



LOCAL SYSTEM OF CARE PLAN

FY 2015 – FY 2017



Community Care Network
Rutland Mental Health Services

THE COMMUNITY ACCESS PROGRAM OF RUTLAND MENTAL HEALTH SERVICES

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The Community Access Program (CAP), a division of Rutland Mental Health Services (RMHS), is the designated agency (DA) for developmental disability services for Rutland County. We are currently providing a range of comprehensive supports and services to 471 children and adults with developmental disabilities and their families. This represents an overall growth of 6% in the last three years in the number of individuals we are serving. At the time the FY'11- FY'14 Local System of Care Plan was developed, CAP was serving 443 individuals. 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), CAP provides Flexible Family Funding (FFF), Targeted Case Management, the Bridge Program, 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 the most cost effective models. We strive for high quality, responsive services while challenged by limited resources and budget reductions.

The Community Access Program supports each person's right to live in and be a valued and respected member of the community, develop meaningful and mutually supportive relationships with family and friends, make choices and decisions that affect his/her life, obtain employment or engage in other meaningful activities, participate in community life and utilize community resources. As our vision statement affirms "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 to inform the State System of Care Plan and the annual budget process.

CURRENT STATUS

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

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 and clinical services, supporting the individual to access benefits, and/or coordinating with educational services. CAP provides service coordination through HCBS to 243 individuals. An additional 33 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.

- 96% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with service coordination supports.

2. Home Supports

CAP offers a wide array of home supports designed to meet individual needs:

- **Supervised/Assisted Living:** Eleven adults are supported through supervised living supports to live in their own home or apartment as independently as possible. 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.
 - 91% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with apartment supervised living supports.
- **Assisted living supports** are also available to provide support to individuals living with their family or in shared living homes (please see Shared Living Homes). CAP currently provides staffed living supports to one individual living in an intensive

Shared Living home and contracted assisted living supports to four individuals living in intensive Shared Living homes, as well as one individual who lives with his family.

- **Staffed Supports:** Three adults receive 24 hour individualized staffed supports to live as independently as possible in their own apartments. Supports may include the supports described above, and/or personal care, medication administration, support to gain skills in emotional regulation. On-call and crisis supports are available.
 - 91% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with staffed living supports.

- **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 Therapeutic Community Residence (TCR). Supports are individualized and include the supports described above.
 - 95% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with Royce St. supports.

- **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 149 individuals in 128 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 include “roommate” supports, “foster family” (in a DCF licensed home for a child), and “intensive shared living” for individuals with complex needs. Additional support is provided in intensive shared living homes to assure the needs of the individual are met. Additional support may be provided through two shared living providers, through “assisted living” to provide 2:1 supports when needed, through increased respite, and/or individual crisis responders. 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 but requires significant oversight and support and skilled shared living providers and support workers. Six individuals are currently supported through the intensive shared living model.
 - 94% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with shared living supports.

- **Westview Court ICF/DD (Intermediate Care Facility for Individuals with Developmental Disabilities):** Westview Court provides 24 hour medical care and supports in a home environment to 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.
 - 87% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with Westview Court supports.

3. Respite

Respite supports assist family members and shared living providers to support individuals by providing the primary care provider a break. 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. One hundred seventy-eight individuals receive respite services.

- 91% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with respite supports for families.
- 92%% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with respite supports for shared living providers.

4. Community Supports

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 staffed community supports as well as small group supports from locations in Rutland and Brandon. LifeSteps also offers Community Campus, a diverse group of participants and instructors, all with interests in learning and enhancing their personal lives. In addition, LifeSteps sponsors the Post-Secondary Educational collaborative with College Steps. Forty-seven individuals receive staffed community supports through the LifeSteps Program; of these, 27 have 1:1 supports and 20 are supported in small groups in our center-based programs.

Community supports are also provided by contracted workers hired by the individual's family or shared living provider. These supports are personalized and support the individual to participate in community-based volunteer, rec/leisure, and social opportunities. Eighty individuals receive contracted community supports. The contracted model of community supports is the model currently most frequently funded by DDS because of its lower cost.

- 92% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with LifeSteps individual supports.
- 90% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with LifeSteps center-based supports.
- 85% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with Community Campus.
- 93% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with contracted community supports.

5. Employment Services

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 individuals receive employment supports through Career Choices; 45 through HCBS funding and 35 through Vocational Rehabilitation (VR) grant funding. An additional five individuals receive employment supports through contracted workers hired by their family or shared living provider.

- 88% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with Career Choices employment supports.

6. Clinical Supports

Individuals are supported to access needed therapies including individual and group psychotherapy, sex offender therapy, and other clinical supports including Occupational Therapy, Physical Therapy, Speech/Language Therapy, and Augmentative/Facilitated Communication training. If a Medicaid provider cannot be identified and the individual has HCBS clinical funding, appropriate services are provided through providers accessed through the Community Access Program. Psychiatric services are available at CAP

through three psychiatrists, including a child psychiatrist who specializes in Autism Spectrum Disorder.

- 91% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with clinical supports.

7. Crisis Services

Crisis services are provided as needed to the individuals we support who are experiencing a psychiatric, behavioral, emotional, or medical crisis. Our apartment program has an on-call team; a number of individuals who experience the most challenging behavior have designated crisis responders; and we access the VCIN beds as needed when a bed is available. Rutland Mental Health Emergency Services are 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.

8. Health Services Coordination

For individuals receiving residential supports Nurse Consultants are available to assist with the monitoring and coordination of routine as well as acute medical care. In addition, staff, home and respite providers receive training on special care procedures as well as other health care related topics on an on-going basis. The Nurse Consultants also provide advocacy around appropriate health care for the individuals served through CAP.

9. Flexible Family Funding

Family Flexible Funding (FFF) is available to families to support their child or adult family member with a developmental disability to live at home. The maximum allocation for each individual is \$990 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 154 children and adults receive FFF through CAP.

- 90% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with FFF.

10. 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 61 families. Families receive an average of three and a half hours per month of care coordination.

- 96% of respondents to our Local System of Care Plan (LSOCP) survey indicated they are satisfied or very satisfied with Bridge Care Coordination supports.

11. 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 who live in Rutland 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.

12. Specialized Services (in a nursing facility)

CAP currently provides Specialized Services to one individual 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 provide additional, individualized services not provided by the nursing facility to support the individual to engage in social, leisure, recreation, and other activities.

II. Status of Local System of Care Plan FY 12 – FY 14 Outcomes

Health and Safety

Goal 1: CAP will enhance its ability to support individuals with complex behavioral and emotional needs and/or who may potentially pose a risk to the community. CAP will develop an infrastructure that builds capacity within its teams, shared living providers and families.

Measure: Given the availability of adequate funding, an experienced professional will be employed who will develop and direct the crisis support methods for teams as well as oversee the crisis bed(s) created in response to community need.

Status: CAP hired Ellen Malone for the newly developed (2011) Director of Specialized Supports. PATH planning, in conjunction with a survey of needed crisis supports, was utilized to identify CAP's strengths and local challenges. Through this process it was determined that increased training, expertise, and consultation resources would better serve local need than would a crisis bed.

Ellen led the initiative to expand CAP's capacity to support individuals with complex behavioral, psychiatric, and/or health needs, or who pose a risk to Public Safety, to have thriving lives. The Prevention Team, a group dedicated and trained in Positive Behavior Supports and intervention strategies, was refined, processes streamlined, and Brandon Pedigo engaged in an increased capacity to support the team. The Prevention Team is available to any CAP team for consultation. Therapeutic Options training is now provided to all non-administrative CAP staff annually and we have new Communication training which facilitates Positive Behavioral Supports. Currently, five CAP staff are trained Therapeutic Options instructors. Despite herculean efforts, we were not able to develop adequate supports in Rutland County to support individuals with the most complex needs and so collaborated with an experienced and skilled resource in Barre willing to contract with CAP to provide intensive supports for several individuals with complex challenges. This team is able to provide crisis response immediately and effectively for these individuals; facilitate a safe, positive home experience; assure community safety; and avoid police intervention and psychiatric hospitalizations.

Goal 2: CAP will expand its residential options for both children and adults to serve the growing number of individuals and families in need within Rutland County.

Measure: Given adequate funding, CAP will create at least 1 new residential option to serve children and at least 1 new model of residential support for adults with complex medical and/or behavioral needs.

Status: Individuals who have needed alternate living have moved to new homes and in some cases are sharing staff to help subsidize increased need for supports. Current residential models include Shared Living, Shared Living with enhanced support, Shared Parenting, Supervised Apartment living, and Staffed Apartments providing support 24 hours per day. Intensive shared living homes, a new model of specialized supports for both adults and children with complex needs, provides a cost-effective contracted model of intensive supports by highly trained teams. This model provides an alternative to the highly expensive staffed model of support which these individuals would otherwise require.

Quality of Service Outcomes

Goal 1: Expand employment options through Career Choices in order to match the interests, needs and capacity of the individuals served through CAP.

Measure: At least 80% of the individuals who are supported by Career Choices will be gainfully employed.

Status: 85% of the individuals receiving employment supports through Career Choices are employed (up from 70% in FY12 and 56% in FY11) at an average of \$9.22/hr. New jobs are now sought and obtained in non-traditional hours on weekends and evenings in addition to the traditional day positions. Micro-enterprise has been explored and developed. The employment teams have received significant and heightened training. The number of job placements achieved by the employment team qualified CAP to receive an incentive payment as outlined in our master grant agreement with the state. Satisfaction surveys completed by individuals at the time of their ISA/ISA review in 2013 indicated that 99% are satisfied with the employment supports they received through Career Choices. In 2013 CAP made 29 job placements. Jobs range from basic entry level positions to small and large scale brass assembly to scanning boats for invasive species and include both year round and seasonal (Killington, Devils Bowl Speedway, etc.) work anywhere from an hour a week to full time employment.

Goal 2: LifeSteps will offer activities that are inclusive, educational and naturally occurring, to enhance status and increase relationships within each individual's community of choice.

Measure: Each person attending LifeSteps will be linked, ongoing, to at least 1 inclusive activity and/or volunteer opportunity that enhances skills, relationships and sense of self within the framework of his/her community (of choice).

Status: The outcome was met for each person attending Life Steps. LifeSteps has restructured transportation hours and activity focus to enhance opportunities and expand participation in community life. Volunteer and citizenship focused activities have increased and include

response to flood victims, contributions of garden produce and baked goods to area food shelves and organizations, hands-on support to families at holidays, annual clean-up efforts at Kehoe Conservation Camp, putting on a spaghetti dinner for the community, and volunteering at nursing homes.

LifeSteps, in conjunction with CAP Community Campus, has also facilitated many day trips to locations throughout the state (e.g., VINS in Quechee, ECHO in Burlington, Billings in Woodstock, Emerald Lake in Bennington county, the Morgan Horse Farm, and the Statehouse, to name a few) to expand individuals' experiences and understanding of our broader community.

An overnight camping trip, swimming, kayaking, paddle boating, and curling have been offered.

A successful partnership has been formed with College Steps and Castleton State College. Four individuals are currently completing their two-year college experience and have become integral members of their college community. One person is manager of the cheerleading team, another writes for the college paper, and another presents a 'heavy metal' show on the college radio station.

Goal 3: CAP will help stabilize and grow the capacity of Shared Living Providers.

Measure: A baseline measuring the Shared Living Providers' satisfaction with the level of support provided through CAP will be determined. The satisfaction level will be raised by 10 points within the 3 year timeframe. (Satisfaction surveys were dropped as a measure based on feedback that people were feeling "over-surveyed".) CAP will also demonstrate the capacity to meet the demand of individuals needing or wanting the support through the Shared Living model.

Status: Coordinated efforts to develop respite options have been made by initiating recruitment efforts and by compiling a respite resources book available to Shared Living providers. An informational newsletter for Shared Living Providers is sent out regularly with enthusiastic and positive feedback from providers providing a formal vehicle for providers to identify resources, get ideas from others, and stay connected with each other. Annual recognition luncheons have been held to recognize and value the longevity of our Shared Living providers. Key trainings on Autism, communication, and therapeutic interventions have been offered to Shared Living providers. 'Town Forums' were held to obtain critical feedback from our Shared Living providers.

Home situations have been developed to meet the needs of both medically and behaviorally complex individuals. In the past year CAP made 27 placements for 25 individuals. Of those, 13

were individuals new to CAP services. There are currently 33 potential providers available to provide a shared living home who are awaiting a placement match; 14 of those are newly recruited providers this past year. As of January 1st, only one individual, currently served and with complex behavioral challenges, was awaiting a new home.

Goal 4: CAP will help increase the numbers of and quality of respite providers.

Measure: A baseline measuring the Shared Living Provider's satisfaction with the level of assistance they receive through CAP in supporting their efforts to obtain and maintain well qualified and trained respite providers will be determined. The baseline will be raised by 10 points over the 3 year time frame. (Satisfaction surveys were dropped as a measure based on feedback that people were feeling "over-surveyed".)

Status: Multiple efforts have been made to improve respite resources. We have implemented intensive recruitment strategies, created a respite resource book available for our Shared Living providers and families, and include detailed information – both 'respite wanted' and 'available to provide respite' – in the newsletter. The respite book is monitored and edited regularly so information in it remains accurate. Flyers have been placed throughout local communities alerting people of the opportunity to be employed as a respite provider or shared living provider. A Hot-line is in place connecting people with CAP should a respite need arise. CAP has collaborated with Rutland Family Support Network to identify a wide range of potential respite resource streams and get this information out by list serve. CAP has requested Rewarding Work to provide updated print materials for distribution and informational sessions to publicize the employment opportunity to communities. 92% of responders to the Local System of Care Plan survey indicated they are satisfied or very satisfied with respite supports for Shared Living providers.

Goal 5: CAP will expand transportation options for individuals that will support the overall involvement of individuals in community life through work, recreation and connections to family and friends.

Measure: There will be at least 1 new option for transportation (public and/or private) that will allow for greater community access for individuals with disabilities in Rutland County.

Results: A transportation re-structure was implemented in LifeSteps, thereby saving on transportation time and cost and effectively increasing time in community activities and events for individuals attending LifeSteps. Collaborative work around transportation with Rutland ARC continues. CAP's Community Services team and the Apartment Team have facilitated significantly increased utilization of Public Transit – The Bus and utilize the system regularly

when supporting individuals to access community. Individuals have been provided education and training on the use of The Bus system and been assisted to obtain vouchers.

Goal 6: CAP will develop specialized children's supports to enhance growth opportunities for children on the autism spectrum.

Measure: Given the availability of adequate funding, at least 1 new on-going after school program will be developed and implemented that enhances growth and social development for children on the autism spectrum.

Status: Funding was not available to develop an on-going, after school program. The workgroup focused on offering after school activities that CAP could afford to fund. Two open houses were held for families and surveys were sent to families to expand and clarify feedback. Annual inclusive holiday activities have been held for children. An inclusive Movement and Music event was highly successful and plans are to repeat this opportunity. Six week Relationship Development Intervention (RDI) training was offered to families with scholarships available. Additional intensive and individualized training in RDI was partially subsidized for several families interested in continuing the program. Autism training has also been made available to families.

Goal 7: Each Individual and his/her circle of support will express a greater level of autonomy and satisfaction with the Individual Support Agreement (ISA).

Measure: A baseline measuring the satisfaction level that individuals express in regard to their ISA process will be determined and raised by 10 points over the 3 year time frame.

Status: All Service Coordinators and key leadership staff received training on PATH and MAPS person centered planning. Practice sessions and refresher training have been provided to teams. The Peer Mentor offers classes each semester to individuals supported by CAP around the process, purpose, and possibilities of their ISAs, as well as around self-advocacy. Currently, 99% of individuals report feeling in charge of their ISA.

Goal 8: CAP will demonstrate effective and consistent communication to its internal and external customers.

Measure: A baseline measuring internal and external customer satisfaction with communication they experience through CAP will be determined and increased by 10 points over the 3 year time frame.

Status: Input was sought from internal and external customers to identify expectations and strategies for improved communication. Strategies to assure guardians and families are

consistently informed were implemented. Communication with shared living providers was enhanced through the informational Shared Living Provider newsletter. A 2012 stakeholder survey assessing progress on our Local System of Care Plan found that 80% of responders indicated communication was improved or much improved. Internally, Team Communication training occurs for all CAP staff. Team meetings and planning occur regularly to improve communication, outcomes and accountability. The agency has adopted a new vision statement, “thriving community, empowered lives”, which more clearly and succinctly defines our purpose.

Expanded public awareness, education, and outreach have been another focus. Articles on CAP events in the local newspaper have increased. Half-hour programs highlighting CAP services and events have occurred on PEG-TV multiple times. Featured articles about CAP individuals, services and supports have been published in the agency newsletter, Annual Report, and semi-annual community newsletter, as well as being featured on the agency website. Presentations have been made to several community groups (e.g., Rotary) to expand the community’s understanding of CAP services. Special focus has been given to Disability Awareness month in March including community education events, a showing of Wretches and Jabberers at the Paramount Theater, accessible exploration of area offerings, and upcoming community education in collaboration with the Rutland Free Library.

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, home providers, contracted workers, clinicians, the Local Standing Committee, and other community stakeholders. The following methods were used to solicit feedback:

- **CAP Local System of Care Plan (LSOCP) Survey:**

A total of 986 surveys were sent to individuals, family members, guardians, shared living providers, staff, contracted workers, the Local Standing Committee, and community partners including physicians, clinicians, advocacy groups, and other local service providers. 184 surveys were returned for a response rate of 19%. The survey assessed the level of satisfaction with services by service category, the value/importance of core services, and 4 open ended questions based on the suggested questions in the LSOCP instructions:

- What CAP services and supports are working well?
- Are there things that get in the way of getting good services? If yes, please explain.
- What new services or initiatives would you like CAP to develop?
- What should CAP's primary goals be for the next 3 years?

- **Targeted Interviews:**

Members of the CAP Leadership Team met with key community partners to gather input for the Local Plan:

- Self-advocates Becoming Empowered (18 members)
- ARC (Advocacy, Resources, and Community for citizens with developmental disabilities and their families) Board (8 members)
- Adult Local Interagency Team (LIT) (14 members)
- Children's Local Interagency Team (LIT) (9 members)
- Children's Integrated Services (CIS) Administrative Team (12 members)

- **RMHS/CAP input:**

Focused meetings were held with a number of teams to solicit their input. Surveys were also emailed to selected RMHS, Behavioral Health, and Behavioral Health Child and Family Services staff who frequently partner with us.

- **Specialized Services Agency input:**

As a Specialized Services Agency that operates within Rutland County, the Executive Director of Specialized Community Care (SCC) was contacted and invited to provide input for the Local Plan. An offer was extended to meet with the SCC Board, but it was declined. The Executive Director agreed to seek input and to share the survey with his Board and the individuals SCC supports, staff, providers, and other stakeholders.

In addition to the more formal process of gathering information for the Local System of Care Plan described above, CAP also relied upon other valuable 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.

- **State Consumer Satisfaction Survey**

The survey results were reviewed and incorporated into the Local Plan.

- **Quality Services Review:**

Feedback, related data, as well as comprehensive interviews related to the Developmental Services Division's Quality Services Review completed in 2012 was analyzed and incorporated into the Local System of Care Plan.

- **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:**

Extensive outcome data related to key outcomes and indicators was reviewed for the previous three years, 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.

- **DDS Legislative Work Group Report:**

The findings and recommendations of the Legislative report were also considered while developing the Local Plan.

2. Priority Needs

Priority needs were identified, assessed, and analyzed based on the information gathered. The high percentage of satisfaction with our services (87%-96%) noted in the Current Status section of this plan indicates that the current needs of the individuals we serve are being well met within available resources. We strive to provide individualized,

high quality services to each person we serve. To assure the needs of the individuals we support continue to be met, current funding and resources must be sustained and not subjected to further reductions. A consistent message we 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 will continue to evaluate and re-shape support models to respond to the needs of individuals, promote greater independence, and maximize the use of resources.

A number of areas were prioritized through the planning process that we will focus on in the upcoming three years to better meet current and anticipated needs of individuals and families we serve. A variety of stakeholders identified the need for alternative housing supports, expanded employment options, and support for families to recruit and train respite and Children's Personal Care workers. Another theme that emerged is the importance of services promoting independence. We had multiple requests from individuals and self-advocates for more social activities with their friends and peers. The need for better communication from the state and clarity on children's services, in particular changes in Children's Personal Care Services and "transition funds", was requested by a number of families and community partners. Through targeted interviews and surveys we identified the need for better community awareness of CAP and understanding who we support and what we do.

1. *Employment: while we have a high level of satisfaction with our current employment services, needs are currently under-met. The need is to increase the number of individuals employed and expand employment options for the individuals we serve.*

Strategies:

- Expand models of employment
 - Participate in DS Taskforce employment workgroup and volunteer to pilot the initiative
 - Explore micro business strategies
 - Explore job carve out and job share options
- Increase network of employer partners
- Utilize the "think tank" strategy to increase employment options and the number of individuals employed

2. *Unify children’s and family services to meet current and anticipated needs. We have been collaborating with Behavioral Health Child and Family Services to develop a process to most effectively utilize the “Non-categorical” funding. We are intentionally building a framework that will also support the broader, more inclusive Integrated Family Services initiative.*

Strategies:

- Develop a unified intake process for children
 - Develop an autism team in collaboration with Behavioral Health Child and Family Services, the RMHS psychiatrist specializing in ASD, Maple Leaf Clinic, and family members
 - Support/assist families to recruit and train respite and Children’s Personal Care workers in collaboration with the Field Services Director and community partners
 - Implement the Integrated Family Services (IFS) model in the Rutland region.
3. *Expand housing options to more responsively meet current and anticipated needs of individuals and promote independent and interdependent living. Needs are currently under-met. This initiative will require resources and collaboration with community partners and DDSD.*

Strategies:

- Build partnerships to develop affordable and accessible housing
- Pilot a new supported living model that promotes independence and interdependence. Meeting this need is dependent on the availability of resources including affordable housing and funding for individual supports.
 - Design and implement an alternative supportive apartment model
 - Participate in DS Task Force workgroup for supervised living
 - Explore development of transitional supportive living initiative for young adults with ASD in collaboration with a community partner

4. *Promote/improve community awareness, understanding, and partnerships with CAP. This is an under-met need. It is anticipated that new resources will not be required.*

Strategies:

- Develop marketing and outreach strategies to increase public awareness and support.
 - Develop communication plan to publicize information and community education about CAP.
 - Enhance CAP's presence in the community and reputation through collaborative efforts, enhanced community partnerships, and co-sponsoring community events.
5. *Advocacy to sustain the developmental disabilities services system and to incorporate developmental services values and sustained funding in system and health care reforms. These needs are unmet.*

Strategies:

- Additional resources, collaboration with stakeholders, and enhanced partnerships with the State will be required to achieve these outcomes.
 - Regionally, we will support individuals, families, and stakeholders to be effective advocates
6. *Advocacy for services and resources for individuals who "fall between the cracks" (i.e., who do not meet eligibility criteria for services or do not meet funding priorities for services). These unmet needs will require additional resources*
7. *Areas identified for CAP internal quality improvement:*
- *More focus on promoting independent living skills*
 - *Continue to improve internal team communication*
 - *Improve technology, including the Electronic Medical Record (EMR), to improve efficiency and decrease paperwork*

3. 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
- Volunteer to be a pilot agency for the initiative
- Expand micro business enterprises
- Explore job carve out and job share options
- Utilize the “think tank” strategy to creatively brainstorm employment options for individuals, in particular for individuals who currently have staffed community supports.

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.
- The models of employment available to individuals will be expanded by at least one per year.
- Our network of employer partners will be increased by six a year.

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.

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

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.

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. Planning for this initiative is underway.
- 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.

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

How we are going to do it:

- With guidance and collaboration with the State, the Integrated 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.

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
- 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.
 - 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.
 - Through participation in the DS Workgroup for supervised living, investigate the viability of implementing the initiative designed by the group in Rutland.

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.

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.
- Develop a communication plan to publicize information and community education about CAP.
- Enhance CAP's presence in the community and reputation through collaborative efforts, enhanced community partnerships, and co-sponsoring community events.
- Additional strategies will be developed with key stakeholder input, including our Local Standing Committee.

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.

4. System Outcomes

Through stakeholder survey feedback and ongoing conversations the following priority needs were identified as System Outcomes. Concerted effort, partnership and support will be required to successfully address these key issues.

1. *Sustainability of Vermont's developmental disabilities services system*

We repeatedly heard from our stakeholders that our system's values need to be sustained. While recognizing the need to maximize resources, funding must be allocated rather than reduced to responsively and responsibly meet the needs of individuals and families we currently serve and those we will serve in the future. Competitive compensation to attract and retain a qualified and skilled workforce is a critical component of system sustainability.

2. *Inclusion of developmental disabilities values in system and health care reforms (e.g., Accountable Care Organizations)*

Concern was expressed about the potential effect of a medical model being imposed on developmental disabilities services by the impending system and health care reforms.

3. *Integrated Children's and Family Services*

The need for greater clarity and guidance from the State about Integrated family Services (IFS), the future of developmental services for children, changes in Children's Personal Care Services and "transition funds" was requested by families, community partners, and children's services providers.

4. *Advocacy for services and resources for children and adults who do not meet current eligibility criteria and/or funding priorities for services*

Concern and frustration continues to be expressed about the lack of resources available for children and adults who "fall between the cracks" but would benefit from services.