~ Blue Book 2005 ~

The Agency of Human Services

Opportunities and Pressures, Accomplishments, and Caseload Data

Charles Smith
Secretary

February 2005

State of Vermont

Agency of Human Services

January 2005

Dear Legislator:

Welcome to the Agency of Human Services (AHS) Blue Book for 2005. Each year the Agency prepares this progress report as a convenient reference tool for the legislators and citizens of Vermont. With programs that span the generations – from Healthy Babies to Alzheimer's Respite, from the Department of Corrections to the JOBS (Jump on Board for Success) program – the Agency affects almost every Vermont family in some way.

The 2005 Blue Book distills this work, bringing together the latest facts and figures, charts, and narratives in an effort to describe the impact we have on the individuals and families whose lives we touch. This document highlights our many successes and accomplishments, while warning of impending pressures.

This past year saw structural change within the Agency, as we moved from the inquiry phase of reorganization to implementation. Departments and Offices have been merged or realigned for more efficiency and to provide better and more streamlined access to services. We've hired 12 Field Directors to provide a strong agency presence in each of our service districts, and to focus on issues of access, service coordination, accountability, and the overall effectiveness of service delivery in each region.

The staff of AHS and our community partners are to be commended – the Agency's innovative approaches to serving the most vulnerable members of our society have yielded impressive results and garnered much national recognition. Within these pages, you will learn how productive the Office of Child Support has been in improving the financial well-being of single parents and children. You will note the remarkable progress made by the Department of Aging & Independent Living's Developmental Disabilities Division providing opportunities for their clients to live independently in the community. You will see data showing that the Department of Corrections' success of treatment programs more than outweighs the costs of re-incarceration, and learn how the Department of Health successfully shepherded Vermonters through the flu vaccine shortage.

While we have had many successes in the Agency, we are faced with the distinct possibility of having to cut or reduce benefits, and/or require a higher cost-share in our health care programs in order to make our budget. Medicaid alone is facing a $70 million deficit for 2006, so these are far from good financial times for the Agency. I look forward to working and consulting with you as we move forward constructively into 2005 to address this and other issues.

Sincerely,

Charles Smith, Secretary

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AHS
Before and After

BEFORE
6 Departments, 2 Offices

AFTER
4 Departments, 1 Office

Office of Child Support (OCS)

Office of Economic Opportunity (OEO)

Dept. of Prevention, Assistance, Transition, and Health Access (PATH)

Dept. of Social and Rehabilitation Services (SRS)

Dept. of Aging and Disabilities (DAD)

Dept. of Developmental and Mental Health Services (DDMHS)

Dept. of Health (VDH)

Dept. of Corrections (DOC)

Office of Vermont Health Access ~ OVHA ~

Dept. for Children and Families ~ DCF ~

Dept. of Aging and Independent Living ~ DAIL ~

Dept. of Health ~ VDH ~

Dept. of Corrections ~ DOC ~

(Effective July 1, 2004)

Charles Smith, Secretary

Office of the Secretary

Number of Positions:	**64**
Funding SFY '06	
General Fund	$ 4,474,553
Health Access Trust Fund	0
Federal/Other	$ 9,256,129
Total	**$ 13,730,682**

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.

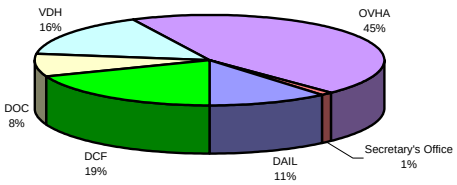
FY 2006 ***Governor's Recommend***	**DAIL**	**DCF**	**DOC**	**VDH**	**OVHA**	**Central Office**	**TOTALS**
Number of Positions	293	958	1,142	811	58	64	**3,326**
General Fund	$ 60,399,406	$104,170,397	$ 103,059,847	$64,115,288	0	$ 4,474,553	**$ 336,219,491**
Health Access Trust Fund	$1,500,000	$ 614,904	0	$421,655	$247,055,099	0	**$ 249,591,658**
Federal/Other Funds	$93,179,595	$162,779,772	$ 9,151,924	$152,611,721	$382,974,276	$ 9,256,129	**$ 809,953,417**
Total Funds	**$155,079,001**	**$267,565,073**	**$112,211,771**	**$217,148,664**	**$630,029,375**	**$13,730,682**	**$1,395,764,566**

Agency of Human Services

January 2005

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

AHS Total Funds FY'06
Governor's Recommend



Secretary of Human Services

Charles Smith, Secretary
Eileen Elliott, Deputy Secretary
Michele DellaSanta, Administrative Asst.

Department of Aging and Independent Living

Patrick Flood, Commissioner
Joan Senecal, Principal Asst.
Theresa Wood, Principal Asst

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

Department for Children and Families

James Morse, Commissioner
Kim Keiser, Steve Dale, Betsy Forrest, Cindy Walcott, Deputies; Jeff Cohen, Trudy Lyon-Hart, Directors; Tony Morgan, Administrator; Les Birnbaum, Gen. Counsel

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

Department of Corrections

Steve Gold, Commissioner
Sr. Janice Ryan, Deputy
S. Santarcangelo, Prin. Assistant

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

Department of Health

Paul Jarris, MD, Commissioner
David Cote, Principal Asst.
Sharon Moffatt, Susan Wehry, MD, and Barbara Cimaglio, Deputies

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

Office of VT Health Access

Joshua Slen, Director
Nancy Clermont, Deputy
Ann Rugg, Deputy

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

Department of Aging and Independent Living

"We are working to ensure that Vermont elders and adults with disabilities live with dignity and independence wherever they reside."

- Patrick Flood, Commissioner

Number of Positions:	**293**
Funding SFY '06	
General Fund	$ 60,399,406
Health Access Trust Fund	$ 1,500,000
Federal/Other	$ 93,179,595
Total	**$ 155,079,001**

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.

Opportunities

The recent reorganization of the Agency brings Vermont's long-term care services together in one Department. While this change includes some challenges, it also 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 with Developmental Disabilities who are "aging out" of children's services;
- Increase opportunities for people to manage services and supports for themselves or their families;
- Improve our efforts to ensure the quality of home and community-based services. *Through a Real Choices Quality Assurance/Quality Improvement Systems Grant from the Centers for Medicare and Medicaid Services (CMS), the Department will develop a comprehensive quality management system in all four Home and Community-Based Services Waivers using the CMS quality framework. The goal is to effect enduring systems change that fulfills Vermont's commitment to ensure the health and well-being of elders and individuals with physical and intellectual disabilities receiving Waiver services within Vermont's community-based long-term case system.*

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

- Develop and implement a Medicaid Waiver program under Sec. 1115 to restructure our long term care system, eliminate institutional bias and give consumers equal access to either a nursing home or home and community-based care. *An 1115 Waiver application has been submitted to the federal government.*
- Maintain a healthy Area Agency on Aging network*. These agencies face impending financial crises as the demand for services and the cost of providing those services continue to increase, while federal funding decreases. Our efforts to build a strong community-based system of care cannot succeed without these Agencies*.
- Continue to develop new housing/service models (e.g. adult family care) and expand programs to make individual homes accessible.
- Expand efforts to attract and retain more people to work as caregivers. Improvements in working conditions are as crucial as adequate wages and benefits.
- Expand adult day services to serve more people in more sites.
- Develop a complete system of care for younger adults with disabilities.
- Expand our public information and outreach to ensure that consumers and their families know how and where to find information about the care options available.
- Increase intervention and prevention services to address the steady increase in Adult Protective Services reported cases.

A federal grant providing long standing services related to assistive technology has been reauthorized for 5 years to provide assessments and technical assistance for people who need assistive devices due to disability. This funding will allow the project to continue all activities.

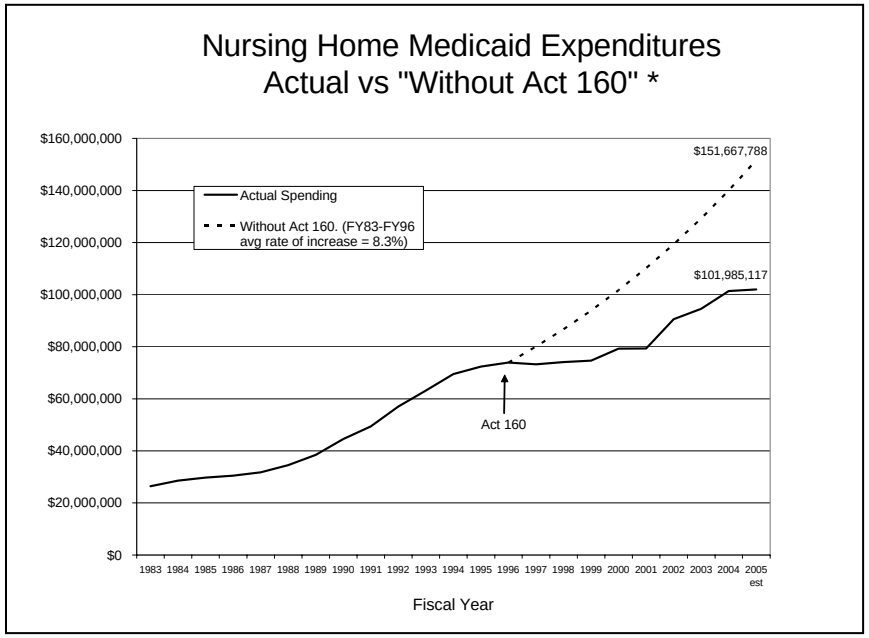
A recent grant from the National Governors' Association Center for Best Practices will help us to better organize and support healthy aging and disease prevention programs.

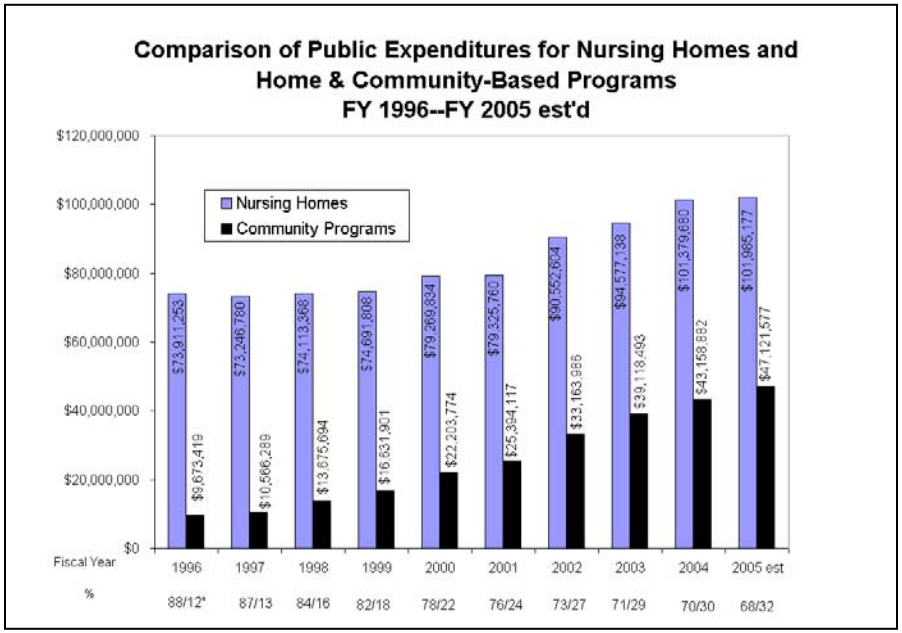
Pressures

- Fewer nursing beds will likely be needed in the future, even though the rate of decreased utilization has slowed. Managing the demand as nursing homes downsize or close will be a challenge. We may need to increase funding to some homes to ensure an adequate level of service is available in all parts of the state.
- Community-based alternatives to institutionalization need to be expanded and enhanced.
- Transportation and housing needs continue to increase for elders and other adults with disabilities. Meeting these increasing needs are difficult in our rural state since costs are rising while federal transportation funding remains stable and federal housing subsidies shrink.
- Vocational Rehabilitation caseloads have risen over 40% in the past years, and we have limited capacity to serve this increase.
- The rate of disability among older people is decreasing, yet life spans and the rate of disability are increasing for younger people.
- There are increasing caseload demands for individuals of all ages with developmental disabilities. This is due to many factors including abuse, neglect and exploitation; personal and public safety; long term supports needed after high school graduation; loss or aging of caregivers; homelessness; institutionalization; youth leaving the custody of the Department for Children and Families at age 18; and individuals who formerly would have been placed in nursing facilities.
- Budgetary pressures have forced the Department to set priorities for eligibility as well as restrict access to services for children and adults under the Developmental Services System of Care Plan since December 2001.
- The Department keeps an Applicant List of people who are not eligible for developmental services funding, but who still seek services. Of the 151 who applied for services since FY ’02 but have not received funding, 123 are waiting for $472,000 in service coordination, 21 are waiting for $421,000 in home supports, 81 are waiting for almost $340,000 in family support, and 12 are waiting for $217,000 in employment supports.
- The number of children who accessed new funds appropriated for developmental services caseload growth doubled in fiscal years 2000 and 2001. A moratorium on new funding serving children with comprehensive services was implemented on December 1, 2001 in response to fiscal pressures. Supports needed for children and their families are extensive and exceed the system's capacity. This moratorium continues and has created a backlog of cases, which would cost between $1.2 million and $1.5 million annually.

Accomplishments

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





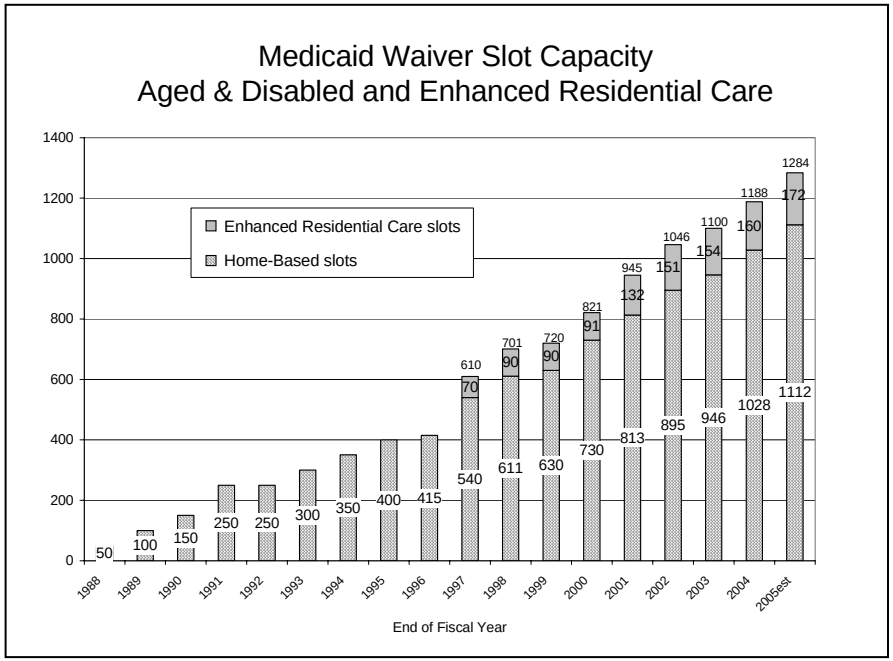
The Department continues its commitment to quality care in nursing homes. Nursing home expenditures continue to grow even as the number of people in nursing homes declines. However, home-based services occupy an increasing proportion of total public long term care expenditures.

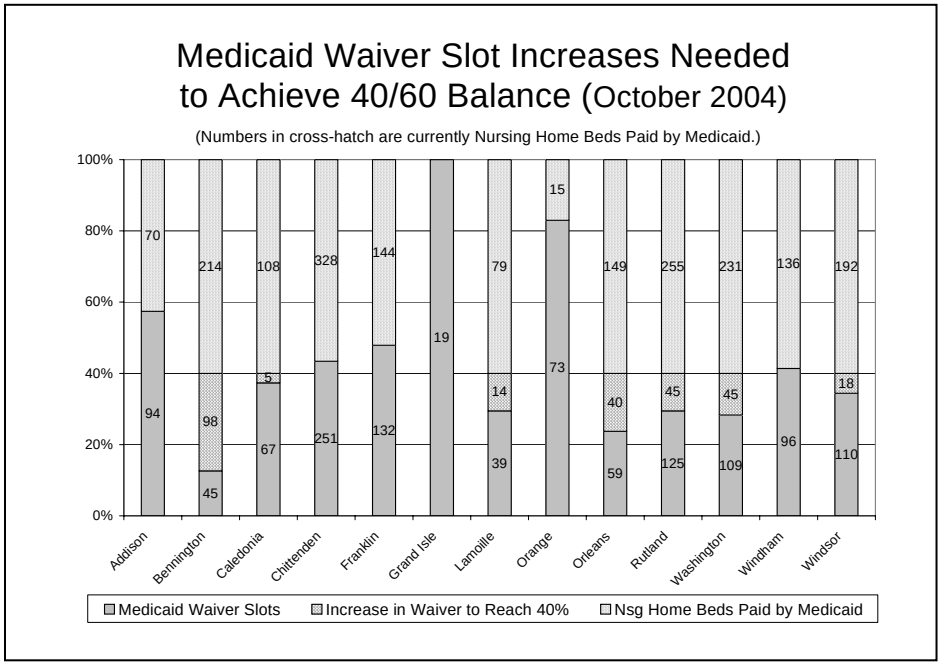
Over the past decade, the number of people utilizing nursing homes has declined in proportion to the number of people served by Medicaid Waivers. Limits on funding for home and community-based services, coupled with an entitlement for nursing home care remains a challenge as we continue to try to find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

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

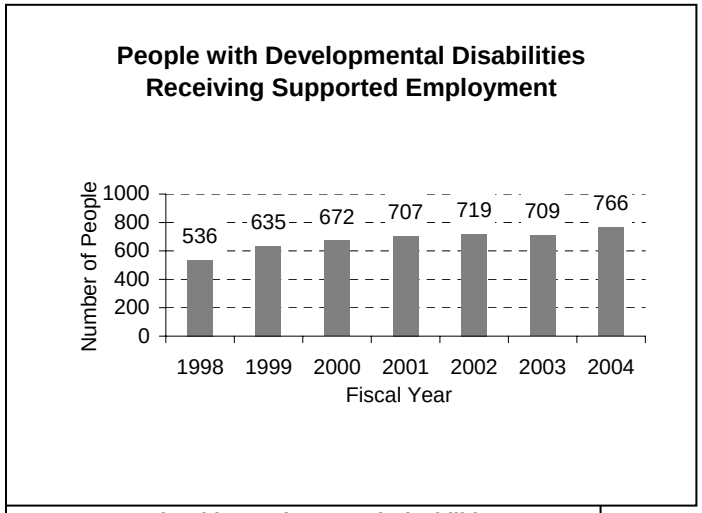
- $800,000 has been invested in cost-effective service coordination and gap-filling services in congregate senior housing.
- Residential care homes have improved their capacity to serve people with higher levels of need. There are currently about 165 people in residential care homes that are nursing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

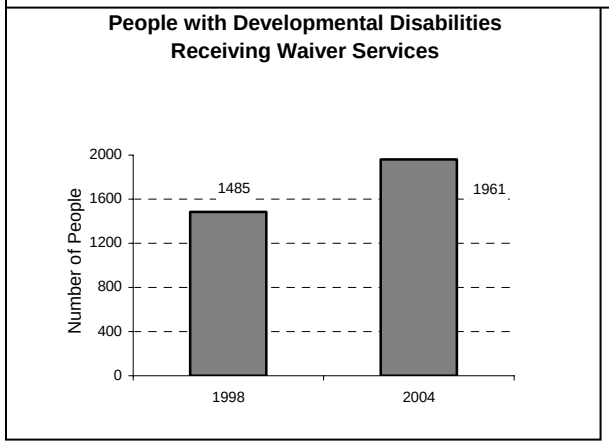
Before the passage of Act 160 in 1996, the number of "slots" in the Home and Community-Based Waiver Program was only 400. This number has grown to nearly 1,300 today.





The Department is committed to achieving a "balance" between Medicaid funded nursing home beds and the Home & Community-Based Medicaid Waiver programs (Aged & Disabled and Enhanced Residential Care). The goal is to establish a county minimum of 40 Home-Based Waiver slots for every 60 Medicaid funded nursing home beds. The Department believes a "40/60" balance is achievable in every county.





Federal Medicaid Waiver

The number of people with developmental disabilities on the DS home and community-based waiver (HCBW) continues to grow each year to meet new caseload demands. The Centers for Medicare & Medicaid Services reviewed Vermont's HCBW services, concluding that Vermont "provides the type of individualized services that people need and want" and Vermont can "serve as a model" for other states.

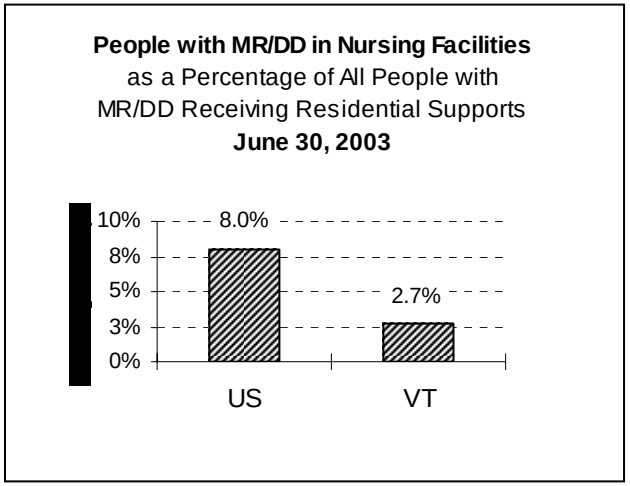
Accomplishments, continued

People with Developmental Disabilities Receiving Supported Employment to Work

Vermont is ranked 1st in the nation for people with developmental disabilities who receive supported employment services. In FY '04, service providers helped 37% of working age adults with developmental disabilities to work, saving an estimated $1,024,464 in public benefits.

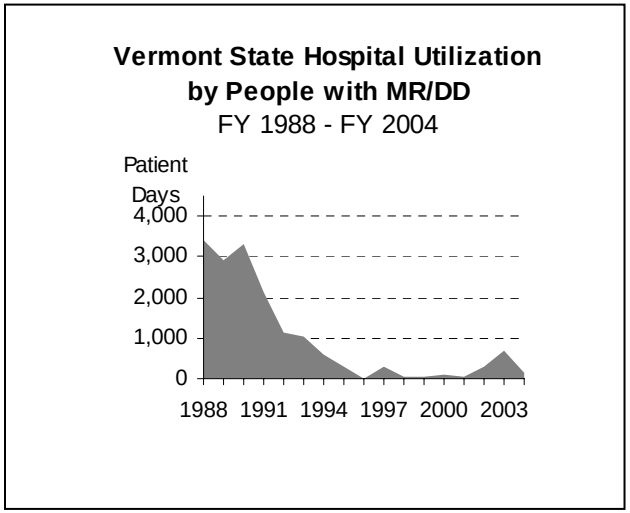
Green Mountain Self-Advocates Grow

A network of 17 peer support groups have formed a strong foundation for the statewide self-advocacy organization that provides public education and awareness, peer mentoring, support, and direct action. Green Mountain Self-Advocacy, with funding through the federal Real Choices Systems Change Grant, is providing education to peers and service provider board members on best practices for including people with disabilities on agency boards. Green Mountain Self-Advocates celebrated its 10th Anniversary in October 2004.



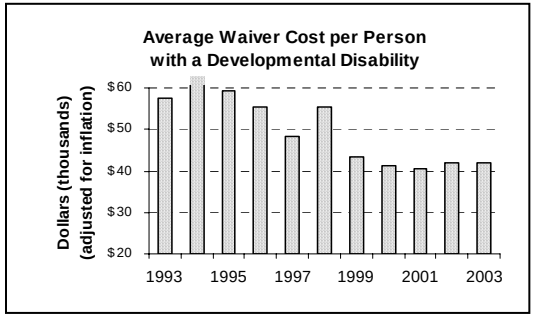
People with Mental Retardation/ Developmental Disabilities in Nursing Facilities

The number of people in Vermont with MR / DD in nursing facilities compared to all residential services for Vermonters with developmental disabilities in is 2.7%, well below the national average of (8.0%).



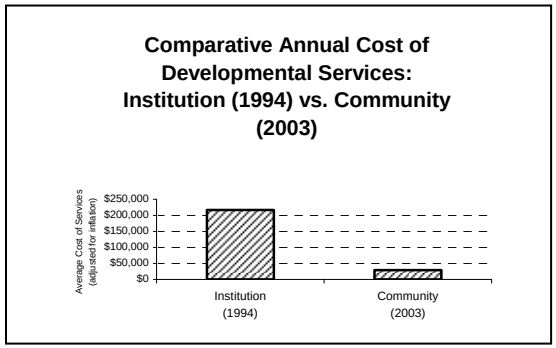
Crisis Services Successful

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



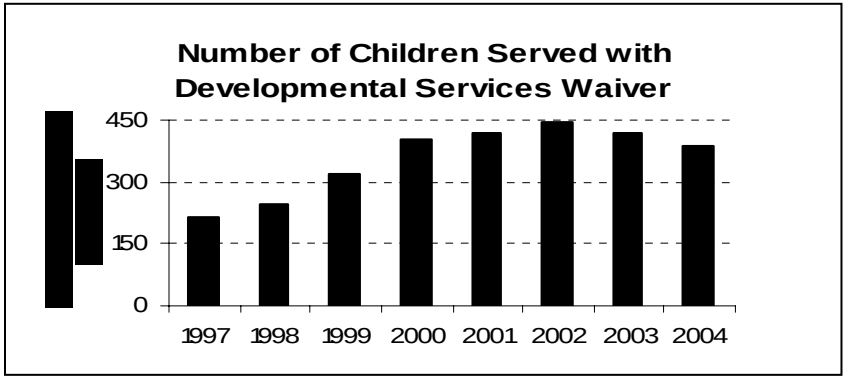
Average Cost Per Person – Waiver Services

Since the Brandon Training School closed in FY '94, the average cost of waiver services per person served has declined. In the last two full years of Brandon Training School, it cost an average of $224,165/year for each person served (adjusted for inflation). In current dollars, 9 families can be supported with intensive in-home support, or 200 families can be supported with respite support, for the same amount of money.



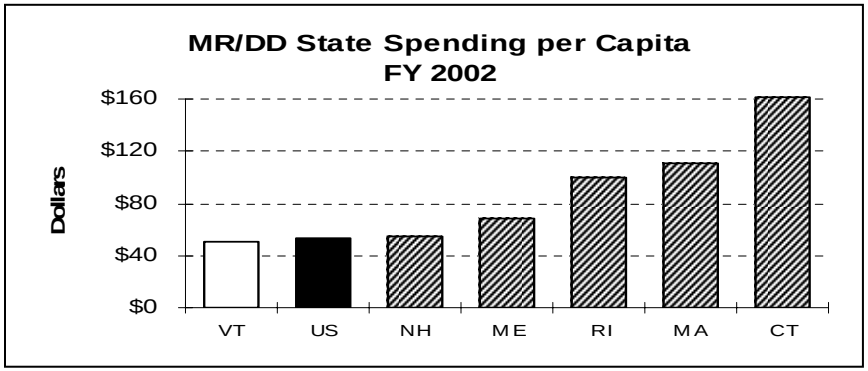
Suspended Services to Youth

As of December 1, 2001, suspended funding priorities in the Developmental Services' State System of Care Plan, FY '02 rescissions, and FY '03 and FY '04 shortfalls have halted new home and community-based waiver services for children and youth with developmental disabilities living with their families.



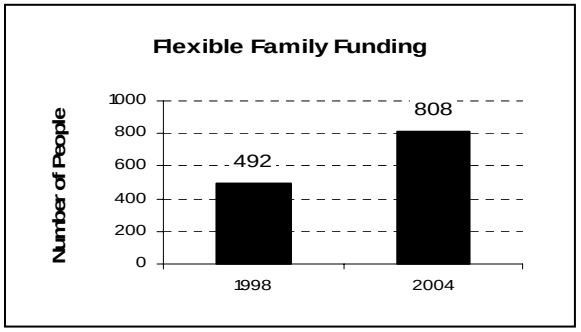
Mental Retardation/Developmental Disability State Spending per Capita

Vermont utilizes a higher percentage of federal funds (67%) than the national average (56%). In addition, Vermont spends less in state funds per capita than any New England state and less than the national average. *(note: National data is only available every other year)*



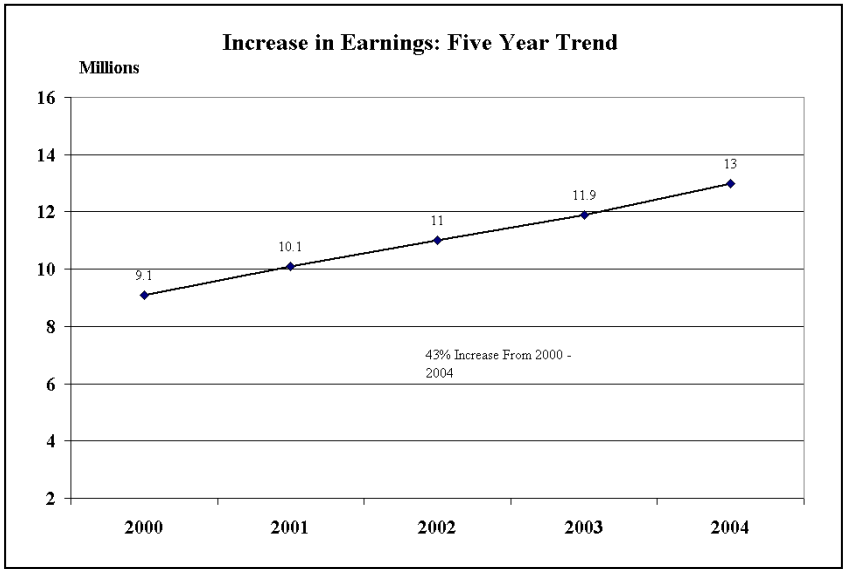
Respite/Flexible Family Funding

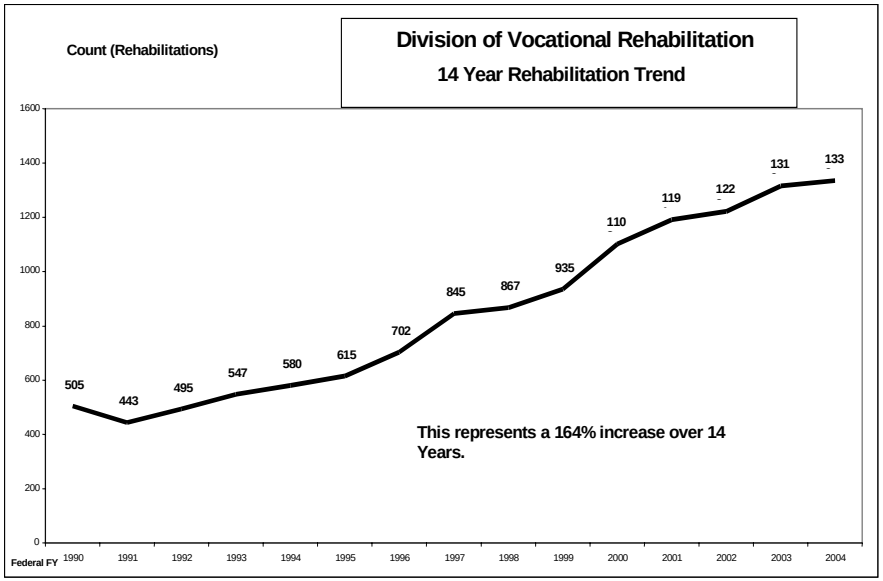
Flexible Family Funding, a unique family respite option, is a low cost program that offers a highly valued benefit to families of young and adult children. These funds, used at the discretion of the family, help provide care and support and avoid the need for more intensive and costly out-of-home services.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



Caseload and Cost Data

Since 1995, Vocational Rehabilitation has increased employment placements for people with significant disabilities by 117%. Employment earnings have increased 43% since 2000.

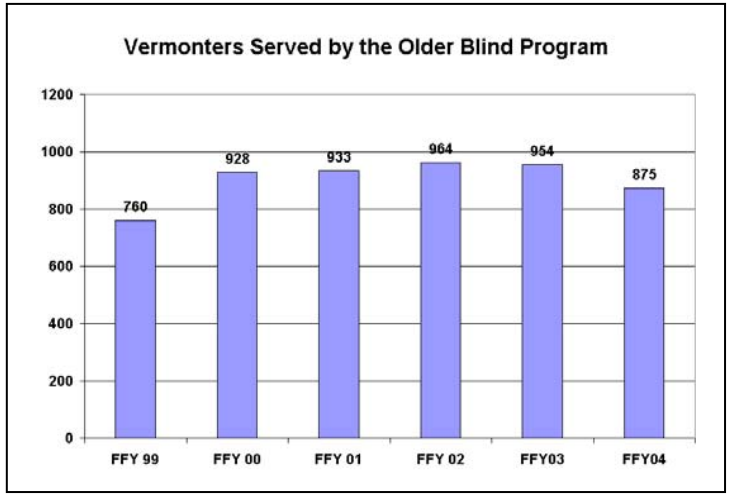




The Older Blind Program

The Older Blind Program will experience a higher demand for services as the population ages. New technology can help blind and visually impaired persons remain independent and participate in their communities. Providing sufficient funding will be an issue.

The Vermont Association for the Blind and Visually Impaired is the sub-recipient of the Older Blind Grant which is a combination of State and Federal funds. This program provides specialized low vision and independent living services to blind and visually impaired individuals over the age of 55. These services include: outreach and peer counseling; low vision evaluations by trained optometrists; provision of optometric and/or low vision aids; rehabilitation teaching; orientation and mobility; and training opportunities to enable optometrists to continue their education in the provision of specialized diagnostic and prescriptive low vision services.



Department for Children and Families

"We are strengthening longstanding relationships and forming new administrative and community partnerships, refocusing our efforts on prevention and early intervention and renewing our commitment to the delivery of respectful, effective service. We expect that in the months and years to come, these efforts will leave us better positioned to meet the needs of Vermont's children and families."

James Morse, Commissioner

Number of Positions:	**958**
Funding SFY '06	
General Fund	$ 104,170,397
Health Access Trust Fund	$ 614,904
Federal/Other	$ 162,779,772
Total	**$ 267,565,073**

The Department for Children and Families (DCF) promotes the social, emotional, physical and economic well being of Vermont's children and families. We achieve this mission by providing Vermonters with protective, developmental, therapeutic, probation, economic, and other support services. To this end, we work in statewide partnership with families, schools, businesses, community leaders, and service providers.

Department Overview

As part of the AHS reorganization, the departments of Social and Rehabilitation Services (SRS) and Prevention, Assistance, Transition, and Health Access (PATH) and the offices of Child Support and Economic Opportunities merged. The new department – the Department for Children and Families (DCF) – is comprised of four new divisions and three offices:

- **Child Development Division (CDD) -** includes the former Child Care Services Division of SRS and several programs formerly in DDMHS and the Health Department. The new Division consists of the following six units: Direct Services, Standards/Licensing, Fiscal, Workforce Development, Data Integration and Quality Assurance and Systems Development.

- **Family Services Division (FSD) -** includes the former Social Services Division of SRS, as well as the staff of the AHS Juvenile Justice Commission. The new division consists of the following four units: Child Protective Services, Resources, Child Safety and Youth Justice.

- **Economic Services Division (ESD) -** includes health care programs, Reach Up, Food Stamps, General Assistance, Fuel, and AABD/Essential Person. ESD consists of the following three units: Welfare to Work, Regulatory and Planning and Economic Benefits.

- **Field Services Division (FSD) -** comprised of the department's twelve newly-merged field offices.

- **Office of Disability Determination Services (DDS) -** continues to function essentially as in the past.

- **Office of Child Support (OCS) -** continues to function essentially as in the past.

- **Office of Economic Opportunity (OEO) -** continues to function essentially as in the past.

It is our hope and expectation that this realignment of government functions, allied with the creation of the new Field Services Division, will provide us with powerful new opportunities to better serve the people of this state. The reorganization has brought together programs that share many of the same clients. Already, this has led to a new spirit of collegiality that is working to improve service.

All ten of the AHS reorganization themes are directly addressed by the creation of DCF.

We are very excited about the new opportunities reorganization has presented, and look forward to an era of cooperative and thoughtful service delivery and improved outcomes for the citizens we serve.

Child Development Division

The Mission of the Child Development Division 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 assure access to high quality, economically viable, child development services.

The Child Development Division was created as a result of the AHS reorganization, which expanded the roles and responsibilities of the Child Care Services Division within the former Department of Social and Rehabilitation 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 targeted specialized therapeutic services.

Opportunities

The establishment of the Child Development Division (CDD) provides an opportunity to reevaluate the array of child development services and the funds supporting them, and to create a true continuum of primary prevention and early intervention services by establishing a system to support all children and families at the level of intensity needed and desired.

- STARS- Step Ahead Recognition System: The graduated system for childcare quality is based on a 5-star rating system. Incentives have been secured through private foundations and businesses.
- The establishment of the Northern Lights Career Development Center: Provide coordination and integration of professional development opportunities in Vermont, resulting in a higher standard of instruction and more consistent support for professional development.
- The creation of the Vermont's Alliance for Children - Building Bright Futures: This initiative will lead to an infrastructure for the early childhood system that will pursue private as well as public funding to enhance early care, health and education services.
- Aligning the Family, Infant and Toddler Program, the Children's Upstream Services, the Early Childhood Mental Health Program and Healthy Babies, Kids and Families in one division allows for implementing a model for early intervention services that includes designated early intervention teams in each region of the state.

As CDD works to define the priorities for the new division, new opportunities for exploring the use of a primary interventionist model for early intervention services are emerging.

Pressures

Recruitment and retention of qualified staff:

- A lack of qualified candidates and non-competitive salaries are prime reasons for an unstable and inadequate child care workforce.
- Limited higher-education opportunities in Vermont for early interventionists and allied health specialists, such as speech therapists, have resulted in serious shortages of therapists and early childhood special educators throughout the state.

Access to services:

- The demand for regulated child care continues to exceed the supply of care.
- Therapeutic child care programs are established in only four of the twelve AHS districts.
- Lack of qualified staff limits access to appropriate early intervention services for children with special needs.

Pressures, continued

Inadequate resources to accommodate increasing demand and utilization:

- The state childcare subsidy rates are far below market rates for most care statewide. This is having an adverse impact on access to care and on the financial stability of providers.

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

	Licensed	Registered	State Subsidy Rates	
			Licensed	Registered
Infants	$143.20	$106.54	$118.30	$97.85
Toddlers	$135.96	$101.17	$118.30	$97.85
Preschool	$126.86	$98.77	$105.10	$84.65
School-Age	$108.83	$87.72	$105.10	$84.65

- The child care subsidy fee scale has not been adjusted for federal poverty guidelines since 1999. This limits access to benefits for eligible families.
- The number of young children with serious behavioral disorders and developmental delays is increasing at a time when state and federal resources are limited.
- While a record number of children have access to the child care subsidy program, the 2006 budget will freeze caseload at the 2005 level.

Medicaid requirements complicate billing.

- Many of the programs within the CDD rely on Medicaid as a funding source. Complex and convoluted methods for billing are used by the various programs. Developing comprehensive and consistent methods for maximizing Medicaid funding will be a challenge.

Accomplishments

The Bright Futures Information System has been developed, is being piloted and will be fully implemented by June, 2005. This system was designed as a child care information system with the capacity to expand and accommodate the new programs and services that are now part of the CDD.

Seven programs that resided in other departments of AHS have been successfully integrated into CDD, creating the capacity to redesign the child development service system for Vermont.

CDD has joined with our state and community partners in a facilitated process known as Appreciative Inquiry to establish the mission, goals and priorities for the new division, resulting in much stronger relationships with these partners.

The Bright Futures Facilities Fund, managed by the Vermont Community Loan Fund, leveraged over $6,000,000 in other funds with the $200,000 appropriated in SFY 04 for improving child care and youth program facilities.

Caseload and Cost Data

Child Care Caseloads:

- The regulated child care system annually serves 38,000 children, from birth to 13 years old.
- The Child Development Division regulates 2,845 programs that employ over 5,000 people as part of the child care industry.
- About one-third of Vermont's children in regulated programs are receiving care for eight to nine hours a day.
- Over 5,600 Vermont families received consumer education and referral services from local child care Resource and Referral agencies supported by the Child Development Division.

Child Care Subsidy Program

Fiscal Year	2001	2002	2003	2004	2005
Subsidy Population	4,805 FTE	4,979 FTE	5,002 FTE	5,366 FTE	5,929 FTE
$$$$	$21,782,248	$24,921,294	$24,921,294	$26,5000,345	$31,336,032

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.

Opportunities

Improving performance and workload efficiencies by developing a data driven, decision support system.

During the final year of a three-year, federally funded research and demonstration project, OCS developed a comprehensive child support performance management and information system, enabling workers to use data and reports to improve decision-making regarding case processing. The decision support system has already allowed managers to improve arrears management and case closure, and has enhanced program performance and productivity. The project is expected to:

- Improve efficiencies in caseload management;
- Improve child support collections;
- Improve services and program operations; and,
- Serve as a model for other child support agencies and a guide to other departments in Vermont.

Enhancing OCS's use of E-government to further improve the quality of customer service.

OCS is constantly enhancing its web site to improve the quality of customer service. This interactive site provides instant input and retrieval of individual case data. Parents can use their Personal Identification Number (PIN) to access case information such as payments, disbursements, scheduled court hearing dates, and other account information. Parents can also report information such as a change of address or employer. Users

Opportunities, continued

can order applications or publications, request help by e-mail, and view the parent handbook, among other features. Employers are able to input information critical to the collection of child support. Customer comment cards, available on the website, indicate that customers are very pleased with the interactive nature of the website and their ability to use the Internet to get case information. Recent updates have increased employer interactive functions. These include electronic notification of wage withholding, availability of health insurance and employment verification forms, and a web-based "wizard" to assist employers in completing health insurance enrollment forms.

Enhancing OCS's ability to collect medical support for children and reduce Medicaid costs through a collaborative effort by OCS, Economic Services Division (ECS), and the Office of Vermont Health Access (OVHA).

DCF, through OCS and ESD, is planning to join with the Office of Vermont Health Access (OVHA) to implement a comprehensive joint program for the establishment and enforcement of medical support for children on Medicaid with an absent parent who has private health insurance. The major benefit of this collaborative effort will be improved coverage for children as private health insurance can provide coverage flexibility for families. Also, the medical support proposal will generate Medicaid cost recoveries to offset the costs. While this initiative has its obvious benefits, it is also a federal mandate. Failure to implement medical support would result in a loss of incentive funding as well as penalties to the TANF block grants of up to 5% of $47.3 million. Crucial to the initiative's success is the addition of key staff to OCS, ESD and OVHA to implement a comprehensive approach to medical support across the state.

Pressures

Management of continually rising caseloads with fixed or declining resources will continue to put pressure on OCS's ability to provide services.

Title IV-D of the Social Security Act requires states to have child support programs. In Vermont, OCS is the sole organization responsible for the child support program, and child support is the only program within the Office. OCS must, under federal and state law, provide the complete array of existing services, regardless of budgetary circumstances. All applicants for services must be accepted. With rising caseloads and the possibility of reduced resources, collections and the federal funding based on performance incentives may be in jeopardy.

Reduced general fund resources may have an adverse impact on Vermont's families and on public assistance recovery efforts.

In SFY 2005 the OCS General Fund appropriation of $1.37 million is expected to generate an estimated $54.2 million in child support collections in addition to other services such as parentage establishment and medical support enforcement. The collections alone return nearly 40:1 on the State's GF investment. Any reduction in staff has a concomitant reduction in collections. Reductions in child support collections affect fragile families who rely on child support to sustain them. Without child support they are more likely to need public assistance.

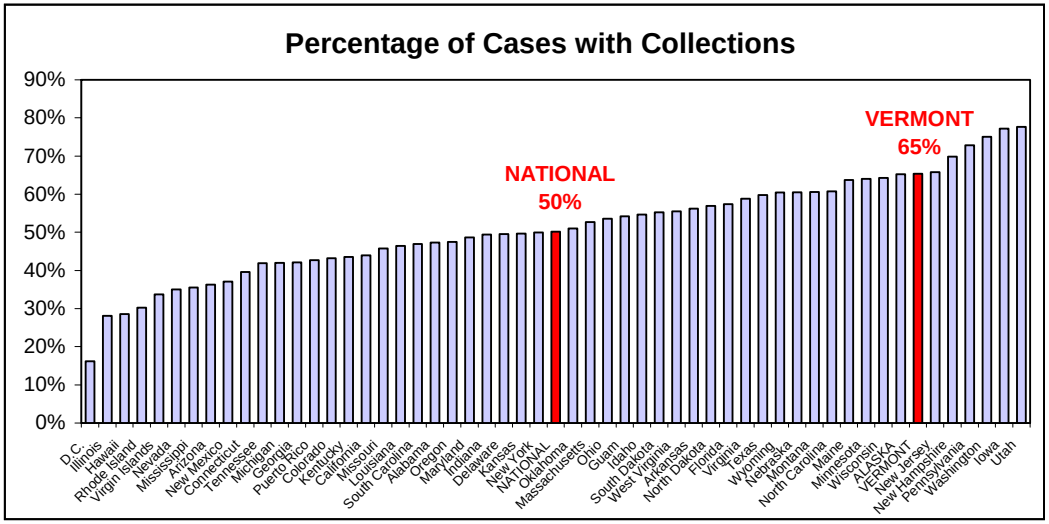
Receipt of federal incentive funds depends upon our maintenance of collection activities.

OCS operates on both state and federal funding. Federal incentive funds are based on the state's performance. Vermont earns incentive funds of approximately $1.2 million 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. These incentive funds come from a capped pool of federal funds and are affected by the performance of other states.

Accomplishments

OCS is a national top performer: OCS 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 and parentage orders and locating missing non-custodial parents. For many years, OCS has ranked as one of the top ten programs in the nation for cases with collections, far outperforming the national average.

Child Support Enforcement is a complicated process with many actions required to move cases along. Among other things, staff must file court actions, appear in court, record the terms of court orders and process employer wage withholding notices and payments. 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 are also required.



U.S. Senate Productivity Award - Ongoing Commitment to Quality: For several years, OCS has worked with the Vermont Council for Quality (VCQ) to improve quality and services by adopting a strategic plan and adhering to the Malcolm Baldridge Performance Excellence Criteria. In May of 2001, OCS was honored with the U.S. Senate Productivity Award, presented by the Vermont Council for Quality, for achieving the largest demonstrated productivity gain over the previous year. It was the first time this award was given to a government agency. OCS continues to work with VCQ and recently completed its 4th. survey in 2004. The score OCS achieved makes OCS eligible for a Governor's Award.

Special Improvement Project (SIP) Grant Award: In August 2004, the Administration of Children and Families awarded OCS a $100,000 federal grant for a project entitled "Web-Med Support" to: (1) increase compliance with medical support provisions in child support orders; (2) increase enrollment of children in health insurance plans through employers of non-custodial parents; and (3) reduce Medicaid costs by moving as many children as possible off public assistance onto private insurance. OCS was the nation's only grant recipient in the funding category "Ensuring Children Receive Parental Financial/Medical Support."

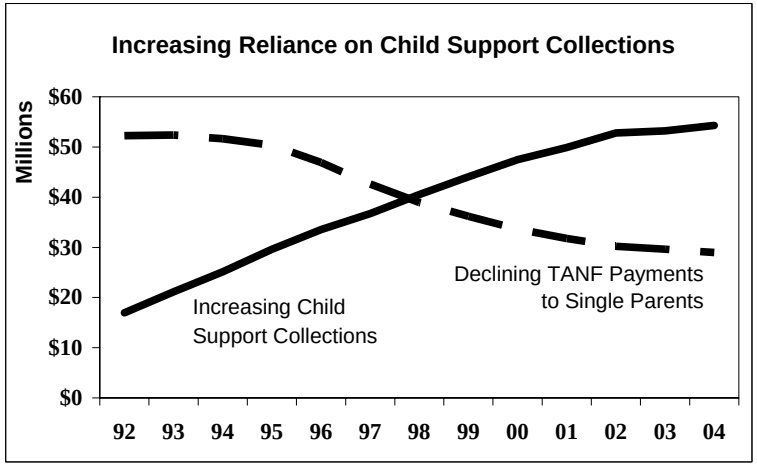
IT Visionary: OCS was named as one of 100 Top Information/Technology (IT) Visionaries for 2003 by "InfoWorld" Magazine, San Francisco, California. The designation was awarded for OCS's child support Business Intelligence (BI) System, a global organizational management component to OCS's Decision Support System (DSS).

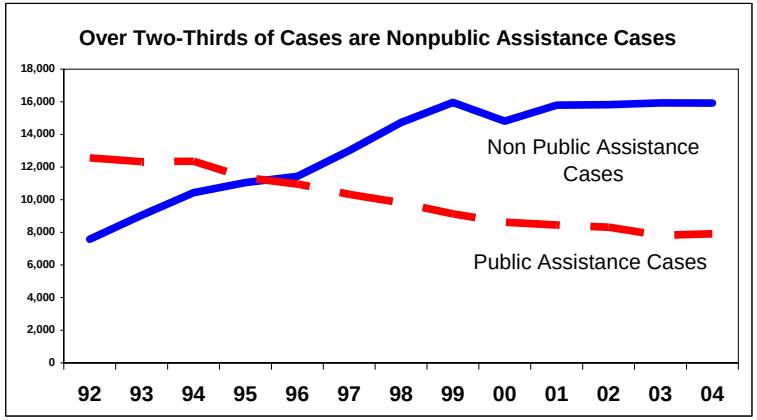
Outstanding Program Achievement Award
In August of 2001, OCS was honored as a finalist for the Outstanding Program Achievement Award given by the National Child Support Enforcement Association to a state or county program for consistently providing effective services to its constituency and community.

Accomplishments, continued

Child support is increasing in importance 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 (TANF) 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 2004, 15,926 OCS cases were non-public assistance cases and 7,909 were 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.

Last year, the Office of Child Support:

- Collected in 65% of its cases.
- Collected $54,285,016 in support payments (SFY 2004).
- Handled over 25,500 cases.
- Responded to over 346,000 calls through its automated phone service with over 72,000 calls answered by our customer service representatives.
- Scheduled over 7,800 court appearances.
- Entered approximately 8,400 new or modified court orders on the computer system.
- Averaged 850 cases per child support specialist.
- Processed over 456,470 payments.

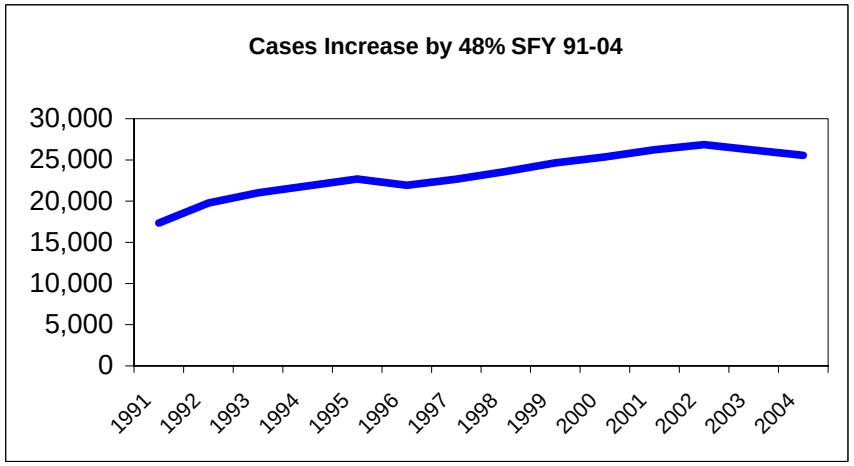
Caseload and Cost Data

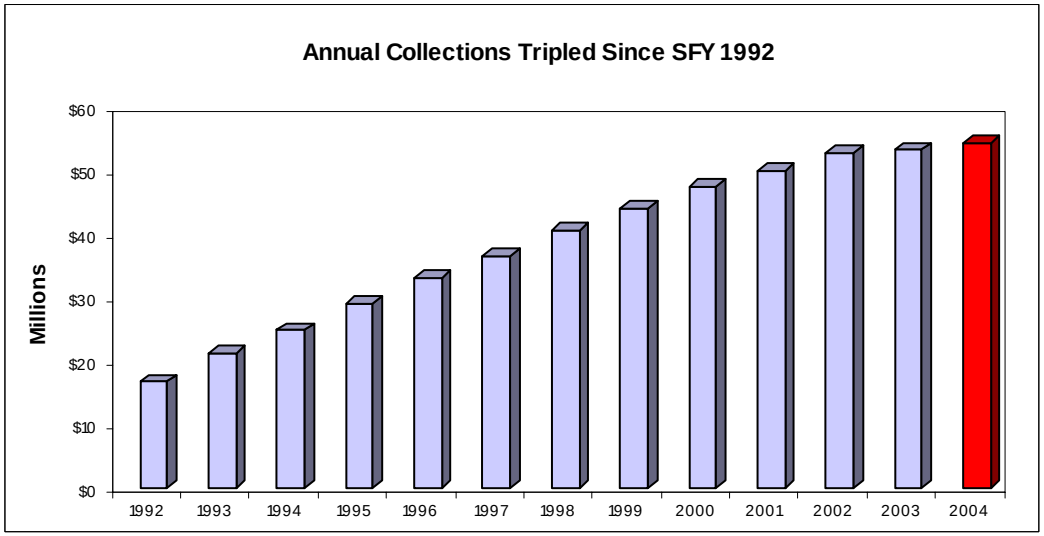
Growth in Cases

Vermont's out-of-wedlock birth rate increased greatly from 13.9% in 1981 to 32% in 2002. There were also 2,653 divorces in Vermont in 2002 with 1,307 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 48% from 1991 to 2004. The Office currently has over 25,500 cases.

Growth in Collections

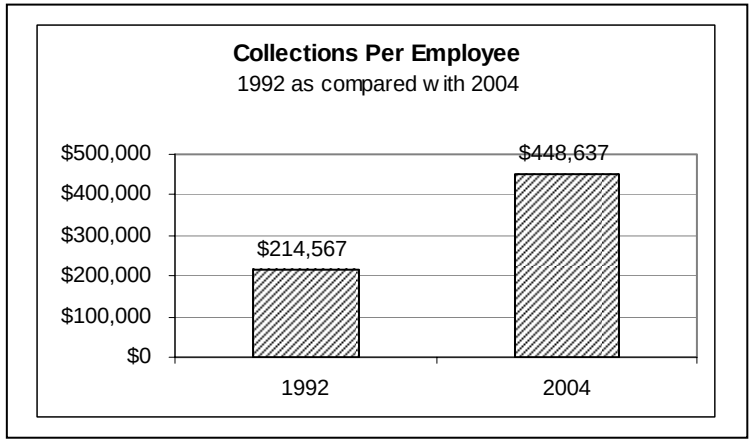
Since its creation as a separate entity in 1990, OCS has continually increased collections. Annual collections have increased by 324% since 1992 to $54,285,016 in state fiscal year 2004. Total collections in the last 13 years are $503,900,448.





Growth in Collections per Employee – More than doubled since 1992

In 1992, the amount collected per employee was $214,567. By 2004, that amount had risen to $448,637. 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.

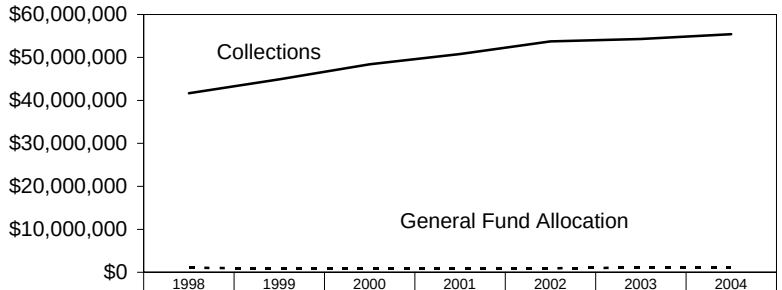


Caseload and Cost Data, continued

In state fiscal year 2004, OCS had just over $1.1 million appropriated from the general fund. This investment generated almost $54.3 million in child support collections that supported families or recovered public assistance expenditures.

In 1998, Child Support's general fund appropriation was $1,065,516. Seven years later it was $1,114,864. Though state funds increased by only 4.6%, collections were up 33.8%. In that seven year period, the state's $6.8 million in appropriations has reaped over one-third of a billion dollars in child support collected for Vermonters.

OCS Collections up 34%- General Fund Expenditures up 5%



	1998	1999	2000	2001	2002	2003	2004
Collections	40,586,163	44,068,650	47,464,925	49,911,479	52,810,417	53,221,762	54,285,016
General Fund	1,065,516	834,874	934,128	878,370	932,556	1,086,425	1,114,864

Family Services Division

Our mission 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 DCF Field Services Division and the Agency of Human Services to achieve articulated outcomes for children and families. Division staff in the field and central office are actively exploring ways to realize the themes of the reorganization.

Opportunities

- The AHS reorganization has created opportunities to find new answers to old questions. New collegial relationships are being forged within and beyond the new DCF.
- A Child Safety Unit has been created to promote quality and consistency of practice in intake, report acceptance, assessment of safety and risk and substantiation decisions.
- The staff of the Juvenile Justice Commission joined DCF on October 1, 2004, bringing with them the opportunity to strengthen the agency's focus on youth justice. The division's new the Youth Justice Unit has developed a plan to implement the recommendations of the Juvenile Justice Commission.
- The division will implement a comprehensive assessment process for all children entering custody, early in 2005. Our goal is to improve the quality of planning for children and their families, thereby improving outcomes.
- Division staff are working together to focus on the need for permanent connections for all children leaving our care and supervision, in the form of one or more meaningful relationships with adults. Staff around the state have volunteered to work in creative ways to achieve this goal.

Pressures

- Increases in substance abuse and domestic violence in Vermont negatively affect children, youth and families–and precipitate DCF intervention. Often, these families' circumstances result in a neglect or risk-of-harm substantiation.
- Implementation of child abuse registry checks for employees who will care for children or vulnerable adults has resulted in as many as 100 checks per week, generating increased work for staff.
- Children and youth committed to the care and custody of the state are increasingly in need of significant and on-going mental health and substance abuse treatment.
- The custody population continues to age: over 60% of children in custody are 12 and older. This requires adjustments to our current systems for placement and treatment.
- IV-E eligibility and receipts continue to decline, as federal law has "frozen" income standards at 1996 ANFC limits and 2001 regulations.
- Social work practice and on-going staff development will need to be better geared toward assuring defined outcomes for children and families.
- Assuring adequate numbers of resource families who have the necessary skills to nurture children with complex behaviors and needs will continue to be a challenge.
- Currently, we provide supports to over 1200 adopted children with special needs. These children, often adopted at an older age, continue to need supportive services after adoption. Resources have not kept pace with this need.

Accomplishments

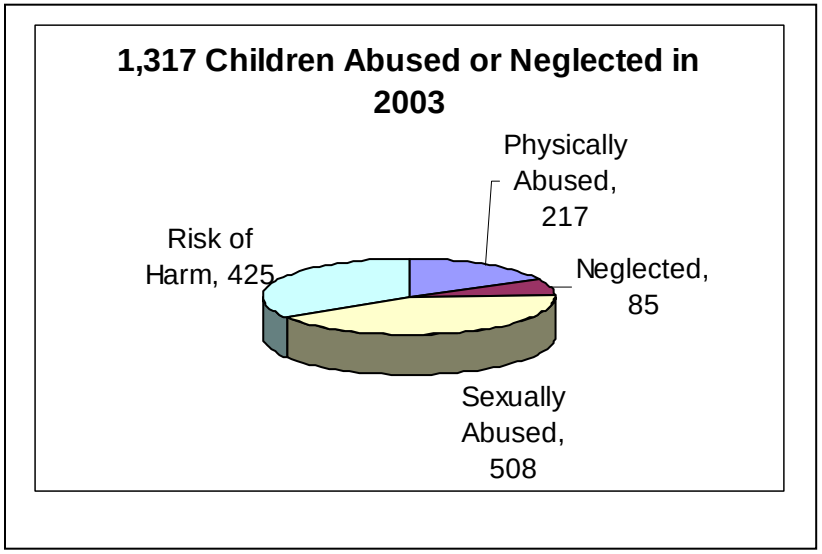
- In July 2004, FSD became the first state child welfare agency to successfully complete a program improvement plan focused on safety, permanency and well-being for children and families served.
- Seven district reviews have been completed as part of the division's new quality assurance system. District reviews engage staff, community stakeholders and clients in assessing the quality of practice and collaboration. Strengths have been identified. A key challenge across all districts is high workload.
- Across the state, the use of Breakthrough methodology for rapid change is resulting in more successful recruitment of foster families to care for children in custody.
- Project Family, a joint venture between DCF and the Lund Family Center, is focusing on finding adoptive homes for older children, and on improving timeliness of adoptions. DCF finalized 217 adoptions in 2004, the most ever in a calendar year.
- We have established a partnership with the Vermont Student Assistance Corporation to ensure that young adults formerly in custody receive the benefits for higher education offered in 2004 by Emily's Bill.
- A partnership with VCHIP has focused on early assessment of health needs. It has been very successful in four districts. Key to this success has been the co-location of VDH public health nurses in FSD district offices.
- New materials developed in collaboration with KidSafe in Chittenden County are enhancing our training of mandated reporters.
- Our ongoing partnerships with Vermont congregations result in the provision of concrete supports for children and families, as well as less tangible benefits such as mentoring opportunities.

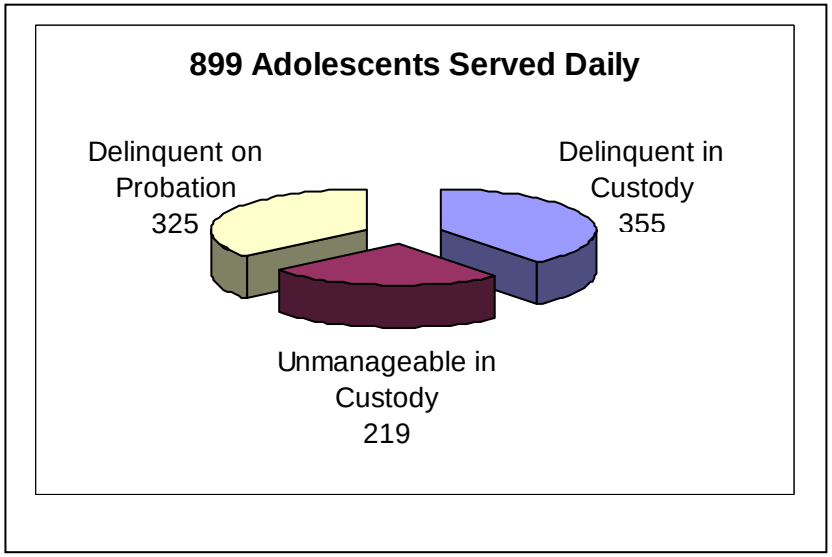
Caseload and Cost Data

On any given day, about 1,300 children and youth are living in out-of-home care provided by the division. On September 30, 2004, there were 849 in foster family care; 145 with relatives (kinship care); 20 in independent living programs; 251 in residential programs, including 57 in specialized, out of state programs; 30 placed at Woodside (including short-term detention and long-term treatment).

In 2003, 1,317 children were abused or neglected. 217 were physically abused, 85 were neglected, 508 were sexually abused and 425 were at risk of serious harm.

In 2003, on an average daily basis, 899 adolescents were being served due to their delinquency or unmanageability.





Office of Disability Services

The 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

The Office of Disability Determination Services (DDS) serves Vermonters who apply for disability benefits under the Social Security, Supplemental Security Income (SSI), and Medicaid programs.

Opportunities

- DDS continues its collaboration with the Social Security Administration to enhance service to Vermonters with disabilities and to ensure stewardship of disability programs and public funds.
- Reorganization has provided DDS new opportunities to collaborate with other segments of AHS to better serve Vermonters with disabilities. Collaboration with such entities as the Interagency Council on Homelessness, the Work Incentive Advisory Panel, and Vocational Rehabilitation Reach-Up Counselors is helping to improve the disability claim process and outcomes for Vermonters.
- Social Security is proceeding with its conversion of its paper disability claim files to an electronic format. Although the transition will be resource-intensive, DDS has the opportunity to reinvent and enhance business processes.

Pressures

- The transition to electronic claim files and business processes will slow DDS case-processing time in the short term. DDS must maintain cumbersome dual processes (paper and electronic) for several years. The electronic conversion of paper records will be resource intensive until more Vermont healthcare sources develop electronic record transmission capability. Ergonomic issues may arise with the DDS workforce, as adjudicators must adapt to reading a large volume of medical records on a computer screen.
- 77% of DDS adjudicators have less than two years of experience. The limited number of experienced adjudicators must handle case processing responsibilities and staff development, mentoring and training. This is also the case with the DDS program technical staff, half of whom require additional training.

Accomplishments

- In federal FY 2004, Vermont applicants for Social Security Disability received a DDS medical decision 25 days faster than the national average. SSI applicants received a DDS decision 28 days faster than the national average.
- The Vermont DDS continued to be the best in the nation in early, accurate SSI allowance predictions that provide expedited benefit checks to SSI applicants prior to a final decision. For FY 2004, DDS provided early benefits to 85.5% of eligible SSI applicants (compared to only 21% nationally).
- During federal FY 2004, the DDS was ranked 7th in the nation for accuracy. At the same time, it processed almost 1300 more cases than it had in 2003. Per-employee productivity increased by 19%.

Caseload and Cost Data

DDS serves the public by making prompt, program-accurate decisions of medical eligibility for disability benefits under Social Security and Supplemental Security Income (SSI). In addition, a small part of the DDS workload (5% in FFY 2004) involves determination of medical eligibility for Medicaid. The full cost of federal claims processing is borne by the federal government.

Federal Fiscal Year	2001	2002	2003	2004	2005 (projected)
Processed Claims (SSA & Medicaid)	6647	5939	7184	8478	8750
$$$ (SSA & Medicaid)	$2,865,522	$3,090,941	$3,060906	$3,179,384	$3,634,589

Office of Economic Opportunity

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

Opportunities

- OEO continues to establish strong partnerships with a variety of community-based organizations. It also works closely with the Department of Economic Development and Vermont Economic Development Authority (VEDA) to help create new job opportunities for low-income Vermonters. In addition, OEO works closely with a number of housing organizations to increase the availability of affordable housing throughout Vermont.
- Innovative programs such as Individual Development Accounts (IDAs) have demonstrated positive outcomes for low-income working Vermonters, enabling them to acquire assets that help move them out of poverty. Last year there were 337 participants, allowing 48 withdrawals for post-secondary education, microbusiness and home ownership. Six people who purchased homes.
- Organizations receiving grants are becoming increasingly sophisticated in their ability to use outcomes-based approaches to gauge effectiveness.
- The Weatherization Trust Fund was reauthorized until June 30, 2008. Increases in funding from the U.S. Department of Energy and successful leveraging activities have stimulated an aggressive ramp-up in weatherization activities statewide. Vermont's weatherization program continues to lead the nation in instituting innovative and cost-effective methods for improving energy efficiency for low-income peoples' homes.
- The federal Community Services Block Grant (CSBG) was reauthorized in 2003. This grant, estimated to be $3.2 million in 2006, provides the "core" funding for Vermont's five Community Action Agencies and is key to providing a host of anti-poverty services to more than 40,000 Vermonters each year.

Pressures

Homelessness plagues many Vermonters.

Families with children are found in increasing numbers in homeless shelters. Homeless shelters, Community Action Agencies and other service providers struggle to find decent housing – at any price – for the large number of working, but homeless, families. Living in shelters and being homeless has a negative effect on children. As shelters reach capacity, more and more Vermonters are turned away, ultimately living on the streets or on someone's couch. Transitional housing with supportive services can alleviate some of this pressure.

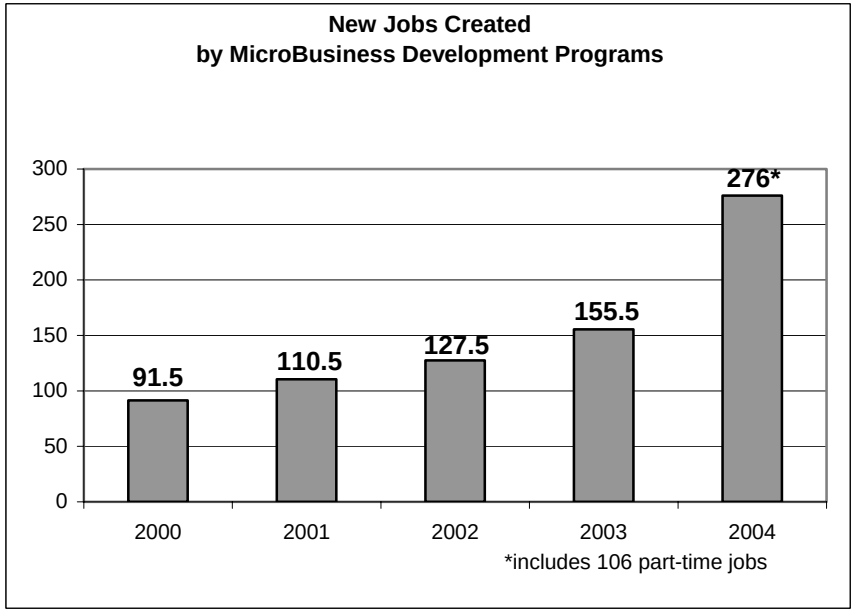
Rising housing costs are a huge burden.

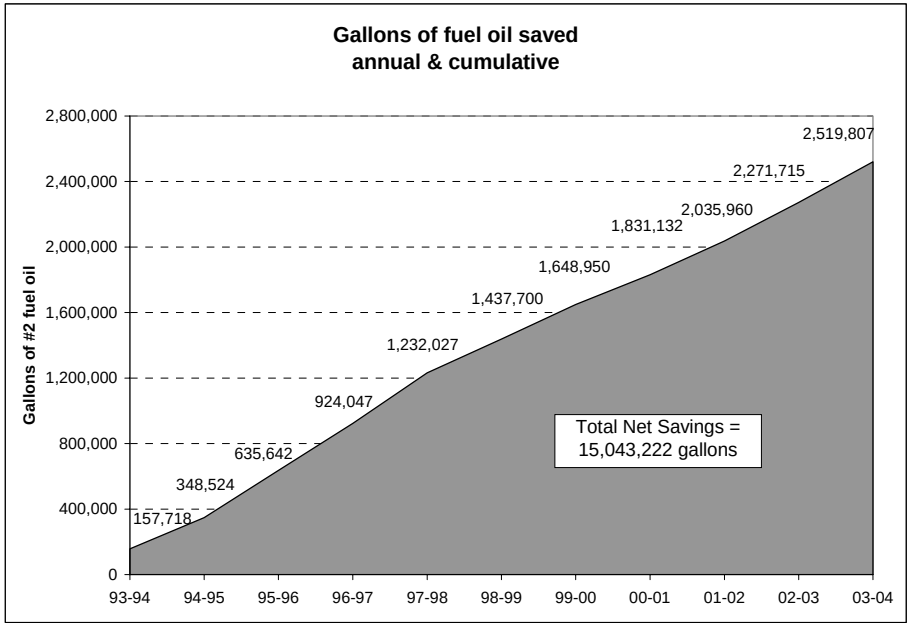
Many Vermont families pay 50 - 75% of their monthly income just to have a place in which to live. As housing costs continue to rise, more and more working Vermonters are caught in this housing "squeeze."

Poverty is a nagging problem in Vermont.

During the '90s, the number of Vermonters at or below the federal poverty level (currently $18,850 for a family of four) rose by 3.6%. We counted 48,483 people in poverty in the 2000 census, causing constant pressure on our emergency service delivery system.

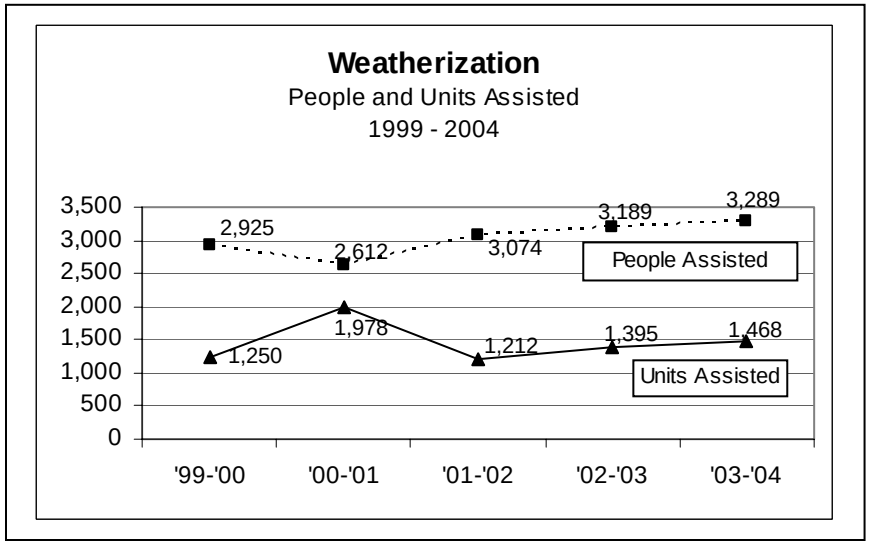
Accomplishments

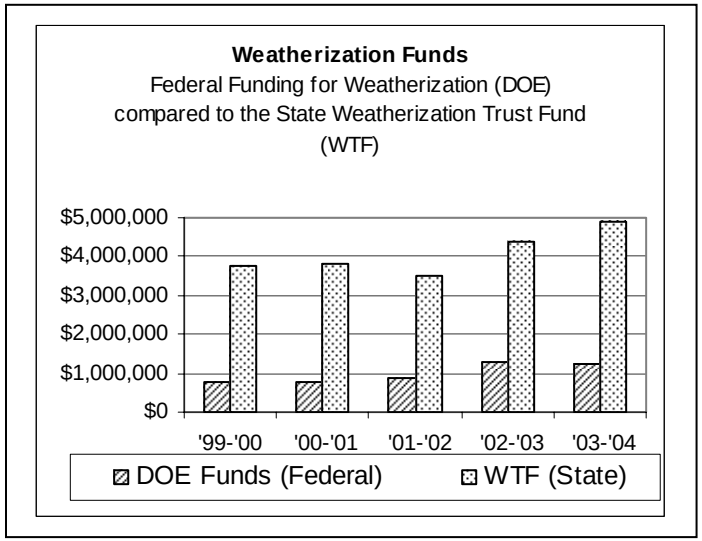




Caseload and Cost Data

OEO seeks to increase the self-sufficiency of Vermonters and strengthen Vermont communities by working in close partnership with over 40 community-based, nonprofit organizations to provide a range of services. These services are aimed at reducing the negative effects of poverty and at strengthening community and other supports, which help Vermonters lift themselves out of poverty.





Economic Services Division

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

Opportunities

Premiums for health care programs

The phase-in period was extended to ensure a smooth transition and to help beneficiaries acclimate to a monthly premium before more stringent requirements are implemented. Enhanced payment options, such as automatic deduction from banks and credit card payments, were implemented in September 2004. Premium payments and enrollment terminations are being monitored in order to assess the impact of the premium program.

Computer-assisted training

The e-Learning Center, an interactive, web-based training environment, created in partnership with the State University of New York (SUNY), enables staff to access training information directly from their offices. Representatives of the federal Food and Nutrition Service are interested in replicating this training nationwide.

Pressures

Federal welfare reform reauthorization

Federal authorization for the Temporary Assistance for Needy Families Block Grant (TANF) – Vermont's primary funding source for the Reach Up program – expired on September 30, 2002. The current federal legislative extension continues funding through March 31, 2005. TANF reauthorization bills advanced to date all maintain level funding and intensify states' participation requirements. To comply with these anticipated changes, Vermont will need to:

- Increase the caseload work participation rate,
- Increase the number of hours participants engage in approved activities,
- Engage participants in approved activities sooner,
- Increase availability of child care, especially for younger children,
- Expand and modify information technology and data collection, and
- Provide more intensive services to help participants overcome barriers to employment in shorter time periods, or in conjunction with their participation in work activities

Reach Up funding

DCF's continuing efforts to improve Reach Up outcomes though evaluation and reallocation of resources will not be sufficient. DCF is searching for new resources to help meet the state's new obligations, including developing job and work placements across the state, funding additional childcare needs, and providing more intensive barrier-removal services.

Long-term-care (LTC) Medicaid administration

The increasingly complex financial situations of many applicants challenge the division to provide additional resources to assure the consistent and accurate administration of the program, including training, supervision, and access to legal assistance. Further legal analysis of federal rules and estate planning vehicles could also yield program savings through changes resulting in increased cost sharing by individuals or estate recovery receipts.

Medicare Modernization Act (MMA)

The MMA will most likely have a significant impact on the Medicare beneficiaries who also receive benefits through the Medicaid, VHAP-Pharmacy, VScript, or VScript Expanded programs. Transitioning beneficiaries to a new prescription drug program will require extensive outreach and education to beneficiaries and the public, data collection from beneficiaries, staff training, and systems and procedures redesign.

Medical support from non-custodial parents

Pursuing medical support from non-custodial parents, which is a mandate to the Office of Child Support, is an opportunity to increase parents' personal responsibility to support their children. The pressure is in the implementation of this initiative, which will require forms and procedure changes, collection of additional data from families, staff training, and the establishment of consequences for families who do not cooperate.

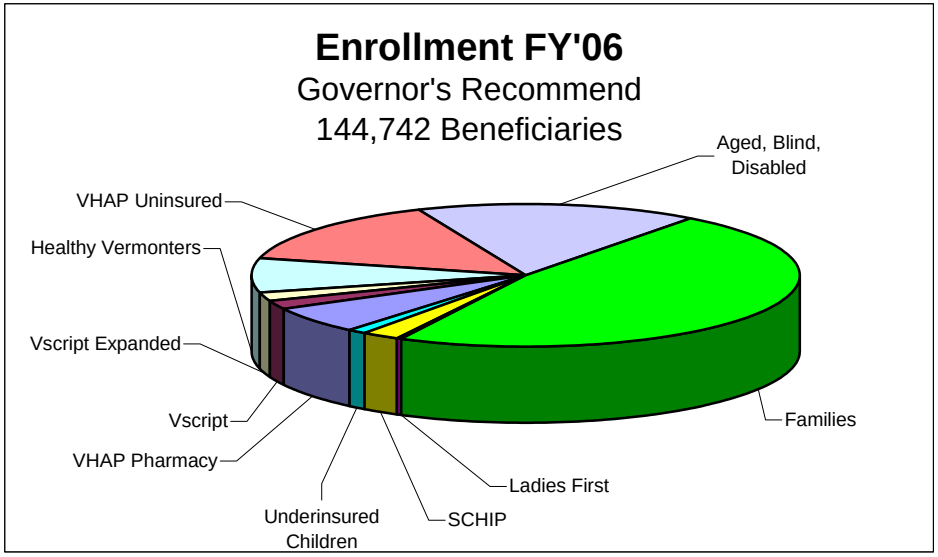
Pressures, continued

Stretching the heating dollar

Federal funding from the Low-Income Home Energy Assistance Program (LIHEAP) is not intended to meet the total cost of heating, but rather to provide supplemental assistance to households. For the 2003/2004 heating season, 18,268 Vermont families received assistance and approximately 5,500 households accessed help to avert a heating emergency. To date, 18,029 Vermont families have been granted seasonal benefits for the 2004-2005 season.

Accomplishments

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



Program	% Poverty Level	Monthly income for 1
Traditional Medicaid – in Chittenden County	N/A	$866
Traditional Medicaid – outside Chittenden County	N/A	$800
VHAP for uninsured and VHAP-Pharmacy	150%	$1,190
VScript (pharmacy)	175%	$1,389
VHAP for uninsured parents & caretakers; Transitional Medicaid for families leaving welfare	185%	$1,468

Program	% Poverty Level	Monthly income for 1
Dr. Dynasaur for pregnant women	200%	$1,587
VScript Expanded (pharmacy)	225%	$1,785
Working people with disabilities	250%	$1,984
Dr. Dynasaur for children under 18 -and- Healthy Vermonters (pharmacy – any age)	300%	$2,380
Healthy Vermonters (pharmacy – aged / disabled)	400%	$3,174

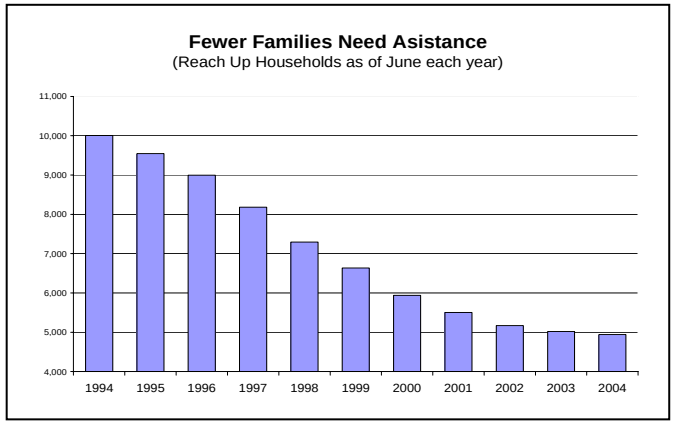
Accomplishments, continued

Families have successfully moved from welfare to work

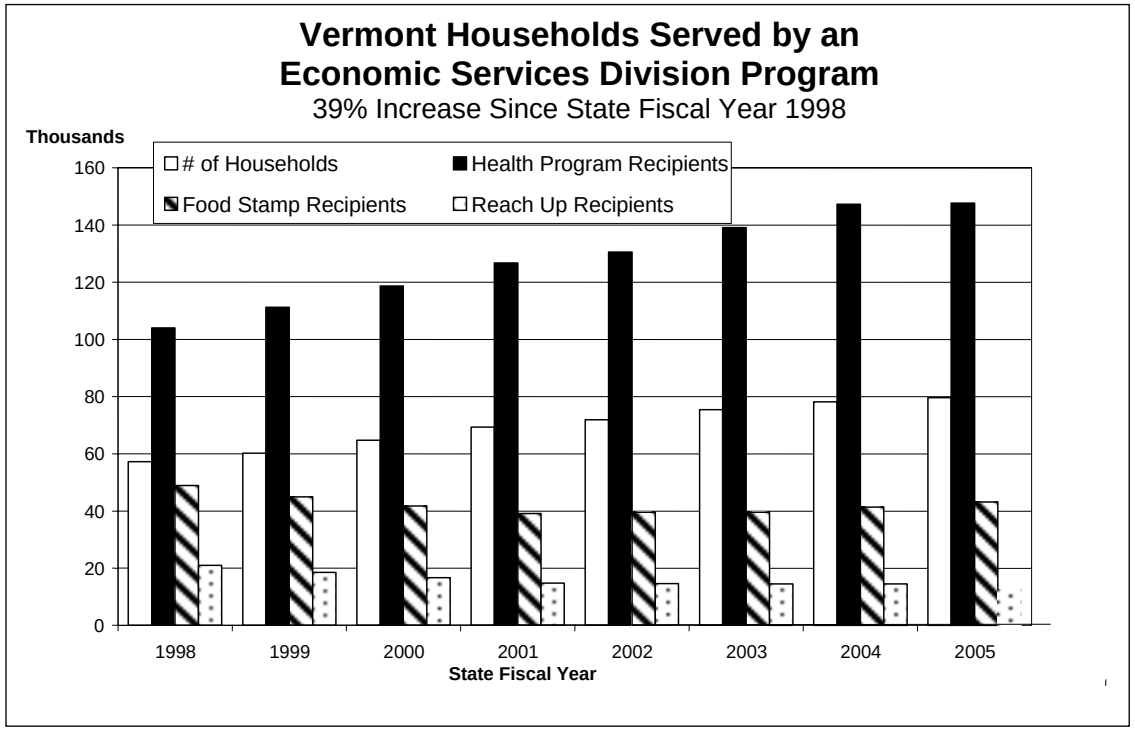
State and local partnerships resulted in new and enhanced programs without risking fiscal sanction for non-compliance with federal welfare rules. The Division began a redesign of its orientation and assessment process to provide a solid foundation for TANF is reauthorization.

Vermont earned $1.8 million in performance bonuses in FY'05 for ReachUp participants' job retention and earnings gains, and for the accessibility of Vermont's child care subsidies.

Case managers continue to prove themselves effective at helping Reach Up participants gain employment, maintain a stable caseload and assure the caseload reduction credit that Vermont needs to meet its federal work participation rate.



Caseload and Cost Data



Historical Data SFY 1998-2004 and Projected SFY 2005

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 ESD this year.

Caseload and Cost Data

Economic Services Division is here to help Vermonters find a path to a better life.

The Economic Services Division:

- Helps Vermonters stay healthy by connecting people to our health care programs.
- Helps put food on the table and improve nutrition. Food stamp benefits average $148 per family each month.
- Helps families go to work. Reach Up's financial assistance, support services, and intensive case management help families on welfare receive the skills and incentives they need to find meaningful work and get off welfare.
- Keeps Vermonters warm. 18,268 families receive fuel assistance during the winter.
- Provides extra cash for basic needs to 12,850 very low-income individuals who are aged, blind, or disabled, as a supplement to the federal Supplemental Security Income benefit (SSI).
- Helps 200 aged, blind, or disabled people stay in their homes by meeting expenses for live-in attendant care.
- Provides emergency assistance to approximately 2,256 individuals and families each month who have little or no income, or have a life crisis and need help with housing, prescription drugs, burial, and other basic needs through the general assistance program.
- Continues to help Vermonters sign up for the monthly telephone lifeline credit program.

Field Services Division

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

Opportunities

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

- *Respectful Service:* Creating a pervasive customer-friendly culture.
- *Access to Services:* Creating a clear and welcoming presence in the community and assuring that people who connect with the agency are guided to the assistance they need. Creating technology that supports easy access.
- *Prevention:* Working together with communities to promote healthy individuals and families.
- *Preventing Crises:* Intervening as early as possible to reduce the need for more intensive services.
- *Effective Service Coordination:* Assuring that individuals and families served by AHS programs have a service coordinator and well-coordinated interventions and supports.
- *Flexible Funding to address gaps in services:* Working to respond to need and to avoid "silo thinking" that creates barriers.
- *Collaboration with Key Partners*: Building on existing partnerships and promoting broader relationships.

Opportunities, continued

- *Support through Transition:* Building smooth bridges between programs defined by age, disability, or situation (e.g. pre-school to school, adolescence to adulthood, school to work, prison to community, hospital to community, etc.)
- *Continuous Improvement and Accountability:* Promoting a significant consumer voice in the process. Assuring tracking and addressing performance indicators related to our success.
- *Information Systems:* Establishing improved information systems to support a more effective and efficient system.

History/Mandate

For the past 35 years, human services in Vermont – as in all other states – have been organized around particular human problems. There have been Departments, Divisions, Offices and Units dedicated to economic problems, substance abuse, mental health, public health, child abuse, corrections, physical disabilities, developmental disabilities, aging, and every other imaginable disability or circumstance. In many of these areas, Vermont's programs have been exceptional–among the best in the country. Despite all of this good work, there are various indicators that demonstrate the failings of a system built primarily around programmatic silos.

Eighteen months of statewide inquiry produced a large body of information, indicating that despite specific programs that have been excellent, there are serious issues around respect, access, and service coordination. In addition, we realize that, as a state, we must become better at addressing problems earlier. Current financial trends in the areas of Medicaid and Corrections are not sustainable.

In May, 2004, our legislature authorized the Agency of Human Services to reorganize pursuant to the plan the Agency submitted to the Legislature. A State Advisory Group will oversee the process for a period of three years.

Population Served

The mission of the Field Services Division covers the full scope of the work of the Agency of Human Services. The whole concept is to begin to view the world through the eyes of actual and potential users of the system and through a community lens. The work of AHS Field Directors is not limited to a particular sub-set of the population, but rather is to assure that the system works for all Vermonters.

Major Programs/Activities

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

Field directors are charged with:

- Managing a consolidated district budget, with flexible funding authority, and overseeing a district global budget of all agency expenditures, including grants and contracts,
- Holding team members and local contract providers accountable for service standards and teamwork focused on client outcomes and prevention,
- Building excellent relationships with community partners, including schools, law enforcement agencies and non-profit housing developers, and
- Leading staff and partners, in conjunction with the regional partnership, to drive positive trends in the region.

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"The Department of Corrections is in the workforce development business. Helping offenders to become productive citizens is our greatest challenge, and our greatest responsibility. We cannot do it alone. We need help from communities, businesses, schools, neighbors, families, and friends."

Steve Gold, Commissioner

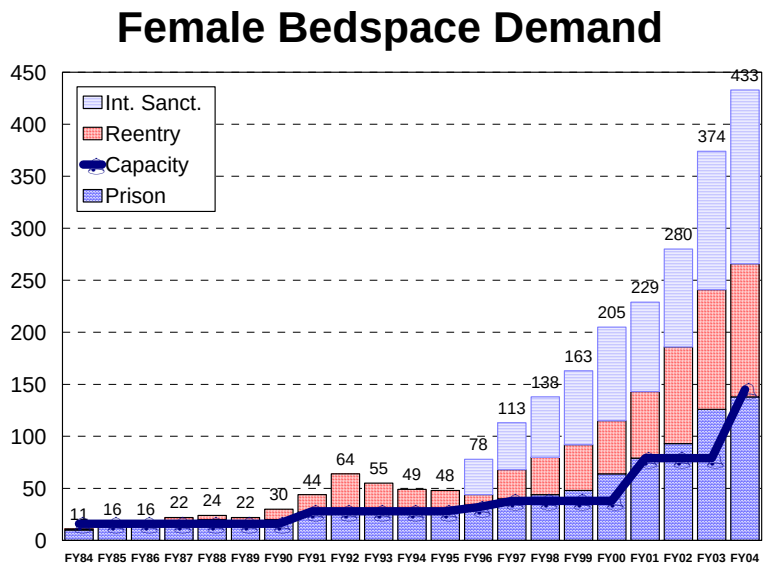
Department of Corrections

Number of Positions:	**1,142**
Funding SFY '06	
General Fund	$ 103,059,847
Health Access Trust Fund	0
Federal/Other	$ 9,151,924
Total	**$ 112,211,771**

In partnership with the community, the Department of Corrections supports safe communities by providing leadership in crime prevention, repairing the harm done, addressing the needs of crime victims, ensuring accountability for criminal acts and managing the risk posed by offenders. This is accomplished through commitment to quality services and continuous improvement while respecting diversity, legal rights, human dignity, and productivity.

The Department manages offender risk in partnership with communities, operates correctional facilities for the disciplined preparation of offenders to become productive citizens, and supervises offenders serving sentences in the community and reintegrates offenders after release. 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.

Prison Overcrowding: Women The criminal justice system is increasingly being used to respond to social issues beyond public safety, and for issues of health rather than crime. This is particularly true with women offenders, who are not nearly as likely to commit violent crime, but are more likely to 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, heroin in particular, they rely more heavily on a criminal justice response. The criminal justice response is often counter-productive and is more expensive, less responsive, less effective, and done at the expense of better alternatives. The women's population is growing faster than any other segment, at twice the rate of men. There are now 131 women in prison, up from fewer than 40 five years ago. In 2003, the Southeast Correctional facility in Windsor was converted from a men's to women's facility last year in response to this pressure. Beyond the number actually housed is the dramatic growth of women sentenced to intensive supervision in the community putting a larger number at risk of incarceration.



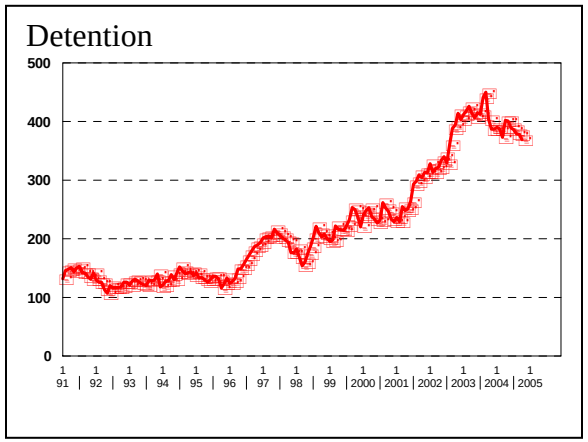
The Department of Corrections is building partnerships with community agencies and organizations to increase the availability of community-based interventions for this growing population. Issues of housing, employability, substance abuse treatment, and mental health services demand a community response from a restructured Agency of Human Services.

Prison Overcrowding: Men For the past ten years there has been an increasing demand for prison space, most evident in the courts' practice of using prisons to detain persons pending disposition. In the past year, with the cooperation of the courts the growth in detention has been slowed. The sentenced numbers have increased, but in the past year the total incarcerated number has been relatively constant.

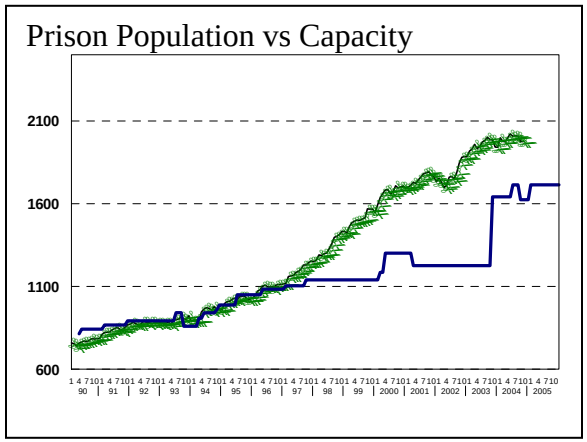
The Governor's Commission on Prison Overcrowding, in its report dated August 19, 2004, stated plainly the crisis facing the Vermont Department of Corrections:

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

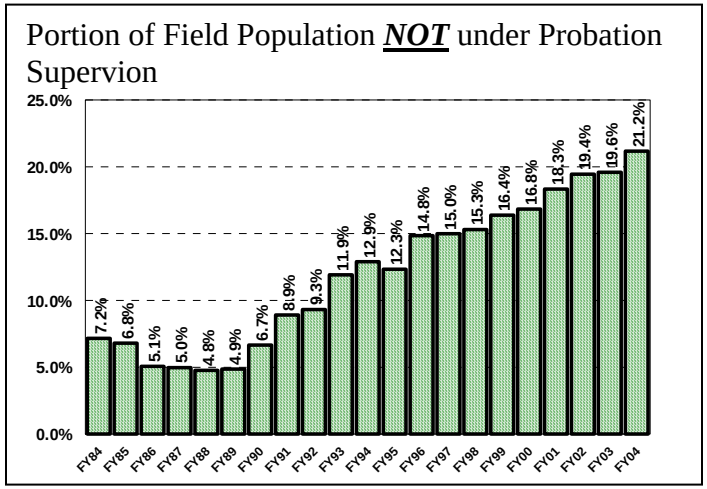
Solutions must include partnerships with Vermont communities and building infrastructures for informal social control within communities by adding resources, authority and legitimacy to community responses to conflict and dispute, as well as crime.



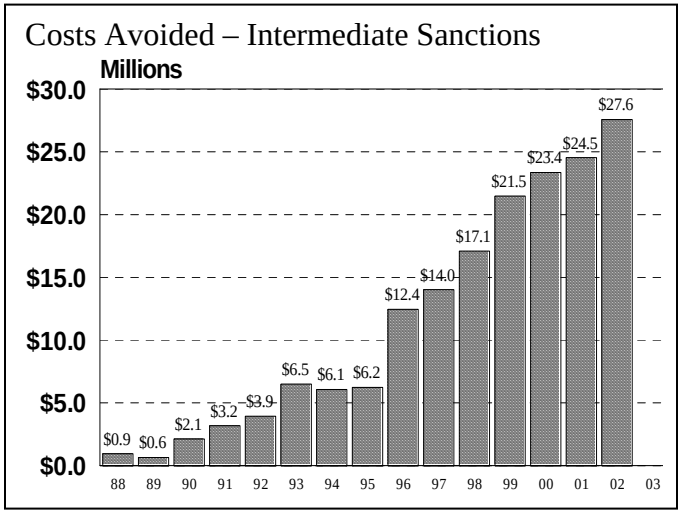
The population in jail detained waiting trial has begun to decrease, with the cooperation of the Vermont District Courts, State prosecutors, and the bar, working to reduce the length of stay prior to resolution. However, the sentenced population has continued to increase.



Overcrowding in Community Corrections: Corrections' biggest cost center is prison space. However, the vast majority (12,400 of a total of 14,500) of the population in custody is under supervision in the community. Increasingly, offenders are placed in the community on sanctions other than Probation. There is an expectation that Corrections will provide risk management and accountability for this population. However, the capacity to manage an increasing number of high risk offenders released from incarceration cannot be sustained.



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



The increase in intermediate sanctions and numbers of offenders on conditional reentry greatly impacts the costs of Corrections, as large numbers of offenders are diverted from incarceration at a fraction of the cost of prison. In FY'04, nearly half (48.5%) of the sentenced population was not in prison. If all of the offenders on intermediate sanctions were housed in prison, the costs would approximate an additional $26 million.

The complexity of needs presented by many offenders in the community requires the coordinated efforts of an array of human and community services, particularly with regard to housing, mental health, substance abuse, and employment opportunities. To a large degree, the restructuring of the Agency of Human Services, with returning inmates as a priority population, will allow the targeting of resources to this high-risk group.

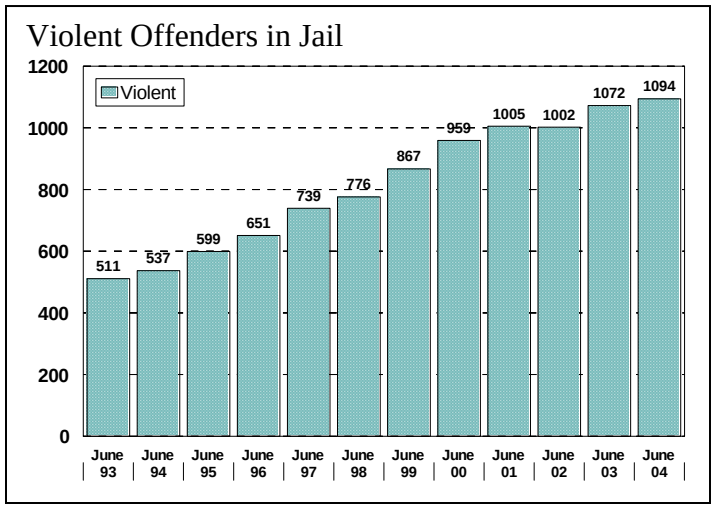
Accomplishments

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

Market Research
Vermont Citizens Survey
1994-2001

Safety from violent predators
Treatment for safe release
Accountability for the crime
Reparation of the damage
Involvement of the community
Quality of service

Performance Indicators:
Safety: Safety from violence is the fundamental expectation of the Vermont justice system. Prison space should, therefore, be reserved for violent and repeat offenders. To measure safety as an outcome we first measure the number of violent and high-risk offenders that are incarcerated. As sentences for serious offenses have increased, the length of stay has increased. Thus the number of violent high-risk inmates has increased. The average time served by violent felons has more than doubled in the past ten years.

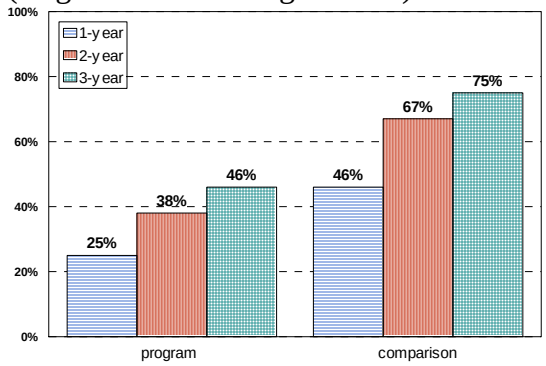


The number and severity of offenses by the prison population has continued to increase, as have sentences for both violent and non-violent offenders. Both the incarceration rate and the length of stay have increased. The result is that the numbers in the incarcerated population of inmates who have committed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

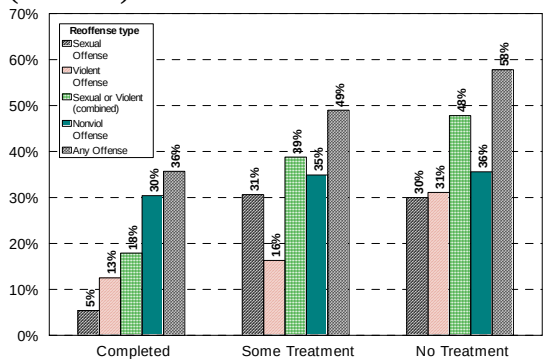
Accomplishments, Continued

Treatment: Vermonters overwhelmingly expect treatment programs for offenders. They don't expect treatment to work every time, but they do expect the Department to administer it. Treatment programs more than offset the costs of re-incarceration. The Cognitive Self Change program

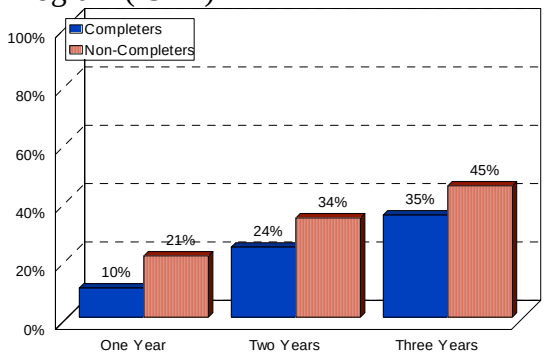
Reincarceration:Violence Program (Cognitive Self Change – CSC)



Re-Offense: Sex Offender Program (VTPSA)

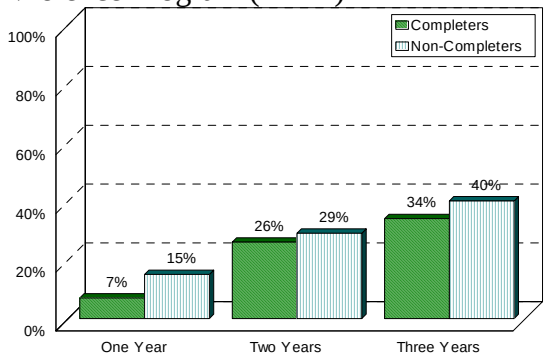


Reconviction: Intensive Substance Abuse Program (ISAP)

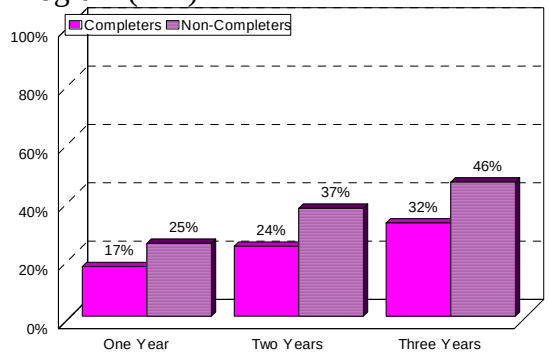


produces a 38% reduction (comparing the rates of completers vs. non-competers) in reincarceration; the Sex Offender Program produces an 83% reduction in repeat sexual offending; the ISAP program produces a 22% reduction in reconviction; the IDAP program produces a 15% reduction in reconviction, the BIP program produces a 30% reduction in reconviction, and the reparative probation program produces a 37% reduction in re-arrest (a different measure, but more significant).

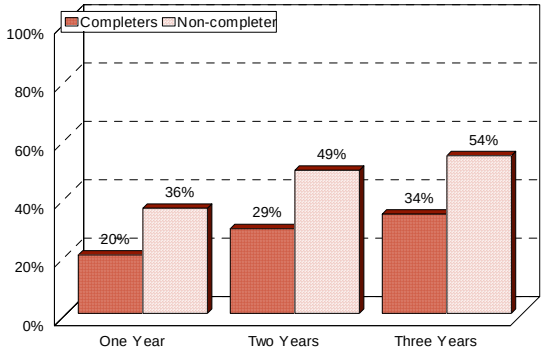
Re-Conviction: Intensive Domestic Violence Program (IDAP)



Re-Conviction: Batterers Intervention Program (BIP)



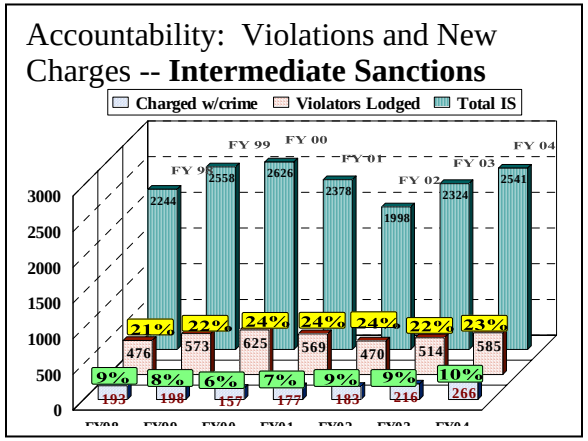
Re-Arrest: Reparative Probation

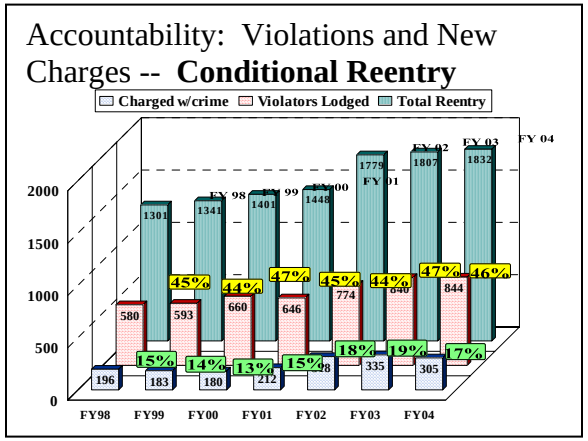


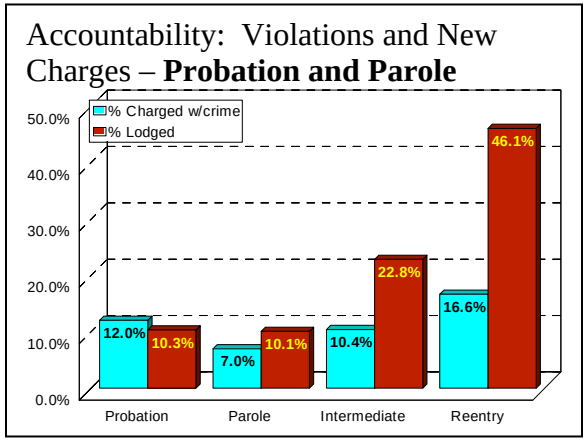
Accomplishments, Continued

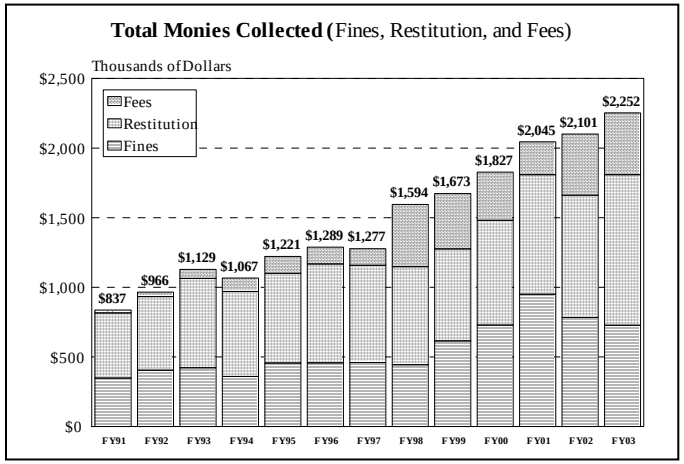
Accountability

In 1995, sentencing options were implemented to give judges alternative sanctions to incarceration. Judges could focus on reserving the most expensive resource (prison beds) on higher risk, violent, and repeating offenders. The Department holds offenders on re-entry to a high level of accountability. Half 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 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 necessarily only achieved through 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 the level of crime. Intermediate sanctions and conditional reentry are extremely successful at this strategy. The offender is found in violation of a condition of release, and brought back to prison for a graduated sanction, short of total revocation. This works. The offenders on these intermediate levels reoffend at levels comparable to those levels in the open community.

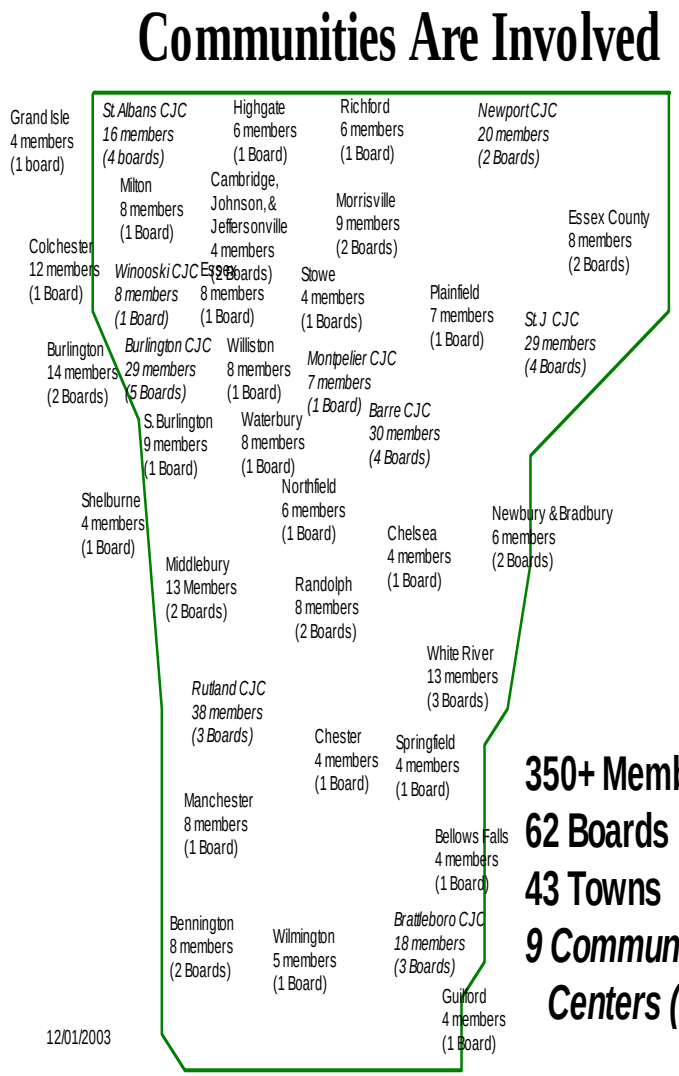
Reparation: Vermonters expect offenders to make amends. Repairing damage and adding value to communities is done by contributions of service to volunteer and non-profit organizations, by working in a correctional work program inside a facility, and by apologizing to their victims. Vermonters want good to come of the event and restitution to be made to victims.

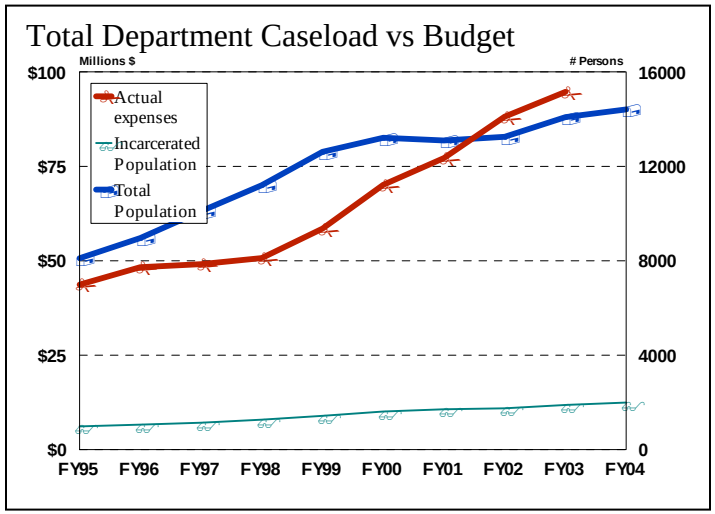
Accomplishments, Continued

Involvement. Vermont citizens amazed the Department with their desire to become involved in the system. More than 400 Vermonters have been reparative board members since the program began. This number continues to rise, and last year 1,537 cases were given Reparative Probation.

This approach uses the strengths of a community as the centerpiece and allows for informal social controls 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 with conflict and disputes early to divert conflict 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 borne 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 low cost to the taxpayer.



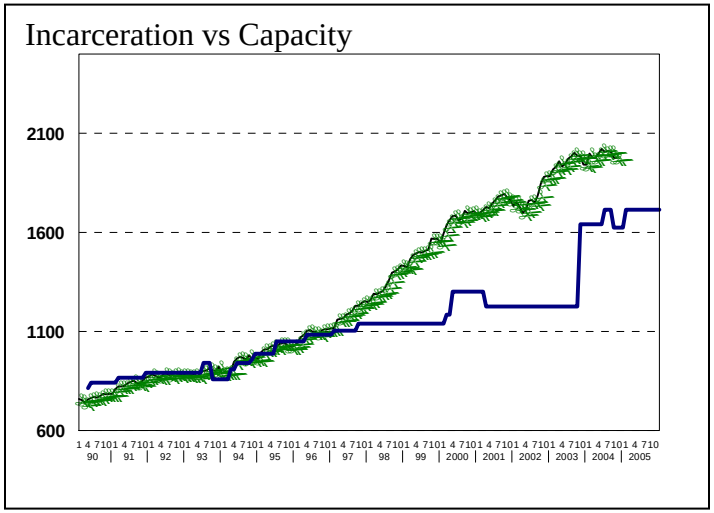


Caseload and Cost Data

Cost: The Department's budget has increased faster than most state agencies' for more than ten years. The total budget has increased from $25 million in FY1990 to $100 million in FY2004. The Department was able to hold growth in FY2003 to 0.6%, but only by closing the Woodstock facility and opening the Springfield facility in October 2003, which has substantially increased capacity, but has increased costs as well.

Total Caseload:
Since FY1995, the total number of individuals under the supervision of the Department of Corrections has increased 63%, from 8,107 to 14,088. The incarcerated population has more than doubled from 989 in 1995 to over 2,000 in 2003. The number of offenders on intermediate sanctions and furlough re-entry has increased five-fold, from 330 to 1,573. More than 44% of the sentenced population is **not** in prison.

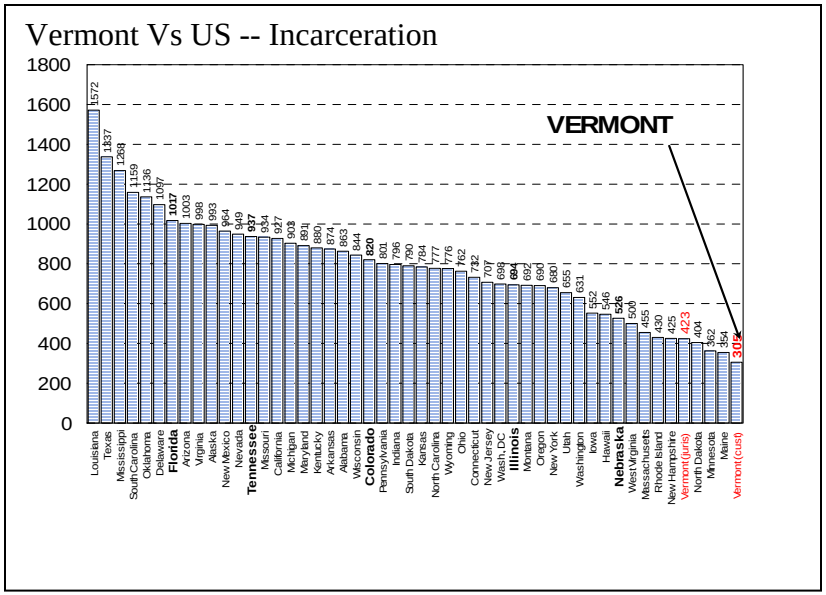
Incarceration:
Facilities are the largest cost item. This caseload has increased far beyond the Department's capacity. As a result, we contract to house over 400 inmates in out-of-state beds, primarily in Kentucky under a contract with the Corrections Corporation of America. The Southeast State correctional facility in Springfield opened in October 2003 and has provided significant relief. However, the overall housed population continues to grow at a rate that far exceeds the capacity of the system, even with Springfield at full occupancy. This results in a continuing need for the use of out-of-state bed space and continues to create the need for either the construction of significant new bed space, or major legislative or judiciary changes to reduce demand.

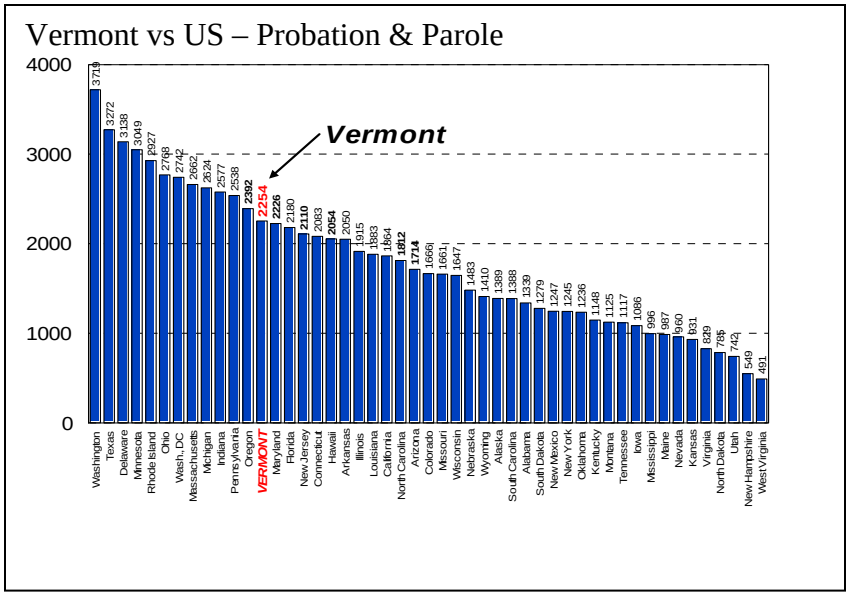


Caseload and Cost Data, continued

The primary source of cost savings on the one hand, and pressures for increased incarceration and state supervision in the community, is the disparity in criminal justice system response to crime. Vermont has one of the lowest crime rates in the nation, and the incarceration rate is the lowest. However, we also have, paradoxically, one of the higher rates of Probation in the nation. This rate translates into the very large number of citizens under the supervision of the State. While this is a form of social control that is relatively benign, it places a large population at risk of incarceration, and provides the pool from which incarceration is drawn. Incarceration is increasing as a portion of that total.

The result of the intersection of these two distributions, combined with increased sentence lengths, creates an ever increasing demand for incarceration.





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

Department of Health

Number of Positions:	**811**
Funding SFY '06	
General Fund	$ 64,115,288
Health Access Trust Fund	$ 421,655
Federal/Other	$ 152,611,721
Total	**$ 217,148,664**

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.

Opportunities

• **AHS Reorganization leads to "new" Department of Health**: Effective July 1, 2004, the mental health components of the former Department of Developmental and Mental Health Services were transferred to the Department of Health, and are now supervised by a deputy commissioner of health for mental health. This realignment constitutes state government's official endorsement of a public health approach to mental health treatment and care, as well as an endorsement of parity. Public health efforts focus on assisting individuals in getting the knowledge and skills they need to thrive. With respect to our mental health system, this will require that we continue support for the social, housing, employment, economic support, and recovery education components of treatment and care.

• **Closer alignment of the State's mental health and substance abuse treatment:** Mental health and substance abuse services maintain an overlapping treatment network, use complementary treatment approaches, serve many of the same Vermonters and have similar need for prevention. The re-alignment will enable us to build a more seamless, well-integrated system that is responsive to Vermonter's needs. And for providers, we are working toward one consistent approach with regard to contracting, fiscal oversight, monitoring, quality improvement, credentialing, paperwork and training, and a closer connection with primary care.

• **Vermont Blueprint for Health:** One of the nation's premier initiatives for improving health is being undertaken by the Department of Health. The Vermont Blueprint for Health involves a new collaborative approach to improving health and health care for people living with life-long illnesses such as diabetes, asthma and cardiovascular disease. This approach involves major changes in the health care system based around the needs of the patients, patients who are being asked to make a lifelong commitment to participating in their own care, dealing with symptoms, taking medications, and changing behaviors. Information systems, effective patient self-management tools and community supports are examples of changes in the health care system being developed as part of this effort. Through expansion of the Blueprint, we have the opportunity to align this framework across physical health, mental health and substance abuse.

• **Reducing Obesity:** Through the Governor's Fit & Healthy Kids program and a new capacity building from the federal Centers for Disease Control and Prevention (CDC), the department is tooling up to prevent obesity. The obesity prevention grant funds states to coordinate nutrition and physical activities, develop a state plan for preventing obesity and related chronic disease, and implement or enhance activities that have been proven effective. These activities will also be linked to the Vermont Blueprint for Health as obesity is a primary risk factor for many chronic diseases.

• **Immunization Registry:** In 1997, the Legislature established a state registry for children's immunization records. According to the law, health care providers must report all data on required vaccinations of children under age 18. The registry moved from pilot to active operation in 2004. The registry allows providers to generate reports such as immunization histories, a list of patients whose vaccinations are due, a list of vaccinations due for an individual patient at an upcoming visit, and more. As providers recognized the benefits to their patients and practices of having a web-based system that can be accessed quickly and securely for up-to-date reports of a child's immunization status, the number participating practices went from just a handful in the summer to 45 as of late November. This is a model for new information systems in health care.

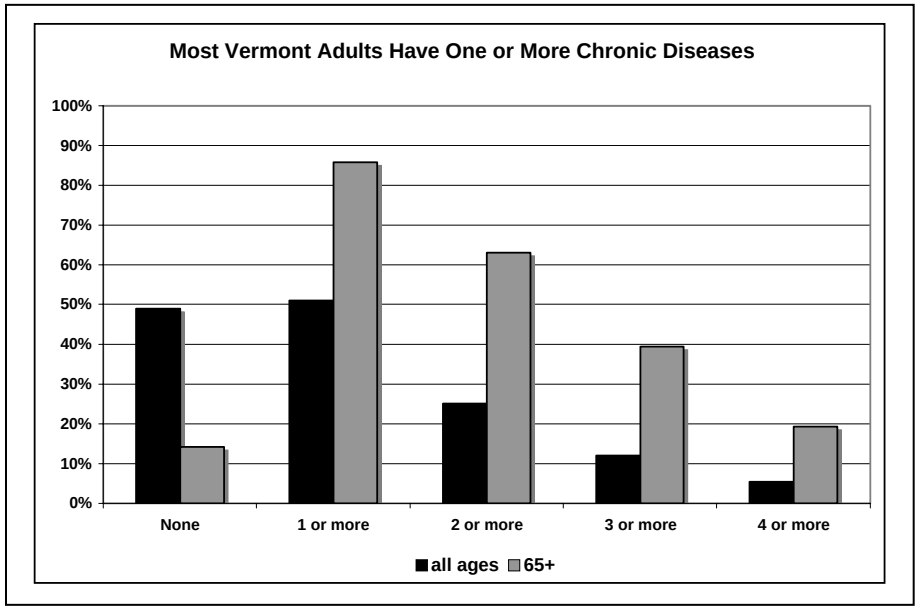
• **Academic Medical Centers Work Together:** Dartmouth-Hitchcock and Fletcher Allen Health Care/UVM are poised to work together, with the department, to guide clinical improvements at the Vermont State Hospital.

Pressures

• **Loss of Institute of Mental Disorders (IMD) Waiver**: As of January 1, 2005 the federal government is phasing out Medicaid coverage of free-standing psychiatric facilities known as IMD's (Institutions for Mental Disease). As a result, the Vermont State Hospital will lose about half of its operating budget.

• **Future of the Vermont State Hospital**: The Vermont State Hospital has 54 beds and is the state's only public psychiatric inpatient facility. It provides specialized mental health care 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 is housed in an aging facility and over the next 2 years faces loss of 50% of federal funding due to loss of its IMD waiver. While alternative plans are being made, it will likely be three to four years before patients are served in a new facility or facilities.

• **Bioterrorism, Public Health Preparedness and Emergency Response**: There is a wide range of potential hazards that can have severe public health consequences: acts of biological, chemical and nuclear terrorism; vaccine shortages; food and water tampering; large scale or unusual infectious disease outbreaks such as SARS, West Nile virus or monkey-pox; chemical spills; weather emergencies; and natural disasters. This reality requires that we take an "all hazards" approach to planning, training and practice drills, and that we maintain a high level of surveillance and readiness both in public health and health care to respond in such emergencies.

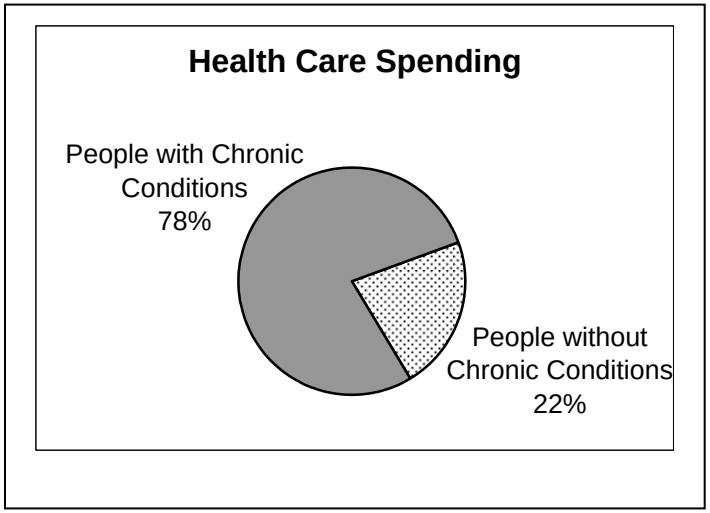


• **Sustaining Vermont's Designated Agency System:** The department contracts with 10 designated community mental health agencies around the state to provide services for adults with severe mental illness, for children and adolescents who are experiencing a serious emotional disturbance, and for substance 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. However, the state needs to work collaboratively with the agencies to develop a long-term funding plan that addresses inflationary pressures and caseload growth.

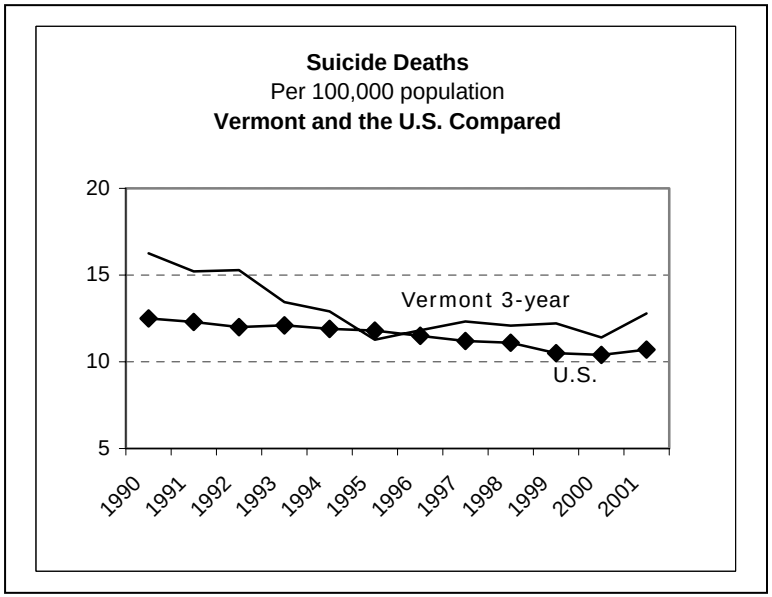
• **Increasing Burden of Chronic Disease:** Chronic diseases are the leading cause of illness, disability and death; and the most costly for the health care system. In Vermont, 51 percent of adults have one or more chronic disease like diabetes, heart disease, asthma, kidney disease, addictions or multiple sclerosis to name a few. People with chronic diseases account for 78 percent of health care spending, 76 percent of hospital admissions, and 72 percent of physician visits. The Vermont Blueprint for Health is a model new initiative under design to retool Vermont's health care system to better address these issues. A new system to include modern information systems, effective community programs, and other changes will changes in practice and dedicated funding.

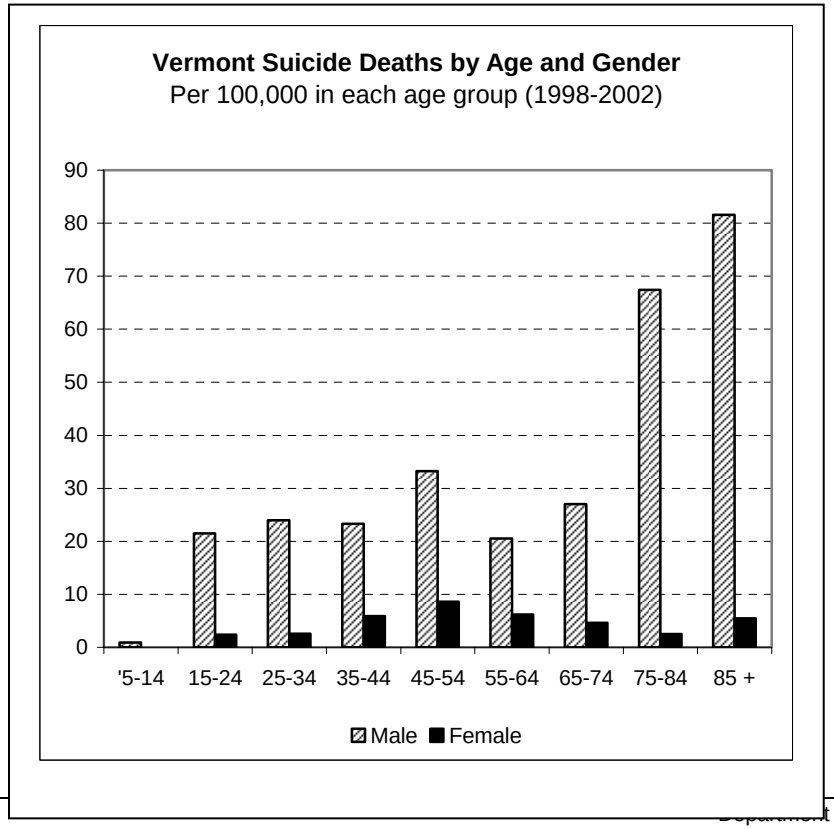
Pressures, continued

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



• **Suicide**: In Vermont, suicide ranks as one of the top 10 leading causes of death each year. It is the third leading cause of death for 10- to 14-year-olds and the second leading cause for 15- to 34-year-olds. Equally troubling is the incidence of suicide among adults and older adults, especially men. Suicide rates are highest among adults age 65 and older. Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. However, the stigma of mental illness and substance abuse, as well as the stigma of suicide itself, prevents many persons from seeking assistance for fear of prejudice and discrimination. Suicide prevention requires a comprehensive and integrated approach to reduce suicide and suicidal behaviors across the entire lifespan.





Pressures, continued

• **Prescription Drug and Opioid Abuse:** While Vermont has taken significant steps to expand treatment services for persons addicted to opioid drugs, use of heroin and illegal use of prescription drugs remains a significant problem. We are seeing increasing concern among primary care and emergency room physicians about patients who need intervention and treatment for their opioid use. Because of the high overdose potential from these drugs, we have increased needs for public education, professional education and additional treatment.

• **Quality Improvement in Corrections Health System**: On April 2004, the Vermont Commissioner of Corrections reported to the Joint Corrections Oversight Committee of the Vermont Legislature with a "plan of response" to the Investigative Report on the Deaths of Seven Vermont Inmates. This report describes a proposed role for the Department of Health in auditing areas of health, substance abuse, and mental health services for the Department of Corrections.

Accomplishments

• **Vermont State Hospital Recertification:** As of November 24, 2004, the federal Center for Medicare and Medicaid Services (CMS) recertified the Vermont State Hospital and restored Medicaid funding. Federal officials had revoked the hospitals accreditation in September 2003 following the suicide deaths of two patients. For the past year, hospital staff and leadership have worked unremittingly to get the hospital back on track implementing new policies and procedures, increasing training and security, and improving conditions and treatment.

• **In-State Residential Treatment for Women and Youth:** October 21, 2004 marked the opening of Valley Vista in Bradford, a new residential treatment facility to serve primarily women and adolescents with alcohol and drug dependency. A centerpiece of Governor Douglas' DETER (Drug Education, Treatment, Enforcement and Rehabilitation) initiative, this state-of-the-art 80 bed facility will provide intensive medical psychiatric care and addiction therapy for Vermonters. Prior to Valley Vista, some 300 Vermonters with the most severe addictive disorders – those needing residential treatment services – had to travel out-of-state because Vermont had no treatment facility to accommodate this level of care.

• **New Pharmacological Opioid Treatment Options:** Vermont continues to make headway in reducing the treatment gap for Vermonters suffering from opiate addiction. Today, 150 Vermonters are able to receive methadone medication treatment at the Chittenden Center in Burlington through a combination of on-site, supervised dispersion and prescription take-home medication. In addition, a mobile methadone treatment van is on schedule to begin serving the Northeast Kingdom this year, and another pharmacological treatment—Buprenorphine—is more broadly available through primary care physicians supported by a treatment hub in Central Vermont.

• **Community Youth Substance Abuse Prevention:** Supported by New Directions grants, local coalitions enlist whole communities in working together to prevent youth from taking up drinking, smoking and other drug use. The grants fund successful prevention projects of all kinds including mentoring and family education programs, drug-free social and recreational activities, and local information campaigns that discourage substance abuse. Youth drinking is down 22 percent since 1997.

• **Vermont Blueprint for Health:** The department has put together a unique coalition of policymakers, consumers, health care organizations and experts, and public and community health agencies to move the Vermont Blueprint for Health from concept to implementation. With full participation and commitment of over 80 members, the Blueprint now has operational working groups devoted to making major system changes in the areas of patient self-management, information technology systems, provider practice of medicine, and community support programs. Current activities

Accomplishments, continued

include researching best practice (both clinical and programmatic), pilot implementation of a model chronic disease self-management program, and coordinating planning for development of joint new information technology.

• **Operation Red Clover:** The Department of Health successfully led Vermont's first large-scale test of its public health and overall health system emergency response capability. The operation was the largest of its kind ever conducted in Vermont involved an estimated 700 participants from the Department of Health, area hospitals and multiple state and local agencies pitted against a simulated outbreak of a deadly infectious disease. For two days, epidemiologists, public health nurses, microbiologists, infection control practitioners, hospital staff, physicians, nurses, government officials, emergency responders, members of the Vermont National Guard, community volunteers and many others played out their various roles in the emergency posed by the simulated release of an infectious agent (smallpox) at a fictitious event.

• **Flu Shots for High Risk Vermonters**: Following the announcement that a national flu vaccine manufacturer would not be distributing vaccine in 2004 leaving the nation with a severe shortage of vaccine, the department successfully led efforts to make sure that limited vaccine supplies within the state were used to provide flu shots to people who are at highest risk for severe complications or even death should they contract influenza. Initial assessment showed that doctors in some counties had vaccine while in other counties there was not vaccine at all. Rather than take the "first come, first served" attitude taken by other states, the department built a coalition of hospitals, health care, public and private non-profits to collect and more equitably redistribute the vaccine through physicians, home health agencies and special clinics.

• **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.

• **Tobacco Use on the Decline:** Vermont's tobacco use prevention programs are working. Cigarette consumption, adult smoking and youth smoking are all declining in Vermont. In fact, the adult smoking rate is declining faster in Vermont than in the U.S. as a whole. Today, 19.5 percent of adults smoke - approximately 10,000 fewer than smoked in 2001. Among youth in 8th to 12th grades, smoking is down nearly 36 percent since 1997.

Office of Vermont Health Access

Number of Positions:	**58**
Funding SFY '06	
General Fund	0
Health Access Trust Fund	$ 247,055,099
Federal/Other	$ 382,974,276
Total	**$ 630,029,375**

"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

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*

Opportunities

Global Commitment

- While there will be many tough choices that must be made over the course of this Legislative session, none have the potential to be as controversial as those impacting the operation of Vermont's Publicly Available Health Care Programs. All of these programs are operated out of the Office of Vermont Health Access within the Agency of Human Services. This challenge, however, is not unique to Vermont. Medicaid expenditure growth continues to be one of the largest pressures on state budgets across the country, and while state funding for Medicaid programs is expected to increase by 12.1 percent in Fiscal Year 2005, total state appropriations grew by only 4.5 percent.
- Many governors and legislatures are beginning to examine the sustainability of the Medicaid program as it is currently structured. A number of states are exploring large-scale reform, including the use of strategies similar to what we in Vermont are referring to as a Global Commitment.
- **The Global Commitment,** as it is currently being discussed, is not a silver bullet that will make all the tough choices unnecessary. However, the concept has the potential to allow Vermont to once again be a leader, and take the next logical step in the evolution of publicly funded health care by providing opportunities that do not exist across the myriad of different programs currently in operation. Vermont is a leader in the country in a number of areas. Vermont's current 1115 Waiver, the number of children as a percent of our population with coverage, and the participation by Vermont providers in national collaboratives are just a few examples.
- Under a Global Commitment approach, states would receive a fixed, federal allotment in exchange for greater flexibility in program design and the assumption of risk if program costs exceed the rate of growth in the federal allotment. States considering such an approach include California, Connecticut, New Hampshire, Florida and Wyoming.
- The Governor's Chronic Care Initiative, the impending financial crisis, and the growing realization that the entire system for the provision of health care needs to be viewed in a holistic manner are coming together this year in a way that presents some opportunities for opening a dialogue with our federal partner over options for the future.
- Why are we exploring this Global Commitment? Under a Global Commitment, Vermont would have the ability to combine a number of waivers and innovative programs under one umbrella. This umbrella would allow the state to continue down the path of innovation while providing the necessary flexibility in program design to afford the state the real opportunity to impact the entire health system. One example might be the ability for the state to provide a seamless health care package to all Vermonters below a set level of Federal Poverty without negotiating multiple independent waivers for each new coverage group with the Federal Government. Another example might be the ability to integrate current best practices in providing evidence based medicine across all coverage groups. The ability for the State's Public Programs to participate fully in quality initiatives around the state would be unleashed in a Global Commitment Environment as conceptualized by the State of Vermont.
- When will we know? It may take a number of months to know if the idea of a Global Commitment as Vermont has conceptualized it is viable and to be able to nail down concrete financial estimates. We will know more each week as Vermont will be in daily contact at the staff level with the Centers for Medicare and Medicaid Services (CMS) and will be holding weekly teleconferences to update the teams at the Federal and State level that have been committed to work on this concept.

Opportunities, continued

Quality Improvement and the Chronic Care Model

A comprehensive Quality Initiative is underway to incorporate the Chronic Care Model into the fabric of the Medicaid Program. Beginning with an updated Mission Statement and continuing with office-wide workgroups, the efficient administration of Vermont's public health insurance system has taken hold. Every aspect of assisting beneficiaries in accessing clinically appropriate health services is being linked to evidenced-based practices to improve health outcomes and cost-effectiveness. Reorganization of the Clinical Unit and creation of a Data Unit has been key in providing much needed expertise in beginning this process. Additionally, computer software enhancements are enabling quick and accurate detection of unusual utilization patterns. Outreach to other health care entities within and without State Government is being vigorously pursued, complementing the "Vermont Blueprint for Health: The Chronic Care Initiative". Supporting the quality process within the Office will be two dedicated nurses working with the Director, Medical Director and OVHA's Quality Council. Benchmarks to measure the success of this effort are being established to allow for quick and accurate re-direction of internal resources.

Program for All-Inclusive Care for the Elderly (PACE)

- The Office of Vermont Health Access, in coordination with the Department of Aging and Independent Living, has been engaged in planning for a new Program for All-Inclusive Care for the Elderly (PACE) project for the last three years. A PACE site consists of a health care clinic within an adult day center, where participant's long-term care and primary care needs are managed by an interdisciplinary team of primary care and long term care providers. PACE providers are paid through a combined Medicare and Medicaid capitation payment which must cover their acute, primary care and long-term care needs. PACE participants are typically frail elderly and other persons with disabilities, age 55 and older, who are eligible for long term care Medicaid and are often eligible for Medicare and Medicaid (dual eligibles).

- This project began with planning grant funds from the John A. Hartford Foundation. Vermont was one of nine states in the country to work on the Accelerating States Access to PACE or ASAP/PACE planning grant. As a result of this planning process, PACE Vermont Inc., a new local non-profit, has been created. Member organizations include: Fletcher Allen Health Care, Champlain Valley Agency on Aging, Visiting Nurse Association of Chittenden and Grand Isle Counties, Rutland Regional Medical Center, Rutland Area Visiting Nurse Association and the Southwestern Vermont Council on Aging.

- In addition, the Office of Vermont Health Access has analyzed Medicaid claims data and set Medicaid capitation rates for PACE Vermont Inc. OVHA, working with staff from the Department for Children and Families, submitted the PACE state plan amendment to the Centers for Medicare and Medicaid Services. PACE will be an additional option for long term care Medicaid beneficiaries in Chittenden, Rutland, and part of Grand Isle Counties in Vermont. PACE complements the options provided to individuals under DAIL's current 1915(c) waiver for elderly and physically disabled Vermonters and will complement the proposed 1115 Long Term Care waiver.

- In June 2004, The Vermont General Assembly appropriated $100,000 to the Office of Vermont Health Access to assist with additional planning efforts and to provide PACE Vermont Inc. with some start up funding. PACE Vermont Inc. is seeking approximately two million dollars in start up funds to establish a PACE Center in Rutland County and a PACE Center in Chittenden County. Once the start up funding is acquired, PACE Vermont Inc. will work with the Office of Vermont Health Access to submit the PACE provider application to the Centers for Medicare and Medicaid Services in 2005.

Opportunities, continued

Real Choice Systems Change Comprehensive Systems Reform Effort

In October 2004, The Office of Vermont Health Access was awarded a $2 million dollar grant from the Centers for Medicare and Medicaid Services (CMS), to plan, design and implement organizations that integrate funding streams and integrate acute/primary and long term care service delivery for frail, vulnerable and chronically ill elderly and physically disabled adults in Vermont.

Co-partnering with the Department of Aging and Independent Living and local agencies on this grant, OVHA will build upon lessons learned from the Vermont Independence Project (VIP) Care Partner program (physical co-location of care partners from local Council on Aging offices at primary care offices in seven practices in Franklin, Grand Isle and Windham Counties in Vermont). The VIP project was funded by the Robert Wood Johnson Foundation's Medicare and Medicaid Integration Program. This grant will also build upon lessons learned from the PACE project. The grant will involve two years of planning and a year of implementing pilot projects/organization in the community that integrate long term care and primary care services for frail, vulnerable and chronically ill elderly and physically disabled adults in Vermont.

Global Clinical Record

The Global Clinical Record (GCR) is a component of the Medicaid Management Information System (MMIS). GCR is a secure, HIPAA compliant web based application designed to increase efficiency and decrease costs associated with managing a wide range of Vermont Medicaid medical information.

GCR has four core components: Prior Authorization (PA), Early and Periodic Screening, Diagnosis & Treatment (EPSDT), Case Tracking, and Health Indicators.

- PA is a tool to review, pre-approve, and manage selected services to ensure that items are medically necessary, clinically appropriate, and cost effective. Providers can now submit their requests for prior authorization via the Internet and State staff can access this information electronically for review. This new process results in considerable time savings for both providers and state staff.
- EPSDT provides all EPSDT eligible persons with a continuing system of preventive health services in order to identify and treat potential chronic and disabling health conditions. GCR produces the federally required informing letters and annual reports for EPSDT. GCR also allows for distinct notices to be sent to targeted populations.
- Case Tracking enables State staff to maintain a case file on selected beneficiaries to streamline continuity of care and increase intra-agency communication.
- Health Indicators allows Providers, Provider staff and State staff to enter and track measurable outcomes, screening and test results, and procedures which, taken as a whole, will reflect progress toward preventing and lessening the effects of specific disabling disease conditions.

The EPSDT and Case Tracking portions of GCR are operational and in use by state staff. Health Indicators is in the final stages of testing. The PA subsystem is currently being piloted by Providers and state staff and is expected to be fully operational and implemented statewide in CY 2005.

Opportunities, continued

Pharmacy Management

- In 2001, the Vermont General Assembly authorized a pharmacy best practices and cost containment program in Vermont's publicly funded pharmacy programs, the Health Access Pharmacy Benefit Management (PBM) Program. It continues to be authorized under Act 127 (2002), §1998.
- In November 2001, the first phases of the Vermont Health Access PBM Program were implemented and included Maximum Acquisition Cost (MAC) pricing, clinical and cost related prior authorization (PA) requirements, application of the generic drug requirements authorized by the Vermont General Assembly's Budget Act of 2002, messaging at the pharmacy point of sale, drug claims processing, prospective and retrospective drug utilization review (DUR), and a preferred drug list (PDL).
- The PDL is a key feature in the program. It is a list of classes that are selected because of use and/or cost concerns. The PDL identifies drugs that are clinically effective and/or less costly. When drugs are not "preferred" they require prior authorization (PA) to obtain. Some require PA solely for clinical health and safety reasons. In other cases, the less costly options are preferred when clinically appropriate options are available.
- In the summer of 2002 First Health negotiated with drug manufacturers on behalf of Vermont to secure supplemental rebates. This concept provided the opportunity to offer more products when the rebates made them comparative to lower cost generics and brands. Twelve manufacturers signed agreements. In the spring of 2003 Vermont joined the National Multi-state Pooling Initiative (NMPI) that made it possible to combine the purchasing power of Vermont with other states in negotiating supplemental rebates. With this, twenty-seven manufacturers were offering agreements. In April of this year the NMPI was approved by the federal Centers for Medicare and Medicaid Services (CMS).
- Annually manufacturers have the opportunity to improve their existing rebate contracts on individual drugs or enter into new contracts on new drugs. This process is referred as the NMPI Refresh. All member states are represented. They include Vermont, Michigan, New Hampshire, Nevada, Alaska, Hawaii and Minnesota. Montana and Kentucky have submitted requests for CMS approval. At this stage the NMPI represents two million covered lives with a total estimated drug spend of $3 billion. With the CMS approval of the NMPI and the real and anticipated increase in state participation, this year's Refresh resulted in forty-two agreements.
- Through the Health Access PBM Program Vermont spent $6.9 million less than was appropriated for SFY 2003 in its pharmacy programs. However, in SFY 2004 spending was $6.5 million over budget. Some of this is related to a shift to premiums from direct cost sharing. Some is related to the fact that supplemental rebate collections for SFY 2004 were largely not realized until SFY 2005 because of the delay in federal approval. A great deal is related to significant increases in utilization and increases in cost. With relatively the same number of covered lives, the number of days supply dispensed in the year increased by 8.79% and the cost per day increased 8.46%.

Pressures

Balancing Act

For public health care programs, access, cost, and available revenues are a balancing act. According to projections, the Health Access Trust Fund is projected to have a deficit of $52.7 million by the end of fiscal year 2006 and there may be a shortfall of $15 to $20 million in FY 2005 (subject to revision as FY 2005 actual spending information becomes available). This problem is attributable to a declining rate of federal reimbursement and an imbalance between growth of state revenue and program spending. Other contributing factors include:

- Increased use and higher cost of health care services impact everyone who pays for health care.
- Health care inflation rates are greater than the growth rates in state revenues. This creates serious fiscal pressures.
- Premium-based cost sharing for beneficiaries was implemented in late 2003 and will continue in 2005.
- The cost of Long Term Care services, particularly nursing home care, is a significant budget pressure.

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

Premiums Continue to be Implemented for Health Programs

OVHA is working with staff in AHS central office and the Department for Children and Families, Economic Services Division on the phased-in approach to implementing the full instructions of Act 66, which authorized the implementation of monthly premiums for participants in VHAP and pharmacy programs, and for higher income beneficiaries in the Dr. Dynasaur and Working People with Disabilities programs. With legislative concurrence, premiums for the Working People with Disabilities Program were eliminated. The extended phase-in period is intended to insure a smooth transition and ensure that individuals and families become accustomed to a monthly premium before more stringent requirements are implemented. In September 2004, individuals and families began to have the option of making payments by credit card or automatic deduction from checking or savings accounts.

The Medicare Modernization Act Presents Significant Challenges

Staff members from the Office are leading the Agency effort to identify the impact of the new Medicare Part D drug benefit (effective January 1, 2006) on Vermonters in our health care programs and on the budget. The Governor has said, "No Vermonter will be financially disadvantaged as a result of the implementation of the Medicare Modernization Act." Our challenge is to analyze the change in the delivery of prescription drug benefits and project the cost to the state of maintaining the current level of coverage. As Part D implementation approaches, policy changes will need to be made to accommodate Medicare as primary payor for Medicare beneficiaries, programming will need to be changed, and outreach and education to beneficiaries will be essential. Our partners in the Department of Aging and Independent Living are chairing an MMA Advisory Committee, including outreach and educational efforts, in which we also participate.

Accomplishments

Access to Care

Medicaid is the second largest Vermont insurer in covered lives, and first in terms of dollars spent according to the Department of Banking, Insurance, Securities, and Health Care (BISHCA). OVHA serves the most vulnerable Vermonters; those with the greatest potential health needs and the least personal resources.

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

Program Integrity

Program integrity includes the provision of medically necessary and appropriate health care services, accurate reimbursement to qualified providers of those services, and efficient administration of the program. Maintaining the integrity of the Medicaid Program is one way to contain costs without adversely affecting beneficiary services or provider reimbursement. The Program Integrity (PI) Unit is housed in the Office of Vermont Health Access and consists of two teams: Quality Improvement (QI) and Surveillance & Utilization Review (SUR). The QI team is overseen by the Medical Director and is staffed by five Nurse Case Managers. Their responsibilities include Case and Disease Management, ongoing quality initiatives and best practice. The SUR team is staffed by two Nurse Case Managers and is overseen by the Director of Clinical Services, also a nurse. The SUR team works closely with each unit within the OVHA (Coordination of Benefits, Policy, Reimbursement, Pharmacy, Long Term Care, and Provider Relations), as well as OVHA contractors and other agency partners.

Technology Initiatives

- During SFYs 2003 and 2004, the OVHA completed the procurements of three information technology projects to facilitate improved and efficient data collection, integrity, analysis, tracking and reporting; enhance the technical infrastructure that supports the Medicaid program; and position the OVHA with a comprehensive Medicaid (technical) solution in SFY'05.
- The first procurement, the Global Clinical Record (GCR), supports a clinical record and includes four primary functional areas: 1. Case Tracking (CT), 2. Prior Authorization (PA), 3. Health Indicators (HI), and 4. Early Prevention and Periodic Screening, Diagnosis, and Treatment (EPSDT). The second procurement, the Coverage and Services Management Enhancement (CSME) includes functionality that accommodates service and program management. The third procurement, operational takeover and enhancement of the Medicaid Management Information System (MMIS) allowed the OVHA to retain viable claims processing and fiscal agent services with system improvements (e.g., platform conversion, ClaimCheck/Claim Review).
- The GCR is operational. One of the six MMIS enhancements is operational. During SFY'05, the OVHA plans to operationalize the remaining MMIS enhancements and the CSME. A fraud and detection-type system is under consideration as an additional enhancement to the MMIS during SFY'05.

Accomplishments, continued

Claims Payment Initiative

OVHA has begun a comprehensive review of its payment policies and the rates it pays for specific services. This effort has multiple purposes:

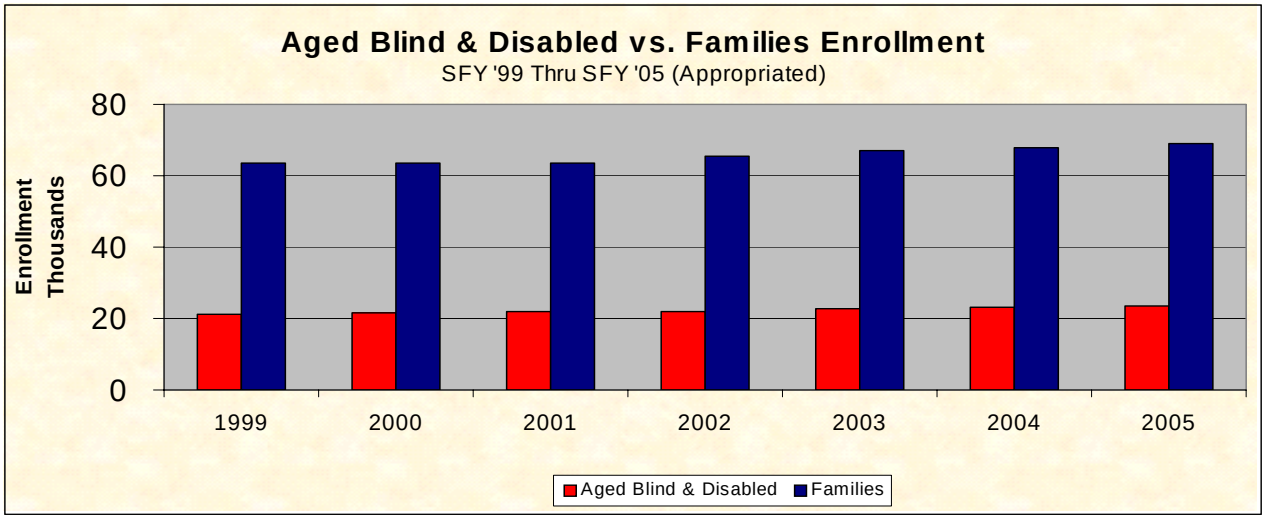
- Identify and correct changes in the relative value of the various services or items;
- Determine the variance between current rates and Medicare rates;
- Correct any anomalies.

This effort will give OVHA a comprehensive review of policies and work toward assuring equity among the various providers, services and items. OVHA is implementing a new software review process that will assure more correct claims payment practices by reducing the number of unbundled services, code/diagnosis mismatch and similar payment anomalies.

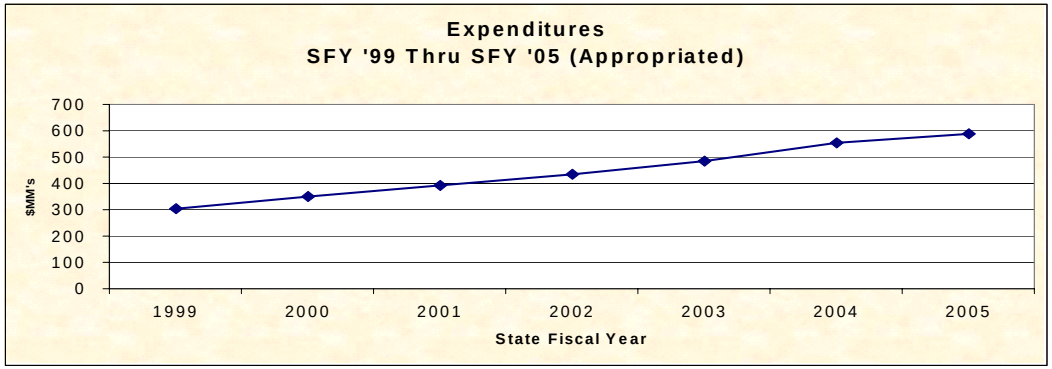
Caseload and Cost Data

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.

Historical Data SFY 1999 – 2004 and Appropriated SFY 2005



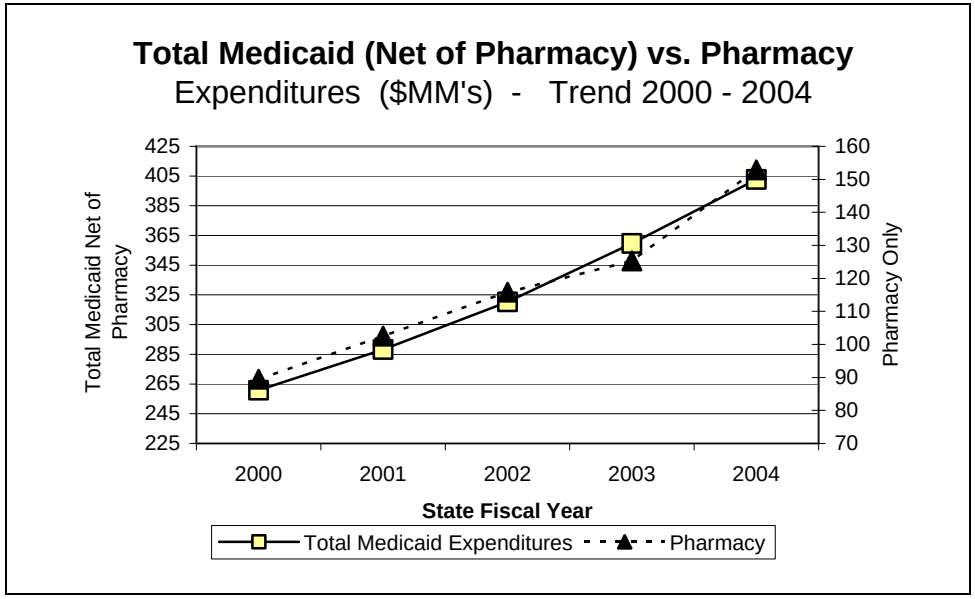
Caseload and Cost Data, continued

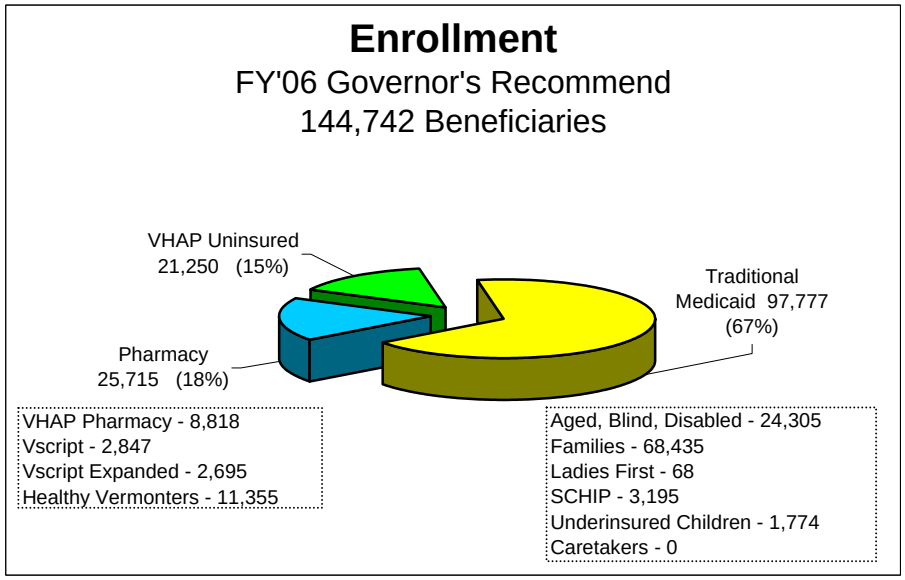


Medicaid v. Pharmacy
% Growth Since 1999

Medicaid Growth *(not including Pharmacy)*	+ 54%
Pharmacy Growth	**+142%**
Total Medicaid Growth *(including Pharmacy)*	+82%

Evolving Trends





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

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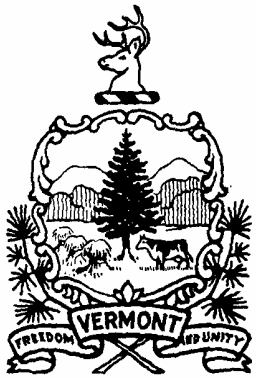
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