LOCAL SYSTEM OF CARE PLAN

FY 2018 – FY 2020
The Community Access Program (CAP), a division of Rutland Mental Health Services (RMHS), is the designated agency (DA) for developmental disabilities services for Rutland County. We currently provide a range of comprehensive supports and services to 457 children and adults with developmental disabilities and their families with an operating budget of 17.3 million dollars for FY 2017. As the DA, CAP has the responsibility to ensure a seamless system of services throughout Rutland County for individuals and families meeting eligibility and funding criteria. In addition to Home and Community Based Services (HCBS), which comprise about 86% of our funding, CAP provides Intermediate Care Facility Services (ICF/DD), Flexible Family Funding (FFF), Targeted Case Management, the Bridge Program, Family Managed Respite, Vocational Rehabilitation grant funded employment services, and Specialized Services in a nursing facility. As the DA, we provide intake services for the county including eligibility evaluations and referral services. We gather relevant data and feedback to ensure that current system models meet the needs of the individuals served, as well as the needs of our community. We continue to reassess, redesign, and restructure services to most effectively meet the needs of the individuals we serve through cost effective models. We strive to provide high quality, person-centered, and responsive services while challenged by limited resources and inadequate funding.

The Community Access Program supports each person’s right to live in and be a valued and respected member of the community, to develop meaningful and mutually supportive relationships with family and friends, to make choices and decisions that affect his/her life, to obtain employment or engage in other meaningful activities, to participate in community life and utilize community resources. We are committed to the RMHS vision “thriving community, empowered lives.”

The Local System of Care Plan process provides the means for the Community Access Program to guide the development of local services and use of resources, to identify gaps in the current system of service delivery, and to direct new service initiatives. The local plan is used by the Developmental Disabilities Services Division (DDSD) to inform the State System of Care Plan and the annual budget process.
CURRENT STATUS

The Community Access Program provides the following services to meet service and support needs currently identified in our region:

*Services were reviewed and discussed with stakeholders during ACT 140 input gathering: All services and programs CAP currently provides were identified as being of benefit and priorities for continuation across stakeholders. Stakeholders noted that service priorities depend on the needs of the individual and the services the individual or family currently receives.*

1. **Service Coordination:** Service coordination assists individuals in planning, developing, accessing, coordinating and monitoring their supports and services. Service coordination is individualized to meet each individual’s unique needs. The service coordinator assists in person-centered planning and in the development, implementation and monitoring of the Individual Support Agreement (ISA). Other responsibilities may include accessing and coordinating medical services, clinical services, housing, benefits, and/or educational services. CAP provides service coordination through HCBS to 234 individuals. An additional 39 individuals who do not meet funding priorities for Home and Community Services funding receive service coordination, referral, monitoring, and advocacy through Targeted Case Management to support them to access needed services.

2. **Home Supports:** CAP offers a wide array of home supports designed to meet individual needs:

- **Supervised Living:** Fourteen adults are supported to live in their own home or apartment as independently as possible. Supervised living supports are individualized and range from several hours a day to several hours a week, and may include support in household management, budgeting, shopping, cooking, independent living and safety skills. On-call and crisis supports are available.

- **Assisted living:** provides support to individuals living with their family or in shared living homes. CAP currently provides staffed assisted living supports to one individual living in an intensive shared living home. Three individuals living in intensive shared living homes are supported with contracted assisted living supports, a model in which the shared living provider hires workers.

- **Staffed Supports:** One individual receives 24 hour individualized staffed supports to live as independently as possible in his own apartment. Supports may include the supports described in supervised living as well as personal care, medication...
administration, and support to gain skills in emotional regulation. On-call and crisis supports are available.

- **Group Living:** Six adults who enjoy group living are provided 24 hour supports to live as independently as possible in our Royce St. group home, currently licensed as a Residential Community Care Home. Supports are individualized and comprehensive to meet personal care, health, social, and daily living needs. Nursing oversight is provided.

- **Shared Living:** Individualized supports are provided for one or two individuals in the home of a shared living provider which may be an individual, couple, or family. CAP currently provides shared living supports to 137 individuals in 118 shared living homes. Individuals are supported to learn or maintain skills, develop relationships, and to develop a sense of belonging at home and in the community. CAP provides a range of models to meet the unique needs of each individual. Models range from “roommate” supports to “intensive shared living” supports for individuals with complex needs. In intensive shared living homes additional support is provided through assisted living to provide 2:1 supports when needed, through increased respite, and/or individual crisis responders to assure the needs of the individual are met. The intensive shared living model is an extremely cost effective “contracted” alternative to staffed living supports for individuals with the most complex and challenging needs. The model requires significant oversight and support, and skilled shared living providers and support workers. Four individuals are currently supported through the intensive shared living model.

- **Westview Court ICF/DD (Intermediate Care Facility for Individuals with Developmental Disabilities):** provides 24 hour comprehensive supports and health care in a home environment for six adults who require significant medical and nursing services. Individuals are enabled to experience a sense of home and belonging, social opportunities, and expanding social networks. Westview Court is the only ICF/DD in Vermont and is a state-wide resource.

3. **Respite:** HCBS funded respite supports assist family members and shared living providers to support individuals by providing breaks for the primary care provider. Respite services are provided hourly and/or daily (overnight) in the respite provider’s home or in the individual’s home, depending on the individual’s needs and preferences.

4. **Community Supports:** Staffed community supports are provided through the LifeSteps Program which offers adults with developmental disabilities a variety of community-
based volunteer, recreation/leisure, social skills, and educational opportunities that promote life-long learning, citizenship, leadership and self-advocacy based on individual interests and abilities. LifeSteps provides 1:1 community supports as well as small group supports. Twenty-seven individuals receive group supports in site-based programs located in Rutland and Brandon. Supports are individualized as much as possible. Seven of these people also receive 1:1 staffed community supports. Twenty individuals receive only 1:1 staffed community supports. Due to staffing shortages, staffed community supports are being inconsistently provided to a number of individuals. We recognize the impact on the individuals we support and are continuously recruiting.

The contracted model of community supports is currently the model most frequently funded by DDSD because of its lower cost. In this model, community supports are provided by contracted workers hired by the individual’s family or shared living provider, or are provided by the shared living provider. These supports are personalized and support the individual to participate in community-based volunteer, rec/leisure, and social opportunities. One hundred and six individuals currently receive contracted community supports.

5. **Project SEARCH**: is a workplace immersion program for students with intellectual disabilities who are in their final year of high school. It is a collaborative program between Education, Vocational Rehabilitation, Developmental Disabilities Services, and a local business. For the Rutland area, the Rutland school district, CAP, and the Rutland Regional Medical Center collaborate to support students with internships that will help them obtain employment upon graduation.

   - For school year ’15-’16, the first year of implementation in this region 6 students were enrolled in Project SEARCH. Five of these students graduated in June 2016 and all 5 were employed upon graduation.

   - For school year ’16-’17, 7 students are currently enrolled in Project SEARCH.

6. **College Steps**: an independent non-profit organization connects students with varying abilities with a college campus based experience. CAP partners with College Steps to support transition age youth to integrate into post-secondary coursework and a college campus experience through collaboration with Castleton State University.

   - In FY 16, 5 individuals were enrolled in College Steps, 3 of whom graduated. In FY 17, 5 individuals are enrolled in College Steps.
7. **Employment Services**: are provided through Career Choices, an employment service that assists individuals with disabilities to obtain gainful and competitive employment in the community based upon interests, abilities and career objectives. Supports are individualized with the emphasis on fostering natural supports and fading paid supports wherever possible. Eighty-four individuals receive employment supports through Career Choices. Fifty-four individuals receive 1:1 employment supports through HCBS funding; thirty individuals receive employment services through Vocational Rehabilitation (VR) grant funding. Four individuals receive employment supports through contracted workers hired by their family.

- Over the last two years, Career Choices has maintained an 81% rate of employment for those receiving employment services.

8. **Clinical Supports**: Individuals are supported to access needed therapies including individual, group psychotherapy, and sex offender therapy, as well as other clinical supports including Occupational Therapy, Physical Therapy, Speech/Language Therapy, and Augmentative/Facilitated Communication training. Individuals are supported to access Medicaid providers for clinical services, including psychiatric services, whenever possible. Psychiatric services are also available through CAP.

9. **Crisis Services**: are provided as needed to the individuals we support who are experiencing a psychiatric, behavioral, emotional, or medical crisis. A number of individuals who experience the most challenging behavior have designated crisis responders. We access the VCIN beds when needed if a bed is available. The RMHS 24/7 Crisis Hotline is available for individuals supported through CAP and the Emergency Services Team is available for crisis screenings and risk assessments. We continue to evaluate the need for expanding crisis services and the most effective ways of providing this service.

10. **Health Services Coordination**: Three Registered Nurse Consultants are available to assist teams supporting individuals who receive 24-hour residential supports with the monitoring and coordination of routine as well as acute medical care. Nurse Consultants also provide advocacy around appropriate health care for individuals. In addition, the Nurse Consultants provide training to staff, shared living providers and other contracted workers on Special Care Procedures when needed.

11. **Flexible Family Funding (FFF)**: is available to families to support their child or adult family member with developmental disabilities to live at home. The maximum allocation for each individual is $1000 per year and is income determined. FFF may be
used to purchase respite or goods to meet the individual’s and family’s needs but is not available to individuals who receive HCBS. A total of 145 children and adults receive FFF through CAP.

12. **Bridge Care Coordination**: The Bridge Program offers care coordination to help families of children with developmental disabilities up to age 22 access and coordinate needed services and resources including educational, medical, and clinical. CAP provides Bridge care coordination to 79 families. The program offers an average of three and a half hours per month of care coordination.

13. **Family Managed Respite (FMR)**: is allocated to provide families with a break from caring for their child with a disability, up to age 22. FMR is available to children with developmental disabilities or mental health needs who do not receive HCBS funding. Thirty-five families currently receive FMR; all families who receive FMR through CAP also receive Bridge Care Coordination.

14. **Transportation**: Individuals requiring an accessible vehicle who live with a shared living provider or a family member may receive HCBS funding for accessible transportation. HCBS funding for transportation is also available to individuals who receive staffed community supports to reimburse staff for mileage to access the community. Transportation is a component of staffed employment supports, staffed residential supports, and shared living supports. Transportation is not funded for contracted community or contracted employment supports, and is often a limiting factor in the individual’s ability to access his/her community.

Individuals are encouraged to use “the Bus” whenever possible. A number of individuals use the Bus through State Plan Medicaid to access medical appointments and Medicaid reimbursable services. In addition, a number of individuals have been supported to purchase a bus pass to increase their independence, increase their access to their community, and transition from dependence on staff for transportation.

Transportation remains an under-met need in our region.

15. **Specialized Services (in a nursing facility)**: CAP currently provides Specialized Services to two individuals residing in a nursing facility. Individuals 18 years old and older who reside in a nursing facility may qualify for Specialized Services through Pre-Admission Screening and Resident Review (PASRR) funding to meet their unique needs related to their developmental disability. Staff provides additional individualized services not provided by the nursing facility to support the individual to engage in social, leisure, recreation, and other activities.
Status of Local System of Care Plan FY ‘15 – FY ‘17 Regional Outcomes

1. **What we are going to do:** The number of individuals employed will increase and the employment options available for the individuals we serve will expand.

   **How we are going to do it:**
   
   - Participate in DS Taskforce employment workgroup
     
     o **Status Update:** We participated in the development of the Employer Contracted Work Supports pilot and timeline. Several local employers provided feedback to the group on the proposed pilot.
     
   - Volunteer to be a pilot agency for the initiative
     
     o **Status Update:** CAP volunteered to be a pilot agency; however, DDSD did not go forward with the initiative.
     
   - Expand micro business enterprises
     
     o **Status Update:** Micro businesses have not expanded; we haven’t had any individuals interested in developing a micro business.
     
   - Explore job carve out and job share options
     
     o **Status Update:** See employment rate increase below.
     
   - Utilize the “think tank” strategy to creatively brainstorm employment options for individuals, in particular for individuals who currently have staffed community supports.
     
     o **Status Update:** The Career Choices team meets bi-monthly to discuss and brainstorm job development strategies. We are active members with our local Creative Workforce Solutions. Additional job seeker skill groups have been developed to help people build skills and brainstorm employment options with other job seekers, including through a *Pathways to Employment* workshop held weekly. There are four people attending this workshop.
     
   - Plan and implement the Rutland Youth Transition Initiative to offer an array of options to graduating students including Project Search, College Steps, and Career Choices.
Status Update: A core transition team has been developed and includes CAP Intake, the Director of Child and Family Services, the Career Choices Transition Coordinator, and the VR Transition Counselor. At monthly meetings the graduate list is reviewed and plans developed to best support graduating students. This has been helpful in ensuring that all potential graduates are receiving the supports and services they need to be successful upon graduation.

Status Update: Rutland Project SEARCH was launched in August of 2015, a collaborative effort between Rutland Mental Health, Rutland Regional Medical Center, Rutland City Public Schools and Vocational Rehabilitation. In the first year of the program, 6 students enrolled with 5 of them graduating in June 2016. All five interns were employed upon graduation. In its second year, beginning August of 2016, the program had 8 interns enrolled. Currently, 7 interns remain in the program and are all showing progress in their skills, as measured by their task checklists each day. CAP representatives participated in the Project SEARCH open house, including Bridge Care Coordinators and the Director of Child and Family Services. Intake staff and Bridge Care Coordinators are developing a transition packet as a resource for families.

Status Update: We continue to collaborate with College Steps to assure this program remains an option for Rutland County students. For school year ’15-’16, the program had 5 participants, 3 of whom graduated in May of 2016. For school year ’16-’17, the program has 5 students enrolled with 2 of these students planning to graduate in May of 2017.

What difference will it make and how will we measure it:
- The number of individuals employed will exceed the target goal in the master grant each year.

Status Update: Our provisional employment rate for FY 2016 is 35%, a 4% increase from FY ’15. For FY ’16 our target number of stabilizations for the year was 8. We exceeded this number of placements, with a final number of 13, to meet our incentive target and earn a bonus for the Career Choices program.

Status Update: The target employment rate for high school graduates is 45% by the end of FY 2017. This will require a 20% growth in employment rate for graduates over the next year. This growth should happen through the
implementation of Project SEARCH, as well as more collaboration with schools and students at an earlier age.

- The models of employment available to individuals will be expanded by at least one per year.
  - **Status Update:** We will continue our work to brainstorm models of employment and offer to participate in the pilot program should the program be offered.

- Our network of employer partners will be increased by six a year.
  - **Status Update:** To date we have increased our employer network by four. New employer partners include Rutland Regional Medical Center, Green Mountain Power, Burger King and Vermont Country Store. This increase is due to building new relationships through the Project SEARCH Program, as well as the hard work and dedication of the employment team at Career Choices. The expansion of our employer network creates positive relationships with the community and fosters other opportunities for people receiving our services now and in the future.

2. **What we are going to do:** *Unify services to more effectively and responsively serve children and families in Rutland County*

**How we are going to do it:**

- Through collaboration, strategizing, and cross training with Behavioral Health Child and Family Services, a unified intake process for children will be developed. An intake assistant has been hired for CAP to facilitate the implementation of this process.
  - **Status Update:** The initiative to develop a unified intake process for children has been incorporated into the agency-wide initiative to redesign, streamline and unify intake processes across all RMHS programs. CAP’s intake coordinator and intake assistant participate in the streamlining intake workgroup that was formed last spring.

**What difference will it make and how will we measure it:**

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• A unified process will be in place. Families will report experiencing a user friendly, accessible, “no wrong door” to access appropriate supports and services for their child.
  
  o **Status Update:** CAP Intake, the Director of Child and Family, and the DD Chief Services Officer meet twice monthly with RMHS Behavioral Health Children’s Director, staff, and Behavioral Health Chief Services Officer to implement a unified approach to meeting the needs of children and their families, discuss ways to manage FMR, and use of non-categorical funding.

  o **Status Update:** All CAP staff on the Child and Family Team have been trained to complete the new CPCS assessment. An average of 6 CPCS assessments has been completed monthly in addition to assessments that are completed for children in the Behavioral Health program.

**How we are going to do it:**

• Through collaboration with Behavioral Health Child and Family Services, the RMHS child psychiatrist specializing in ASD, Maple Leaf Clinic, and family members an autism team will be developed.

• The team will initially address children with autism spectrum disorder (ASD). The second phase of the initiative will expand the team to adults with ASD.

• Brochures will be developed to inform the community of the resources available and to assist families to access resources.

**What difference will it make and how we will measure it:**

• Families will be aware of resources for ASD and how to access services. Referrals to the team will indicate the success of the initiative.

  o **Status Update:** An autism planning team met periodically to discuss regional ASD resources and develop a brochure to identify those resources. Referrals for children with ASD that each program received were reviewed to assure families and children have access to all appropriate services. This team was disbanded when the child psychiatrist left and Maple Leaf Clinic was no longer able to participate. ABA meetings have been scheduled monthly with CAP Bridge Care Coordinators to review referrals and current status/needs of children and families.
Status Update: An Autism Partnership Team was formed with representatives from RMHS, Maple Leaf and the Vermont Achievement Center (VAC) to share information about resources and collaborate to assure the community is aware of all resources and services available. RMHS participated in the open house at VAC to share resources and information with families and other community partners. The team was active for nine months and due to changes at VAC has not been reconvened.

How we are going to do it:

• In collaboration with the Field Services Director and community partners CAP will support families to recruit and train respite and Children’s Personal Care workers.

• In collaboration with Rutland Family Support Network (RFSN) a resource guide and recruitment strategies will be shared with families.

What difference will it make and how we will measure it:

• Given the availability of needed resources, at least one training will be offered over the next year. We will measure success by the number of families who attend the training and report they have the resources to recruit and train workers as a result of the training.

  Status Update: The resource guide developed to assist families in recruiting respite and CPCS workers following the first training is up-dated regularly and available through Rutland Family Support Network (RFSN). Families continue to report it’s a valuable resource.

• As indicated by the satisfaction of the participants and continued requests for training, additional training may be offered.

  Status Update: At the request of RFSN CAP provided training for families who expressed an interest in gaining a better understanding of the service system for people with developmental disabilities and their families. We shared information regarding intake and eligibility, budgets/funding, choice of providers, management options, children’s services, transition to adult services, and an overview of adult services. Nineteen people including families, individuals who receive services and other community partners attended. A survey conducted by the VT I-team consultant who helped sponsor the meeting indicated high satisfaction with the training and that the training received highly positive feedback (e.g., “it was great and so helpful”).
How we are going to do it:
- With guidance and collaboration with the State, the Integrating Family Services (IFS) model will be implemented in the Rutland region. CAP and Behavioral Health Child and Family Services will jointly lead the initiative. The timing of implementing this initiative in Rutland is dependent on State approval.

What difference will it make and how we will measure it:
- IFS will successfully be implemented in Rutland County within the next three years.
  - **Status Update:** Since the Agency of Human Services slowed the implementation of IFS statewide, we have not yet had the opportunity to initiate IFS in Rutland County.

3. **What we are going to do:** Expand housing options to more responsively meet current and anticipated needs of individuals and promote independent and interdependent living.

How we are going to do it:
- Build partnerships in the community and state to develop affordable and accessible housing.
  - **Status Update:** To date there have been no opportunities that have come to fruition. Affordable and accessible housing continues to be an unmet/undermet need and we will continue efforts to build partnerships with community (e.g., Housing Trust of Rutland County) and state housing coalitions.

- Explore, design, and evaluate supported living options that will promote independence and interdependence. The following options will be explored:
  - An “alternative” supportive apartment model sharing a building, staff, common resources.
  - **Status Update:** CAP’s apartment program has successfully supported six individuals to move into their own apartments and become more independent over the last 3 years. One individual is successfully living in her own apartment by sharing overnight staff with another individual who lives in an apartment in the same building. Another individual is starting to develop skills to live independently through the use of a mother-in-law apartment. Through the use of a mother-in-law apartment, another individual has increased her independence and now receives only Targeted Case Management supports. Alternative models of home supports continue to be a need identified by stakeholders.
Status Update: Funding decisions that limit the number of hours of home supports for individuals to transition to apartment living has impacted the willingness of individuals and/or guardians to go forward with moves. Investing in more intensive supports up front for individuals transitioning from 24/7 supports has proven to help individual transition to more independent living. We will continue to advocate for support for a model that provides a high level of supports initially and decreases over time as the individual gains independent living skills.

- A transitional supportive living initiative for young adults with ASD. A community partner has expressed interest in collaborating with CAP to design and develop this option.
  - Status Update: Unfortunately this initiative was not able to move forward due to the community partner’s unexpected health issues.

- Through participation in the DDSD Workgroup for supervised living, investigate the viability of implementing the initiative designed by the group in Rutland.
  - Status Update: We participated in the DDSD work group, but unfortunately after two meetings this group was dissolved with no viable outcome. We will continue to seek out opportunities to investigate viable initiatives.

What difference will it make and how we will measure it:
- At least one new model of supportive living not currently available through CAP will be implemented/piloted over the next 3 years. This outcome is dependent on the availability of resources including affordable housing and funding for individual supports.
  - Status Update: An apartment model with shared overnight staffing has successfully supported an individual who was previously unsuccessful in shared living and other 24 hour support models in living more independently.

4. What we are going to do: Promote/improve community awareness, understanding, and partnerships with CAP.

How we are going to do it:
- Develop marketing and outreach strategies to increase public awareness and support.
- **Status Update**: The RMHS website has been redesigned and is being updated to highlight services and supports offered by CAP.

- Develop a communication plan to publicize information and community education about CAP.
  - **Status Update**: A formal communication plan has not been developed by RMHS. CAP/RMHS continues to seek opportunities to inform and involve the community. CAP/RMHS has had increased presence at community job fairs. During Direct Support Professionals Week, CAP celebrated DSPs through Public Service Announcements on the local radio station and a banner hung on the Fair Ground fence in the center of town.

- Enhance CAP’s presence in the community and reputation through collaborative efforts, enhanced community partnerships, and co-sponsoring community events.
  - **Status Update**: As described above, through Project SEARCH CAP has partnered with Rutland High School and Rutland Regional Medical Center. Career Choices has developed partnerships through participation with Creative Workforce Solutions and the Rutland Youth Transition Initiative. CAP collaborated with RFSN to sponsor a forum for local stakeholder input (see Plan Development section) and discussion of dd services, and to provide training for families. Feedback was highly positive for both events. CAP’s peer mentor is a member of the state-wide initiative to formalize Peer Mentoring. CAP’s local self-advocacy group continues to develop and partner with GMSA.

**What difference will it make and how we will measure it:**

- Awareness of CAP’s services and how to access services will be raised throughout Rutland County. Our success in achieving this outcome will be measured by the feedback we receive through FY 2018 - FY 2020 Local System of Care Plan information gathering. Community stakeholders will express an understanding of CAP and accessing developmental services; community awareness and education will not be identified as an issue.
  - **Status Update**: Awareness of CAP and accessing our services was not identified as a need during information gathering for the Local System of Care Plan. CAP has partnered with local groups and been responsive to requests to provide trainings on accessing services and the developmental disabilities services system. Families and community partners have reported these meetings and trainings have been very helpful in understanding what services CAP provides and how to access services.
PLAN DEVELOPMENT

1. Planning Process

The Local System of Care Plan was developed with input from individuals who receive services, family members, guardians, self-advocates, community partners, local service providers, staff, the Local Standing Committee, and other community stakeholders. The following methods were used to solicit feedback:

- **Local System of Care Plan Input for Act 140:** To comply with Act 140 the Developmental Disabilities Services Division (DDSD) requested DAs begin the Local System of Care Plan process in spring of 2016 by providing input on four specific topic areas that are proceeding through rule-making.

  CAP gathered input through two meetings with our Local Standing Committee, interviews with our local self-advocacy group Dream Catchers, discussions with children’s mental health staff, a LIT (Local Interagency Team) meeting, and a community forum.

  The forum was a collaborative effort of the Rutland Family Support Network (RFSN), ARC (Advocacy, Resources, Community) Rutland Area, VT I-Team, and CAP. It was widely advertised through list serves, Facebook, ARC webpage, PEG TV, Front Porch Forum, PSAs for local radio stations and newsletters, direct email to the ARC board and self-advocacy group members, and direct mailings. The event was attended by a wide range of stakeholders and community members including members of RFSN, Self Advocates Becoming Empowered Rutland, the AKTION club, individuals who receive CAP services, individuals with developmental disabilities who don’t receive CAP services, parents of children and adults with developmental disabilities who receive services and some who don’t, ARC members, representatives from education, I-Team, Castleton State University, and Children with Special Health Needs.

- **Local Standing Committee input:** The Local Standing Committee reviewed the Act 140 input from stakeholders and prioritized needs for the three year local plan.

- **CAP staff input:** An input and brainstorming meeting for the Local System of Care Plan was held with CAP service coordinators, employment and community coordinators, Bridge Care coordinators, directors, supervisors, nurses, and intake.

In addition to the more formal processes of gathering information for the Local System of Care Plan described above, CAP also relied upon other available information as part of the overall analysis and planning process. The following is a brief description of these additional sources.
• **CAP Annual Individual Satisfaction Surveys:** CAP annually assesses the satisfaction of individuals served. This data was reviewed and reflected in the Local Plan.

• **Quality Services Review:** Verbal feedback from DDSD’s Quality Services Review completed in the fall of 2016 was considered when developing the Plan. (The Quality Services Review report had not yet been received when this plan was developed.)

• **Licensing Reviews for Westview Court ICF/DD and Royce St. group home:** Formal feedback and reports from the Division of Licensing reviews were analyzed and incorporated into the planning process.

• **CAP Internal Outcome Measures:** Data related to key outcomes was reviewed, analyzed, and incorporated into the Local System of Care Plan.

• **Incident Reporting Trends and Appeals and Grievances Data:** Incident reports and other relevant trend reporting were reviewed for the previous three years in preparation to develop this Plan.

• **Rutland County Area Schools:** CAP has had ongoing formal and informal meetings with area schools on issues around children’s services. This information is represented in the Local System of Care Plan.

2. **Priority Needs**

Priority needs were identified, assessed, and analyzed based on the information gathered. Ninety-five percent of the 103 individuals responding to the CAP Individual Satisfaction Survey for the first two quarters of FY’17 reported that they are receiving the help they need, indicating that current needs of individuals we serve are being well met within available resources. A consistent message we again received is that additional funding and expanded funding priorities are needed to create alternative models of supports, promote independence, and provide higher pay for direct support professionals. We continually evaluate services and resources to design person-centered supports that respond to the needs of individuals, promote greater independence, and maximize the use of resources.

Through the Act 140 input gathering process multiple stakeholders identified that the following services be expanded or developed locally and/or statewide: (excerpted from the Input for Act 140 FY 2017 report)

- *More employment; more jobs*
- *More options like Heartbeet Lifesharing*
- *Disability communities*
• More crisis beds; crisis beds available locally
• Crisis supports to avoid emergency room; increase partnerships with hospital
• More College Steps
• More resources for continuing education
• More residential options, beyond shared living
• Home/housing alternatives for independent living; true choices in adult living options
• More affordable housing
• Programs for emerging needs like dementia
• Expanding supports for families to prevent crisis as families age
• Aging population support- support to live at home, support for aging parents
• Training for staff, home providers, and contracted workers
• Transportation
• Targeted support for truly meaningful participation, naturally inclusive activities, like College Steps. Transition age services—start earlier so families know what’s available and can plan
• Transition to adult services are a real challenge and need to be improved so there are no gaps
• More funding for respite/FMR for families to replace supports previously provided by CPCS
• Funding/services to support safety and supervision needs of children

The following areas were prioritized for CAP to focus on in the upcoming three years to better meet current and anticipated needs of the individuals and families we serve: employment, housing options, emerging needs related to dementia and aging parents, and crisis services. Workforce issues, adequate funding, and sustainability of the developmental disabilities services system were identified as areas for system focus.

1. Increasing employment opportunities was again prioritized as a regional outcome for the FY’18-FY’20 Plan. While we have a high level of satisfaction with our current employment services, increasing the number of individuals employed and expanding employment options for the individuals we serve were again identified as under-met needs. Strategies are described under Regional Outcomes.

2. Expanding housing options to more responsively meet current and anticipated needs of individuals and promote independent and interdependent living was again identified as a regional outcome. Needs are currently under-met. This initiative will require resources and collaboration with community partners and DDSD. Strategies are described under Regional Outcomes.
3. The need to develop expertise and models of support to meet the emerging needs of individuals we serve who develop dementia and of individuals with aging parents was prioritized as a regional outcome for this plan. Needs are currently under-met. Strategies and resources needed are described under Regional Outcomes.

4. Crisis services were again identified as under-met need. Stakeholders support development of another statewide bed through DDSD. The need for a local crisis/emergency bed continues to be evaluated, while recognizing that additional resources would be needed to make it achievable. Strategies are described under Regional Outcomes.

5. Workforce issues including lack of workers, inadequate pay, and workforce development were identified as issues impacting CAP and as statewide/system issues that will require collaboration, innovation, and additional resources to address. RMHS prioritized recruitment and hired an experienced, forward thinking recruiter for the agency. Also, last fall we were able to provide a much needed 3% pay increase for staff and 2% increase for shared living providers. Even with the increases, pay rates are not competitive with similar positions with the State, school system, other health care organizations, or positions within RMHS funded by the Department of Mental Health. Workforce needs are currently under-met and impact our ability to recruit and retain trained staff and to consistently provide quality supports to individuals.

6. Sustainability of the developmental disabilities services (DDS) system was again identified as an issue that must be addressed by all system stakeholders. New resources and collaborative strategies will be required. Concerns include securing adequate funding, maintaining DDS values, and the future of the DDS system with health care and payment reforms.

3. Regional Outcomes

1. **What we are going to do:** The number of individuals employed will increase and the employment options available for individuals we serve will expand.

   **How we are going to do it:**
   - Be an active member of the Rutland Core Transition Team
   - Work collaboratively with high schools to support youth transitioning into employment, College Steps or Project Search.
   - Explore job carve out and job share options.
• Expand community connections/partnerships by increasing presence with the Chamber of Commerce and Creative Workforce Solutions (CWS).

**What difference will it make and how we will measure it:**

• The number of individuals employed will exceed the target goal in the master grant each year.

• At least 50% of graduating youth will have obtained employment or be involved in the program of their choice, i.e., College Steps or Project Search, upon graduation.

• Our network of employer partners will be increased by three a year.

2. **What we are going to do:** Housing options will be developed to more responsively meet current and anticipated needs of individuals and promote independent and interdependent living.

**How we are going to do it:**

• Explore supported living options that promote independence and interdependence such as a supportive apartment with shared staff and modular additions for homes.

• Approach the Land Trust and/or a housing developer to partner to develop affordable apartment living.

• Build rapport with local landlords to better support individuals who want to live independently.

**What difference will it make and how we will measure it:**

• At least one new model of supportive living will be implemented over the next 3 years to provide additional housing options and better meet individuals’ needs. This outcome is dependent on the availability of resources including affordable housing and funding for individual supports.

3. **What we are going to do:** Expertise and models of support will be developed to meet the emerging needs of individuals we serve who develop dementia and the needs of aging parents

**How we are going to do it:**

• Develop expertise within CAP to support individuals with dementia. Last June two staff were certified as NTG (National Task Group on Intellectual Disabilities and Dementia Practices) Affiliated Regional Trainers. Training on Dementia Capable
Care of Adults with ID and Dementia will be provided for staff, shared living providers, and families.

- Partner with other organizations with expertise in supporting people with dementia (e.g., Our House, Interage).

- Explore and plan a transition of our Level III Residential Care Home, 7 Royce St., to a dementia support focused home. This will involve short- and long-term planning and require collaboration with the Developmental Disabilities Services Division (DDSD) and the Division of Licensing and Protection (DLP). An application to become an Assisted Community Care Services (ACSS) is under review and will increase resources available to the home. A one-floor, accessible home will need to be purchased. Partnerships and resources within our community (e.g., Land Trust) will be explored. Specialized staff training will be provided. Nursing oversight is already in place.

- Develop support group for caregivers of individuals with dementia or Alzheimer’s.

- Explore Home Share for Rutland County as an option for supporting aging parents.

- Similar to family-based model of services for children, explore incorporating support needs of aging parents in inclusive person-centered planning for individuals who want to remain living at home.

**What difference will it make and how we will measure it:**

- Individuals who experience dementia will receive supports they need throughout the progression of the illness. We will measure our success through feedback from individuals, guardians/families, team members, and our staff.

- Staff and providers will report they have the training and resources needed to support individuals with dementia.

- The transition of our 7 Royce St. group home to a dementia care capable home will be planned and implemented over the next three years.

- Aging parents of individuals we support will report they have support options and resources.
4. **What we are going to do:** Crisis services will be available to respond to the needs of individuals we serve

**How we are going to do it:**

- Assess unmet needs for crisis services and evaluate current crisis supports available.

- Partner and cross team with RMHS Crisis Team. Provide training to the RMHS Crisis team so they can better respond to the needs of individuals with developmental disabilities in crisis. Explore using their expertise in crisis training for CAP staff.

- Strategize ways to enhance current crisis supports that do not require additional resources.

- Provide training for service coordinators by experienced dd crisis workers that includes in-depth discussion of scenarios and solutions.

- Explore resources to contract/consult with clinicians with dd expertise supporting individuals with complex and challenging behavior (e.g., mobile consultation from Leo Veccione and Mike Vandenberg to support teams to implement the strategies Al Veccone introduced at our Professional Development Day).

- Assess viability of reallocating internal funds to develop local crisis resources.

- Evaluate the need for a local crisis bed and resources required.

**What difference will it make and how we will measure it:**

- Teams will report crisis supports are available to meet needs.

- Cross teaming with the RMHS Crisis Team will be established.

- Service coordinators will report they have training, skills, support, and resources needed to plan proactive strategies and to respond to crisis situations.

- Depending on crisis needs assessment and availability of resources, new models of crisis supports may be developed (e.g., access to clinical consultation, CAP crisis team, CAP crisis bed).

4. **System Outcomes**

Through the Act 140 input gathering process and ongoing stakeholder discussions the following priority needs were identified as System Outcomes. We appreciate the collaboration and responsiveness of DAIL Commissioner Monica Hutt and DDSD Director
Roy Gerstenberger in acknowledging and working with us to address these system pressures. Continued focus, collaboration, and advocacy will be required to successfully address these key issues.

1. **Workforce issues**: lack of staff and contracted workers, inadequate pay, and workforce development were identified as statewide/system issues that will require collaboration, innovation, and additional resources to address. Staff and worker shortages are resulting in needed services not being provided and individuals and families are being impacted. Competitive compensation and training to attract and retain a qualified and skilled workforce is a critical component of system sustainability.

2. **Sustainability of Vermont’s developmental disabilities services system**: inadequate funding remains a concern and underlies agency sustainability and workforce issues. Additional resources are required to reimburse agencies for actual costs of services and to provide competitive pay. Stakeholders also want to assure that the values of Vermont’s developmental disabilities system are sustained in payment and health care reforms.