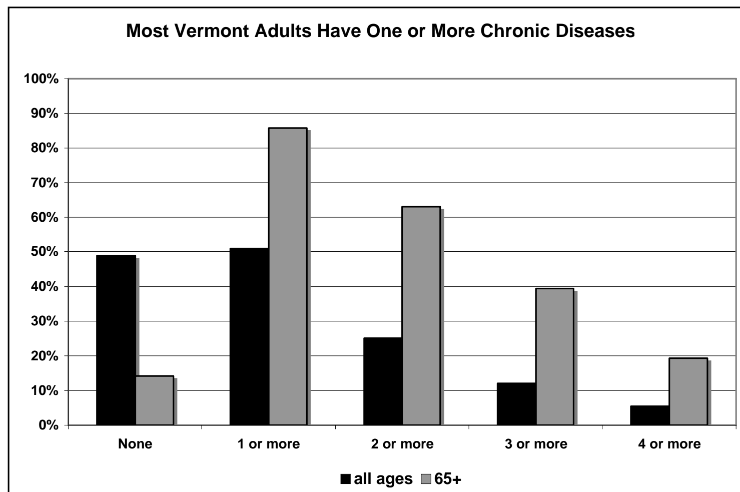


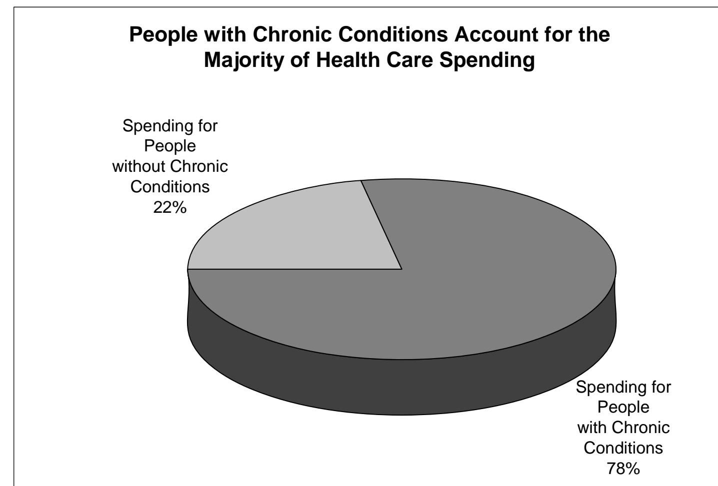


- **Immunization Registry:** The Vermont Immunization Registry improves health care for children by providing a central web-based system for tracking immunizations and vaccines administered to children from birth to age 18. Since its release in July of 2004, 423,255 immunizations have been entered, and over 20,000 children have immunization histories recorded in the Registry. Over a third of providers who administer vaccine to children (57) were using the Registry by the end of 2005. Eventually, all pediatric providers will use the system since participation is required by law. The Vermont Immunization Registry is the first module in a more comprehensive Child Health Profile, a state-wide, electronic medical record system that will help health care providers monitor important health measures for children including lead screening, metabolic screening, and early hearing screenings as well as immunizations.

PRESSURES

- **Increasing Burden of Chronic Disease:** Chronic diseases are the leading cause of illness, disability and death; and the most costly for the health care system. In Vermont, 51 percent of adults have one or more chronic diseases like diabetes, heart disease, asthma, kidney disease, addictions, depression or multiple sclerosis to name a few. People with chronic diseases account for 78 percent of health care spending, 76 percent of hospital admissions, and 72 percent of physician visits. By 2030, it is estimated that the proportion of the population with chronic diseases will have increased by approximately 37 percent over the year 2000. This trend is driven by an aging population and an increasing prevalence of obesity.





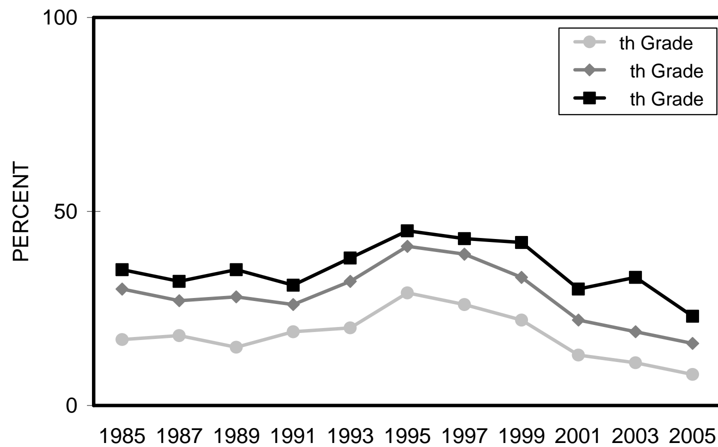
- **Obesity and Lack of Physical Activity:** The prevalence of obesity in Vermont and the nation is increasing at an alarming rate. In 2003, 26 percent of Vermont youth in grades 8 through 12 were above what is considered a healthy weight, and more than 50 percent of Vermont adults are either obese or overweight. Being overweight substantially increases risks for many chronic diseases such as high blood pressure, diabetes, osteoarthritis, heart disease, stroke and certain cancers including breast, prostate and colorectal cancer.

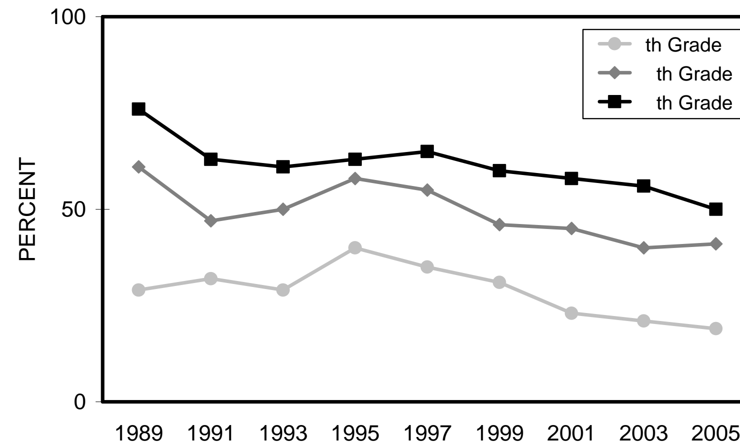
- **Future of the Vermont State Hospital**: Vermont State Hospital is the state's only public psychiatric inpatient facility. It has 56 beds and provides specialized mental health services to patients who have not been successfully treated in other environments and to patients with the highest need due to complex diagnoses or patients at highest risk for dangerous behavior. The hospital, decertified for a year now, is housed in an aging facility that needs to be replaced. It will lose federal funding during calendar year 2006 from the waiver for Institutes for Mental Disease (IMD). Together with a wide representation of stakeholders, the department is working to create a range of service capacities to replace the hospital while maintaining and enhancing the quality of care within the VSH until it can be replaced. Replacement capacities will include an inpatient facility for tertiary psychiatric care and the development of community-based alternatives such as sub-acute rehabilitation and secure residential programs. In addition, services need to be developed to enhance care management and collaboration among community providers and across programs as people move through the public systems continuum of care. Pending budget allocations, additional areas of focus will be housing, peer support, crisis stabilization, and transportation services.

- **Public Health Preparedness and Emergency Response** - A wide range of hazards can have severe consequences for the health of Vermonters: acts of biological, chemical and radiological terrorism; vaccine shortages; food and water tampering; chemical spills, weather emergencies, natural disasters and large-scale or novel infectious disease outbreaks such as West Nile virus, SARS, monkeypox or pandemic influenza. This reality requires that we take an "all hazards" approach to planning, training, and practice – and that public health and health care providers maintain a high level of surveillance and readiness to respond quickly and effectively to any emergency. Vermont's emergency response plan is designed to be adaptable and quickly implemented no matter what the emergency.
- **Pandemic influenza** - A global outbreak of a new strain of flu that spreads easily from person to person and causes unusually severe illness and high death rate – is the public health threat of most concern right now. The current outbreak of avian influenza (bird flu) H5N1 is an example of a type of flu virus that is causing illness in birds and some humans, but is not a pandemic yet. Flu viruses change all the time, and if this type of bird flu changes so that it can easily spread from sick to healthy people, then it becomes public health threat #1. No one can say when a pandemic will strike, or if bird flu will be the trigger, but most scientists believe that a pandemic is likely. Slowing the spread of a possible pandemic flu and caring for the many people who become sick will require strong measures such as vaccine rationing, isolation, quarantine, helping our neighbors in isolation or quarantine, ban on public gatherings and travel restrictions. These are protective measures that, as a society, we have not used in a generation. The Vermont Department of Health is working with local, state, national and Canadian partners to prepare.
- **Preparing for Methamphetamine** – Nationally, use of methamphetamine is a serious and growing problem. Methamphetamine is a powerfully addictive stimulant associated with serious health conditions including aggression, violence, psychotic behavior and potential neurological damage. Once considered an urban drug problem it has spread to rural areas throughout the country. It is a drug easily made from common ingredients in makeshift laboratories (set up in rented apartments, hotel/motel rooms, storage facilities, isolated camps, barns, or even parked cars). Health and law enforcement officials are working together to raise awareness and take action to stop this drug from gaining a foothold in Vermont. As of December 2005, there have been 12 information sessions statewide attended by nearly 1,000 community health and safety professionals.
- **Sustaining Vermont's Designated Agency System:** The department contracts with 10 designated community mental health agencies around the state to provide services for adults with severe mental illness, for children and adolescents who are experiencing a serious emotional disturbance, emergency services for anyone in a mental-health crisis, and for substance abuse services for youth and adults. An additional specialized agency provides a statewide resource for children with a serious emotional disturbance. A 2004 consultant's report stated that the system is highly effective in meeting the unique needs of Vermont communities and that Vermont compares favorably to other states in New England and the nation. The state needs to work collaboratively with the agencies to develop a long-term funding plan that addresses inflationary pressures and caseload growth.
- **Prescription Drug and Opioid Abuse:** While Vermont has taken significant steps to expand treatment services for persons addicted to opioid drugs, use of heroin and illegal use of prescription drugs remains a significant problem. We are seeing increasing concern among primary care and emergency room physicians about patients who need intervention and treatment for their opioid use. Because of the high overdose potential from these drugs, we have increased needs for public education, professional education and additional treatment.

ACCOMPLISHMENTS

- **Youth Smoking Rates Cut in Half, Declining Drinking and Drug Use** - Vermont's prevention programs are working. The smoking rate among Vermont 8th through 12th graders has dropped from 31 percent in 1999 to 16 percent in 2005. And among 8th graders the smoking rate has dropped from 22 percent in 1999 to 8 percent in 2005. Alcohol and marijuana use have also declined, although not quite as dramatically. The percentage of students drinking alcohol went from 46 percent in 1999 to 37 percent in 2005, and the percent using marijuana dropped from 32 percent in 1999 to 22 percent in 2005.





- These results show that our comprehensive approach to prevention is working. This approach includes effective education for youth and families, student assistance programs and other early interventions, fun and meaningful opportunities for youth to develop leadership skills, drug-free social and recreational programs, coalitions to build citizen involvement, media to raise public awareness, and enforcement of policies and laws designed to reduce access.

- **Vermont Blueprint for Health:** The department has put together a unique coalition of policymakers, consumers, health care organizations and experts, and public and community health agencies to move the Vermont Blueprint for Health from concept to implementation. Over the past year, work groups have developed implementation plans; full scale pilot projects have been initiated in St. Johns bury and Bennington; the Healthier Living Workshop is already available in five communities; development of the new health information system is progressing and being aligned with the work of VITL, and, staff at the VDH are in place to direct implementation and expansion to mental health and substance abuse.

- **New Online Quit Smoking Aid** – The Vermont Department of Health now offers Vermonters free access to QuitNet, a worldwide website designed to help people successfully quit smoking. Quitnet offers peer support to help stop smoking through an online community with hundreds of individuals logged on at any given time, as well as expert advice and nicotine replacement therapy product information to help them quit. Smokers can also find out how much they'll save by quitting with QuitNet smoking calculator. Vermonters can access the only resource by going to www.VermontQuitNet.com and entering their zip code.

- **Public Health Preparedness and Emergency Response** - The Vermont Department of Health has focused over the past year on detailing plans to prepare for and respond to pandemic – a worldwide outbreak – of a lethal strain of influenza. If we prepare as much as we can for pandemic flu, we will be as prepared as we can be for any serious infectious disease outbreak. Vermont's pandemic influenza response plan, which is being continually strengthened, revised and practiced, is available at HealthVermont.gov.
- Key elements of the plan include:
  - enhanced disease surveillance, investigation and epidemiological response to detect and control spread of pandemic flu
  - laboratory capacity to test and confirm clinical specimens
  - rapid information exchange among health professionals
  - delivery of timely, accurate, credible and useful information to health care providers and the public
  - system to monitor distribution and use of influenza vaccine and antivirals to prevent and treat disease
  - system to monitor and reallocate health care resources such as beds, respirators and inpatient staff
  - activation of the Health Department and State Emergency Operations Centers to manage emergency response
  - community clinics to deliver vaccine and antivirals
  - isolation and quarantine
  - deployment of stockpiles of vaccine and medications

During the flu vaccine shortage of fall 2004, the capacity to vaccinate 8,000 high-risk people in one day was successfully tested in simultaneous community clinics around the state. In May 2005, the Vermont Department of Health hosted a pandemic influenza planning meeting of public health and emergency management colleagues from New York, New Hampshire and Quebec. In a June 2005 tabletop exercise, the Health Department tested its draft pandemic response plan with more than 100 health, hospital and emergency officials around the state. The Health Department is now organizing volunteers who can help in clinic and other response capacities, and mental health professionals are being trained to help Vermonters cope with traumatic events such as pandemic flu. On Nov. 1, 2005, hospitals conducted a statewide mutual aid drill to test their capacity to admit 350 patients with a diagnosis of avian influenza. The Health Department has expanded agreements with partner agencies, including the Medical Reserve Corp, Vermont National Guard, Agency of Transportation, Vermont Association of Hospital and Health Services, and the Metropolitan Medical Response System, to ensure a well-coordinated response to emergencies. The Health Department is now planning for a pandemic influenza functional exercise in May 2006, with a five-day full-scale exercise in July 2006, with tabletops, drills and other practices leading up to the full-scale event.

- **Ambulance Crews Deployed to Aid in Hurricane Rita Response** – The Vermont Department of Health supported 13 ambulance crews and more than 30 Vermont EMS personnel deployed from Vermont and working Texas as part of the national Hurricane Rita response. The crews moved patients out of harms way to more secure facilities from hospitals and elder care settings and they supported local EMS providers in already damaged by the storm.
- **Katrina Medical Recruitment** – More than 100 Vermonters with specialized medical skills were recruited for possible deployment to areas devastated by Hurricane Rita. Working closely with the Department of Emergency Management, the Health Department signed on emergency physicians, primary care physicians, surgeons, epidemiologists, nurses and respiratory therapists.

- **Collaborative Cancer Plan** – An average of 3,064 new cases of cancer are diagnosed and 1,236 people die from cancer each year. Unlike heart disease and stroke, the death rate for cancer has risen steadily over the last few decades. Approximately one out of two men and one out of three women will develop cancer in their lifetime. Working with a coalition of over 150 Vermonters including many cancer survivors and health care providers, the department unveiled a plan with action steps aimed at preventing future cancers, detecting new cancers earlier, increasing access to cancer care, improving quality of life for people living with cancer, and improving end of life care for those in need.
- **Fletcher Allen Recommended for New Psychiatric Hospital** – The Vermont State Hospital Futures Advisory Group's recommendation that Fletcher Allen Health Care be the first choice for hosting a new psychiatric hospital to serve Vermonters was accepted by Human Services Secretary Michael K. Smith in November 2005. The size of the new hospital will depend on the outcome of a pending actuarial study. The Futures Group, made up of mental health professionals, advocates, clients and family members, outlined its general recommendations a year ago and has been working out specific proposals since then. Its goal is to strengthen the continuum of care for Vermonters with mental illness, and to create replacement services for the day when Vermont State Hospital will be closed.
- **In-State Residential Treatment for Women and Youth:** October 21, 2004 marked the opening of Valley Vista in Bradford, a new residential treatment facility to serve women and adolescents with alcohol and drug dependency. A centerpiece of Governor Douglas' DETER (Drug Education, Treatment, Enforcement and Rehabilitation) initiative, this state-of-the-art 80 bed facility will provide intensive medical psychiatric care and addiction therapy for Vermonters. Prior to Valley Vista, some 300 Vermonters with the most severe addictive disorders – those needing residential treatment services – had to travel out-of-state because Vermont had no treatment facility to accommodate this level of care.
- **New Pharmacological Opioid Treatment Options:** Vermont continues to make headway in reducing the treatment gap for Vermonters suffering from opioid addiction. Today, 150 Vermonters are able to receive methadone medication treatment at the Chittenden Center in Burlington through a combination of on-site, supervised dispension and prescription take-home medication. A mobile methadone treatment van has begun serving the Northeast Kingdom this year with approximately 75 patients being served in Newport and St. Johnsbury locations. Another pharmacological treatment—buprenorphine—is more broadly available through primary care physicians supported by a treatment hub in Central Vermont.
- **Fit & Healthy Kids:** More and more children are taking up healthy activities through successful programs like Run Girl Run, the Governor's Daylight Savings Challenge, Fit WIC, and Fall Back Into Fun. These health and fitness programs supported in communities by the Health Department engage children of different ages and their families in physical activity, healthy choices, and building self-esteem. Over 1,000 girls participate each in programs such as Girls on the Run for 3rd – 5th grade and Runs Girls Run for middle school age girls. After school programs around the state are beginning to add more physical activities.
- **Integrating Mental Health Care with Pediatric Health Care:** Mental health staff placed in pediatric offices is emerging as an effective way to meet all the health needs of Vermont's children. Five different pediatric practices in Vermont now have mental health staff person in their offices in addition to two hours a week of psychiatric consultation. These programs are being piloted as a best-practice model, with plans for expansion as resources permit. In addition, collaborating with medical and dental care for clients of Children's Services is an important part of the system of mental health care in Vermont. Assistance to clients with keeping their appointments with physicians, dentists, and other health-care professionals is a routine part of community-based services and supports (case management). Coverage for medical and dental care for all children up to the age of 18 is available through Vermont's state-sponsored Dr. Dynasaur program. Dr. Dynasaur is open to all Vermont families with income up to 300 percent of the federal poverty level.

Office of Vermont Health Access

"The Office of Vermont Health Access, more than ever before, is called upon to provide for efficient and effective management of the public health insurance program for the State of Vermont."
~ Joshua Slen, Director

Number of Approved Positions:	**83**
Number of New Positions In Process:	**5**
Number of Filled Positions:	**60**
Funding SFY '07	
General Fund	$ 0
Global Commitment Fund	$ 758,103,799
Federal/Other	$258,521,347
Total	**$1,016,625,146**

OVHA's mission is three-fold:
To assist beneficiaries in accessing clinically appropriate health services
To administer Vermont's public health insurance system efficiently and effectively
To collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries

Year	FY '05	FY '06 Est.	FY '07 Gov Rec.
General Fund	1,066,438	0	0
Federal/Other	634,630,547	874,447,086	1,016,625,146
Total	635,696,985	874,447,086	**1,016,625,146**

OPPORTUNITIES

- **Quality Initiative:** The Office of Vermont Health Access (OVHA) is taking steps to become an active partner with clinicians in the delivery of high quality health care. Several new initiatives will address the need for enhanced coordination of services in a climate of increasing complex health care needs and scarce resources. Our goal is to facilitate the patient - provider relationship by providing services that help primary care practices to attend to the complex needs of Medicaid beneficiaries without increasing administrative burden. The following four initiatives are designed to achieve this goal:
  - Care Coordination: OVHA, through locally-based Registered Nurse/Social Worker Teams, will work with primary care practices, hospitals and other service providers to assist beneficiaries with complex health care needs by: 1) facilitating communication between the beneficiary and clinicians; 2) coordinating care plans among all providers; accessing claims data to demonstrate utilization profiles; and 3) following up on hospitalizations to assure primary care provider involvement and beneficiary compliance with plans of care. Field testing will begin at designated sites in Caledonia, Washington and Chittenden counties in winter 2005 - 2006.
  - Capitated Program for Treatment of Opioid Dependency: OVHA, in cooperation with the Vermont Department of Health Alcohol & Drug Abuse Program, the Department of Corrections, and the commercial insurers, aims to increase access to effective treatment for opioid dependency by supporting primary care practices for this challenging population through: 1) the development of a state-wide, integrated protocol for the treatment of opioid dependency; 2) development of a capitated payment methodology to provide incentives to clinicians for treating this population and account for the level of practice resources consumed by their complex needs; and 3) development of an evaluation plan with benchmarks to assess program outcomes.
  - Enhanced Regional Disease Screening: In cooperation with the Vermont Department of Health, the American Cancer Society, the Regional Community Partnerships, and local providers, OVHA will seek to promote primary disease detection by heightening awareness of ongoing screening programs, including: 1) the Vermont Department of Health's Ladies First and Wise Woman Programs; 2) supporting local efforts to implement innovative, evidence-based screening and intervention models; and 3) using Medicaid claims and Centers for Disease Control (CDC) prevalence data to develop regionally-targeted outreach and screening priorities.
  - Chiropractic Trial: The goal is to conduct a limited study where several chiropractors will be selected to treat adult Medicaid patients with diagnoses such as Lumbago and compare to a control group with the same diagnosis as treated by conventional providers (i.e.: physical therapists, family doctors, orthopedic doctors) for a period of six to twelve months.

- **Global Clinical Record:** Utilize the Global Clinical Record to support the Care Coordination Initiative - The Case Tracking and Health Indicators components of the Global Clinical Record will be enhanced to support the requirements of the care coordination team. This will allow OVHA to take advantage of existing infrastructure in support of this program initiative and not invest in a new technology system.

  Purchase a Decision Support Solution - This system will provide the technology to analyze health care claims and financial data in ways that will guide the course of care coordination and other initiatives designed to improve care and result in program savings. For example, the Decision Support Solution will enable OVHA to project expenditures and utilization based on historical and user input trend factors and other variables, review provider profiles and perform multi-variable trend analysis, and evaluate patterns of care and health status. The Decision Support Solution will enable data driven decision making by integrating data from the current Medicaid Management Information System as well as a variety of other relevant data sources. It will provide dynamic reporting capabilities with user defined relationships and fields for flexible reporting using both character and graphic displays. It is anticipated that the procurement process will be completed by March 31, 2006. It is hoped that the Decision Support Solution will be available for use by mid-2006.

- **Pharmacy Management:** Effective January 1, 2006, the Office of Vermont Health Access has used a new pharmacy benefit management company – MedMetrics Health Partners (MedMetrics). MedMetrics brings a number of innovative approaches to Vermont, including automated step therapies using claims history vs. claims rejections for prior authorization requirements and more specific messaging sent to pharmacies with clear instructions on how to deal with claims processing exceptions.

  Vermont has joined together with the States of Maine and Iowa forming the Sovereign States Drug Consortium. This effort differs substantially from the existing multi-state pool because it is state, not vendor administered. It is a truly State-directed and entirely State-controlled effort. Each state has an equal vote and can act independently as deemed necessary. Participating states will pool their purchasing power for their Medicaid Programs using combined leverage of Medicaid-members (populations) to obtain better drug pricing.

- **Employer Subsidy Insurance Program:** At the direction of the Vermont Legislature in Act 71 of the 2005 session, the Office of Vermont Health Access has been collaborating with the Department of Banking, Insurance, Securities, and Health Care Administration; the Department for Children and Families; and the Agency of Human Services central office to prepare a plan to provide subsidies for individuals in the Vermont Health Access Plan (VHAP) and Dr. Dynasaur populations who have employer-sponsored health insurance. The report will include a recommendation for affordable coverage, the minimum health insurance to be subsidized, cost estimates, and implementation timelines. The analysis will include a comparison of various health insurance programs available in the state and their respective employee cost-sharing requirements, related to the average per member per month costs to the state currently. The report will describe a possible program design and delineate implementation issues for the Legislature's consideration.

- **Medical Support Initiative:** OVHA's Coordination of Benefits unit has been partnering with the Office of Child Support and the Department for Children and Families on implementing the Medical Support Initiative. From this initiative the Coordination of Benefits unit is expecting to cost-avoid more medical claims because the Office of Child Support has been able to secure private health insurance for the Medicaid eligible child.

PRESSURES

- **Balancing Act:** Public health care programs must balance access, cost, and available revenues. This problem is attributable to a declining rate of federal reimbursement and an imbalance between growth of state revenue and program spending. Other contributing factors include:

  - Increased use and higher cost of health care services impact everyone who pays for health care.
  - Health care inflation rates are greater than the growth rates in state revenues, which creates serious fiscal pressures.
  - Premium-based cost sharing for beneficiaries was implemented in late 2003 and continued in 2005.
  - The cost of long term care services, particularly nursing home care, is a significant budget pressure. The Choices for Care 1115 Long Term Care waiver would impact this by encouraging more people who are able to be served in the community to be served in the community and hopefully reduce Medicaid spending for long term care services.

  Prescription drug cost containment initiatives have moderated costs somewhat. Our goal is to provide access to health care for eligible Vermonters through the Vermont Health Access Plan and Pharmacy Programs. However, with little flexibility in the traditional Medicaid Program, this goal is becoming increasingly difficult to meet.

- **Quality Initiatives:** Care Coordination: While OVHA's Quality Initiatives will benefit program delivery, outcomes and costs, they each require substantial efforts in a short amount of time. The commencement of Care Coordination Initiative pilot program in January 2006; hiring of six new staff members between January and June 2006, consisting of three Registered Nurses and three Social Workers, and to activate the Registered Nurse/Social Worker teams in Caledonia and Washington county within three months and in Chittenden county within three to six months; the continued development of the Global Clinical Record; training for OVHA staff and providers to use the Global Clinical Record in their practices; drafting of the Request For Proposal for the Support Help Line; and continued effective outreach within Caledonia, Washington and Chittenden communities to identify stakeholders with which to collaborate, that will include providers, hospitals, beneficiaries, advocacy groups, and other departments and offices within the Agency of Human Services.

- **Capitated Program for Treatment of Opioid Dependency:** development of a capitation methodology, arrangement of a symposium organized to assist practices with the logistics of program participation, formulation of an integrated protocol, exploration of access to free technical assistance from the Substance Abuse and Mental Health Services Administration, creation of a provider toolkit, and collaboration with initiative partners to establish an evaluation plan with benchmarks.

- **Enhanced Regional Disease Screening:** determination of screening rates for screenable conditions regionally, collaboration with the Vermont Department of Health and American Cancer Society partners, and facilitation of screening activities for Medicaid beneficiaries.

- **Chiropractic Trial:** obtaining federal financial participation, implications of Managed Care Organization and Global Commitment requirements, and outreach to the chiropractic community to effectively implement their recommendations.

- **The Medicare Modernization Act (MMA) Part D Implementation:** On November 15, 2005, enrollment began for the new prescription drug benefit from Medicare. The Agency of Human Services has had an MMA workgroup planning for this implementation for over a year, which was led by OVHA and included representation from the Department of Disabilities, Aging and Independent Living as well as the Department for Children and Families. We have successfully developed eligibility system changes, claims processing changes, and claims and premium payment changes necessary to implement MMA/VPharm in Vermont. We have assisted the Department of Disabilities, Aging and Independent Living with education and outreach efforts including educating consumers, advocates and providers.

  Since the inadequacies of the federal MMA system became apparent on the implementation date of January 1, 2006, OVHA immediately reversed the new process to enable the state to continue to process claims and expend state-only funds to ensure that duals receive their prescription medications. OVAH also has been engaged in numerous activities to resolve Medicare Part D implementation issues for Vermont, including communicating with the Centers for Medicare and Medicaid Services (CMS), other states and other entities to clarify reimbursement details and to receive performance data (metrics) to support Federal claims that the system is operating appropriately; drafting a transition/contingency plan and coordinating activities which support that plan; drafting language for a public service announcement (PSA) and press releases to provide beneficiaries with Medicare Part D information and resources.

- **Pharmacy Programs:** As the Medicare Part D benefit unfolds, it will be critical that we monitor the effect of MMA Part D on Vermont beneficiaries, in terms of both financial cost and drug availability for beneficiaries. We want to provide effective wrap around pharmacy coverage so that the beneficiaries of our programs continue to obtain therapeutic equivalents for their current medications that are clinically appropriate. We will continue to research and develop new cost containment strategies for our pharmacy benefit.
- **Information Technology:** Numerous health care related technology projects, including those being undertaken at OVHA and the pilots proposed by Vermont Information Technology Leaders and the Blueprint for Health, result in a need for coordination to avoid a duplication of effort, to best use resources, and to result in an appropriately inter-operative electronic health information environment.

- **Global Commitment to Health:** On October 1 2005, Vermont entered into a new five year comprehensive 1115 federal Medicaid demonstration waiver called the ***Global Commitment to Health.*** The goals of the Global Commitment to Health waiver are to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes.

  The Waiver program consolidates funding for all of the state's Medicaid programs, except for the new Choices for Care (long-term care) waiver and several small programs (SCHIP and DSH payments for hospitals). It also converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). Primary advantages of the Global Commitment to Health Waiver are: 1) the MCO can invest in health services that typically would not be covered in our Medicaid program; 2) it will enable Vermont to bring in new federal funds to help address our Medicaid deficit and invest in new health care initiatives; and 3) the programmatic flexibility provides an opportunity to implement creative programs and reimbursement mechanisms to help curb our health care inflation and thereby reduce even more of the projected five year deficit.

  Because OVHA is now a MCO, it must adhere to federal rules for Medicaid MCOs. One of these is to have an internal Grievance and Appeals process to acknowledge and resolve service and benefit disagreements between beneficiaries and the MCO in a timely and fair manner. This new process will apply to all Medicaid programs operated within AHS (with the exception of long-term care programs), which will be much more user-friendly for our beneficiaries.

- **Program Integrity Across AHS:** On October 1, 2005, The Department of Disabilities, Aging and Independent Living's Choices for Care 1115 Long Term Care (LTC) waiver officially began. This new 1115 LTC waiver equalizes the entitlement to both home and community based services with nursing home services for all long term care Medicaid eligible Vermonters.

  The Department of Disabilities, Aging and Independent Living is the lead on the 1115 LTC waiver but works with both the Office of Vermont Health Access and the Department for Children and Families on implementing this waiver.

  The Office of Vermont Health Access and The Department of Disabilities, Aging and Independent Living are working together on implementing two other coordinated care efforts. First, the Project for All Inclusive Care for the Elderly (PACE) project is moving forward after four years of planning. PACE offers comprehensive coordinated care services for frail elderly at a PACE center which is an adult day center with a health care clinic. The State of Vermont is working with PACE Vermont, a coalition of local providers in both Rutland and Chittenden counties, on submitting a provider application to the Centers for Medicare and Medicaid Services (CMS) to operate PACE centers in Vermont in the fall of 2006. The provider application is expected to be submitted to CMS in January 2006 with approval by September of 2006. The PACE center will be paid by both Medicare and Medicaid capitation payments and PACE Vermont will assume all of the risk for this frail population. The first PACE center in Vermont will be at the former convent which is attached to the Fanny Allen Hospital buildings which are part of Fletcher Allen Health Care.

  Vermont was awarded a Real Choices Comprehensive System Change grant in 2004. OVHA and The Department of Disabilities, Aging and Independent Living (DAIL) are working together on the implementation of this grant. The purpose of this $2.1 million dollar planning grant is to follow up on the work of PACE. Specifically, the grant allows OVHA and DAIL to work with interested community providers on planning for an integrated care delivery system (acute, primary and long term care services) and hire a contractor, Bailitt Health Purchasing of Wellesley Massachusetts, to assist the state in developing an integrated care delivery system for either younger physically disabled Vermonters or frail elderly that can not access a PACE center. The center that is developed will be reimbursed using both Medicaid and Medicare capitation payments. This is a 3 year planning grant which began in 2005 and will end in 2008. At the end of the grant the state hopes to have a provider

that will work with the state on submitting a waiver of the federal government or a speciality needs application (SNP) to the Centers for Medicare and Medicaid Services (CMS). A SNP is a new provider designation that is allowed as a result of the Medicare Modernization Act of 2003 and allows other coordinated care capitated funded providers to submit applications to CMS for permanent provider status.

- **Technology Initiatives:** The Coverage and Services Management Enhancement (CSME) component of the MMIS is operational and providing initial reports. The CSME is a health care focused data warehouse which contains records from several Agency of Human Services databases. It provides executives, policy makers, and field administrators with comprehensive, multi-program information about populations and cases. The CSME supports informed decision making for program development and evaluation, while providing the field with information which it needs to manage people with multiple needs. Additional data will be added and reports created as programmatic directions are identified.

  The Fraud and Abuse Detection System (FADS) enhancement to the MMIS is under development and will be completed during FY '06. This system will provide OVHA with information to monitor program utilization through analyzing claims data to identify health care providers suspected of Medicaid fraud, abuse or wastefulness. By identifying suspicious activities that have previously gone undetected, and suspects for the state to investigate, FADS will play a critical role in recouping misused or misallocated Medicaid funds.

  Three other MMIS Enhancements were completed:

  Claim Check/Claim Review validates submitted claims against industry billing protocols. This comprehensive auditing software evaluates physician claims with sophisticated clinical logic before reimbursement, applies consistent payment policies across physicians, and offers a variety of reports, detailing such information as coding problems and potential savings. It uses comprehensive clinical databases that are developed and maintained by a team of full-time physicians, registered nurses, coding experts and other healthcare professionals.

  The Recipient Eligibility Verification system was updated. In order to be HIPAA compliant, a provider accessing the voice response system is now required to enter a four digit PIN in addition to the provider number previously required. Providers can now check eligibility and claims status on-line either as a batch or single interactive transaction. Lastly, the Point of Service swipe boxes used by some providers to verify Vermont Medicaid eligibility were replaced with new HIPAA-compliant hardware and software.

  Provider enrollment functions were integrated into other MMIS functions.

- **The Medicare Modernization Act (MMA):** OVHA staff have led the Agency effort identifying the impact of the new Medicare Part D drug benefit (effective January 1, 2006) on Vermonters in our health care programs and on the budget. Policy changes have been made to accommodate Medicare as primary payor for Medicare beneficiaries. The Coordination of Benefits Unit has been designing the coordination of benefits process involving Medicare Part D with Med Metrics, OVHA's pharmacy benefit manager. Our partners in the Department of Disabilities, Aging and Independent Living are chairing an MMA Legislative Advisory Committee, including outreach and educational efforts, in which we also participate. We have also created and implemented VPharm, a wraparound, or secondary, benefit for Medicare Part D beneficiaries.

- **Quality Initiatives**

  Care Coordination:

  - program outreach to approximately 10 practices, 45 physicians, two hospitals, 12 state offices, and 20 community organizations in Caledonia, Washington and Chittenden counties;
  - identification of two practices in Caledonia county, two practices in Washington county and local hospitals, Northern Vermont Regional Hospital in Caledonia county and Central Vermont Medical Center in Washington county, that are willing to participate in field testing;
  - allocation of work space for Registered Nurse/Social Worker teams in St. Johnsbury District Office and Northern Vermont Regional Hospital, Newport District Office and North Country Hospital, Barre District Office and Central Vermont Medical Center;
  - establishment of criteria for utilization and cost baselines for the target population, including Emergency Room utilization per 1000 days, Hospitalization per 1000 days, Admission Rate and Pharmacy Utilization;
  - identification of criteria for patient selection; stakeholders meeting at Northeastern Vermont Area Health Education Center with participants from Northern Vermont Regional Hospital, Area Agency on Aging, Northern Counties Health Care Inc., AHS and OVHA.

  Capitated Program for Treatment of Opioid Dependency: outreach and collaboration with Vermont Department of Health Alcohol & Drug Abuse Program, Department of Corrections, Blue Cross/Blue Shield, MVP Health Care and Vermont Harm Reduction Coalition to explore introduction of legislation and identification of existing available services.

  Enhanced Regional Disease Screening: recognition as a collaborator on the Vermont State Cancer Plan; participation in American Cancer Society sponsored Colorectal Work Group; collaboration with commercial plans on project to identify beneficiaries due for Colorectal Screening; improvement of communication and coordination with Vermont Department of Health's Ladies First and Wise Woman programs, participation in the Ladies First Clinician Advisory Board, and identification of cancer prevalence data by county from the American Cancer Society.

  Chiropractic Trial two meetings with representatives from the provider community and the development of a request for legal advice regarding the implications of a pilot program for the Managed Care Organization. The anticipated commencement of the pilot program is July 2006.

- **Access to Care:** According to the Department of Banking, Insurance, Securities, and Health Care's (BISHCA) Health Insurance Coverage Profile of Vermont Residents from 1997 to 2004, in 2004, Medicaid (comprehensive medical coverage) ranked third in the number of covered lives (104,567) behind Self-Insured Employer Plans (135,011) and Blue Cross/Blue Shield (129,384). If everyone who receives some form of Medicaid medical assistance were counted, Medicaid would then be ranked first with 144,233 covered lives. BISHCA has not published 2004 expenditure information on their web site, but in their 2003 Vermont Health Care Expenditure Analysis, Medicaid was the highest spender with $762,963. The spending by Vermonters covered by Self-Insured Employer Plans was $537,645 and by those covered by Blue Cross/Blue Shield was $357,147.

  Over the past five years, the health care programs have expanded with higher income eligibility limits and new programs. Eligibility for new programs is based on the federal poverty levels and is tiered according to the program. OVHA also provides financial support for rural health clinics and Federally Qualified Health Centers to support access to dental care through these safety net providers. OVHA serves the most vulnerable Vermonters; those with the greatest potential health needs and the least personal resources.

- **Pharmacy Program:** The State Pharmaceutical Assistance Program (SPAP) Data Sharing Agreement between the Centers for Medicare & Medicaid Services (CMS) and OVHA has been completed and signed. This electronic file transfer between CMS and OVHA will be instrumental in ensuring successful coordination of benefits.

  A Request for Proposal for Pharmacy Benefits Management Services was completed; candidates were interviewed; a vendor selected and contracted with; and a successful transition to MedMetrics in approximately three and a half months. VPharm, Vermont's MMA Part D wrap around pharmacy coverage was implemented. Successfully completed the rebate bid process through the Sovereign States Drug Consortium. The in-state dispensing fee was increased to $4.75 and the pharmacy assessment was instituted. The study of Managed Severe and Persistent Mental Illness (SPMI) classes was completed with assistance from University of Rhode Island. OVHA was awarded a grant from CMS to educate State Pharmaceutical Assistance Program (SPAP) beneficiaries about MMA Part D benefits, to contract with state health insurance programs to bring information about MMA Part D to Medicare beneficiaries, and aired five presentations on Vermont Interactive Television that provided information to community partners and providers about the impact of MMA Part D and VPharm. We implemented several cost containment measures during the year which include: a clinically appropriate maintenance drug definition for coverage in VScript and VScript Expanded programs to be implemented January 1, 2006, modified the SPMI exemption to realize savings in the use of behavioral health drugs, and applied claims processing rules to require a greater days' supply in drug dispensing with clinically appropriate measures.

CASELOAD AND COST DATA

OVHA helps Vermont's most vulnerable people. We serve more than 75,000 families – about 150,000 people – at any given time. More than one in five Vermonters will receive one or more benefits from OVHA this year. We serve individuals and families, the young and the old, people with and without disabilities, those with no money and others with limited income.

OVHA helps Vermonters stay healthy. Our health insurance programs and services include Medicaid, Dr. Dynasaur, the Vermont Health Access Plan (VHAP) for the uninsured, and pharmacy benefits: VHAP Pharmacy, VScript, VScript Expanded, VPharm and the Healthy Vermonters program.