CAMPAIGN FOR VERMONT

A New Social Contract:
Seeking Effect and Efficiency in
The Agency of Human Services

March 18, 2015

"It is easier to build strong children than to repair broken men."
-Frederick Douglass

Table of Contents

CAMPAIGN FOR VERMONT

A New Social Contract – Seeking Effect and Efficiency in the Agency of Human Services
Executive Summary

> "The Agency of Human Services (AHS) has the widest reach in state government and a critical mission: to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves." – Former Secretary Douglas A. Racine

It is easy to assume the human services system is a support for certain economic strata, or social classes. Yet, it has been decisively proven that overall community wellbeing is a key economic force affecting all Vermonters. The Vermont Agency of Human Services has a noble but overly broad mission.

At its core, AHS is charged with the nurtured development of our children. From a fiscal perspective, this is a very expensive social contract but we know smart investments in human capital can pay back a whopping $96.80 for every $1 invested[1]. However, funding human services with a blank check as we've done will not effectively improve the lives of Vermonters. Human Services expenditures have risen 24% or $450 Million since 2010[2], with little social outcomes to show for the investment.

In a landmark study by Dr. Robert Anda and the Centers for Disease Control, researchers found overwhelming evidence of the impact of "Adverse Childhood Experiences" on adult functioning and community-wide wellness.

Adversity should not be part of the Vermont lifespan experience, and the mandate of the Agency of Human Services may be a never-ending one. However, the performance of this Agency is unacceptable. By their own report[3], the Agency of Human Services has missed numerous critical outcome targets. There are three broad targets outlined in the strategic plan, with specific goals under each. Sixteen of the twenty-eight metrics are currently trending flat or moving in the wrong direction. Most metrics present little to no progress over time. Only twelve of the metrics track data as recent as 2013. The remaining metrics display data as old as 2009.

In this paper, we examine previous recommendations toward a more efficient and effective human services system. We have an opportunity to learn from our history. Rather than initiate more studies, we can simply take up the efforts that have repeatedly stalled under a revolving door of political appointees.

With targeted reforms to the Agency of Human Services, Vermont has an opportunity to ensure its people are healthier and equipped to thrive. By focusing on effective programs through a robust outcomes measurement efforts, it is likely that significant savings will also be found.

Sincerely,

Cyrus Patten, LICSW

---

[1] Pacific Institute for Research and Evaluation
http://www.nursefamilypartnership.org/assets/PDF/Communities/CA-Documents/ROI-California.aspx
[2] Legislative Join Fiscal Office
[3] AHS Results Scorecard
[1] Pacific Institute for Research and Evaluation
http://www.nursefamilypartnership.org/assets/PDF/Communities/CA-Documents/ROI-California.aspx
[2] Legislative Join Fiscal Office
[3] AHS Results Scorecard
[3] Agency of Human Services Strategic Plan
[2] Legislative Join Fiscal Office rates of antidepressant prescriptions.

Executive Director

The need for reform

The status quo

The Agency of Human Services consists of six Departments: Corrections, Aging & Independent Living, Mental Health, Health Access, Health, and Children & Families. With an incredibly broad mission, the Agency of Human Services is responsible for the wellbeing of cohorts of Vermonters from birth through death. "The Agency of Human Services strives to improve the health and well being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves."[4]

This broad mission is clouded by incredibly complex funding systems and non-germane programs that have no business under the Human Services umbrella. A few of these odd programs include: a micro-business development program, a mail order pharmacy program, a home telephone subsidy program, a home weatherization program, and a low cost spay/neuter program. Although these programs may offer value to the community, they contribute to the complexity of this unwieldy state agency.

Further, the mission is so broad that the Agency oversees prenatal programs alongside programs that support our oldest citizens.

With that, there is a strong body of research that emphasizes the importance of a safe, stable and nurturing childhood. By doing so, we could not only improve Vermonter's general wellbeing, but also avoid massive expenditures in jails, substance abuse, child protection and poverty mitigation arenas.

The most direct measurement of a healthy childhood (and consequently a healthy and productive adulthood) has been found to be the occurrence of "Adverse Childhood Experiences". We cannot say these experiences cause adult disorders, but we can say the relationship between them is incredibly strong. The following table highlights Vermont's standing.

Adverse Childhood Experiences	Vermont Prevalence	National Prevalence
Child had **one or more** Adverse Child or Family Experiences	50.6%	47.9%
Child had **two or more** Adverse Child or Family Experiences	23.3%	22.6%
Socioeconomic hardship	24.9%	25.7%
Divorce/separation of parent	26.2%	20.1%
Death of parent	14.5%	3.1%
Parent served time in jail	7.9%	6.9%
Witness to domestic violence	10.9%	7.3%
Victim or witness of neighborhood violence	5.7%	8.6%
Lived with someone who was mentally ill or suicidal	5.9%	8.6%
Lived with someone with alcohol/drug problem	1.8%	10.7%
Treated or judged unfairly due to race/ethnicity	3.0%	4.1%

[4] Agency of Human Services Strategic Plan

Source: Vermont Data on ACE Risk and Resilience: The Call for Mind/Body Interventions

By these measures, Vermont children are not being provided with the best possible developmental scaffolding. When compared nationally, Vermont children experience more adverse events. Although the gap is relatively small, we cannot afford to expose our children to experiences that will negatively impact their entire lives.

Population level outcomes for Vermonters are not positive

Now that we know adverse childhood experiences are positively correlated with adult rates of obesity, criminality, alcoholism, intravenous drug use, risky sexual behaviors, diabetes, hypertension, persistent psychopathological conditions including most notably antisocial personality disorder and depression.[5] Put simply, failing to prevent children from experiencing adverse events is the single most important component of the AHS charge.

The importance of a healthy population (on the economy)

As Vermonters, we are compelled to look out for our most vulnerable. Beyond that, failing our children costs our economy dearly. "Adverse early environments create deficits in skills and abilities that drive down productivity and increase social costs—thereby adding to financial deficits borne by the public." - James J. Heckman[6]. Programs like Head Start are correlated with increased high school graduation rates[7]. When high school graduates earn, on average, $9,000[8] more annually than high school dropouts, the impact of a broken social contract on our economy is severe. Inversely, the positive impact of effective and efficient investments in Vermonters' wellbeing would be profound.

Shortsighted policy of investing in programs that score political points has led to an array of programs that are ineffective and/or generate a negligible impact per dollar invested. The following two examples highlight the nice-sounding but statistically hollow outcomes.

Beginning in 2011, the Vermont Rental Subsidy Program has doubled in size from $500,000 to $1,000,000. The program works similar to a Section 8 housing voucher, asking participants to contribute 30% of their income toward housing. The VRSP covers the rest. In the first two years (the only time period outcomes data is available) the program claims 123 homeless households were placed in affordable housing with a subsidy. In the first year, only 4% of participants raised their income enough to afford market rent – the stated goal of the program. In the second year, less than 24% were able to realize self-sufficiency while 47% were removed from the program for "non-compliance." The goal of the VRSP is a good one, but the evidence suggests it is ineffective. The resources could be redirected to a program that works.[9]

The General/Emergency Housing Assistance Program provides financial support for housing for low income individuals and families. The program has grown from $1.34 Million in 2010 to $4.48 Million in 2013. Much of this money, but not all, is spent purchasing hotel nights for emergency needs. Yet it is widely known in the human services community that this program is grossly abused. The need for

---

[5] Depression as measured by rates of antidepressant prescriptions.

[6] Henry Schultz Distinguished Service Professor of Economics at The University of Chicago and Nobel Laureate in Economics.

[7] The Battle over Head Start: What the Research Shows. (2002) http://lcearlychildhood.org/wp-content/uploads/2012/04/BattleHeadStart.pdf

[8] U.S. Department of Labor. Bureau of Labor Statistics. (2011) http://www.bls.gov/emp/ep_chart_001.htm

[9] Department for Children & Families Outcomes Book: http://www.leg.state.vt.us/jfo/appropriations/fy_2015/Department%20Budgets/DCF%20-%202015%20Outcomes%20Book.pdf

emergency housing assistance is real, especially for families with children. But the rate of growth in spending is a result of poor oversight.

Although the need for an effective human service sector is a cultural imperative and part of the social contract, we must also act as responsible fiduciaries over public resources. Perhaps even more important is the need to invest in programs with evidentiary support; programs that actually achieve the intended outcome.

The Agency of Human Services consumes the largest portion of the state budget at $2.3 Billion or 42% of all state appropriations. This is more than any other state function including pre-k – 12 education spending. [10] When these funds are poorly managed, the financial and social impact on Vermonters is real.

In relation to our education system

A strong public education system is a priority for Vermonters. Students cannot be expected to learn when their basic needs are not being met. The negative correlation between stability at home and educational outcomes is a well documented.[11] Rather than continuing to magnify our investment in an administratively heavy education system, we must target our investments in human services that will create safer, more stable and nurturing home environments so that children have both the capacity and the opportunity to learn.

The Vermont Department of Mental Health recognizes the impact childhood adversity has on educational outcomes: "The negative impacts of trauma are seen in adverse child and adult outcomes including reduced school readiness and performance".[12] Recent research[13] by Campaign for Vermont found no statistical relationship between school spending and educational outcomes, but found a significant relationship between educational outcomes and household Adjusted Gross Income (AGI). This finding reinforces the importance of an effective and efficient human services system that strives to raise the median household income or replicate qualities associated with the attainment of higher incomes.

The relationship between a vibrant education system and a healthy population is strong and complex. Not only does a healthy population improve educational outcomes, a well-educated population experiences less poverty and consequently, achieves better education outcomes. The relationship is self-reinforcing. The numbers support this connection.
Students from impoverished homes are seven times more likely to drop out of school.[14] Thirty-one percent of adults without a high school diploma live in poverty compared to 24% of those who finished high school.[15] Less than 30% of students from the bottom-quartile of incomes enroll in a 4-year school. Less than 50% of that group finish.[16]

---

[10] VT Legislature Joint Fiscal Office http://www.leg.state.vt.us/jfo
[11] Bradley et. al., 1988 http://www.jstor.org/stable/pdf/1130253.pdf
[12] http://mentalhealth.vermont.gov/topics/trauma
[13] http://www.campaignforvermont.org/wp-content/uploads/2014/09/Report-on-Education-Spending-and-Outcomes.pdf
[14] KewalRamani, Angelina, Jennifer Laird, Nicole Ifill, and Chris Chapman. "Trends in High School Dropout and Completion Rates in the United States: 1972–2009." National Center for Educational Statics. Accessed March 1, 2014, http://nces.ed.gov/pubs2012/2012006.pdf.
[15] Aud, Susan, Angelina KewalRamani, and Lauren Frohlich. "America's Youth: Transitions to Adulthood." National Center for Educational Statistics. Accessed March 14, 2001, http://nces.ed.gov/pubs2012/2012026.pdf.
[16] Deparle, Jason. "For Poor, Leap to College Often Ends in a Hard Fall." The New York Times. Accessed March 1, 2014, http://www.nytimes.com/2012/12/23/education/poor-students-struggle-as-class-plays-a-greater-role-in-success.html?pagewanted=all.

The research is clear that income is linked with the most concerning social challenges faced by Vermonters including mental health[17], crime, substance abuse and even life expectancy.[18]

Despite shocking growth in spending

In 2000, the total budget for the Agency of Human Services was $863.1 million, with $380.8 million of this amount supported by Vermont taxpayers and the rest by the federal government. For the current year, fiscal 2015, the AHS budget now sits at $2.31 billion with $1.03 billion coming from the pockets of Vermonters. Thus, over the past 15 years the AHS budget has grown at the rate of 6.9 percent per year, with non-federal funds growing at 7 percent annually.

Often it is said in the media and by the media that the human services budget has been cut. The above hard data proves otherwise. To give context to the above 7 percent growth rates, consider the following data covering the same 2000 to 2015 time period:

- Population Growth: 609,618 to 627,286 for an annual growth rate of .19 percent[19]
- CPI inflation index: 172.2 to 242.1 for an annual growth rate of 2.3 percent[20]
- Gross State Product: $17.9 billion to $31.3 billion for an annual growth rate of 3.8 percent[20]

Clearly, state and federal taxpayers have been supportive of the human services budget. However, these extraordinary investments of funds have not had a measurable effect on Vermont's poverty rate.

Since 2000, Vermont's poverty rate has ranged from a low of 7.6 percent in 2005 to a high of 11.6 percent in 2011[21]. In three of the last four years, the poverty rate has been at 10.8 percent or above, dropping to 8.7 percent as the economy recovers from the recent recession[22]. It is clear that the sustained growth in human services spending has not mitigated the cycle of poverty and that low income Vermonters are as vulnerable today to poverty as they were fifteen years ago.

The above broad view over time of spending growth on human services and poverty levels indicates that the more resources, while usually helpful, may be less important than restructuring human services investments such that they achieve better results.

Vermonters are not better off

The Agency of Human Services strategic plan identifies the following four statewide goals as codified by the legislature in 1998 and again in 2010.

1. Decrease the Lasting Impacts of Poverty on Individuals, Children and Families in Vermont and Create Pathways Out of Poverty
2. Promote the Health, Well-Being and Safety of Individuals, Families and our Communities
3. Enhance AHS's focus on program effectiveness, accountability for outcomes, and workforce development and engagement

---

[17] http://archpsyc.jamanetwork.com/article.aspx?articleid=211213

[18] Rowlingson, 2011 http://www.jrf.org.uk/sites/files/jrf/inequality-income-social-problems-full.pdf

[19] http://www.leg.state.vt.us/jfo/education/2014-10%20VT%20Enrollment%20and%20Population%20Projections.pdf

[20] http://www.leg.state.vt.us/jfo/education/2014-10%20Relevant%20Inflation%20and%20Other%20Economic%20Measures.pdf

[21] http://www.census.gov/hhes/www/poverty/data/historical/people.html

[22] http://www.nber.org/cycles.html

4. All Vermonters Have Access to High Quality Health Care

They further identify twelve outcomes[23] that will indicate Vermonters are healthy.

1. Families, Youth and Individuals are engaged in their community's decisions and activities
2. Pregnant women and young children thrive
3. Children are ready for school
4. Children succeed in school
5. Children live in stable, supported families
6. Youth choose healthy behaviors
7. Youth successfully transition to adulthood
8. Adults lead healthy and productive lives
9. Elders and people with disabilities live with dignity and independence in settings they prefer
10. Communities provide safety and support to families and individuals
11. Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time
12. Families and individuals move out of poverty through education and advancement in employment

How many of these outcomes has the State of Vermont achieved? The Agency of Human Services Results Scorecard publishes data that are between one and six years old[24]. While there are both positive and negative outcomes reported (suicide rate is down but criminal recidivism is up), the data is dated and sporadic. Examining the statewide goals set by AHS, an even less rosy picture is painted.

Human and educational wellbeing are inextricably linked. Any educator will tell you their students struggle when homes are unstable, food insecure or otherwise chronically stressed. By creating a more effective human service system in Vermont, we would reduce pressures on the education system as well.

<u>Goal #1: Decrease the Lasting Impacts of Poverty on Individuals, Children and Families in Vermont and Create Pathways Out of Poverty</u>

More Vermonters are living in poverty, especially children. 1,974 more people lived below the poverty line in 2013 than in 2012 according to the U.S. Census. The data is supported by the annual Kids Count research by the Casey Family Foundation. Although overall poverty rates were flat, more children found themselves impoverished. The annual Kids County report completed by the Casey Family Foundation describes a long and troubling trend. Since 2007, the percent of Vermont children living in poverty has risen every year. This period covers an economic recession to which a well-run AHS could have responded. However, AHS programs were so dilute and over-committed that there was no capacity (neither financial nor programmatic) to absorb the economic conditions that increased poverty in Vermont.

Our youngest and most vulnerable are even worse off. The number of children living beneath the Federal Poverty Threshold rose by 3,000 or 3% between 2007 and 2013.[25] Evidence of both worsening income inequality, lingering impacts of the 2008 recession and <u>ineffective social programs</u>. Programs that are intended to lift Vermont families out of poverty.[26] These programs have shifted over the years to serve as a crutch, not a path out of poverty.

[23] Agency of Human Services Strategic Plan
[24] http://humanservices.vermont.gov/copy_of_ahs-results-scorecard
[25] http://datacenter.kidscount.org/data#VT/2/0
[26] http://datacenter.kidscount.org/data/tables/52-population-in-poverty?loc=47&loct=2#detailed/2/47/false/36,868,867,133,38/any/339,340

The Governor's Council on Pathways from Poverty called on the Governor to "bring together the disparate efforts and funding streams of state government to create integrated collaborations that will house the homeless, transport low-income workers, and create real economic development for people most in need."[27] To date, the efforts and programs on these fronts remain disparate.

Goal #2: Promote the Health, Well-Being and Safety of Individuals, Families and our Communities

Are Vermonters, specifically our children, safer? Despite an average 5% increase in the number of child protection calls fielded by the Department for Children and Families (DCF) since 2009, substantiated investigations have gone up an average of 1% during the same period.[28] After several tragic deaths, DCF was closely examined. The results found the social workers were not at fault, the system was.[29]

While the number of calls made to DCF increased, the proportion of calls that were investigated decreased between 2009 and 2013 (the latest data available) from 20% to 15%. This increase is in spite of recent policy changes that divert some cases away from formal intervention and should have lessened caseload pressures. The death of two children in 2014 launched an in-depth look at DCF. Yet, on average, nearly two children die in Vermont every year due to maltreatment.[30] Two is too many.

The agency began a reform effort[31] in 2010, aimed at integrating services, and increasing communication and collaboration between departments. This effort has not achieved the intended outcomes and has become another effort in a stack of failed reforms. Rather than learn from our history, AHS leaders continue to re-examine their processes with consultants and strategic planning, expecting to find new results.

The integration of services is the most fundamental and impactful change that could be made to address poor outcomes and uncontrolled spending increases in AHS. It is not a matter of missing resources.

The data have been presented to make the case for change; funds have been made available from time to time to pay for the change process; talented individuals have committed their time to the change effort. So why hasn't it happened yet?

Change has been hindered by high-level officials that are unwilling to accept new ways of thinking. It has been stymied by stubborn resistance to commingling funds. Addison County is part of a payment reform pilot that has greatly increased system flexibility, increased the number of clients that can be served, eliminated unnecessary paperwork and delivered the same quality of service; all without increasing funding. However, resistance to innovation from AHS Department leaders has minimized the impact of this reform and hindered the spread to other counties.

Two things are necessary to realize this much needed change: a deep organizational culture shift that signals a commitment to reform that comes from the top; and a breakdown of the firewalls between department and program budgets. Until the money can be easily and quickly moved laterally across the human services system, Vermonters in need will continue to fall victim to bureaucracy.

Goal #3: Enhance AHS's focus on program effectiveness, accountability for outcomes, and workforce development and engagement

---

[27] Report to the Governor from the Council on Pathways from Poverty, November 2014 http://governor.vermont.gov/sites/governor/files/2014%20report%20to%20Governor%20FINAL.pdf

[28] http://dcf.vermont.gov/sites/dcf/files/pdf/fsd/2013_Child_Protection_Report.pdf

[29] http://www.burlingtonfreepress.com/story/news/local/vermont/2014/07/10/report-dcf-worker-acted-properly-baby-death-case/12500773/

[30] https://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf

[31] http://humanservices.vermont.gov/integrated-family-services

The AHS budget has grown by 24% since 2010. While during the same period, poverty, child abuse and mental health disorders have become more prevalent. According to the Department of Mental Health, substance abuse caseloads have grown by 324% between 1986 and 2011. During the same period, child mental health caseloads grew by 206%.[32] This was in part due to expanded eligibility and new resources injected into the system[33]. Immediate caseload relief can be achieved by adding front line workers, but will invariably produce only temporary relief until the systemic causes are resolved.[34]

The upward pressure on caseloads is real. There are myriad relational factors that could be driving the growth. It is likely a blend of new knowledge about mental disorders, the increasing prevalence of substance abuse, and the confounding relationship between substance abuse, mental health and child abuse.

As we see from the AHS Scorecard, outcomes are not being measured with any consistency. The Agency of Human Services once published an annual report that examined important outcomes. The "Social Indicators Sourcebook" included important measures of Vermont well being. It hasn't been published since 2008.[35] By most measures, outcomes reporting and strategic planning within AHS stalled around this time.

The gutting of outcomes measurement capacity was a leadership decision, not a funding decision. The entire AHS outcomes system required, at its peak, .5 fulltime equivalent to manage. With this relatively small resource, the Agency was able to track population-level data, along with local-level outcomes.

Goal #4: All Vermonters Have Access to High Quality Health Care

Perhaps the most disappointing results are found in the fourth and final statewide goal of ensuring access to high quality healthcare.

The Vermont Health Connect website which was intended to increase the ability of Vermonters to make decisions about their healthcare has been an epic failure, lacking critical functionality necessary for an exchange. The Green Mountain Care Board has somewhat limited growth in medical spending, but the overarching plan of implementing a single payer healthcare model was a failure just recently realized as such by the Governor.

The uncertainty caused by the lack of transparency of the planning process along with the embarrassing mismanagement of the rollout dampened the economic recovery following the 2008 recession. Businesses didn't expand, didn't hire[36], and Vermont's middle class suffered and the lower-income Vermonters that depend on the Agency of Human Services the most took the hardest hit.

What reform looks like

Recommendation #1: Establish a common view of the client

A common view of the client can best be explained by describing silos on a farm. The departments within the Agency of Human Services are separated by philosophical, structural, legal, logistical and financial barriers. Each department functions as a relatively independent silo. In most cases, individuals in need of services are dependent on more than one AHS department. For example, mental health needs

[32] http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_May_11_2012.pdf
[33] Personal correspondence with AHS staff
[34] http://vtdigger.org/2014/07/24/new-social-workers-merely-tourniquet-dcf-says/
[35] http://humanservices.vermont.gov/publications/publications-by-title/
[36] Vermont Department of Labor, Seasonally adjusted labor and unemployment http://www.vtlmi.info/public/lfvtsa.xls

frequently co-occur with substance addiction. Yet the departments that provide funding to treat these conditions are separate in every way. Further, there is little relationship or visibility among these AHS silo programs and others throughout the state, such as the EITC and income sensitivity programs at the Tax Department.

Communication and collaboration that does occur between departments is due to the extraordinary efforts of individuals who believe it important to collaborate. But money is not blended as easily as efforts.

Recognizing the importance of breaking down these silos, the state embarked on a change initiative that grew from ideas within Challenges for Change:

> The Integrated Family Services Initiative 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.[37]

The idea behind this effort was honorable. Provide the right service, at the right time, to minimize long-term effects and streamline the process for helping Vermonters. Sadly, this effort has failed. Some might disagree, but the proof is in the pudding. The IFS initiative began in 2010. But for a couple pilot projects in Addison and Franklin Counties, no permanent reform has been realized.

Despite the valiant efforts of some advocates and state employees, the bureaucracy of state government has killed this initiative. Specifically, the unwillingness of high level administrators to let go of their budgets in favor of a more integrated approach to human services.

Simplify service delivery and funding by creating a single port of entry for Vermonters needing support. Create a single eligibility determination process that taps data available from various state systems. Empower local offices and front line social workers to approve services and authorize funding.

Force the various department leaders to give up control of their budgets, centralizing the management by districts, not divisions. Establishing a common view of the client will require significant payment reform. Various models will need to be used, but the simplest option is a case rate model in which the front line worker, in partnership with the client, decides the mix of services most appropriate for the individual or family. This model virtually eliminates unnecessary billing paperwork while leaving plenty of room for accountability. When agencies operate efficiently, they keep a portion of the savings. The portion of the savings they keep grows with the positive outcomes they generate for clients. This would create a two-tiered incentive system to encourage lasting impact and stewardship of resources. The flexibility to design such innovative models exists within AHS's chief funding source, Medicaid.

The Medicaid Global Commitment Waiver provides great flexibility with which AHS can innovate. The Waiver is now ten years old, and the flexibility provided by it has yet to find its way to the front lines. The number one goal of the waiver was to seek programmatic and financial flexibility in order to support innovation[38].

Recommendation #2: Update antiquated IT systems

[37] http://humanservices.vermont.gov/integrated-family-services
[38] Kaiser Family Foundation, Vermont's Global Commitment Waiver

The Department for Children and Families serves 185,000 Vermonters annually or nearly 30% of our population. The Department for Disabilities, Aging and Independent Living serves 89,574 Vermonters. The Department of Mental Health reports 25,192 served, with a high level of duplication with DCF. To manage all of these stakeholders, AHS maintains multiple complex and outdated IT systems to keep track of data. Add in the importance and complexity of securing private medical records and any major IT overhaul becomes a massive project. Having said this, the state of Vermont has a dismal record of procuring and facilitating IT projects.[39]

Yet technology has the power to streamline the eligibility process, the information-gathering phase, and the documentation of service provision. Not to mention the potential to improve the quality of services provided by improving communication between providers. Another reason to break down barriers between departments within AHS.

Procure the development of a state-of-the-art software system that can be used by all AHS employees to determine eligibility for services, document service provision, and facilitate payment for services rendered outside the AHS system by the private provider system. The system should be informed by the users, and developed by a firm with local talent.

Recommendation #3: Implement Payment Reform

Vermont has a vibrant private provider system. In fact, the majority of services paid for by the Agency of Human Services are provided by the private sector. The way in which this sector is paid for services creates a disincentive to seek efficiency and innovation. This model follows the medical model, paying for single services that each generate a trail of documents. Each service is typically billed independently, requiring significant administrative resources for both payers and payees.

Revise the Medicaid payment provisions within statutes to allow for more flexible spending akin to the Addison County pilot project. This will allow for innovation among providers, and for the adoption of the latest evidence-based interventions.

Reform the payment system for private providers, using a case-rate model wherever possible. Rather than paying for an individual unit of service, compensate providers for providing supports for a given month. This model simplifies the billing process and encourages providers to address the holistic needs of an individual.

Recommendation #4: Create an Office of the Child Advocate

Rarely is the creation of another government office the solution to a government problem. In the case of AHS, it is. Thirty-six states have an Office of the Child Advocate or Child Ombudsman. It is difficult to compare the effect of these offices among states because each state has implemented the office differently. Perhaps more important is that Vermont child protection leaders claim Vermont "counts differently", making state-to-state comparisons inaccurate. Unless their comparison serves to further their point. This is an individual, appointed or elected to act on behalf of all children in the state – especially those under the auspices of AHS. This person is supported by a professional staff and empowered with the power to make change on a system level. The Child Advocate is both empowered and entrusted to pass through confidentiality barriers to seek information about cases or system performance. They are also empowered in statute to recommend and follow up on reforms to state programs.

Although different states structure these offices differently, the most empowered offices have authority to affect change. This authority may include the right to subpoena people or records, to examine any

[39] http://vtdigger.org/2012/12/04/state-governments-virtual-growing-pains/

record from any department within the Agency of Human Services, and the authority to demand policy changes when they are necessary.

The Child Advocate's Office cannot be housed "under" any of the Departments it is charged with holding accountable. An argument could be made to house the Child Advocate under the State Auditor. It must be financially and structurally independent. The person that holds this immense responsibility must also be well-versed in the systems they are charged with observing. A political appointee cannot fill this role. Rather, a seasoned expert in the human services advocacy field. Lastly, the office needs enough resources to maintain a professional staff of researchers and policy and legal advisors.

Recommendation #5: Build a state-of-the-art outcomes system

The goals of AHS are to ensure Vermonters are healthy. Yet a surprisingly small number of programs are evaluated for the outcomes they aim to achieve. With the recent efforts toward integrating a Results Based Accountability system in state government, the groundwork has been laid. The State's Chief Performance Officer, Sue Zeller admits we have a data problem, "in many cases, the state already collects sufficient data, but doesn't manage it in a way that allows robust analysis. In other cases, data collection overlaps. Elsewhere, it's lacking."

We cannot hope to make informed decisions about funding programs when their impact cannot be measured; even if such measurement occurs on the population level vs. the individual level. A program "doing good" does not necessarily mean "good at what we're doing". Data can help clarify.

At times, we need to invest in the "firehouse model". That is, we need to pay for the availability of the service, even if the need for such a service experiences ebbing demand from time to time. For these programs, it is expected that the outcome generated will be the absence of a condition, such as preventing child abuse. The impact of prevention programs is notoriously difficult to measure, but not impossible. A robust outcomes system would provide us with the critical data to make critical decisions.

Recommendation #6: Create a robust outcomes measurement system

Relying on the integrated software system described above, the state could monitor the effectiveness of programs based on data generated at the point of service delivery.

We should build on the implementation of Results Based Accountability (RBA) in 2014 in which state programs and contractors will be collecting data that answer these core questions: "How much are we doing? How well are we doing it? And is anyone better off because of it?" Outcomes evaluations on each AHS program (both internal and external) should be made publicly available annually. Included in the evaluation of each program should be the measured impact against the intended outcome, as well as the financial cost to taxpayers. With public pressure, legislators may be able to make the courageous decision to end funding.

AHS should form a small, high-level and relatively independent data and outcomes team that will compile and analyze national, state and local data. While state level outcomes help keep leaders on task and national data helps provide important context, the local-level outcomes are instrumental in engaging communities to address problems. When this level of examination was done previously, local communities could pinpoint unacceptable social indicators and resolve them. This model not only gets results, it relieves pressure on AHS staff by shifting change efforts to the local level.

Recommendation #7: Shift investments to intervene earlier

Once substantive savings have been found, a portion of these resources should be shifted toward providing high quality, early intervention services for Vermont children. By doing so, we might hope to avoid the saddening, expensive and reactive expenses currently soaking up AHS resources.

Increase access to free, quality early childcare and preschool, most importantly for at-risk children. Too many Vermont children are growing up without fundamental assets in the early years. Most notably: a stable family environment. However you define family, the stability experienced during the early years is the strongest predictor of social factors we all seek to improve. These include crime, poverty, obesity, chronic health conditions, unwanted pregnancy; and much more. As 80% of all neural connections are formed by age 3, it's no wonder the early years are the most important[40].

By providing Vermont children with access to free, high quality early childcare and preschool, we can prevent a lifetime of dependence on AHS services – saving millions of dollars and unnecessary struggle.

Dr. Jim Heckman, a Nobel Prize winning economist that specializes in the "economics of human potential" makes a compelling case for investing in early childhood programs as a means of curbing the social challenges facing Vermont. "The longer society waits to intervene in the life cycle of a disadvantaged child, the more costly it is to remediate disadvantage. Similar dynamics are at work in creating child health and mental health."[41]

Vermont's recent expansion of this service is a great first start – but an unfunded mandate on school systems only increases the upward pressure on property taxes and contributes to the crisis of affordability that drives many of the social factors AHS is struggling to address.

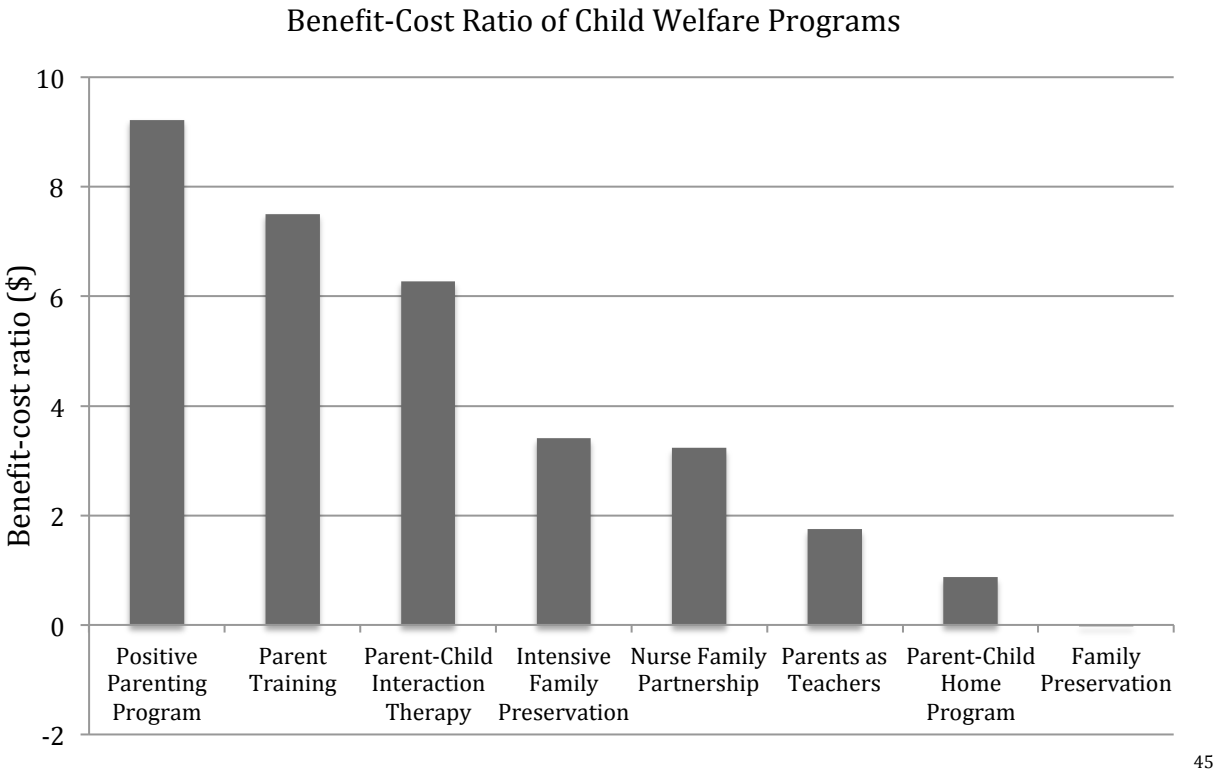
With the guiding light of performance based budgeting, shifting resources from ineffective AHS programs to pay for early childhood services is a more prudent approach, and a strong recommendation of this paper.

Where to seek efficiency

Recommending efficiencies and shifts in funding can make political enemies, and raise alarms within various offices around the state. Yet if we hope to shift resources toward programs that generate measurable outcomes, it is a necessary step. This is perhaps why state leaders have struggled to make tough choices about funding, and perhaps why the AHS budget has grown at an unsustainable rate. The needs of Vermonters continue to grow, while the political bravery necessary to make hard choices remains hard to find.

The coalition for Evidence-Based Policy[42], a nonprofit, nonpartisan research organization looks for interventions that have strong, scientific evidence of their efficacy. Often lauded as the example of best "bang for your buck" is the Nurse Family Partnership. Few programs earn the "Congressional Top-Tier"[43] classification; this is one. Vermont policy makers would be wise to review all currently funded social intervention programs against this model. Programs don't have to offer a financial return on investment. A model for Social Return on Investment[44] is well researched and standardized.

[40] Let's Grow Kids Campaign, http://www.letsgrowkids.org/building-brain
[41] http://heckmanequation.org/content/resource/presenting-heckman-equation
[42] http://evidencebasedprograms.org/about/full-list-of-programs
[43] http://toptierevidence.org/
[44] http://www.thesroinetwork.org/what-is-sroi



[45]

The above chart displays a selection of child welfare programs studied by the Washington State Institute for Public Policy. The Instituted specifically examined the cost to deliver the programs and the direct and non-direct monetary benefits of the program. The State of Vermont might adopt a similar approach, examining each program within AHS for the real financial return. When compared alongside the Social Return on Investment (or lack thereof), the decision to reduce or cease funding is made easier.

The status quo is to fund any program that makes an adequate emotional case for funding, often ignoring evidence. For example, Prevent Child Abuse Vermont seeks to "end the generational cycle of abuse" and received over $1,000,000 from the State of Vermont[46]. Yet, their outcomes are measured in terms of number of trainings facilitated, not the safety and wellbeing of Vermont children. Perhaps they're generating outcomes, but we can't say for sure.

Vermonters simply deserve the right to decide which programs are worth the investment. Without access to objective, measurable data on the wellbeing of Vermonters, they are not given the opportunity to decide.

The list of ineffective social interventions is long and spans far beyond Vermont's borders. History and research eventually identify programs that don't work. Some of the more notable programs (that are still implemented in some communities) include the D.A.R.E., Scared Straight, and more.

The recent implementation of RBA lays the groundwork for outcomes-based decision making. The key will be whether or not the legislature can use this data to make difficult decisions about programs that don't generate outcomes.

[45] Washington State Institute for Public Policy, Return on Investment: Evidence-Based Options to Improve Statewide Outcomes

[46] IRS Form 990 (2013) http://www.guidestar.org/FinDocuments/2012/030/267/2012-030267183-09b2f2b7-9.pdf

The benefits of reform

A healthier, thriving community is found through smart investments in social programs. Investing early in our communities, and ensuring their wellness throughout their development into adulthood has myriad positive long-term benefits for Vermont. Including a necessary component of a thriving economy: a "more capable, productive and valuable workforce".[47] What's more, investing in the quality of services provided under the AHS umbrella have a self-reinforcing effect. Healthy children grow into healthy adults, and the multi-generational nature of poverty and dependence on public systems is ended. Thriving adults contribute to their community as productive members of society, leading to a stronger economy. As the rising tide lifts all boats, the cycle reinforces itself. The charge of the Agency of Human Services is to ensure everyone has a boat that floats.

Summary of Recommendations and Discussion

1. Establish and operationalize a common view of the client
2. Cutting edge technology reform executed intelligently.
3. Payment reform, dismantling the medical model and fee-for-service structure, develop a combined pay-for-outcomes and firehouse model of funding.
4. Establish an Office of the Child Advocate.
5. Build on recent focus on Results Based Accountability to create a fully integrated outcomes system that can leverage localized data.
6. Do not fund anything that is not measured, analyzed and evaluated.
7. Increase access to free, quality early childcare and preschool, most importantly for at-risk homes.

The Agency of Human Services periodically embarks on restructuring and reform efforts. However, these reforms often seem to stall. Workgroups assembled to recommend reforms all seem to come to similar conclusions: there is not enough integration between departments; the client experience is poor due to overwhelming complexity of this system; there is not nearly enough accountability built into the system; and outcomes are not measured effectively.

Before embarking on yet another reform effort, all the previous evaluative documents should be dusted off and examined for the inevitable common denominator. Only then might we understand why Vermont's behemoth state agency has yet to implement systemic change on behalf of its constituents.

An audit of reports, dating back to 1997, and submitted to recent Human Services leadership found the following common themes represented in <u>all</u> of them.[48]

- Vermont families experience co-occurring conditions that span AHS practice areas (substance abuse, economic services, child welfare, etc.)
- Vermonters want to experience "no-wrong-door" service or a single point of entry into the AHS system. This is not the case currently.
- Systems should leverage strengths to help Vermonters move past challenges.
- Sometimes families need short-term support so that minor problems don't become larger ones. This should take the form of respite services that are flexible and easy to access.
- The entire Vermont human services system needs to focus on prevention and earlier supports.
- The entire system should adopt evidence-based practices.
- The funding system is based on the medical model, preferring quantity over quality. Reform of this system should emphasize coordinated care across services.

[47] http://heckmanequation.org/content/resource/heckman-equation-brochure-0
[48] Internal AHS memo.

- The does not need to expand to better serve Vermonters. Rather, it needs to be better integrated horizontally across systems.

Perhaps the most comprehensive examination of Human Services reform in recent history was embedded within Challenges for Change. Widely supported by the legislature and Governor at its passage in 2010, Challenges for Change called for sweeping reforms; not the least of which was establishing a common view of the client.

> The State's vision begins and ends with the client. Adopting best practices from Vermont's groundbreaking *Blueprint for Health*, human service clients will have a "medical home" for state services where a "community care team" will help guide them to self-sufficiency using an integrated, individualized approach.
>
> This approach will make the myriad of federal and state programs invisible to the client. Instead of receiving separate assistance from WIC, fuel assistance, food stamps, Reach-Up, and child care subsidy, a primary care manager could comingle funds or service allocations into one budget – and then clients would create self-sufficiency plans ("exit strategies") designed to move them out of poverty as quickly as possible.[49]

The need was firmly established and the solutions outlined in the Challenges for Change report. Many of the reform concepts within the report aligned with an existing reform plan called Integrated Family Services (IFS). IFS was destined for the reform graveyard when Secretary of AHS Doug Racine assigned it to one talented but solitary state worker. Four of Campaign for Vermont's seven recommendations (numbers 1, 2, 3 and 5) are consistent with the goals of Integrated Family Services[50], demonstrating the need remains while progress proves elusive.

In 2012, the vision behind IFS was reinforced by the Jeffords Center, an independent research group.

> Families continue to experience multiple partners in their midst who work hard at coordination but have difficulty communicating and providing services in concert rather than piecemeal. An integrated family oriented model should be structured to be integrated at the state, community and family levels.[51]

The following year, AHS staff updated the plan to integrate services with the goal to "integrate human and health service efforts to create a continuum of supports and services for families to experience and choose from and base service on diagnostic and functional needs of the child, youth and family."[52] Despite the dedication of these staff, leadership was unable to muster the political will to move forward given the push-back of those invested in the status quo.

In 2015, there remains a dire need to move toward this important goal of simplifying access to services and creating a common view of the client.

---

[49] http://mentalhealth.vermont.gov/sites/dmh/files/legislative/for_20Change_20-_20PSG_20Report_2001-05-2010.pdf

[50] http://www.leg.state.vt.us/jfo/appropriations/fy_2015/Department%20Budgets/Integrated%20Child_family%20system.pdf

[51] http://www.uvm.edu/~jeffords/reports/pdfs/Jeffords%20Center%20Report_Identifying%20Opportuntities%20for%20Integrated%20Services.pdf

[52] http://www2.leg.state.vt.us/CommitteeDocs/2014/House%20Human%20Services/Integrated%20Family%20Services/W~Melissa%20Bailey~Integrated%20Family%20Services%20prenatal%20to%2022%20years%20old%C2%A6%20Redesign%20Concept%20Final%20Paper~1-31-2014.pdf

With each new leader, there seems to be a resetting of organizational priorities and a new array of studies to identify the problem. We don't need more studies, we don't need consultant reports, we need action.

Appendix A – AHS Outcomes Scorecard

All Vermonters are free from the impacts of poverty:

1. % of Pre-Term Births (<37 weeks)
2. Achievement Gap: Test score gaps between students eligible for free & reduced lunch and those not eligible
3. 3SquaresVT Enrollment
4. AHS Consumers engaged in Creative Workforce Solutions who achieve a successful employment outcome (90 consecutive days of competitive employment)

All Vermonters are healthy and safe:

1. % of Recidivism among offenders released from prison within 3 years
2. Obesity in Vermont
3. Rate of fall-related deaths among older adults 65+ (per 100,000 people)
4. Rate of childhood abuse and neglect (per 1,000 children)
5. Rate of Vermont resident suicides annually (per 100,000 people)
6. # of Vermonters who are homeless
7. % of Adults binge drinking in the past 30 days
8. % of Adolescents binge drinking in the past 30 days
9. % of Persons age 12+ who need and do not receive alcohol treatment
10. % of persons age 12+ who need and do not receive treatment for illicit drug use

All Vermonters have access to high quality health care:

1. % of Eligible Vermonters enrolled in Medicaid (Medicaid, VHAP, and Dr. Dynosaur/SCHIP)
2. % of Vermonters with access to patient-centered medical homes and community health teams
3. % of Vermonters receiving recommended and effective preventive health care
4. % of Adults (18+) using dental system annually

Appendix B – AHS Organizational Chart