

# **Vermont Agency of Human Services**

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**Accomplishments,  
Opportunities, Pressures,  
and Caseload Data**



Cynthia D. LaWare  
Secretary  
February 2007





**State of Vermont  
Agency of Human Services**

February 2007

Dear Legislator:

I am pleased to present to you the 2007 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, providing essential health promotion and disease prevention services, helping a family access child care, supporting youth and adults through physical and mental illness and addiction into recovery or reaching out to elder Vermonters in need of at-home or nursing home assistance, our agency provides support to Vermonters across an entire lifespan.

Our work is guided by our Agency values of respect, integrity and a commitment of excellence which translate into 4 Key Practices: customer service comes first; the holistic needs of the individual/family are addressed; we build on strengths rather than concentrating on deficiencies; and, we are focused on results measuring to what extent Vermonters' lives are better because of our efforts.

Over the past year, we have addressed many policy challenges and accomplished a great deal. In an increasingly difficult fiscal environment, we are utilizing our first-in-the-nation Global Commitment to Health 1115 waiver to leverage state and federal dollars as we maximize health benefits for those we serve. We are working with other Agencies and Departments to implement the new Catamount Health Plan and the Blueprint for Health, and reduce the number of uninsured Vermonters. Our groundbreaking Choices for Care waiver received national recognition for innovation in state government. It offers Vermonters equal choice among all long-term settings – nursing facility, enhanced residential care home or home care – it has removed institutional bias, present for decades, in the Medicaid program and has resulted in broad-based reform of Vermont's long term care system. And, at the same time that we are moving forward with plans to replace the antiquated Vermont State Hospital, we are improving care and conditions at the current facility and working to strengthen community-based programs, the foundation of our mental health continuum of care in the state.

Utilizing our statewide system of Field Directors – my representatives in the community – we are continuing to make progress on interagency initiatives regarding incarcerated women and transition-aged youth. We can and must do more to reverse the growing number of women in our correctional system. Incarcerated mothers and their children need our help to become stable, healthy families. More data is emerging through this project and we 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. And working with our community partners, our Field Directors participating in the challenges associated with supporting youth transitioning out of foster care.

As I look to the year ahead, I know we will continue to face challenges in the key areas mentioned above as well in developing transitional housing options, complying with new, complex, unfunded federal mandates regarding citizenship and TANF work participation requirements, and addressing the population growth in Vermont's prisons. 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, does extraordinary work. It is a privilege to work with them, as together; we serve the needs of Vermonters.

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 addiction 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. 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*

<b>Number of Positions: 103</b>	
<b>Funding</b>	
General Fund	\$122,174,835
Global Commitment Fund	0
Federal/Other	\$780,275,058
<b>Total</b>	<b>\$902,449,893</b>

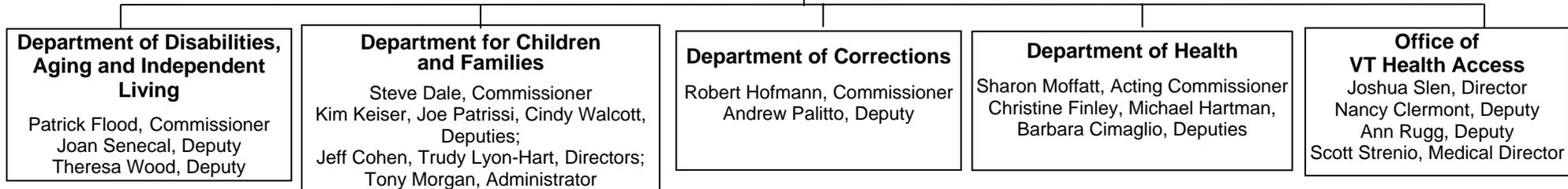
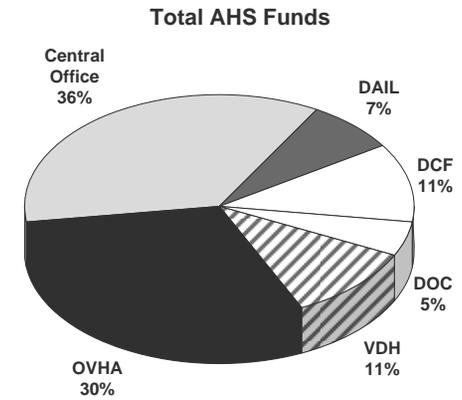
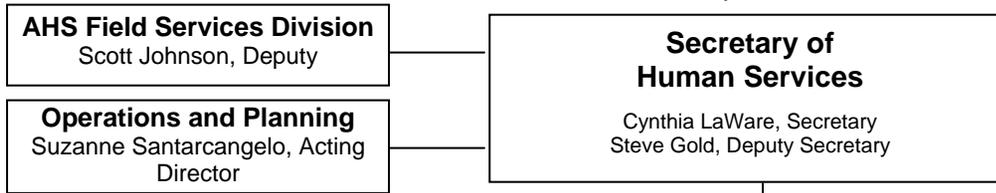
*AHS works as one agency, in partnership with communities, to provide effective services that are delivered respectfully, easy to access, well coordinated, and aimed at promoting well-being and intervening before crisis.*

FY 2008 Governor's Recommend	DAIL	DCF	DOC	VDH	OVHA	Central Office	TOTALS
Positions	305	1000	1164	876	101	103	<b>3,549</b>
General Fund	\$18,278,310	\$79,193,409	\$118,217,554	\$29,229,846	\$128,077,901	\$122,174,835	<b>\$495,172,155</b>
Global Commitment Fund	\$140,068,768	\$61,969,929	\$2,894,144	\$29,229,846	\$471,121,614	0	<b>\$850,238,060</b>
Federal/Other Funds	\$28,510,852	\$147,304,802	\$6,862,586	\$174,183,604	\$147,834,615	\$780,275,058	<b>\$1,184,949,889</b>
<b>Total Funds</b>	<b>\$186,658,230</b>	<b>\$288,468,140</b>	<b>\$127,974,284</b>	<b>\$277,575,427</b>	<b>\$747,034,130</b>	<b>\$902,449,893</b>	<b>\$2,530,360,104</b>



# Agency of Human Services

January 2007



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

- ➔ Provides leadership, funding, & program coordination for quality early childhood & afterschool services in Vermont.
- ➔ Provides intervention services to young children 0-6 & their families.
- ➔ Increases the self-sufficiency of Vermonters through welfare-to-work programs.
- ➔ Provides assistance to address basic economic needs of eligible Vermonters.
- ➔ Determines eligibility for Social Security disability claims & health care coverage.
- ➔ Provides parentage determination, child support, & medical support.
- ➔ Investigates child abuse & neglect
- ➔ Promotes safety, permanency, & well-being for children living at home or in alternative care settings.

- ➔ 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 & reintegrates offenders after release.
- ➔ Helps communities with Reparative Boards & Community Restorative Justice Centers.

- ➔ Leads state & communities in developing systematic approaches to health promotion, safety & disease prevention.
- ➔ Investigates disease outbreaks & prevents spread of infectious disease.
- ➔ Protects against health threats in air, water, food & housing.
- ➔ Promotes healthy behaviors & activities.
- ➔ Prepares for & responds to medical emergencies, disasters & disease terrorism threats.
- ➔ Provides mental health & 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 & resources for prevention of youth substance abuse.
- ➔ Ensures access to quality medical & mental health care & substance abuse treatment.

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



## **AHS – Field Services Division**

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The Field Services Division was created in 2004 as a result of the AHS Reorganization to maximize the effectiveness of the human services system in each region of the state. The Division's scope covers the entire Agency of Human Services, including services provided by private designated and contracted organizations. An AHS Field Director has been established in each of the 12 AHS districts 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.

### **AHS Field Directors serve as the direct representatives of the AHS Secretary's Office within the districts to:**

- Achieve better outcomes for Vermonters by transforming the delivery of human services through dramatically changing the structure, leadership and authority of human service districts;
- Achieve key results established by the Agency Secretary, promote high profile issues identified by Commissioners, and provide leadership around outcomes identified by the District Leadership Team, Regional Partnerships and Advisory Councils;
- Hold team members and local providers accountable to address client outcomes and prevention;
- Deliver coordinated services and find creative, flexible and efficient solutions for cross agency cases and operations;
- Manage flexible funds to address the unmet needs of Vermonters;
- Ensure that all individuals and families readily access needed services by creating an effective system for navigation of services;
- Ensure that all individuals and families involved with multiple programs have service coordination teams and lead service coordinators;
- Respond responsibly and effectively to inquiries, concerns and issues raised by legislators, stakeholders and other community members regarding the needs of specific individuals and families or the human services system; and
- Ensure the overall identity and unified organizational culture of human services in the region, including AHS district operations and contracted services.

### **ACCOMPLISHMENTS**

- **Service Coordination:** Service Coordinators, located in all 12 AHS districts, 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.

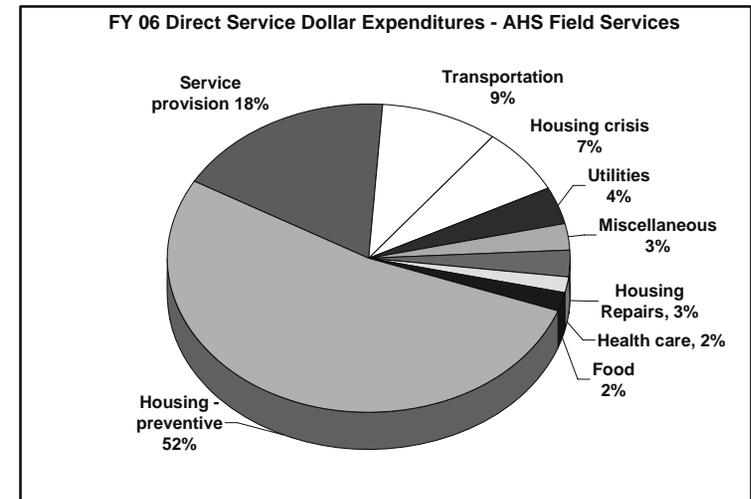
*“Working with my service coordinator, we were able to bring together a service team for a very complex case that had many agencies involved and were at cross-purposes. The service coordinator is not only knowledgeable of resources and system, she is very skilled at helping to clarify issues, one at a time, in a non-threatening and respectful manner. Due to clear communication and patient problem-solving, we left on a very positive note with a clear plan for the family that all the members of the team could subscribe to.”*

## AHS – Field Services Division

- **Direct Service Dollars:** Direct Service Dollars are designed to temporarily support individuals and families in need when those needs fall into gaps within the current system and cannot be met with any other categorical resources.

*A Field Director had a call from a customer supported by AHS in the last year, “just to tell me and the Disability Program Navigator that he has secured a job on a local farm, has a place to live that he is ecstatic about, and is making \$10/hour. This is after almost a year of living in very temporary housing, in part funded by AHS, and receiving considerable support from our system of care. It was great to hear him doing so well and moving toward self sufficiency...”*

- **District Leadership Teams:** The District Leadership Teams are comprised of district service delivery organizational 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 are dedicated to improving the outcomes for all Vermonters.
- **Regional Advisory Councils:** The Advisory Councils are made up of individuals and family members served by AHS 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. The Councils meet three times a year with the AHS Secretary and the Field Services Division to advise them on policy, practice and resource issues in the districts.
- **Peer Navigators:** The Peer Navigators were developed through a statewide collaboration with family organizations and a Federal Grant to offer individuals and family members with disabilities the support of someone who has experienced the system as a consumer. Located in every AHS district, Peer Navigators assist individuals and families to access and navigate the health, education and human service systems. At any given time during FY 2006, Peer Navigators were serving an average of 200 Vermont families.
- **Incarcerated Women’s Initiative:** Each Field Director has established a local team and strategies to bend the curve on the number of women entering the criminal justice system, reduce female incarceration rates, and ensure that appropriate community supports are in place to prevent recidivism. Several efforts are now in place or emerging that should have an impact on those trends including: the involvement of three districts in developing case management and treatment options utilizing DETER funds; development of transitional and temporary housing options; and implementation of community based treatment and reentry teams to support women entering the community.
- **Access to AHS System:** Field Services has been involved in the partnership with Vermont 2-1-1 to expand its database and statewide usage to offer Vermonters access to community resources information and referral. Additionally, we support utilization of the AHS Screen Door, an internet-based screening tool to help determine eligibility for supports. With the development of warm, welcoming and safe district environments and Information, Referral and Assistance (I,R&A) centers, Field Services seeks to create an environment which connects Vermonters to AHS supports in an effective and respectful way.
- **New Agency Team:** The New Agency Team (NAT), comprised of representatives of policy executives from all AHS departments and key outside agencies, was designed to create and sustain a culture of transformation and as an active vehicle for achieving the goals of the re-organization. With an emphasis on cross agency policy review and development, the NAT utilizes examples from the field to assess the effectiveness of policy and practice and create operational solutions.



### **OPPORTUNITIES**

- **Organizational Culture:** Field Services is playing a lead role to ensure the delivery of Beyond the Boxes, a focused effort defining common vision, values and vocabulary for all AHS staff, which embeds the following Four Key Practices into our AHS organizational culture: customer service, holistic service, strength-based relationships and a results focus.
- **Interagency Agreement:** Field Directors occupy a pivotal role in providing oversight and support to the children's system of care through the expanded 2005 Interagency Agreement between the AHS and the Department of Education, ensuring that youth with disabilities receive integrated services and have a smooth transition to adult life.
- **Benefits Enrollment:** Field Directors are working closely with DCF-Economic Services, Corrections and Vocational Rehabilitation to establish benefits enrollment for offenders leaving facilities to be activated immediately upon release in order to maximize opportunities for successful re-entry and reduce recidivism.
- **Military, Family and Community Network:** Field Services has partnered with the Vermont Military and the National Guard to create a network of support for returning vets and their families to ensure a successful return and transition back to family, community and employment.
- **Vermont Mentors!** Field Services is overseeing an AHS contract with The Permanent Fund for the Well-Being of Vermont's Children in support of a public, private partnership that is designed to produce 250 new adult mentors for children and youth throughout Vermont.
- **Transition Age Youth:** Field Services is working with AHS partners to develop a comprehensive system of care for transition age youth in order to ensure a smooth transition into adult life and self-sufficiency within the community.

### **PRESSURES**

- **Incarcerated Women's Initiative:** The number of women in the prison system has climbed steadily in the past decade. We are working closely with corrections and the community support system to relieve this upward pressure and to bend the curve on the number of women in corrections and those facing imminent incarceration, and to minimize the overall impact on their children, families and communities.
- **Housing:** The needs of individuals and families for affordable, temporary and emergency housing remains significant. In 2006 and 2007, over 50% of Field Services direct service dollar allocations went to support the immediate housing needs of families to prevent displacement, re-incarceration, child custody and a negative impact to the overall health and well being of families. Direct service dollars prevented many families from becoming homeless and requiring more intense and costly intervention from AHS. Additionally, Field Services is developing General Assistance (GA) pilot projects to test innovations that mitigate poverty and serve applicants more effectively than those currently served with the same amount of general assistance funds.
- **Emergency Management:** The creation of an effective, timely and coordinated response for Vermonters in times of disaster is critical. Field Services is responsible at the district level for State Support Function #6, to coordinate assistance in support of State and local efforts to meet the mass food, water and care needs of victims of either local or statewide disasters.





# Department for Children and Families

*“The Department for Children and Families has been created to support children, families, and individuals in a holistic way. We are committed to exceptional customer service in the delivery of our benefit programs and many services. We are also passionate about prevention, looking beyond the administration of programs and seeking to help people fundamentally change their lives and realize a brighter future.”*

*~ Stephen R. Dale, Commissioner*

<b>Number of Positions: 1000</b>	
<b>Funding</b>	
General Fund	\$79,193,409
Global Commitment Fund	\$61,969,929
Federal/Other	\$147,304,802
<b>Total</b>	<b>\$288,468,140</b>

**MISSION:** *The Department for Children and Families, in partnership with others, promotes the healthy development, well-being, economic security, and self-sufficiency of Vermonters.*

**VISION:** *We are passionate about prevention!*

*We contribute to reducing poverty; promote the safety and healthy development of children; promote permanent connections for children and youth; provide timely and accurate financial benefits; and equip, support, and value our employees.*

<b>Year</b>	<b>FY '06</b>	<b>FY '07 Est.</b>	<b>FY '08 Gov. Rec.</b>
General Fund	\$92,485,973	\$79,144,204	\$79,193,409
Federal/Other	\$190,087,467	\$215,360,685	\$209,274,731
<b>Total</b>	<b>\$282,573,440</b>	<b>\$294,504,889*</b>	<b>\$288,468,140</b>

**\*11M Carry Forward in LIHEAP**

## ***DCF – Child Development Division***

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*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.*

The Key State Outcomes for Children and Families that guide the work of the division are:

- Pregnant women and young children thrive;
- Children are ready for school;
- Children succeed in school;
- Children live in stable, supported families;
- Communities provide safety and support to families and individuals.

### **ACCOMPLISHMENTS**

- The Bright Futures Information System for CDD has expanded with over 60% of all child care providers in the state now enrolled as e-providers. The system allows providers to manage all of their business interactions with the division on-line including applications for licensure or registration, applications for grant funding, invoicing for the subsidy program and enrolling in and tracking their professional development.
- The model for integrating early intervention services for pregnant women and children to age six into a holistic approach has been designed and each of the 12 AHS regions are working on defining next steps for their region. Beginning in January, 2007, 3 to 4 regions will begin to pilot the delivery of the family support services in this model through performance based grants instead of fee for service billing.
- The Building Bright Spaces for Bright Futures Child Care Facilities Fund generated \$33,000 through the sale of the specialized license plate last year. This is 3 times the revenue generated in previous years. To date \$110,000 has been granted to twelve child care and youth programs in SFY' 07 to increase capacity in quality programs.
- Vermont continues to be ranked 1st in the nation for the percentage of nationally accredited child care centers based on per capita statistics. There are currently 107 accredited centers (16%).
- The STep Ahead Recognition System (STARS) for child care programs now has 137 participants. The goal is to increase enrollment to 200 by January 2007.
- The State Building Bright Futures Council has formed under a new Executive Order issued in June, 2006. An RFP to select an agency to be the host and fiscal agent for the State and Regional Building Bright Futures Council has been released with services to begin July 1, 2007.
- Each of the units within the Child Development Division now has an established action plan with goals and activities that are updated monthly. The plans establish the operational base for the Division of which all funding and policy decisions are made.

## **DCF – Child Development Division**

### **Child Development Division Caseloads:**

- The regulated child care system serves approximately 38,000 children, ranging in age from 6 weeks to 13 years old, at any given time.
- There are currently 699 licensed child care centers, 1,253 registered family child care homes and 1,052 certified exempt providers. The Child Care Licensing Unit regulates all of these programs. This includes processing over 4,000 criminal and child abuse screens annually.
- In 2006, the Child Care Subsidy Program served an average of 7,546 children enrolled in child care programs statewide.
- In 2006, Healthy Babies, Kids & Families served 4,624 individuals ages birth to six and mothers.
- In 2006, the Early Childhood Mental Health Programs served 589 children.
- In 2006, the Family, Infant and Toddler Program served 685 children on active IFSP's at any given time. Approximately 1,200 children were served over the course of the year.

### **Child Development Division Programs and Costs**

Fiscal Year 2006		
<b>Program</b>	<b>Average # Served</b>	<b>Cost</b>
Child Care Subsidy	7,546	\$34,087,451
Healthy Babies, Kids & Families	4,624	\$ 1,625,703
Early Childhood Mental Health	589	\$ 2,613,299
Family, Infant and Toddler Program	685 Active 1,200 seen over 12 months	\$ 4,699,860

### **Child Care Subsidy Program**

Fiscal Year	2003	2004	2005*	2006	2007 Estimate
Subsidy Population	5,002 FTE	5,366 FTE	7,720	7,546	7,848
\$\$\$\$	\$24,921,294	\$26,500,345	\$33,000,320	\$34,087,451	\$35,300,000

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

### **OPPORTUNITIES**

- 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) is designed 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 will result in a higher quality and more stable child care system where providers meet progressive performance standards and parents are informed consumers.

## ***DCF – Child Development Division***

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- 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 are being enhanced and directly connected to a comprehensive career lattice with established articulation agreements between the various institutions of higher education in Vermont. This is positively impacting our ability to recruit and retain qualified staff for the diverse programs within the Child Development System.
- 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 accessible through this system. While designed originally as a child care management system, the web design allows for additions to the system to accommodate the other child development programs now in the division including, the Family, Infant and Toddler Program; Healthy Babies, Kids & Families; and Early Childhood Mental Health Programs.
- Through the integration of three early intervention programs into a single service delivery model, the CDD is establishing 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 model that utilizes designated early intervention teams and a primary interventionist model in each of the 12 AHS regions. Flexibility for the use of some funds created as a result of Global Commitment will allow CDD to implement performance based grants for many of the services, moving away from a fee for service billing system.
- The establishment of the Building Bright Futures Council ensures 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 local and state levels.

### **PRESSURES**

- A lack of qualified candidates and non-competitive salaries continue to result in an unstable and inadequate child care workforce which contributes to lower quality overall in the child care system.
- 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. This is impacting our ability to ensure appropriate services for all eligible children.
- The demand for regulated child care continues to exceed the supply of care statewide.
- The state child care subsidy rates are far below market rates for most care. This is having an adverse impact on access to care for families receiving the subsidy assistance and on the financial stability of the providers serving subsidized families.
- The child care subsidy fee scale has not been adjusted for federal poverty guidelines since 1999. This limits the benefit eligible families receive and thereby reduces their ability to access quality care.

## ***DCF – Child Development Division***

- Specialized child care programs, capable of serving children with challenging behaviors, are expanding but they continue to be unable to meet the needs of an increasing population of children requiring these services.
- The number of children with significant needs is growing, including the number of children diagnosed with autism. This is putting extreme pressure on limited resources, human and financial.
- Large caseloads for Vermont’s 9 child care licensers, 1:190, continue to impede the ability to monitor all regulated programs and provide the required technical assistance to ensure the health and well being of children in care.
- The decline in federal receipts utilized for specialized child care, particularly IV-B, is beginning to impact the amount of support available for children considered at risk for abuse or neglect.
- The increasing federal mandates for Part C of IDEIA, that require more rigorous assessment measurements and reporting of outcomes for children and families, are placing increased pressure on the budget and are creating more work for staff without any new resources.
- The Federal Child Care Bureau is beginning to implement a new protocol requiring States to identify payment errors in the Child Care Subsidy Program, track these errors and recoup all overpayments. This will have a fiscal impact and will result in increased work for the subsidy unit as well as the business office.
- Increasing and changing federal requirements for many of the grants and services within CDD, without new resources for additional staff, are resulting in a diminished capacity to meet accountability standards.
- The anticipated retirement of several senior staff will result in a loss of expertise that will be most difficult to replace.

### **Comparison of Statewide Average Weekly Market Rates for Full-Time Care by Age and Program to Subsidy Rates**

	Average Weekly Market Rates	Average Weekly Market Rates	State Subsidy Rates	State Subsidy Rates
	Licensed	Registered	Licensed	Registered
<b>Infants</b>	\$143.75	\$122.71	\$125.46	\$100.98
<b>Toddlers</b>	\$142.38	\$117.03	\$124.42	\$99.96
<b>Preschool</b>	\$135.70	\$113.02	\$110.82	\$86.70
<b>School-Age</b>	\$130.11	\$107.18	\$108.12	\$86.70

### **Comparison of Eligibility Thresholds for the Child Care Subsidy Program**

	1999*	2006
<b>Family Size of 4</b>		
<b>100% of FPL</b>	\$16,704	\$20,000
<b>82.5% of SMI</b>	\$37,380	\$54,348

\* Vermont currently uses 1999 guidelines for determining eligibility

## ***DCF - Economic Services Division***

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*The Economic Services Division administers assistance that meets the basic needs of Vermonters. 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 find employment.*

### **ACCOMPLISHMENTS**

- **Medical Support from Non-custodial Parents:** Pursuing medical support from non-custodial 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 worked with OCS on a phased-in implementation that began in the fall of 2005 and continued through 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.
- **Medicare Modernization Act (MMA):** The Economic Services Division worked diligently with Office of Vermont Health Access (OVHA) and the Department of Aging and Independent Living to prepare for the January 1, 2006 implementation of the MMA, which had a significant impact on Medicare beneficiaries who also received benefits through Medicaid, or the VHAP- Pharmacy, VScript and VScript Expanded programs. Transition to a new wrap-around pharmacy program (VPharm) was part of this implementation. 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. When it became clear that the new federal systems were initially not working well, 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 until initial Federal implementation issues were resolved. While issues of eligibility and coverage that need attention will persist in year two, problems of the magnitude experienced last year are not anticipated.
- **Food Stamp Program:** DCF ESD maintained its successful working partnerships with Community Action agencies, Area Agencies on Aging, and the Vermont Campaign to End Childhood Hunger to carry out its annual Food Stamp program outreach initiatives. These partnerships have contributed to a steady up tick in the number of Vermonters receiving food stamp benefits. 48,207 people got food stamp benefits in October 2006 as compared to 43,745 in July 2004 – a 10.2 percent improvement.

As our caseload has increased, our payment error rates have dropped to their lowest levels in history, and have remained below the national average. In federal fiscal year (FFY) 2005, the national average for payment errors was 5.84 percent; our payment error rate for the same period was 5.64 percent. We delivered the correct amount of food stamp benefits 94.34 percent of the time.

We have also dramatically improved our performance vis-à-vis our rate of inappropriate denials or case closures, otherwise known as negative errors. Vermont received a \$531,432 performance bonus for being one of the two most improved states nationwide in terms of its FFY 2005 negative error rate, which was 5.81 percent, an overall improvement of 4.45 percentage points from FFY 2004. Our performance for this year is even more spectacular. With all negative case action reviews completed for FFY 2006, we have found no errors. Once FNS validates and releases final performance numbers in June 2007, we expect DCF/ESD to be well-positioned to receive another round of performance bonus money.

### **OPPORTUNITIES**

- **Process Enhancements for Health Care Program Applications:** To begin the expansion of the use of Imaging and Voice Response systems, we will conduct an RFP process for support and maintenance agreement enhancements necessary to our environment. The imaging work will support both the Health Access Eligibility Unit and the Fuel units initially, then expand to support Family Services Division licensing, Lifeline and possibly to our twelve district offices.
- **Improving Program Integrity:** Economic Services continues to match information reported by recipients of the Reach Up, Food Stamp, and health care programs with a number of databases. In 2005 Vermont elected to access the new federally-administered National Directory of New Hires (NDNH) to identify unreported employment of Reach Up recipients. Federal legislation recently added food stamps to the list of programs for which participating states may access this federal repository of data, and Vermont will consider increasing its scope to include this population. The NDNH provides information on recipients working in other states and from employers based outside Vermont reporting their new hires to another state.

Economic Services is requesting additional staff resources necessary to expand any match activity. This would include extending the new hire report from in-state employers and/or the Vermont Department of Labor's quarterly wage match to health care program beneficiaries. Although new or changed income may not affect a household's eligibility or coverage level due to broad income ranges and other rules, some program savings are anticipated. Increases in matches would likely occur in FY08 following implementation of major health care initiatives, such as Catamount Health and Employer-Sponsored Insurance.

Additionally, Economic Services is collaborating with the Office of Vermont Health Access (OVHA) to explore incentive funding for computer programming for an additional federal match. The Public Assistance Reporting Information System (PARIS) identifies individuals receiving benefits in multiple states as well as income paid to military and federal employees.

- **Document Management:** A contract is currently being negotiated to start implementation on a document management project, which initially will streamline the rule-making and procedure writing processes for Economic Services and the Department of Corrections. This is a small but very important step towards an electronic, paperless environment where cost and time efficiencies are gained. The document management system moves us closer to the DCF vision of uniting division functions and providing better means of communication to each other and to the public. This is stage one of many stages of implementation for document management. Future plans being contemplated for the document management system include implementing it for all DCF rule-making and procedure writing activities; contracts and grants; imaging of client case files, and managing training activities for DCF staff. January, 2007 is the target start date with completion by the end of 2007 for the first phase of implementation.

### **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.

## ***DCF - Economic Services Division***

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The overall effects of the TANF reauthorization legislation 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 law 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. The eligibility sampling plans were approved by the Centers for Medicare and Medicaid Services in early February 2007 and the Economic Services Division will begin to review cases in approximately March 2007. 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. Vermont is evaluating its options under the new law and in the Reach Up program to increase the state's work participation rate and avoid fiscal penalties.

- **Premium Assistance Programs:** Act 191, passed during the 2006/2007 legislative session, created premium assistance programs for Employer-Sponsored Insurance (ESI) and Catamount Health. Catamount Health is the new private insurance product that will be offered by one or more of Vermont's largest carriers to uninsured Vermonters. Premium assistance programs are intended to allow more uninsured Vermonters to obtain affordable and comprehensive health care coverage. The ESI component of premium assistance has the potential of saving several million dollars each year in Vermont Health Access Plan (VHAP) expenditures.

This initiative will result in the transition of some VHAP beneficiaries to the ESI program and an increase in health care program applicants through the Economic Services Division. It also creates a new level of complexity in eligibility determination and administration of the program. We have been working collaboratively with OVHA, to develop the system design, rules, notices and related information for these new programs. Thus far, work on this new initiative is proceeding on schedule.

- **Long-term-care (LTC) Medicaid administration:** Staff throughout the division continue to dedicate a significant effort 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.

## ***DCF - Economic Services Division***

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- **Increasing access to Food Stamp Program benefits for all eligible individuals:** Studies recently released by the Economic Research Service of the United States Department of Agriculture show some distressing indicators for Vermont in terms of the number of families that are unable to access adequate quantities of nourishing food to sustain them through each month.

One study, *Household Food Security in the United States, 2005*, released during November 2006, shows that the average number of Vermont households living with the most severe shortage of food - "food insecurity with hunger" – increased to 3.9 percent during the period 2003 – 2005, from the previous average of 2.4 percent reported during the study period 2000 – 2002. In plain terms, this means that during the period 2003 – 2005, over 10,000 Vermont families did not always know where their next meal was coming from, and probably did not have enough to eat at their last meal.

Another study, *Reaching Those In Need: State Food Stamp Participation Rates in 2004*, released during October 2006, shows that during 2004, less than two-thirds of 68,000 potentially eligible Vermonters received food stamp benefits. At 62 percent participation overall, Vermont ranked at number 21 in the nation for Food Stamp Program participation. The study also showed that only 53 percent of working poor households received food stamps. Members of this population segment may mistakenly believe that employment precludes them from being eligible.

These studies show clearly that there is much work for us to do to ensure that no person in this state goes to bed hungry at night. The pressure comes from trying to be able to provide better service through technology advancements and program modernization, as well as more aggressive and targeted outreach.

- **Stretching the Home Heating Dollar:** The Low Income Home Energy Assistance Program (LIHEAP) is traditionally funded through a federal block grant, with Vermont's portion +/- \$11,000,000. The LIHEAP program 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. Last year (the 2004/2005 heating season) because of the soaring costs of home energy and the volatility of the market, the state committed \$10,200,000 in state funds to the program to maintain a benefit level with purchasing power similar to previous years. Low income Vermont households are very fortunate to live in a state that is committed to keeping them warm, but if the price of home energy continues to rise, or even stabilizes, can we continue to support the program at this level? So far, approximately \$16,738,000 in LIHEAP benefits has been issued to eligible households who applied between July and October. The program continues to accept applications through the last day of February.
- **Citizenship:** In the Deficit Reduction Act of 2005, passed in February of 2006, Congress mandated a new verification requirement for Medicaid applicants and beneficiaries. The law now requires most U.S. citizens who apply for or receive Medicaid to present documentary evidence of their citizenship status and identity. Medicaid applicants and beneficiaries who also receive either Supplemental Security Income or Medicare are exempt from the requirement, as they had to prove citizenship and identity when they applied for those federal programs. A bill awaiting the President's signature would also extend the exemption to those who receive Social Security Disability Income (SSDI), foster children, and recipients of Title IV-E adoption assistance."

## ***DCF - Economic Services Division***

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In an effort to minimize the burden of this new requirement, the Economic Services Division of the Department for Children and Families is attempting to obtain the needed documentation through available data matching. When that is not feasible however, individuals will need to get the documents themselves.

The resources required to implement this new requirement include staffing to perform data-matching operations and process documentation and funding to underwrite procurement of Vermont birth records, increased mailing costs, and provision of financial and other assistance.

For the most part, individuals need only satisfy the verification requirements one time. Thus, after the task is met for active beneficiaries, only new applicants will be subject to the requirement. While the scale of the effort drops significantly at the close of the initial first-year phase, there is a significant and ongoing work effort that will be associated with the verification requirements.

- **Payment Error Rate Measurement (PERM):** This new federal mandate requires review of up to 1400 Medicaid and State Children's Health Insurance Program beneficiaries' eligibility once every three years. The eligibility sampling plans were approved by the Centers for Medicare and Medicaid Services in early February 2007 and the Economic Services Division will begin to review cases in approximately March 2007. In addition to a final federal report due July 2008, monthly reports are required. We plan to issue an RFP for oversight and review of these cases. The pressure is significant to contract for this work and complete the required tasks and reports in the compressed timeframe.

## **DCF - Family Services Division**

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*The mission of the DCF 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 delinquent are free from criminal behavior.*

The Family Services Division works in partnership with the other DCF divisions, AHS Field Services Division and the Agency of Human Services to achieve articulated outcomes for children and families.

### **ACCOMPLISHMENTS**

- A careful focus on residential care has resulted in a 30% reduction in the average daily count of children placed in residential care.
- In partnership with the University of Vermont Social Work Department, Family Services has developed a new social work practice framework that emphasizes family engagement strategies, as well as a focus on minimizing risk and increasing protective factors. We are currently re-vamping our approach to staff training to ensure ongoing learning opportunities to support this approach.
- 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.
- A partnership with the Vermont Department of Health and VCHIP focusing on early assessment of health needs was expanded to all 12 districts in FY '06.
- The Baby Safe Havens law has been implemented; training for potential safe havens will be implemented early in 2007.
- We have substantially reduced the use of restraints during the transportation of young people in DCF custody. New transportation options have been developed to make this possible.

### **OPPORTUNITIES**

- Family Services has placed considerable emphasis on achieving permanency for teens in custody; our goal is to ensure that no young person leaves our care and custody without meaningful connections with adults who can provide supports into early adulthood. We hosted two day-long “permanency convenings” last spring and have reconfigured staff resources to ensure a focus on this issue.
- Considerable work has been done during the past year to craft an agenda to improve services and supports to youth transitioning out of DCF custody.
- The Child and Family Council for Prevention Programs has awarded the Juvenile Justice Commissioner funds to hire a contractor to study jurisdictional issues for older adolescents served by the justice system.
- An evaluation of the Woodside program has helped us to focus our ongoing quality improvement efforts for that program.

### **PRESSURES**

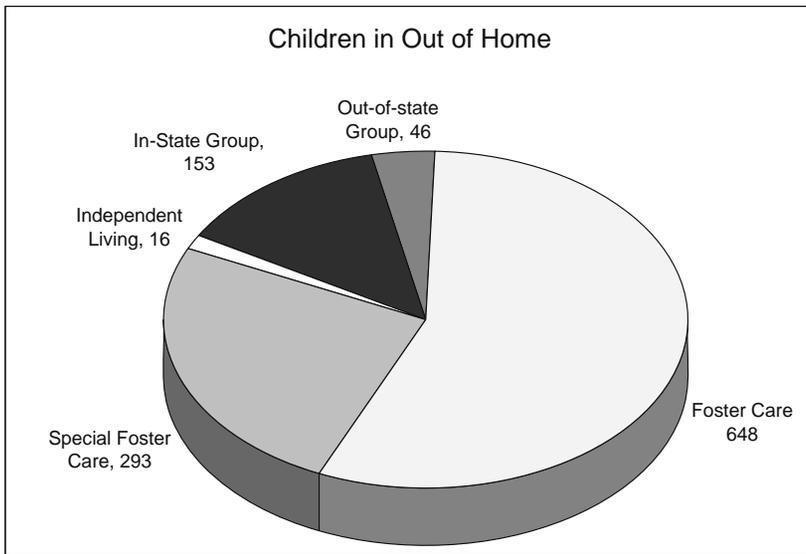
- Implementation of child abuse registry checks for employees who will care for children or vulnerable adults has resulted in over 400 checks per week.

## ***DCF - Family Services Division***

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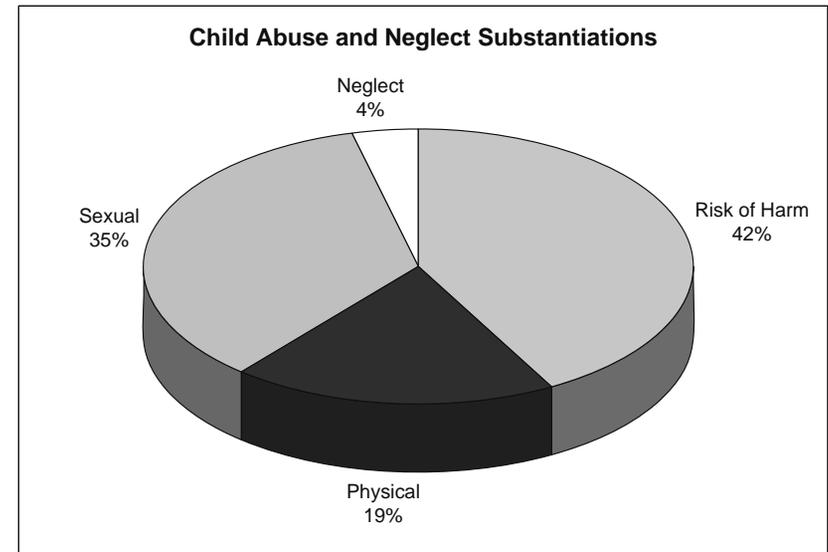
- Children and youth committed to the care and custody of the state are increasingly in need of significant and on-going mental health and substance abuse treatment. Ensuring placement stability for these children, while controlling costs, is challenging.
- The custody population continues to age: over 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.
- Family Services is preparing for the second round of federal Child and Family Services Reviews, to be held in April 2007. In the first round, no state was found in substantial compliance and all states were required to complete program improvement plans. Financial sanctions were held in abeyance pending successful completion of a negotiated program improvement plan and Vermont was able to avoid sanctions in the first round. Now, in this second round Vermont is the third state up for review and the bar has been raised even higher. Almost certainly, Vermont and every other state will have to write and implement a program improvement plan that will focus on continued progress on federally defined measures of quality.
- 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.

**CASELOAD DATA**

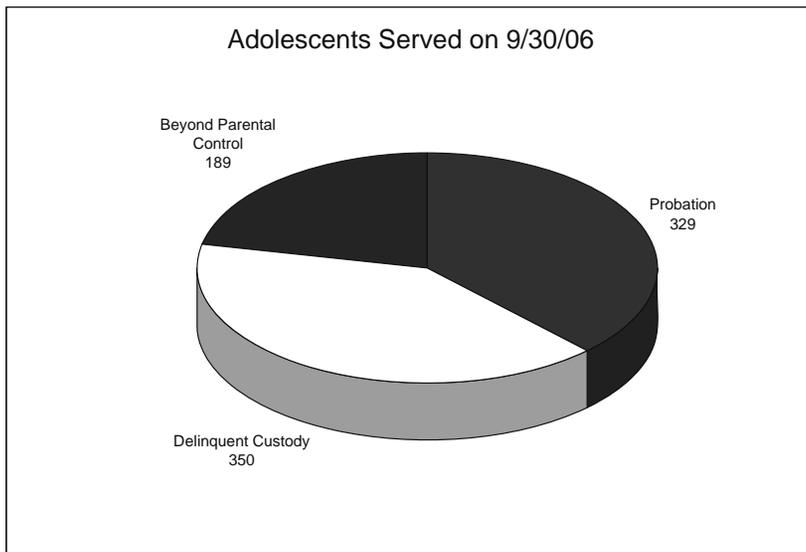


On any given day, about 1,226 children and youth are living in out-of-home care provided by the division:

In 2005, Family Services made 890 substantiations of child abuse or neglect:



On 9/30/2005, 868 adolescents were being served due to their delinquency or behavior issues:



## ***DCF - Family Services Division***

### **Services We Provide:**

<b>What?</b>	<b>How many?</b>
<b><i>Child Abuse and Neglect Intake</i></b> – Community members may contact our district offices during the work day to report suspected child abuse or neglect. Our Emergency Services Program accepts reports after hours.	13,000 annually
<b><i>Child Abuse and Neglect Investigation and Assessment</i></b> – Specialized social work staff conduct these investigations, with a primary focus on the immediate safety of children.	2,846 investigations conducted in FFY 2006  97% of children served remain safe for at least 6 months.
<b><i>Ongoing Services to At-Risk Families</i></b> – Based on a validated risk assessment, a decision is made whether to provide ongoing services to a family.	On 9/30/06, 89 families were receiving services.
<b><i>Children in Custody</i></b> -- A police officer may take a child into DCF custody for one of the following reasons: <ul style="list-style-type: none"> <li>• Child abuse or neglect</li> <li>• Truancy</li> <li>• Child is beyond parental control</li> <li>• Child is delinquent</li> </ul> Children live with: <ul style="list-style-type: none"> <li>• <b><i>With Parents – 216</i></b></li> <li>• <b><i>With Kin – 164</i></b></li> <li>• <b><i>With Foster Families – 725</i></b></li> <li>• <b><i>With Pre-Adoptive Families – 71</i></b></li> <li>• <b><i>In Group Care – 168</i></b></li> <li>• <b><i>In Institutions, including Woodside – 31</i></b></li> <li>• <b><i>Living Independently -- 18</i></b></li> </ul>	At any point in time, about 1,450 children are in DCF custody. <ul style="list-style-type: none"> <li>• 310 age 0-5</li> <li>• 260 age 6-11</li> <li>• 835 age 12-17</li> <li>• 38 over 18 receive support to finish high school.</li> </ul>
<b><i>Permanency Planning Services</i></b> – for all children in DCF custody, the focus is on ensuring that a child has a permanent home in which to grow up. Preferably, that home is with the child’s own parents. If that is not possible, adoption is the second choice. Long term foster care is not considered an acceptable plan for a child.	Over 50% of children return to live with a parent or relative. About 28% of children are exit to adoption.
<b><i>Youth Justice Services</i></b> – DCF social workers supervise youth on juvenile probation, using the principles of balanced and restorative justice. YouthNet services, such as “streetcheckers” also provide developmentally appropriate services for these youth. Delinquents may be in DCF custody depending on their treatment needs and/or community safety concerns.	About 330 children are on juvenile probation.
<b><i>Special Needs Adoptions</i></b> – Children in DCF custody who have special needs may be eligible for a monthly financial subsidy to make adoption possible. In addition, a network of post-adoption services is available to help families weather the predictable stresses.	Over 1,400 children receive a subsidy. 350 children receive post-adoption services.

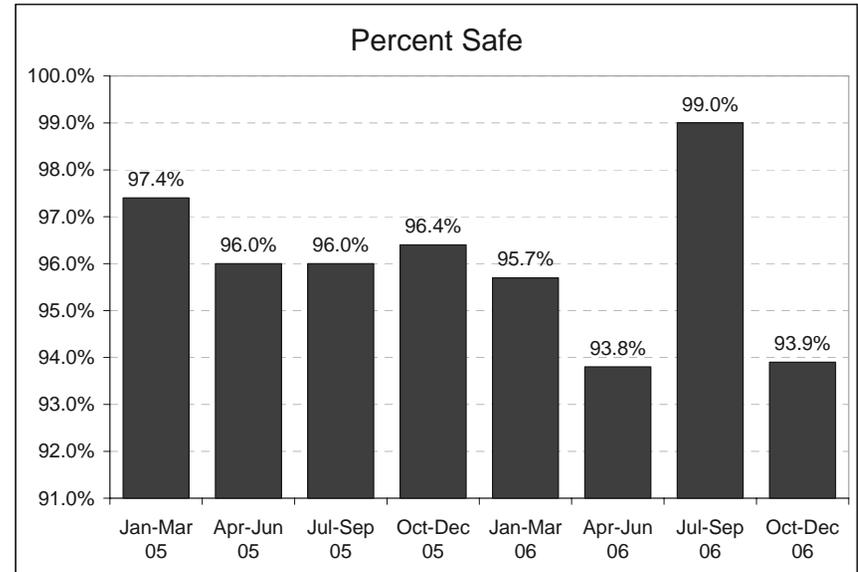
**OUTCOME MEASURES**

The division regularly produces data and tracks performance on five outcomes defined by federal regulations.

**Outcome: Safety** Children are, first and foremost, protected from abuse and neglect.

**Measure:** Percent of children who are safe from a second abuse/neglect substantiation within a 6 month time period.

**National Std:** 93.9%

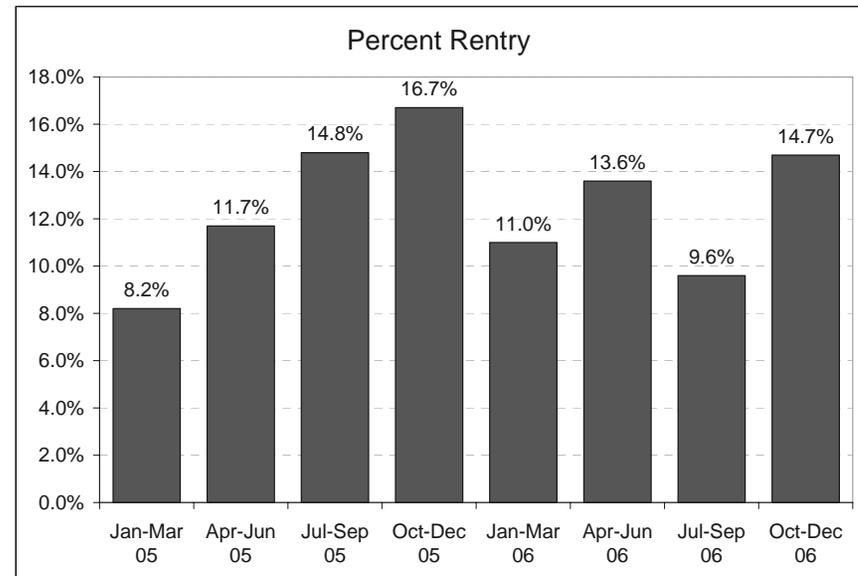


**Outcome: Permanency** Children have permanency and stability in their living situations.

The continuity of family relationships & connections is preserved for children.

**Measure 1:** Percent of children entering out-of-home care who were discharged from out-of-home care within last 12 months.

**National Std:** 8.6%



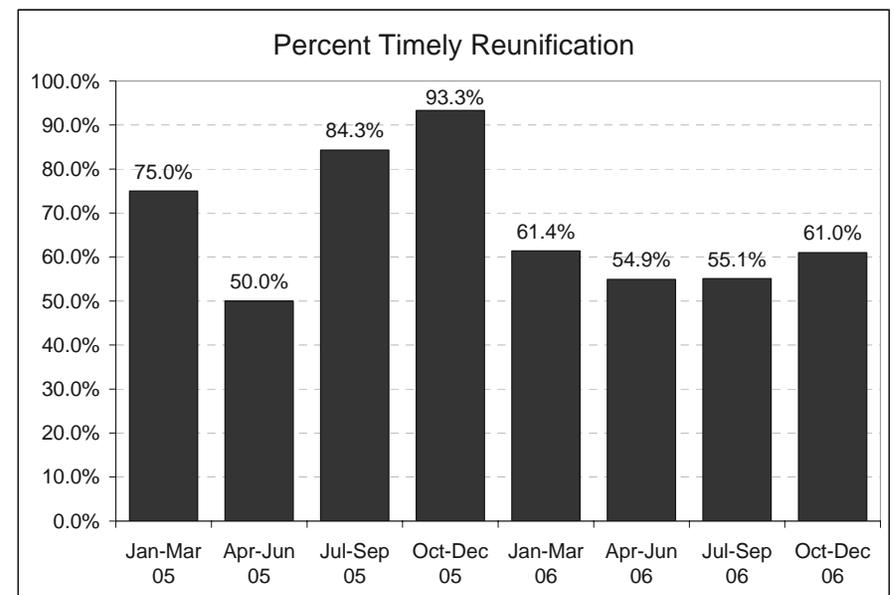
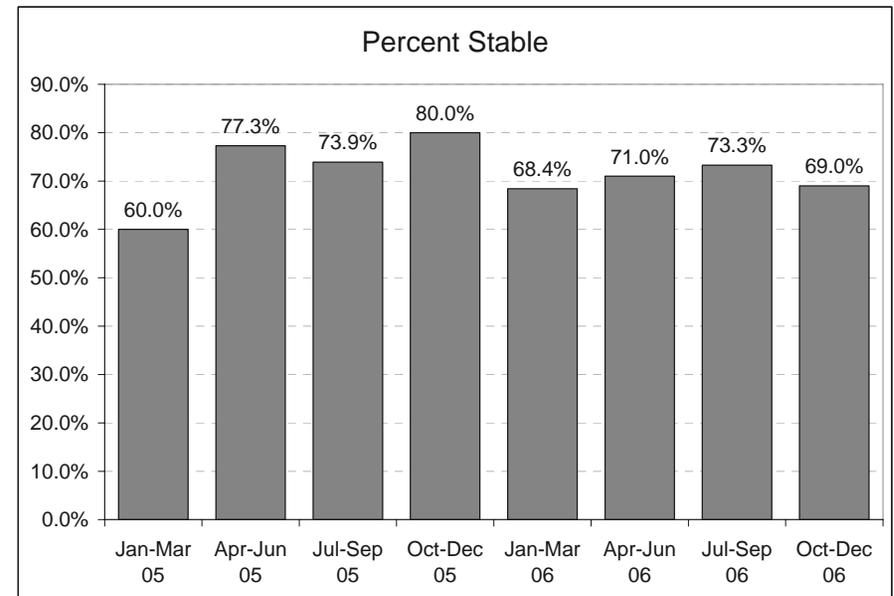
## DCF - Family Services Division

**Measure 2:** Percent of children who have no more than 2 placements within the first 12 months of out-of-home care.

**National Std:** 89%

**Measure 3:** Percent of reunified children who are reunified within 12 months of entering out-of-home care.

**National Std:** 76.2%

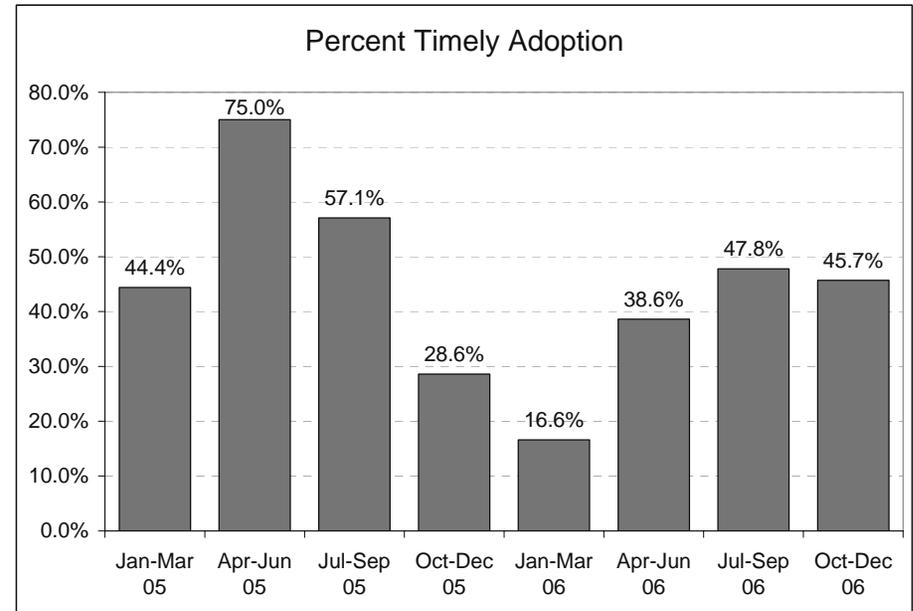


**DCF - Family Services Division**

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**Measure 4:** % of adopted children who adoptions are finalized within twenty-four months of entry into out of home care.

**National Std:** 32.0%

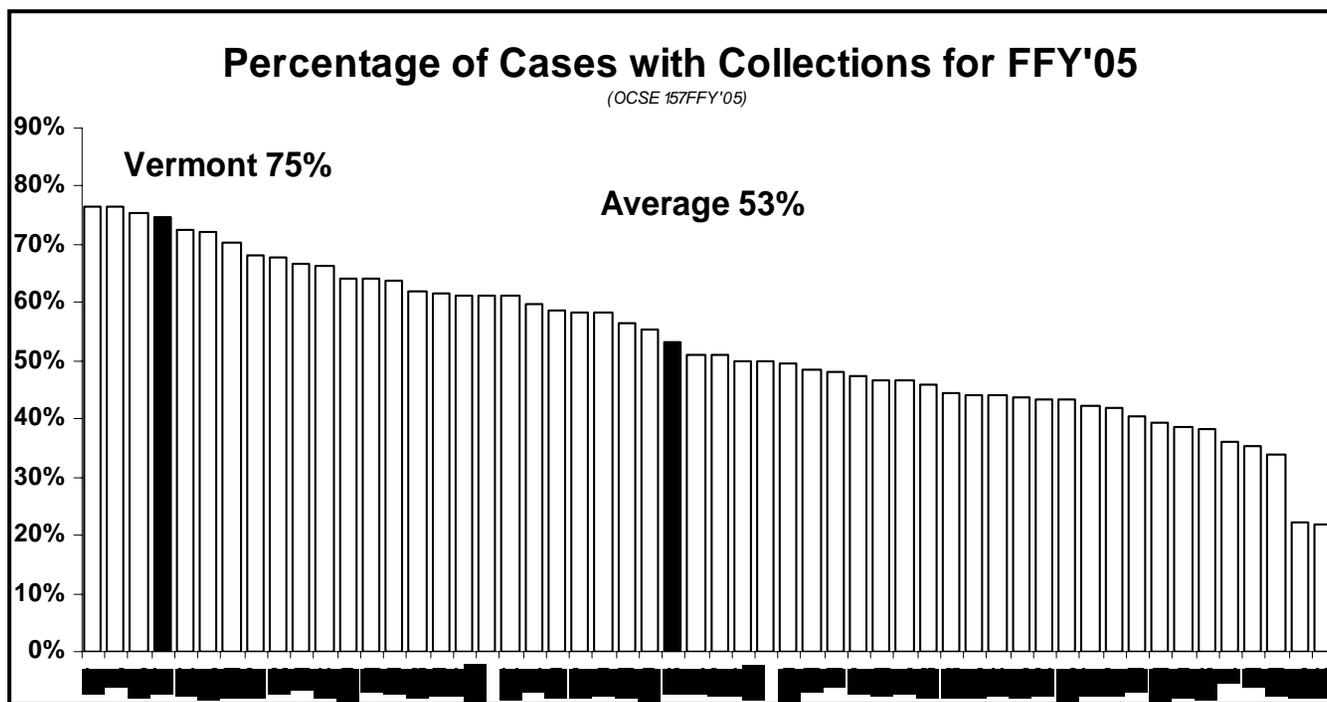


## DCF – Office of Child Support

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.

### 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 2005 Vermont collected child support on 75% of its cases, compared to the national average of 53%.

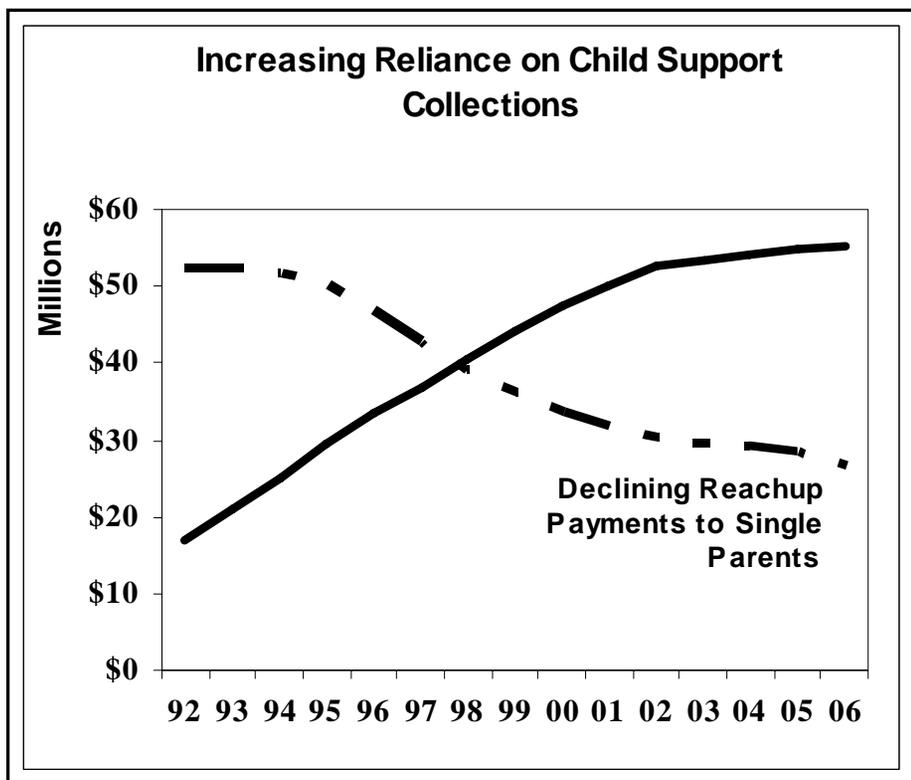
#### Last year, the Office of Child Support:

- Collected on 75% of its cases.
- Collected \$55,175,161 in child support.
- Handled 22,400 cases.
- Scheduled 9,303 court appearances by legal staff.
- Entered 5,592 court orders on the computer system.
- Averaged 637 cases per child support specialist.
- Processed 426,237 payments.

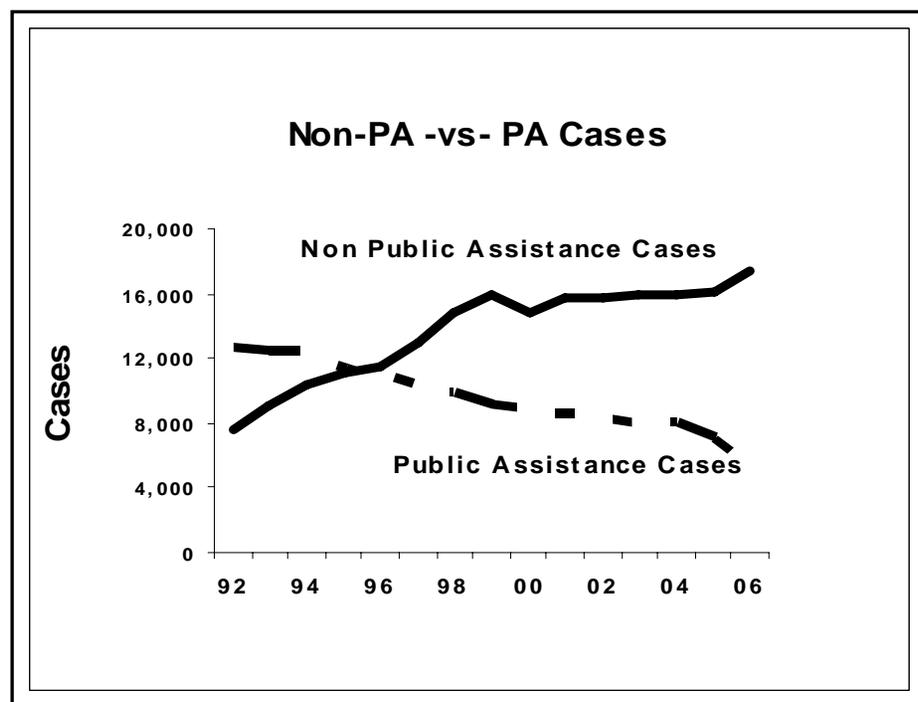
Child Support Enforcement is a complicated process with many actions required to move cases along. Filing court actions, appearing in court, recording the terms of court orders, processing employer wage withholding notices and payments are only a few. Other steps such as finding employer addresses in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

## DCF – Office of Child Support

### 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 (Reach Up) and the increasing fragility of the safety net, child support payments are a crucial way for parents to sustain their families.



In state fiscal year 2006, 17,325 Office of Child Support cases were non-public assistance cases and 5,379 were public assistance cases. 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.

### **OPPORTUNITIES**

#### **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.

#### **Enhancing Medical Support Collaboration Project with Federal Grant**

In September 2005 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." The project builds upon the collaborative work of the 2004/2005 Medical Support Workgroup, staffed by the OCS, OVHA and ESD.

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 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.

#### **Enhancing services to Employers with the creation of the Employer Services Unit**

In SFY 2006 the Office of Child Support created the Employer Services Unit with some of the new positions created for the implementation of the program with OVHA and ESD for the establishment and enforcement of medical support. The creation of the unit recognizes the significant partnership employers have with OCS. Approximately 70% of child support collections result from wage withholding by employers. In addition, employers are responsible for enrolling children of employees in health insurance plans when the employee is ordered to provide health insurance by the court. The unit focuses on the needs of the employers by providing information and technical assistance regarding new hire reporting, wage withholding and health insurance enrollment. The response from employers has been extremely positive.

**PRESSURES**

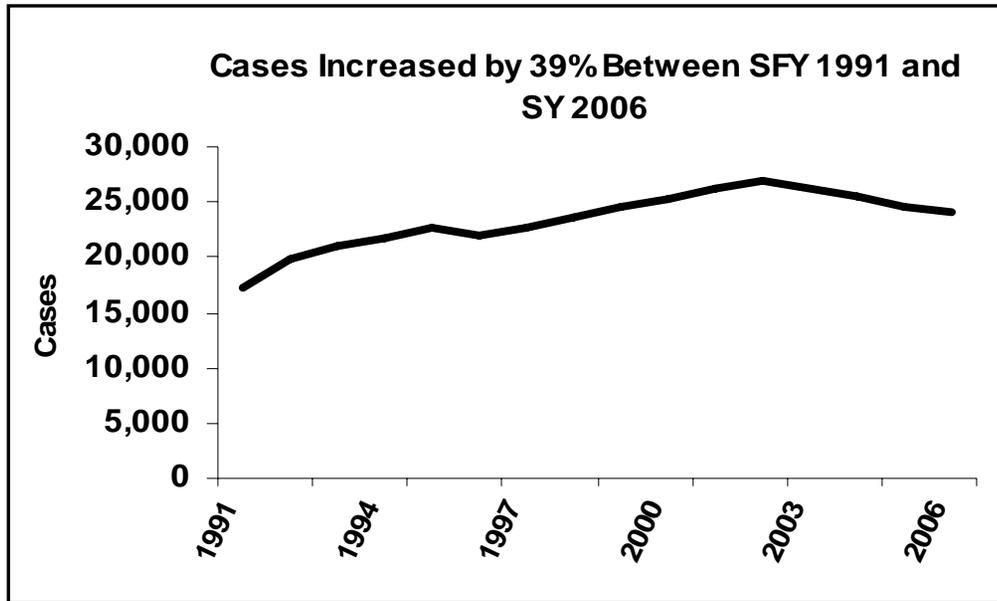
**The Deficit Reduction Act 2005 has an adverse impact on budget of OCS.**

One provision of the Act negatively impacts OCS' budget beginning in federal fiscal year 2008 when state child support agencies will no longer be permitted to use incentive funds as state match to draw down Federal Financial Participation. The Deficit Reduction Act of 2005 eliminated the state's ability to receive 66% match on federal incentive payments. This amounts to approximately a 19% cut in federal funds which translates into approximately \$1.9M. If this shortfall is not filled, it could have a significant adverse impact on OCS customers and other state programs.

**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.

**HISTORICAL CASELOAD AND COST DATA**

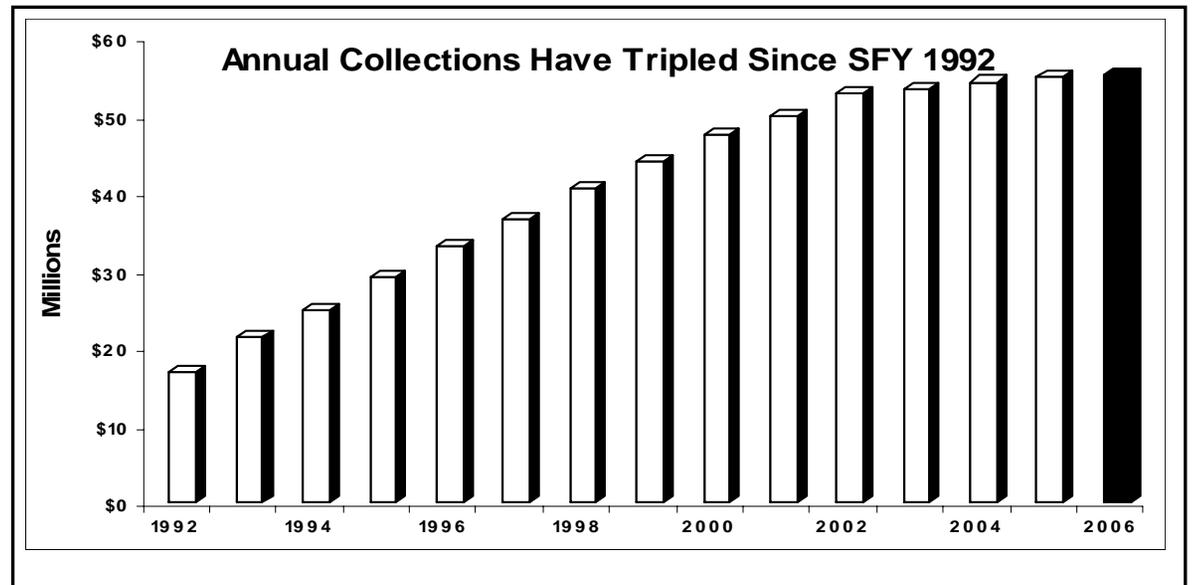


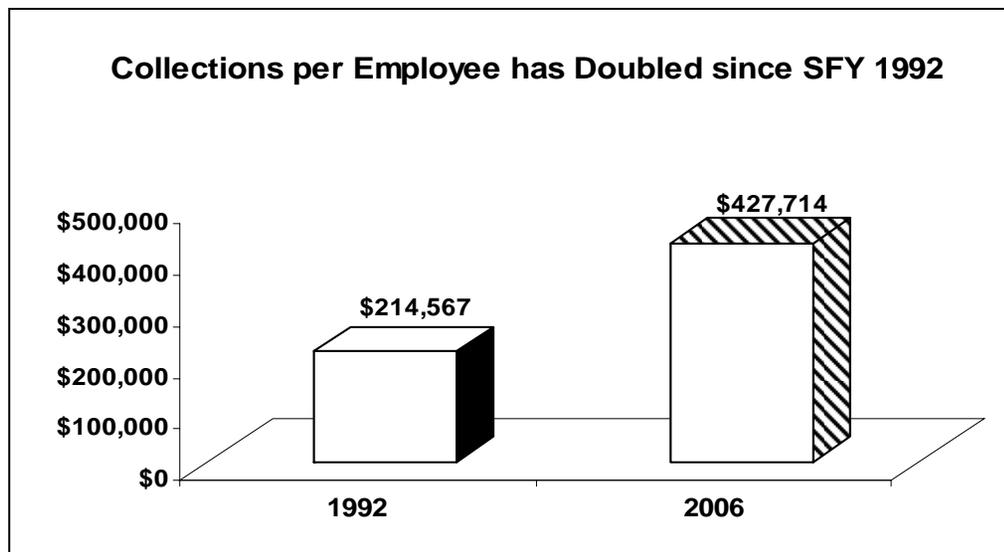
**Growth in Cases**

Vermont's out of wedlock birth rate increased greatly from 13.9% in 1981 to 30% in 2003. There were also 2,495 divorces in Vermont in 2003 with 1,273 involving children under 18 years of age. Over the last several years, the number of cases served by the Office has risen at a rapid pace – up 39% from 1991 to 2006. The Office currently has over 22,500 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 more than tripled since 1992 to \$55,175,161 in state fiscal year 2006. Total collections in the last 15 years are \$613,965,562.

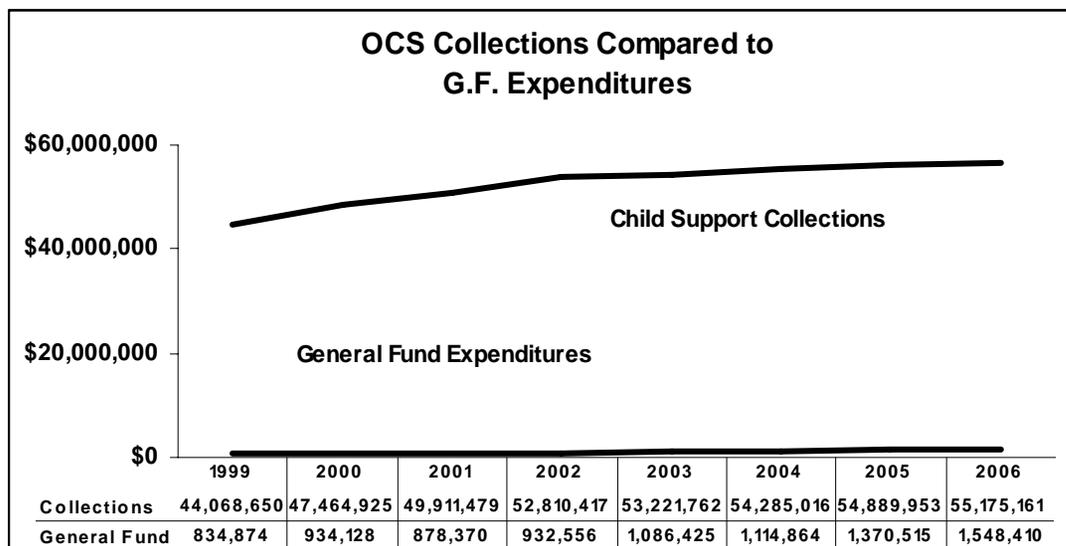




**Growth in Collections per Employee**

In 1992, the amount collected per employee was \$214,567. By 2006, that amount had almost doubled to \$427,714. 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.

In state fiscal year 2006 the Office of Child Support program had \$1.5 million appropriated from the general fund. This investment generated almost \$55.2 million in child support collections that supported families or recovered public assistance expenditures.



During the last seven year period from 1999 through 2006, the state's \$8.7 million in appropriations has reaped almost \$411 million in child support collected for Vermonters.

## **DCF – Office of Disability Determination Services**

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*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.*

### **ACCOMPLISHMENTS**

- During federal FY 2006, the Vermont DDS was ranked fourth among the nation's 52 DDSs for initial performance accuracy.
- For federal FY 2006, the Vermont DDS achieved the second lowest medical cost per case in the nation.
- For federal FY 2006, the Vermont DDS still ranked in the top ten DDSs for speed in processing initial SSI claims, despite the fact that its processing time increased by 35 days.
- The DDS makes early, accurate SSI allowance predictions that provide expedited benefit checks to SSI applicants prior to a final decision. For federal FY 2006, the Vermont DDS was able to initiate early benefits to 73% of eligible SSI applicants (compared to the national rate of 22.8%).
- In February 2006, the DDS achieved SSA/NARA certification to process disability claims electronically
- In August 2006, the DDS successfully began implementation of the new Disability Service Improvement regulations

### **OPPORTUNITIES**

- **Ongoing partnership with the Social Security Administration to enhance service to Vermonters with disabilities and to ensure stewardship of disability programs and public funds.** Current opportunities include being part of the first region to roll out the Disability Service Improvement regulations that Social Security published in March 2006. The New England region is working closely with Social Security to operationalize the regulations, including the development of Quick Disability Decision units, decision tool software and enhanced decision explanations.
- **Collaboration with other state offices to improve service to Vermonters with disabilities.** Examples of areas of collaboration include cross training with Child Benefits Unit of Family Services, Vocational Rehabilitation Reach Up Counselors and SSI Assistants. DDS is currently working with AHS Field Services, Vocational Rehabilitation, and Social Security to develop training for community service providers in assisting SSI applicants with the claim process. Through this and other similar projects, the DDS hopes to enhance public understanding, quality of claim information, and consequently, the quality of decisions and service provision.
- **Assumption of the Katie Beckett Medicaid waiver level-of-care determination.** The DDS has recently assumed this part of the Katie Beckett eligibility determination, in addition to the disability determination part. Once the new process is fully established, it will provide significantly faster eligibility determinations for these children with equal quality, greater efficiency, and lower cost, due to DDS's ability to develop and determine both aspects of eligibility simultaneously.

### **PRESSURES**

- **Processing time needs improvement.** The transition to Social Security's electronic claims processes and the new disability regulations has slowed case processing significantly in the past year. While the changes have the potential to enhance quality and improve the overall process, many of the changes add tasks and lengthen task times for the DDS. The system tools that Social Security is developing are not yet fully functional and require temporary but time-consuming workarounds. Average processing time for a medical determination for SSI has lengthened from 53 days in federal fiscal year 2005 to 88 days in October 2006. The DDS has hired and is training additional staff for the new, more labor-intensive workload.
- **Healthcare facilities not yet prepared to transmit records to DDS electronically.** The conversion of paper evidence into electronic format adds excessive mail time as substantially all evidentiary material must be sent to Social Security's national scanning contractor in Kentucky. The DDS has requested that Social Security support a local scanning operation. The DDS plans to work individually with the larger healthcare providers in Vermont to see whether direct electronic transmission processes between their facilities and DDS can be developed.
- **Lack of sufficient consultative examination providers in local communities.** The DDS needs to purchase consultative examinations for some claimants in order to meet the federal documentation requirements for their claims. Social Security limits DDS to the Medicare fee schedule for paying healthcare providers to perform these examinations. The DDS has great difficulty recruiting providers, especially psychiatrists and licensed psychologists, to perform these examinations. The limited number of professionals with the required credentials, particularly in rural parts of the state, and the fact that other state agencies and insurance companies pay much more than the Medicare fees, means that DDS claimants often wait months and travel long distances for these examinations. DDS adjudicators also work hard to obtain sufficient information from the applicants' treating sources to avoid the necessity of consultative examinations whenever possible. The DDS continues to actively recruit community professionals; if unsuccessful, we may be able to support a request for an exception to Social Security's fee limitation.
- **Potential federal budget cuts for Social Security and DDS.** Federal budget shortfalls in Social Security, along with increased numbers of initial claims, have led to cut backs in continuing disability reviews. These reviews serve the important function of ensuring that beneficiaries whose condition improves enough for them to return to work leave the rolls. Although only a small portion of those reviewed are removed from the rolls, the savings for the state are a very high return on the administrative cost of the reviews: more than \$10 for every dollar spent. Without these reviews, at least for SSI, not only does the federal government continue to pay benefits to people who no longer meet the criteria; the state also continues to pay the state supplement for SSI and Medicaid.

### **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 (6% in FFY 2006) involves determination of medical eligibility for Medicaid. The full cost of federal claims processing is borne by the federal government.

## ***DCF – Office of Disability Determination Services***

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The drop in the processed workload starting in 2005 and continuing is largely due to the decision of Social Security to decrease DDS reviews of continuing eligibility on a national basis. The Disability Service Initiative regulations also changed the first level of appeal, moving it from DDS to a federal component; this leads to lower numbers of claims starting in 2007. Increased costs from 2005 on reflect the technical and resource demands of the transition to electronic case processing and the Disability Service Initiative.

<b>Federal Fiscal Year</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007 (projected)</b>
Processed Claims (SSA & Medicaid)	7184	8478	7301	6203	6300
\$\$\$ (SSA & Medicaid)	\$3,058,649	\$3,149,282	\$3,390,710	\$3,545,443	\$3,850,143

## ***DCF – Office of Economic Opportunity***

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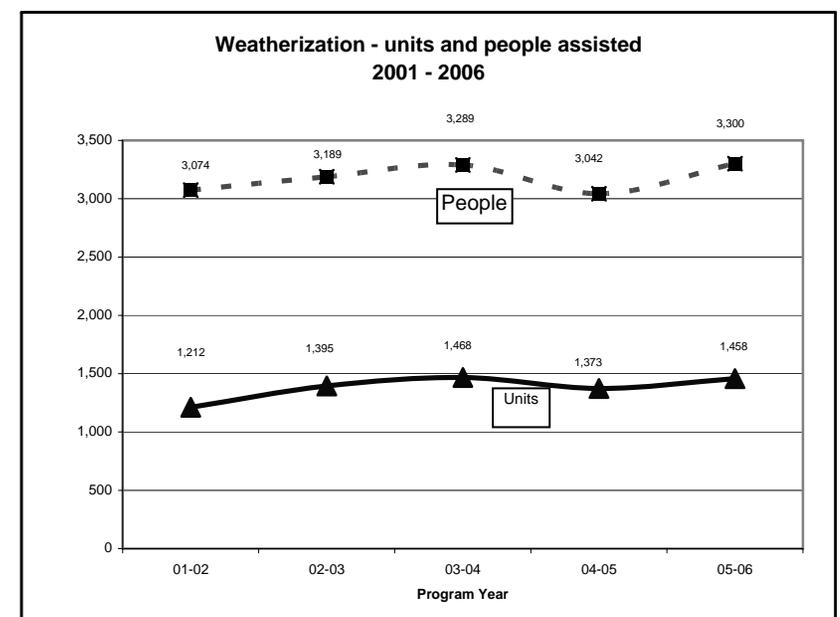
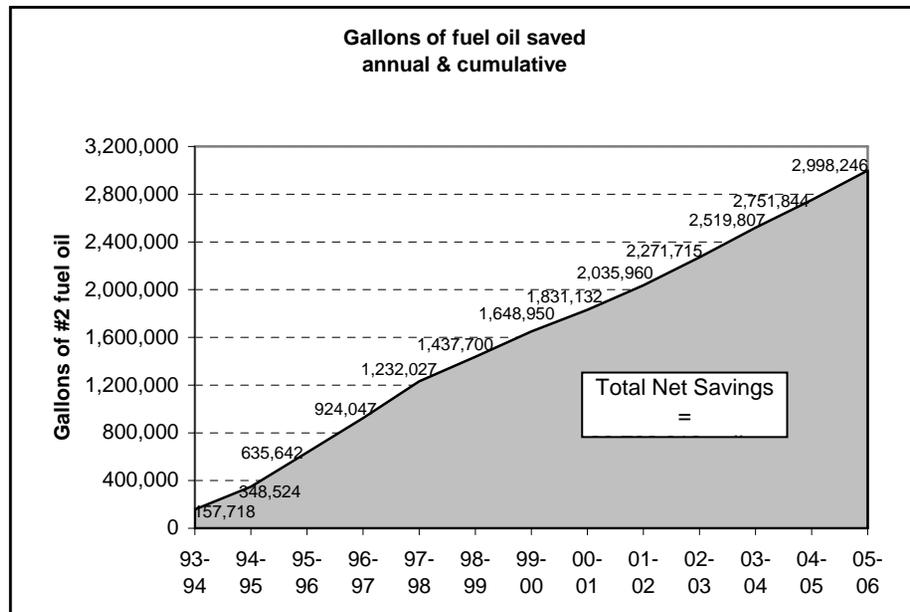
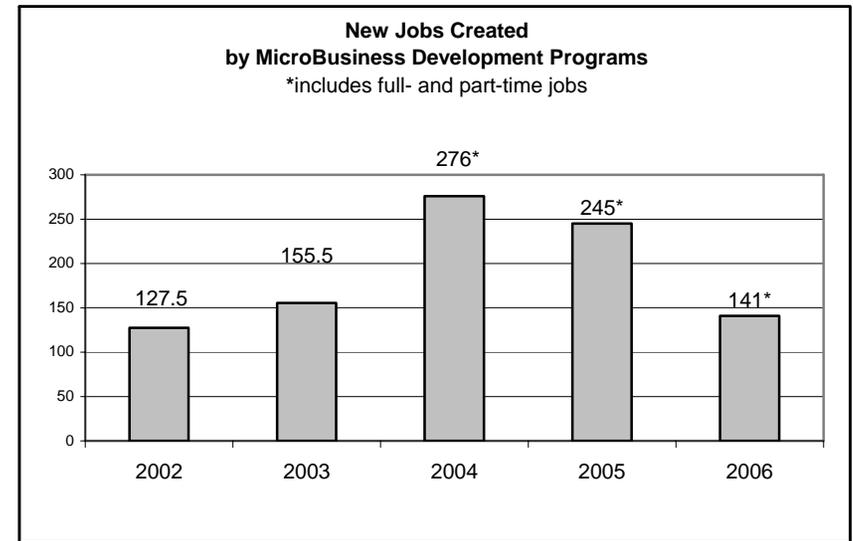
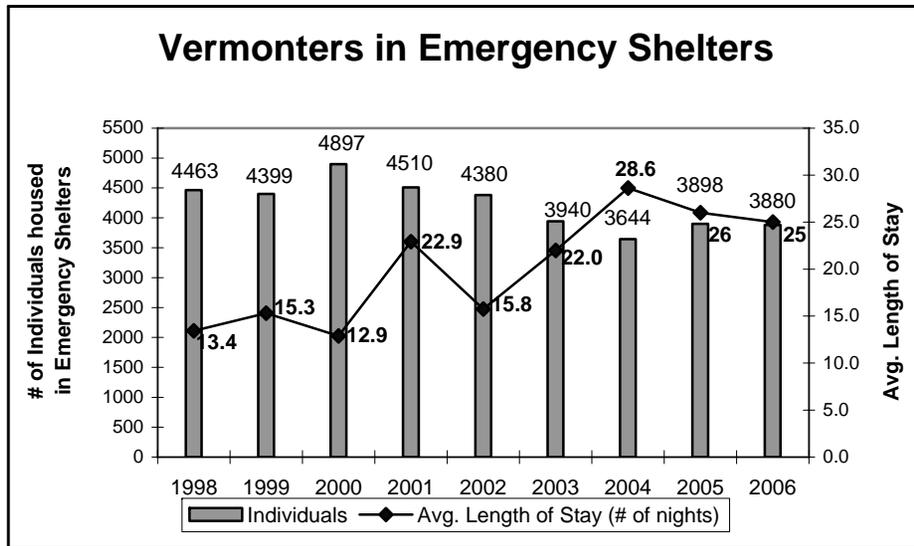
*The Office seeks to increase the self-sufficiency of Vermonters and strengthen Vermont communities by providing training and technical assistance, resource identification and development, and program and grants management for community-based organizations. The Office connects communities to resources 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 Community Services Block Grants are required to use **Results Oriented Management and Accountability** practices 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. Small increases in funding from the U.S. Department of Energy combined with 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 the energy efficiency of low-income people's homes.

### **PRESSURES**

- **Homelessness:** 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 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 pervasive problem in Vermont. During the '90s, the number of Vermonters at or below the federal poverty level (currently \$20,000 for a family of four) rose by 3.6%. In the 2000 census, we counted 48,483 people in poverty, creating constant pressure on our emergency service delivery system.





# 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: 1,164**

**Funding**

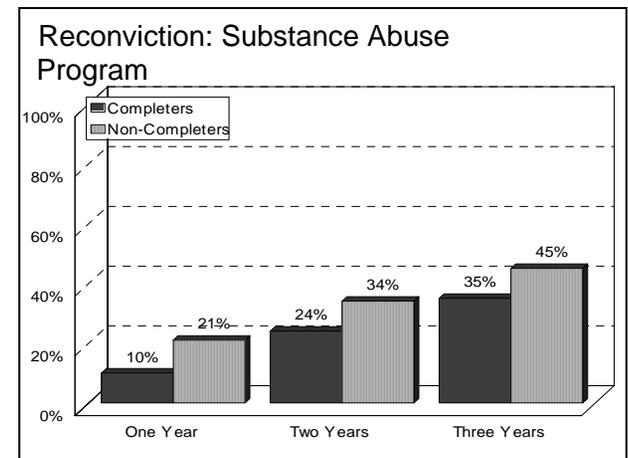
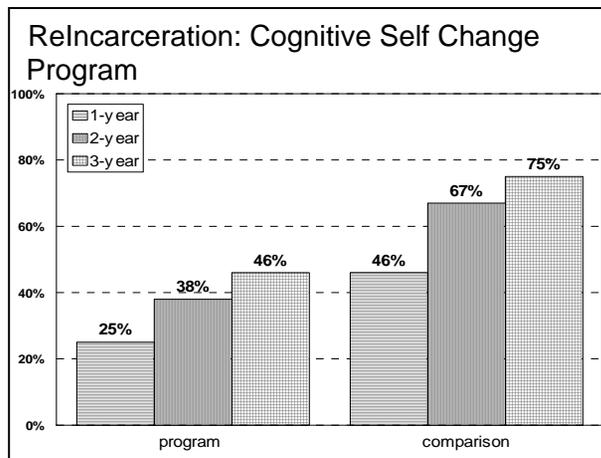
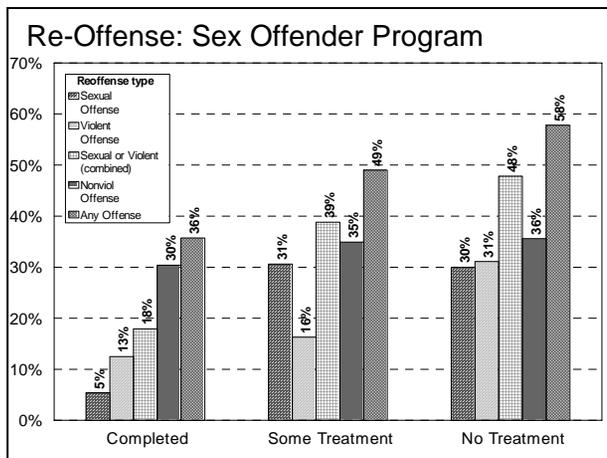
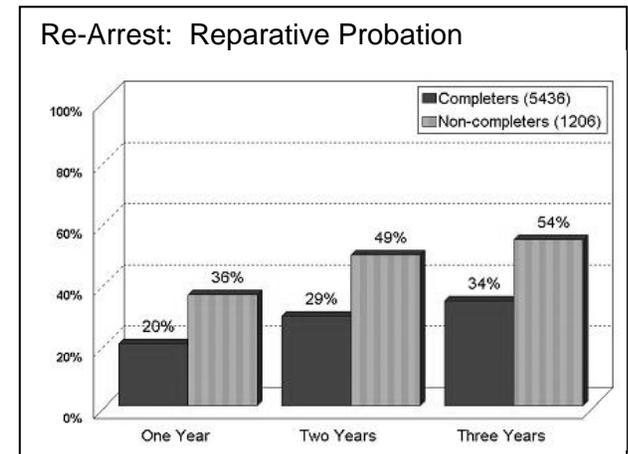
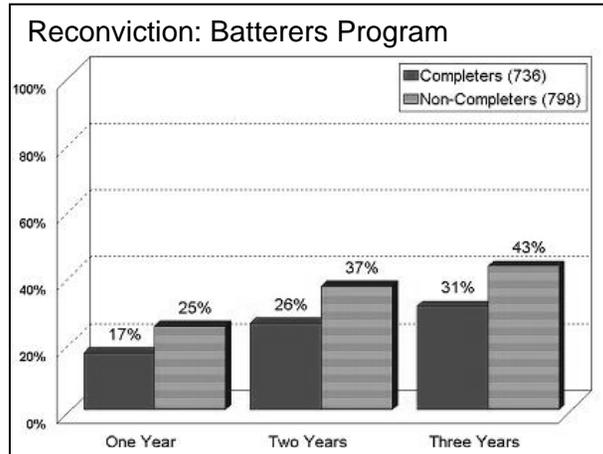
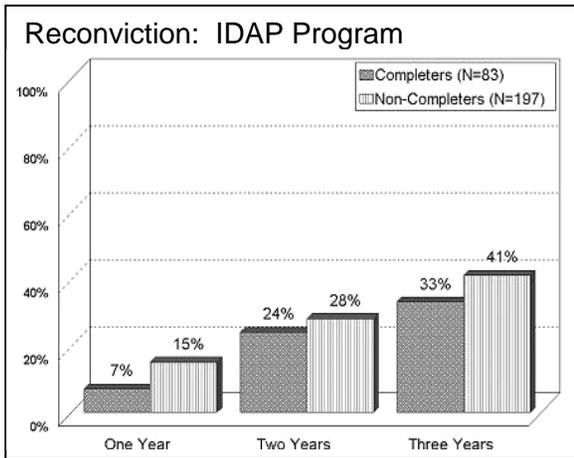
General Fund	\$118,217,554
Global Commitment Fund	\$2,894,144
Federal/Other	\$6,862,586
<b>Total</b>	<b>\$127,974,284</b>

*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.*

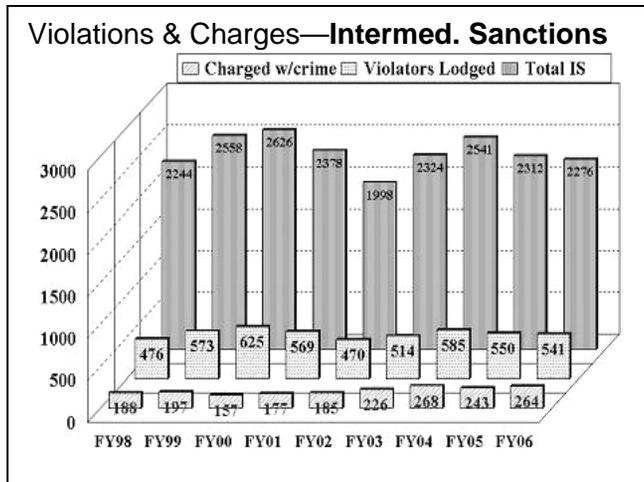
<b>Year</b>	<b>FY '06</b>	<b>FY '07 Est.</b>	<b>FY '08 Gov Rec.</b>
General Fund	\$102,353,779	\$111,186,257	\$118,217,554
Federal/Other	\$10,032,161	\$10,120,236	\$9,756,730
<i>Total</i>	<b>\$112,385,940</b>	<b>\$121,306,493</b>	<b>\$127,974,284</b>

**ACCOMPLISHMENTS**

**Treatment:** Vermonters expect treatment programs for offenders. They do not expect treatment to work every time, but they expect it will be provided. 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 36% reduction in reconviction; the Intensive Domestic Abuse Program produces a 19% reduction in reconviction, the Batterer's Intervention Program produces a 28% reduction in reconviction, and the reparative probation program produces a 37% reduction in re-arrest (a different measure, but more significant).



# Department of Corrections



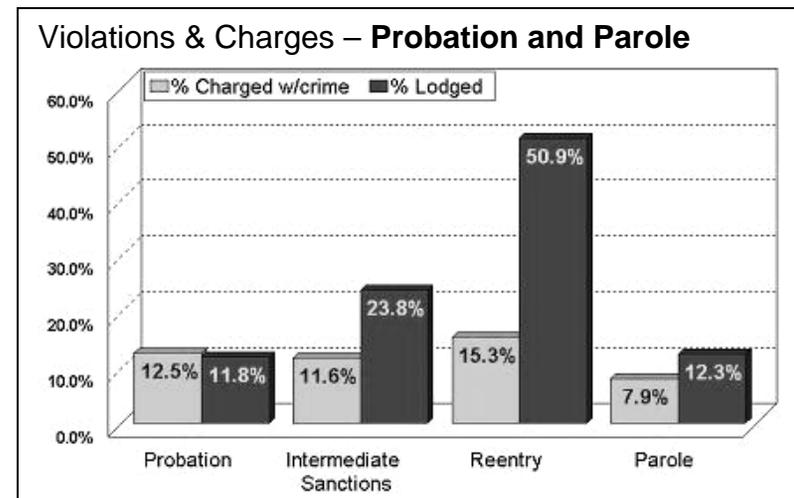
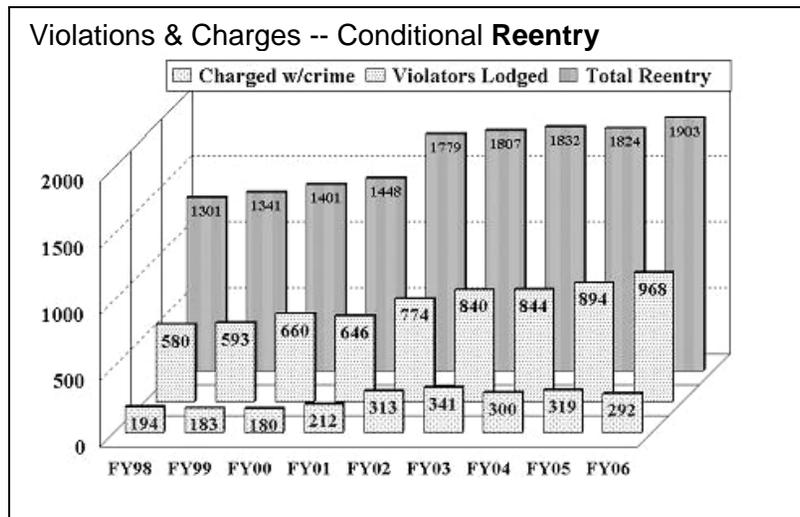
## Accountability

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.

It should be noted that persons under active corrections supervision account for only 20 percent of all charges brought by State's Attorneys last year. An additional 20 percent are charged against persons no longer, but formerly, under supervision. The other 60% is charged against persons who were never under supervision of the Department, in any capacity.



## ***Department of Corrections***

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### **Community High School of Vermont:**

The New England Association of Schools and Colleges (NEAS&C) Commission on Independent Schools (CIS) voted unanimously on February 12, 2007 to recommend an initial accreditation for the Community High School of Vermont (CHSVT). The NEAS&C Board of Trustees is expected to approve the final accreditation at its upcoming March meeting. Founded in 1885, NEAS&C is the nation's oldest regional accrediting association whose mission is the establishment and maintenance of high standards for all levels of education, from pre-K to the doctoral level. With NEAS&C accreditation, CHSVT will join elite institutions such as Philips Exeter Academy in New Hampshire and the University of Vermont.

CHSVT is primarily designed to serve individuals who have not obtained a High School Diploma, are under the custody of the Vermont Department of Corrections (DOC), and have a high need in the area of employment, as identified by DOC classification procedures. The mission of CHSVT is to provide quality educational services responsive to the academic, vocational and social needs of Vermont residents without a basic education, to improve their knowledge, skills and abilities to function as meaningful participants in the community.

### **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. 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.

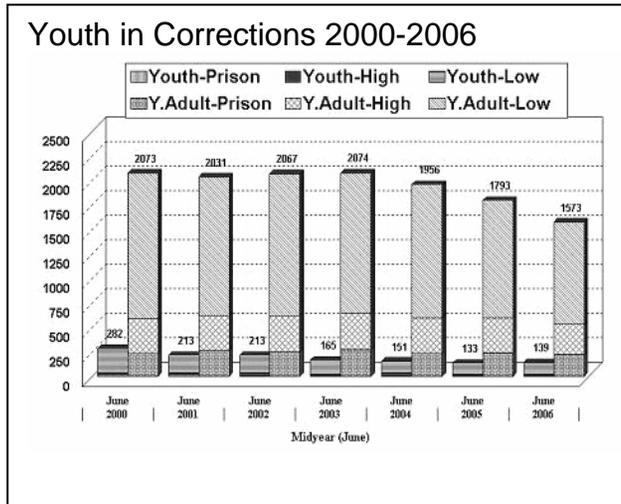
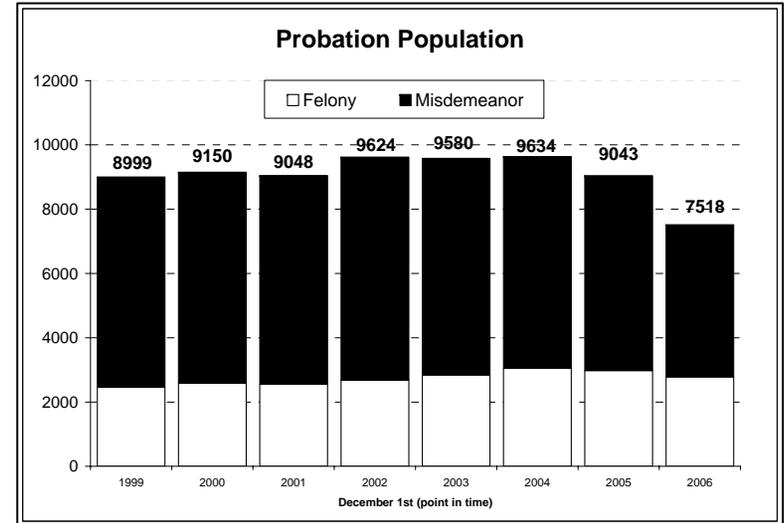
**Involvement.** Vermont citizens amazed the Department with their desire to become involved in the system. Nearly 1,500 Vermonters volunteer in some capacity in the corrections system. More than 400 Vermonters served on 72 reparative board last year. In 2006, some 1,375 cases were given Reparative Probation, 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.

**OPPORTUNITIES**

**Community Corrections Caseload Reductions:** Corrections' biggest cost center is prison inmates, but by far the largest share of the population in custody are under supervision in the community. The 2005-6 legislature recognized the dynamic of failure on probation leading to incarceration, and created two processes to help alleviate caseload: Act 63 of 2005 created term probation, allowing the court to specify a term of probation for misdemeanors instead of the traditional use of probation as an ongoing conditional suspension. Act 63 also required the department to review all misdemeanor cases older than 2 years and petition the court for discharge unless there were specific reasons to maintain supervision, such as restitution payment. Since the passage of these laws, the number of persons on probation for misdemeanors has fallen 28 percent. In 2006, the legislature extended term probation to sentencing non violent felons as well. The number of felons on probation has also decreased, by nine percent.



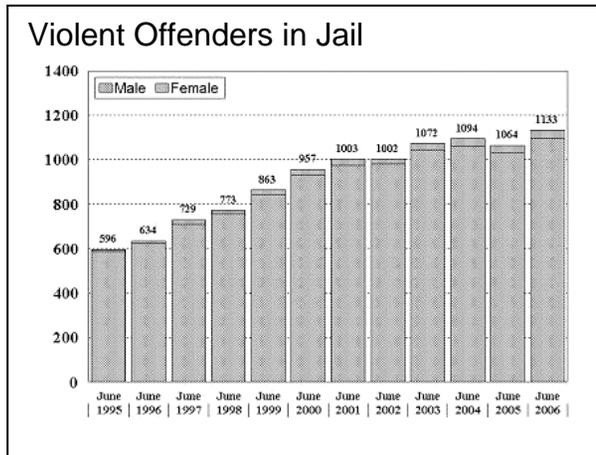
**Youth under supervision or custody of Corrections:** for many years, a primary concern

of many Vermonters has been the perception of a growing number and proportion of young men and women under corrections custody. In fact, the largest growth in DOC population has been among young adults 21-25, not younger offenders. The 16-17 year old population has actually decreased by more than half since 2000, and the population of 18-21 year olds has decreased by nearly a quarter in the same period. This population peaked in 2000-01 and the decline is attributed to several factors: first, the diversion of significant numbers of youth to community justice centers; second, the implementation of term probation; third, the implementation of misdemeanor case review; and finally, changes in criminal penalties for Possession of Malt Beverage by a Minor and Driving with License Suspended.

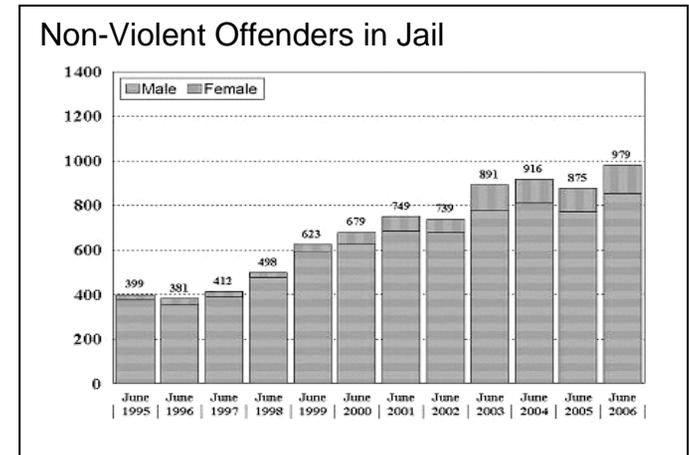
This diversion of young people from adult corrections and the reduction of caseload in the community and a decline in the numbers of very young (16/17) offenders housed in prison have been welcome. In addition, the numbers of older persons (22+) under supervision in the community have also declined, though not as dramatically (-1%) However, the population of older persons in prison has more than offset the decline in youth. The older population increased 29 percent in the same period.

The strategic opportunity results from the decrease in the numbers of young Vermonters who, rather than being under corrections supervision are under the informal social controls of their communities. The research (in Vermont and elsewhere) is clear – community and restorative justice interventions reduce recidivism. In a recent (October 2006) large study of Vermont's Reparative probation program, conducted under the auspices of a National Institute of Justice grant, offenders placed on reparative probation showed 23% lower recidivism than offenders given traditional probation, controlled for age, offense, gender and prior offenses.

# Department of Corrections



**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 held 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.

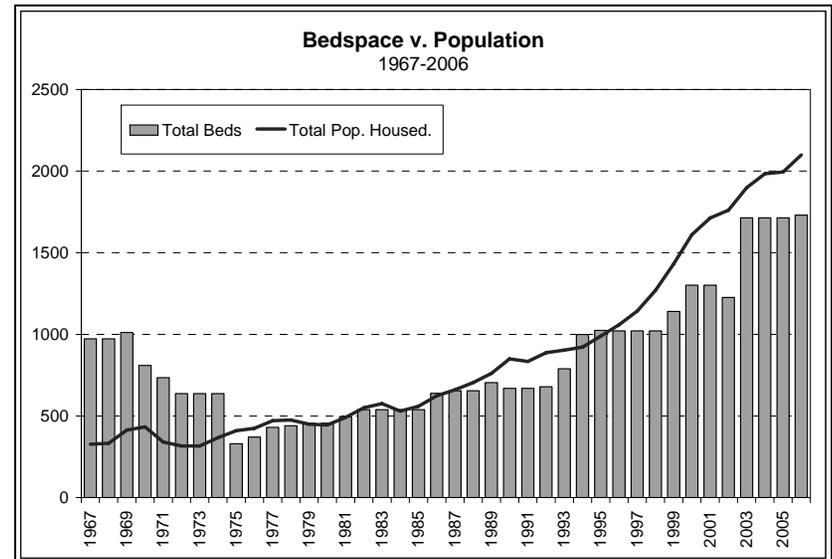
## PRESSURES

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

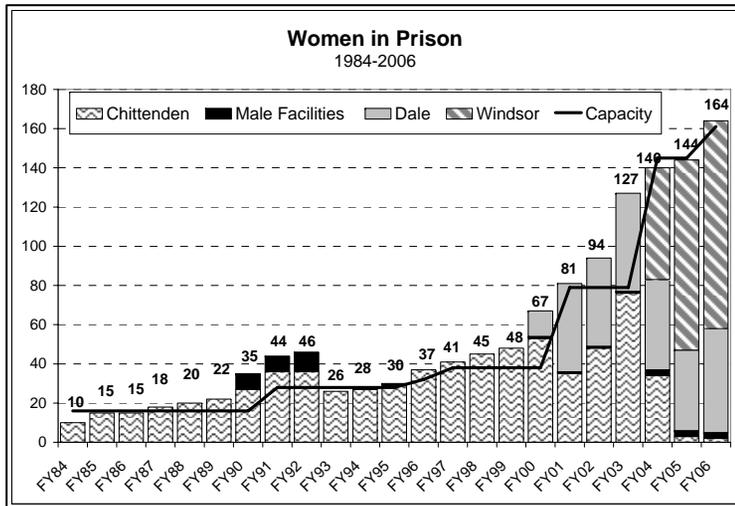
**“Corrections in Vermont is in serious, if not dire, circumstances. If the current growth of incarceration continues unabated, Vermont will need to build the equivalent of three more Springfield facilities within 6 years at a construction cost of about \$32 million per prison. This would require a total 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: Men:** The prison population has been growing at a rate of more than 100 beds per year for the past dozen years. During the period 2003-04 there was some leveling of growth, but in the past two years the numbers have returned to the trend. The result has been an increasing use of



## Department of Corrections

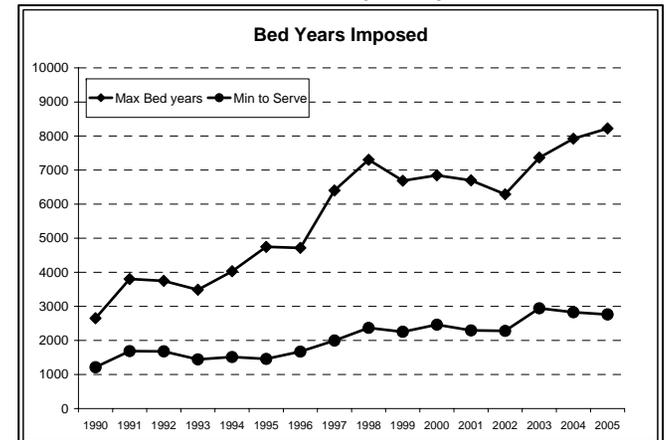


contracted bedspace out of state. In November, 2006, there was an average of 507 Vermont inmates housed out-of-state in private correctional facilities under the Corrections Corporation of America (CCA), up from 437 last year. The instate facilities are at capacity, at 1700 inmates.

**Women:** The criminal justice system responds to social issues as well as public safety. This is particularly true with women inmates, 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 and continues to grow at twice the rate of men. There were 172 women in prison in November, 2006, up from fewer than 50 in FY1999. 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 Agency of Human Services under Cindy LaWare has identified reduction of growth in women's incarceration as a major objective for the restructured Agency of Human Services. All AHS field sites are implementing comprehensive plans to build partnerships increasing availability of community-based interventions for women coming out of prison. Issues confronting women reentering the community include housing, employability, substance abuse treatment, and mental health services, and services which cross traditional department and agency lines.

**Prison Overcrowding: Sentencing** For the past fifteen years there has been an increasing demand for prison space. The core demand for space is more felons sentenced to prison. Violent crime in Vermont and felony sentence lengths have remained stable during the past decade; however, twice as many felons were sent to prison in 2005 as in 1990. The increase is in volume, not duration. With misdemeanors it is both volume and duration. In 2005 the average misdemeanor sentence is **five times** longer than in 1990. In addition, there were twice as many sentences imposed in the same period. The net effect is an increase in bed years "reserved" by the courts from 496 bed years to 5,304 bed years, more than a tenfold increase.

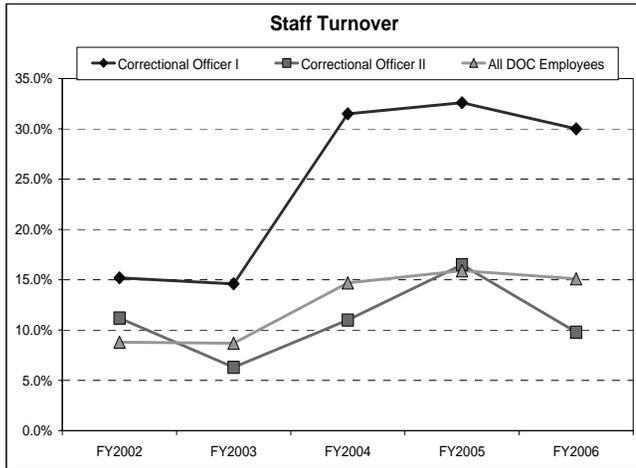


### Prison Overcrowding: Reentry & Parole

As significant a factor in crowding as admission is release. The difficulties faced by returning inmates in successfully reintegrating with the community are great. The stigma of being a returning inmate, coupled with significant policy barriers to employment and social supports, as well as the continuing deficits in basic skills and education (which impede return as much as they contributed to the original criminality), make it challenging to succeed, especially when attempting to repair the damages of addiction and abuse of substances. This is particularly true of women offenders. Nearly half of all admissions of women in the past three months were re-admissions, for violation of conditions of release in the community. Most of these were for sanctions for substance abuse violations. For men and women, a major obstacle to success is the lack of

# Department of Corrections

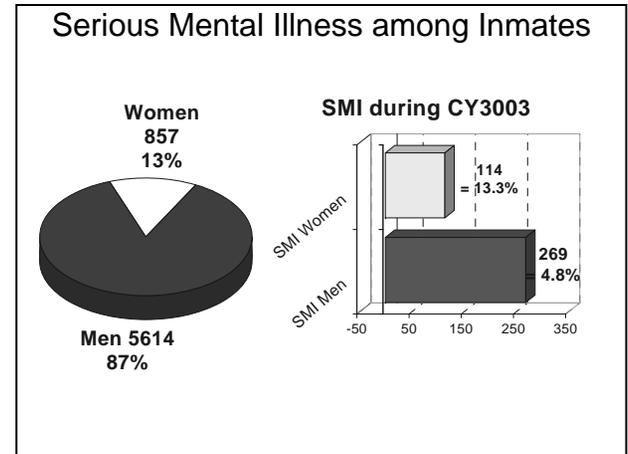
suitable housing. There are over 100 inmates held in prison past minimum release, primarily for lack of approved housing. Many inmates remain in the “revolving door” of violation and return. The Department received federal funding, to involve the community in reentry, but these funds are in jeopardy unless Congress passes the “2<sup>nd</sup> Chance Act”.



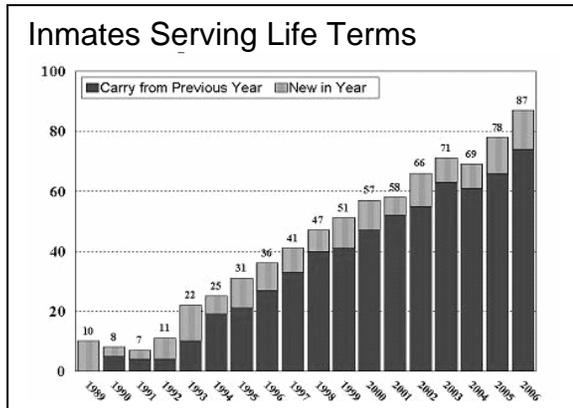
**Prison overcrowding: Staff turnover** In the past three years, staff turnover among line correctional officers has remained at over 30%, twice the rate of all DOC staff. In FY2007, the administration supported, and the legislature added, 15 new correctional officer positions, which has had a positive effect.

### Prison Overcrowding: Special Populations

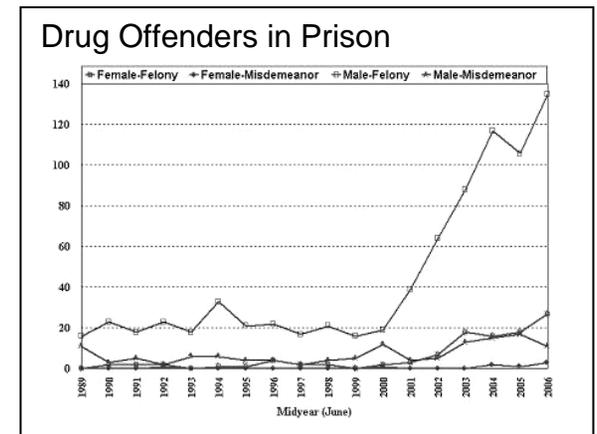
A small but significantly resource consuming part of the prison population are those inmates who have serious mental illness, and while not requiring acute care, nonetheless require intensive intervention



and special housing, both for treatment and to protect this vulnerable population. A study completed this year of the overlap in 2003 between mental illness and the incarcerated population revealed that 4.8% of the men and 13.3% of the women who spent time in prison had been in treatment for Serious Mental Illness in community or hospital setting. This proportion is lower than had been previously reported. Nonetheless, inmates with serious mental illness continue to pose extremely challenging management, security, and care issues for corrections.



**Safety:** Safety from violence is the fundamental expectation of the Vermont justice system. Prison space should, therefore, be reserved for violent and repeat offenders. Two significant pressures, one current and the other future, will increase demand for beds. The first is an increasing number of persons incarcerated for serious drug offenses. For the most part, these are drug dealers, among the males. For the women, however, these are mostly addicted persons.



A future demand for incarceration is just beginning to show in the numbers. The changes the legislature made to the sex offender statutes last year to increase minimum sentences for serious sex offenders will have a long-term effect on demand. With longer minimums, and with life maximum sentences, more offenders will remain at risk of incarceration longer.

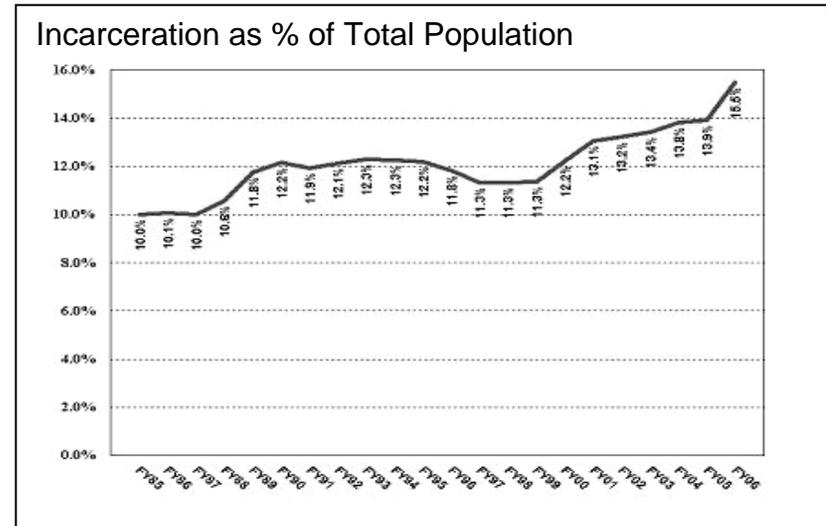
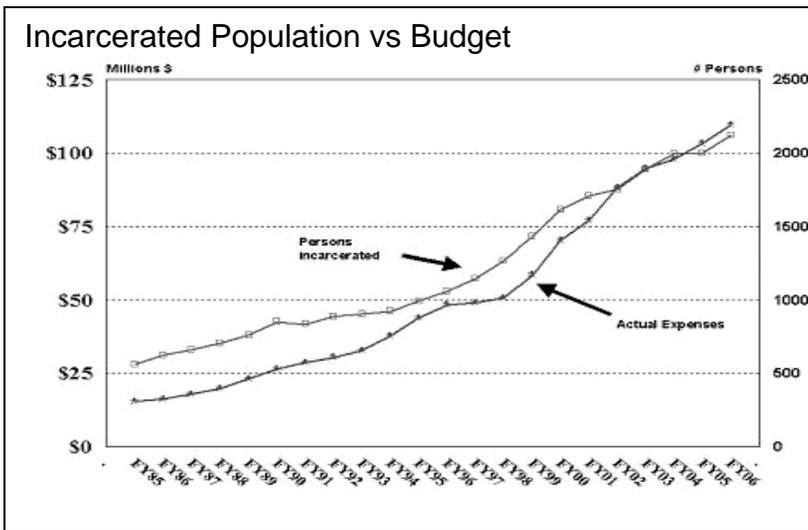
# Department of Corrections

## 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 FY1995 to \$119 million in FY2007.

### Total Caseload:

Since FY1995, the total number of individuals under the supervision of the Department of Corrections has increased steadily, rising 63%. Last year, however, the total decreased, to 13,720, down for the first time in 15 years. The decrease was in community supervision, however. The incarcerated population has more than doubled from 989 in 1995 to nearly 2,123 in 2006. The number of offenders on intermediate sanctions and furlough re-entry has increased five-fold, from 330 to 1,573. Nearly 44% of the sentenced population was **not** in prison.

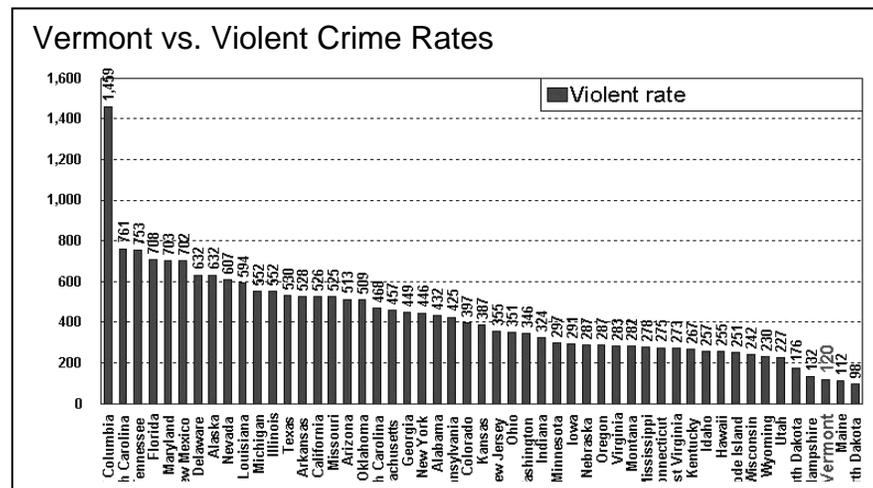
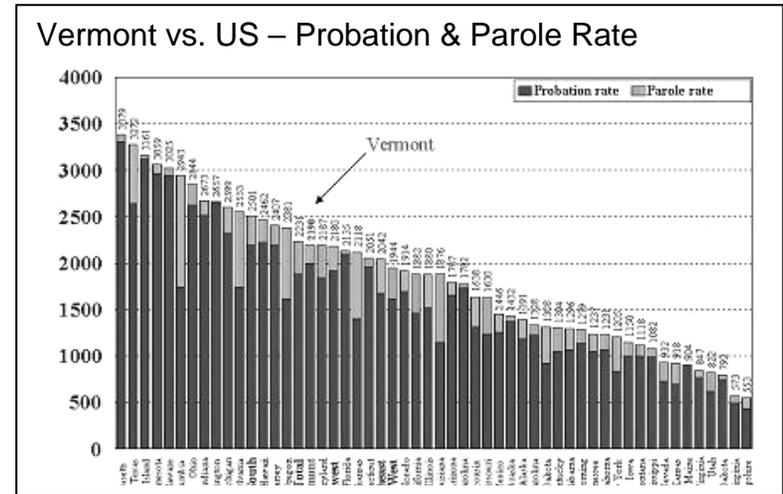
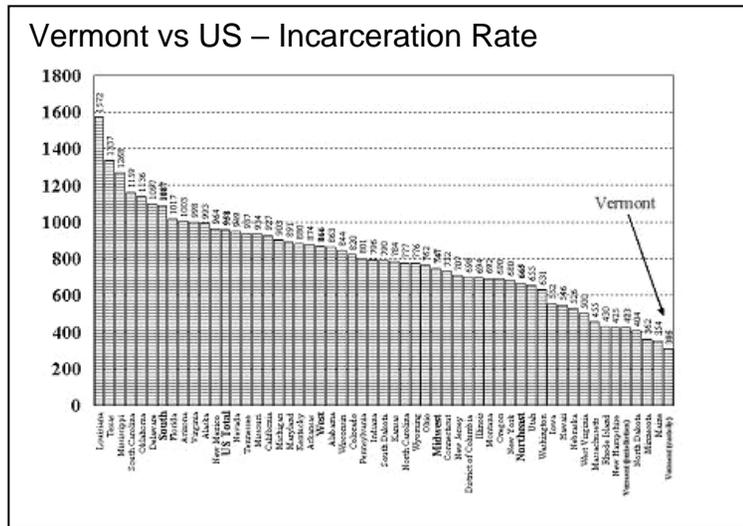


### Incarceration:

Incarceration increased by 6% in FY2006 over FY2005. 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 500 inmates in out-of-state beds, primarily in Kentucky under a contract with the Corrections Corporation of America. This has enabled the State 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 it currently faces.

# Department of Corrections

Vermont has one of the lowest crime rates in the nation, and the lowest incarceration rate. Vermont has had one of the higher rates of Probation & Parole. (this rate will decrease in next year's report). 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. 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.





# Department of Disabilities, Aging, and Independent Living

*“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*

Number of Positions 305	
<b>Funding:</b>	
General Fund	\$18,278,310
Global Commitment Fund	\$140,068,768
Federal/Other	\$28,510,852
<b>Total</b>	<b>\$186,658,230</b>

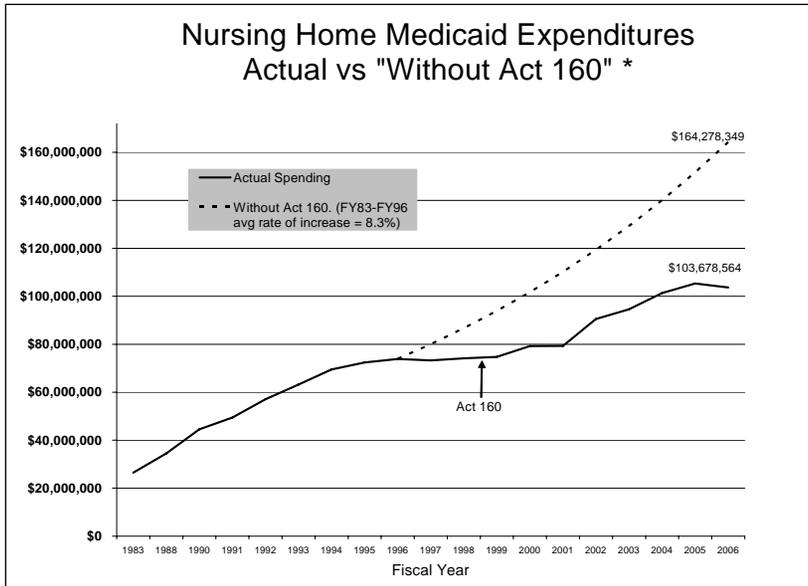
*The Department assists older Vermonters and people with disabilities to live as independently as possible. It provides support to families of children with disabilities to help maintain them in their home. It helps adults with disabilities find and maintain meaningful employment and it ensures quality 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 '06	FY '07 Est.	FY '08 Gov. Rec.
General Fund	\$27,384,391	\$18,494,612	\$18,278,310
Federal/Other	\$131,652,110	\$155,916,222	\$168,579,620
<b>Total</b>	<b>\$159,036,501</b>	<b>\$174,410,834</b>	<b>\$186,658,230</b>

# Department of Disabilities, Aging, and Independent Living

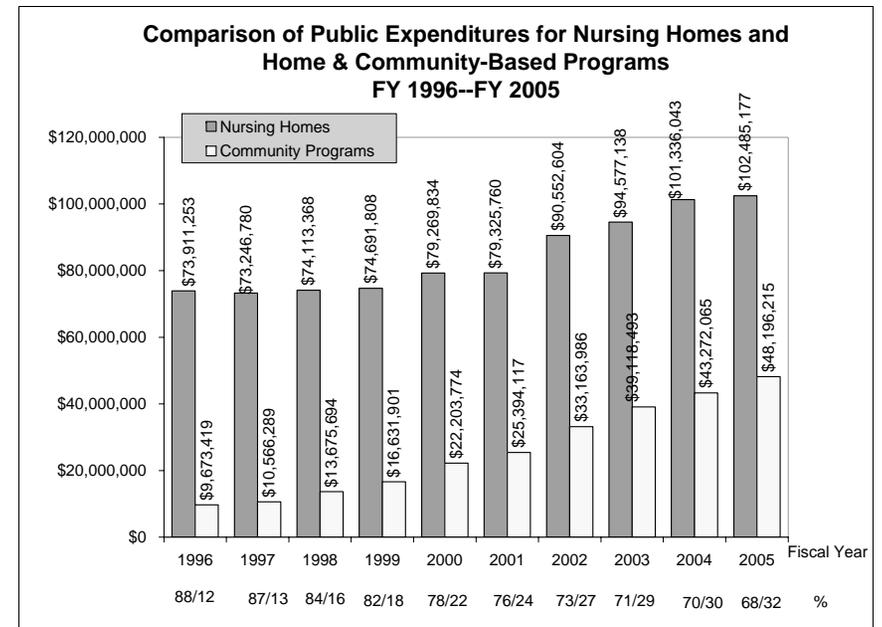
## ACCOMPLISHMENTS

Over the past decade, the number of people utilizing nursing homes has steadily declined in proportion to the number of people served by Medicaid Waivers. This trend continues due to the Department's 1115 Choices for Care Medicaid Waiver giving equal entitlement to either home based or nursing home care.



Over \$60 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. Until FY2006, nursing home expenditures have grown 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 33% in Fiscal Year 2006.



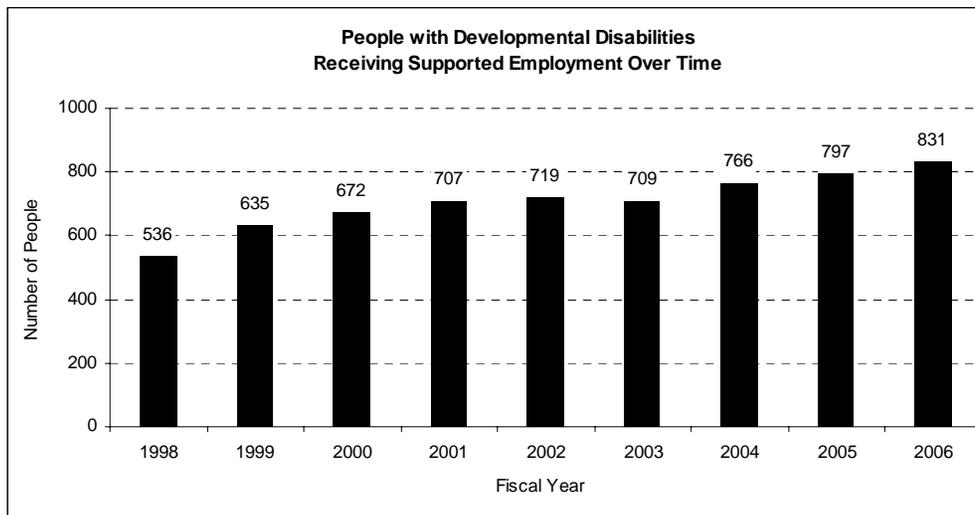
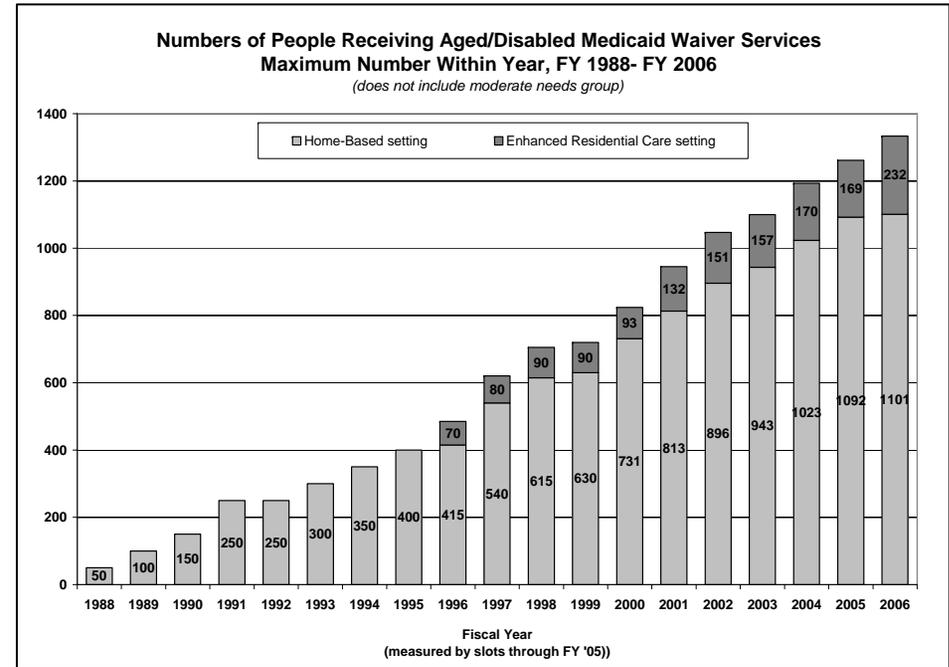
# Department of Disabilities, Aging, and Independent Living

## Choices for Care 1115 Demonstration Waiver

Vermont's innovative Choices for Care waiver for long term care has been in effect since October 2005 and recently received the Council on State Governments "Silver Society Award" for innovation in state government. At that time, individuals who were eligible for nursing home level of care and required services to be paid for by Medicaid were given the choice of receiving their care in a home setting or in a nursing facility. Previous to this waiver, individuals were only entitled to receive their care in a nursing facility. This new waiver opened up the entitlement services to include home based and residential care to all Medicaid Long Term Care eligible individuals as well as the traditional nursing facility services.

With the onset of Choices for Care, as expected, there has been an increase in the use of home based services along with a steady decline in the use of nursing facility services.

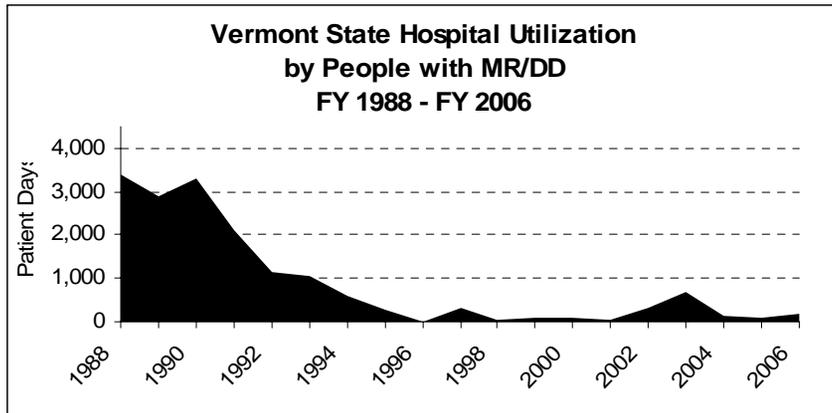
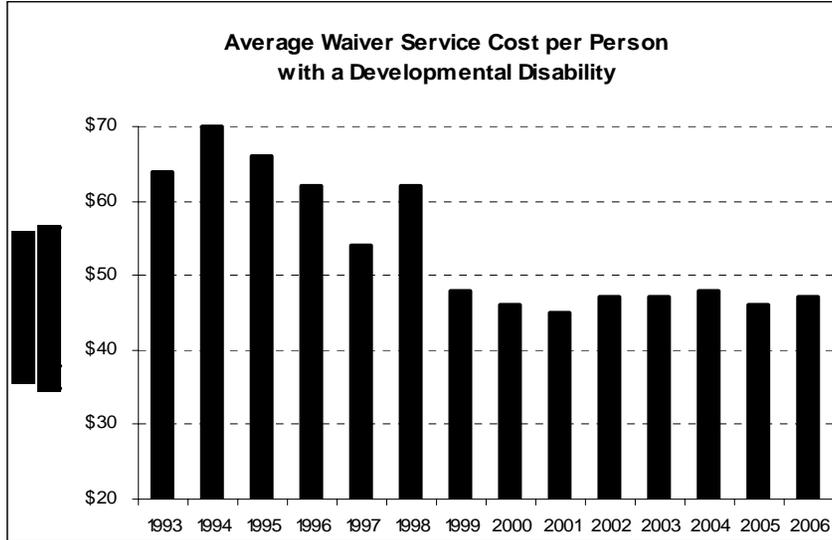
Vermonters have also been given additional options in the home based program. Individuals are still able to choose to receive their services from a certified home health agency or directly hire staff under the consumer/surrogate directed option. Choices for Care expanded those options to include the Flexible Choices option. Under this alternative, individuals who are consumer/surrogate directed "cash out" their service plan and are then able to select the kind and type of services and goods that will best meet their needs. This option continues to support the Departments' commitment to encouraging and supporting Vermonter's ability to take charge of their lives. Use of this option has grown since Choices for Care began.



## Supported Employment to Work

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

## Department of Disabilities, Aging, and Independent Living



### 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. The Network recently created a second statewide crisis bed along with increased regional clinical and crisis capacity.

### Federal Medicaid Waiver Service 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 seven years.

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 '05, it cost \$27,349 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.

COS	Description of Service		Actual	% Change	2007 est-2008 Approp % Change
29-00	Personal Care Services				
	SFY '99		2,159,543		
	SFY '00		3,635,964		
		1999-2000		68.4%	
	SFY '01		4,236,044		
		2000-2001		16.5%	
	SFY '02		5,715,027		
		2001-2002		34.9%	
	SFY '03		8,165,126		
		2002-2003		42.9%	
	SFY '04		10,615,921		
		2003-2004		30.0%	
	SFY '05		13,131,328		
		2004-2005		23.7%	
	SFY '06		16,411,319		
		2005-2006		25.0%	
	Go. Recommend SFY '07		19,866,073		
		2006-2007		21.1%	
	Est'd SFY '07		19,866,073		
		2006-2007		21.1%	
	Req'd SFY '08		24,226,034		21.9%

### Children's Personal Care Services Reach an All Time High

The number of people receiving Children's Personal Care Services increased by 23% in the past year.

A stakeholder group assisted in the development of new program guidelines and new assessment of need for Children's Personal Care Services.

## **Department of Disabilities, Aging, and Independent Living**

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### **OPPORTUNITIES**

The 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.
- 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 Department has continued to work towards improving the system of supports and services for older Vermonters and its citizens with disabilities. Work is planned or underway in a number of different areas, including:

- Viewing the needs of Vermonters across all disabilities and ages, rather than through the more narrow lens of specific programs.
- Transition planning, in concert with other AHS departments and the Department of Education, for youth with disabilities as they leave the school system and enter the worlds of work and higher education.
- Developing and launching an improved quality management system to assess and ensure the quality of home and community-based services across services systems serving older Vermonters, people with developmental disabilities, individuals with traumatic brain injury and people with physical disabilities.
- Continued planning to improve the transition of youth as they move from children's personal care to adult services, as needed and appropriate.
- Enhancing and expanding the accessible information for individuals through the use of Aging and Disability Resource Collaboratives across the state involving 211, the Area Agencies on Aging, the Developmental Services Providers, the Brain Injury Association of Vermont and the Vermont Center for Independent Living.
- Implementing the Governor's "Health Aging Initiative" including the development of a Center on Aging at the University of Vermont.
- Maintaining or improving the health of our community provider system by devising a mechanism to provide appropriate cost of living increases.
- In the face of budget pressures, maintaining a federal grant that provides long standing services related to assistive technology and technical assistance for people who need assistive devices due to disability.

## ***Department of Disabilities, Aging, and Independent Living***

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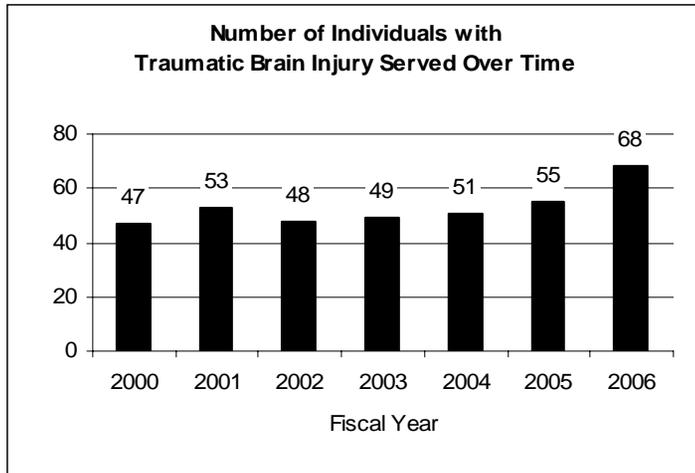
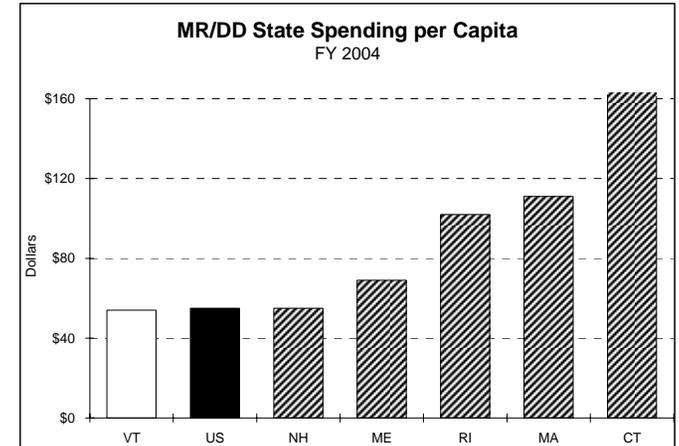
### **PRESSURES**

- The Department expects fewer nursing home beds will be needed in the future. Managing the demand as nursing homes downsize or close will be a continued challenge. At the same time, we may need to increase funding to some nursing homes to ensure an adequate level of high quality service is available in all regions of the state.
- Budgetary pressures have forced the department to limit services to children with disabilities, particularly developmental disabilities, to primarily the Children's Personal Care Program. Some children need more intensive services that could be provided via the Medicaid waiver; however, due to insufficient state funds, those services have been suspended since December 2001.
- Caseload demands for individuals with developmental disabilities continue at a significant rate. The Agency of Human Services is undertaking a sustainability study to address this issue.
- Vocational Rehabilitation caseloads have risen over 40% in the past years and the Department will be challenged to assist more people with disabilities to find work. Without additional capacity to serve this growth, consumers may be placed on waiting lists for the first time in the program's history.
- Adult Protective Services has experienced a continuing increase in the number of reports of abuse, neglect and exploitation of vulnerable adults.
- Flat or decreasing Federal funding for key programs like the Older American's Act and Survey and Certification create a major challenge for Vermont to meet increased demand.

**CASELOAD AND COST DATA**

**MR/DD State Spending per Capita Remains Low**

Vermont utilizes a higher 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.

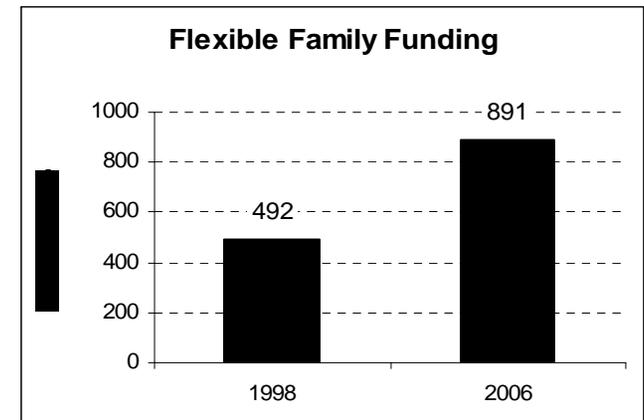


**Traumatic Brain Injury (TBI) Program**

The number of people with brain injuries served has continued to rise dramatically. The TBI program is collaborating with the Veteran's Administration and the Military Family and Community Network to proactively make services accessible to returning Veterans and their families, including applying for a grant to develop a Resource Facilitation service for returning Veterans with TBI.

**Respite/Flexible Family Funding**

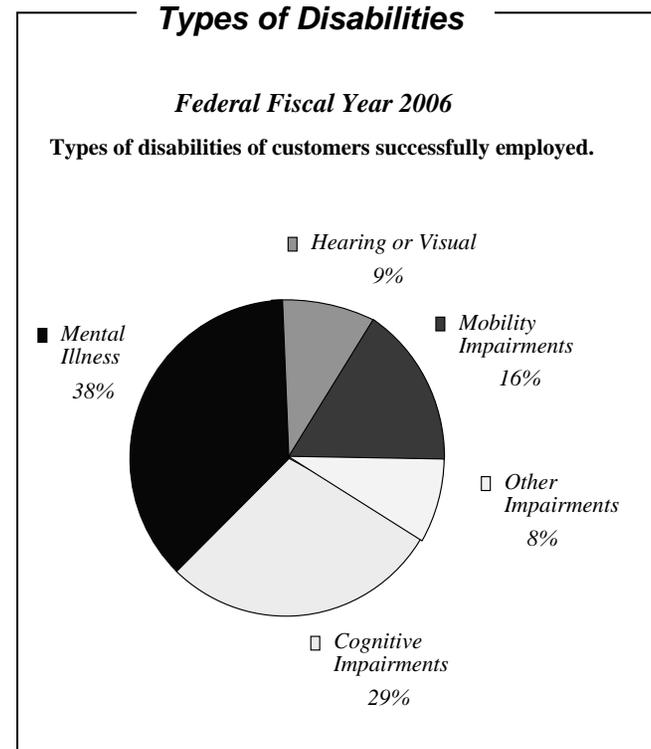
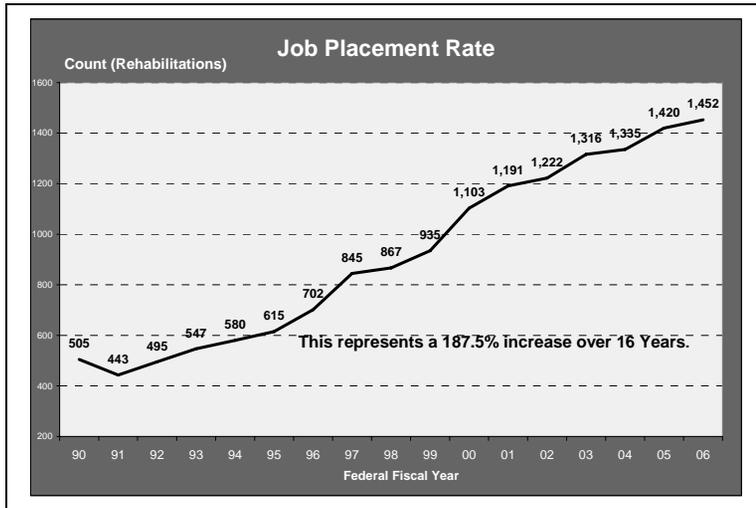
Flexible Family Funding, a unique family respite option, is a low cost program that offers a highly valued benefit to families of young and adult children. These funds, used at the discretion of the family, help provide care and support and avoid the need for more intensive and costly out-of-home services.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



## Department of Disabilities, Aging, and Independent Living

### More People Are Working

In FFY 2006, VocRehab Vermont counselors provided services for **8,557** Vermonters with disabilities, and assisted **1,452** people to become employed.



### Youth in Transition from School to Careers

*Vision: Vermont will be a State where youth with disabilities have the same educational and employment opportunities and outcomes as their non-disabled peers.*

Transitioning from high school to adulthood is something everyone goes through. For most, it is a time of making choices and decisions, excitement with possible frustration, some false starts, and some successes. For youth with serious disabilities of any kind (learning, emotional, or physical), the challenges that accompany transition can seem daunting. With a focus on early involvement, career preparation and work-based learning, opportunities for youth development and leadership, support for attending college, acquiring independent living skills including financial planning, transportation, and family involvement, youth with disabilities will succeed..

## ***Department of Disabilities, Aging, and Independent Living***

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### **VocRehab Vermont School Transition Program**

As of January, 2007, there are 15 VocRehab Vermont Transition Counselors, both full and part-time, based in all VocRehab Vermont districts and working directly with all Vermont high schools and a variety of technical centers, and alternative or independent schools. Since 1999, the number of transition-aged youth served by VocRehab Vermont has increased by almost 85%.

These Counselors have a dedicated caseload of transition-aged youth (between the ages of 14 and 23) and aim to improve employment and post secondary outcomes of these youth by meeting with students in their local high schools, sometimes as early as their freshman year, and focusing on both short and long term goals. They also assist schools with information and resources, collaborate with interagency partners, and work as catalysts for change to improve the transition process for youth.

### **Career Start Project**

The Career Start initiative began in October 2003 with funding from the federal U.S. Department of Labor's Office of Disability and Employment Policy for the purpose of improving transition outcomes for Vermont youth with disabilities moving from high school to adulthood. A Career Start Steering Committee representing diverse constituencies has produced a white paper entitled: *Successfully Transitioning Vermont's Youth with Disabilities*. This report articulates the nature and scope of the challenges facing Vermont youth with disabilities as they transition from high school to adulthood and suggests strategies that will address these challenges. As the grant funding ends in September, 2007, the Steering Committee will evolve into an Inter-Agency Transition Task Force for Youth with Disabilities and will continue to encourage implementation of the recommendations.

### **JOBS**

The Vermont JOBS program is spearheaded by VocRehab Vermont in partnership with the Department of Corrections, Department of Health/Division of Mental Health, and the Department for Children and Family Services to serve youth with serious emotional behavioral disabilities (EBD).

JOBS is an innovative supported employment and intensive case management service for youth with EBD that uses work as a means to reach this challenging population. As a result of this partnership, the JOBS Program is operational in 11 AHS districts with 337 youth participating in FY 2006. Of those without a GED or High School Diploma at intake, 35% were assisted in reaching one of these educational goals. Of those listed as homeless at intake, 58% were assisted in obtaining stable housing and of those not working at intake 67% were employed. The support provided to assist youth in obtaining stable housing, reaching educational goals and finding employment also reduces involvement with corrections and supports youth to become productive members of their communities.

### **Youth Demonstration Project to Serve Youth Receiving SSI Benefits**

The Vermont Division of Vocational Rehabilitation has been chosen to be a pilot site for the Youth Transition Demonstration (YTD) study funded by the Social Security Administration (SSA). The study is developing and testing interventions to help youth with disabilities maximize their economic self-sufficiency as they move from school to work. Key elements of the initiative include waiving of certain rules by SSA to provide incentives for youth with disabilities to initiate work or increase their work activity, and providing services to help youth obtain jobs and remain employed. Vermont's plan includes imbedding the YTD into the existing statewide service system for youth in transition. Specifically, the team of VR Transition Counselors will work closely with the team of Benefits Counselors and the newly created Youth Employment Specialist positions.

## ***Department of Disabilities, Aging, and Independent Living***

### **Youth Benefits Counseling**

Approximately 2,000 youth with disabilities in Vermont receive Social Security Administration disability benefits (SSI and SSDI). Many choose not to work or are underemployed because they or their families are afraid of what will happen to their benefits. As a result they often spend a lifetime in poverty.

Benefits counselors help young people and their families plan for something other than poverty, for example:

- Youth who receive SSI are almost always financially better off if they go to work. A young person in Vermont can earn over \$29,000 per year and retain their eligibility for SSI.
- Work incentives such as the PASS or Student Earned Income Exclusion can be used to help a young person pay for college or post secondary education.
- Other work incentives, such as Impairment Related Work Expenses, help youth retain more of their earnings to pay for costs associated with work.

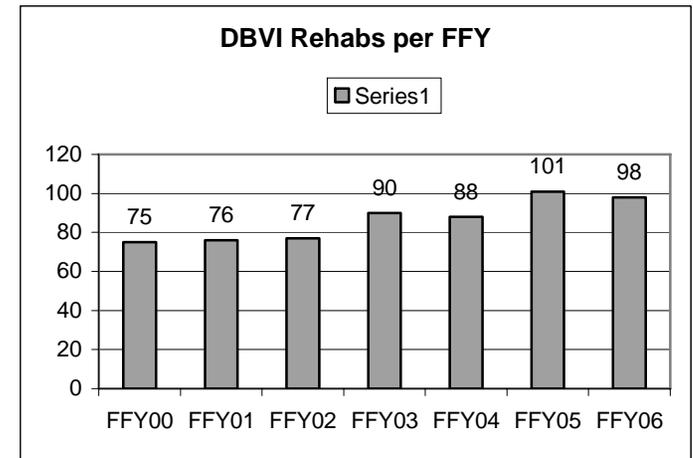
The benefits counselors have provided services to **over 700** youth in transition and their families since 2002. By providing accurate information counselors are assisting these young people plan for college and careers rather than a government check.

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### **Division of the Blind and Visually Impaired**

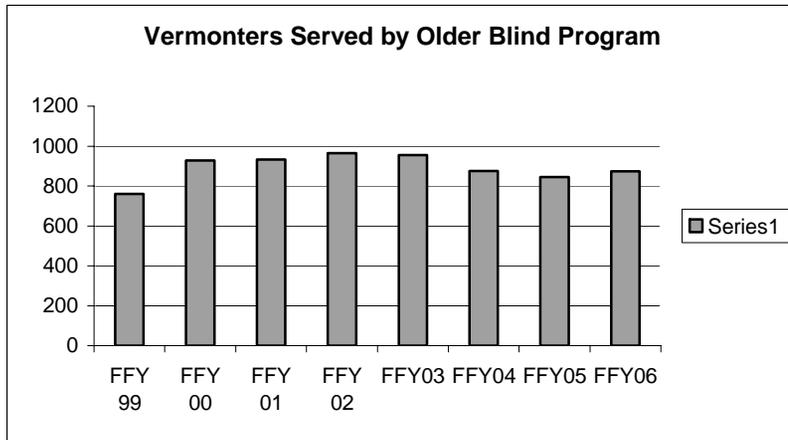
In FFY 2006 the Vermont Division for the Blind and Visually Impaired (DBVI) continued to provide significant service to Vermonters with vision impairments. In the area of vocational rehabilitation the number of successful closures was 98, down 2 from FFY05, but the level remains well above the level for FFY04 (88) and the preceding years. (see chart below) DBVI also served 395 individuals last year, down slightly from FFY05 (412), but again above levels from the years previous (380 and lower). DBVI achieving outcomes and doing so in a high quality manner. From the Rehabilitation Services Administration's most recent Report Card DBVI is #1 among all Blind Agencies in the country in the number of employment outcomes per \$1 million dollars spent and #1 in serving eligible cases per \$1 million dollars spent.

DBVI also continues to provide services to consumers needing Independent Living services. In an effort to increase the scope of services to Vermonters who are visually impaired DBVI has sought out areas of need that may not be covered by vocational rehabilitation services. One area of note was pre-transition services to youth under the age of sixteen. It has become obvious that youth who are visually impaired were often lacking independent living skills, skills that would allow them to live and participate fully in the community, whether going on to post-secondary education or to seek work after high school. It is often very late to address these gaps once a student turned sixteen and was eligible for transition services. DBVI has started a pilot program, in conjunction with the Vermont Association for the Blind and Visually Impaired, which provides weekend apartment sessions for youth. These sessions are designed to assess and train youth in areas of independent living such as finance, cooking, transportation and housekeeping.



## ***Department of Disabilities, Aging, and Independent Living***

The Vermont Association for the Blind and Visually Impaired (VABVI) continues to receive both federal and state allocations via DBVI and DAIL to provide services to adults with impaired vision who are over the age of 55. These high quality services provided in the home, community and at central sites include travel skills, low vision rehabilitation and a whole range of independent living skills. As the chart below indicates the numbers are down slightly since 2003. This can be attributed to the difficulty of finding qualified teachers, a national issue. Now that staffing is full it is expected that VABVI can again serve close 1,000 older Vermonters a year, individually or through groups, but will find it difficult to go much above this mark with resources remaining as they are.



Work is progressing on a very promising alliance with a national software company that would allow Vermont to be a pilot state for the hiring of individuals who are visually impaired into high paying jobs that can be done from home. This is a tremendous opportunity for Vermont as transportation is often the major obstacle for blind and visually impaired consumers looking for quality employment.

In the area of Transition DBVI is moving forward in its attempts to increase opportunities for youth seeking rewarding careers. As stated above DBVI is piloting a program to train pre-transition students in the important independent living skills. DBVI, in collaboration with VABVI continues to provide a week long "camp" for youth with vision impairments that combines vocational exploration, social interaction and independent living training. One of the parents wrote, "Our son came home with increased confidence in himself and a willingness to try new things. He was proud of himself for successfully living away from home - a large accomplishment for a young adult with visual, hearing and motor impairments. I will end this with a BIG thank you that Vermont has organizations like DBVI and VABVI who help students and parents prepare themselves and society for a world where all are included."



The most exciting initiative this year is the teaming with the Vermont Youth Conservation Corps, ReCycle North, Linking Learning to Life, VABVI, and the Gibney Family Foundation to create a summer youth employment program in Burlington. It will combine a residential component with work, independent living and community service.

As always DBVI believes the best way to represent its work is through the stories of some of its consumers. This shows how, with creativity and determination on the part of DBVI, the consumer and other community partners, that even seemingly difficult situations can end with wonderful results.

## **Department of Disabilities, Aging, and Independent Living**

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*Joe - Joe had an interest in working with young children in childcare/recreation. During his senior year in high school he was able to work at the local elementary school in Bradford through the Workforce Investment program of the Department of Labor. He organized recreational activities for kindergarten and first and second graders. Joe also worked in the daycare at his high school through the Human Services program at the Technical Center. After graduation the Workforce Investment program was able to set up a work experience for Joe at a daycare in White River Jct. He has taken the bus from Fairlee on a daily basis. Joe needed support with issues associated with living away from home for the first time and developing consistently appropriate work behaviors. DBVI has provided vocational guidance and counseling, job development services, transportation assistance and adaptive aids. Joe started this work experience in late August and he was hired into a full time position in early November. This represents a significant amount of growth for Joe over a short period of time. He is working in his career of choice less than 6 months from his high school graduation. Joe does a great job interacting with the children and as a male in a predominantly female environment; his positive presence is greatly valued by his employer.*

### **Division of Licensing and Protection (DLP)**

The Division of Licensing and Protection provides regulatory oversight of health care facilities and agencies under state and federal regulations. Periodic and routine regulatory oversight is the best method of ensuring quality of care and services. DLP accomplishes this by conducting unannounced onsite visits both routinely and as a result of complaints received. Providers receiving regulatory oversight and/or periodic review include: Nursing Facilities, Residential Care Homes, Therapeutic Care Residences, Assisted Living Residences, Home Health Agencies, Hospice Programs, Renal Dialysis Units, Rural Health Clinics, Acute Care Hospitals, Critical Access Hospitals, Portable X-ray Units, Clinical Laboratories, and Rehabilitation or Psychiatric Units.

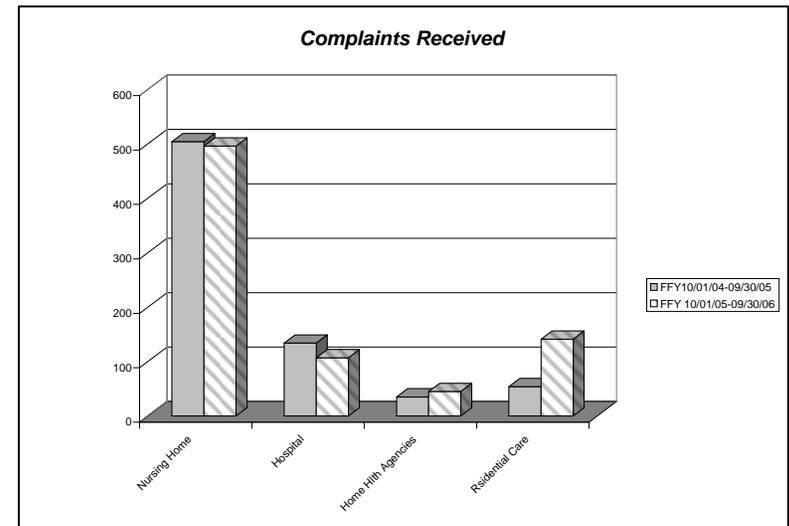
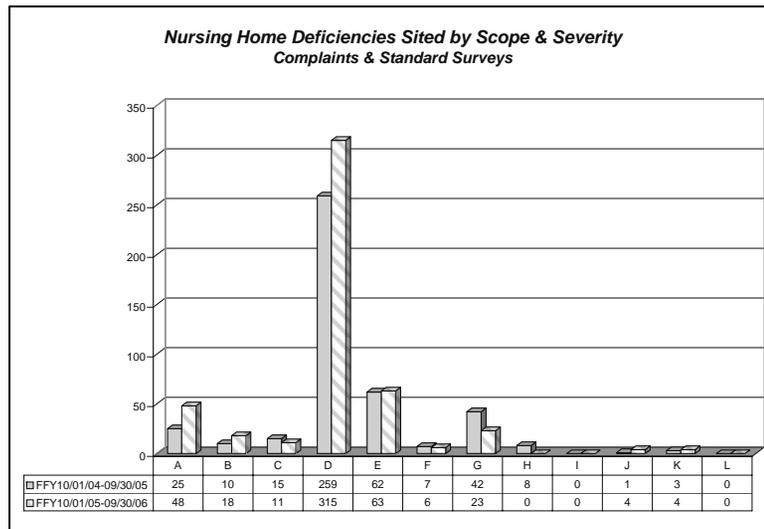
The purpose of onsite surveys is to evaluate provider performance and to determine whether consumers are satisfied with the care and services. Surveys consist of on-site reviews of care and services, including resident and staff interviews, record reviews and observations. Most health and residential facilities are surveyed on at least an annual basis. Onsite visits, whether for a full review of the range and scope of services or for a complaint investigation, are unannounced and are conducted by registered nurses who have had extensive training in how to conduct broad-based or focused reviews. In the case of nursing facilities, the nurses are required to have successfully passed a test conducted by the Center's for Medicare and Medicaid Services prior to surveying independently. Onsite visits range in scope from a one-day focused review conducted by one staff person, to a five-day comprehensive review conducted by a team of registered nurses. All onsite visits are followed by a written report to the facility. Reports that result from routine reviews and substantiated complaint investigations are public information and can be obtained by calling 802-241-2345 or consulting the Department web page, [www.dail.state.vt.us](http://www.dail.state.vt.us).

Vermont facilities have generally relatively few regulatory deficiencies when compared to the rest of the country. In addition, indicators of nursing home care collected by the federal government show that Vermont homes frequently do better than the national averages.

## ***Department of Disabilities, Aging, and Independent Living***

Nonetheless, the health care system is stressed. In 2006, DLP received an increase in the number of reports expressing concern about the quality of care and services in certified and licensed facilities. Qualified and competent caregivers are increasingly hard to find and retain. In addition to staffing issues, nursing facilities in general have experienced decreased occupancy. Residential Care Homes (RCH) have had a similar decline. Vermont currently has 3,425 licensed nursing home beds with a statewide occupancy rate of 91-92%. Ten years ago there were 3,738 beds with an occupancy rate of 97%. Currently there are 111 RCHs with 2302 beds. Ten years ago there were 162 homes with 2,442 beds. As home and community-based services continue to expand, we anticipate additional right-sizing of nursing facilities as the long-term care system strives to reach a balance point over the next few years.

*Note: The deficiency letters refer to the CMS scope and severity grid. Deficiencies at level A-C indicate no Actual harm with potential for minimal harm. Deficiencies at level D-F indicate no actual harm with potential for more than minimal harm that is not immediate jeopardy. Deficiencies at level G-I indicate actual harm that is not immediate jeopardy. Deficiencies at level J-L indicate immediate*



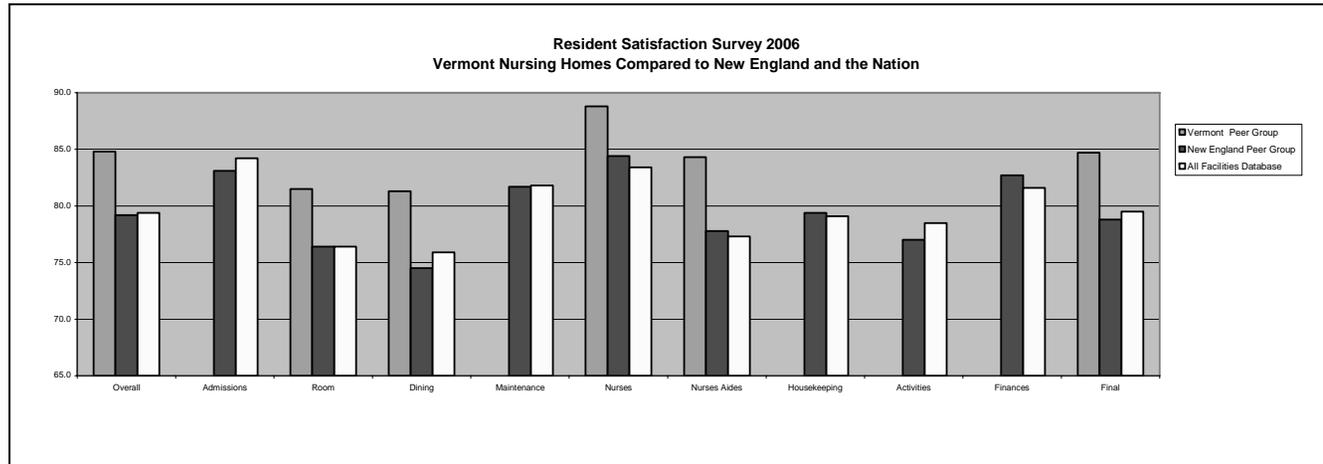
The Division of Licensing and Protection continues to work with health care providers to improve quality of care. A number of significant initiatives continue on an on-going basis. Some of them are:

- The Gold Star Employer Improvement Program
- The Resident Satisfaction Surveys Program
- The Home Health and Nursing Home Quality Improvement Initiatives
- Nursing Home Quality Awards

The Gold Star initiative is designed to improve working conditions and practices in long-term care, to improve job satisfaction and reduce employee turnover rates. Particular emphasis is on retention efforts. Improved staffing will have a positive impact on quality of care and services for elders and persons with disabilities.

## ***Department of Disabilities, Aging, and Independent Living***

Vermont was the first in the nation to establish a standardized statewide resident satisfaction survey in nursing facilities who volunteer to participate in the program. An independent survey company conducts the satisfaction surveys in collaboration with the Vermont Health Care Association and the nursing facilities. The results of the surveys are posted on the DAIL web page. Results of the surveys are a valuable resource to the public and to the facilities, where they can be used in continuous quality improvement efforts.



DLP continues to work collaboratively with the Northeast Quality Foundation, the quality improvement organization for Northern New England States, and with representatives from nursing facilities and home health agencies to identify and implement standards of practice known to improve quality. This is an expanding initiative. Areas targeted thus far are restraint reduction, pain reduction, reduction of pressure sores and improvement in a resident's ability to perform activities of daily living.

Establishing a person-centered culture in nursing homes has been added as a new scope of work. As a result of collaborative efforts over the past year, Vermont nursing homes have made significant improvement in management of resident's pain. At this point in time the area receiving the greatest focus is the reduction of pressure sores. Division staff have presented information regarding the regulatory requirements surrounding the topic of pressure sore prevention and treatment at different venues throughout the past year. This area of concern will remain both a Federal and Vermont specific focus throughout 2007. Quality measures for nursing facilities and home health agencies are public information and can be found on the Centers for Medicare and Medicaid Services website (<http://cms.hhs.gov>).

### **Quality of Life Awards**

In FY 2006, five nursing facilities that met high standards of resident care were presented with Quality of Care awards. The nursing facilities selected had to meet specific criteria: excellent survey results; efficient operation; better than average resident satisfaction, and no substantiated resident complaints. The five recipients of the awards in 2006 were: Bel-Aire Center in Newport, Centers for Living and Rehabilitation in Bennington, Gifford Extended Care Menig Unit in Randolph, Mayo HealthCare in Northfield, and Woodridge Nursing Home in Barre.

### **Adult Protective Services**

Adult Protective Services (APS) is a public safety program within the Division of Licensing and Protection (DLP) charged with investigating allegations of abuse, neglect and exploitation of vulnerable adults in Vermont. APS also coordinates protective services for victims of abuse and conducts community education around the state to improve reporting and the effectiveness of timely interventions that reduce or prevent abuse. APS is committed to proactively addressing the safety concerns of vulnerable adults through preventative, cooperative and solution based interventions.

## ***Department of Disabilities, Aging, and Independent Living***

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### **A Profile of the Problem:**

Reports: In FY 2006, APS received 1,485 reports of suspected abuse, neglect or exploitation of vulnerable adults.

Types of abuse: Physical and emotional abuse make up approximately 46% (630 out of 1376) of the total number of APS investigations and financial exploitation approximately 28% (384 out of 1376). The percentages of sexual abuse and self-neglect cases have remained fairly constant.

Alleged Victims: In FY 2006, 52% (510 of 984 victims) of investigations involved alleged abuse of vulnerable adults over the age of 60. In 34% (336 of 984 victims) of investigations, the vulnerable adult had a significant physical disability and in 40% (395 of 984 victims) of cases, a mental health or developmental disability was present.

Alleged Perpetrators: Family and friends continue as the people most often reported for possible abuse of a vulnerable adult. Investigations of family and friends comprised 65% (685 of 1049) of our work. Other investigations include individuals that are agency or facility staff, private caregivers, landlords, businesses, guardians etc.

Protective Services and Prevention Efforts: Ongoing community education efforts by APS and collaborative efforts with other concerned groups and organizations have enhanced the public awareness of abuse issues, preventative actions and reporting responsibilities throughout the state. Continuing education, timely reporting, APS consultations and proactive interventions are critical activities to address the abuse issues of our vulnerable adult population. APS made protective service referrals to other community service providers, such as Area Agency on Aging, home health, Medicaid Fraud Unit, Vermont Center for Independent Living, to ensure that vulnerable adults received necessary care and 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.”*  
~ Sharon Moffatt, Acting Commissioner

<b>Number of Positions: 876</b>	
<b>Funding:</b>	
General Fund	\$29,229,846
Global Commitment Fund	\$174,183,604
Federal/Other	\$74,161,977
<b>Total</b>	<b>\$277,575,427</b>

*We will have the nation’s premier system of public health, enabling Vermonters to lead healthy 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.*

<b>Year</b>	<b>FY '05</b>	<b>FY '06 Est.</b>	<b>FY '07 Gov Rec.</b>
General Fund	\$63,520,011	\$31,015,980	\$29,229,846
Federal/Other	\$157,220,298	\$230,067,062	\$248,345,581
<b>Total</b>	<b>\$220,740,309</b>	<b>\$261,083,042</b>	<b>\$277,575,427</b>

### **ACCOMPLISHMENTS**

**Vermont was ranked the second healthiest state** in the nation according to the United Health Foundation, together with the American Public Health Association (APHA) and Partnership for Prevention, 2006 America's Health Rankings: A Call to Action for People & Their Communities™. Vermont also ranked second in 2005, both years finishing behind Minnesota.

Of all the states, Vermont had the lowest number of motor vehicle deaths per 100 million miles driven, and the lowest percentage of children living in poverty. Vermont was also highly rated for ready access to adequate prenatal care (2nd best in nation), a low violent crime rate (3rd in nation) and a low premature death rate (3rd in nation).

**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** - In 2006, as the result of a competitive bid process, four additional hospital service areas were funded as part of the Vermont Blueprint for Health to comprehensively address chronic disease in their communities. Mt. Ascutney Hospital, Springfield Hospital, Central Vermont Hospital in Berlin and Fletcher Allen Health Care in Burlington joined Northeastern Regional Medical Center in St. Johnsbury and Southwestern Medical Center in Bennington both of which began as pilot programs in 2005. All of these funded communities have regional coordinators who oversee implementation including provider recruitment, education and payment of provider stipends for participation and outcomes, and coordinate with community physical activity and patient self-management programs. Last year, over 300 individuals completed the "Healthier Living Workshop" an evidence based program developed by Stanford University and adopted by the Blueprint in 2004. This course teaches successful self-management of chronic conditions through a variety of skill building techniques.

**Vermont Blueprint for Health Information Systems Development** - The Blueprint has worked closely and effectively in partnership with Vermont Information Technology Leaders (VITL) during 2006 and the recently executed contract between the Department of Health and VITL is testimony to the success of the complex bid selection process and resulting contract negotiations. Based on this work, GE Health Care and Orion Systems are partnering with the Blueprint IT team and provider stakeholders to develop the standards and requirements necessary to implement the Blueprint Chronic Care Information System (CCIS). The CCIS will support development of an integrated health data system for proactive patient care and give providers more complete information during each visit. Treatment guidelines will be imbedded into the system for decision support and laboratory results will be downloaded into the CCIS, providing consolidated clinical information required for effective medical decision making. Mt Ascutney Hospital will be the first installation in 2007.

**Quit@Work** – The Vermont Department of Health is also making a new quit smoking toolkit available for employers in 2007. This includes information and resources about why employers should care, how to set a workplace smoking policy, how to go 100% smoke-free, how to promote quit smoking in the workplace and how to support employees who are quitting.

## ***Department of Health***

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**Pandemic Flu Preparedness Summits** - On January 12, 2006, Governor Jim Douglas and U.S. Health and Human Services Secretary Mike Leavitt addressed more than 300 public health officials, business and community leaders about pandemic flu preparedness as the nation prepares for the possibility of an influenza pandemic. Vermont was the third state to host a summit, and the first to sign a federal/state Memorandum of Understanding. The Vermont Department of Health, in cooperation with Vermont Emergency Management and Vermont Homeland Security, sponsored local emergency planning committees (LEPCs) to host regional summits on pandemic influenza planning for community leaders and first responders around the state. These took place during March – June 2006 and reached about 900 people. At the regional summits, state health, emergency management and homeland security officials presented information on emergency management coordination, public health response, emergency risk communication and the National Incident Management System (NIMS). Community planning for continuity of operations for critical functions in case of a widespread emergency is now underway, with funding from the Health Department's pandemic influenza grant.

**“Operation Pandemic Flu” Preparedness Exercise** - The State of Vermont's plan to respond to avian influenza in birds, as well as to an influenza pandemic, was tested during a full-scale, two-week exercise conducted July 17 to 28. The emergency scenario involved the discovery of avian influenza (“bird flu”) on a poultry farm in southern Vermont, and quarantine of students at two Vermont colleges. At the outset, details of “Operation Pandemic Flu” were known only to the few state employees and hospital personnel who had been involved in planning the exercise. All other responders to the mock emergency operated as if the situation were unfolding as a real event. Exercises of this type are essential if we are to be fully prepared for a widespread disease outbreak or other public health emergency. Should avian influenza or pandemic influenza strike, we must be ready and able to carry out a rapid and well-coordinated response among many response agencies and officials. During the exercise, epidemiologists, infection control practitioners, Vermont state veterinarians and animal health specialists, hospital staff, government officials, communication professionals and emergency responders carried out their roles in the emergency posed by the simulated event.

An estimated 700 people (more than 300 of them evaluated participants) at multiple sites, including the Health Department Operations Center, the State Emergency Operations Center, a poultry farm, the University of Vermont, Southern Vermont College and local emergency operations centers were involved in this Homeland Security Exercise and Evaluation Program (HSEEP) event. An After Action Report will detail improvements to be made in the coming year based on performance during the exercise.

**Collaborative Cancer Plan** – An average of 3,064 new cases of cancer are diagnosed and 1,236 people die from cancer each year in Vermont. 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.

**Expanding Pharmacological Opioid Treatment Options:** Vermont continues to make headway in reducing the treatment gap for Vermonters suffering from opioid addiction. Today, over 150 Vermonters are able to receive methadone medication treatment at the Chittenden Center in Burlington through a combination of on-site, supervised dispensation and prescription take-home medication. A mobile methadone treatment van now serves the Northeast Kingdom with approximately 150 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.

**Newest Tobacco Countermarketing Campaign Encourages Young Women to be Smoke-Free** - A new series of TV ads targeting young women age 18 to 28 in lower income groups highlight real Vermont women sharing their experiences with tobacco and kicking the habit. In addition, the Health Department's network of statewide partners – such as community coalitions and hospital-based Ready, Set...STOP programs – will be distributing Women's Health headwear, fact sheets and postcards that feature tips and resources to help women quit smoking. As always, the Vermont Quit Line 1-877-YES-QUIT is featured.

## ***Department of Health***

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**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:** Placing mental health staff in pediatric offices is emerging as an effective way to meet all the health needs of Vermont's children. This collaborative model links the community mental health agency with physician practices and uses a team approach to assist primary care providers integrate new processes for mental health services into their practices; gives them the tools needed for screening, diagnosis, treatment and on-going management; and provides psychiatric consultation services to the physician. It assures that children needing services of a licensed mental health therapist receive individual therapy, case management and connection to other resources on site or through the community mental health agency. Medicaid reimbursement for services covers the costs of these interventions. The collaborative approach to services has been well received by primary and behavioral health providers and is greatly appreciated by families. It has increased the number of children receiving services overall and reduced the waiting time for child psychiatry services by several months. Five different pediatric practices in Vermont now have a mental health staff person in their offices in addition to two hours a week of psychiatric consultation.

**Further Expansion of Recovery Centers** - DETER funding has increased Vermont's network of recovery centers. Nine Recovery Centers are currently being funded. They are located in Brattleboro, Bennington, Barre, St. Johnsbury, Middlebury, Burlington, White River, Rutland and Springfield. These centers provide a wide variety of peer support services in safe, drug and alcohol free environments, and help people reach and maintain recovery.

### **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, meaning systems that remind providers and patients of needed tests, follow up care and appointments. This involves enhanced patient information systems, office practice redesign strategies, and access to referral opportunities in the community, as well as 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 helps people make a lifelong commitment to participating in their own care, dealing with symptoms, taking medications, and changing behaviors. The Blueprint is working with communities, both geographic and social, to look at ways to better raise awareness and support providers and patients in maintain healthy lifestyles. 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. For providers, we are working toward one consistent approach with regard to contracting, fiscal oversight, monitoring, quality

## ***Department of Health***

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improvement, credentialing, paperwork and training, and a closer connection with primary care. A new Co-occurring State Incentive grant (COSIG) 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.

**Integration of Physical Health and Behavioral Health** - Integration of programs and services is an essential policy response to the integration of body, mind and behavior that characterizes every human being. Every life stage, “disorder” and encounter with a provider is a co-occurring series of events. Segmentation of services may have evolved for many different reasons, but can no longer be justified. At this point in time separation of services has become more of a habit and a convenience to providers, payers and others than an optimal approach to the people who need services. We must hold a full health care system view and continue to work toward an integrated physical and behavioral health care system if we are to best serve the needs of all Vermonters young and old, well or not.

**Youth Transitioning into Adulthood** - It is difficult in our culture for many young people to successfully transition to adult life, even those with the advantages of a loving, financially stable family. For some groups of youth, the odds against success are high. For example, data and research show that youth who have been in state custody, have dropped out of school, have abused alcohol or other substances, and/or have had involvement with the justice system are at particularly high risk for negative outcomes. Of the 14 disabilities in special education, the disability group with the highest school dropout rate is that of serious emotional disturbance. Many specific programs have been tried in Vermont over the last two decades to improve this situation. The Division of Mental Health’s and other AHS partners JOBS program, for example, has achieved excellent outcomes with a very high risk population. At this point, we need a coordinated approach across departments, agencies, and communities to pull together a coherent and accessible system of services and supports. Because the issues and barriers to success are so broad, we believe it is necessary to pursue outside grant funding to help in the development of strategies for services, supports, funding, and evaluation of outcomes. Many stakeholder groups are poised to act with us in such an endeavor.

**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 help 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 grant 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.

**Vermont Blueprint for Health Depression and Substance Abuse Screening** - Depression is the most common mental health problem affecting an estimated 25 percent of the population each year including 40-60 percent of people with chronic physical health conditions, and 85 percent of people with substance abuse problems. Treating depression has been demonstrated to lead to improvements in clinical outcomes in people with diabetes and other chronic conditions. The evidence base for depression screening and care in the primary care setting has grown rapidly in the past several years but existing standards for screening, treatment and referral are not as well developed; further, depression services are not offered in all practices. These factors require more research, piloting and training than is true for addition of physical conditions.

## ***Department of Health***

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A pilot project is in development that will identify standards for incorporation of depression screening and management for people with chronic conditions served under the Vermont Blueprint for Health; develop standard depression guidelines for use by health insurers, primary and specialty health care providers, substance abuse counselors and others; and test those methods in three practices in Washington county. It is being funded with \$25,000 in diabetes and rural health funds, which we will need to supplement from other VDH grant funds or outside contributions.

**An Integrated Approach to Maternal Depression** - Research clearly shows that simple screening for maternal depression by and subsequent referral for assessment and treatment as indicated not only helps the mother, but also her children. We have begun building connections with private pediatric practices screening for general mental health issues. With a small amount of additional focused staff attention, the departments of Health and Children and Families are poised to act. The strategy is to approach OB/GYN and pediatric practices and urge them screen pregnant women and mothers for depression and to refer potentially depressed mothers for a full assessment and evidence based treatment when indicated. This strategy would replicate, with a different population and with different providers, our Vermont Blueprint for Health work with depression and substance abuse screening among people with chronic disease. Funding for project planning, development, training and purchase of screening devices is being sought.

### **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. Over 50 percent of adults have one or more chronic disease, the most common of which are arthritis, asthma, cancer, cardiovascular disease, lung disease, depression, diabetes, obesity, and osteoporosis. All are serious conditions that, left untreated, can lead to the need for acute or emergency care—typically the most expensive and complex type of medical care. Caring for people with chronic conditions consumes 70 percent of the \$3.3 billion spent in Vermont each year on health care. The number of people with chronic conditions – and the cost of their care – is expected to double by the year 2050.

**Obesity and Lack of Physical Activity:** The prevalence of obesity in Vermont and the nation is increasing at an alarming rate. Approximately 25 percent of Vermont youth in grades 8 through 12 are 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 54 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 over a year, is housed in an aging facility that needs to be replaced. It lost 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.

**Pandemic influenza** - A worldwide 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 a type of flu virus that is causing illness in birds and some humans but is not yet pandemic. Flu viruses change constantly, and if this type of bird flu changes so that it

## ***Department of Health***

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can easily spread from sick to healthy people, then it will become 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 pandemic flu and caring for the many people who become sick will require strong measures – such as isolation and quarantine – that have not been used in a generation. The Vermont Department of Health and Vermont Emergency Management are working with key partners in 12 workgroups to expand statewide plans for bird flu and pandemic:

- antiviral medication and vaccine utilization
- community containment and support (includes isolation and quarantine)
- laboratory testing
- healthcare surge capacity
- mass fatalities and morgue capacity/animal depopulation and disposal
- risk and emergency communication
- legal/policy issues
- personal protective equipment
- continuity of operations
- recovery
- community planning support
- volunteer requirements

The Vermont Department of Health is also working closely with the New England states and New York, national and Canadian partners to coordinate preparedness and response planning. A rigorous exercise program for 2007 will test plans and capabilities to respond to pandemic flu and other public health emergencies.

**HIV Name-Based Reporting** - The Vermont Department of Health is working to transition from an HIV code-based reporting system to a confidential HIV name-based reporting system beginning in 2007. The transition will allow Vermont, one of only four states that had yet to move to a name-based reporting system, to comply with a strong recommendation by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). Name-based reporting for AIDS cases has been in place in Vermont for the past 22 years. HIV is the virus that causes AIDS. The CDC's policy is to accept only HIV case surveillance data collected, reported and maintained in state HIV/AIDS surveillance systems using confidential name-based methods.

**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.

## ***Department of Health***

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**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 is working collaboratively with the agencies to develop a long-term funding plan that addresses inflationary pressures and caseload growth.

**Childhood Lead Poisoning** – In 2006, the Commissioner of Health and Attorney General established a joint task force to research and evaluate the myriad of issues surrounding lead poisoning, and to develop recommendations aimed at dramatically reducing the prevalence of childhood lead poisoning in Vermont. According to the task force report, after more than a decade of active interventions that substantially reduced the incidence of lead poisoning among our children, lead, a highly toxic element, continues to poison approximately 350 children in Vermont each year. In addition, lead adversely affects as many as 2,500 more children who may have lower, but still detectable, levels of lead in their blood. Lead will continue to harm Vermonters and to cost the state millions of dollars unless current practices are substantially changed—landlords are held accountable for cleaning up lead in housing stock with essential maintenance practices, physicians routinely screen children for lead poisoning, parents receive lead poisoning prevention information, and at risk children are well-nourished and educationally stimulated.

**Indoor Air Quality and Building-Related Health Concerns** – The Department is receiving a growing number of requests to investigate health concerns related to public buildings and workplaces. Examples include concerns about cancer clusters, mold and odors, respiratory symptoms, and carbon monoxide. In June 2006, the Department of Health was made aware of health concerns among employees of the Bennington State Office Building. The primary health concern was identified as **Sarcoidosis** - a disease characterized by inflammation in one or more organs. The cause of sarcoidosis is not known, although treatments are available. Sarcoidosis is not a type of cancer, and is not passed from person to person. Because sarcoidosis is a serious illness of unknown cause, the Department of Health and the Department of Buildings & General Services have undertaken an extensive investigation that includes building inspection, environmental testing, health surveys of current and former employees, medical screening tests, review of medical records and regular meetings with employees. While critical to our work protecting public health, these investigations draw on expertise and resources from throughout the department, and in so doing, redirect resources from other critical areas of public health.



# 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 Positions: 101**

**Funding SFY '07**

General Fund	\$ 128,077,901
Global Commitment Fund	\$ 471,121,614
Federal/Other	<u>\$ 147,834,615</u>
<b>Total</b>	<b>\$ 747,034,130</b>

*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*

<b>Year</b>	<b>FY '06</b>	<b>FY '07 Est.</b>	<b>FY '08 Gov Rec.</b>
General Fund	50,000	121,225,950	128,077,901
Federal/Other	612,120,857	563,625,532	618,956,229
<i>Total</i>	612,170,857	684,851,482	<b>747,034,130</b>

**ACCOMPLISHMENTS**

- **Capitated Program for Treatment of Opiate Dependency:** The OVHA has collaborated with the 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 services to enhance the program. The Howard Center for Human Services, The Clara Martin Center, Northeast Kingdom Human Services, and United Counseling Services of Bennington County won the Request for Proposal (RFP) for A Pilot Project for the Development of Care Coordination within Community Based Medical Settings Offering Opiate Treatment Utilizing Buprenorphine.
- **Chronic Care Management Program (CCMP):** By pre-planning, the OVHA was able to first consult with other states and national experts about the best approach to creating a Vermont chronic care management system. The OVHA developed a proactive work plan, made early connections with the Blueprint for Health and other collaborating efforts, and is on target for implementing the CCMP in a timely and well planned manner.
- **Global Commitment to Health Waiver:** The OVHA has completed many of the tasks associated with the transition to a Managed Care Organization (MCO) structure. Some of the completed tasks include the implementation of 1) interpreter services (i.e., oral interpreter services included free of charge to non-English speaking enrollees who request assistance), and 2) a web based provider directory (i.e., provider names, locations, telephone numbers for all primary care and specialty providers and hospitals participating in the Medicaid program). The enrollee handbook (i.e., information on access care, enrollee rights, and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal) is targeted for completion by Spring 2007.
- **Medicare Modernization Act (MMA):** In 2006, with the approval of the Legislature and the Administration to expend state-only funds, the OVHA was able to immediately reinstate its programs for Medicare Part D eligibles to ensure that dual eligibles (i.e., Vermonters covered by both Medicare and Medicaid) and VPharm eligibles (i.e., Vermonters covered by both Medicare and a state pharmacy program) received their medications while their Medicare Part D Prescription Drug Plans (PDPs) resolved their issues. In March 2006, the OVHA determined that the PDPs were insufficiently operational and switched back to the original plan of being secondary coverage after Medicare. The OVHA continues to monitor individual circumstances to assure transitional coverage when there is a problem with a Medicare PDP selection or with cost sharing requirements when a beneficiary's low income subsidy (LIS) status has not properly registered with the Centers for Medicare and Medicaid Services (CMS). To date, Vermont has successfully received over \$5 million as federal reimbursement that is due to compensate the state for expenditures on behalf of Part D.
- **Premium Assistance Programs:** A Global Commitment to Health waiver amendment request was submitted to CMS in September 2006 related to the premium assistance programs. The basic system design for the premium assistance programs has been completed, and work on the draft rules has begun. A report analyzing Employer-sponsored Insurance (EDI) estimated cost savings was submitted to the Joint Fiscal and Health Access Oversight Committees on November 22, 2006.
- **Reimbursement:** In SFY 2006, legislation required that the OVHA make significant reductions to the fee schedule for many providers. Effective January 1, 2007, dentists and Current Procedural Terminology (CPT) billers have had those rates restored. The SFY 2008 budget proposes to increase hospital reimbursement at a cost of \$2 million; CPT codes at a cost of another \$2 million; and home health agencies at a cost of \$400,000.

### **OPPORTUNITIES**

- **Clinical Initiatives:** The Office of Vermont Health Access (OVHA) is developing a comprehensive, systematic, and continuous *Quality Assessment and Improvement Strategy* to verify that the clinical services provided to Medicaid beneficiaries conform to professionally recognized standards.
  - **Capitated Program for Treatment of Opiate Dependency:** The OVHA, in collaboration with the Vermont Department of Health Alcohol & Drug Abuse Program, the Department of Corrections, and commercial insurers, aims to increase access to effective treatment for opiate dependency by supporting primary care practices through: 1) development of a statewide, integrated protocol for the treatment of opiate 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; 3) development of an evaluation plan with benchmarks to assess program outcomes; 4) development of a statewide electronic registry and treatment service assessment of patients with opiate dependency; and; 5) identification of the administrative and financial resources necessary to successfully implement and maintain the capitated program.
  - **Care Coordination:** Care Coordination in conjunction with the Chronic Care Management Program, is the Chronic Care Model in action. Both programs are the culmination of a system redesign to improve the health outcomes of Medicaid beneficiaries. The Mission Statement of Care Coordination is to: 1) Identify and assist with the most complex Medicaid beneficiaries in accessing clinically appropriate health care services, 2) Coordinate the efficient delivery of health care to this population by removing barriers, bridging gaps, and avoiding duplication of services, and 3) Educate, encourage and empower participants to self-manage their chronic conditions.
  - **Chronic Care Management Program (CCMP):** The OVHA is in the process of procuring chronic care management intervention and health risk assessment administration services (i.e., provider outreach and education, targeted self-management mailings, telephonic nurse support, and face-to-face care management) for approximately 25,000 - 30,000 non-dually eligible beneficiaries. The OVHA expects to see an improvement in clinical outcomes and a reduction in utilization for enrolled beneficiaries. CCMP begins in Summer 2007.
- **Communications:** The OVHA has transitioned its Provider Relations Unit to include more comprehensive communication activities. In addition to provider communications, the OVHA's Communications Unit (CU) is responsible for legislative and external/internal communications. The CU also supports beneficiary communication activities. Major communication projects for 2007 include: 1) enhancing provider communications, 2) re-organizing and re-launching the OVHA website; 3) marketing/outreach for the Premium Assistance Programs; and 4) preparation for Vermont hosting the National Association of State Medicaid Directors' Conference in June, 2007.
- **Global Commitment to Health Waiver:** On October 1, 2005, Vermont entered into a new five year 1115 federal Medicaid demonstration waiver called the Global Commitment to Health. The goals of the waiver are to: 1) provide Vermont with financial and programmatic flexibility to maintain broad public health care coverage; 2) continue to lead the nation in exploring ways to reduce the number of uninsured Vermonters; and 3) foster innovation in health care by focusing on health care outcomes. The waiver consolidates funding for all of the state's Medicaid programs except for the Choices for Care (long-term care) waiver, and the State Children's Health Insurance Program (SCHIP) and Disproportionate Share Hospital (DSH) payments.

The waiver also converts the OVHA to a public Managed Care Organization (MCO). As an MCO, the OVHA must adhere to federal rules for Medicaid MCOs. One of these rules is to have an internal Grievance and Appeals (G&A) process to acknowledge and resolve service and benefit disagreements between beneficiaries and the MCO in a timely and fair manner. The new G&A process applies to all Medicaid programs operated within AHS (with the exception of long-term care programs), and is more user-friendly for beneficiaries.

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Primary advantages of the waiver are: 1) the MCO can invest in health services that typically would not be covered by Medicaid; 2) it enables Vermont to invest in new health care initiatives; and 3) it provides the programmatic flexibility to implement strategies and reimbursement methodologies aimed at curbing health care inflation.

- **Medicare Modernization Act (MMA):** MMA has provided the OVHA with the opportunity to work with both partners in the Agency of Human Services (AHS) and representatives from a variety of community-based non-profit agencies, including the Area Agency on Aging (AAA) Senior Health Insurance and Assistance Program (SHIP) and Vermont Legal Aid's Health Care Ombudsmen's Office (HCO). This collaboration occurred during all of 2006 and will continue into 2007 to serve Vermont Medicaid beneficiaries impacted by varying changes in Medicare. The OVHA and SHIP staff have provided several train-the-trainer sessions for state staff and community advocates to assist Medicare beneficiaries directly with the most current information about enrolling in or changing a Medicare Part D plan.
- **Oral Health:** Many Vermonters face challenges in receiving appropriate oral health care due to the limited number of practicing professionals, the affordability of services, and a lack of emphasis on the importance of oral health care. The *Dental Dozen* are 12 targeted initiatives to improve the oral health for all Vermonters, establish a framework to remedy existing delivery system issues and proactively confront future challenges. The Dental Dozen are: 1) Ensure Oral Health Exams for School-age Children; 2) Increase Dental Reimbursement Rates; 3) Reimburse Primary Care Physicians for Oral Health Risk Assessments; 4) Place Dental Hygienists in Each of the 12 District Health Offices, 5) Selection/Assignment of a Dental Home for Children; 6) Enhance Outreach; 7) Codes for Missed Appointments/Late Cancellations; 8) Automation of the Medicaid Cap Information for Adult Benefits; 9) Loan Repayment Program; 10) Scholarships; 11) Technology Grants; and 12) Supplemental Payment Program.
- **Premium Assistance Programs:** Act 191 passed during the 2006/2007 legislative session created premium assistance programs for Employer-Sponsored Insurance (ESI) and Catamount Health. Premium assistance programs are intended to allow more uninsured Vermonters access to affordable and comprehensive health care coverage. ESI has the potential of saving several million dollars per year in VHAP expenditures. Catamount Health is the new private insurance product to be offered by one or more of Vermont's largest carriers to uninsured Vermonters.
- **Program Integrity:** The OVHA has combined its Surveillance and Utilization Review (SUR) staff and Data staff to form the Program Integrity Unit. The Program Integrity Unit is responsible for utilization review, preliminary review of suspected fraud and abuse, analysis of inappropriate billing, and the extraction and compilation of data to support OVHA operations. The Program Integrity Unit will be supported by technical systems including the Fraud and Abuse Detection System (FADS) and Claim Check/Claim Review. The Program Integrity Unit will meet federal requirements for program integrity activities and will oversee federal program integrity projects such as the Payment Error Rate Measurement (PERM) program.
- **Reimbursement:** The SFY 2008 budget proposes to increase hospital reimbursement by \$2 million; CPT codes by \$2 million; and home health agencies by \$400,000. The OVHA plans to align with the Blueprint to base future reimbursement changes on performance. The OVHA has contracted with a consultant to develop an improved reimbursement system for hospitals with preliminary recommendations for both inpatient and outpatient in February, 2007 for implementation as early as October 1, 2007.
- **Transportation:** The OVHA is conducting a study of the Medicaid transportation system to determine if there are policies or procedures that can be implemented to stabilize or reduce current expenditures. Medicaid will pay for transportation to medically-necessary services for beneficiaries who do not otherwise have access to needed transportation. Transportation services are provided via contract with the Vermont Public Transportation Association (VPTA). VPTA works with regional transportation agencies to provide or arrange for transportation (e.g., Addison

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County Transit Resources, Chittenden County Transportation Authority, Marble Valley Regional Transit District, and Rural Community Transportation). Regional brokers provide transportation using community volunteers, buses and vans, taxi or other means as required. In SFY 2006, volunteers logged nearly six million miles in about 155,500 trips. Transportation expenditures have increased from \$6.7 million in SFY 2005 to \$9.9 (budgeted) for SFY 2007.

### **PRESSURES**

- **Citizenship:** In the Deficit Reduction Act (DRA) passed in February of 2006, Congress mandated a new verification requirement for Medicaid applicants and beneficiaries. The law requires most U.S. citizens who apply for or receive Medicaid to present documentary evidence of their citizenship status and identity. Medicaid applicants and beneficiaries who also receive either Social Security Income (SSI) or Medicare are exempt from the requirement because they had to prove citizenship and identity when they applied for those federal programs. Non-citizens are already subject to a similar documentation requirement. In an effort to minimize the burden of this law, the Economic Services Division (ESD) of the Department for Children and Families (DCF) will attempt to obtain the needed documentation through electronic data matching. A centralized Identity-and-Citizenship Help Line (800-250-8427) has been established utilizing the existing OVHA Member Services facilities to assist applicants and beneficiaries when electronic data matching is not feasible.
- **Healthcare Information Technology (HIT):** Numerous health care related technology projects, including those undertaken at the OVHA and the pilots proposed by Vermont Information Technology Leaders (VITL), the Blueprint for Health, Medicaid Information Technology Architecture (MITA), State Self Assessment (SSA), and the multi-payer claims database, require coordination to avoid duplication of effort and result in an inter-operative electronic health information environment. For the OVHA to receive federal funding for Medicaid Management Information System (MMIS) procurement/enhancements, the OVHA must ensure that its business goals, objectives and framework align with MITA principles. CMS is requiring the OVHA to complete an SSA to accompany its Advance Planning Document (APD) funding request. Five (5) data exchanges between the state and the federal government have been added. An initial review of the MMA data exchanges indicates a significant discrepancy between the newly available data and the data in current use and significant IT work is required to make use of the information available in the new interfaces. The IT staff responsible for this work resides in DCF but OVHA must help guide the work and oversee implementation.
- **Medicare Modernization Act (MMA):** There are two primary challenges involved in continuing to implement MMA in 2007: 1) onset of the second year of Medicare Part D and the transition of some beneficiaries from their 2006 Prescription Drug Plan (PDP) to new plans; 2) introduction of Medicare Managed Care (Part C) as an option for Vermonters has plans that either are a Medicare Advantage (MA) plan which includes both Medicare Part A (hospital services) and Medicare Part B (physician services) coordinated by one company or a Medicare Advantage Prescription Drug plan (MA-PD) which includes Parts A, B, and D (prescription drugs) coordinated by one company; 3) monitoring of the state's supplement to Part D coverage because it is necessary to assess the comparability of this "wrap coverage" to the coverage that the state provided prior to Part D, and 4) pursuit of collections for the remainder owed the state by Medicare and/or the PDPs for pharmacy claims paid on their behalf in 2006 and on an ongoing basis.
- **Provider Taxes:** Provider taxes may be used as federal Medicaid matching funds if the tax meets specific federal requirements. One of the requirements is an upper tax rate limit which is currently 6%. Recent federal action has reduced the upper tax limit to 5.5% for January 1, 2008. Since none of Vermont's taxes are at 6% upper tax rate limit there will be no revenue lost in SFY 2008.
- **Chronic Care Management Program (CCMP):** The CCMP will be challenged to demonstrate savings in a short time frame. When beneficiaries begin to better manage their chronic conditions there can be an initial increase in pharmacy usage and physician visits because of

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adherence to prescribed regimens that can be measured against anticipated reductions in hospitalizations and emergency room usage for long-term cost savings.

### **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 including a comprehensive wrap for Medicaid beneficiaries with Medicare as their primary pharmacy insurer, and copay in Fall 2007 Catamount Health Premium Subsidy for Vermonters up to 300% of the Federal Poverty Guidelines (for example, \$5,163 for a family of 4).