agent across a desk or counter, and the agent doing data entry. This would free time so staff can more fully assist clients with profound needs.

Application of These Principles

Thus far, this client centric package consists of four specific applications of the principles described above:

Part A: Client Centric Intake and Care Management
Part B: Empower Families to Support Their Elderly
Part C: Purchasing Results, not Units of Service
Part D: Focus Designated Agencies on Client Outcomes

Part A - Client Centric Intake and Care Management

The Challenge

Improve the outcomes for AHS clients while spending 5% less in FY11 and 10% less in FY12.

Redesign Options

Intake into Vermont's human service system - especially for children - occurs through many different portals. Then care is managed by a disparate group of professionals who share a commitment to serving clients, but see cases through different perspectives.

What if Vermont's human service intake was unified and systematized statewide, with an eye toward not only good client outcomes but also the use of highest value interventions, and avoidance of duplication and overlap? What if intake and care management professionals knew as much about service cost effectiveness and resource maximization as they do about good care? For example, AHS is aware that Federally Qualified Health Center pharmacy pricing is lower than regular Medicaid; and is actively pursuing how to steer more of the qualified people to the FQHC for their medications. This kind of re-direction could occur in many other interventions.

Vermont human services could be re-tooled, retrained and recommitted to getting the most out of limited resources. Challenge AHS to redesign its intake and case management approaches and thereby achieve productivity gains. A modest challenge could involve expecting a 5% productivity improvement ($10 million savings) in FY11 and a 10% productivity improvement ($20 million) in FY12 and thereafter. Depending of Vermont's fiscal realities, the challenge could be more demanding and still be realistically achievable.

Some design elements for a new approach might include:

- Develop a unified eligibility and intake strategy; perhaps consolidate the functions even though eligibility standards and criteria vary greatly from one human service program to the next.
- Develop an integrated tracking system that is client centric rather than program centric.
- Braid federal and state funding streams into a single delivery system focused on the client or the client/family.

- Expect case managers—whether state professionals or those under contract with the state—to manage to a set of outcomes rather than to manage programs.
- Build delivery systems around the client and client needs rather than around programs and organizations. Use state dollars strategically to break down the walls of programmatic silos.

One-time Investment

In FY11 and FY12, one-time investments of $2 million will be made available to the AHS for initial design, research and planning, protocol development, IT support development, and training.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation	$200.0		
Cost Containment **Access** **Quality**			
Investment		$2.0	$2.0
Net Total Savings		$8.0	$18.0
Net GF Savings		$3.2	$7.2

Part B - Empower Families to Support Aging Vermonters and Individuals with Disabilities

The Challenge

Maintain or improve service quality to aging Vermonters and individuals with disabilities while spending 2% less in FY11 and 5% less in FY12.

Redesign Options

Aging demographics and reduced public resources may be requiring Vermont to reconsider its expectations about whom it can afford to serve. Could the state raise the criteria for service eligibility for the most able elders and individuals with disabilities, and convert part of the savings into less formal, service assistance grants to offset the cost of care supports for these people? Or to more family and caregiver supports? Some elements of the redesign might include:

- Analyze and adjust the eligibility criteria for the most able elders and individuals with disabilities.
- Design a flexible assistance program for the affected population.
- Engage such clients and their families in the redesign process in order to find the critical value/cost leverage points
- Research best practices for family and caregiver support programs (e.g., promising research about effectiveness of counseling programs for caregivers of people who suffer with early stage Alzheimer's Disease.)

In FY10 spending on supporting older Vermonters and individuals with disabilities in all settings totaled $172 million. Of that about 40% is state GF dollars and the balance federal funds. Pursuing a 5% saving strategy over the next two years creates an opportunity that involves cutting that amount from the long term care budget as service grants and supports are redesigned.

One-time Investment

An investment of $500,000 is required in FY11 for designing the new system, IT system modifications and transition planning.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation for elderly service in community/home	$172.0		
Ability to Age in Place – Client/Family/ Provider Surveys			
Investment		$0.5	$0.5
Net Total Savings		$2.94	$8.10
Net GF Savings		$1.18	$3.24

Part C - Purchasing Results, not Units of Service

The Challenge

Improve the state's overall human services outcomes while spending 5% less in FY11 and 10% less in FY12.

Redesign Options

Vermont purchases most human services through fee-for-service units, paying providers "hit by hit" rather than through bundled or capitated payments or paying for outcomes (e.g., successful permanent placements for children in custodial care). What if Vermont embarked on a system-wide effort to change the incentives for the way it delivers human services? What if it endeavored to always buy results for people, not just pay for service activities? Some options for redesigning the way the state contracts for such services might include:

- Establish a high-level AHS Purchasing Redesign Project
- Invest in building credible outcome measurement infrastructure
- Subject every purchasing activity to a rigorous analysis -- What are we buying? How do we know we're getting it? How could the way we buy it increase the value through better outcomes and lower costs?
- Design results based mechanisms in areas where major purchases are made
- Renegotiate existing contracts to be results based
- Make streamlining the red tape burden on the contractors an important part of the renegotiation
- Design results-based purchasing strategies for new contracts
- Create regular forums for capturing learning from applications of these principles in various areas

Experience with these approaches in other settings suggest double digit savings can readily be accomplished through the combination of a focus on results, a reduction of unnecessary red tape, and firm but open negotiations with affected contractors. A very modest challenge would be to expect 5% improvement in FY11 and 10% in FY12. If Vermont's fiscal conditions so dictate, a more aggressive challenge could be realized.

One-time Investment

This is a big change. It will require a lot of thought by and dialog among the affected parties. *Under investing in support of the change is the number one reason why other such efforts have fallen short of expectation.* And, doing this properly requires a credible measurement infrastructure so that there is accountability in performance-based arrangements. Simple new information systems will also smooth the implementation of this approach. Therefore, in each of FY2011 and FY2012, a one-time investment of $1 million will be made available to AHS to realize the challenge.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation	$380.0		
% of results delivered in the new procurement grant process Performance pilots as models ROI measure for MCO Investments			
Investment		$1.0	$1.0
Net Total Savings		$18.0	$37.0
Net GF Savings		$7.2	$14.8

Part D - Focus Designated Agencies on Client Outcomes

The Challenge

Improve the outcomes produced by the 17 legislatively designated agencies while spending 5% less in FY11 and 7.5% less in FY12.

Redesign Options

Vermont has contracts, totaling $272 million per year, with 17 "designated agencies" to deliver community mental health services and services for the developmentally disabled. By law, the providers do not compete for business. Yet, there is an opportunity to use competitive incentives and enhanced collaboration, so that they each are motivated to create better results for the money.

The challenge, here, is to expect these instruments of Vermont's human service delivery system to help address Vermont's fiscal issues by improving their productivity up to 7.5% over the next two fiscal years. And, to give them help in doing so.

The 17 agencies meet regularly in various forums for coordination and sharing. How could performance and cost data for each of the 17 be collected and shared in order to incent and facilitate better sharing and implementation of best practices? How could administrative services be shared and jointly administered by these providers to create cost savings? This challenge involves adjusting how we pay the designated agencies to capture the savings. Then, help them plan new ways to do their work.

Some design options for a better arrangement with the designated agencies might include:

- Careful and regular collection and reporting of outcome and cost data of the designated agencies.
- Statistical "leveling of the playing field" to make results comparable among providers with differing caseload difficulty, and socio-economic realities.
- Create a design that allows the agencies to share administrative services and provide incentives for such
- Streamline the red tape involved
- Focus on the high performers; develop and disseminate best practices from their experience.
- Use performance information as a learning tool to improve designated agency performance and cost effectiveness

One-time Investment

In FY11, a one-time investment of $500,000 will be made available AHS to launch this collaboration, develop the performance measurement, and facilitate the service sharing.

The Bottom Line (Millions)

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation	$272.0		
DA client/family perception of service quality and impact in client			
Investment		$0.5	
Net Total Savings		$13.10	$20.40
Net GF Savings		$5.24	$8.16

4 - Corrections Rebalance

The Challenge

Improve the recidivism rate and community safety while spending 8% less in FY11 and FY12.

Redesign Options

Vermont may be incarcerating some offenders who do not need to be incarcerated and would be less likely to recidivate if not incarcerated in traditional setting. Substance abuse treatment that uses early evidence-based intervention can, also, reduce recidivism. The December 2007 report by the Department of Corrections, "Plan to Reduce Correctional Costs and Achieve Savings for Reinvestment" provides a number of design elements that can be implemented while improving recidivism and community safety outcomes (freeing up 219 beds for short term non violent and transition housing could result in the savings). There are current positive examples of new designs such as Northern Lights and Return House. Vermont has a history of using restorative justice that should provide learning for the redesign. Some design options for reducing the prison population include:

- Lower cost alternatives for public intoxication – including expanding the Chittenden County pilot
- Establish lower cost alternatives for weekenders
- Probation time limits for non-violent offenders
- Identify lower cost alternatives for non-violent offenders with terms of less than 90 days
- Increase substance abuse treatment interventions at evidence-based appropriate times
- Provide increased transition housing of at least 200 beds in 2011
- Either close a state facility or move out-of-state placements in state to replace beds used currently by non-violent less than 90-days offenders, weekend sentenced offenders and or offenders lacking transitional housing

One-time Investment

In FY2011, a one-time investment of $5 million will be made available to the Department of Corrections to establish a transition housing program, weekender program, chemical dependency treatment programs, and other measures that evidence shows will decrease recidivism.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation	$127.0		
Recidivism Rate	One Year 29% Two Year 42% *Three Year 50%		
Investment		$3.0	$2.0
Savings (GF)		$7.0	$8.0

* Source is Facts and Figures FY 2008, Vermont Department of Corrections, p. 121

Education

5 – Focus on Learning

The Challenge

Improve student learning and growth (graduation rates) while spending less on administration, specifically 5% less in FY11 and 15% less in FY12. In FY12, 25% of the savings will be reinvested in instructional activities.

Redesign Options

This approach does four things:

1. In FY12 it reduces education spending on administration by $40 million which is about 15% of total school spending on administrative functions.
2. It reallocates $10 million of that administrative money to instructional activities; and it provides new mechanisms for investing that money.
3. It provides $2 million in FY11 for special one-time investments that make this design work.
4. Net savings after investment will be used to reduce property taxes (65%) and the state General Fund budget amount (35%).

There is an opportunity to speed up Vermont's "Transformation in Education". Because of the large number of relatively small school districts, Vermont is spending more money on administration and governance of its education system than is most effective or efficient. Consolidation is politically difficult in many communities. An alternative is to create incentives for consolidation and sharing in the administrative and "back office" functions.

The reform can be started by reducing spending on administration/governance by 15% ($40 million) and increasing spending on instruction by $10 million. This would force school districts to find more efficient ways to provide administrative services **and** increase the time spent and focus of people in the system on children learning. Wider learning opportunities could be provided students throughout Vermont. That is the demand side of the equation.

At the same time we are suggesting some design elements that could facilitate administrative streamlining and sharing as well as supporting a strategic reinvestment of the $10 million in student learning.

Potential design elements that help reduce administrative and governance costs:

- Incentives to reduce the number of governing units and school buildings through the reduction of administrative/governance funds. Set basic standards for administration and only fund (from the Education Fund) to that level.

- Place a ceiling on the amount the state will reimburse for administrative expenses. For example, benchmarking funding reimbursement for administration to national average or median spending per pupil on administration. Vermont's administrative spending is significantly above these levels currently some estimates are at 190%.

- Move to a larger unit (regional/state) contract for teachers that includes performance incentives based on student learning.

- Create a statewide master contract for therapists and other professionals hired by schools that has approved rates, and pay based on performance.

- Establish on-line mechanisms that encourage schools to purchase from statewide commodity contracts (paper, supplies, etc.).

- Increase e-procurement for schools.

- Pre-qualify vendors across the state.

Potential design elements that help the reinvested dollars promote student learning:

- Create mechanisms that promote distance-learning initiatives.

- Use a results based approach to investing the $10 million. Don't just spread it around to school districts. Use the money to promote collaboration.

An additional design element should also be considered. Make all Vermont schools charter schools. Make the schools accountable to the chartering organization (probably the local school board) for student achievement outcomes. Keep the school boards focused on getting the best outcomes for their children rather than on running schools. Leave each school with the freedom to use its funds in the best way it sees fit to produce learning outcomes including the freedom to create regional or statewide collaboratives for any and all administrative functions. Give the school boards the choice of purchasing, on behalf of their children, some educational services from charter schools located in other districts or from other chartered educational organizations (such as distance learning) that serve regions or the whole state.

One-time Investment

In FY11, a one-time investment of $2 million will be made available to the Department of Education to establish sharing and collaboration mechanisms, regional or statewide solutions to particular administrative functions, and to give school districts results based alternatives for investing the additional $10 in student learning in FY12.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation GF **Total System-wide Admin spending**	$280.0 (includes $38.5m ARRA) $266.6		
Graduation Rate	91.26%*		
Investment		$2.0	$10.0
Net Total Savings		$11.33	$30.0
Net GF Savings		$3.97	$10.5
Tax Rate Savings		$7.37	$19.5

*Source is State of Vermont Part B Annual Performance Report for FFY 2007, Vermont Department of Education

6 - Special Education Incentives

The Challenge

Improve student graduation rates while spending 5% less in FY11 and 7.5% less in FY12.

Redesign Options

Redesign of Vermont's special education services can revolve around three key elements: First, special education outcomes (graduation rates, employment) can be improved by encouraging mainstreaming and local placement. Second, the amount of paperwork professionals are expected to do can be significantly reduced, thereby giving them more time with kids. This can also improve outcomes and reduce cost. Third, by increasing investments in "positive behavioral supports approach", "Vermont integrated instructional model" and "response to intervention model", better outcomes can be achieved.

Actions that help move to best practice:

- Gradually reduce state aid of 90% for those cases costing over $50,000 annually (up to a reduction of $8 million of state GF).
- Give the Commissioner discretion to pay some extra costs over a threshold for small communities that face unusual situations.
- Set dollar limit for out of state programs.
- Manage out of state placements at the *state* level.
- Develop a statewide master contract for therapists and other professionals hired by schools that have approved rates, pay for performance.
- Provide state certification of special-ed status to decrease variations and increase accuracy (range is currently 0% to 38.9% of a district's children).
- Secure a waiver from federal government on paperwork and/or find ways to streamline paperwork required of special education teachers.
- Create special-ed performance grants that pay school districts or organizations that support local school districts for results

VT LEG 251508.1

- Invest in training and supports for mainstreaming and local placement.

One-time Investment

In FY11, a one-time investment of $1 million will be made available to the Department of Education to increase investments in support of local placement and mainstreaming and to establish statewide certification and contracts.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation	$140.0		
Graduation Rate	80.62%*		
Investment		$1.0	
Total Savings		$6.0	$10.5
Net GF Savings		$2.1	$3.68
Tax Rate Savings		$3.9	$6.83

*Source is State of Vermont Part B Annual Performance Report for FFY 2007, Vermont Department of Education

Regulatory Reform

7 - Regulatory Reform

The Challenge

Increase compliance with state regulations while spending 3% less in FY11 and FY12, by redesigning the compliance process, reducing the compliance burden on the complier, and streamlining bureaucratic processes.

Redesign Options

Raising compliance by spending less can be accomplished in two ways: 1) Winning compliance, and 2) Streamlining processes.

Winning compliance moves beyond the bureaucratic approach of promulgating regulations, inspecting, and penalizing violators through due process. Regulatory agencies have achieved more compliance at less cost by using these five strategies:

1. Engage the compliers in the rule making process,
2. Educate compliers about their obligations,
3. Make it easy for people to comply,
4. Give people constant feedback on their level of compliance (not just their non-compliance), and
5. Make compliance consequential (not just enforcement and penalties, but rewards, as well).

Streamlining bureaucratic processes could provide faster licensing and permitting without compromising quality standards. Experience has proven that generally people will comply with standards when the standards are clear and compelling. The state could generate a check list as clear guidance for compliance and self certification. Then the state could audit compliance selectively based on past compliance data. This will improve customer service and cost less.

There are multiple approaches for streamlining processes and reducing costs. For example, one state used the Kaizen continuous improvement approach to reduce the time to approve air quality construction permits from 62 days to six days, landfill permits from 187 days to 30 days, clean water construction projects from 28 months to 4.5 months, and wastewater permits from 425 days to 15 days. The Natural Resources Board could be combined with the Environmental Court to streamline the appeal process and save money. Regulatory agencies could designate consumer advocates to guide consumers through the complicated permit application processes.

One-time Investment

In FY2011, a one-time investment of $500,000 will be made available as seed money to win compliance, invest in technology improvements, or facilitate streamlining projects.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation	$57.2		
Compliance rate **Complier burden**			
Investment		$0.5	
Net Total Savings*		$1.22	$1.72
GF Savings		$0.36	$0.51

*reduction in non-general fund costs could be used to reduce licensing/permit fee amounts
Base appropriation reflect ANR and Agriculture activities, there is the potential for inclusion of other regulatory entities in this challenge.

Commerce and Community Development

8 - Implement an Economic Development Strategy

The Challenge

Improve the economic development results (jobs, GDP, personal income) while spending 10% less in FY2011 and FY12.

Redesign Options

One approach to economic development is to fund a number of programs that each produces some benefit. There is no accounting or measurement of the overall results of these programs. This appears to be Vermont's current model.

Another approach to economic development is to consider economic development in Vermont as an overall outcome, develop a strategy to produce the desired outcome and implement the strategy.

- Begin by identifying measurable results such as job creation, gross domestic product and personal income as the desired results for Vermont and select targets for those results.
- Second, understand what produces those results in Vermont, using proven research.
- Third, develop strategies, based on evidence that will get the greatest results for Vermont.
- Fourth, use investment dollars in the budget to fund those programs that best leverage the identified strategies by getting the greatest return on investment (*i.e. link the dollars invested to the results desired).*
- Finally measure the overall results in Vermont, the results of the strategies and the performance of the funded programs. Use the data to improve strategies and programs in order to improve the overall economic development results for Vermont.

The Unified Economic Development Report 2009 states that Vermont has a total general fund appropriation of $34.27 million for economic development efforts. The report states the need for a clear definition of economic development and recommends performance measurement. Vermont has the opportunity to *invest strategically* in economic development rather than *distributing* its resources among programs or constituencies.

Consolidating economic development programs in order to save costs has been recommended. Rather than organizational consolidation it would be better and easier to integrate the programs strategically. By having a unified strategy and by allocating funds among the various programs on an outcomes basis, the advantages of integration can be

achieved while maintaining opportunities for experimentation and innovation that come from a disaggregated system.

Experience shows that outcomes can be improved even as the appropriation is reduced. This is particularly true if the investment strategy includes a competitive, results based approach (in contrast to an "entitlement" approach) to allocating economic development funds. A modest challenge would be to expect this sort of integration to produce a 10% savings.

One-time Investment

In FY2011, a one-time investment of $.3 million will be made available to develop a state economic development strategy and results based budget for these funds and to develop a results measurement infrastructure that holds programs accountable for contributing to the strategy.

The Bottom Line

	FY 2010 (in Millions)	FY2011 (in Millions)	FY2012 (in Millions)
Appropriation	$34.3		
Jobs created **GDP** **Personal Income**	March 08-09 -9,613 2008 21.697 2008 $38,686/cap		
Investment		$0.4	
Net GF Savings		$3.03	$3.43

Ideas to Consider For Longer Term Implementation

Purchase Health not Procedures for Public Employees

The Challenge

Improve the quality of Vermont public employee health care while spending less in the future through pooling purchasing power that can bring a large pool into alignment with the Vermont Blueprint for Health.

Redesign Options

Health care for public employees is now purchased by the state, by individual municipalities, and by separate school districts throughout the state. Over $310 million is spent annually. They are all public employees, spending public dollars for health, but they are not taking advantage of their collective purchasing power. Vermont could pool the health care purchasing for ALL its public employees—state actives, state retirees, teachers, municipal and county—and triple its purchasing power, giving this group a significant impact on health care throughout the state. Some features of this pooling might include:

- Leveraging increased purchasing power to negotiate better health care outcomes for lower rates
- Increase number of options for many employees now in smaller groups
- Use the volume to negotiate "total cost of care" contracts – with health plans or provider collaborative – paying for a year's worth of health, rather than for episodes of illness
- Use the influence of unified public health care buying to fundamentally change the payment system and outcome expectations in the Vermont health care market, thereby creating benefits for all Vermonters
- Individual school districts and municipalities could still make contributions to premiums at their particular rates

One-time Investment

Investment will be needed to design a pooled purchasing system, to coordinate the implementation of a new system, and to negotiate the first round of new contracts.

COMMITTEE CHARGE

Sec. 5 of Act 205 Of 2008

Sec. 5 JOINT LEGISLATIVE GOVERNMENT ACCOUNTABILITY COMMITTEE

(a) There is created a joint legislative government accountability committee. The committee shall recommend mechanisms for state government to be more forward-thinking, strategic, and responsive to the

long-term needs of Vermonters. In pursuit of this goal, the committee shall:

(1) Make recommendations for enhancing the state's ability to measure the performance of programs which have been or will be undertaken with government investments.

(2) Propose areas for the review of statutory mandates for public services that may result in service duplication and to review the alignment of financial and staff resources required to carry out those mandates.

(3) Review the legislative process for the creation and elimination of positions and programs and make recommendations for enhancements to the process that support greater long-range planning and responsiveness to the needs of Vermonters.

(4) Recommend strategies and tools which permit all branches of state government to prioritize the investment of federal, state, and local resources in programs that respond to the needs of the citizens of Vermont in a collaborative, cost-effective, and efficient manner. Pursuant to those strategies and tools, functions which are not critical to an agency or department mission may be recommended for elimination, while other functions may be optimized.

(5) Review strategies with similar aims in other jurisdictions in the context of federal, state, and local relationships.

(b) The membership of the committee shall be appointed each biennial session of the general assembly. The committee shall comprise eight members: four members of the house of representatives who shall not all be from the same party, one from the committee on government operations, one from the committee on appropriations, and two other members, appointed by the speaker of the house; and four members of the senate who shall not all be from the same party, one from the committee on government operations, one from the committee on appropriations, and two other members, appointed by the committee on committees. The committee may also include in its recommendations that the committee membership be altered.

(c) The committee shall elect a chair, vice chair, and clerk from among its members and shall adopt rules of procedure. The chair shall rotate biennially between the house and the senate members. The committee shall keep minutes of its meetings and maintain a file thereof. A quorum shall consist of five members.

(d) When the general assembly is in session, the committee shall meet at the call of the chair. The committee may meet up to four times during adjournment, and may meet more often subject to the approval of the speaker of the house and the president pro tempore of the senate.

(e) For attendance at a meeting when the general assembly is not in session, members of the committee shall be entitled to compensation for services and reimbursement of expenses as provided under subsection 406(a) of Title 2.

(f) The professional and clerical services of the joint fiscal office and the legislative council shall be available to the committee.

(g) At least annually, the committee shall report its activities, together with recommendations, if any, to the general assembly.

Sec. H.47b subsection (b) Act 1 of 2009 Special Session

(b) The $100,000 appropriation in Sec. B 1101 (a) (10) of the this act is to fund the joint legislative government accountability committee established in Sec. 5 of No. 206 of the Acts of the 2008 General Assembly (adj. sess.) for the purpose of hiring consultants to make recommendations for further efficiencies in state government.

CHALLENGES FOR CHANGE: PROGRESS REPORT

TO THE JOINT LEGISLATIVE GOVERNMENT ACCOUNTABILITY COMMITTEE

MARCH 30, 2010

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PROGRESS REPORT

PROGRESS REPORT

This is the first progress report on Challenges for Change, a plan to make Vermont government and services more effective so that better results are delivered at lower cost to taxpayers. Challenges for Change was authorized by Act 68 (the Challenges Bill) of the 2009-2010 legislative session; this report and subsequent quarterly reports are required by the act.

The Challenges Bill specifies the broad areas from which savings must come and identifies those outcomes which agencies and programs must achieve. This initial report details the progress made by the executive branch since the passage of the bill one month ago; this report is not intended to be a full or final plan, but rather an update to solicit feedback and promote refinement of ideas. The report also contains, as required by the bill, proposed measures by which the General Assembly can track progress towards the outcomes and proposals for changes in existing legislation necessary to achieve the outcomes and meet the budget constraints.

Although much of the initial planning since the Challenges Bill was passed has been done internally, we have now reentered a very public phase of the Challenges for Change approach. This is the beginning – not the end, not even the middle – of a process that needs ongoing and robust public participation. Direct feedback and creative alternatives from lawmakers and members of the public will enhance these plans and help the State achieve the required outcomes.

Not Traditional Cost-Cutting

Although the initial impetus for the Challenges was a need for constructive ways to address part of our anticipated $154 million fiscal year 2011 budget gap, this is not a traditional cost-cutting exercise. In cutting, one starts with the way we do things today and asks: How can we reduce the cost? There is usually no consideration of the outcomes involved. The focus is on trimming inputs, e.g., the number of people involved, office equipment, travel, or other such expenses.

By contrast, this reform package starts with the desired outcomes and the amount of money Vermont can afford to spend and then asks: If we rethink how we do things, how could we improve our outcomes with this amount of money?

In fact, the appropriations decision for Challenges has already been made with the passage of the initial Challenges bill in February. In FY2011, agencies and programs under the Challenges umbrella must deliver desired outcomes for $38 million less in general funds, as well as relieving $11 million of property tax pressure. These endeavors pave the way to $72 million less in general funds and $26 million of property tax relief in FY2012.

These budget goals are critical as the State grapples with the lingering recession. To meet these targets without the Challenges process, the alternative is to revert to the usual cost-cutting methods – an option all parties are trying to avoid.

After a month of planning, it is possible to identify much of the $38 million in required General Fund savings. The next report, due in three months, will have sufficient detail on all of the plans to see how money will be spent in a way which accomplishes the outcomes while achieving all of the savings.

Emergence of Key Redesign Themes

State employees and private citizens have worked hard and with great energy and innovation to make these initial plans. The plan to meet each challenge is different, but several broad themes have emerged across many of the challenges:

1. Program & Service Integration: Clients and taxpayers are better served by a few coordinated programs with more flexibility than a confusing morass of hundreds of programs. Service delivery needs to and can focus on clients rather than programs. Geographic and administrative consolidation of some functions is essential to effective delivery of many services.
2. Better Outcomes through Improved Technology: In the age of the Internet, technology can often be used to provide service more quickly and conveniently to clients at lower cost to the State. Automation of basic administrative functions frees skilled professionals to have more direct personal contact with clients when in-person time is crucial to good outcomes.
3. Path to Independence: The success of many aid programs is best measured not by how many they serve but by how many they help toward self-sufficiency and independence.
4. Performance Incentives: Just as a focus on outcomes allows state workers to deliver better service at lower cost, state contractors and grantees will perform better at lower cost when they are offered incentives for performance and judged by results rather than having to jump through bureaucratic hoops.

Improving Outcomes, Acknowledging Impacts

The savings which have been identified and will be identified come through being more effective rather than from abandoning clients or slashing services. Nevertheless, when government spends less, someone receives less – and someone pays less taxes or someone else has benefits preserved. Our decisions will have an impact.

In some of the easy cases, when we purchase fewer postage stamps or less fuel oil, the effect is mainly felt out-of-state. In other cases, we will purchase less from in-state non-profit partners or for-profit vendors; where we can, we give them an opportunity to recoup by being more effective themselves.

In some cases, because of our budget constraints, we must choose either to provide more effective service to Vermonters or to retain the existing administrative infrastructure within organizations. There simply are not enough resources to support both.

In other cases, being more effective over time will reduce the need for workers at the state or partner level. Given the upcoming demographic bulge in retirements, attrition

should allow most of these internal economies to be achieved, but, given economic uncertainty, there is no guarantee against selective reductions in the future.

That said, without the constructive approach of Challenges for Change, there would be few options outside benefit cuts and further reductions in force to close persistent budget gaps for FY2011 and beyond. There is no doubt that those impacts would be much more severe than the plans presented within this progress report – and, more importantly, without the corresponding benefits of improved outcomes.

Form of this Report

The portion of this report dealing with the Education and Special Education Challenges was prepared independently by the Commissioner of Education. The Corrections Challenge report was produced by the Agency of Human Services in conjunction with the Judiciary and law enforcement representatives. All other reports were produced by appropriate departments of the executive branch. The official report to the General Assembly consists of this book and its Human Services addendum. However, agencies have developed and will develop further information in support of their plans for use by the various committees of jurisdiction.

In general, each section details:

1. Progress Report: General discussion of work to date, process to brainstorm ideas, key plans and implementation outlines.
2. Challenge Outcomes and Proposed Measures: The outcomes and measurements as required by the Challenges Bill.
3. Savings Identified To-Date: These are preliminary estimates based on available data. These estimates will continue to be refined as the process continues and plans are informed with legislative feedback and public input.
4. Legislation Required: If plans require statutory changes, those modifications are outlined.

Next Steps

The Challenges for Change process is new territory for everyone. We are confident that this initiative will prove a better way to deliver the highest quality services to Vermonters in the years to come. Public participation is critical for its success. A joint public hearing will be scheduled within the next ten days and the legislative committees of jurisdiction will take testimony and receive public input beginning immediately. Based on feedback and new ideas, we will continue to fine tune plans to achieve the desired outcomes.

If an individual or group disagrees with a proposal offered in this report, we will ask for and welcome an alternative that achieves the mandated outcomes, is fiscally sustainable, and does not raise taxes or use reserve funds. The pace will continue to be swift and creative proposals will be a positive addition to the dialogue. We look forward to working with the General Assembly and all Vermonters on this important endeavor.

CHARTER UNITS

CHARTER UNITS

A. Progress Report

We have identified seven "first wave" charter units:

- Tax Department
- Department of Information and Innovation
- Fish and Wildlife Department
- Department of Liquor Control
- Department of Labor
- Department of Forest, Parks and Recreation
- Buildings and General Services

Each Charter Unit offers Vermonters the benefits of a "better deal." These along with the individual legislation requirements of each charter unit are listed below. More charter units may be added prior to the next quarterly report; these will not be dependent on new legislation.

The Secretary of Administration will grant appropriate administrative flexibility to each charter unit to allow that unit to more effectively achieve its goals. These flexibilities may include but are not limited to relief from bulletin 3.5 (contracting procedures), flexibility in part time and seasonal hires, exceptions from requirements to use certain BGS services, and latitude in website and marketing material development. Where flexibilities prove effective, they may be extended to other units; where appropriate, flexibility can also be withdrawn.

Some of the General Fund relief from charter units will actually come from an increase in entrepreneurial revenue; examples are more paid visits to state campsites and better collection of taxes owed.

B. Challenge Outcomes and Proposed Measures

1. Meet challenge target of reducing spending or generating entrepreneurial revenue of $2 million in general funds in FY2011 and $4.5 million in general funds in fiscal year 2012.
    - Measured from financial reporting
2. Increase employees' engagement in their work.
    - Measured by employee and client surveys
3. Produce outcomes for Vermonters that are the same or better than outcomes delivered prior to redesign.
    - (See individual charter unit summaries below)

C. Savings Identified To Date (FY11 target net $2,000,000)

The $2 million target will be met partially by entrepreneurial revenue increases and partially by savings apportioned over the Charter Units.

D. Legislation Required

Below is general legislation required for the Charter Unit Challenge as a whole. In addition, some of the charter units need some specific legislation in order to accomplish their missions. Charter unit specific legislation is listed in Section E below under the appropriate units.

1. Notwithstanding any other provisions of law, for a period of two years the Secretary of Administration may grant to designated charter units the ability to discount statutory fees, retain and reinvest savings or revenues in excess of the $3 million savings or revenue target, and transfer appropriations or funds as deemed necessary to accomplish the results specified for the Charter Unit Challenge and consistent with plans to improve business processes presented to the Secretary.

2. Notwithstanding any other provision of law, the Secretary of Administration may authorize web site and web portal development necessary for meeting the Challenges when either funded by the investment funds available for challenges or through the state's current web portal contract.

E. Individual Charter Units

Department of Taxes

Vermonters will get:

- More personal income tax revenue owed that is collected, as measured by the amount of income tax revenues above the amount currently estimated.
- Greater taxpayer satisfaction, as measured by customer surveys of the specific categories of taxpayers affected.

The primary initiatives the Department will undertake:

- Electronic filing of many W-2s
- On-line business tax applications

Legislation required:

- A mandate for businesses with more than 250 employees to electronically file their W-2s.

Department of Information and Innovation

Vermonters will get:

- Rapid development of online alternative to traditional ways of dealing with Charter and other Challenge units.
- Much more information available and searchable online.
- Faster processing of applications and permits.

The primary initiatives the Unit will undertake:

- Create a fast-response unit within DII to provide and/or contract for rapid development of web sites, the myvermont.gov web portal, document handling, and other appropriate online technology

Legislation required:

- Add a member of Joint Fiscal to the Web Portal Board and remove the requirement that both the Board and Joint Fiscal approve self-funding web portal development (note broader authority requested for the Secretary of Administration in Section D above)

Department of Fish and Wildlife

Vermonters will get:

- Additional revenues into the state's economy based on increased outdoor opportunities for families and people of all ages, as measured by license sales and the National Survey of Fishing, Hunting, and Wildlife-Associated Recreation.
- Improved public safety as measured by the number of shooting-related deaths and injuries.
- Improved shooting and hunter education as measured by number of graduates from hunter education and conservation camp programs.
- Improved access to and safety of public and private shooting facilities as measured by the number of publicly accessible shooting ranges in the state.
- Better licensing, registration, and permitting services, as measured by reduced turnaround times and applicant satisfaction as measured by surveys.

The primary initiatives the Agency will undertake:

- Develop a more effective, streamlined process for selling Department licenses and permits
- Generate additional revenues by promoting the sale of Department merchandise such as t-shirts, mugs, hats, books, posters, patches and stamps
- Reduce fee-for-space costs
- If feasible, collaborate with VT Lottery Commission to develop new mutually beneficial products

Legislation required:

- Allow permanent licenses to be sold by Point of Sale license agents [Title 10, Chapter 105, Section 4255 (c)]
- Change the amount a Point of Sale license agent can charge for a lost license to $1.50 [Title 10, Chapter 105, Section 4261 (a) and (b)]

Department of Liquor Control

Vermonters will get:

- Additional revenue for the general fund through increased sales.

The primary initiatives the Unit will undertake:

- A gift card program generating $50,000 in new revenue the first year of sales.
- Updates to the retail portion of the Department website

Legislation required:

- None

Department of Labor

Vermonters will get:

- Faster resolution of disputed worker's compensation claims
- More accurate and timely receipt of the benefits to which they are entitled
- More timely payment of medical bills
- Reduced and stabilized W.C. insurance premiums paid by employers and a stabilized W.C. special fund assessment on those premiums
- More accurate data in a timely fashion to allow better utilization of resources, including better targeting of safety and health consultation and enforcement resources
- Potential General Fund or Other Savings -- Since W.C. is a special fund program this initiative may not result in immediate direct savings to the general fund, but, over time, efficiencies may allow funding fraud enforcement through the special fund – returning approximately $308,212 to the General Fund

The primary initiatives the Unit will undertake:

- A review and refinement of existing processes and procedures to streamline processes and reduce paper handling and processing and allow active electronic case management
- Fully implemented electronic filing of W.C. claim information, forms, medical records into an improved, more responsive database, utilizing tested programs developed by IAIABC and other W.C. jurisdictions. This data system will be either integrated with, or at least fully compatible with the U.I. database systems
- Active electronic claim file case management

These outcomes will be measured by:

- Comparing time of injury report/notification of dispute to time of informal/formal resolution
- How quickly injured workers entitled to benefits receive them and how quickly medical providers are reimbursed for there services
- Changes in W.C. cost per case and W.C. premium paid

Legislation required:

- Statutory authority to fully implement electronic filing and data collection, a statutory change to 21 V.S.A. §660a is needed to permit collection of more information electronically and to permit the Commissioner of Labor to adopt an electronic signature protocol. Language similar to that provided the Commissioner of taxes a few years ago would be a start.

Department of Forests, Parks and Recreation

Vermonters will get:

- More and better state park and other recreational opportunities
  Measure: Total Park Utilization Increase of 15%-20%/2 years
- A park system that is financially sustainable, more resistant to cyclical downturns in General Fund revenue and increasingly less reliant on taxpayers
  Measure: Total Park Revenue Increase of 5%/year and 10%/2 years
  Measure: A Decrease in the Park's General Fund Expenditures of 50%/ 2 years & 100%/4 years
- An increase in the ancillary economic benefits of a robust park system
- A Forestry Division better able to sustain its natural resource stewardship mission and capable of sustaining its contribution to Vermont's forest products economy
  Measure: Preservation of Core Programmatic Services
  Measure: Diversification of Revenue and Decreased Forestry General Fund Expenditure of 10%/2 years
- Improved access to conservation, land management and recreation information

The primary initiatives the Department will undertake:

- Develop more effective, targeted, system-wide promotional efforts
- Boost outreach and cross-promotional opportunities with local community-based enterprises
- Provide an incentive system to seasonal staff to build and maintain expanded community relationships
- Improve the process for marketing and sales of season passes, punch cards and merchandise
- Develop an internet-based data management system to improve collection, sharing and use of state lands stewardship data; streamline the Department's license and special use permit process; and provide the public dramatically improved access to information like maps and recreation trail information.
- Augment seasonal staff levels to improve guest experiences and allow fulltime staff to prioritize state lands stewardship activities like timber treatments and other critical forest management activities
- Implement a fleet management pilot project in its Essex District
- Collaborate with the Department of Fish and Wildlife to leverage additional cross-promotional opportunities

Legislation required:

- Flexibility to use Special Funds for operational investments that produce necessary increases in non-General Fund revenue.
- Ability to reinvest proceeds of the sale of surplus FPR land into priority capital investments.
- Authority for the Commissioner of FPR to set fees through an exemption from, or through an abbreviated form of, the rulemaking process.
- Streamlining of the AA-1 process to accept donations or grants greater than $5,000 into the State.
- Eligibility to receive reimbursement for staff time associated with enforcement of water quality, AMP, Act 250 or Heavy Cut regulations.

Building and General Services

Vermonters will get:

- More of the state budget allocated to directly serving Vermonters rather than to government operations overhead
- More accessible and modern state facilities
- Buildings returned to local tax base
- Freed up capital funds to be used for purposes other than major maintenance of state buildings.

The primary initiatives the Department will undertake:

- BGS will work to divest the State of up to 500,000 square feet of state building assets to reduce future Capital Bill requirements, to provide flexibility to the changing face of state government, to improve and sustain the quality of facilities, and to reduce operating expenses in the next three years.
- In the Postal Service mission area, BGS will increase participation in usage of their services through a focused customer education initiative, the elimination of redundant and duplicative processes, and the maximizing of the use of electronic communications to create economies and standardize the quality of service in central Vermont.

Legislation required:

- Relief from certain Title 29 leasing and selling restrictions to provide flexibility.
- Legislative mandates that restrict leasing and purchasing of mail services equipment and permits.

PERFORMANCE CONTRACTS

PERFORMANCE AND GRANT MAKING CHALLENGE

A. Progress Report

Instituting the philosophy and adopting the practice of Performance Contracting and Grant Making will result in better outcomes for Vermonters receiving services; more clearly defined goals for consultants, contractors, and community partners; more efficient and effective programs for the same or less money; and a more transparent and responsive government. Aligning contracts and grants by evaluating them based on performance indicators and outcomes will provide a more cohesive approach to contracting and grant making.

State contractors and grantees will be given the freedom to concentrate on specified outcomes rather than on a set of bureaucratic specifications of how they should do their jobs. It is expected that this freedom will permit them to pass on reduced costs to the State. This reduced cost along with reduced payments in cases where outcomes are not achieved and direct or indirect savings when outcomes are exceeded will result in the required savings.

The challenge team has begun negotiating a performance based consultant contract to work with department contract owners targeting the largest GF or GF equivalent funded contracts and grants to negotiate or renegotiate in order to achieve the net savings target of $2.6 million. The vendor will be responsible for the tracking of performance measures, and reporting of savings. Incidentally, this vendor's contract will be this challenge's first to incorporate performance contracting principles.

Additionally, the team has already contracted for training services during April for approximately 80 Contract and Grant Managers from around the state that will provide specific training in performance based RFP's, best practices, etc. The training will focus on developing the scope of work, identifying incentives and disincentives, monitoring, etc.

Long Term – FY12 and beyond

While we have the consultant focus on achieving the $2.6 million in FY11 savings, the Challenge Team will be in a position to focus on creating systems and business processes that will go to the longer term goals of designing, documenting, implementing, and training necessary for the statewide performance contracting and grant making systems will be developed and instituted.

We will work with the Performance Measure Group to expand on their initiative to define, design, create and document standard statewide performance measure guidelines. The Performance Measure Group is the first step necessary to define mission goals for each department/program that will then lead to measurements used to determine if goals are being met; which then leads to specific performance measures in each contract that show the mission is being achieved. A training course will result from this document and become part of the annual curriculum at The Summit Center. The document will be

applicable to both grant making and contracting and may well become a new Administrative Bulletin when published.

We are currently working with the Department of Information and Innovation and Finance and Management to develop a mechanism to track performance contracts and grants, and compliance with performance measures.

B. Challenge Outcomes and Proposed Measures

1. *Increase the use of performance contracts with the goal of converting $70 million of contracts to performance-based contracts.*
   - The percent of all contracts that contain performance measures and the value of same will be tracked by use of a modified contract database already in use within the State's financial system.
2. *Contractors and grantees meet performance targets specified in contracts.*
   - A survey will be used to determine if specific performance measures were met or not among the departments, contracts and grants with performance measures – reported based on percent of measures met.

C. Savings Identified To date (FY11 target net $2,600,000)

The FY11 target will be met through renegotiations of our largest contracts.

D. Legislative Language Changes:

No legislation is needed to implement the Performance Contracting and Grant-Making Challenge within the executive branch. However, if the Legislature's intent is to include the Judiciary, elected offices, the Legislative Branch, and/or quasi government units (i.e. Vermont Veteran's Home) under this challenge then new language similar to that below is required:

It is the intent of the legislature that all branches, elected offices and units of government participate in the performance Contracting and grant making challenge, as defined in Act 68 Sec. 3 of the 2010 session, and notwithstanding any other provision of law, memorandums of understanding be executed between the administration and the afore mentioned government units to achieve the desired outcomes and implementation of this initiative.

REGULATORY

REGULATORY CHALLENGE
ACT 68, §7 (2010)

A. Progress Report

The Regulatory Challenge was charged with achieving the current standards, goals, and requirements of federal and state environmental and energy laws and regulations through improved administrative, application review, and compliance processes while achieving spending targets for fiscal years 2011 and 2012. Significant outcomes of the Regulatory Challenge include permitting and licensing processes that are timely, predictable, and cost effective; enabling applicants to readily obtain information and determine regulatory requirements; allowing citizens to understand and comply with the environmental laws; and providing a user friendly, transparent decision-making process for citizens. The proposals below have been developed through an intensive series of meetings by the Regulatory Challenge agencies: Agency of Natural Resources (ANR), Natural Resources Board (NRB), Public Service Board (PSB), Public Service Department (PSD), and the Court Administrator (collectively Team Regulatory Challenge or TRC). TRC and its subgroups have been meeting weekly and bi-weekly to develop these proposals. Specific proposals will, however, continue to be refined based on additional input by agency staff, legislative committees, and the public.

Central to achieving the objectives of the Regulatory Challenge is the use of Information Technology to improve the way information is delivered to the public and to enable state agencies to process permit and license applications and court filings using more efficient, fully electronic, paperless systems. Web Portals devoted to Permitting and Licensing requirements, Compliance Information, and Rulemaking, will be developed to enable citizens to more readily determine regulatory requirements and which specific permits and licenses are necessary to comply with those requirements. Deploying a Rulemaking Web Portal, in particular, will not only provide citizens with 24x7 access to current and proposed rules, but will also result in significant savings in newspaper publication costs to state agencies. Clear instructions will be provided so that the public can subscribe to automatic notification of proposed rules of interest by email, RSS feed, or twitter. The use of electronic Case Management Systems will enable citizens applying for permits and licenses to submit applications on line using smart forms that incorporate a master cover sheet to eliminate redundant data entry and separate schedules for individual regulatory programs. Electronic Case Management Systems will also enable state regulatory agency staff to process applications in an efficient manner using electronic work flow and to post permit applications and associated documents on agency web sites, providing transparency for agency decision making and opportunities for citizen participation.

Permitting and Licensing Efficiencies will be achieved through the expanded use of expedited Agency of Natural Resources (ANR) permitting methods such as general permits, permits by rule, conditional exemptions and acceptance of professional certifications. In addition, the permitting process will be streamlined by revising permit thresholds in some cases to match federal requirements, eliminating duplicative permit requirements, and increasing the duration of some certifications. Similarly, the Agency

of Agriculture, Food, and Markets (AAFM) seeks the flexibility to administer its regulatory programs with multi-year terms instead of currently mandated annual terms, thereby gaining administrative efficiencies and reducing the filing and compliance burden on the regulated community. ANR also proposes to obtain reimbursement from applicants for a portion of the costs associated with some types of permit reviews and appearances before the Act 250 District Environmental Commissions, Environmental Court and Public Service Board.

Increasing Compliance is also a primary objective of the Regulatory Challenge. Better compliance will be achieved through a comprehensive review of educational and compliance related agency web and print resources to allow consumers to better understand requirements and comply with the law. In addition, compliance will be increased though improved coordination between local and state permitting processes by, for instance, placing a notice on all local permit application forms and local permits to inform permittees of state permit requirements. State agencies (NRB, ANR, PSB, AAFM) also seek the authority to require permittees to periodically file a Certification of Compliance. Additional Municipal Outreach will include targeted training of town staff by ANR, AAFM, and Act 250 staff in coordination with the Vermont League of Cities and Towns and UVM Extension Service. Funding for these efforts is proposed by expanding the scope of Supplemental Environmental Projects (SEPs) currently authorized under 10 V.S.A. §8007(2) to cover education and outreach through information technology.

B. Challenge Outcomes and Proposed Measures

1. *Permitting and licensing processes achieve environmental standards and are clear, timely, predictable and coordinated.*
    - Applications and renewals are processed more quickly, meeting statutory and internal permit processing times.
    - Phosphorus in Lake Champlain is decreased.
    - Vermont air quality program tracks federal program for Green House Gases.
    - Fewer permits are needed for the same activity.

2. *Applicants are able to readily determine what permits and licenses are needed and what information must be submitted.*
    - Permitting and Licensing Web Portal is used by the majority of citizens seeking information about permits and licenses.
    - Incomplete applications to regulatory agencies are reduced after Electronic Case Management Systems and Web Portals have been implemented.
    - Staff time is redeployed from ministerial functions to customer service and technical assistance.

3. *Permit and enforcement processes enable people to understand and comply with environmental and agricultural laws.*

- Compliance increases as permittees are required to give attention to permit terms.
- There is a decrease in enforcement cases/costs in which lack of understanding of state permit requirements plays a role in the cause of the violation.
- Education and outreach increases with the expenditure of Supplemental Environmental Program (SEP) funds.

4. *Permitting, licensing and environmental protection services are cost-effective and user friendly.*
    - More permits are issued as general permits and permits by rule.
    - Applicants use professional certifications to meet permitting requirements.
    - Applicants submit more permit applications on line.
    - Investigators from other state agencies refer more cases to environmental regulators for enforcement and compliance.
    - Service of process is accomplished more easily and less expensively.

5. *Decision making is transparent and encourages citizen understanding and participation.*
    - Citizens use web portal to review notices and draft permits, read rules, determine hearing times, and make comments on proposed rules.

C. Savings Identified To date (target net $360,000)

1. *ANR*
    - ANR estimates that reimbursement of certain costs in permitting, including Act 250 and PSB proceedings, will save $75,000 per year as an offset to staff costs.

2. *Rulemaking*
    - State agencies currently pay to have notices of proposed rules published in newspapers; over 51 rule proposals per year, on average. The Secretary of State recently reduced publication costs effective January 27, 2010 to $1900, 2100, 2300, depending on word count, from $2100, 2300, and 2500. Even using these reduced costs, changing to online publication will save upwards of $96,900 statewide, on an annual basis.

D. Summary of Proposed Legislation

- Revise the State APA to allow for expanded use of electronic data
- Put notices of rule making on state website rather than newspapers
- Have all state rules in one location and accessible for free
- Allow for electronic filing of proposed rules

- Change permit terms for some AAFM permits, registrations and certifications to allow for increased efficiency in processing applications
- Allow PSB to publish notice of certain applications and hearings on PSB website rather than newspaper
- Give ANR authority to issue permits in various ways for categories of activities that are subject to the same regulatory requirements
    - General Permits, Permits by Rule, Conditional Exemptions
    - Authorize ANR to accept professional certifications that permit applications are complete and accurate and eliminate application review
- Authorize ANR to implement specific program efficiencies such as notice on website v. newspaper, extending the term of some permits, and eliminating permit duplication.
- Revise the permit threshold for Air Pollution Permits to track federal program
    - Necessary to avoid unanticipated expansion of permitting requirements to farms, some small businesses, schools, etc.
- Provide authority to require people with existing permits to certify compliance with the permit
- Allow some penalty moneys to be used for enhancing public awareness of environmental laws
- Make method of service for enforcement orders consistent with the means of service for other court documents
- Allow ANR and the NRB to retain that portion of a penalty that covers the actual costs of enforcement (ex: mediation, discovery)
- Allow ANR to seek reimbursement of costs from an applicant before ANR, Act 250 and the PSB and from a person appealing in Environmental Court under limited circumstances
- Require local applications and permits to clearly state that a state permit may be required.
- Seek legislative authority to create cross-agency task forces and assign positions as required to implement the Challenge tasks and expectations

ECONOMIC DEVELOPMENT

ECONOMIC DEVELOPMENT CHALLENGE

A. Progress Report

The challenge is to improve economic development results. The specific charge is to create sustainable non public sector jobs, improve median income in Vermont and to expand telecommunications infrastructure and usage throughout the state. The financial goal is to reduce spending included in the Unified Economic Development Budget (UEDB) by $3.4M in FY11 and FY12. The agencies represented in the UEDB have met to analyze current programs and to develop strategies for meeting the challenge.

Those agencies considered that there are now many regional entities supported by the state through the UEDB, including:

- 12 Regional Development Corporations
- 11 Regional Planning Commissions (heavily involved in economic development activities)
- 14 Regional State Employment Offices
- 5 Regional Micro Business Development Programs
- 8 Regionally deployed Small Business Development Center Councilors
- 4 Statewide and simultaneous, employer outreach programs for employee training

There are significant redundancies and overlaps in regionally provided services and many opportunities for enhanced services by reducing the number of regional offices and combining their operations into no more than nine Regional Service Centers (RSCs) that will provide the following services:

- The full range of planning functions currently provided by the Regional Planning Commissions.
- The full range of economic development services currently provided by the Regional Development Corporations.
- A single employer outreach program for employee training delivering multiple products in each region.
- Micro and small business development services for very small and small business assistance as well as agricultural based businesses.
- All the employment services currently provided by the Department of Labor at 14 locations.

Clients will benefit from a one-stop shop for employer assistance, integrated planning and economic development for more effective site location, permit assistance, and economic development planning, and reduced employer outreach from four different, product-centered programs to one outreach program which includes all existing, training products.

The plan is to issue a request for proposals to procure services in no more than nine regions. This requires memorandums of understanding with Department of Labor, Agency of Human Services and Vermont Small Business Development Center for continued operations in the new regions. The RFP will allow for any configuration of

region and organizational structure that achieves the RFP's required outcomes. The state would offer performance based contracts to the successful proposing entities. These contracts would be for three years with renewable options. RSCs would be required to report to the state on their performance quarterly during the first year and semiannually thereafter. Annual compensation would be adjusted to reflect performance or lack thereof for each RSC. The contracts would require collocation within the first three year period. There will be no further funding for any regional or statewide economic development or planning entities outside of the nine regional service centers. However, there will be no limitations on other activities of Regional Service Centers. The state will provide up to ten $10,000 grants to help existing grantees develop proposals

The RFP will be issued as soon as the reconciliation bill enabling the necessary changes was passed into law and contracts will be issued for FY11.

B. Challenge Outcomes and Proposed Measures

1. Vermont achieves a sustainable annual increase in non public sector employment and median income.
    - Create one non public sector job for every 200 persons in the region served per year.
    - Retain one job for every 100 persons in the region served per year.
    - Seventy five percent of non-incumbent Workforce Education and Training Fund participants will have wages reported in the first quarter following completion of training.
    - Eighty five percent of non-incumbent WETF participants with wages reported in the first quarter after completion will have wages reported in the second and third quarters.
    - The average WETF training program participants will earn between 150 – 200% of the minimum wage.
    - Ninety five percent of incumbent workers participating in WETF programs will retain their employment in the first and second quarter following completion.
    - The average earnings increase for those incumbent workers who retain their employment in the first and second quarters following completion will be up to four percent.
    - Sixty percent of internship participants will be post secondary students.
    - Ten percent of post secondary internship participants will enter employment following completion of the internship.
    - US Department of Labor statistics on Vermont's median household income.
    - RSCs will be required to record the range of household income for every served person before and after assistance is provided. This information will be provided by region and in the aggregate annually.

2. Vermont attains a statewide, state of the art telecommunications infrastructure. [note: currently the budget for telecommunications initiatives is not in the UEDB; so, although broadband is essential for economic development, it is not controlled or managed by any of the agencies represented by the UEDB. The legislature may want to change this in future years. The metrics below will be supplied by the Vermont Telecommunications Authority]

   - Percentage of residence with broadband access using the current Vermont definition of broadband
   - Percentage of cellular coverage on major roads
   - Percentage of cellular coverage on minor roads

C. Savings Identified To Date (target net $3,030,000)

The savings below are achieved through the consolidation proposed above. Organizations shown with zero funding from UEDB may actually receive funding as sub-contractors to the Regional Service Centers.

ACCD	**Now**	**After**	**Savings**
RDC Grant	1,076,468	839,645	236,823
RPC Grants	2,632,027	2,052,981	579,046
SSJF	233,890	0	233,890
VCRD	47,500	0	47,500
VEOC	23,750	0	23,750
VWBC	19,000	0	19,000
One Position	75,000	0	75,000
Total	4,107,635	2,892,626	1,215,009
AHS			
Micro	328,000	0	328,000
Labor			
Adult Tech Ed	430,000	0	430,000
WIB Funds	145,000	80,000	65,000
Total	5,010,635	2,972,626	2,038,009

D. Legislation Required

1. Repeal of 24 V.S.A. Chapter 76 on Economic Development Grants: Chapter 76 establishes a grant program authorizing the ACCD secretary to provide subsidies to Regional Development Corporations (RDCs). Repeal of this Chapter would allow incorporation of the economic development elements into 24 V.S.A. Chapter 117 related to Regional Planning Commissions.

2. Amendment of 24 V.S.A. Chapter 117 on Municipal and Regional Planning and Development: Chapter 117 establishes, among other things, the Regional

Planning Commission (RPCs). Provisions from Chapter 76 of Title 24 would be added to Chapter 117 to consolidate the services and activities of the RDCs and RPCs into a new organization called a Regional Service Center.

3. Repeal of 24 V.S.A. § 4305 on the Council of Regional Commissions: The Council of Regional Commissions has been inactive for several years and is not needed for the transition to a Regional Service Center model.

4. Amendment of 10 V.S.A. § 541 on the Workforce Development Council: Delete language requiring one third of the governor's appointees to be selected from a list of names provided by the regional Workforce Investment Boards, as well as delete the Council's responsibility for establishing and overseeing workforce investment boards and make other programmatic changes.

AGENCY OF HUMAN SERVICES

Overall Human Services Challenge

A. Progress Report

The solutions developed by the Agency of Human Services to meet the Challenges for Change are based partly on the rapid expansion of existing successful programs like Blueprint for Health and integrated service delivery initiatives in the Department of Children and Families and partly on rapid innovation by agency management and employees in response to the challenges.

There are several unifying themes in the responses to the four sub-challenges posed by the legislature to the agency:

- Integration of the services offered to a family or individual across the many silos of existing programs
- Substituting more effective lower cost strategies like preventive care for more disruptive and expensive treatments like emergency room care
- Providing a pathway to full or partial independence
- Managing vendors and grantees by outcomes

Brief descriptions of the sub-challenges are on the pages that follow in this report. Much more complete descriptions of the progress made to date on these challenges as well as detailed measures for the outcome mandated by the legislature can be found in an appendix to this document devoted to the AHS Challenges.

In order to enhance its response to all the challenges, AHS is also undertaking two agency wide initiatives outlined here and detailed in the AHS appendix.

Employment Workgroup Initiative
Employment research has repeatedly shown that having and keeping a job reduces dependency on services and benefits for Agency of Human Services (AHS) consumers. The Challenges Workgroup has developed a consolidated and coordinated approach to employment services, moving from services dispersed across AHS to a single entity within AHS called Creative Workforce Solutions (CWS). CWS will provide equal access to meaningful work in the competitive job market for all AHS program participants. It will also offer employers a single point of contact for coordinated job development and placement services across AHS programs. This approach will significantly improve ease of access for employers.

IT Enterprise Infrastructure
As a foundation to all these specific proposals and in an effort to promote more client centric intake and care management, AHS proposes to modernize the IT infrastructure. The redesign relies on constructing an enterprise architecture for technology, information

and the business of AHS. An enterprise architecture creates a roadmap for the use by the same or similar technologies across the all of AHS. These will provide guidance for future investments. It is built on the principles and products of a service oriented architecture (SOA) of common technologies and shared services that provide reusable components for various needs. For example, AHS would purchase and install one master-person index or one imaging solution that was configured for Agency wide utilization.

B. Legislation required

- legislation that exempts IT investments made in conjunction with the Challenges initiatives, including the purchase and implementation of components of the enterprise architecture including Master Person Index, work flow engine, enterprise bus and rules engine. The exemption could sunset at the end of FY12

Client Centric Intake and Care Management

A. Progress Report

Integrated Family Services

AHS will design and implement a family and child centered system of early intervention, treatment and support. Funding will be flexible and based on best practices and family needs. The system will strive to intervene early in a preventive fashion, and provide services to the family unit, not just the child. Each child and family in the early intervention, treatment and support system will have measurable goals against which progress will be assessed. We believe this approach will produce better outcomes for children and families, reduce unnecessary administrative work, and save money through earlier intervention and family support.

As part of integrated family services, we propose to improve early childhood services for families while increasing effectiveness by consolidating child development services for families and children through a single community partner contract within each region. This will include consolidating child care referral services for families by changing from 12 local service providers to one statewide entity supported by modern web-based technology and communication systems. Supports for early childhood and after school practitioners and programs will be improved to assure a systemic approach to program consultation, quality improvement, and professional development.

Statewide Expansion - Blueprint Coordinated Health Systems

We propose to reduce overall healthcare expenditures through the accelerated expansion of the Blueprint model and to expand it to other populations and systems, building off a primary care foundation of medical homes and community health teams. Work is underway with the Office of Vermont Health Access (Medicaid), the Vermont Department of Mental Health, the Vermont Department of Health, as well as non-governmental organizations to develop models of sustainable integrated health services. As an example, planning is underway to establish Mental Health & Substance Use Medical Homes with similar financial reforms that can support high quality outpatient services and preventive care, with reductions in avoidable acute care expenditures. Similar work is underway to expand the Blueprint to pediatric services.

Modernization of Benefits Eligibility Determination

For the past two years, DCF has been involved in modernizing its processes for determining eligibility for various benefits programs, such as Three Squares and LIHEAP. Staffing will be reduced while consumer access and self service options are increasing. This is being accomplished by utilizing such tools as a Benefits Service Center (call center), Web Access, an Application Processing Center, Specialized Eligibility Determination and Supports for Community Providers. We propose to expand this effort to include eligibility determination for child care financial assistance. This will involve replacing private contracts at 12 community agencies (which have been in place for the past 15 years) and centralizing the work within the ESD eligibility system described above.

B. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

D. Legislation required

- Statutes detailing the power and authority of the Commissioner of DMH (18 V.S.A. § 7401 must be amended to include the concept of "at risk" into statutes related to serving the target population of children with a severe "Severe Emotional Disturbance" by the DMH. This would give clear authority to provide services earlier.
- Language will be necessary to require commercial insurers to participate, amending previous language (Act 204, 2008) that required commercial insurers to participate in the currently operating Blueprint Integrated Pilots.

Support Services Promoting Independence of Elderly and Individuals with Disabilities

A. Progress Report

DAIL intends to aggressively assist Vermonters to remain independent using home and community based services and as a result reduce nursing home utilization In some counties in Vermont nearly 60% of all persons needing nursing home level of care are served at home or in alternative community based settings. In other counties, the utilization of home and community based services hovers around 40%. Greater utilization of home and community based services is achievable, with an accompanying reduction in nursing home utilization.

Vermonters who need long term care, and choose home based services, can benefit from more flexibility in how the dollar allocation in their plans of care are utilized. This strategy is intended to allow more participants to remain independent. For example, Choices for Care has a limited set of service options that are paid for on a fee for service basis, unless the consumer chooses the Flexible Choices option, where, with the help of a counselor, the consumer manages his/her budget. Only a small group of consumers have selected this option. DAIL is exploring different payment mechanisms that can provide more flexibility to consumers.

Providers can also benefit from flexibility. For example, moving away from a fee for service system could reduce paperwork requirements and time for both providers and State staff.

DAIL is exploring how to utilize the Developmental Services individualized service plans, which the Designated Agencies (DAs) and Specialized Services Agencies (SSAs) develop with consumers, as performance based contracts based on achieving better outcomes for consumers.

DAIL has also proposed legislative changes to Medicaid estate recovery law to increase revenues for the program to ensure persons most in need can continue to receive services.

Another concept involves redesigning the delivery and financing system to have home and community based providers in the long term care system receive bundled rates based on consumers' needs and preferences. The provider agencies, instead of being specialty providers, would accept the responsibility to provide or arrange for all the services a participant needs. In return the provider would be paid a bundled rate based on a plan of care and perhaps a tiered system of rates. We believe this would create opportunities for savings; but it is a large and complicated change that will require more discussion and design time.

B. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

D. Legislation Required

- Legislation will be needed to amend Medicaid Estate Recovery law. Such legislation is already under consideration in the legislature.

Purchasing Results, Not Units of Service

A. Progress Report

OVHA Direct Care Coordination
The Office of Vermont Health Access (OVHA) will expand its direct care coordination capacity in two additional areas of the state to improve the health care and outcomes for Medicaid beneficiaries with significant medical needs. FY11 will focus on two additional areas of the state. This expansion will directly reduce costs in the Medicaid program and if successful will be expanded statewide in FY12.

OVHA Clinical Utilization Review Board
No later than May 15, 2010, OVHA proposes to establish a Clinical Utilization Review Board, to ensure that medical treatments and services paid for with state health care dollars are safe and clinically effective. This board will work collaboratively with the DMH utilization board and jointly they will address both medical and mental health practices in the Medicaid program. It will also ensure that public funds are used in the most cost effective manner that promotes positive health outcomes. Ultimately, the goal is to provide coverage for evidence-based care that meets the specific needs of our beneficiaries in the most cost-effective manner.

B. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

D. Legislation Required

- Section 6 of 33 VSA §1903a must be amended to remove language requiring that a private entity administer the program.
- OVHA needs the statutory authority to:
  - Have the final authority to evaluate and implement recommendations of the CURB.
  - Develop rules if necessary for the specific recommendations, as prescribed by state and federal guidelines

Focus Designated Agencies on Client Outcomes

A. Progress Report

The Department of Mental Health
The Agency proposes to improve the mental health of citizens by increasing access, decreasing redundant services and documentation, and actively working with the Blueprint for Health and other areas of health care reform involving OHVA. The Department of Mental Health proposes substantial changes in the adult mental health services area, and smaller changes in other areas of care through partnerships with the designated agencies as well as the Office of Drug and Alcohol Programs and the Department of Disabilities, Aging and Independent Living.

Adult services are now composed of acute care services in Adult Outpatient Programs (AOP) and ElderCare Program (ECP), as well as in Community Rehabilitation and Treatment (CRT), the long term program for adults with serious mental health conditions. The changes proposed will begin to address several challenges. First, the need to provide more flexible services for those longer term consumers who wish to transition towards more independence but who are fearful that they will not have services if they need them in the future. Second, by creating a continuum of service for adults more consumers would be able to benefit from packages that are supportive of their individual choices and needs at the time.

Family and child program redesigns are encompassed in a larger effort to address services across all areas of AHS via Integrated Family Services (IFS) and addressed in a separate proposal. DMH is a full partner in that proposal.

DMH has a number of additional system efficiencies including changes in technology, a centralized crisis line for after hours' coverage, and streamlining of administrative oversight and paperwork to produce additional savings.

Department of Disabilities, Aging and Independent Living
DAIL is exploring how to utilize the individualized service plans the DA's have with consumers with developmental disabilities as performance based contracts based on better outcomes for consumers.

B. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

D. Legislation Required

- The Department of Mental Health (DMH) proposed two areas of legislation for the 2010 session which can be preferred methods for improving outcomes and reducing unnecessary expense to state government. Both bills are focused on the Challenges for Change main concept, to alter areas of service that do not achieve outcomes useful to clients, and/or are poor use of resources by which a better investment of funds could improve the lives of those persons. These two areas, involuntary medication and court ordered forensic observation, were proposed for legislative action in the form of two bills:
  - H. 616 An act relating to involuntary mental health treatment, and
  - H. 631 An act related to court ordered forensic evaluation of criminal defendants.

- The Department of Disabilities, Aging and Independent Living will need language will to ensure that efficiencies gained in the developmental services are not subject to continuing benefits during any appeal that might be filed. Individuals may appeal a change in their individual budgets, but continuation of benefits without change shall not apply to efficiencies identified and implemented during the pendency of any appeal.

CORRECTIONS

CORRECTIONS CHALLENGE

A. Progress Report

Central to achieving the objectives of the Corrections' Challenge is creating a unified criminal justice system. This system will utilize strategies to enhance community capacities so that offenders may receive services that reduce needs, such as transitional housing and treatment, at the lowest level of intervention by the Department of Corrections, consistent with public safety. These strategies will ensure that secure incarceration beds are prioritized for those offenders who need a higher level of correctional intervention.

By strengthening community capacities with additional probation office resources (such as staff and electronic monitoring equipment), creating residential substance abuse opportunities, using home confinement/incarceration as a sanction and expanding drug courts, technical violation behavior of lower level offenders can be more effectively addressed.
The incarcerated population and resulting costs can be decreased in line with the Corrections' Challenge goal by:

- Creating alternative sentencing options for the Court, such as home incarceration (24/7 at home) and home confinement (allows for participation in employment, treatment and community service).
- Expanding the time prior to serving the minimum sentence that an offender may be released to reintegration furlough.

A major result of this work will be an overall decrease in the use of incarceration within the Department of Corrections while maintaining public safety through enhanced supervision of offenders (consistent with their level of risk) in the community. Additionally, as this plan is implemented, there should be an increase in the use of alternative sanctions by the Courts, such as reparative board referrals and diversion, and a decrease in the number of people entering the Correctional system. Vermonters who commit crimes will be dealt with at the lowest appropriate level and diverted, wherever feasible, away from incarceration. In the past the Department has utilized electronic monitoring and alternative sanctions as deferring or release mechanisms. We believe that these strategies have lessened, though not erased, the rise in incarceration numbers.

B. Challenge Outcomes and Proposed Measures

(See the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(See the detailed report from AHS in the appendix to this report)

D. Summary of Proposed Legislation

a. Enact S, 292 as passed by the Senate and expand the bill to include the original Senate Judiciary Committee language regarding DUI 3 and greater.
b. Amend the reintegration furlough statute, 28 V.S.A. §808(a) (8), to expand its timeframe from 90 days to 180 days for all offenses. DOC's current utilization of reintegration furlough is less than 20%.
c. Amend 13 V.S.A. §7030(a) to include a sentencing option known as a "supervised release sentence" and prohibit the use of non-consecutive sentences such as a weekend interrupt sentence.
d. Enact a statute to create a "Supervised Release" status based on the New Hampshire model.
e. Establish home confinement as an optional condition of release to 13 V.S.A. §7554 and home incarceration as a sentencing option for courts.
f. Authorize judges to grant "use immunity" to offenders charged with a violation of probation based on new criminal charges.
g. Enact a statutory limitation on use of arrest warrants and incarceration for failure to pay a fine or surcharge.
h. Authorize referral of misdemeanants to reparative boards at sentencing and authorize the boards to return such offenders to court for further sentencing for failure to comply with board requirements.
i. Amend 28 V.S.A. §205(a) (3) (A) to standardize the probation term limit for felonies to a set period of years.
j. Eliminate mandatory minimums for misdemeanor offenses by amending 23 V.S.A. §674(b) (DLS) and 13 V.S.A. §1028(a) (simple assault on a police officer).
k. Adjust caseload ratios for lower level offenders.
l. Combine Community Justice Centers and Diversion Boards to streamline and coordinate their efforts. This proposal was discussed by the stakeholder group as an option to explore for FY12.

EDUCATION

Introduction

1. Progress Report on the Education Challenges Plan of Implementation

A committee composed of a teacher, school board member, high school principal, supervisory union business manager, a superintendent, a technical center director, special education director, a State Board of Education member and a person from the private sector was formed and met six times with the Education Commissioner Armando Vilaseca, Bill Talbott and Tom Evslin to develop ideas for meeting the two challenges and six outcomes as stated in Act 68 of 2010, Section 6. The pros and cons of the ideas discussed at these meetings are the basis for this plan. While the complete discussion has informed my decisions, these recommendations are mine. I also include two other options as alternatives.

Status Report of the Plan

Act 68 of 2010 has fiscal challenges for FY 2011 and FY 2012. Given that school budgets adopted this past town meeting for FY 2011 were $22,000,0000 below "the 2009 estimates of fiscal year 2011 education spending used to determine property tax rate adjustments under 32 V.S.A. § 5402b" I am concluding that the FY 2011 fiscal challenge have been met. If my conclusion is not accepted we have estimated that $3.5 million of the savings in the adopted budgets can be attributed to administration. This leaves a remaining amount of $9.8 million to be reduced from the FY 2011. Given that budgets have already been adopted by the voters these savings could be made by assigning further reductions district by district using an allocation method sensitive to those districts that have been reducing costs or seen fewer spending increases. The rest of this status report refers to meeting the outcomes and the FY 2012 fiscal challenges.

General Education

The major driver of administration costs in the current system is the 307 schools in 280 schools districts administered through 58 supervisory unions and districts (two others are interstate school districts). Department staff point out that the cost of administration is mostly driven by the number of entities that need to be administered and less by the number of students. The most direct way to reduce administration costs is to reduce the demand for administration by reducing the number of entities needing administration. Ultimately, significantly reducing any costs in Vermont's education system means reducing staff because at least 80 percent of the total cost of education comes from staff salaries and benefits. My proposal is as follows:

1. Merge the member districts of the 46 supervisory unions into supervisory districts by school year 20012-2013 so that the total number of supervisory districts (including the 12 already in existence) in the state is no more than 50. These districts averaging some 1800 pupils will be larger than what we are accustomed to but will still be small.

2. Establish minimum student-to-staff ratios in Year 1 at 4.75:1 (currently at 4.55:1) and 4.95:1 in Year 2. "Staff" refers to all staff employed by school districts and supervisory unions. "Pupils" refer to the full-time equivalent enrollment of the public schools. School districts should take advantage of attrition as much as possible to achieve the higher ratios. Even with the increased student-to-staff ratio proposed Vermont will still be among the fewest student-per-adult ratio of any state and, by national standards, our schools and districts will still be small. Arguably, our larger schools and districts will not lose the value of small size. They will be in a structure that gives the benefits of relatively small size complemented by at least some economies of scale.

3. Create a commission to review the viability of schools with enrollment of fewer than 75 students considering issues such as geographic isolation and the capacity of any surrounding schools. The purpose of the commission would be to identify small schools that should remain open.

I believe this plan will serve to reduce costs as well as increase learning opportunities leading to the desired outcomes for students. Simply put, smaller districts have fewer options financially and programmatically, larger districts have more.

Vermont's 246 towns are served by over 280 school boards, with over 1,480 members, for approximately 92,000 students. Substantially reducing the number of school districts, and in turn boards, will provide consistent, high-quality opportunities to students. There is no magic number of school districts. However, they would have to be large enough to expand school choice for students, reduce the administrative inefficiencies we currently experience and economize the school staff.

In a more streamlined administrative structure, opportunities not currently available to our students and families could be realized. If there were more schools within each educational district, districts could offer options based on the interest and needs of individual students and families.

Middle and high schools could offer different options for students in order to attain their diploma. These schools could offer specialties in particular areas, while still providing the liberal arts education our public schools have traditionally provided. Schools could offer students the opportunity to do semester-long internships while still attending their school of choice. Not all high schools would operate this way, as our current structure serves many students well. However, for those capable students who do not reach their potential currently, these schools would offer an alternative. Schools partnering with private business could provide workforce development, internships, job shadowing or other forms of real-life learning that could be enhanced by such a model.

Schools could expand their offerings to concentrate on having a richer curriculum in specific topics, while their neighboring school may have a different focus. This type of "magnet" school concept could allow for one school to have a focus on arts/humanities while another school in their district could concentrate on math/science/technology. The

convergence of theory and application could be accomplished, as schools would not be expected to offer everything to everyone because students/parents would have a choice in their education.

Special Education

Special education is part of Vermont's education system offered by school districts and is not a separate system. The plan for meeting the two outcomes referring to students who have or may have special needs (numbers 5 & 6) listed below must be taken as a whole. For example, Item 1, providing a block grant for special education funding, will not work if districts remain small and are not merged and the other four components are not implemented.

The timeline for this plan has yet to be established. One gauge of the process is to consider that the department has been working with schools to implement the Response to Intervention for three years reaching about one-third of the schools.

1. Institute a block grant for special education based on ADM with a weighted system regarding individual student services to determine required allocation.
    a. A separate process for residential students would need to be created.
    b. Continue current process for state-placed students.
    c. Continue process for unexpected and unusual cost requests.
    d. Create a statewide limit on what schools can pay for an hourly rate for related service providers and daily rates for outside placements in day school programs. (The remainder cannot fall to the local budget.)

2. Require a specific team process to determine the need for paraeducator services. When a paraeducator is necessary, require a fading plan in the IEP.

3. Increase implementation of co-teaching through Education Service Areas (ESA) using reinvestment funds.

4. Require all schools to implement Positive Behavioral Intervention and Supports, Differentiated Instruction and Response to Intervention.
    a. Training would be facilitated through ESAs using reinvestment funds.
    b. All educators and administrators would be required to participate in the training.

5. Require a specific process/protocol for all service decisions at an IEP meeting with required training annually of all individuals serving in the role of the Local Education Agency at team meetings.

Option 2
If the proposal above is not accepted the fiscal challenge in FY 2012 can be met by establishing minimum student-to-staff ratios to take effect in FY 2012 at 4.95:1 (currently at 4.55:1). "Staff" refers to all staff employed by school districts and supervisory unions. "Pupils" refer to the full-time equivalent enrollment of the public schools.

Option 3
If Option 2 is not accepted the fiscal challenges in FY 2012 can still be met by allocating to each school district a mandatory reduction amount so that its FY 2012 education spending will be lower the its FY 2011 education spending by that amount. Leave to the local boards and administrators to determine the manner in which those cuts should occur.

2. Needed Changes to Laws and Regulations
In order to meet the challenges outlined above, session law with a limited life of three years that overrides current law and permits the commissioner to organize the new district configuration would need to be created. Once accomplished a proper review of Title 16 can be made so that statutes can be amended or repealed as required.

Suggested language for session law
Sec. xx. Merging School Districts
a. Notwithstanding any law to the contrary, the commissioner of education in consultation with the State Board of Education's Policy Commission on Redistricting shall reorganize the current school districts so that each supervisory union comprises no more than one district. The commissioner shall also review all existing and new supervisory districts and merge smaller ones so that the total number is no greater than 50. Each new district shall be organized so that each member town is proportionally represented in the new district board either in number or by means of weighted voting.

b. The commissioner shall establish a timeline so that boards of school directors for the new districts can be elected before the school year beginning on July 1, 2011. That year shall be used for planning the operation and staffing of the new district, preparing a budget for the ensuing year and presenting it to the voters on Town meeting day in 2012. Each new district shall begin providing for the education of its pupils for the 2012 – 2013 school year.

c. A commission is established composed of xxxxx to examine the viability of each school operating with an enrollment in FY2010 of fewer than 75 students. In determining viability the commission shall consider the geographic isolation of the school and the capacity of the surrounding schools to accept more students. Upon completion of its review the commission shall determine which schools shall be closed and present this list the Legislature on January 15, 2012.

d. The commissioner shall review all pertinent statutes regarding the organization and governance of school districts and recommend to the Legislature necessary changes resulting from this reorganization.

3. System to Measure the Success for Meeting Challenges and Achieving Outcomes
Outcomes measures under the Act are to be "simple, objective, consistent, and based on data that are currently collected or could easily be collected."

(1) Increase electronic and distance learning opportunities that enhance learning, increase productivity, and promote creativity.

This is more of a "how" or way to achieve the outcomes than an outcome itself. By the end of this month the Learning Network of Vermont will be up and running in 90 schools across the state. This system allows students to use internet video to engage in learning experiences from anywhere in the world. To increase the capacity of this type of system high-quality broadband access must be delivered to each school. Work is currently under way using Stimulus funds toward this end. We also have many schools without LNV that are taking part in Scopia desktop trainings which include Webcam connections, sharing of desktop content and connecting to LNV cameras. Ninety-nine percent of schools do have some form of broadband, however, the quality differs greatly throughout the state.

In addition, we are exploring ways to partner with New Hampshire to combine our two states' initiatives on virtual high schools.

(2) Increase the secondary school graduation rates for all students.

Sec. 44 of Act 44 of 2009 established a goal for all secondary schools in Vermont to achieve a completion rate of 100 percent by 2020. Each year the department publishes the high school completion rate for each school so that the attainment of this goal can be tracked. Two measures are used: 1. the event rate or the percentage of seniors who graduate and 2. a cohort rate or the percentage of ninth-graders who graduate in four years. The cohort rate is now the standard measure across the nation.

(3) Increase the aspiration, continuation, and completion rates for all students in connection with postsecondary education and training.

Beginning this year (FY 2010) the department has subscribed to the data service of the National Student Clearing House. The Clearing House has a post-secondary database of all students attending post-secondary institutions eligible to receive federal aid. This would include trade schools as well as four-year higher education institutions. With this student-level data we will be able to track graduated seniors who are attending one of the institutions in the Clearing House database. FY 2010 will be the first year we have these data and this year can be used to establish the baseline. I propose achieving this outcome in the same way the graduation rate outcome is proposed. By 2020, 100 percent of high school graduates will be attending a post-secondary institution.

(4) Increase administrative efficiencies within education governance in a manner that promotes student achievement.

This outcome will be achieved when school districts have merged into no more than 50 supervisory districts. This will provide opportunities for increasing administrative efficiency because fewer governance units will need to be administered. This will also improve student outcomes and increase equal educational opportunities because larger districts will have more choices to offer students and more opportunities to effectively use limited staff.

(5) Increase cost-effectiveness in delivery of support services for students with individualized education plans.

(6) Increase the use of early intervention strategies that enable students to be successful in the general education environment and help avoid the later need for more expensive interventions.

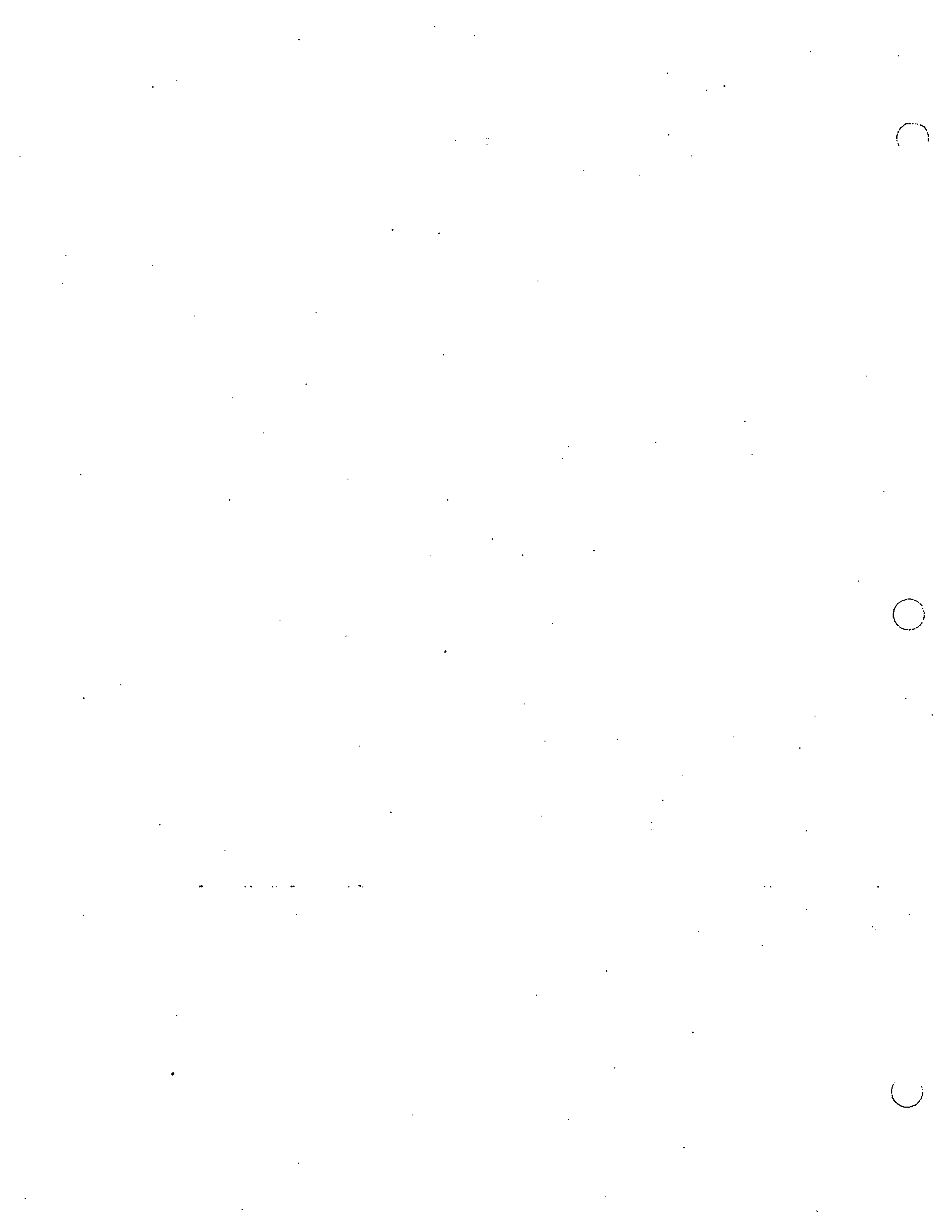
Outcomes 5 and 6 will be measured by a reduction of the number of paraprofessionals needed and the number of referrals for special education services, as well as a decline in the special education child count.

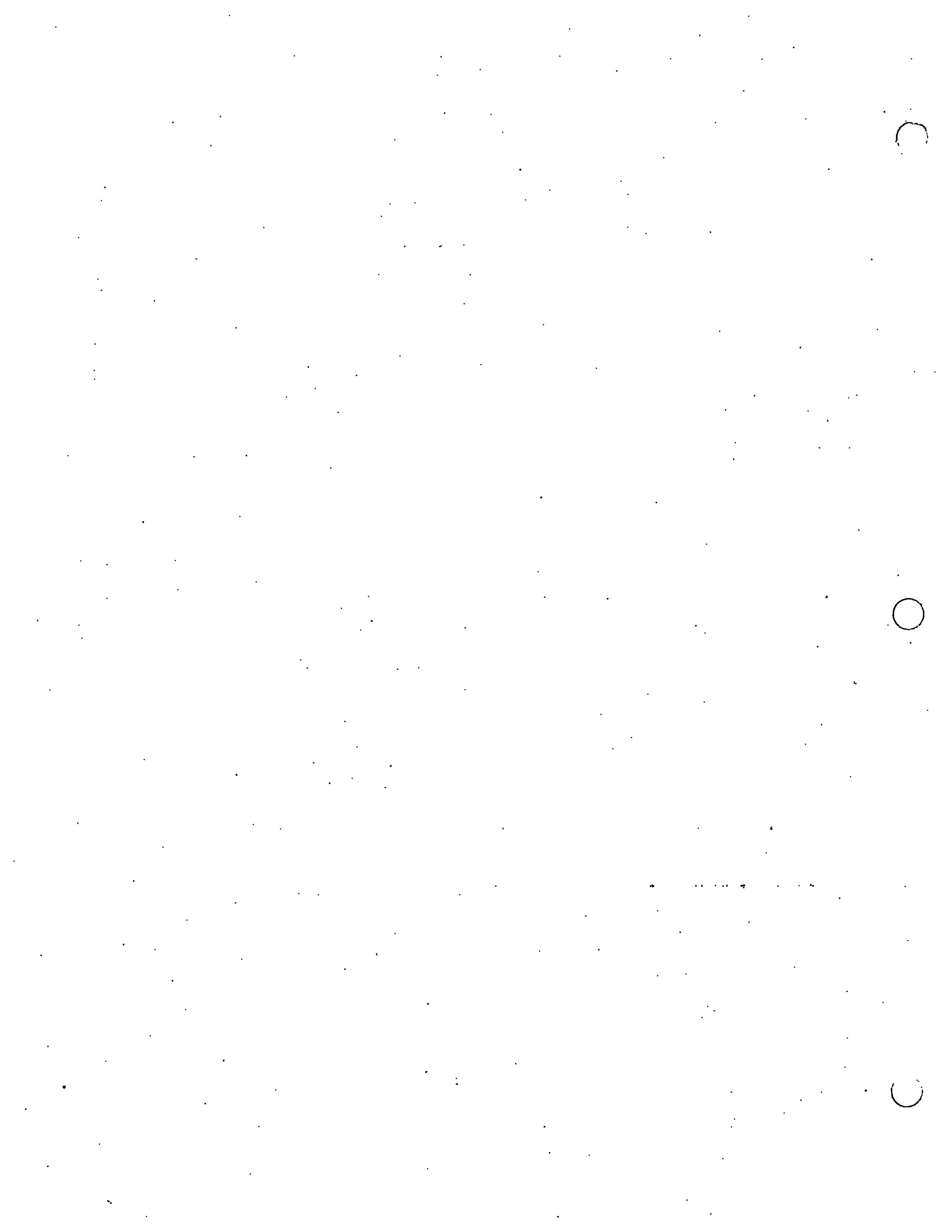
CHALLENGES FOR CHANGE: PROGRESS REPORT

TO THE JOINT LEGISLATIVE GOVERNMENT ACCOUNTABILITY COMMITTEE

VERMONT AGENCY OF HUMAN SERVICES (AHS) ADDENDUM

MARCH 30, 2010





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Challenges for Change

Overview

Overall Human Services Challenge

A. Progress Report

The solutions developed by the Agency of Human Services to meet the Challenges for Change are based partly on the rapid expansion of existing successful programs like Blueprint for Health and integrated service delivery initiatives in the Department of Children and Families and partly on rapid innovation by agency management and employees in response to the challenges.

There are several unifying themes in the responses to the four sub-challenges posed by the legislature to the agency:

- Integration of the services offered to a family or individual across the many silos of existing programs
- Substituting more effective lower cost strategies like preventive care for more disruptive and expensive treatments like emergency room care
- Providing a pathway to full or partial independence
- Managing vendors and grantees by outcomes

Brief descriptions of the sub-challenges are on the pages that follow in this report. Much more complete descriptions of the progress made to date on these challenges as well as detailed measures for the outcome mandated by the legislature can be found in an appendix to this document devoted to the AHS Challenges.

In order to enhance its response to all the challenges, AHS is also undertaking two agency wide initiatives outlined here and detailed in the AHS appendix.

Employment Workgroup Initiative
Employment research has repeatedly shown that having and keeping a job reduces dependency on services and benefits for Agency of Human Services (AHS) consumers. The Challenges Workgroup has developed a consolidated and coordinated approach to employment services, moving from services dispersed across AHS to a single entity within AHS called Creative Workforce Solutions (CWS). CWS will provide equal access to meaningful work in the competitive job market for all AHS program participants. It will also offer employers a single point of contact for coordinated job development and placement services across AHS programs. This approach will significantly improve ease of access for employers.

Information Technology (IT) Enterprise Infrastructure
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technologies across the all of AHS. These will provide guidance for future investments. It is built on the principles and products of a service oriented architecture (SOA) of common technologies and shared services that provide reusable components for various needs. For example, AHS would purchase and install one master-person index or one imaging solution that was configured for Agency wide utilization.

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- legislation that exempts IT investments made in conjunction with the Challenges initiatives, including the purchase and implementation of components of the enterprise architecture including Master Person Index, work flow engine, enterprise bus and rules engine. The exemption could sunset at the end of FY12.

Corrections Challenge

A. Progress Report

Central to achieving the objectives of the Corrections' Challenge is creating a unified criminal justice system. This system will utilize strategies to enhance community capacities so that offenders may receive services that reduce needs, such as transitional housing and treatment, at the lowest level of intervention by the Department of Corrections, consistent with public safety. These strategies will ensure that secure incarceration beds are prioritized for those offenders who need a higher level of correctional intervention.

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A major result of this work will be an overall decrease in the use of incarceration within the Department of Corrections while maintaining public safety through enhanced supervision of offenders (consistent with their level of risk) in the community. Additionally, as this plan is implemented, there should be an increase in the use of alternative sanctions by the Courts, such as reparative board referrals and diversion, and a decrease in the number of people entering the Correctional system. Vermonters who commit crimes will be dealt with at the lowest appropriate level and diverted, wherever feasible, away from incarceration. In the past the Department has utilized electronic monitoring and alternative sanctions as deferring or release mechanisms. We believe that these strategies have lessened, though not erased, the rise in incarceration numbers.

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A. Enact S, 292 as passed by the Senate and expand the bill to include the original Senate Judiciary Committee language regarding DUI 3 and greater.
B. Amend the reintegration furlough statute, 28 V.S.A. §808(a) (8), to expand its timeframe from 90 days to 180 days for all offenses. DOC's current utilization of reintegration furlough is less than 20%.
C. Amend 13 V.S.A. §7030(a) to include a sentencing option known as a "supervised release sentence" and prohibit the use of non-consecutive sentences such as a weekend interrupt sentence.
D. Enact a statute to create a "Supervised Release" status based on the New Hampshire model.
E. Establish home confinement as an optional condition of release to 13 V.S.A. §7554 and home incarceration as a sentencing option for courts.
F. Authorize judges to grant "use immunity" to offenders charged with a violation of probation based on new criminal charges.
G. Enact a statutory limitation on use of arrest warrants and incarceration for failure to pay a fine or surcharge.
H. Authorize referral of misdemeanants to reparative boards at sentencing and authorize the boards to return such offenders to court for further sentencing for failure to comply with board requirements.
I. Amend 28 V.S.A. §205(a) (3) (A) to standardize the probation term limit for felonies to a set period of years.
J. Eliminate mandatory minimums for misdemeanor offenses by amending 23 V.S.A. §674(b) (DLS) and 13 V.S.A. §1028(a) (simple assault on a police officer).
K. Adjust caseload ratios for lower level offenders.
L. Combine Community Justice Centers and Diversion Boards to streamline and coordinate their efforts. This proposal was discussed by the stakeholder group as an option to explore for FY12.

Client Centric Intake and Care Management

C. Progress Report

Integrated Family Services

AHS will design and implement a family and child centered system of early intervention, treatment and support. Funding will be flexible and based on best practices and family needs. The system will strive to intervene early in a preventive fashion, and provide services to the family unit, not just the child. Each child and family in the early intervention, treatment and support system will have measurable goals against which progress will be assessed. We believe this approach will produce better outcomes for children and families, reduce unnecessary administrative work, and save money through earlier intervention and family support.

As part of integrated family services, we propose to improve early childhood services for families while increasing effectiveness by consolidating child development services for families and children through a single community partner contract within each region. This will include consolidating child care referral services for families by changing from 12 local service providers to one statewide entity supported by modern web-based technology and communication systems. Supports for early childhood and after school practitioners and programs will be improved to assure a systemic approach to program consultation, quality improvement, and professional development.

Statewide Expansion - Blueprint Coordinated Health Systems

We propose to reduce overall healthcare expenditures through the accelerated expansion of the Blueprint model and to expand it to other populations and systems, building off a primary care foundation of medical homes and community health teams. Work is underway with the Office of Vermont Health Access (Medicaid), the Vermont Department of Mental Health, the Vermont Department of Health, as well as non-governmental organizations to develop models of sustainable integrated health services. As an example, planning is underway to establish Mental Health & Substance Use Medical Homes with similar financial reforms that can support high quality outpatient services and preventive care, with reductions in avoidable acute care expenditures. Similar work is underway to expand the Blueprint to pediatric services.

Modernization of Benefits Eligibility Determination

For the past two years, DCF has been involved in modernizing its processes for determining eligibility for various benefits programs, such as Three Squares and LIHEAP. Staffing will be reduced while consumer access and self service options are increasing. This is being accomplished by utilizing such tools as a Benefits Service Center (call center), Web Access, an Application Processing Center, Specialized Eligibility Determination and Supports for Community Providers. We propose to expand this effort to include eligibility determination for child care financial assistance. This will involve replacing private contracts at 12 community agencies (which have been in place for the past 15 years) and centralizing the work within the ESD eligibility system described above.

D. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

E. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

F. Legislation required

- Statutes detailing the power and authority of the Commissioner of DMH (18 V.S.A. § 7401 must be amended to include the concept of "at risk" into statutes related to serving the target population of children with a severe "Severe Emotional Disturbance" by the DMH. This would give clear authority to provide services earlier.

- Language will be necessary to require commercial insurers to participate, amending previous language (Act 204, 2008) that required commercial insurers to participate in the currently operating Blueprint Integrated Pilots.

Support Services Promoting Independence of Elderly and Individuals with Disabilities

A. Progress Report

DAIL intends to aggressively assist Vermonters to remain independent using home and community based services and as a result reduce nursing home utilization In some counties in Vermont nearly 60% of all persons needing nursing home level of care are served at home or in alternative community based settings. In other counties, the utilization of home and community based services hovers around 40%. Greater utilization of home and community based services is achievable, with an accompanying reduction in nursing home utilization.

Vermonters who need long term care, and choose home based services, can benefit from more flexibility in how the dollar allocation in their plans of care are utilized. This strategy is intended to allow more participants to remain independent. For example, Choices for Care has a limited set of service options that are paid for on a fee for service basis, unless the consumer chooses the Flexible Choices option, where, with the help of a counselor, the consumer manages his/her budget. Only a small group of consumers have selected this option. DAIL is exploring different payment mechanisms that can provide more flexibility to consumers.

Providers can also benefit from flexibility. For example, moving away from a fee for service system could reduce paperwork requirements and time for both providers and State staff.

DAIL is exploring how to utilize the Developmental Services individualized service plans, which the Designated Agencies (DAs) and Specialized Services Agencies (SSAs) develop with consumers, as performance based contracts based on achieving better outcomes for consumers.

DAIL has also proposed legislative changes to Medicaid estate recovery law to increase revenues for the program to ensure persons most in need can continue to receive services.

Another concept involves redesigning the delivery and financing system to have home and community based providers in the long term care system receive bundled rates based on consumers' needs and preferences. The provider agencies, instead of being specialty providers, would accept the responsibility to provide or arrange for all the services a participant needs. In return the provider would be paid a bundled rate based on a plan of care and perhaps a tiered system of rates. We believe this would create opportunities for savings; but it is a large and complicated change that will require more discussion and design time.

B. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

D. Legislation Required

- Legislation will be needed to amend Medicaid Estate Recovery law. Such legislation is already under consideration in the legislature.

Purchasing Results, Not Units of Service

A. Progress Report

OVHA Direct Care Coordination

The Office of Vermont Health Access (OVHA) will expand its direct care coordination capacity in two additional areas of the state to improve the health care and outcomes for Medicaid beneficiaries with significant medical needs. FY11 will focus on two additional areas of the state. This expansion will directly reduce costs in the Medicaid program and if successful will be expanded statewide in FY12.

OVHA Clinical Utilization Review Board

No later than May 15, 2010, OVHA proposes to establish a Clinical Utilization Review Board, to ensure that medical treatments and services paid for with state health care dollars are safe and clinically effective. This board will work collaboratively with the DMH utilization board and jointly they will address both medical and mental health practices in the Medicaid program. It will also ensure that public funds are used in the most cost effective manner that promotes positive health outcomes. Ultimately, the goal is to provide coverage for evidence-based care that meets the specific needs of our beneficiaries in the most cost-effective manner.

B. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

D. Legislation Required

- Section 6 of 33 VSA §1903a must be amended to remove language requiring that a private entity administer the program.
- OVHA needs the statutory authority to:
  - Have the final authority to evaluate and implement recommendations of the CURB
  - Develop rules if necessary for the specific recommendations, as prescribed by state and federal guidelines

Focus Designated Agencies on Client Outcomes

A. Progress Report

The Department of Mental Health
The Agency proposes to improve the mental health of citizens by increasing access, decreasing redundant services and documentation, and actively working with the Blueprint for Health and other areas of health care reform involving OHVA. The Department of Mental Health proposes substantial changes in the adult mental health services area, and smaller changes in other areas of care through partnerships with the designated agencies as well as the Office of Drug and Alcohol Programs and the Department of Disabilities, Aging and Independent Living.

Adult services are now composed of acute care services in Adult Outpatient Programs (AOP) and ElderCare Program (ECP), as well as in Community Rehabilitation and Treatment (CRT), the long term program for adults with serious mental health conditions. The changes proposed will begin to address several challenges. First, the need to provide more flexible services for those longer term consumers who wish to transition towards more independence but who are fearful that they will not have services if they need them in the future. Second, by creating a continuum of service for adults more consumers would be able to benefit from packages that are supportive of their individual choices and needs at the time.

Family and child program redesigns are encompassed in a larger effort to address services across all areas of AHS via Integrated Family Services (IFS) and addressed in a separate proposal. DMH is a full partner in that proposal.

DMH has a number of additional system efficiencies including changes in technology, a centralized crisis line for after hours' coverage, and streamlining of administrative oversight and paperwork to produce additional savings.

Department of Disabilities, Aging and Independent Living
DAIL is exploring how to utilize the individualized service plans the DA's have with consumers with developmental disabilities as performance based contracts based on better outcomes for consumers.

B. Challenge Outcomes and Proposed Measures

(see the detailed report from AHS in the appendix to this report)

C. Savings Identified To Date

(see the detailed report from AHS in the appendix to this report)

D. Legislation Required

- The Department of Mental Health (DMH) proposed two areas of legislation for the 2010 session which can be preferred methods for improving outcomes and reducing unnecessary expense to state government. Both bills are focused on the Challenges for Change main concept, to alter areas of service that do not achieve outcomes useful to clients, and/or are poor use of resources by which a better investment of funds could improve the lives of those persons. These two areas, involuntary medication and court ordered forensic observation, were proposed for legislative action in the form of two bills:
  - H. 616 An act relating to involuntary mental health treatment, and
  - H. 631 An act related to court ordered forensic evaluation of criminal defendants.

- The Department of Disabilities, Aging and Independent Living will need language will to ensure that efficiencies gained in the developmental services are not subject to continuing benefits during any appeal that might be filed. Individuals may appeal a change in their individual budgets, but continuation of benefits without change shall not apply to efficiencies identified and implemented during the pendency of any appeal.

Corrections Challenge

A. Progress Report

Central to achieving the objectives of the Corrections' Challenge is creating a unified criminal justice system. This system will utilize strategies to enhance community capacities so that offenders may receive services that reduce needs, such as transitional housing and treatment, at the lowest level of intervention by the Department of Corrections, consistent with public safety. These strategies will ensure that secure incarceration beds are prioritized for those offenders who need a higher level of correctional intervention.

By strengthening community capacities with additional probation office resources (such as staff and electronic monitoring equipment), creating residential substance abuse opportunities, using home confinement/incarceration as a sanction and expanding drug courts, technical violation behavior of lower level offenders can be more effectively addressed.
The incarcerated population and resulting costs can be decreased in line with the Corrections' Challenge goal by:

- Creating alternative sentencing options for the Court, such as home incarceration (24/7 at home) and home confinement (allows for participation in employment, treatment and community service).
- Expanding the time prior to serving the minimum sentence that an offender may be released to reintegration furlough.
- Utilizing other strategies detailed later in this report

A major result of this work will be an overall decrease in the use of incarceration within the Department of Corrections while maintaining public safety through enhanced supervision of offenders (consistent with their level of risk) in the community. Additionally, as this plan is implemented, there should be an increase in the use of alternative sanctions by the Courts, such as reparative board referrals and diversion, and a decrease in the number of people entering the Correctional system. Vermonters who commit crimes will be dealt with at the lowest appropriate level and diverted, wherever feasible, away from incarceration. In the past the Department has utilized electronic monitoring and alternative sanctions as deferring or release mechanisms. We believe that these strategies have lessened, though not erased, the rise in incarceration numbers.

G. Challenge Outcomes and Proposed Measures

Detailed in the Corrections section which begins on page 103.

H. Savings Identified To Date

Detailed in the Corrections section which begins on page 103.

D. Summary of Proposed Legislation

M. Enact S, 292 as passed by the Senate and expand the bill to include the original Senate Judiciary Committee language regarding DUI 3 and greater.
N. Amend the reintegration furlough statute, 28 V.S.A. §808(a) (8), to expand its timeframe from 90 days to 180 days for all offenses. DOC's current utilization of reintegration furlough is less than 20%.
O. Amend 13 V.S.A. §7030(a) to include a sentencing option known as a "supervised release sentence" and prohibit the use of non-consecutive sentences such as a weekend interrupt sentence.
P. Enact a statute to create a "Supervised Release" status based on the New Hampshire model.
Q. Establish home confinement as an optional condition of release to 13 V.S.A. §7554 and home incarceration as a sentencing option for courts.
R. Authorize judges to grant "use immunity" to offenders charged with a violation of probation based on new criminal charges.
S. Enact a statutory limitation on use of arrest warrants and incarceration for failure to pay a fine or surcharge.
T. Authorize referral of misdemeanants to reparative boards at sentencing and authorize the boards to return such offenders to court for further sentencing for failure to comply with board requirements.
U. Amend 28 V.S.A. §205(a) (3) (A) to standardize the probation term limit for felonies to a set period of years.
V. Eliminate mandatory minimums for misdemeanor offenses by amending 23 V.S.A. §674(b) (DLS) and 13 V.S.A. §1028(a) (simple assault on a police officer).
W. Adjust caseload ratios for lower level offenders.
X. Combine Community Justice Centers and Diversion Boards to streamline and coordinate their efforts. This proposal was discussed by the stakeholder group as an option to explore for FY12.

Challenges for Change

Outcomes and Measurements

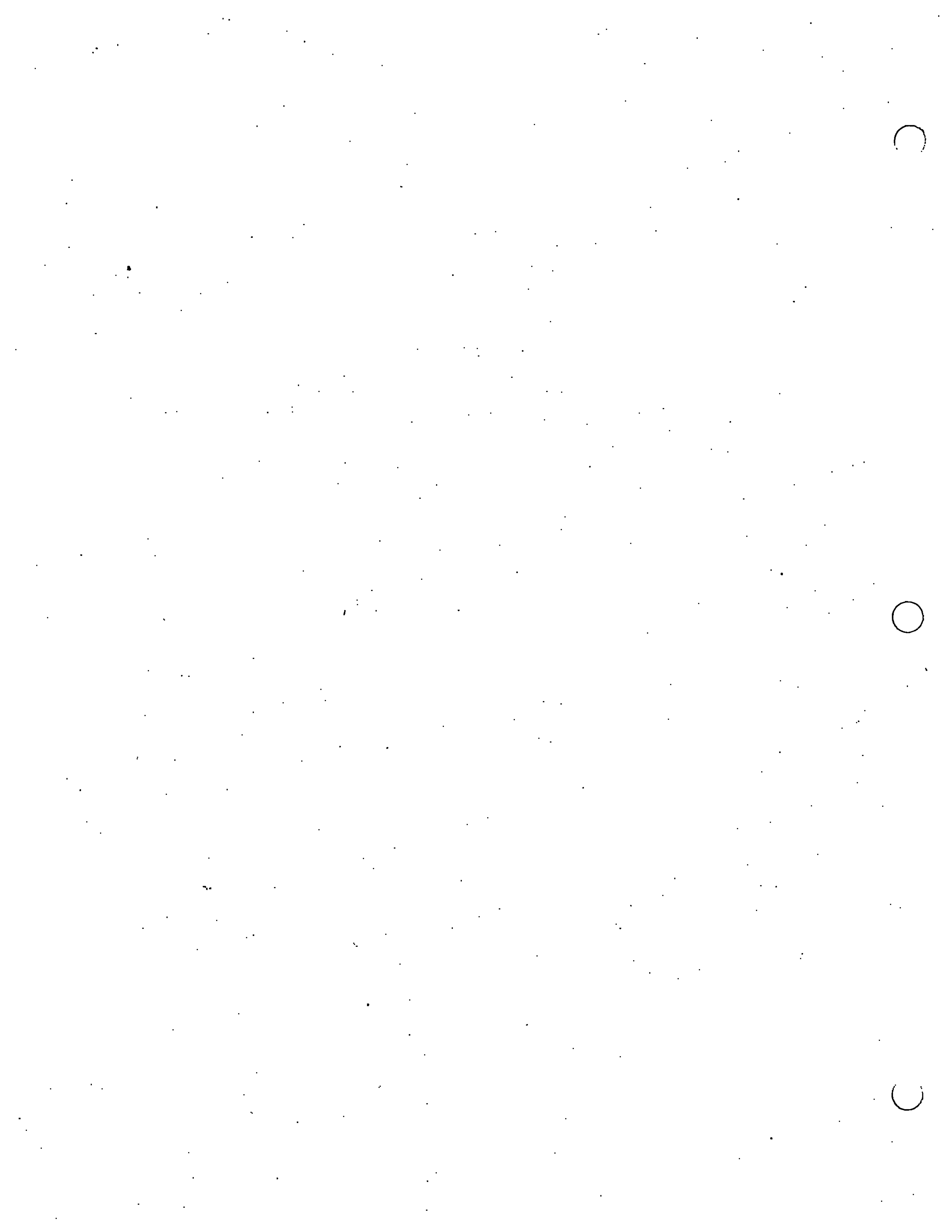
AGENGY OF HUMAN SERVICES
CHALLENGES FOR CHANGE

Initiative	Challenge	Outcome	Measurement
Integrated Family Services (pg. 26)	• Client Centric Intake and Care Mgmt. • Purchasing results, not units of Service • Focus Designated Agencies on Client Outcomes	• Pregnant Women and Young Children Thrive	Developmental Progress measures used in 0-6 early childhood programs • Increase the percent of children 0-6 years old who achieve 1 or more of their goals as defined annually in their Integrated Services Family Plan National HEDIS Measure used in Global Commitment to Health • Increase the percent of women receiving prenatal and post care in the Global Commitment to Health Population • Increase the percent of well child visits in the first 15 months of life-in the Global Commitment to Health Population • Increase the percent of well child visits in the third - sixth year of life in the Global Commitment to Health Population School Readiness Survey Data • Increase the percent of children who are ready for Kindergarten Increase the rate of developmental screening in early childhood according to national guidelines
"	" "	• Children live in Stable and Supported Families	• Decrease the rate of child abuse and neglect substantiations • Decrease the percent of children and youth in out of home placement • Increase positive family reports of experience of care (did you get what you need, were you treated with respect, did it help, etc) • The percent of families who have one integrated family plan • The percent of goals of integrated family plans which are met Increase the percent of family and youth competencies outside of the clinical range as measured by the Achenbach System of Emotional Behavioral Assessment. (ASEBA) for children, youth and families.
" "	" "	• Youth Choose Healthy Behaviors	• Decrease in the percent of youth reporting substance abuse, smoking and unhealthy behaviors as self reported by youth using the Youth Risk Behavior Survey • Implement an assets based data collection tool for youth system wide and report on the percent of youth reporting indicators of positive youth development

Initiative	Challenge	Outcome	Measurement
CDD Integrated Child Dev. Services (pg. 34)	• Client Centric Intake and Care Mgmt. • Purchasing results, not units of Service • Focus Designated Agencies on Client Outcomes	• Pregnant Women and Young Children Thrive • Children live in Stable and Supported Families • Youth Choose Healthy Behaviors	• The key outcomes and indicators for this effort are the same as the Integrated Family Services Efforts. Please see that proposal for a complete compilation.
Modernization of Benefits Eligibility Determination (pg. 37)	Client Centric Intake and Care Management	• Children live in safe, nurturing, stable, supported families	• Average length of time to process applications is decreased. • Accuracy of determinations is increased (Determined by ongoing QC and by triennial Improper Payments Review) • Cost per processed application decreases. • Customer satisfaction increases This initiative will make benefits more accessible to Vermonters much more efficiently.
Improved Child Support Collections (pg. 39)	Client Centric Intake and Care Management	• Children live in safe, maturing, stable, supported families	• Percent of child support cases with collections. • Increase in child support collections ($) to families and to offset TANF Expenditures. • Increase in cash medical support ($) that offset Medicaid expenditures.
Statewide expansion of Blueprint coordinated Health System (pg. 44)	Client Centric Intake and Care Management	Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time	• A sustained increase in practice adherence with National Committee on Quality Assurance Patient Centered Medical Home standards • An increase in the proportion of patients that receive recommended health maintenance and preventive assessments • An increase in the proportion of patients that receive guideline based care for chronic conditions • An increase in the proportion of patients that achieve improved control of their chronic health condition • A shift from episodic to preventive patterns of healthcare and resource utilization including a reduction in avoidable hospitalizations and emergency department visits • A reduction in the rate of growth of healthcare expenditures

Initiative	Challenge	Outcome	Measurement
OVHA Community Care Teams (pg. 56)	Client Centric Intake and Care Management	• Adults lead healthy and productive lives • Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time	• Reduction in unnecessary inpatient admissions • Reduction in unnecessary emergency room (ER) use • Increased consumer satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey
OVHA Clinical Utilization Review Board (pg. 61	Client Centric Intake and Care Management	• Adults lead healthy and productive lives • Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time	• Number of services reviewed by the CURB • Number of recommendations implemented • Reduction in both the over and under utilization of services (e.g., decreased overuse of elective, non-emergent out-of-state outpatient and hospital services) • Member satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey • Changes in costs of medical services for specific medical conditions
Mental Health (pg. 66)	• Client Centric • Focus Designated Agencies on Client Outcomes	• Elders, people with disabilities and individuals with mental health conditions live with dignity and independence in settings they prefer • Adults lead healthy and productive lives • Vermonters receive affordable and appropriate health care at the appropriate time and health care costs are contained over time.	• Decrease response time callers for after hours emergency callers • Decrease in redundant quality reviews/decrease administrative cost for DA's to support a 1% productivity • Improve employment of CRT consumers, minimally 1.5% annually • Goal of 50% of DA clients in 8 locations use FQHC 340-B pharmacy • Use of data from DA assessments to identify best practices and outcomes in variety of areas. • Decrease use of local hospital emergency departments for emergency intervention/decrease medical and surgical and psychiatric inpatient care for person with Co-Occurring Conditions (substance abuse and mental health conditions)
DAIL (pg. 84)	• Client Centric Intake and Care Management • Empower Families to Support their elderly • Focus Designated Agencies on Client Outcomes	Elders, people with disabilities and individual with mental health conditions live with dignity and independence in settings they prefer.	• Nursing home bed days are reduced • Number of persons on home and community based programs increase. • Percentage of respondents who report that they had a say in the decision about where they live • Percentage of respondents who report that they are happy with their case manager • Percentage of respondents who report that they are happy with their service agency

Initiative	Challenge	Outcome	Measurement
Creative Workforce (pg. 88)	• Client Centric Intake and Care Mgmt. • Purchasing results, not units of Service • Focus Designated Agencies on Client Outcomes	• Youths successfully transition to adulthood • Elders, people with disabilities, and individuals with mental health conditions live with dignity and independence in settings they prefer, • Adults lead healthy and productive lives, • Families and individuals move out of poverty through education and advancement in employment	• More AHS customers will be employed • Wages will increase • Employment retention will increase • Benefits utilization and recidivism will decrease • Cost per outcome will decrease • Customer satisfaction will increase for employers, consumers and stakeholders
Corrections Rebalance (pg. 104)	Reduce the number of people entering the corrections system, decrease the recidivism rate, improve community safety and reduce the corrections budget.	Families and individuals live in safe and supportive communities.	• Decrease the number of offenders returned to prison for technical violations of probation and parole while ensuring public safety. • Decrease number of offenders coming into the corrections system. • Increase number of nonviolent offenders (in this proposal defined as an offense that does not constitute a listed crime) diverted from prison into the community while ensuring public safety and providing effective behavior. • Decrease in Recidivism • Establish a unified crime prevention and justice system • Increase revenues realized by DOC from programs designed to develop skills of offenders • Decrease short term lodgings



Challenges for Change

- Integrated Family Services
- Integrated Child Development Services
- Modernization of Benefits Eligibility Determination
- Improved Child Support Collections

AHS Integrated Family Services
Challenges for Change

Executive Summary

AHS will design and implement a family and child centered system of early intervention, treatment and support. Though reduced to adhere to the *Challenges* constraint, funding will be flexible and based on best practices and family needs. The system will strive to intervene early in a preventive fashion, and provide services to the family unit, not just the child. Each child and family in the early intervention, treatment and support system will have measurable goals against which progress will be assessed.

- The early intervention, treatment and support system will:
  - retain content experts in early childhood, mental health, developmental disability, substance use, etc.,
  - operate with standards for best practice and,
  - develop unified AHS guidelines for effective treatment and family support.
- The early intervention, treatment and support system will be readily available to meet the child protection and guardianship responsibilities of the state.
- The early intervention, treatment and support system must be linked to and support those health and human services which are preventative in nature and which address the whole population and offer developmental, health and behavioral health benefits.
- The early intervention, treatment and support system will actively collaborate with DOE on efforts to unify services for families in a comprehensive manner.

Goal

Integrate human service efforts to create a continuum of services for families to choose from and base service on diagnostic and functional needs of the child, youth and family.

Services will be guided by best practices in clinical service, early intervention and family support. The system will monitor outcomes and integrate AHS funding across programs in order to meet these goals effectively.

Operational Design

Currently AHS children's services fall in five Departments and multiple divisions of the agency. Division and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for managing sub-specialty populations within various departments. While the best approaches available at the time, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines about our work with children and families. With the inception of the Global Commitment waiver, these siloed Medicaid funding structures no longer exist.

The Integrated Family Services Initiatives seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families. **The premise being that giving families early support, education and interventions will produce more favorable outcomes at a lower cost then the current practice of *waiting until circumstances are bad enough* to access *high end* funding streams which often result in out of home or out of state placement.**

Efforts across the agency in the agency over the past several years have moved in the direction that this initiative champions. For example, DCF- Family Service Division has instituted a Differential Response system which seeks to apply resources and intervention earlier to focus on mitigating risk and thus increase child safety and family unity. VDH- Children with Special health Needs and DCF- Child Development Division and OVHA have been fully integrating administrative and operational procedures for service authorization, billing and tracking for the last 10 months.

The Basic elements of this model will also be integrated with the Blueprint Community Health Teams and the expanded OVHA Chronic Care initiative. The integrated family services effort will support and overtime expand on wellness coaching and ensure a connection with the developing health information exchange network and modernized information technology efforts to maximize their applicability to the child and family services efforts. Additionally, proposals by OVHA and DMH to assure that the best clinical practices are utilized in the Medicaid program will be integral to this initiative relative to clinical practices in mental health, behavioral health, medical and medication management for children, youth and families.

Basic elements of the redesign are detailed in the table on the next page.

Basic Elements Integrated Family Services

Policy

From Current	*To Redesign*
Family centered, child focused	Family systems, strength based & shared decision making with families
Eligible only when *bad enough*	Early intervention, treatment and support
Diagnosis driven	Diagnostic and functionally driven

Program

From Current	*To Redesign*
Separate screenings, intakes and assessments	Common & consistent family screening, intake and multi-disciplinary assessment process
Separate guidelines and criteria	Unified and common AHS guidelines and criteria
Separate programs, separate plans	Integrated services and single plan,
Separate documentation	One common documentation set
Multiple case management/service coordination definitions and providers	One definition and single lead coordinator
Child diagnosis	Family & child functioning
Medical home separate from social/behavioral	Integrated medical home & teaming

Fiscal, Contract, IT

From Current	*To Redesign*
Units of service	Bundled rate and outcome measures
Multiple contracts and grants– similar services	Unified and simplified administrative and program oversight activity
Individually negotiated rates/budgets for each provider by each AHS division	Statewide rate/outcomes drive budget
Fragmented or outdated IT	HIE/HIT advances & modern IT structures

Structural – Central Office

From Current	*To Redesign*
Individual departments/division	Integrated family services team and global budget for early intervention, treatment and support

Structural –Regions

From Current	*To Redesign*
Multiple individual providers with separate systems and standards, intakes, budgets based on separate expectations from each AHS division	Unified local network/continuum for direct services Multi-disciplinary team approach available with consistent guidelines in each region: - triage, intake, referral, plan - expert consultation/assessment team

Outcome/Indicators

System of Measurement (Annually)

Note: Overtime and with full modernization of the AHS Information technology Infrastructure (see separate detail write-up), more precise longitudinal and other intervention specific measures will be available for implementation in outcome tracking. This capability is currently inhibited by disparate and out dated technology systems and the historical isolation of programs that resulted in separate program and data collection efforts.

Outcome	**Indicators**
Pregnant Women and Young Children Thrive	Developmental Progress measures used in 0-6 early childhood programs • Increase the percent of children 0-6 years old who achieve 1 or more of their goals as defined annually in their Integrated Services Family Plan Increase the percent of children enrolled in child care programs who regularly attend a quality child development program. National HEDIS[1] Measure used in Global Commitment to Health • Increase the percent of women receiving prenatal and post care in the Global Commitment to Health Population • Increase the percent of well child visits in the first 15 months of life-in the Global Commitment to Health Population • Increase the percent of well child visits in the third - sixth year of life in the Global Commitment to Health Population School Readiness Survey Data • Increase the percent of children who are ready for Kindergarten To be developed • Increase the rate of developmental screening in early childhood according to national guidelines
Children live in Stable and	• Decrease the rate of child abuse and neglect

[1] HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many health plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. *HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

Outcome	Indicators
Supported Families	substantiations • Decrease the percent of children and youth in out of home placement • Increase positive family reports of experience of care (did you get what you need, were you treated with respect, did it help, etc) • The percent of families who have one integrated family plan • The percent of goals of integrated family plans which are met • Increase the percent of family and youth competencies outside of the clinical range as measured by the Achenbach System of Emotional Behavioral Assessment. (ASEBA) for children, youth and families.
Youth Choose Health Behaviors	• Decrease in the percent of youth reporting substance abuse, smoking and unhealthy behaviors as self reported by youth using the Youth Risk Behavior Survey • Implement an assets based data collection tool for youth system wide and report on the percent of youth reporting indicators of positive youth development

Savings Goal

5% of total GF in the current AHS system of services targeted at early intervention, treatment and/or family support – estimated at $2.5 million GF or $6.5 million Global Commitment.

- 2.5% to come from administrative simplification and global commitment flexibilities
- 2.5% to come from reduction in more costly services by employing a comprehensive model of prevention early intervention and family support across all AHS programs and efforts

Changes Needed in Statute and Regulation

Statutes detailing the power and authority of the Commissioner of DMH (18 V.S.A. § 7401 should be amended to include the concept of "at risk" into statutes related to serving the target population of children with a severe "Severe Emotional Disturbance" by the DMH. This would give clear authority to provide services earlier.

Analysis needs to be completed in the coming months to determine if the following types of changes are needed

1. Potentially remove eligibility definitions from State Statute and instead place updated process in rule applicable to all AHS programs and not isolated funding streams. This may include changes to Act 264. And changes in the terms that define "Disability" in various DAIL and DMH statutes related to developmental disability.
2. Possible amended or suspend DD Act Regulations for individual up to the age of 22 until updated rules can be put in place for children and family.
3. Potentially remove from statute characteristics of Woodside as a *detention* only facility and recognize a role for the facility in a continuum of care as short term stabilization,

assessment and treatment facility. This would allow both Global Commitment and general funds to support the operations and bring a vital assessment and short term treatment focus to the overall system of care.

4. Possible rule changes in Agency Designation process

Timeline for Implementation

July 1, 2010 – Implement strategies to decrease administrative burden within provider system

1. Implement a single set of documentation requirements across all AHS programs
2. Eliminate Child Psychiatric sign off on charts where psychiatric level of care is not warranted
3. Implement a single audit process across AHS programs
4. Determine if converting the use of Woodside to a secure treatment facility is a viable role in the continuum of care.
5. Determine if paying parents to stay at home with their children who have significant physical disabilities is a viable option under Medicaid law and the terms and conditions of the Global Commitment to Health waiver. If so, develop clear criteria and safeguards to prevent, financial or other abuses to the consumer and Medicaid system.
6. Work with OVHA and the Blueprint team to develop communication and other protocols for integration of care coordination and other efforts

October 1, 2010 – Begin program changes to unify guidelines and practices of similar services and services to similar or the same populations

1. Restructure all Early Childhood Programs for families with children prenatal to six years (see Child Development Services detail in separate analysis))
2. Focus all Departments on practice changes that will:
    a. Reduce hospitalizations and out-of-home placements; For example
        - Combine funding and create one set of guidelines for out-of-home placements
        - Combine funding for IFBS, in home waivers, and some ADAP money for Enhanced Family Treatment and intervene earlier.

    b. Apply a blended funding model up front to support respite, behavioral consultation, hi-tech services and personal care as needed before family situations escalate to a higher level of need or crisis. Including paying parents to stay at home with their children who have significant physical disabilities if it is determined a viable state option with clear criteria and safeguards.

3. Work with OVHA and DMH utilization management entities to continue analysis of medication management practices within the Medicaid program for youth and families

4. Work with DOE and all AHS programs to integrate and streamline funding and oversight of school based programming for FY12 implementation. For example DMH sponsored School Based Clinicians and Behavioral Interventionist, ADAP sponsored Student Assistance Program services, EPSDT School Nurses and others

January 1, 2011

1. Begin using IT enhancements to further decrease administrative burden and eliminate redundant business processes. Including the creation of Information exchange technologies that will allow us to identify who are all the families and youth, what they receive for services, costs and outcomes.

2. Implement guidelines for integrated screening, intake and assessment process

3. Implement unified out of home placement guidelines across AHS programs

4. Implement a care management model integrated with OVHA and Blueprint as appropriate for the top 200 beneficiaries with the highest utilization of AHS child and family services

July 1, 2011

1. Unified and simplified financial structure
2. IT enhancements
3. Outcome tracking

September 1, 2011

1. Integrate and streamline funding and oversight of school based programming – School Based Clinicians, Behavioral Interventionist and SAPs

October 1, 2011

1. Implement any best practices identified for better medication management within the Medicaid program for youth and families

Investments Needed

1 FTE AHS Senior Leaders established in Secretary Office to oversee and have ultimate authority to implement and monitor initiative and budget objectives.

Contractor Time

- Ad hoc Policy/Fiscal Analysis – (Pacific Health Policy group)
- 1 FTE Business Process Consultant – (To define work flow for IT)
- .5 FTE Reporting set up and Data Analysis - (timely access to data to answer policy and stakeholder questions)

Accelerated IT development

Backfill positions reassigned to Challenges work.

Information Technology (IT) Needs

EMPI - unduplicated information and ability to track for consumers prenatal to 22 years old.

MMIS – service authorizations, ability to make payments from all fund sources combined (not just Medicaid), utilization and costs reports

Case tracking/management tools - within AHS and between AHS and its grantees and contractors

Health Information Exchange networks within AHS and between AHS and its grantees and contractors

Data warehouse and central source for the measurement and integration of data from disparate AHS and provide sources.

Stakeholder Involvement

2008-2009 The Integrated Family Service Concepts grew out a process that began with an intensive focus on children and families prenatal to six years old. Stakeholders in these 0-6 year old discussion included legal aid staff, parents and staff from Vermont Children's health Improvement Program at UVM

July 2009 Families were invited to join AHS staff to begin discussions of the larger continuum of services from prenatal to 22 years of age. The Vermont Federation of Families for Children's Mental Health sent a designee to what was then a cross departmental work group of AHS staff.

September 2009 – A large Stakeholder group (Educators, DA reps, primary care and family practice doctors, early childhood and other provider networks) were asked to attend a workshop on integrated services and promotion of health and well being for children. This workshop was provided free of cost to Vermont by the Maternal and Child Health Division of Federal Department of Health and Human Services.

Feb 2010 Vermont Family Network joined the AHS discussion by designating a parent representative to group.

March 19, 2010 – A large Stakeholder group was convened for the purpose of getting feedback and guidance on the overall vision, the process and the basic elements of the redesign as well as to indicate interest and willingness to participate in workgroups targeting basic elements of the system redesign. Over 50 participants from all aspects of child, youth and family system (public and private) attended.

In Process - Identify and convene ad hoc work groups on various aspects of the redesign basic elements including participation of providers and other stakeholders.

In Process – Form a 5-7 person parent advisory panel to review guidelines and other products that emerge from the redesign work – youth voice will be added using the current youth in transition grant connection.

On- Going - Individual departments use their existing advisory bodies as needed for input.

Integrated Child Development Services
Challenges for Change

Executive Summary

This Early Childhood challenge is part of the Integrated Family Services (see separate description) efforts. It presents an opportunity to improve early childhood services for families while increasing effectiveness. It also presents the opportunity for more local flexibility in designing a comprehensive approach to the work, rather than asking a wide range of providers to each perform a more narrow set of activities through separate contracts with the Child Development Division (CDD) of the Department for Children and Families.

CDD currently administers a continuum of essential services for children and families in Vermont which range from primary prevention to early intervention and treatment for children and families with particular needs. The programs defining these services have been created as separate initiatives over 25 years and have been consolidated more recently at CDD. Currently, these services are delivered in Vermont communities by 37 different private organizations as 8 connected but still disparate programs. The result is an evolved patchwork of partners that generates multiple points of contact, mixed messages and redundant or overlapping functions. Individuals are burdened with multiple contacts at CDD and separate non-integrated budgets and reporting requirements for different programs.

This effort proposes to build on work of the Division over the past few years and fully integrates all child development services administered by CDD through three related strategies:

A. Consolidate child development services for families and children in each AHS region through a single community partner contract within each region. Community partners will deliver and coordinate the following services:
   a. Children's Integrated Services: These services, which include Nursing and Family Support, Early Intervention, and Early Childhood and Family Mental Health, and specialized child care services are fully integrated with the Integrated Family Services "Challenges effort" described elsewhere in the AHS proposal. This prenatal-6 effort has been working toward this goal for the past several years and will be fully connected to Blueprint and integrated AHS efforts to promote developmental, mental and physical health outcomes.
   b. Parent Child Centers and Learning Together: These services include outreach and information for families, parenting education, peer support, and playgroups, home visiting, support for pregnant and parenting teens and other primary prevention services.
   c. Building Bright Futures Direct Services: These are services designed and delivered within each community to promote good parenting and healthy child development.

   In communities where multiple providers currently deliver portions of this work, the integrated grant is intended to fuse effort and expertise. CDD staff will oversee the work via an integrated grants management team with integrated budgets and reporting requirements and a single point of contact at CDD for each community partner.

Energy and resources will be focused on innovation, integration and the development of data driven policies and strategies that produce positive outcomes for children and families. Significant savings can be achieved while fairly allocating and managing available resources across regions in accord with demonstrated community needs.

B. Consolidate child care referral services for families by changing from 12 local service providers to one statewide entity supported by modern web-based technology and communication systems with a defined connection to the Vermont 2-1-1 information and referral line. These information services are accessed primarily via telephone and internet. Centralization will improve consistency and quality in customer service while reducing costs. Local assistance for families who require direct help will be provided through the consolidated program outlined in section A above.

Restructure delivery of supports for early childhood and after school practitioners and programs to assure a systemic approach to program consultation, quality improvement, and professional development. The system to advance improved quantity and quality of child care in Vermont will be supported with a consolidated contract that balances access to available resources and consistent, well designed and widely communicated services throughout the state. Some of this work will be centralized, some may be regional, and much will be delivered locally.

Outcome/Indicators

The key outcomes and indicators for this effort are the same as the Integrated Family Services Efforts. Please see that proposal for a complete compilation.

Estimated Savings and Return on Investment

Savings – Part of the total 6.5 million Integrated Family Service Efforts

Changes Needed in Statute and Regulation

None

Timeline for Implementation

Part A: Issue RFP for 12 CDD Community Partners in July 2010 with implementation of integrated grants on October 1, 2010.
Transition of specialized child care services between October 1, 2010 and January 31, 2011, depending on current delivery system in particular regions.

Part B & C: Issue two separate RFPs, one for a single statewide child care referral contract and one for a consolidated delivery system of early childhood and after school practitioner and program supports in October 2010 with implementation of new systems by January 31, 2011.

Investments Needed

Part A. Minimal – an integrated data system is being designed and developed with Federal ARRA funds – implementation is anticipated in Spring 2011.

Part B. One time IT investment to create data sharing capacity between CDD Bright Futures Information System (BFIS) child care provider data and (National Association of Child Care Resource and Referral Agencies) NACCRRA-ware software to be used by statewide services provider. Provider training on NACCRAA-ware estimated to cost $75,000 - $90,000.

Part C. IT investment to upgrade BFIS centralized capacities related to practitioner qualifications and training and a centralized professional development calendar.
Approx. $80,000

Information Technology (IT) Needs

See Above

Stakeholder Involvement

What has been stakeholder involvement to date? What is planned?

DCF has introduced these concepts to stakeholder groups in the early childhood and after school community: Community Child Care Support Agencies; the Interagency Coordinating Council; the Parent Child Center Network, the Child Care Advisory Board and the Building Bright Futures Council.

Over the next 6 – 8 weeks, staff will continue to engage in substantive discussions with these and other stakeholder groups in every region of the state to gather input and discuss outcomes and strategies. We will seek to fully engage local and state Building Bright Futures teams. Community input will be used to develop RFPs and fine tune the details of this proposal.

Modernization of Benefits Eligibility Determination
Challenges for Change

Executive Summary

For the past two years, DCF has been involved in modernizing its processes for determining eligibility for various benefits programs. The effort currently involves:

- 3SquaresVT
- Health Care Programs
- Home Heating Assistance
- Reach Up
- General Assistance

The primary elements of a modernized system are as the following capabilities across these vertical programs:

- Benefits Service Center (call center)
- Web Access
- Application Processing Center
- Specialized Eligibility Determination
- Supports for Community Providers

The system is designed to be fully functional by June 1, 2010. It is designed to give quicker and more accessible service to individuals while reducing the human resources needed to process benefits eligibility. DCF is slated to be able to save 30 positions on June 1, 2010 as a result of the process improvements.

The "Challenges" effort proposes to expand this effort to include eligibility determination for child care financial assistance. This will involve replacing private contracts at 12 community agencies (which have been in place for the past 15 years) and centralizing the work within the ESD eligibility system described above.
This effort is a prototype for many other services which can be folded into similar technologies.

Outcome/Indicators

The big outcome of this effort will be to achieve the vision described in Challenges as *Client-Centered Intake:*

> *Individuals and families will direct their own lives and will be supported in pursuing their own choices, goals, aspirations, and preferences.*
>
> *Individuals and families will have access to apply for health and human services programs for which they are eligible through any department or office of the agency.*

Key to achieving that outcome will be the speed, accuracy, and efficiency of financial eligibility determination, and customer satisfaction with the process.

Key indicators will be:

- Average length of time to process applications
- Accuracy of determinations (Determined by ongoing QC and by triennial Improper Payments Review)
- Cost per processed application
- Customer satisfaction

This initiative will make benefits more accessible to Vermonters much more efficiently.

Estimated Savings and Return on Investment

Primary Modernization	
In FY11 Base Budget—30 fewer positions	$1,950,000 gross
Child Care Addition	
In FY11 Proposed Budget effective 1/31/11	200,000 GF
Challenges for Change effective 1/31/11	100,000 GF
Estimated Savings in FY12	500,000 GF

Changes Needed in Statute and Regulation

None

Timeline for Implementation

Full Economic Services implementation 6/1/10
Implementation of Child Care Eligibility 1/31/11

Investments Needed

One Time IT investment to:

1.) Create data sharing between the ESD ACCESS system and the CDD Bright Futures Information System (BFIS).
2.) Make changes within each system to accommodate the data.
3.) Update the ESD Modernization process.
4.) Update the ESD Notice system.

Total estimated cost(s) $150,000

Information Technology (IT) Needs

See Above

Stakeholder Involvement

- Extensive meetings with advocates, consumers, partners and staff over a two year period related to the large modernization effort.
- Several meetings with Community Child Care Service Providers.
- Overview for other early childhood providers and advocates.
- There will be extensive ongoing work with providers who will be directly affected.

Improved Child Support Collections
Challenges for Change

Executive Summary

In any given month approximately 25% of child support cases have noncustodial parents fail to make even a single child support payment resulting in $18,000,000 per year accruing in unpaid child support. Additionally, thousands of noncustodial parents are making no medical support contributions for their children who are receiving Medicaid despite having the ability to do so. A package of statutory changes and related resources could significantly improve these outcomes. Specifically,

- Tighten existing New Hire Reporting laws to shorten the reporting window, improve compliance by employers, and address the problem of "self employed" employees who are characterized as "subcontractors". To the extent this information is also used by other divisions that need income and employment verification this should also reduce improper payments by those divisions. This project would involve working with the Department of Labor to develop a plan for implementation.
- Amend existing license suspension statutes to permit administrative suspension and expand the scope to include nonrenewal of vehicle registrations. This would require working with the Department of Motor Vehicles to develop a process for implementation.
- Update the state's criminal nonsupport statutes to clarify the penalties for nonsupport and provide OCS attorneys concurrent jurisdiction to prosecute these cases.
- Amend existing statutes to require a cash medical contribution in Medicaid cases where the parents cannot provide for private coverage at a reasonable cost.

Outcome/Indicators

Children live in safe, nurturing, stable, and supported families.

- Percent of child support cases with collections.
- Increase in child support collections ($) to families and to offset TANF Expenditures.

Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time.

- Increase in cash medical support ($) that offsets Medicaid expenditures.

Estimated Savings and Return on Investment

With the investments noted below, the following earnings/savings can be conservatively expected in FY12:

Revenue earnings for families	$675,000
GF gains for the state	$347,730GF (including cost avoidance)
Revenue returned to the feds	$410,220
Total gains:	$1,432,950

Net GF Savings (after investments below) $238,280

GF Savings in FY'11 would be ¾ of this amount $178,710

Changes Needed in Statute and Regulation

- Statutory changes are needed to implement all four of these initiatives.

Timeline for Planning and Implementation

- New Hire Reporting - It is necessary to work with DOL during the upcoming year. Estimated implementation (assuming no major I.T. changes are necessary is January 2011.
- License, registration, and criminal procedures - It is necessary to work with DMV for this new project. This would require I.T. support, as well as ramping up staffing. Earliest full implementation July 1, 2012.
- Cash Medical Contributions - This process can start immediately, if legislative wording changes and we work our existing cases. If, however, OCS were to assume more cases, which would include significant programming and staff ramp up time, the implementation could be October, 2010.

Investments Needed

Note: all investments and IT are reimbursed at 66% IV-D Match Rate

Four FTEs are needed to implement these strategies:

- New Hire Reporting – 1 FTE
- License, registration, and criminal procedures – 1 FTE's (FY'12)
- Cash Medical Contributions – 2 FTE's

FY'11 GF Cost of 3 FTEs $72,270
One-Time IT Investments $80,000

FY'12 Cost (4 FTEs) $96,360

Information Technology (IT) Needs

- New Hire Reporting - Additional programming for monitoring reporting and ongoing maintenance
- License, registration, and criminal procedures - Additional programming for interfaces as well as ongoing maintenance
- Cash Medical Contributions - If simple legislative word changes, none. (This assumes currently pending related IT work will be done by then.)

Stakeholder Involvement

- New Hire Reporting – We have been discussing this with DOL and would work with them on this.

- License, registration, and criminal procedures – We will need to discuss this with DMV, States Attorneys, and the Court Administrator.
- Cash Medical Contributions – The House Health and Welfare Committee has expressed interest in pursuing this.

Challenges for Change

- Expansion of the Blueprint for Health
- Office of Vermont Health Access (OVHA)
  - Direct Care Coordination Expansion
  - Clinical Utilization Review Board

Statewide Expansion
Blueprint Coordinated Health Systems
Challenges for Change

Executive Summary

Vermont's Blueprint for Health is a highly coordinated, systemic approach to health, wellness, disease prevention, and care coordination. The Blueprint, which has implemented delivery system transformation with Integrated Health Services Pilots in three communities, is poised to expand in multiple dimensions. First, over the course of the next three years, the Patient Centered Medical Homes (PCMHs) – supported by Community Health Teams (CHTs) and a health information technology infrastructure – will expand to primary care and pediatric practices in Hospital Service Areas statewide. Second, the Community Health Teams that support guideline based care, population reporting, and coordination of care and services through health information exchange, will dramatically expand their integration with state and community based public health and human service programs. Just as the PCMH serves as the focal point for patient health care, the expanded CHT connectivity with Agency staff and AHS contractors will ensure more comprehensive integration of and communication with health and human services providers and programs.

The functional Community Health Teams will form a bridge between AHS clients' Patient Centered Medical Homes and the Agency's human services programs. While the Blueprint itself is focused on the total population, the new links that will be implemented in connection with multiple Challenges initiatives will help integrate specific sub-populations and programs, such as those associated with the Department of Health (VDH), Department of Mental Health (DMH), Department for Children and Families (DCF), and the Office of Vermont Health Access (OVHA) in the broader Blueprint delivery system reform.

As an example, Vermont Medicaid is expanding the capacity of community health teams with care coordinators that will work with high risk patients to improve control of chronic conditions and prevent avoidable hospitalizations. Similar planning is underway for extension of the model to include Pediatrics and family wellness, coordinated care for high risk seniors, and coordination between healthcare and public health prevention programs. The program's guiding principles are being applied in each case with investment in preventive community based outpatient services, an emphasis on enhanced self management and healthy behaviors, and financial sustainability based on reductions in avoidable expenditures for poorly controlled health conditions.

In another example, planning is underway to establish Mental Health & Substance Use Medical Homes with similar financial reforms that can support high quality outpatient services and preventive care, with reductions in avoidable acute care expenditures. This would establish a continuum of mental health and substance use services for patients. They would receive better screening and counseling for lower acuity needs provided by their primary care medical home and community health team. Patients with higher level need would have coordinated referrals to specialty services in the mental health and substance use medical home.

The Blueprint model is designed to be sustainable, scalable, and adaptable to variable practice sizes and settings, and it is supported by a health information and evaluation infrastructure. This IT infrastructure includes data sources to evaluate the clinical and financial impacts of the model. Routine reporting provides a basis for ongoing quality improvement and planning for statewide expansion. Many of the Agency's Challenges initiatives will be able to leverage the Blueprint data and evaluation infrastructure to integrate performance measures across the Agency focused on specific programs and populations.

Currently, the CHTs include members such as nurse coordinators, social workers, and behavioral health counselors who provide support and work closely with clinicians and patients at a local level. Services include individual care coordination, outreach and population management, counseling, and close integration with other social and economic support services in the community. This high level of care incorporates strategies to enhance self management and is designed to integrate with community-wide prevention efforts guided by Public Health Specialists that are part of the CHT. As the Agency programs become more integrated and patient-centered, the CHT's will become venues in communities for making connections between programs, providers, and the populations they serve.

Two key ingredients are essential for full statewide Blueprint expansion:

1. Commercial insurers and Vermont Medicaid need to agree to a plan for expanding the payment reform model that supports medical homes and community health teams across the state.
2. Medicare participation must be obtained.

The first component is being addressed: Medicaid is committed to the expansion strategy and legislation pending in the House Human Services Committee (H.627) will ensure the participation of Vermont's commercial insurance carriers.

As for the second, U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced Medicare's plans to participate with state led multi-insurer reform as part of an Advanced Model of Primary Care Demonstration Program in September 2009. Application guidance for the Demonstration Program is expected to be released by CMS imminently.

Initiative

a) Conduct readiness work in HSAs across Vermont that prepares communities to implement the Blueprint Integrated Health Services Model.
b) Readiness work includes training and preparation for practices to operate as patient centered medical homes, design and implementation of community health team operations, and set up of a supportive health information infrastructure with data transmission from hospitals and practices to a centralized registry.
c) FY11: The Blueprint will adjust its budget to support statewide implementation and expansion. This includes HSA grants and expansion of the Blueprint team. The Blueprint team will include facilitators who can provide on the ground support for planning and implementation in each HSA, practice transformation to operate as medical homes supported by community health teams, and data-guided ongoing quality improvement.
d) Statewide expansion of the Blueprint model with a goal of establishing medical home and community health team operations in all HSAs by July 2011 and expansion to 80% of Vermont's population by July 2012.

e) A process of structured evaluation of the health and financial impacts of the Blueprint model, with ongoing adjustments designed to result in a refined model of integrated health services.

Expansion of the Integrated Health Services Model across Vermont- The Blueprint Integrated Health Services (IHS) model is designed to improve the health of the population, and improve control over escalating healthcare costs. Pilots have been implemented in 3 Hospital Service Areas (HSAs) that include multi-insurer payment reform, medical homes supported by community health teams (CHTs), expanded use of health information technology, and an evaluation infrastructure designed to determine program impact and guide ongoing quality improvement.

The Blueprint model starts with a relatively comprehensive approach that will support an advanced model of primary care, establishing a foundation for broader restructuring of healthcare delivery. Multi-insurer payment reform, which supports medical homes and community health teams, has stimulated interest among providers across Vermont and set the stage for statewide expansion. This interest extends beyond the natural attraction that would be expected for primary care providers to include hospitals. Multi-insurer payment reform means that hospitals can re-examine how they look at primary care, which has traditionally been difficult to support financially due to low fee for service reimbursement.

With adequate financial support, hospitals can consider expanding primary care networks in their HSA and may even consider a transition towards a business model that begins to balance primary care, specialty care, and acute care resources based on a community need. To date, high reimbursement rates for acute care and specialty care has led hospitals to emphasize these services, while low reimbursement has de-emphasized preventive services. The Blueprint model has initiated a shift with insurers investing in primary care and prevention, providing an opportunity for providers to recalibrate their predictable emphasis on well-reimbursed services for people who are already sick.

Financial Support for Expansion- The Vermont Association of Hospitals and Health Systems (VAHHS) Board unanimously supported a motion that all acute care hospitals would provide strong leadership in their community to expand the Blueprint Integrated Health Services Model into all hospital service areas by July 2010. VAHHS supported efforts to add funds to the state budget to support Blueprint expansion statewide, reflecting the commitment to utilizing the Blueprint for substantive transformation of our health care delivery and payment system. The FY10 appropriation is being used to support medical home and community health team preparations statewide.

Expansion of payment reform requires participation of Vermont's insurers, and ideally the participation of Medicare as part of multi-insurer payment reform. Active negotiations and planning is underway for these steps. The readiness work in each HSA will allow a faster and more efficient roll out of the model should insurers agree to expansion. The goal is to establish a set of primary care practices in each HSA that are ready to operate as medical homes, with plans in place for a local CHT, better coordination across existing community services, and a health information infrastructure that supports well coordinated care and panel management. Given Vermont's healthcare landscape, and the experience with the Integrated Pilots, the best route to achieve these goals is to work closely with hospitals and practices in each HSA to establish

operations. The steps that are involved to set up medical home and community health team operations are outlined.

- Conduct presentations and discussion sessions with key stakeholders in each HSA. These sessions include hospital administrators, primary care providers, other clinicians such as care coordinators and social workers, local public health personnel, and information technology personnel. Participants are provided an opportunity for detailed understanding of the Blueprint model. With this information, the local stakeholders can identify the participants for planning and implementation of the model. The number of presentations and meeting sessions may vary in each community in order to build consensus, momentum, and understanding.

- Identify a select number of primary care practices in each HSA to participate. The number of practices in each HSA varies and may depend on a number of complex cultural and business issues including; whether a practice is affiliated with a hospital or other organization with administrative and technical support, whether the clinicians feel overwhelmed by their work load, whether the clinicians are cautious regarding substantive change and want to see how things progress in other practices, or whether a practice is already in the middle of significant change such as implementing an electronic medical record.

- Identify key personnel for two parallel planning and work processes. This includes planning and implementation of the health information infrastructure. It also includes planning for PCMH and CHT operations. For each of these processes, planning is likely to include lead contacts from the hospital, practices, local public health office, and other service organizations.

- Health information infrastructure work includes;
    - Identify important data sources in the practices and hospital that should be integrated through the VITL / GE health information exchange (e.g. practices' EMRs and hospital data sources).
    - Map existing EMRs and data sources against core Blueprint data elements (Health Maintenance & Prevention, Asthma, Diabetes, HTN)
    - Update EMRs against core data elements and answer options to assure structured data entry for key measures that will be used for individual patient care, population management, and program evaluation.
    - Practices that do not have an EMR will be provided licenses to use DocSite directly to support individual patient care
    - Develop interfaces between practices, hospitals, and VITL / GE health information exchange
    - Establish data transmission of core Blueprint measures from data sources through VITL / GE to DocSite
    - Conduct quality testing on transmitted data and reports generated
    - Establish functional DocSite reporting that works across organizations and clinical tracking systems.

- Clinical and health services work includes;
  - Clinicians participate in learning collaboratives and practice transformation training that is aligned with NCQA PPC-PCMH standards
  - Identify existing personnel in the community who can work and coordinate with the core CHT that will be supported by payment reform.
  - Identify what staffing and skills are needed for the core CHT
  - Identify and establish planning contacts with key service organizations in the community that will coordinate with the CHT
  - Plan clinical operations for the new Community Health Team (new personnel + existing personnel) that will provide care support for primary care practices
  - Plan referral and population management priorities for medical homes, CHT, and public health services.
  - Plan coordination with other services, including public health, economic support and social services
  - Plan administrative structure for managing enhanced payment to practices and funding for CHTs
  - Participate in training to use centralized registry for reporting, panel management, and quality improvement

In each HSA, the number of practice sites that are involved, the size of the population served, and the IT development work will vary. A project plan to accomplish the steps outlined above is to be developed in each HSA.

As the Blueprint Integrated model (including payment reform) expands, each participating practice is scored against NCQA PPC-PCMH standards. These scores are used to guide quality based payment and to plan quality improvement. Insurers will attribute patients to the participating practices and their medical claims data will be flagged in the multi-insurer claims database.

Advantages & Risks for Participants in each HSA- There are several advantages to each HSA for establishing PCMH and CHT readiness. First, operable population based reporting and care coordination will improve outpatient preventive care, and begin a cultural transition towards structured guideline based processes. Second, having these clinical operations in place provides a better opportunity to realize gain in any gain-risk sharing financial arrangement such as global budgets or an Accountable Care Organization. Third, these preparations, with a clinical and information infrastructure, position each HSA to more rapidly implement full PCMH and CHT operations if payment reform expands to their area.

It is important to note that working with the Blueprint to establish medical home and CHT readiness does not assure that payment reform will expand to each HSA. The risks taken by each HSA are the local investments made in order to accomplish PCMH and CHT readiness. These risks are real but mitigated because the Blueprint and Vermont Information Technology Leaders (VITL) are sharing costs and supporting most direct expenditures for readiness work. The major cost for participants in each HSA is the time commitment. Participants need to balance this commitment to readiness work, and the uncertainty of insurers expanding payment reform,

against the current trends in national healthcare reform policy, and the growing engagement in this model by some of our commercial insurers and Vermont Medicaid.

Financial support for readiness work- The currently planned shared cost structure for readiness expansion includes the Blueprint supporting health information technology enhancements and interfaces for clinical practice sites, costs for the DocSite clinical tracking and reporting system, training and support for the DocSite system, and, training and facilitator support for medical home readiness and practice transformation. VITL is supporting costs for development and operation of the health information exchange including the HIE side of interfaces, and overall health IT project management in each community. Local costs will include a care coordinator dedicated to a select group of primary care practices. This care coordinator will work with existing care support personnel, public health personnel, and existing social and community services to improve overall integration of services for primary care populations (the so-called "CHT lite"). The planned cost structure for health IT may change depending on availability of Federal support through the American Reinvestment and Recovery Act (ARRA). In each community, the Blueprint, VITL, the local hospital, and participating practices will develop a budget plan for the HSA specific circumstances.

Expansion of payment reform across Vermont is linked to a couple of key advancements. First, the commercial insurers and Medicaid must agree to expand, either on their own or in conjunction with Federal participation. Second, the Federal Government (in particular Medicare) must participate as part of a state led multi insurer initiative. Currently, progress is being made on both fronts. Vermont's substantial health reforms, and the Blueprint Integrated Health Services model, have attracted great interest across Vermont, other states, and as part of the national healthcare reform discussion in Washington, DC. On September 16, 2009, Health and Human Services (HHS) Secretary Kathleen Sebelius announced the launch of a new (to be fully defined by HHS) Medicare demonstration project for "an initiative that will allow Medicare to join Medicaid, and private insurers in state-based efforts to improve the way health care is delivered." **http://www.hhs.gov/news/press/2009pres/09/20090916a.html** This Advanced Model of Primary Care demonstration project's specific design is still to be defined, and states (including Vermont) have to apply to be a demonstration project state once the guidance is published. The more specific Fact Sheet that was embedded in the HHS press release can be found at: **http://healthreform.gov/newsroom/factsheet/medicalhomes.html**. The hope is that this demonstration project will provide an opportunity to engage Medicare as part of multi-insurer payment reform in Vermont. HHS has stated that they are working towards a rapid implementation cycle for this demonstration project.

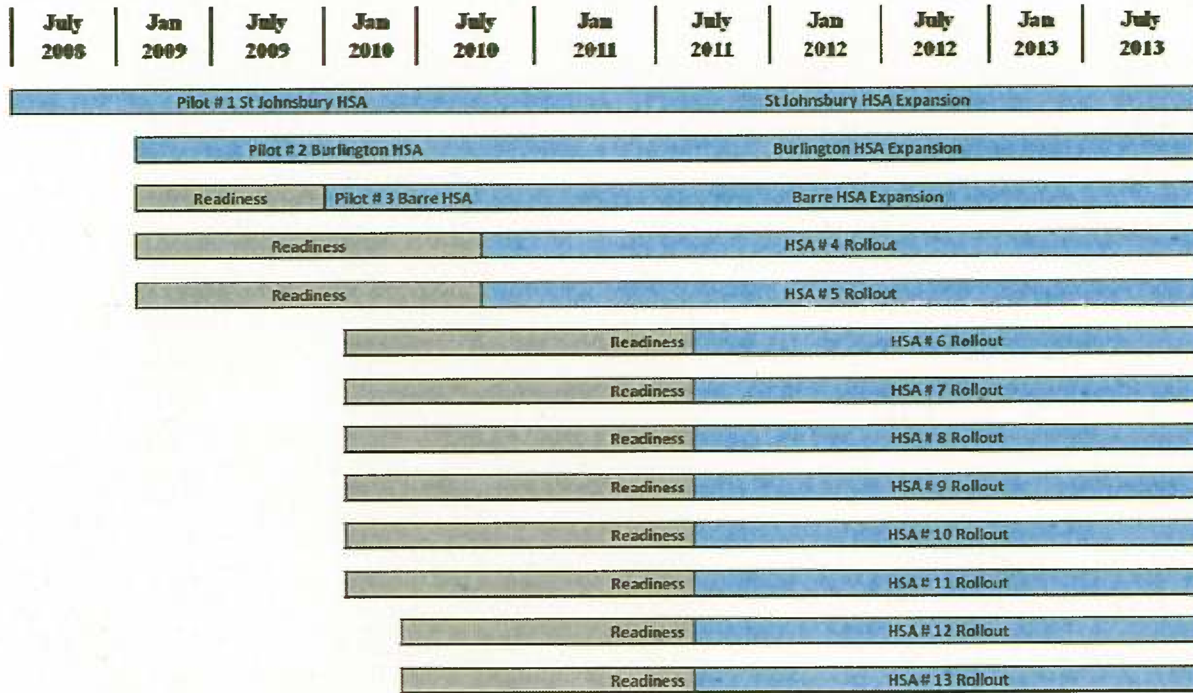
The opportunity offered by the HHS announcement, and Medicare participating as part of multi-insurer reform, has provided an impetus for the Blueprint to work with Vermont's commercial insurers and Medicaid to consider an accelerated time cycle for statewide expansion. The Blueprint is currently in active discussions regarding a plan for expansion. Two competing lines of thought have dominated the discussions. First is the desire to see outcomes data that supports a decision for insurers to invest in statewide expansion. Second is the understanding that shifting their expenditures from disease management contracts to local CHTs will in part offset the insurers' investment in the model. This important offset cannot be realized until enough of the population is involved allowing insurers to end their disease management contracts and shift

their expenditures. These two competing priorities present a situation where either the insurers don't expand until sufficient outcome data is available, or expansion moves ahead regardless in order to take advantage of the financial offset and the ability for an expanded program to more rapidly support a robust evaluation of clinical and financial outcomes.

Proposed Timeline for Statewide Expansion- The Blueprint is currently proposing a plan to expand the Integrated Health Services Model to 5 Hospital Service Areas by July 2010, and to all HSAs by July 2011. The proposed timeline also includes steady expansion within each HSA to include providers and populations that weren't part of the first 3 pilot programs. This proposal may need to be adjusted based on the timeline for Medicare participation, should Vermont be selected as one of the Advanced Model of Primary Care demonstration sites. However, it is also possible for expansion to occur without Medicare participation. For this to occur, providers would need to accept payment reform that doesn't include Medicare's portion.

The current proposal includes several important adjustments to what was initially planned for the pilot program. The first 3 pilots were going to operate for a minimum of two years each, with a subsequent decision for expansion. The current proposal considers the work to date as an implementation phase, with a transition to a demonstration phase that aligns with the Federal demonstration program. This embeds five years of experience, with the ability to evaluate clinical and financial impacts on a statewide basis. This amount of time for operations to mature, along with the Blueprint's robust evaluation framework and data sources, will provide an extraordinary opportunity to determine the impact of the model. It is important to note that the model will not remain static. The evaluation framework is designed so that routine reporting and comparative benchmarks provide a basis to guide ongoing quality improvement. The proposed expansion is designed to result in a highly refined model of Integrated Health Services.

Blueprint Integrated Health Services Model - Proposed Timeline for Expansion



Implementation Phase	Demonstration Phase (Medicare?)

Target Population	**42,179**	**126,286**	**316,662**	**508,17**	**637,130**
% of VT Population	**6.7%**	**20%**	**50%**	**80%**	**100%**
# CHTs	**2**	**6**	**16**	**25**	**32**

Outcome and Indicators

Statewide expansion of the Blueprint Integrated Model has the following advantages:

- A statewide primary care foundation of patient centered medical homes and community health teams, supported by multi-insurer payment reforms that begin to align financial incentives and healthcare goals.
- Coordinated care for patients and families across a continuum that includes; primary care practices, community health teams, specialty care, and improved linkages to a broad range of social and economic support services.
- Increasing the rate that patients receive recommended health maintenance and preventive assessments, and guideline based care for established conditions.
- A healthcare infrastructure and culture oriented towards prevention, healthy lifestyles, and enhanced self management.
- A statewide foundation of medical homes and community health teams designed to result in a reduction in avoidable hospitalizations and emergency care visits thru improved engagement of patients in preventive care, improved transitional care from hospitals and emergency rooms to preventive care, and, targeted disease management programs.

- Improved control over growing healthcare costs despite new investments in medical homes and community health teams thru a reduction in avoidable acute care expenditures, and a shift in expenditures from contracted disease management services to local community health teams.

Based on the above, the Challenges for Change Outcomes that will be addressed include:

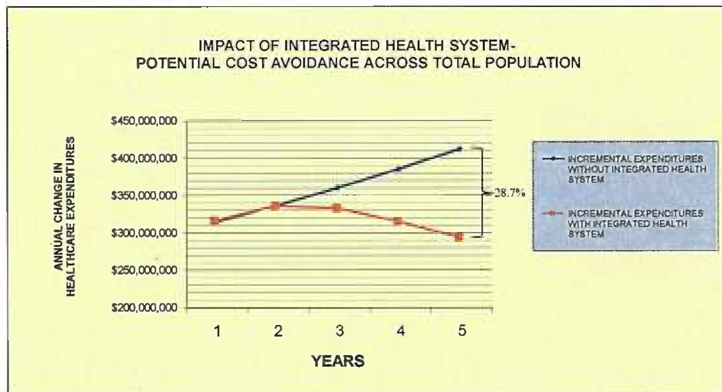
- Individuals and families will better direct their own lives and will be supported in pursuing their own choices, goals, aspirations, and preferences
- The individual will be at the core of all plans and services and will be treated with dignity and respect
- Individuals and families with multiple needs will have coordinated services with a single point of accountability to manage services
- Adults lead healthy and productive lives
- Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time

The Blueprint will conduct a comprehensive evaluation of the program's success at improving clinical and utilization outcomes using administrative (claims) data supplemented with information on clinical quality metrics and health status measures. In FY11, the Blueprint anticipates that there will be a 12% reduction in inpatient admissions and a 13% reduction in emergency room (ER) visits for patient populations receiving care in the Blueprint Integrated Health Services model. In CY12, the Blueprint anticipates a changing trend with a reduction in the rate that overall healthcare expenditures are growing in the state of Vermont. This expectation is predicated on expansion to a sufficient portion of Vermont's population, a reduction in avoidable hospitalizations and emergency department visits, and insurers shifting expenditures from contracted disease management programs to local community health teams. Predictions were arrived at using the Blueprint business model for costs savings and reduction in utilization.

Savings

Utilizing estimates from the Blueprint business model, if program expansion occurs as proposed the model projects that in CY 2011 the annual growth of healthcare expenditures in Vermont will be reduced by $26,923,428, and in CY 2012 the annual growth of healthcare expenditures will be reduced by $69,630,923.

However, the Blueprint will conduct an analysis of healthcare expenditure patterns in CY 2011 with appropriate adjustment of the business model to more accurately project CY 2012 financial impact.



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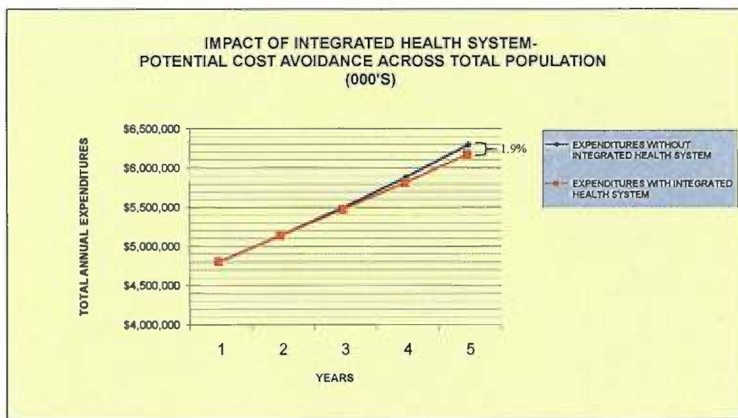

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It is important to note that integration of the Blueprint model with Medicaid, Mental Health and Substance Use, Children's Services, and high risk senior groups, will lead to further opportunities for reduced healthcare expenditures. Planning for integration across the broad range of human services is underway (see executive summary) including the development of financial models that will determine the potential for further savings.

Changes Needed in Statute and Regulation

For the Blueprint to expand multi-insurer payment reform statewide, it will be necessary to require commercial insurers to participate. Legislation is pending in the House Health Care Committee (H.627) will amend previous language (Act 204, 2008) that required commercial insurers to participate in the currently operating Blueprint Integrated Pilots to require participation in the expansion detailed above.

Timeline for Planning and Implementation

Hire (contract with) and train Blueprint facilitators for a July 1, 2010 implementation date. Hire 2 new core Blueprint team members.

Investments Needed

Two new core Blueprint team members (State employees). Eight new facilitator-coaching positions (most likely contracted positions).

- SFY 2011: Level funded budget that shifts expenditures from Blueprint Community Grants to HSA grants, adds two State employees to the core Blueprint team, and supports eight facilitators/coaches (contracted positions).

Information Technology (IT) Needs

Expansion of health information infrastructure that includes data transmission from EMRs and hospitals to the Blueprints web-based centralized registry (DocSite).

- Medical home practices and Community Health Team members (including OVHA CCs) have access to DocSite to support patient care, care coordination, panel management, and patient outreach.
- Updates to EMRs to include core data elements for health maintenance, prevention, and chronic disease.
- Updates to DocSite are in progress to support tracking of CHT care coordination activities, pediatrics, and other targeted health conditions.

Stakeholder Involvement

The Blueprint consistently engages a broad range of key stakeholders in planning and implementation of the integrated health services model thru its Executive Committee, Planning & Evaluation Committee, and Physician Advisory Committee. Broader local stakeholder engagement is inherent in the design of the integrated health services model. In each community, program leaders work with local stakeholders to design their Community Health Team, plan clinical operations, and assure linkages with a broad range of social and economic services. In this way the Blueprint is leading a process of transformation guided by a strong state level commitment, while assuring that respect for local expertise leads the design and coordination of services, and engagement with a broad array of community based services. The Blueprint has worked closely with OVHA leadership on this expansion proposal to assure that OVHA care coordinators become a fully integrated part of the Community Health Teams. Collaboration with the University of Vermont's medical informatics program will provide additional resources for sophisticated data analysis and evaluation of the program.

OVHA Direct Care Coordination Expansion
Challenges for Change

Executive Summary

The Office of Vermont Health Access (OVHA) wants to expand our direct care coordination capacity so we can improve the health care and outcomes for our beneficiaries with significant medical needs in two areas of our state as an initial trial. We believe this coordination will reduce OVHA's health care costs as well as improving medical outcomes.

As background, in 2007 OVHA implemented a statewide Chronic Care Initiative (CCI) for Medicaid beneficiaries who have chronic health conditions that result in high health costs, high medication utilization, and/or high preventable emergency room and inpatient utilization. The CCI is a holistic approach; it addresses physical, behavioral, and socioeconomic conditions that present barriers to health improvement. The CCI is tiered with intervention services along a continuum from printed education and self-management information for lower risk beneficiaries, to telephonic disease management services for those at moderate risk, to intensive face-to-face care coordination of medical and social services for the most costly and medically complex beneficiaries. OVHA's existing 12 care coordination staff, spread across 8 districts to provide a statewide presence, performs the intensive face-face case management services and APS contract staff provides predominantly telephonic disease management services.

The OVHA CCI goals and objectives fully align with Vermont healthcare reforms. For example, the OVHA CCI staff work with the Blueprint Community Health Teams (CHT's) to foster adherence to clinical best practices and lower health care expenditures for chronic conditions in partnership with the primary care physicians. Specifically, the existing OVHA CCI staff located in the three Blueprint integrated pilot sites function as core members of the Blueprint CHT's, and explicitly address the needs of the Medicaid beneficiaries with complex needs. This *Challenges for Change* Initiative will add three new OVHA direct care coordination staff in two additional areas of the state (a total of 6 new staff) with high Medicaid beneficiary needs. In addition to providing better care for beneficiaries, it also will enhance "Blueprint readiness work" in these locations.

Initiative

f) Use geographic distribution of Medicaid population and financial modeling to identify two high utilization, high penetration hospital service areas to enhance OVHA's current presence by adding on-site OVHA direct care coordination staff in each of two areas in FY11 *(Preliminary locations are Rutland and Franklin counties)*
    - Composition: New on-site staff will consist of 1 RN and 2 licensed clinical social workers for each of the two areas. The six additional OVHA staff will expand upon the work of the existing CCI staff in those areas

g) FY11: Divert approximately $500,000 in funds from current APS Healthcare Disease management contract to fund teams

h) Formally evaluate the effectiveness of new OVHA staff and, if successful, fully transition away from telephonic disease management to statewide OVHA direct care coordination staff by FY12

These new OVHA care coordination staff will work closely with existing OVHA CCI staff in the field to harmonize with other personnel and services in the community, establishing a functional beneficiary support network that is much larger than the proposed new 6 full-time employees (FTEs). The model is designed to be sustainable, scalable, and adaptable for all practice sizes, from rural to urban settings.

Outcome and Indicators

Positioning new Medicaid direct care coordination staff in two additional communities has the following service delivery advantages:

- Further integrates Medicaid chronic care initiative with Blueprint financial reform and establishment of patient-centered medical homes (PCMH)
- Accelerates Blueprint "readiness work" in the two Hospital Service Areas (HSA)
- Assists practitioners in preparing for Blueprint's National Committee for Quality Assurance (NCQA) PCMH accreditation
- Improves beneficiaries' ability to self-manage through closer on-site collaboration with the physician and community
- Phases out telephonic services and expands face-to-face support resulting in a lower per member per month (PMPM) cost
- Provides greater integration at community level, establishing a functional care support team that is much larger than the proposed 6 FTEs
- Enables faster and more efficient support to Primary Care Physicians (PCPs)
- Intervenes on a larger scale as staff time locating beneficiaries is diminished
- Expands Blueprint model to include Medicaid children

Based on the above, the Challenges for Change Outcomes that will be addressed include:

- Individuals and families will better direct their own lives and will be supported in pursuing their own choices, goals, aspirations, and preferences
- The individual will be at the core of all plans and services and will be treated with dignity and respect
- Individuals and families with multiple needs will have coordinated services with a single point of accountability to manage services
- Adults lead healthy and productive lives
- Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time

OVHA will conduct a comprehensive evaluation of the program's success at improving clinical and utilization outcomes using administrative (claims) data supplemented with information on clinical quality metrics obtained through medical records reviews. Specific indicators include:

- reduction in unnecessary inpatient admissions
- reduction in unnecessary emergency room (ER) use
- increased consumer satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey

Savings

Utilizing the Blueprint business model for savings, OVHA has projected a $652,000 net additional savings for FY11 by adding these six (6) additional staff. It is anticipated that the

FY12 savings will be significantly higher than the FY11 net savings. Prior to formalizing those projections, OVHA will have an independent third party analyze the effectiveness of the pilot project. The analysis also will help determine the future direction of the APS contract.

Changes Needed in Statute and Regulation

In order to give OVHA more flexibility to alter the Chronic Care Initiative program as we examine the effectiveness of the direct care coordination staff expansion, Section 6 of 33 VSA §1903a should be amended to remove language requiring that a private entity administer the program. The specific changes needed are as follows:

§ 1903a. Chronic care management program

(a) The secretary of administration or designee shall create a chronic care management program as provided for in this section, ~~which shall be administered or provided by a private entity~~ for individuals with one or more chronic conditions who are enrolled in Medicaid, the Vermont health access plan (VHAP), or Dr. Dynasaur. The program shall not include individuals who are also eligible for Medicare, who are enrolled in the Choices for Care Medicaid Section 1115 waiver or who are in an institute for mental disease as defined in 42 C.F.R. § 435.1009. The secretary may also exclude individuals who are eligible for or participating in the Medicaid care coordination program established through the office of Vermont health access.

(b) The secretary shall include a broad range of chronic conditions in the chronic care management program.

(c) The chronic care management program shall be designed to include:

(1) a method involving the health care professional in identifying eligible patients, including the use of the chronic care information system established in section 702 of Title 18, an enrollment process which provides incentives and strategies for maximum patient participation, and a standard statewide health risk assessment for each individual;

(2) the process for coordinating care among health care professionals;

(3) the methods of increasing communications among health care professionals and patients, including patient education, self-management, and follow-up plans;

(4) ~~the~~ educational, wellness, and clinical management protocols and tools ~~used by the care management organization~~, including management guideline materials for health care professionals to assist in patient-specific recommendations;

(5) process and outcome measures to provide performance feedback for health care professionals and information on the quality of care, including patient satisfaction and health status outcomes;

(6) payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to establish management systems for chronic conditions, to improve health outcomes, and to improve the quality of care, including case management fees, pay for performance, payment for technical support and data entry associated with patient registries, the

cost of staff coordination within a medical practice, and any reduction in a health care professional's productivity;

~~(7) payment to the care management organization which would put all or a portion of the care management organization's fee at risk if the management is not successful in reducing costs to the state;~~

(8) a requirement that the data on enrollees be shared, to the extent allowable under federal law, with the secretary in order to inform the health care reform initiatives under section 2222a of Title 3;

(9) ~~a method for the care management organization to~~ Close participateion ~~closely~~ in the blueprint for health and other health care reform initiatives; and

(10) participation in the pharmacy best practices and cost-control program under subchapter 5 of chapter 19 of this title, including the multi-state purchasing pool and the statewide preferred drug list.

~~(d) The secretary shall issue a request for proposals for the program established under this section and shall review the request for proposals with the commission on health care reform prior to issuance. The issuance of the request for proposals is conditioned on the approval of the commission in order to ensure that the request meets the intent of this section, section 702 of Title 18, and chapter 19 of this title. Any contract under this section may allow the entity to subcontract some services to other entities if it is cost-effective, efficient, or in the best interest of the individuals enrolled in the program.~~

(e) The secretary shall ensure that the chronic care management program is modified over time to comply with the Vermont blueprint for health strategic plan and to the extent feasible, collaborate in its initiatives.

(f) The terms used in this section shall have the meanings defined in section 701 of Title 18. (Added 2005, No. 191 (Adj. Sess.), § 6; amended 2007, No. 70, §§ 22, 23.)

Timeline for Planning and Implementation

Hire and train new teams for a July 1, 2010 implementation date.

Investments Needed

Six new state positions

- FY11: Divert $ 500,000 in funds from current APS Healthcare Disease Management contract to fund new direct care coordination staff.
- FY12 and beyond: If successful, use entire APS contract funds to support statewide enhanced OVHA direct care coordination staff and BP health teams (CHT) and provider incentives.

Information Technology (IT) Needs

The new OVHA direct care coordination staff will use Blueprint's DocSite:

- DocSite is a web-based patient registry and point of care decision support system that stores and tracks key quality and care improvement information on patients. Additionally, it has the capability to report information for purposes of population measurement, quality of care improvement and identification of patients whose care may require better coordination and management.
- OVHA's existing Care Coordinators already have access to DocSite for administrative claims data
- HP, OVHA's fiscal agent, will provide DocSite with monthly eligibility and claims data
- Care Coordination data elements and care plans already integrated into DocSite

Stakeholder Involvement

OVHA CCI has engaged in outreach and collaboration with other internal and external agencies, stakeholders, providers and healthcare system entities statewide since its inception in 2006. These efforts have included, but are not limited to, other AHS departments and divisions and other agencies, regional mental health services and substance abuse treatment providers, homeless shelters; hospitals and provider practices, the University of Vermont School of Medicine, Area Health Education Centers; and other healthcare-related associations (e.g., Vermont State Nurses Association, Visiting Nurses Association, etc.).

OVHA has been working closely with Blueprint leadership on this expansion proposal; and, if it is approved, Blueprint and OVHA senior managers will jointly reach out to the two HSAs and fully imbed the OVHA enhanced care coordination capacity in these communities and help them prepare for NCQA certification as a PCMH.

Lastly, OVHA will present the redesign to the Medicaid Advisory Board at the next available meeting.

OVHA Clinical Utilization Review Board
Challenges for Change

Executive Summary

The Office of Vermont Health Access (OVHA) must ensure that medical treatments and services paid for with state health care dollars are safe and clinically effective. Ultimately, the goal is to provide coverage for evidence-based care that meets the specific needs of our beneficiaries in the most cost-effective manner.

Nationally and in Vermont, health care costs are rising at an unsustainable rate. The cost of healthcare in Vermont is estimated to increase by $1 billion from $4.9 billion to $5.9 billion by 2012. Factors that influence increased costs in Vermont Medicaid programs include under and over utilization of services and inappropriate use and over-use of new technology.

As such, OVHA proposes to establish an Independent Clinical Utilization Review Board (CURB) to examine current medical services and emerging technologies and make recommendations to OVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services. OVHA currently uses these clinical care management approaches much less than commercial insurers, and many other state Medicaid programs that contract with traditional Managed Care Organizations (MCO) to manage some or all of the Medicaid benefits. In addition, as a public Managed Care Organization under Vermont's Global Commitment to Health 1115 Demonstration waiver, OVHA has a responsibility to adhere to CMS MCO regulations, including those in C.F.R. § 438.236 regarding practice guidelines, which state that MCOs must have practice guidelines that (1) are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the MCO's enrollees; (3) are adopted in consultation with contracting health care professionals; and (4) are reviewed and updated periodically as appropriate.

The CURB approach is similar to the existing OVHA Drug Utilization Board and programs such as the Washington State Health Technology Assessment program which established an independent clinical committee to determine which medical treatments and devices are the safest and most effective for patients.

Initiative

i) No later than May 15, 2010, establish the OVHA Clinical Utilization Review Board
   - Composition: 10 members with medical expertise appointed by the Governor upon recommendation of the OVHA Director
   - CURB meetings will occur no less than ten times per year, and no less than monthly for the first six months in existence

j) CURB responsibilities:
   - Identify and recommend to the Director opportunities to improve efficiencies in the OVHA medical programs, by:
     - Examining current high cost and high use services, as identified through medical claims data

- Reviewing current utilization controls to assess areas where improved utilization review might be indicated (e.g. use of elective, non-emergency out-of-state outpatient and hospital services)
    - Reviewing medical literature on current best practices and where current services do not have supportive evidence for their effectiveness
    - Conferring, as appropriate, regarding specific opportunities for exploration and subsequent recommendations, with the Commissioners of Health, Mental Health, and Disabilities, Aging and Independent Living, the Deputy Director of Alcohol, Drug Abuse and Prevention, the Blueprint Director, the Department of Corrections Medical Director, and the Department of Mental Health Clinical Practice and Advisory Council
    - Analyzing if it would be clinically and fiscally appropriate for OVHA to contract with the Centers of Excellence. The Centers of Excellence has a proven record of success in treating difficult health conditions or performing specialty procedures (e.g. oncology, transplants, bariatric surgery, pediatrics), and ensures that beneficiaries are seeing professionals and experts who are accredited and experienced in treating specific conditions with proven techniques
    - Considering the administrative implications for providers (positive or negative) of possible recommendations
  - Recommend to the Director the most appropriate utilization control mechanisms to implement the recommended evidence-based coverage guidelines (e.g., prior authorization; pre-payment, post-service claim review; frequency limits)
  - Prior to final recommendations to the Director, ensure that time is allocated during the CURB meeting for public comment and identify other ways to solicit input

k) OVHA Responsibilities
  - The OVHA Medical Director will provide OVHA leadership for the CURB
  - OVHA will provide data support to the CURB to assist in their reviews
  - The OVHA Program Integrity (PI) Unit will inform the CURB of practices that have already been identified though PI reviews to avoid duplication of effort and estimated savings
  - OVHA will provide a per diem to the CURB members
  - OVHA will provide meeting space and other necessary resources required to meet the objectives of the CURB

l) OVHA Authority
  - OVHA shall have the final authority to evaluate and implement recommendations of the CURB
  - OVHA will implement rules, if necessary, for the specific recommendations, as prescribed by state and federal guidelines

Outcome and Indicators

The Challenges for Change Outcomes that will be addressed include:

- Adults lead healthy and productive lives
- Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time

Indicators of achieving these outcomes include:

- Number of recommendations implemented
- Reduction in both the over and under utilization of services (e.g., decreased overuse of elective, non-emergency out-of-state outpatient and hospital services)
- Member satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey
- Changes in costs of medical services for specific medical conditions

OVHA will conduct a comprehensive evaluation of the program's success at improving clinical and utilization outcomes using administrative (claims) data.

Savings

OVHA anticipates that savings in the range of $3 - $5 million (gross) funds may be saved in FY11 through the CURB efforts. This is in addition to the following utilization management savings already proposed in the Governor's recommended budget for FY11:

- $2 million (gross) via Prior Authorization for selected high tech radiology
- $110,000 (gross) via reducing the urine drug test reimbursement rate
- $135,000 (gross) via limiting Pt/OT/ST to a total of 30 visits per year
- $450,000 (gross) by reducing urine drug testing to 8 per year
- $310,530 (gross) by limiting ER visits to 12 per year if not resulting in inpatient admission, transfer or death
- $1.17 million by adding 3 new Program Integrity Staff

Changes Needed in Statute and Regulation

In order to give OVHA the flexibility to achieve these savings and improve clinical outcomes, OVHA needs the statutory authority to:

- Have the final authority to evaluate and implement recommendations of the CURB
- Develop rules if necessary for the specific recommendations, as prescribed by state and federal guidelines
- In all other case, OVHA will not be required to submit these changes to a legislative review process

Timeline for Planning and Implementation

In order to achieve savings for FY11, the CURB must be established by May 15 and begin meeting no later than July 1.

Investments Needed

- OVHA will need additional human resources to provide the on-going data analyses for the CURB activities. This can either be in the form of additional contractor (HP) staff or OVHA staff.
- OVHA will potentially need other resources to implement the CURB recommendations. The type of needed resources will depend on the CURB recommendations (e.g. specialized vendor for specific prior authorizations, utilization management software, claim check software, additional clinical staff).

- OVHA will need resources to pay the CURB member per diem and other associated expenses.
- The range of these investments is from $200,000 to $500,000.

Information Technology (IT) Needs

None beyond those identified above.

Stakeholder Involvement

OVHA has worked with healthcare providers regarding the utilization management proposals in the Governor's recommended budget, which are very similar to the work proposed for the CURB. OVHA will continue to engage the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, and other providers and healthcare system entities statewide as this new Board is convened. As previously noted in the CURB responsibilities section, the CURB will confer as appropriate with relevant medical professionals and leadership with state government when considering specific areas for utilization management and best practices. In addition, OVHA will present the redesign to the Medicaid Advisory Board at the next available meeting.

Challenges for Change

Vermont Department of Mental Health
Vermont Department of Health: Alcohol and Drug Abuse Programs

Vermont Department of Mental Health
Vermont Department of Health: Alcohol and Drug Abuse Programs
Challenges for Change

Executive Summary

The Department of Mental Health (DMH) was created in 2007 to address the "mental health needs of all Vermonters". This proposal was developed with that mission as its foundation. The goal of this effort is to continue to improve the mental health of citizens by increasing access to a continuum of services, decreasing redundant services and documentation, and actively working with the Blueprint for Health, OVHA within the overall health care reform framework. DMH and the Designated Agencies have worked collaboratively with Blueprint staff and consultants to work toward the creation of medical homes with mental health and substance abuse screenings and supports. Along these lines, the Blueprint concepts will be expanded by developing integrated mental health and substance abuse medical homes, which will provide physical health supports as an aspect of their service menu. DMH has formed a strong partnership with the ADAP office of the VT Department of Health to offer services that are co-occurring informed and coordinated.

In addition to OHVA and VDH the Department of Disabilities, Aging and Independent Living is a partner with DMH in providing funds for the ElderCare outpatient care program and a variety of supports for persons with serious mental health conditions. DAIL also provides significant support to the Designated Agency system through Vocational Rehabilitation programs for adults and teens, across a number of AHS funded programs.

The initiatives, outcomes, and savings reported here reflect a unified vision of health, mental health, and substance abuse programming. The changes proposed reflect that inpatient and outpatient services will be re-designed and be based on the needs and demographics of the consumers walking in the door, rather than programming for one or two specific populations or needs. There success will be based on a systemic ability to adopt more client centered practices, to determine effectiveness of services and to constantly adjust the level and type of service needed to get the best outcomes for the consumer.

Initiatives

The department proposes substantial changes in the adult mental health services area, and smaller changes in other areas of care. Adult services are now composed of acute care services in Adult Outpatient Programs (AOP) and ElderCare Program (ECP), as well as in Community Rehabilitation and Treatment (CRT), the long term program for adults with serious mental health conditions. The changes proposed will begin to address several challenges. First, the need to provide more flexible services for those longer term consumers who wish to transition towards more independence but who are fearful that they will not have services if they need them in the future. Second, by creating a continuum of service for adults more consumers would be able to benefit from packages that are supportive of their individual choices and needs at the time.

The need for a redesign of children's health services—inclusive of physical health, mental health, and substance use prevention—is an area of improvements that are necessary, but not directly addressed in this document. Family and child program redesigns are encompassed in a

larger effort to address services across all areas of AHS via Integrated Family Services (IFS) and addressed in a separate proposal. DMH is a full partner in that proposal.

The next areas of care addressed in this document involve emergency services, health improvements, and better uses of current technology. The initiatives include:

- The integration of currently separate adult mental health programs into one continuum of care based on levels of functional need. This is a radical departure from the current diagnostically driven admission to one program or another. The expertise of clinicians would more easily be used across programs while changing the reimbursement to a case rate method based on service need as is currently used in CRT.
- Creation of a 1-800 statewide mental health services phone line for after hours emergency needs
- Backfill federal grant funds that are ending to continue to support improvements for co-occurring conditions (substance abuse and mental health conditions) across the system of care
- Monitoring Designated Agency (DA) quality for mental health and substance abuse services via national quality and accreditation bodies instead of by the state
- Changes in documentation and billing procedures, treatment planning and required sign-off by physicians will be expanded to include nurse practitioners.
- Annual improvement of employment of CRT consumers, with incentive based contracting in partnership with the creative workforce (VR) proposal. .
- Development of web-based data on mental health outcomes to better track improvements of clients and assess use of inpatient and crisis services.
- Training of DA providers and related private providers in core and expert services to improve outcomes for all Vermonters and decrease use of inpatient and other out of home care
- Reduce the number of days of hospitalization at VT State Hospital by 1260 days annually through changes in forensic observation and involuntary medication statutes and practices.
- In collaboration with Blueprint for Health efforts
  - Provide evidence based services to support physical activity and improve overall health of persons with serious mental illness.
  - Support DA collaboration with Federally Qualified Health Centers (FQHC) for 340-B pharmacy use—substantial savings for purchase of medications in the Medicaid program.
  - Ensure that best practices are utilized by health care professionals regarding the use of child psychotropic medications

(Further detail on the savings and necessary steps to gain them are in the appendix of this document.)

Outcome and Indicators

DMH will be working collaboratively with OHVA, VDH, DCF, and other state departments and divisions to obtain and assess indicators and outcomes for the Challenges initiatives. Our outcomes and indicators will include the ability of the system of care to:

- Maintain access/allow for variation of service use by improved assessment and client directed goals/create tier oriented services across adult services
- Decrease response time callers for after hours emergency callers
- Decrease redundant quality reviews/decrease administrative burden for DA's to support a 1% increase in staff productivity
- Improve employment of CRT consumers, minimally 1.5% annually
- Achieve a goal of 50% of DA clients in 8 locations use of FQHC 340-B pharmacy
- Improved use of data from DA and AHS assessments to identify best practices and outcomes in variety of areas.
- Decrease attrition and improve skills of DA staff by increasing ongoing training and learning opportunities.
- Decrease use of local hospital emergency departments for emergency intervention
- Decrease medical and surgical and psychiatric inpatient care for person with Co-Occurring Conditions (substance abuse and mental health conditions)
- Closer adherence to best practices for health professionals—e.g. limit use of more than one antipsychotic medication and
- Complementary use of therapy in situations where psychotropic medications are prescribed

Savings

DMH has estimated a savings of $5.2-6 million dollars in savings in FY 2011. There still are estimates which must be completed in various areas.

Changes Needed in Statute and Regulation

The Department of Mental Health (DMH) proposed two areas of legislation for the 2010 session which can be preferred methods of reducing unnecessary expense to state government. These two areas, involuntary medication and court ordered forensic observation were proposed for legislative action in the form of two bills:

- H. 616 An act relating to involuntary mental health treatment, and
- H. 631 An act related to court ordered forensic evaluation of criminal defendants

Both bills are focused on the Challenges for Change main concept, to alter areas of service that do not achieve outcomes useful to clients, and/or are poor use of resources by which a better investment of funds could improve the lives of those persons.

House Bill 616 was introduce by Representatives Koch of Barre Town, Lenes of Shelburne and O'Brien of Richmond in the 2010 session and supported by DMH as well as NAMI-VT, and many inpatient providers in the state. The bill is referred to the House Human Services Committee, but has not yet been engaged by the committee. The issue the bill was created to address is the extraordinary delay that the current legal process for application of treatment with the use of involuntary medication for those persons who are not responding to other, less invasive interventions. Currently the time required for the current process is an average between 60-70 days. For the past three years DMH has attempted to reduce this timeline, with limited success. As noted by consultants employed by the 2007 Legislature, the average time was 109 days. Efforts by DMH Legal and VSH physicians has reduced this time, however, there is little else that can be done to go any further. At this time the initial committal court hearing,

subsequent filing, and application for involuntary medication use hearing is approximately 70 days.

H. 616 proposes an alternative that utilizes a standard used by many states in recognition of the need to assure any proposed patient is lacking in the capacity to make decisions on their care, and that when this it is determined they do not, whether the use of medication against their consent may be given. The intent of the legislation is to focus on helping the patient to regain adequate capacity to participate in the treatment planning for their recovery. Once capacity has been restored the patient would again retain their right to guide treatment as they see fit. It is recognized by the DMH that this does not infer that medication alone will accomplish recovery, nor does it infer that the use of medication for all patients lacking capacity is the only choice for care. However, it is observed by DMH, VSH, and many psychiatric providers that the current process fails to address the needs of patients, primarily those with highly disabling psychotic disorders, to regain capacity in as timely manner as possible. It is recognized by this same group and others such as NAMI-VT, that there is a higher probability of trauma to the patient, and to fellow patients when involuntary treatment is delayed, sometimes resulting in serious physical and emotional harm. Most recently the peer community has expressed concern that persons with debilitating psychosis and who are violent should be able to move through the medication process as quickly as possible—while still maintaining all due process rights—in order to minimize possible harm to other patients.

In the past three years DMH observes that patients have often experienced delays in resolution of involuntary treatment applications for 90 days or more. Reducing this length of time would allow for a reduction in the use of extra staffing, a reduction in the number of days of hospitalization, and most importantly a reduction in the number of events when restraint and seclusion, and patient and staff injuries occur. DMH estimates that if the 20 persons—about the average number of involuntary treatment orders granted annually—were granted orders in 30 days or less from admission to use of medication VSH would reduce bed days by approximately 600 bed days annually. The cost of these bed days, at $1,378 per day, would equal about $826,800.

The second bill, H. 631 addresses a similar issue of the use of beds at VSH when other avenues of care could be more useful. DMH estimates it is the case that as many as a third of the forensic observation patients now orders to VSH for forensic observation, when their need for inpatient care is not necessary. House bill 631 is referred to the House Judiciary Committee this session, but no action has occurred this session. The bill proposes that an individual who does not meet criteria for acute inpatient hospitalization not be admitted to VSH, but instead returned to the court for other disposition. The data on the forensic population 2009, which involved about 100 admissions for observations--fairly close to a three year period of similar annual numbers, indicate that the 43 people found to be competent at VSH averaged 20 days to discharge or 860 bed days. Added to this are the 25 people found to be sane at VSH averaged 16 days to discharge or 400 bed days. Thus these two categories give us 1260 bed days used annually. We cam not assert that all these persons are not meeting criteria for hospitalization, but our review would find it reasonable that about half these days are not likely to be needed, for at total of 660 bed days. The cost for care in the use of 660 bed days is approximately $909,480 annually. It is noted that concern could be focused on the DOC risk of increased need were this legislation have the expected impact. However, of the 68 persons who were evaluated as sane and competent in

2009 only 8 were placed in DOC custody after the forensic evaluations were reviewed by the court.

DMH has been in consultation with Judge Davenport of the Court Administrator's office to discuss both of these proposals. The department is highly committed to working with the Administrator's office to make changes in the areas of involuntary medication court processes and alteration of the current inpatient forensic observation process.

The total for both legislative actions could reduce the use of approximately 1260 less bed days, and represents 7% of all bed days at VSH (based on a 3 year average of 18,579 annual bed days). The value of the savings here would be difficult to quantify exactly, however 1260 less bed days would reduce VSH by 3.45 beds annually, or approximately $1,736,280. The reduction of these beds in the month of March 2010 would reduce the census to 41.5 per diem. At that level VSH would be able to engage in cost savings that could equal data projected for DMH from Pacific Health Policy Group regarding being able to run VSH at a 40 bed census. This data indicates it is reasonable that a reduction of these beds annually could reduce VSH cost by a net of $850,000 (currently this would be in General Fund dollars). The savings in the proposals are established by fewer full time positions as well as a reduction in overtime costs; possible without reducing services for persons who need them. A note that the governor's budget for FY 2011, does have a reduction for overtime and costs that would likely limit savings here to a net of no more than $200,000-$300,000.

The total savings are subject to many forces that could reduce or enhance that value. The overall reduction in use of 3-4 beds at the hospital would be preferable to reductions in the community system which already is under stress. This combination could allow for an overall reduction in spending that would adhere to the Challenges for Change targets, perhaps encompassing the reduced spending for FY 2012 as well. DMH would strongly recommend consideration of these two actions, already in bill format and assigned to committee.

Timeline for Planning and Implementation

The DMH and ADAP projects areas identified for savings can commence at the start of the Fiscal 2011 year.

Investments Needed

At this time the total investment cost is yet to be determined. An RFP has been issued for the 1-800 line, but responses are not yet in to determine what kind of model might be employed. Investments in other areas remain in need of reasonable estimates. There are some IT related costs that are indicated below.

Information Technology (IT) Needs

The use of the 1-800 line will likely require some IT consultation, but the hardware needs are not yet clear. The investment for web based data is a current IT project, and has been estimated to have a need of 1 FTE data administrator.

Stakeholder Involvement

DMH has been engaging with both the DA system representatives in adult and children's mental health, and been meeting with the Adult and Child State Standing Committees, the VT State Hospital Steering Committee, and the Mental Health Transformation Council since November of 2009 to discuss the budget for 2011. These meetings have provided input from the peer community on a consistent basis, and DMH has received outlines of possible areas of attention from the DA's. DMH has also been engaged with other AHS departments—primarily DAIL, DCF, and VDH. As well as the DA's we have also consulted with substance abuse providers, homeless shelter leadership, and other community services agencies.

APPENDIX A

INDIVIDUAL PROJECT PLANS

FQHC/DA Collaboration for Prescription Services and 340 –B Savings

The establishment of the use of the FQHC system of care as a dispensing agent for the individuals who now uses DA MD/APRN services for psychopharmacological needs is a prime area for cost reduction. With a well designed collaboration the psychiatric needs of DA patients can be shared with the FQHC for expense both to the agencies and to OHVA for pharmacy costs.

Currently the DA system is challenged to gain adequate reimbursement that can cover the cost of prescriber expense. (All DA's currently have at least a psychiatric physician and many also now have APRN's to address pharmacological needs of patients.) The reimbursement to FQHC's for the same services are greater due to cost based reimbursement thus they can better absorb these costs. An even greater gain in terms of reduced state expense is the use of the FQHC pharmacy for the DA consumer, especially for the CRT population that has significant pharmacy cost. Savings for use of this pharmacy system are estimated here at a level of 6% overall savings for OHVA and an estimate of what the DA cost reduction could be for psychiatry should be at least 50% of that cost be shifted to the FQHC via collaborative agreement. There are complications to address in this system—record access, agreements that are in keeping with the federal and state requirements for DA's and FQHC's, but with a properly constructed system these can be managed to maintain the overall gain. The current estimate of savings, if 50% of DA patients were to use the 340-B option for pharmacy, would be at least $350,000. The estimate is based on a conservative expectation of 6% savings to OHVA and the only on 50% patient use of FQHC in 8 of the 10 DA locations for which a FQHC is located within 20 miles. The development of an FQHC for the Bennington area, and the location of future clinics within the areas of greater populations would boost these saving considerably.

As well a further savings may be gained in sharing the prescriber cost between the FQHC and the local DA. Average psychiatric costs nationwide are currently in excess of $150,000 annually (**http://swz.salary.com/salarywizard/layouthtmls/swzl_compresult_** national_hc07000027.html). For APRN the average is $80,000 nationally, based on information from payscale.com.(**http://www.payscale.com/research/US/Certification** =Advanced_Practice_Registered_Nurse-Board_Certified_(APRN-BC)/Salary). The DA reimbursement is possible to afford for the APRN, but this is the upper limit. For a DA to cover the cost of a psychiatrist is not possible with current reimbursement. For both areas of practice reimbursement via the FQHC model is far superior for both the rate of reimbursement and the increase federal match provided for the FQHC provider. Even a 10% savings for the cost of these professionals would add approximately $200,000 in cost reductions to the DA. The final savings, taking into account that OHVA would still be providing payment for the FQHC services should still allow for substantial savings. Thus the final savings for implementation of this plan would be estimated between $100-200,000 annually.

Adult Services Consolidation

The community mental health designated agencies (DA) have operated separate Adult Outpatient (AOP) and Community Rehabilitation and Treatment (CRT) Programs for decades. AOP has traditionally been funded through a fee-for-service reimbursement structure, providing primarily psychotherapy and medication management services to individuals with a multitude of mental health conditions. These individuals tended to have situational issues or stressors impacting their current mental health, but this program was not intended to maintain chronic or enduring conditions; nor was it structured to provide skill building or case management services to this population. Additionally, AOP services operate as clinic or office-based therapeutic services to the population served with little outreach presence or larger social mission to their community.

The CRT Program on the other hand serves a mandated population who has serious and persistent mental illness and provides a variety of support and psychosocial rehabilitation services. These services are frequently community-based and enhance the social networking needs necessary to connect individuals with their communities. The services focus on essential functional skill development and active rehabilitation for mental health conditions that inhibit daily activities, social connections, and employment opportunities.

Under the Global Commitment Medicaid Waiver, the funding silos existing between these two programs is no longer required nor do the silos support or encourage a transition between these programs for individuals who are recovering from their mental illness. Individuals in the CRT Program, who may require some support services, but no longer require an extensive array of mental health services, have few options for intermittent support in AOP. Investing existing adult services resources in a more broad-based manner, allowing a more fluid benefit package for persons served across the adult services continuum, supports a more client-centered service approach.

A designated agency adult services program would be designed to bring persons served into a program that will meet their individual treatment needs without service parameters subject to a specific funding stream. Drawing upon the existing CRT Program capitated payment funding structure, adults would be served by local DA's who will receive a monthly reimbursement for these services. Resources in the adult services program would be targeted to individuals who have more intensive and ongoing skill building, case management, and psychosocial services and support needs. The allocated resources would be tiered to reflect the intensity of services needs for persons served in the program. Resources in this program would be dedicated to the more community-based social service mission and limits placed on the provision of clinic-based therapy via this funding. Further criteria for transition and referral out of the adult service program would be established and limits placed on and diminishing funding reimbursement for the population at low levels of need and continued in service beyond a threshold established for service delivery. Incentives within the capitated funding structure would be created to encourage and welcome new enrollment of more complex and ongoing clients served. This approach would both encourage movement through the service continuum by diminishing reimbursements for long-term service attends and establish incentives to outreach and enroll new persons served.

By contract, the Agency of Human Services through DMH would begin to initiate these changes in the upcoming fiscal year. Identification of priority populations, who would benefit from a broader mental health services program, would be identified via agreement with service

providers. Traditional referral partners would continue and include the forming Local Adult Interagency Teams and State Adult Interagency Team as priority sources of referral. The development of a payment methodology to support this change concept would also need to be established with existing funding resources.

While this start-up activity will be time intensive over the next few months and generate concerns that this redesign in expectations of the existing service programs will weaken the DA's capacity to provide traditional psychotherapy services, these program changes are directly in line with addressing more proactively the needs of individuals at higher risk in their communities for health, mental health, and social service expenditures. These savings would be realized over time through more timely and successful mental health intervention and service coordination efforts for individuals who would otherwise. The redesign is also consistent with and responsive to what has been identified by the DA's as the population most at risk in the community by reductions proposed in the existing AOP services. This redesign proposes to continue service to this population and decrease the use of existing resources for those individuals who could be served by private mental health practitioners who are enrolled Medicaid providers.

This plan would reduce the total allocation to AOP, CRT, ECP, and CRT Inpatient, $44,657,779 by $3.0 million dollars. The remaining funds would be redistributed with an emphasis on Urgent and Emergent Care Services and Adult Treatment and Support Services. Urgent and Emergent Care Services would combine existing Emergency Service Program funding to maintain emergency response and capacity for urgent, brief stabilization-focused care. DMH funding would target this service capacity and limit its funding to no more than six follow-up therapy services for this population. This limit is necessary to immediately influence and decrease DA utilization of its funding from an unlimited clinic-based outpatient therapy service treatment model to one of brief treatment and referral for the population intended to be served. This change in program focus will also need to be identified in the Master Grant Agreement for FY 11.

The Community Mental Health Adult Support and Treatment Services (CAST) program would similarly combine existing CRT Program Adult Outpatient and ElderCare Programs. This program would maintain parameters for the CRT Program by serving a new Intensive Needs program service recipient. The CAST would also serve a new Moderate Needs program service recipient. DMH funding would target case management services and psychosocial rehabilitation skill building supports for a population who previously either did not respond effectively or need traditional clinic-based outpatient therapy service parameters or who were ineligible for these service interventions given Medicaid State Plan limitations targeting the most disabled. The moderate needs group would also be identified through referrals from the Urgent and Emergent Care Program who do not refer to other community mental health practitioners. The moderate needs group would also be subject to service limits, but program duration could be from 18 – 24 months to promote stability, avert development of more chronic mental health care needs, and establish better connectivity with other community organizations and social services networks. Again, without the identification of time-limited mental health supports services and focus on mental health recovery and skill development, there is little incentive for movement through and out of program services. An investment of DMH dollars to serve this target group will divert individuals from high cost or institutional care services over time. This change will require additional financial analysis over the next couple of months to establish a case rate payment

methodology and structure for Intensive and Moderate needs clients, comparable to the CRT Program as it currently exists, for each DA to serve this target population.

Emergency Services redesign/1-800 statewide services for after hours calls

Currently, each Designated Agency (DA's) has a Emergency Services program, which function 24 hours a day. These clinicians provide crisis intervention, assessment and triage both telephonically and in person. One DA, Washington County Mental Health, answers calls and provides after hours emergency services for Clara Martin Center and for Health Care and Rehabilitative Services. This arrangement resulted in increased positive remarks by consumers on services at all DA's, and resulted in savings for CMC and HCRS.

As part of the Challenges for Change for the mental health system redesign DMH supports consolidating the after hours DA emergency services delivery to either one that is a centralized or regionalized point of service. In order to promote this idea and move it forward, an RFP (or limited bid) has been issued to the DA system to manage a 1-800 crisis call center, with awake Master's level staff to answer crisis calls after hours.

Because DA's largely function independently from one another, to make a change to the pre-existing Emergency Services program would necessitate a change to the DA master grant agreement to reflect that after hour calls would be either centralized or regionalized and managed by either the DA system or an outside vendor.

It is anticipated that the deliverable could be finalized and made operational by July 1, 2010.

Savings on this plan are difficult to estimate beyond a range of $100,000 to $200,000.

Quality assurance would occur as response time by phone, and follow up in person by local agencies would be recorded.

Health Integration - Physical health and wellness for severely mentally ill population (In Shape Program)

Many people who live with severe mental illness are beset with multiple medical problems, the reasons for which are multi-factoral. One way to mitigate the multiple medical problems is through the application of and participation in an exercise and lifestyle change program.

Currently, there is one such program in NH which has had great success in moving health indicators for people living with severe mental illness in positive directions. Dartmouth Psychiatric Research Center has partnered with the mental health agency to track and measure outcomes. Since its inception in 2003 the In Shape program has demonstrated these results:

- 20% of participants have ↓ their weight by > 10 lbs
- 20% of participants have ↓ their waist circumference by > 10 cm
- 33% of participants have had a ↓ in systolic Bp of > 10Hg
- 25% of participants with depression showed a more than 50% ↓ in symptoms

A $25k start up fee is required in order to have the NH mental health agency provide training and technical assistance for its In Shape program. Designated Agencies could certainly design and implement their own health and wellness program which could produce similar outcomes for

participants. There are options available to encourage and motivate people around engaging in healthy lifestyles (Wii Fit is an example of something more cost effective then a $25k fee). The design and implementation of such a program would dovetail with the Blueprint for Health in that people living with severe mental illness participating in a Designated Agency sponsored health and wellness program would be managing their health, improving their quality of life, increasing their confidence while potentially decreasing pharmacy and inpatient hospital costs.

If Designated Agencies chose to develop their own programs independent of the In Shape program, they could potentially have an in-house program operational by July, 2010, with an identified staff and a cohort of participants.

Increased use of data indicators of client wellbeing

Level of Care Utilization System (LOCUS) - The Vermont Adult Mental Health Care Management Steering Committee has recommended adoption of the LOCUS tool to aid the Department of Mental Health (DMH) management in guiding treatment decisions for locations such as group homes, crisis beds, and inpatient beds. The LOCUS tool will facilitate the collection of data regarding level of care utilization and provide scoring and reporting based on that data, resulting in more accurate placements and less work for DMH and its provider staffs. Use of the data will maximize efficiency in resource utilization and reduce staffing needs at the provider level, aid in the proper evaluation of clients and placements, and support the decision making processes throughout DMH and partner agencies.

This project has been presented to the AHS IT Strategies group and is awaiting approval. DMH cost to implement is $25, 300 with a $3,289 annual support fee. (This investment is in the 2010 budget of DMH.) Additional costs are operational in nature (estimated 1 FTE for training, monitoring, AHS IT for acquisition, project management, contracting, etc). This cost would be shared among other IT initiatives, such as ASEBA. As a part of their contracts, DMH currently asks that facilities report this information but have not provided a mechanism for the reporting. Considerations have been made to ensure that duplicate data entry by facilities already transmitting data to DMH is kept to a minimum.

Return on investment will amount to savings generated by ensuring proper placements and measurable outcomes at discharge.

Achenbach System of Empirically Based Assessment (ASEBA) - The Child, Adolescent and Family Unit is continuing to move forward with the use of the ASEBA. Currently the ASEBA is required for the Youth in Transition Grant, the Trauma Grant, the Behavior Interventionist Minimum Standards, and all waiver and residential referrals. We are also working on pilot project in Franklin/Grand Isle to try and streamline the administration and sharing of ASEBA data between NCSS, primary care, DCF and schools. Additionally we are working with the DA's and SSA's to begin implementation of the ASEBA across all their programs and hope to have that up and running by the end of the fiscal year. This information will help clinicians and treatment teams assess current functioning in the 8 syndrome areas and gauge response to treatment. Additionally this will allow managers to look at programs as a whole and make programmatic changes as needed.

The Youth in Transition (YIT) grant has built in dollars to support their ASEBA requirement. The other required programs and the implementation to all programs will cost approximately $22,800 per year. However there may be areas that we can save on costs because the school, primary care or the DCF office had recently completed an ASEBA. That is the goal of the Franklin/Grand Isle project to determine how to best share that information in order to reduce redundancy. The Franklin/Grand Isle project is being supported by ARRA funds.

DMH/Futures Bed Board - The Futures Project is developing an electronic bed board which can track the use of residential, crisis, long term care, and psychiatric inpatient bed use across the state. With LOCUS in use as well, this would better measure the outcome of the use of these resources and help to create an environment of using the best level of care for patient need. An RFP for this project will be issued shortly.

Quality Management More efficient/cost-effective Departmental oversight mechanisms

Prior to staff reductions, DMH maintained a schedule of site visit activities annually or bi-annually to assess the quality of DA Programs and clinical documentation. All site visit activity was directed toward the monitoring of standards outlined in Administrative Rules and rolled up to an every four year Agency Designation process. The activities were time intensive for both the DA's and the DMH central office for pre-planning and data collection activities, on-site meetings with staff and stakeholders, and post-site visit report creation/dissemination.

These oversight mechanisms were modeled after national quality accreditation standards and tailored to meet agency designation requirements. DA's have long felt this to be a redundant oversight process when a DA was accredited by a national organization. Recently, some DA's have discontinued accreditation as both a cost savings for their agencies and given ongoing DMH and DAIL oversight processes, regardless of accreditation status.

A proposed change for quality management oversight would be the introduction of incentive funding for the DA's to seek and then maintain national accreditation by an external review organization. Requiring the DA's to become accredited would then reduce the need for both DMH and DAIL to conduct on-site reviews allowing both the DA's and the state agencies to experience cost reduction and savings over time.

There is currently $500,000 available for new initiative incentives. This funding could be used as incentive funds to jump start DA's who have not had national accreditation. DMH and DAIL could also pull back out funds from current DA allocations to support this process and make a lump some payment to the DA upon receiving accreditation. The DA's would transfer existing staff time from preparing for DMH site visits to preparing for national accreditation survey. DA's could also benefit from accreditation by securing better reimbursement rates from private insurance contracts. DMH could scale back activities to only monitor Vermont specific Administrative Rules requirements, much of which could be done through desk audit activity rather than on-site review. DMH could focus on specific issues that arise, rather than generic evaluation activities. These activities would also follow and rely heavily upon the existing accreditation cycles and reporting requirements, which would then inform the Agency Designation process.

It is anticipated that the deliverable could be introduced and phased in through master grant agreement beginning July 1, 2010. There would be immediate implementation for DA's that are nationally accredited currently. Crosswalk of Joint Commission and CARF standards is nearly complete and "deeming" of provider standards for accredited DA's is already beginning for the present Agency Designation process. This should be an immediate efficiency with regard to staff productivity at the DA level and travel cost savings for DMH staff.

Chittenden Project: VDH/ADAP Maple Leaf Farm and the Howard Center

The following parts of the Chittenden Project could be expected to produce clear outcomes with a high level of confidence. Should they produce or exceed the expected results, they could easily be folded into a full Chittenden Project in the future.

1. Maple Leaf Farm and the Howard Center are implementing a joint Intensive Outpatient Program (IOP) in anticipation of the Project. A staff member who runs the IOP meets with Maple Leaf Farm patients before they are discharged to discuss and arrange for IOP participation. Increased Medicaid allocation will allow the Howard Center/Maple Leaf Farm IOP to serve these additional patients. <u>This increases access to ongoing treatment services.</u>

2. Additional medical and psychiatric services at MLF will allow response to more complex cases. <u>This reduces psychiatric unit stays at hospitals.</u>

3. Outcome measures:
   a. Increase access to addictions treatment.
   b. Decrease use of ED for emergency intervention
   c. Decrease medical/surgical and psychiatric inpatient care for co-occurring disorders (number of bed days)
   d. Decrease DOC costs (number of bed days)

4. As of 3/26/10 the expected cost for this project is approximately $400,000. Based on current estimates of savings it is reasonable to estimate a savings of approximately $100,000 due to decreased inpatient (both medical/surgery and psychiatric related). ASAP will be working with OVHA, CSME and Blueprint to gain a more precise determination on measures for all costs savings related to this project—other than inpatient there are estimates that less service use over time, less benefit need overtime, and other areas of savings may be possible. ADAP will start by identifying 10 patients and determining Medicaid costs pre-treatment, during and post-treatment. This will establish baseline data to develop a better model for savings. ADAP will also work with CSME staff to determine how to include this ADAP data component as part of ongoing AHS work (Medicaid only).

Best practices are utilized by health care professionals regarding the use of child psychotropic medications

Through work with a DMH Child Fellow Grant (via reallocation of funds) to the UVM Department of Child Psychiatry's, VT Center for Children, Youth and Families (VCCYF) DMH will begin an academic detailing effort concerning use of psychotropic medications for children by primary care providers. The DMH led Child Medication Review Team, with ongoing support

with BISHCA and OVHA and DCF for data and staff time will continue this effort begun in 2008. Data from BISHCA regarding private insurance prescription trends will be used as will data from OHVA on similar areas. DMH Research and Statistics staff will continue to analyze data and provide reports. The outcomes for this project will be:

- Closer adherence to best practices for health professionals [i.e. 1) limit use of more than one antipsychotic medication and
- Complementary use of therapy in situations where psychotropic medications are prescribed

Projected cost savings by this practice support will need further analysis of current practice patterns and increased adherence to evidence-based prescribing patterns. At this point in time it is likely any cost savings would be indicated through less expenditure by OVHA, thus specific tracking measures will have to be developed.

(Note - Included here are the 10 strategic initiatives identified by the new SAMHSA administration. Numbers 1, 5, 7, 8, and 9 all relate to the targets of the DMH/ADAP/Blueprint efforts in the Challenges for Change document. DMH has other efforts via SAMHSA grants in the areas of numbers 3, 4, and 10 as well. This alignment increases the opportunity for DMH, VDH/ADAP or OHVA to win future grants to further help adjustments to the new Challenges environment.)

SAMHSA's 10 Strategic Initiatives

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Over the years SAMHSA has demonstrated that; prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the Nation's health. To continue to improve the delivery and financing of prevention, treatment and recovery support services SAMHSA has identified 10 Strategic Initiatives to focus the Agency's work on people and emerging opportunities. The 10 Initiatives are described below with the Agency lead identified.

1. Prevention of Substance Abuse and Mental Illness (Fran Harding, Director, CSAP)
Create prevention prepared communities and to focus on prevention of mental illness and substance abuse, focusing first on children and youth, and eventually serving individuals, families, peers, schools, businesses and communities across the lifespan.
(This is highly correlated to the work of Blueprint and other AHS health improvement efforts.)

2. Violence and Trauma (Kana Enomoto, Principal Senior Advisor to the Administrator)
Reduce the behavioral health impacts of violence and trauma and integrate trauma-informed services in prevention and treatment programs in States and communities, and throughout the health service delivery system to address root causes of pervasive, harmful, and costly public health problems. Divert youth and adults with substance use, mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.
DMH currently has a three year SAMHSA grant for addressing trauma care for children. We will be continuing to work to expand this to all populations.

3. Military Families – Active, Guard and Veteran (Kathryn Power, Director, CMHS)
Support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.
(DMH and UVM are collaborators on a SAMHSA grant, MHISSION -VT to address needs of veterans related to the criminal justice system, and the children's trauma grant includes working with military families.)

4. Housing and Homelessness (Kathryn Power, Director, CMHS)
Provide housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience when accessing programs that sustain recovery.
(DMH is working with Housing First to improve outcomes for persons with mental health conditions and housing needs.)

5. Jobs and Economy (Larke Huang, Senior Advisor to the Administrator)

Use funding streams to boost employment opportunities in communities for people in need of jobs including people with mental and substance use disorders.
(The Challenges proposals in this document address this area.)

6. Health Insurance Reform Implementation (Eric Broderick, Deputy Administrator)
Achieve equality with all other health conditions for the prevention and treatment of mental and substance use disorders.
(This is highly correlative to the Blueprint for Health efforts by VDH and DMH)

7. Health Information Technology for Behavioral Health Providers (Wesley Clark, Director, CSAT)
Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participate with the general health care delivery system in the adoption of health information technology.
(DMH is working with OHVA's lead on developing this area for mental health care)

8. Behavioral Health Workforce – In Primary and Specialty Care Settings (Wesley Clark, Director, CSAT)
Provide a coordinated approach to address workforce development issues affecting the behavioral health service delivery community.
(This is directly related to the Blueprint and the efforts by DMH to establish a DA training on health/mental health related concerns of clients.)

9. Data and Outcomes – Getting Results (Pete Delaney, Director, OAS)
Realize an integrated data strategy that informs policy and measures program impact leading to improved outcomes for people in need of services.
(Through Challenges for Change DMH is increasing our attention to develop of improved data gathering and meaningful outcome measures)

10. Public Awareness and Support (Mark Weber, Director, Office of Communications)
Change how mental health and substance abuse services are perceived so that people seek help for these conditions with the same urgency as any other health condition.
(DMH currently has a SAMHSA grant to increase awareness of teen suicide and prevention strategies)

Challenges for Change

Department of Disabilities, Aging and Independent Living (DAIL)

Department of Disabilities, Aging and Independent Living
Challenges for Change

Executive Summary

The Department of Disabilities, Aging and Independent Living (DAIL) is utilizing the opportunity presented by Challenges for Change to improve and modify our existing client centered systems of care.

DAIL intends to aggressively assist Vermonters to remain independent using home and community based services and as a result reduce nursing home utilization. In some counties in Vermont, nearly 60% of all persons needing nursing home level of care are served at home or in alternative community based settings. In other counties, the utilization of home and community based services hovers around 40%. Greater utilization of home and community based services is achievable, with an accompanying reduction in nursing home utilization.

Vermonters who need long term care and choose home based services can benefit from more flexibility in how the dollar allocation in their plans of care are utilized. This strategy is intended to allow more participants to remain independent. For example, Choices for Care has a limited set of service options that are paid for on a fee-for-service basis, unless the consumer chooses the Flexible Choices option, where, with the help of a counselor, the consumer manages his/her budget. Only a small group of consumers have selected this option. DAIL is exploring different payment mechanisms that can provide more flexibility to consumers.

Providers can also benefit from this flexibility since moving away from a fee-for-service system would reduce paperwork requirements and time for both providers and State staff.

DAIL is also exploring how to utilize the Developmental Services individualized service plans, which the Designated Agencies (DAs) and Specialized Services Agencies (SSAs) develop with clients, as **performance-based contracts** supporting better outcomes for consumers.

DAIL has also proposed legislative changes to **Medicaid estate recovery** law to increase revenues for the program to ensure persons most in need can continue to receive services.

Another concept involves redesigning the delivery and financing system to have home and community based providers in the long term care system receive **bundled rates** based on consumers' needs and preferences. The provider agencies, instead of being specialty providers, would accept the responsibility to either directly provide or arrange for all the services a participant needs. In return the provider would be paid a bundled rate based on a plan of care and perhaps a tiered system of rates. We believe this would create opportunities for savings; but it is a large and complicated change that will require more discussion and design time.

Initiatives

1. Create incentives for home and community based providers to serve additional persons in community based settings.
2. Expand the list of available providers of home and community based services where necessary to assist in the aggressive effort to decrease nursing home utilization.
3. Expand the service menu and flexibility for home-based consumers to allow them to remain independent, even with constrained funding.
4. Develop different funding mechanisms for providers to reduce administrative burdens, while focusing more on outcomes for consumers.
5. Expand opportunities for elders and adults with physical disabilities to benefit from a 24/7 service option similar to the concept of developmental homes.
6. Encourage small nursing homes to convert to Enhanced Residential Care Homes, thus reducing the regulatory requirements for those homes while reducing expenditures.
7. Develop a process for "presumptive eligibility" to ensure consumers do not have to wait for long periods while eligibility is being determined, sometimes putting their independence at risk.
8. Set up an interdepartmental team to ensure that DAIL clients with mental illness are served in an integrated fashion and avoid unnecessary or prolonged stays at Vermont State Hospital.
9. Convert Vermont's last six-bed Intermediate Care Facility for the Mentally Retarded (ICF/MR) to an Enhanced Residential Care Home, reducing regulatory requirements while reducing expenditures.
10. Strengthen estate recovery and maximize private contributions to Long Term Care Medicaid.

Outcome/Indicators

Outcome from Statute	Indicators (data source)
Elders, people with disabilities and individual with mental health conditions live with dignity and independence in settings they prefer.	• Reduction in paid claims to nursing homes (EDS/HP claims) • Increase in the number of persons enrolled in Choices for Care in home and community based settings. (DAIL's SAMS database)
	• Percentage of respondents who report that they had a voice in the decision about where they live • Percentage of respondents who report that they are living in the setting they prefer. • Percentage of respondents who report that they are happy with their case manager • Percentage of respondents who report that they are happy with their service agency Note: consumer surveys are carried out by an independent contractor.

Estimated Savings and Return on Investment

We estimate that aggressive efforts to reduce nursing home utilization can result in up to $5 million in net savings. This will mean that 167 additional beds will remain vacant on an annualized basis. This is after re-investing the funds necessary to serve additional persons at home or in alternative settings.

We estimate $7.5 million in savings by utilizing individual service plans in developmental services as performance based contracts with better outcomes for consumers.

Changes Needed in Statute and Regulation

For estate recovery and liens, DAIL will require legislative changes in Title 33.
We also need the language we proposed that would protect us and the DAs and SSAs from the continuing benefits issue.

Timeline for Implementation

DAIL will begin the effort to further reduce nursing home utilization immediately, and this effort will ramp up once the incentives are designed and implemented.

Research on alternative financing mechanisms will begin immediately.
Work groups will be identified and assigned the weeks of March 29 and April 5.

Investments Needed

DAIL will need some up front expenditures, approximately $500,000 to serve additional persons at risk of nursing home placement until savings begin to materialize.

If a decision is made to move forward with financing changes such as tiered rates or bundled rates, DAIL will require a contractor to assist in the development of those mechanisms, in the range of $50,000 to $70,000.

Information Technology (IT) Needs

DAIL will rely on the AHS enterprise service oriented architecture to meet IT needs for these initiatives.

Stakeholder Involvement

DAIL leadership met twice the week of March 22 with key leadership from the provider community to discuss major concepts. DAIL leadership met with consumers and advocates twice on March 26, and in a meeting on March 29.

Consumers, providers and advocates will be integral part of all work groups as we move forward.

Challenges for Change

Creative Workforce Solutions

Creative Workforce Solutions
Challenges for Change

Executive Summary

Employment is the road to self-sufficiency
Employment is the only practical mechanism to reduce dependency on services and benefits for Agency of Human Services (AHS) consumers. Recent and prospective reductions in AHS services increase the need for return to work services. Without effective employment services, reductions in AHS services may simply result in consumers returning to the system through another door. Yet, despite the critical importance of work in the lives of the people we serve, AHS employment programs are dispersed across four separate departments and at least seven divisions.

Creative Workforce Solutions (CWS)
The Challenges Workgroup has developed a consolidated and coordinated approach to employment services under a single entity called Creative Workforce Solutions (CWS). CWS will provide equal access to meaningful work in the competitive job market for all AHS program participants. It will also offer employers a single point of contact for coordinated job development and placement services across AHS programs.

Operational Design
All AHS employment services will be coordinated through CWS. CWS will establish common standards and tools for marketing and account management. Employer contacts statewide will be managed through a common account management system using Microsoft SharePoint.[2] At the local level CWS Business Account Managers will coordinate employer outreach through local employment teams built on the existing employment coalitions.

The service infrastructure behind CWS will vary based on consumer need, program requirements and program infrastructure. Some AHS programs already have well established employment services and these programs will coordinate employer outreach through CWS. Other programs that have almost no or limited community-based employment services will contract for employment services directly from CWS, based on the level of demand in their program.

Outcome/Indicators

AHS employment services are provided across four departments and seven divisions. While the broad outcomes are similar, meaningful indicators of progress will vary across populations and programs. Given the barriers to sustained employment among these populations, these goals are very ambitious.

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[2] Microsoft SharePoint is a business collaboration platform that will offer a feature-rich integrated environment for CWS business account managers and job developers both within AHS and in our partner community agencies to collaborate; share job leads; employment market knowledge and ideas; connect with their colleagues, and easily find information and experts. Features that will be particularly useful for CWS include shared employer contact data, calendars and tasks, contact notes and email storage and management, document collaboration and versioning, resource libraries of employer marketing materials, and SharePoint's extensive tools for site administration, security and customization.

Outcome	Indicators
More AHS customers will be employed	▪ CWS employment rates overall as measured though Vermont Department of Labor (VDOL) Unemployment Insurance (UI) quarterly earnings data. ▪ Department of Mental Health (DMH) Community Rehabilitation and Treatment (CRT) Program: Employment rate of CRT consumers as a percentage of total served based of VDOL UI data. ▪ Department of Disabilities, Aging and Independent Living Services Developmental Disability Services (DDAS) Program: Employment rate of DDAS consumers as a percentage of total served based on annual program reports. ▪ Department for Children and Families (DCF) Reach Up Program (RU): Work participation rates of RU consumers. ▪ Department of Corrections (DOC): Percentage of DOC consumers employed post release. ▪ Division of Vocational Rehabilitation (DVR) and Division for the Blind and Visually Impaired (DBVI): Number of individuals closed as successfully employed.
Wages will increase	▪ CWS consumer earnings across programs as measured quarterly through VDOL UI data
Employment retention will increase	▪ CWS consumer employment retention across programs as measured through VDOL UI data
Benefits utilization and recidivism will decrease	▪ RU consumer grants closed or reduced because of employment. ▪ Cash benefit reductions—ReachUp, Supplemental Security Income (SSI), and General Assistance (GA)— resulting from employment for DVR, DBVI, Refugee Resettlement, and DOC populations served by CWS. ▪ Reduced recidivism (re-conviction) for DOC and RU consumers
Cost per outcome will decrease	▪ Cost for initial placement and support. ▪ Cost for long and short term post placement support.
Customer satisfaction will increase for employers, consumers and stakeholders	▪ Employers: Feedback through CWS coalitions and formal survey data. ▪ Consumers: Survey data as measured through the various departments/divisions. ▪ Stakeholders: CWS partner meetings.

Estimated Savings and Return on Investment

Return on Investment

Effective employment services will reduce recidivism and benefits utilization. Employment will reduce dependency on services and benefits for AHS consumers. With reductions in other AHS services, effective employment services will be needed more than ever to prevent adults and families returning to the benefits rolls or service systems.

Supporting Savings Across AHS Programs

- By consolidating Reach Up grants management through Creative Workforce Solutions we will both meet the 3% DCF.

- The employment initiative will support savings in the General Assistance (GA) program by moving chronic GA recipients to Social Security disability benefits and moving GA recipients off the rolls to work or elsewhere.
- The employment initiative will support and sustain the DOC Challenge savings. As more offenders are being managed in the community, finding and maintaining work becomes an essential service to sustain successful reintegration and reduce recidivism of offenders overall.

Performance Based Contracting and Revenue Generation

- Over the next two fiscal years, $2 million in VR funding for JOBS, CRT and DDS supported employment will transition to a structured pay for performance model.
- The last year of DVR's Medicaid Infrastructure Grant funding as well as possible federal VR reallocation and DVR ARRA funds will be dedicated to the implementation of this initiative.
- By increasing employment outcomes for Social Security disability program beneficiaries, CWS will generate additional federal revenue for the CRT, DDAS and VR employment programs.

Changes Needed in Statute and Regulation

At this time, we have not identified any legislative or statute changes necessary to implement Creative Workforce Solutions as designed.

Timeline for Implementation

The initial launch of employment as an AHS priority and the coordination of employment services through Creative Workforce Solutions is scheduled for a cross-agency Employment Institute on June 29th at the Statehouse. Work will continue within the 12 AHS districts to bring the CWS teams together under consistent operating principles. CWS will continue to work on the establishment and measurement of population-specific outcomes and indicators. CWS will host a follow-up statewide training event in the fall.

Investments Needed

We request that AHS make available $200,000 in General Fund dollars on a one time basis to the Division of Vocational Rehabilitation to draw down available federal vocational rehabilitation funds through re-allotment. $200,000 would potentially draw down an additional $800,000 in federal funds that could be used to seed this effort. The availability of re-allotment funds are dependent on other states not being able to draw down their full allotments and are therefore not guaranteed.

Other than this one time investment, Creative Workforce Solutions will be implemented primarily through reallocation of existing resources. The emphasis will be on using resources currently assigned to employment services in a more coordinated and effective manner.

Information Technology (IT) Needs

We are in the process of developing an employer accounts management database using Microsoft SharePoint. This will be a key tool. We are in discussions with S-3 Technologies (a

preferred vendor) about assisting us with business process definition, workflow design and a simple database to begin early tracking of employment outcomes through CWS. S-3 is finishing up work with us to define the business processes for an integrated VR case management system that will allow partner participation and could be a platform for Creative Workforce Solutions across the agency.

We will be looking to the AHS Central Source for Measurement and Evaluation data (CSME) warehouse to track a number of key outcome indicators. These will include:

- Reductions in benefits utilization as a result of employment
- Increases in work participation rates for Reach Up participants
- Recidivism and re-offense rates for offenders

Several departments and divisions involved in CWS currently have access to Department of Labor Unemployment Insurance earnings data to track employment outcomes.

Stakeholder Involvement

Impacted departments and divisions are all involved in the subgroups working on Reach Up, DOC, CRT, DDS populations and youth. Designated Agency staff are represented on the supported employment groups. As the implementation plans are developed it is our intention to fully involve AHS field staff and to conduct customer focus groups including employers.

Challenges for Change

Information Technology
Enterprise Infrastructure

IT Enterprise Infrastructure
Challenges for Change

Executive Summary

Technology is a key component of the charge to AHS to redesign its delivery systems to achieve a client centric approach in the "Challenges for Change: Results for Vermonters" January 5, 2010 report to the Joint Legislative Government Accountability Committee. Although redesign efforts have been organized around particular areas or target populations, multiple demands on information technology require the IT professionals both participate in these groups and establish a separate forum for determining the technology needs and priorities.

We can no longer rely on an IT strategy of working sequentially from project to project, hoping that an initial deployment can grow to serve other divisions or departments. Too often we found that solutions were unique and had been designed to fulfill a narrow niche and could not be easily expanded. Our redesign of IT is a redesign of our strategy to implement IT in support of business needs. The result will be faster development of critical technologies, reuse of components across many services, and better and more maintainable systems. These improvements in IT are necessary to support the goals of the functional areas involved in Challenges for Change.

The redesign relies on constructing an enterprise architecture for technology, information and the business of AHS. An enterprise architecture creates a roadmap that can provide guidance for future investments. It is built on the principles and products of a service oriented architecture (SOA) of common technologies and shared services that provide reusable components for various needs. For example, we will purchase and install one master-person index or one imaging solution that is configured for wide utilization across functional areas. A division or program will conduct a business process analysis; and, if imaging and unique identification of individuals, are required, the tools already purchased and installed will be used as part of the IT solution.

More importantly, by purchasing re-usable components, staff members' skills are transferrable and implementation times will decrease dramatically. In some areas projects that would have been scheduled sequentially, can be accomplished in parallel if resources are available. For example, a business rules engine that can structure statute and policy and translate it to create web-based questions that determine eligibility can be implemented for 3Squares for DCF at the same time the component is being used to structure sentencing rules for Corrections. Over time standard processes will decrease costs in many areas and support more effective business processes.

On a broader level, some solutions are being purchased and implemented for use across state government. AHS IT is contributing to and coordinating with this effort so that common components can be used across all agencies.

Goals and objectives

The goal is to implement systems and install infrastructure in time to meet the needs of the

programs as the AHS service delivery model is redesigned. A key to reaching this goal is to identify all anticipated IT needs and create a plan to successfully implement new technologies while responding to current IT needs in a thoughtful, structured manner. With the new technologies in place, individual projects, some running in parallel, can be implemented to support the redesign initiatives. Transition strategies include:

- **Business Needs Drive Technology Choices**

Create a "technology map" based on the AHS functional areas to provide guidance about the business strategic decisions and directions.

- **Acquire Once, Re-use**

Acquire technologies—particularly enabling technologies—that can be re-used across departments/programs/business functions with minimal modifications while building enterprise capability (e.g., business rules engine, identity management, and imaging). This can be done by 1) implementing a new instance of a common technology or 2) extending the current base to other programs/functional areas.

- **Leverage Platform/Technology Experience and Knowledge**

Build on successful implementations and operational experience rather than acquiring new technologies (e.g., experience with deploying IVR for call center operations).

- **Prioritize Realistically**

Not all things are possible, especially concurrently; high-impact (real savings) projects take priority over minor efficiency gains; business and IT sides must partner on setting priorities.

- **Account for ROI**

Honestly and completely understand the true costs of transformational projects (e.g., required project management, business analysis, process re-engineering, implementation, and support\maintenance resources) on both IT and operational sides of the equation.

- **Leverage Innovative Funding and Align with State HIT Plan**

Initiatives such as Medicaid Management Information System (MMIS) and ARRA provide limited-time windows of opportunity for acquiring and deploying enabling technologies associated with the initiatives. Alignment with the State HIT plan will be required to ensure funding is appropriate and that deployed technologies strengthen these initiatives.

- **Encourage Technologies that are Extensible to Statewide Use**

When evaluating technologies/projects, give priority to those with wider application across other agencies in accordance with Vermont State IT strategic planning and planned initiatives.

Information Technology Strategic Plan

(A) Core components. Many of the deficiencies cited in the Challenges for Change report and visions for the future correspond to the components we have identified as a priority for our enterprise architecture. These priorities evolved from key efforts like Vermont Integrated Eligibility System (VIEWS) and MMIS and include the technologies implemented as part of Strategic Transformation Effective Enterprise Realignment (STEER).

The goal is to move each component to the technology implementation stage with a plan for how the model would be expanded throughout the Agency.

- Stage 1: Acquisition plan for the technology
- Stage 2: Implementation plan (propose proof of concept, pilot or phased rollout(s)
- Stage 3: Technology Transfer Implementations
  - Model expansion, common tool set(replication or enhancements)
  - Licenses and maintenance
  - Vendors
  - System integration issues
  - Internal resource requirements
  - Implementation issues/learning
  - Scheduling

The following critical components have been identified and assigned to these stages:

- Business rules engine – stage 1
- Enterprise Master person Index (EMPI) – stage 2
- CSME data warehouse – stage 3
- Imaging – stage 2
- Call center – stage 3
- Workflow – stage 1
- Web portal – stage1/2
- Enterprise bus – stage 1

A team was assigned to each component and they created a vision/scope and work plan. For those at stage 1, requirements and acquisition strategy were identified; stage 2, as implementations are being completed documents are to be compiled to help in technology transfer; and for stage 3, document the technology transfer covering the areas listed above, as well as act as consultant to other departments for this technology. Additional work to estimate costs and resources for these components is underway with preliminary estimates included later in the document.

(B) Challenge for Changes specific IT requirements. In addition to the core components, we recognize that each of the subject matter groups may have unique IT requirements that cannot be met by current systems or implementation of a core component. However, to date, none of the groups have developed plans in sufficient detail for them to identify IT needs.

(C) IT changes required because of FY11 budget. System changes and other IT support required to implement the initiatives and cuts proposed in the FY11 departmental budget submissions are dependent on the actual budget that is passed and none have been compiled.

(D) Current projects. A prioritized listing of projects currently underway or proposed, including enterprise projects (VIEWS and MMIS) and division specific projects are being completed by individual departments for inclusion in the plan.

When all tasks are complete, the plan will strive to identify dependencies among projects and complementary projects that can be acted on together. It will produce descriptive data and recommendations for the Secretary and Commissioners to be able to prioritize the projects and apply appropriate resources.

Because of the complexity of capturing this data and the lack of project management tools in use at AHS, the AHS project management group was added as a core team and they have identified a project management toolset to pilot during this process.

Outcome/Indicators

IT changes are proposed that will help meet the outcomes and indicators of the business proposals. As IT solutions are developed and implemented to meet the needs of the program changes, separate performance indicators will be developed.

Estimated Savings and Return on Investment

Savings accrue to the respective initiatives.

Changes Needed in Statute and Regulation

Statute requires an Independent Review for any IT acquisition over $500,000. (Title 3, Chapter 45, 3 V.S.A., paragraph 2222) AHS requests legislation that would exempt IT investments made in conjunction with the Challenge initiatives including the purchase and implementation of components of the enterprise architecture including Master Person Index, work flow engine, enterprise bus and rules engine. The exemption will sunset at the end of FY12.

Independent oversight of this work will be provided by the State Chief Information Officer (CIO) and AHS will be required to submit written materials that fulfill the components of the independent review to the CIO.

Timeline for Planning and Implementation

The only timelines that have been discussed relate to the acquisition and installation of the infrastructure, and only at a summary level. These installations are a precursor to the implementation of new systems using these components that will support the redesign of the programs.

Task	Proposed Timeframe
Confirm acquisition strategy and plan	Last week March
IAPD submission to CMS (for possible 90-10 funding)	1st week of April
RFP issuance	2d week of April

Vendor selection and contract	June
Installation	July - August

This timing is consistent with the issuance of an RFP for MMIS and VIEWS implementation in the July – August timeframe. By then, we will have selected and installed our enterprise architecture which will be defined as the platform upon which the new systems could be built – or will have to integrate with should a vendor propose a hosted or proprietary solution for these programs. This schedule is extraordinarily aggressive and will require total cooperation with CMS and DII as well as waiver from the Independent Review statute.

As various projects are defined, separate implementation schedules will be developed. For example, imaging hopes to be operational in April [will it be]and we hope to have a governance structure in place to accommodate other department's expansion of the use of imaging. Health has a project well defined with all business process work completed and will be the first to add about 6,000 items concerning paternity to this repository. Because it is so small with one discrete form, we project about a month for implementation.

Investments Needed

We are still collecting some rough target numbers for various components and these will have to be updated based on actual quotes as well as the final determination in some areas of the amount of licenses to purchase initially versus those that can be added as we proceed with the implementations; i.e. how much do we need to invest during an initial installation versus costs to increase or upgrade at later dates.

Technology Procurement- preliminary numbers

Product	Estimated cost to procure and install
Enterprise Master Person Index (EMPI)	$350,000 - $500,000
Workflow	$500,000- $750,000
Business Rules Engine	$750,000 - $1,000,000
SOA suite-enterprise bus	$750,000 - $1,000,000
Call center	Infrastructure priced by implementation or expansion of existing deployments; each call center has been in the $80,000 - $100,000 range
Imaging Services	Expansion of storage costs at implementations
Web services	Infrastructure in place with VIC, costs for development of actual applications with VIC
CSME Data warehouse	Infrastructure in place, additional storage and potential costs for additional licenses or enhancements if user base is extended
Project management (pilot)	$20,000
Staffing to support core components	$800,000

Human Resources/Staffing Model

In addition to investment in IT products and personal services to implement various implementations of these products for PSG needs, a new staffing model must be considered to support implementation and operation of this enterprise architecture.

Each application is different and will have different human resource needs. Many of these skills are not held by staff at AHS and we will need to develop these skill sets to be able to support this new environment. The applications also require new duties that will require additional staffing after implementation. We hope to hire interim staff and use them to help alleviate current operational burdens on existing staff so existing staff can develop the new skill sets for this technology.

It is important to reinforce the fact that the resource requirements are not only on the technical side and we will need to reassign or supplement departmental program staff to be able to implement new systems using these technologies. A good part of the effort after procuring the technology is for business process analysis to determine the requirements and define how the technology fits into the redesign systems.

Our overarching vision is to introduce enterprise architecture to AHS. Enterprise architecture covers not only technology but also information and the business/programs. To be successful we will need to introduce an SOA- Enterprise Architecture Governance team that can represent all 3 components, technology, information and business. This may require designating internal staff members to take on these roles, and/or supplementing staff with additional positions.

The staffing model also changes during the phases of acquisition, implementation, and operations. Each team has been asked to create a staffing model that includes both the technical and program resource requirements. Our acquisition model uses a 4-5 member technical team lead by a project manager to define requirements, write appropriate IAPDs, RFPs, select vendor, prepare work plans, begin training to develop new skill sets and install, with the vendor's assistance, the new architecture. This installation may include a proof of concept or pilot in which case an implementation team is required. Resources can vary significantly depending on the acquisition model.

Our staffing plan starts with one IT individual assigned to each component with one additional individual identified during installation as backup and during implementation as full-time to work with implementation teams. If several parallel implementations are underway additional staffing may be required. The goal is to have at least 2 individuals with high knowledge of the application; i.e. 2 each for workflow, rules engine, enterprise bus and related messaging, and EMPI. EMPI will require additional staff to resolve potential duplicates. Depending on how tightly the workflow, enterprise bus and rules engine are integrated, this staffing level might be reduced when the system matures and we are in an operational mode. Across components we expect the need for one highly trained and experienced DBA with a less experienced assistant. Currently we have no experienced DBAs available. The addition of 2 project managers, 2 business analysts and 1 security analyst (to work with the security director) to support the departments efforts during implementation will be needed. This staff does not include project leads and requirements definition participants from the departments and this can be a significant dedication of staff as noted with the work done on VIEWS and STEER.

Operational needs will vary significantly depending on whether the solution is hosted or run in-house.

Help desk support across the agency should be analyzed to determine how best to provide the on-going support as well as testing, training and change management for users. The help desk functions can be critical for successful implementations as well as operations and potentially restructuring the agency approach to this support might provide resources for this type of coverage without additional resources.

Information Technology (IT) Needs

IT needs are specified in the investment section.

Stakeholder Involvement

A team was organized that consisted of 3 groups:

- Core component implementation
- PSG group IT representatives who are IT Managers of AHS departments
- Programmatic stakeholders who include the chairs of each workgroup as well as the program leads for the key enterprise projects

The IT groups have met weekly, the full group monthly. The leads for each of the core components were asked to set up a small group with mainly technical staff (at first) to set scope and complete preliminary research as needed.

Workgroups will identify additional stakeholders and means to involve them in the process. The weekly meetings have been used to report on status and provide more information on details of the products and functionality. It has given us an opportunity to be sure each group is progressing and we have not omitted areas of work that are needed by the other work groups. We have identified the functional area of identity management (broader than just EMPI) as a function that needs additional research and meetings are being scheduled for that purpose.

Two monthly meetings were held with internal stakeholders to inform and seek alignment with the needs of the subject matter groups and major projects. Discussion has been general and we do not have any clear definition of IT work that may be required for these initiatives. We believe this is because the redesign is still at a high level. We have had demonstrations of product and the web group has had meetings with DII and VIC to plan and coordinate activities. DII staff members are included on many of the work groups and DII representatives have participated in the larger monthly meetings as well.

As we near implementation plans, stakeholders will include more members of departmental program staff.

Glossary of Terms

Some of the terms we use may not be familiar to the reader and so we have attached a brief definition.

Business rules engine – Business rules engine is software used to track, manage and revise enterprise business processes. This software system typically executes business rules that might be derived from legal regulations or in-house corporate policies. A business rules engine

registers, defines, classifies and manages all of the rules. It will verify consistency and define relationships between different rules to ensure the uniformity and integrity of the rule sets.

CSME data warehouse – The Central Sources for Measurement and Evaluation (CSME) is a data warehouse tools that combines individual client-level data from different source systems. The extract, transformation and populating of the data warehouse is structured and consistent to provide an unduplicated, aggregate view of AHS clients for planning and decision-making purposes.

Enterprise Master Person Index – An authoritative central repository of individual demographic information and identifiers. It can be used to de-duplicate records and facilitates sharing of information from different applications.

Enterprise service bus – is a centralized infrastructure component that makes a set of reusable services widely available and to communicate with each other. It supports various protocols, can transform data and combine services to create a new service and govern the use of the services based on security rules. [For those who find this definition too technical, if you have seen Avatar, the planet Pandora is analogous to an enterprise service bus]

Imaging services - The representation or reproduction of an object, in this instance unstructured information. Imaging is one module that is part of a larger enterprise content management system (ECM). An ECM is a set of strategies, methods and tools used to capture, manage, store, preserve and deliver content and documents related to organizational process. For our purposes imaging services define the modules purchased to scan and process documents at AHS.

Service Oriented Architecture - is an architectural method or design style that results in and supports shard, reusable services by multiple business entities.

Workflow engine –Workflow is automation of a business process in whole or in part. Workflow dispatches work and sends notifications based on the pre-defined process. It manages the program/business process based on the organization for approval authority, delegation and substitution. It can manage deadlines and priorities and support reporting of workflow status.

Challenges for Change

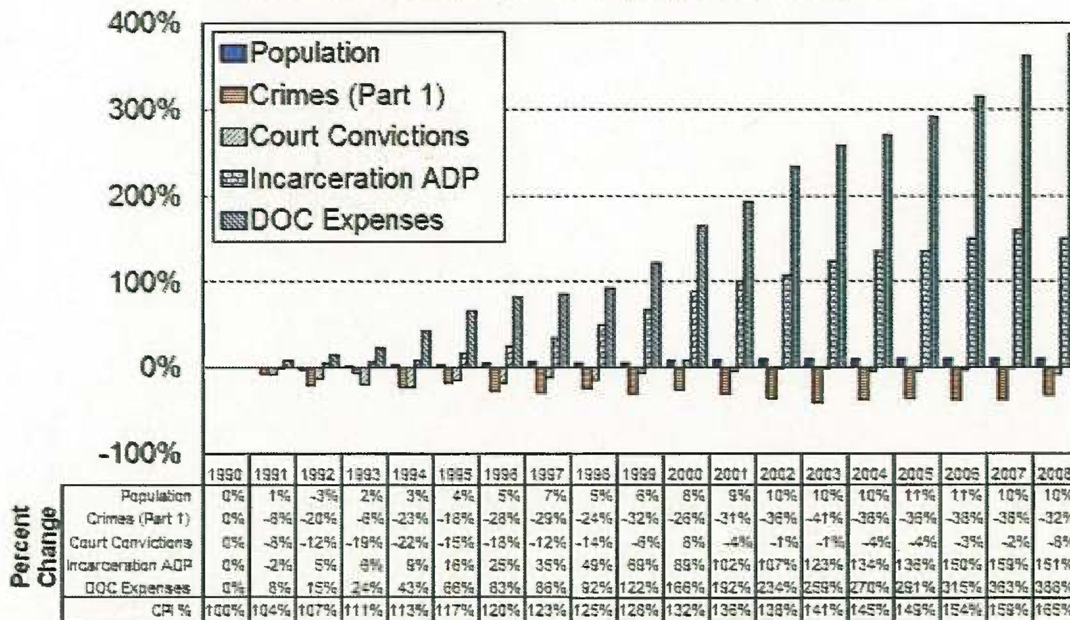
Corrections Rebalance

Corrections Rebalance
Challenges for Change

Executive Summary

In directing a fundamental review in Correctional practices, the Challenges for Change target reduces Vermont's annual Correctional Budget by $10 Million. This legislation recognizes that spending on Corrections is crowding out other budget priorities that are important to individual Vermonters and our local communities, such as investments in higher education, agriculture, job development, the environment, human services and infrastructure.

Specifically over the last two decades, Vermont's population increased from 563,000 to 621,000 or approximately 10%. During the same period, crime rates were essentially flat and our incarceration rates skyrocketed from 850 inmates housed in 1990 to 2,160 in 2009 – an increase of 154%.



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Population	0%	1%	-3%	2%	3%	4%	5%	7%	5%	6%	8%	9%	10%	10%	10%	11%	11%	10%	10%
Crimes (Part 1)	0%	-8%	-20%	-6%	-23%	-16%	-28%	-29%	-24%	-32%	-26%	-31%	-36%	-41%	-38%	-36%	-38%	-36%	-32%
Court Convictions	0%	-8%	-12%	-19%	-22%	-15%	-18%	-12%	-14%	-6%	8%	-4%	-1%	-1%	-4%	-4%	-3%	-2%	-8%
Incarceration ADP	0%	-2%	5%	8%	9%	16%	25%	35%	49%	69%	89%	102%	107%	123%	134%	136%	150%	159%	151%
DOC Expenses	0%	8%	15%	24%	43%	66%	83%	86%	92%	122%	166%	192%	234%	259%	270%	291%	315%	363%	386%
CPI %	100%	104%	107%	111%	113%	117%	120%	123%	125%	128%	132%	136%	138%	141%	145%	149%	154%	159%	165%

Population census/estimates from U.S. Census Bureau (April or July); Part 1 Crime from Vermont Department of Public Safety as reported for FBI Uniform Crime Reports (calendar year); Court Convictions from Vermont Judiciary reports on District Court dispositions (fiscal year); Incarceration Average Daily Population and Expenses from Vermont Department of Corrections (fiscal year). Expenses are not adjusted for inflation.

(Note: data taken from Department of Public Safety and Department of Corrections Public websites.)

Fundamental, lasting change will require a substantial change in culture. Change needs to occur at every level of the criminal justice system and in every branch of government. Over the course of the past two decades, we have come to view incarcerated bed space as an unlimited resource – always available to meet an ever expanding demand without regard to cost. Our real challenge is

to convince not only the criminal justice community, but also the public, that incarcerated bed space is an expensive and limited resource that should be reserved for violent and dangerous offenders and those that habitually reoffend. Our challenge is to build a "unified crime prevention and justice system" consistent with evidence-based practices and a model that uses risk management and community based programming to identify offenders at certain intercept points in the criminal justice system and match them to the program that aligns with their treatment and supervision needs, leading to reduced recidivism and better outcomes. To be successful, we need to build on the recent collaborative efforts of the three branches of Vermont State Government with Justice Reinvestment efforts.

Strategies will need to be implemented to reduce the number of lower level offenders coming into the Department of Corrections' supervision and particularly into costly prison beds. Some of these strategies will include the Judiciary expanding the use of term probation and reducing the term in certain cases, use of judicial summons in lieu of arrest warrants for failure to pay fines, expanded use of community restitution, and the referral/deferral of more cases to community justice centers or diversion boards. We will explore the advisability of combining the resources for this work through a unified program. Additionally, we propose reinvestments into community- based treatment options as well as increasing capacities for drug courts.

Community safety will be enhanced by:

- Building community capacities for structured re-entry.
- Offering increased and newly designed treatment strategies.
- Supporting increased and more specialized transitional housing and support services.

The proposal below is divided into two sections. First are recommendations that our working group discussed and were able to reach conceptual consensus though not necessarily to every detail. This recommendation package includes proposals for savings of $6,245,640 with reinvestment proposals totaling $3,164,500. The proposals address 5 of the 7 outcome indicators described in S. 286.

Cost saving proposals include the use of home incarceration as a status (24/7 in the home) and home confinement (allowing for participation in employment, treatment and community service) with electronic monitoring as an alternative to detention, supervised release as a sentencing option in lieu of interrupted sentences, expansion of reintegration furlough, and decreased sanctions for program termination by incarcerated offenders.

Reinvestment proposals significantly enhance community strengths through enhanced workforce development efforts, electronic monitoring technologies to include ignition interlock devices, residential substance abuse treatment, recovery-supportive housing, additional transitional housing for complicated populations, re-entry services that are individually tailored to specific needs, and the expansion of drug court capacity. It also provides funding for a second community based case management and assessment program similar to the Windsor Sparrow Project. It is important to understand that these are not a set of stand-alone options but rather a system of inter-dependent designs that link facilities, field services, external agencies, criminal justice partners, local government, and citizens.

A second set of proposals that would be needed to reach the targeted savings of $10,000,000 is included in a separate section. The working group did not reach any consensus on these proposals or necessarily discuss them in detail. However the group recognizes that with the FY11 correctional budget already reduced by $10 Million through the Challenges legislation, broad changes are needed to address this fiscal reality while maintaining public safety.

The additional proposals are premised on limiting incarceration to 1,800 beds. In order to stay below the cap, DOC would be authorized to release incarcerated offenders who have not reached their minimum sentence to a different form of supervision. This would be considered only after a review of each individual's case and circumstances. If released, the remainder of the sentence could be served in a home confinement or home incarceration status as opposed to incarceration in a prison. If alternative supervision is recommended for an offender with over six months remaining prior to the minimum, the Commissioner would be required to inform the prosecutor and the sentencing court of the offender's release on a "supervised sentence" and there would be an opportunity to object to the release. This proposal is modeled after a statute from New Hampshire.

The total savings from both sets of proposals equals $10,664,000 (before investments), slightly surpassing the Challenges goal.

There are some caveats with this approach. First, all savings estimates for FY 11 are for a full year, which is admittedly aggressive. This presumes that DOC receives the authority to proceed with these ideas before the legislature adjourns and promptly implements the authority to gather a full year savings.

Second, there may be some implications to the DOC contract with Corrections Corporation of America (CCA). If Vermont's out-of-state bed count drops, CCA may object to Vermont falling short of the contractual floor for minimum bed utilization of 400 beds. Recent out-of-state use is 685 beds, substantially above the contract minimum, but these proposals, when combined, will likely lead to utilization below the 400 bed level.

The following are the proposals in approximate order of concurrence.

Proposals Developed With Input from Stakeholders

An initial stakeholder working group was able to reach partial consensus on a number of proposals that would produce savings of around $6.2 million with an investment of approximately $3.2 million, largely in community-based resources. These are titled *Proposed Savings* and appear immediately below.

Additional proposals were made that would increase the total savings to $10,664,000 with an additional investment of $476,128. No consensus was reached to support these proposals, but they are described later in the document in a section titled *Additional Proposals to Meet the $10 Million Target.*

I. Proposed Savings

(A) S. 292 as Proposed by Senate Judiciary Committee:

S. 292 addresses Outcomes 1, 2, 3, and 7.

Reduce Detention Beds by 25%	$1,734,900
Release nonviolent offenders who have served their minimum sentence including DUIs	1,896,824
Total Savings:	**$3,631,724**[3]

(B) Decrease Detainee Population (Outcome 7)

S.292 incorporates savings of $1,734,900 which requires a reduction of 75 beds currently used for the detention of defendants who have been charged, but whose charges have not yet been adjudicated. In order to make this possible while maintaining public safety, we propose the following:

- ☐ **Home Confinement through electronic monitoring**: Add home confinement through electronic monitoring as a condition of release to 13 V.S.A. §7554 (a) (1). Further exploration on a monitoring method will occur. Please see section below with respect to home confinement equipment.
- ☐ **Fast Track Violation of Probation (VOP) merits hearings** and give judges ability to grant use immunity to offenders who have committed new crimes. Many detentioners are offenders on probation who have allegedly committed new offenses which, once adjudicated, may not result in incarceration. Speeding up the adjudication process for the violation of probation, will reduce bed days related to detention.
- ☐ **Limit use of Arrest Warrants for a failure to pay fine** by requiring judges to use a judicial summons first. If an arrest warrant is required because a judicial summons failed, arrests would be limited to court hours only. (Note: Currently these are not maintained by VCIC— we are exploring the issue.)
- ☐ **Reduce Number of Offenders Lodged** pre-arraignment by providing training to judges/court managers on how to evaluate pre-arraignment bail requests from law enforcement and developing consistency with respect to the amount of bail that is set pre-arraignment.
- ☐ **Estimated Savings: Already incorporated into savings from S. 292,** but these steps make the target more practical to achieve.

(C) Post Plea: Decrease use of Probation/Reduce VOPs:
(Outcomes 1, 2, 4)

- ☐ Expand use of diversion for 2nd offenses and low level felony offenses.
- ☐ Refer offenders to a reparative board post-plea without placing the offender on probation. If offender completes the reparative board successfully, case is closed without the offender going on probation. If not, the reparative board can return offender to court for sentencing (diversion model).
- ☐ Decriminalize DLS offenses unless offense involves an aggravated driving offense. There was not unanimous support for this proposal.
- ☐ Set a probation term limit in non-violent felony cases. While there was no consensus on what the limit should be there was on the concept and that the maximum term should be no more than 4 years.

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[3] Note that this is the savings from the bill as proposed by the Judiciary Committee. An amendment was added in the Senate that reduces the savings by $ 416,376 by eliminating DUI offenders. It is unclear at this time whether the savings will be restored in the House.

- **Estimated Savings: There are minimal savings from these proposals that will be reflected mostly in reduced caseloads for field services. A decreased need for field services for probationers could allow diversion of some resources to support supervised community sentences and home confinement as a detention option. These proposals will also send a clear message that probation supervision should be used only for those offenders who really need it.**

(D) Post Plea: Decrease Incarcerated Bed Days (Outcomes 2, 3)

- **Eliminate mandatory minimums** for all misdemeanors. Currently, there are mandatory minimum sentences for certain DLS offenses and for simple assault when a police officer is involved. Eliminating mandatory minimums recognizes that incarceration is an expensive and limited commodity. The use of incarceration as a penalty should be carefully considered on a case-by-case basis and never used as an across-the-board remedy for misdemeanor offenses.
- **PSI:** Eliminate specific sentencing recommendations in Pre-Sentence Investigations (PSI's) that DOC provides the Court.
- **Reintegration Furlough:** Increase the use of reintegration furlough by extending the length of time that a defendant can be released on a reintegration furlough prior to completion of a defendant's minimum. The current time frame is 3 months prior to completion of the minimum unless the sentence is 180 days or less in which case the time frame is one half of the minimum sentence. We propose increasing the reintegration furlough time frame to six months for sentences which are over one year. The time frame for sentences under one year would be half of the minimum sentence. The DOC's current utilization of reintegration furlough is less than 20%. (Note: an alternative recommendation is that the time frame be one-third as opposed to one-half for sentences under a year.)
- **Supervised Release:** Create a new sentencing option for judges known as "supervised release." This option is similar to pre-approved furlough status, but without a specific programming requirement. A "Supervised Release" sentence would include conditions such as employment and the offender continue substance abuse programming in the community. DOC could use "home confinement" with electronic monitoring and furlough type supervision to ensure compliance. In such a case, based on the restrictions imposed by the Court, the offender may be allowed to leave home for work, community service or treatment. DOC would have authority to incarcerate for violations without going through a violation of probation process. Interrupted sentences (sentences served on weekends usually used to preserve employment) would be eliminated as a sentencing option.
- **Decrease Sanctions for Program Termination:** Currently, under DOC's own policy, the sanction for a termination from prison treatment programming is ineligibility to re-enter the program for 12 months. This results in at least a 12 month increase in an offender's minimum sentence because the offender cannot be released until programming is complete. We propose that DOC reduce the sanction from 12 months to no more than 6 months.
- **Estimated Savings:**

Expansion of Reintegration Furlough	$1,156,600

Supervised Release Sentencing Option	TBD
Sanction for Program termination	578,300
Total Savings	**$ 1,734,900**

(E) **Decrease Violation Of Probation Filings** (Outcomes 1, 3)

- **VOP Sanctions:** Authorize DOC to impose graduated sanctions (such as community work crew service, home confinement or therapeutic intervention) for technical violations.
- **Estimated Savings: Minimal**

(F) Savings from Investments (see below)

Savings over and above the amount invested **$ 879,016**

(G) Total Savings Package **$6,245,640**

Proposals for Re-Investment of Savings

DOC details on a separate spreadsheet investments of $3,641,000 in FY11. The following were agreed to by the working group. Investments associated with proposals on which there was not consensus are discussed below as potential additional areas to explore for additional savings. **The reinvestment of the $3,164,500 listed below yields savings of approximately $0.9 million over and above the amount invested primarily by reducing incarceration.**

Increase in Transitional Housing Capacity (Including beds needed to implement S. 292)	$1,324,000
Decreased sanctions for program termination	80,000
Expand Community Re-entry services	350,000
Increase Community Capacity Grants	500,000
Electronic monitoring equipment and additional field Services for home confinement and supervised release	910,500
Total Reinvestment	**$3,164,500**

Additional Proposals to Meet the $10 Million Target

The savings proposals above fall approximately $3.8 million short of the $10 million challenge. DOC offered additional proposals that are not in the list of recommended savings. They are included here for consideration.

1. **Close South East State Correctional Facility Windsor Work Camp (SESCF):** Work camps house non-listed (non-listed crimes as defined by statute) offenders and many work camp participants would be offenders targeted for reduced incarceration in S.292. With insufficient work camp participants Vermont would not be able to populate two work camps, likely leaving one camp empty. This is particularly true if we were able to efficiently add twenty beds to the St Johnsbury work camp.

If the non-listed offender population drops substantially while DOC has not reached the required $10 million overall savings, DOC would be forced to consider a facility closure. Some staff could be reassigned to available positions including those created through this proposal. All staff would be assisted by the Human Resources Department as was successfully done following the closure of the DALE Women's Prison in Waterbury. The Correctional Industries operation (if DOC retains the DMV license plate contract) would need to be relocated to another facility. There are potential savings related to BGS staff (through their budget). This option would result in savings of **$2,643,092**. Though not yielding the targeted savings, SESCF could be re-designated to its former role and operate as a standard facility for male inmates.

2. **Cap the number of incarcerated offenders at 1,800:** Use of beds would be based on risk and intervention needs as determined by DOC after sentencing. This means a hard cap on the number of beds purchased from Corrections Corporation of America, as opposed to an unlimited cap. **Savings: $3,839,912**

3. **Create a "Supervised Release" status** to allow the Commissioner or his designee to manage the population more effectively and stay under the 1,800 cap. The Commissioner or his designee would be authorized to release any inmate who had served at least 1/3 or 60% of their minimum or flat sentence (whichever is more) in accord with public safety and the needs of the Department. The sentencing court, State's Attorney and Defender General would be notified of the release and would be given 10 days to object. If an objection is filed, the court would schedule a hearing to review the release. Savings – see Cap savings immediately above.

4. **Home Confinement** for all offenders with a minimum sentence of less than 180 day sentences. These offenders would not be incarcerated. Instead, they would be confined to their homes through the use of electronic monitoring with possible permission for employment, treatment or community service purposes. **Savings: $578,300**

Outcome/Indicators

Desired outcomes as defined in ACT 68 as follows:

1. **Decrease the number of offenders returned to prison for technical violations of probation and parole while ensuring public safety.**

2. **Decrease number of offenders coming into the corrections system.**

3. **Increase number of nonviolent offenders (in this proposal defined as an offense that does not constitute a listed crime) diverted from prison into the community while ensuring public safety and providing effective behavior.**

4. **Decrease in Recidivism**

5. **Establish a unified crime prevention and justice system**

6. **Increase revenues realized by DOC from programs designed to develop skills of offenders**

7. **Decrease short term lodgings**

The largest outcome from this work will be an overall decrease in the use of incarceration within the Department of Corrections while protecting public safety by maintaining and enhancing supervision of offenders (consistent with their level of risk) in the community. Additionally, as this plan moves forward over the next few years, the number of people who come to the DOC on any status, should decrease, and the use of alternative sanctions by the Courts (reparative board referrals, diversion) should increase. If this happens, people who commit crimes will be dealt with at the lowest level possible and diverted, wherever feasible, away from incarceration. In the past the Department has utilized electronic monitoring and alternative sanctions as deferring or release mechanisms. We believe that these strategies have lessened, though not erased, the rise in incarceration numbers, while maintaining public safety.

Estimated Savings and Return on Investment

If all the options were selected, full year savings in SFY 2011 are $10,664,000 with $3,641,000 in reinvestments for a net savings of $7,023,000.

Changes Needed in Statute and Regulation

The DOC proposes the following statutory introductions and amendments:

Y. Enact S. 292 as passed by the Senate and expand the bill to include the original Senate Judiciary Committee language regarding DUI 3 and greater.
Z. Amend the reintegration furlough statute, 28 V.S.A. §808(a) (8), to expand its timeframe from 90 days to 180 days for all offenses. As noted earlier, the DOC's current utilization of reintegration furlough is less than 20%.
AA. Amend 13 V.S.A. §7030(a) to include a sentencing option known as a "supervised release sentence" and prohibit the use of non-consecutive sentences such as a weekend interrupt sentence.
BB. Enact a statute to create a "Supervised Release" status based on the New Hampshire model.
CC. Establish home confinement as an optional condition of release to 13 V.S.A. §7554 and home incarceration as a sentencing option for courts. Home incarceration is 24/7 at home, while home confinement allows for participation in employment, treatment and community service.
DD. Authorize judges to grant "use immunity" to offenders charged with a violation of probation based on new criminal charges.
EE. Enact a statutory limitation on use of arrest warrants and incarceration for failure to pay a fine or surcharge.
FF. Authorize referral of misdemeanants to reparative boards at sentencing and authorize the boards to return such offenders to court for further sentencing for failure to comply with board requirements.
GG. Amend 28 V.S.A. §205(a) (3) (A) to standardize the probation term limit for felonies to a set period of years.

HH. Eliminate mandatory minimums for misdemeanor offenses by amending 23 V.S.A. §674(b) (DLS) and 13 V.S.A. §1028(a) (simple assault on a police officer).
II. Adjust caseload ratios for lower level offenders.
JJ. Combine Community Justice Centers and Diversion Boards to streamline and coordinate their efforts. This proposal was discussed by the stakeholder group as an option to explore for FY12.

Timeline for Implementation

Planning has already started regarding offenders who would be affected by this plan. The complicating factor is that in order to save $10 million in FY11, DOC must act promptly and with ample time to reduce incarceration by the *start* of the new fiscal year. This timeline is admittedly aggressive, but must be adhered to in order to make the stated budget target.

Investments Needed

A total investment of $3,641,000 is needed in FY11 to build or enhance the infrastructure within communities to support and hold accountable re-entering offenders and to divert from incarceration offenders who commit non-violent crimes.

Information Technology (IT) Needs

The above proposals will need some adjustments to the DOC data system, however, no substantial investment in the DOC I/T system is planned at this time.

Stakeholder Involvement and Process

In addition to Robert Hofmann, Secretary of the Agency of Human Services and the Hon. Amy Davenport, Administrative Judge for the Trial Courts to whom the corrections challenge was specifically issued, the recommendations contained in this report were developed by a work group that included Cindy Maguire from the Attorney General's office; James Mongeon from the Department of State's Attorneys, Matt Valerio, Defender General; Andrew Pallito, Commissioner of Corrections; and Karen Gennette from the Court Administrator's Office. This group met on four occasions and at times was augmented by participation by legislators and Thomas Tremblay, Commissioner of Public Safety. We are in the process of engaging other key constituencies such as victims' advocates, local municipalities/law enforcement, offender advocates and community based organizations. It is our intent to expand this group as we move forward, particularly as we consider the challenge for FY12.