

HEALTH CARE & REHABILITATION SERVICES (HCRS)  
VERMONT DEVELOPMENTAL DISABILITIES SERVICES  
LOCAL SYSTEM OF CARE PLAN

Three-Year Plan FY 15 – FY 17

The development of this Local System of Care Plan, for Fiscal Year 2015 through Fiscal Year 2017, is a combined effort between Health Care and Rehabilitation Services (HCRS), Lincoln Street, Families First, our clients and self advocates, and stakeholders from the community. The purpose of this plan is to review our progress from the previous Local System of Care Plan for Fiscal Year 2012 through Fiscal Year 2014 and to identify the key service priorities in which we will focus our efforts over the next three years.

HCRS’ Developmental Services division provides comprehensive developmental supports for individuals throughout Windsor and Windham counties. This division serves 233 home and community based waived clients; of those 233 clients, 18 are from the Brick by Brick Program, five are served through our Community Placement Program, 54 are targeted case management clients, 61 are Bridge clients and, for the first two quarters of Fiscal Year 2014, we have served 27 clients through the Transition Grant.

**CURRENT STATUS**

*1. Briefly identify service and support needs, by service category (e.g. home supports, work supports, crisis services), that are currently being met in your region.*

HCRS provides a wide array of supports designed to meet the needs of our clients. A summary of supports and the number of individuals receiving those supports is outlined below.

Support Type	Number of Clients Served
Service Planning and Coordination	233
Employment Supports	99
Community Supports	165
Respite Supports -	
• Hourly	39
• Daily	164
Clinical Supports	144
Individual Crisis Supports	16
Housing and Home Supports -	
• Hourly	35
• Staffed Living	5
Shared Living Providers	120

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2. *Update the status of each specific outcome identified in your previous FY 12 – FY 14 Local System of Care Plan.*

Reduce the amount of staff turnover

a) *What did you do?*

In an effort to reduce the amount of staff turnover, during the last three years we have focused on fine-tuning our interview process and carefully selecting staff with appropriate credentials who are the right “fit” for our division. Once hired, employees participate in a New Employee Training Week which introduces them to our Management team, our five DS offices, and an overview of the Developmental Services division and our regulations. Continued training, ongoing supervision (once monthly at minimum), and regular communication between supervisors and staff ensure all staff feel they are supported, their voices are heard, and that each of them plays an important role in the Developmental Services division.

We have just completed a staff engagement survey to identify training needs as well as a communication plan to ensure we effectively and consistently communicate relevant information to staff. We also held our second Leadership conference in 2013 for supervisors and managers to promote best practices across the Agency. We anticipate this will help us retain outstanding staff moving forward.

b) *How well did you do it?*

In Fiscal Year 2011, we had a total of 83 staff in the Developmental Services program. Throughout FY11, 14 of those staff left the Developmental Services program (10 voluntarily, 4 involuntarily). This calculates to a staff turnover rate of 16%. In Fiscal Year 2013, we had a total of 90 staff in the Developmental Services program. Throughout FY13, 15 of those staff left the Developmental Services program (12 voluntarily, 3 involuntarily) for a staff turnover rate of 17%.

c) *What difference did it make?*

Our staff turnover rate was similar in both 2011 (16%) and 2013 (17%). We will continue to focus on training, ongoing supervision, and regular communication to ensure that our percentages remain the same, or ideally, decrease. Decreasing the amount of staff turnover will make a difference for our staff and clients, because it will allow us to have the solid foundation of trained and experienced staff we need to continue to provide quality services to our clients.

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We are developing a comprehensive exit interview process to be reviewed periodically. HCRS specifically will not continue to include this as a goal in this System of Care Plan. HCRS Human Resources will be responsible for retention and recruiting agency wide.

Increase the level of peer support functions

*a) What did you do?*

Peer Support groups are active throughout Windsor and Windham counties. The focus of the peer support groups is driven by our Self Advocacy and Local Standing Committees. Peer Support groups provide opportunities for clients to work on skill building as well as socialization with their peers. Examples of social activities include: arts and crafts, gardening, and dances. Skill building activities include topics such as hygiene, nutrition, cooking, and other daily living skills. In the Peer Support groups, offered both weekly and monthly, our current attendance averages 50 clients participating throughout Developmental Services. Case Managers and direct care staff collaborate with clients to lead these groups.

Our Local Standing Committees and Self Advocacy groups have been created and are offered to clients in Windsor and Windham counties to give clients an outlet to voice their opinions and speak for themselves. The consensus of these committees confirms a desire for an increase in peer functions by our clients. Participation in Self Advocacy groups has increased by approximately 50%, since 2012, with a total of thirty (30) clients currently participating.

HCRS Self Advocates are very active both locally and on the state level with Green Mountain Self Advocates. Every year, several HCRS Self Advocates attend the National Self Advocacy conference. In 2013, HCRS sent ten Self Advocates to the National Self Advocacy conference in Minnesota.

HCRS has one centralized Local Standing Committee led by 20 clients. The Local Standing Committee is an integral part of our Agency. Local Standing Committee members review incident reports, grievances, and policies and procedures to ensure client needs and interests are represented. The DS Local Standing Committee organizes events such as Disability Awareness Day at the State House each year where they recently coordinated a group of 30 to participate.

*b) How well did you do it?*

We have increased the number of peer support functions available to include activities such as movie and bowling nights, cooking class, and the annual Thanksgiving dinner with over 120 people in attendance in 2013. Though we have increased the number of peer support functions available, one obstacle that continues to effect participation levels is transportation. Some clients, who receive community supports, are able to attend these events when their Community Outreach Specialist transports them to the events. In some cases, Shared Living

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Providers have transported clients to these peer support functions. In an effort to continue to increase the number of peer support functions as well as attendance, staff will need to continue to brainstorm and think of creative ways to ensure clients who wish to attend, are able to attend. Although we've made a significant amount of progress in increasing the number of peer support functions, feedback from our clients clearly indicates a need for a continued increase in the number of these events.

*c) What difference did it make?*

Clients consistently report that they have a strong interest in peer activities, such as spending time with their friends, meeting new people, and building relationships with their peers. With the increase in peer functions, it has made a difference in client's lives because it has allowed them to interact with their peers, voice their opinions, and speak for themselves.

Increase the number/types of residential programming/placement options

*a) What did you do?*

The traditional Shared Living Provider model remains the most popular and successful option for our clients. We created a Community Placement Program to provide safe, highly interactive housing options for clients who have not been successful in traditional models. This model currently provides specialized support for six clients. This program has created a safe and stable housing environment for clients with the most extremely dangerous behavioral challenges who would otherwise require significant inpatient level care. We also have an apartment program that provides housing for up to three clients. These individuals live together as roommates, sharing expenses and providing supports for one another while receiving basic supports from HCRS staff. We have collaborated with other departments within HCRS to offer creative housing options based on the DS model.

*b) How well did you do it?*

HCRS is committed to meeting the unique housing needs of our clients. We are currently offering more housing options than ever before with several new initiatives in development. Clients in need of housing are given choices with long-term placements occurring in a timely manner. In the 2013 State Consumer Survey, 91% of clients report being satisfied with their housing. Individuals surveyed primarily live in traditional Shared Living Provider models. Housing needs continue to be under met for those clients who have not been successful in traditional Shared Living Provider model homes.

*c) What difference did it make?*

Most clients are living in stable, long term homes. Shared Living Providers and staff are well trained and supported. We have increased our capacity to effectively respond to emergency

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housing needs. Our newly developed Community Placement Program has decreased the numbers of inpatient hospital admissions and Emergency Room visits by our clients. The six clients who have been served by our Community Placement Program represented a significant inpatient bed usage prior to entering this program. For example, one client spent 270 consecutive days at the Brattleboro Retreat. He was released to the Community Placement Program in January 2013. Since entering our program, he has spent only 2 nights at the Retreat. Another client was incarcerated for approximately 11 months prior to entering the Community Placement Program. After over a year in our program, has only been hospitalized once for 5 nights. For all of the clients, Critical Incidents and violent episodes have consistently decreased.

There is still a great deal of work to be done. The complexity of needs for new clients continues to increase. The demand for unique, specialized, non-traditional developmental housing is higher than ever before. We need to continue to develop new housing models to meet the needs of clients entering services, especially those who are high risk. This goal will be carried over in the new System of Care Plan.

Increase the number of gainful employment opportunities

a) *What did you do?*

Over the last three years, Employment Services has used strength based Employment teams to maximize the strengths of each staff person to serve each client with the best practices available. Employment teams participate in team meetings to discover the wants, needs, and desires of clients interested in pursuing employment opportunities. Job development was increased by reaching out to employers to receive tours of their businesses and then carving out part-time positions. Employment staff met with the Creative Workforce Solutions (CWS) Business Account Manager every two weeks to collaborate on possible job leads and share job development opportunities.

Natural support on the job by co-workers was increased by educating co-workers and supervisors on the needs of the clients we serve. Clients and employers received follow up on a regular basis to retrain clients at the request of the employer and in an effort to ensure clients maintain their current employment status.

The Work Opportunity Job Trial, offered through Vocational Rehabilitation, was used to help locate the perfect job matches for clients interested in finding employment. Monthly and quarterly meetings with Vocational Rehabilitation counselors allowed Employment staff and the Vocational Rehabilitation counselors to work as a team with the best interests of the clients we both serve in mind.

Employment staff were involved with each June graduate's transition process. This includes collaboration with the graduate's high school and the Developmental Services Intake

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Coordinator to develop a Needs Assessment that speaks to the client's employment needs after graduation.

To show our support for employers, we hosted a successful Employer Appreciation Day to recognize employers for their support over the years in working with individuals with developmental disabilities.

*b) How well did you do it?*

The Developmental Services Employment program exceeded all expectations for rehabilitation and grossed earned income requirements set forth by the State of Vermont for Fiscal Year 13. We have decreased the number of waived employment hours by providing, as needed, initial 1:1 on the job supports and client training. Natural support, on the job, has increased to support client's needs at their place of employment.

We increased the number of rehabilitations from 48 in FY12 to 57 in FY13. This represents an increase of almost 20%. Management of the Developmental Services Employment program has been centralized resulting in increased collaboration and more opportunities for our clients.

*c) What difference did it make?*

We maximized communication with Vocational Rehabilitation, local High Schools, and employers to locate gainful employment for the clients we serve. As a result, our relationships with these community partners improved and new employer contacts have increased. Clients were satisfied with the process to locate gainful employment. Employment teams were able to share this information with Vocational Rehabilitation on a monthly basis to ensure effective communication between Employment services and Vocational Rehabilitation.

Attending team meetings has allowed Employment staff to get to know the client, not only for their employment needs, but as a whole person. By getting to know the whole person, Employment staff are better equipped to support the clients with their needs on the job and to create real life goals to promote independence and successful employment placements.

Reduce the level of individual/public risk and exposure

*a) What did you do?*

In an effort to reduce the level of individual/public risk and exposure, we have provided ongoing Agency and statewide collaboration to learn and implement updated therapy techniques to teach clients ways to reduce public risk. We have trained and offered peer discussion with Shared Living Providers regarding offending issues and behaviors within the home and community. In addition, we have provided intensive behavioral assessments and

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training regarding at risk behaviors and increased team communications and training in order to support and increase safety and independence.

*b) How well did you do it?*

In the past three years, we had zero recidivism for sexual public safety risks. Over the past year, we've gathered information from our new Community Placement Program. We will continue to track the progress made by participants in this program. We will compare the data collected in the last year with future data to measure the reduction in the level of individual/public risk and exposure.

*c) What difference did it make?*

Our efforts have allowed clients to pursue education and therapy that has increased their individual level of independence and least restrictive living. It has allowed clients to obtain reasonable employment within the community and has allowed clients to experience freedom of choice and acknowledgments from the community and within their environment.

Identify "best practice" trainings that are unique to every level of position within DS

*a) What did you do?*

In accordance with the regulations, we have created a list of "best practice" required trainings for staff and Shared Living Providers to attend. Many of these best practice required trainings are appropriate for all Developmental Services staff from our direct care staff (Community Outreach Specialists, Employment Specialists, and Residential Specialists) to our Management Team. These trainings include such topics as CPR/First Aid, Medication Delegation/Education, and Therapeutic Options.

In addition, we have developed a New Employee Training Week that encompasses information outlined in the regulations for "pre-service" training. The New Employee Training Week is attended each month by new hires. The New Employee Training Week is facilitated by staff at each of our five HCRS offices. This allows new hires to meet a variety of staff and familiarize themselves with each office. There is a similar "pre-service" training opportunity for our Shared Living Providers, also offered once a month. The Shared Living Provider pre-service training is facilitated by Program Development.

We have also developed an "in-service" training that encompasses information outlined in the regulations under "in-service" training. The in-service training is facilitated by individual supervisors. It is the supervisor's responsibility to ensure each new hire completes the in-service training. There is also an in-service training opportunity for our Shared Living Providers, offered twice a year, which includes material related to nursing, clinical, and Shared Living topics.

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*b) How well did you do it?*

To track our compliance with training requirements, we created a spreadsheet which tracks best practice required trainings for staff and Shared Living Providers. This spreadsheet has been made available for DS staff to view on a shared network drive. The spreadsheet includes the most recent date an individual has attended each training in an effort to ensure staff and providers remain up to date and in compliance with their training requirements. The spreadsheet also includes columns for additional trainings offered to staff on site as well as external trainings staff may elect to attend.

The Quality Assurance Coordinator is responsible for collecting training documentation and updating the training tracking spreadsheet. In addition, we have assigned one point person to be responsible for collecting information about, gaining approval, and registering individuals for external trainings that are appropriate for their professional development. This has allowed us to streamline the process and ensure that staff are not only receiving best practice required trainings, but also trainings related to their positions and topics of interest that will be beneficial to them in their role at HCRS.

*c) What difference did it make?*

Over the last year, we have spent a considerable amount of time reviewing the training tracking spreadsheet to ensure appropriate trainings are offered to staff and Shared Living Providers. We have significantly increased the number of staff who have attended best practice required trainings, and now have an effective method to keep this training documentation as proof of staff and Shared Living Provider attendance at these trainings. We also now have internal staff certified to provide high quality trainings in such topics as CPR, First Aid, and Water Safety, to name a few.

Documentation for all of the trainings discussed above (and the other trainings outlined on the training tracking spreadsheet) are submitted to our Quality Assurance Coordinator who maintains the training spreadsheet. Documentation includes sign in sheets, training documentation forms which give staff an opportunity to discuss what they have learned at each training they attend, and training evaluations forms which allow the training facilitators, the Quality Assurance Coordinator, the DS Director, and the rest of the Management team to review how training facilitators are being received by training attendees.

Continue to broaden the number of experts/practitioners with DS specific experience

*a) What did you do?*

In 2012, we hired two Behavior Specialists - one full-time position to provide behavioral services and supports for DS adults and a part-time position to work with DS and Outpatient Children's services. Also in 2012, we hired a Behavior Analyst to work full-time with the Community Placement Program's high needs clients. We transferred supervision of the B3

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Clinician to the Adult Mental Health and Addiction Services division as a means of providing peer support.

*b) How well did you do it?*

The Behavior Specialist working with DS adults has successfully served over 25 clients and continues to provide behavioral training and support to treatment teams as needed. The Behavior Specialist working with both DS and Outpatient Children's services has successfully served over 41 clients and continues to provide behavioral training and support to treatment teams as needed. The Behavior Analyst working with the Community Placement Program has designed and implemented intensive behavioral programming in structured residential settings enabling several clients with extreme behavioral challenges and high recidivism rates to succeed in the community.

*c) What difference did it make?*

The addition of these staff and the implementation of the behavioral services they provide, have improved the quality of life for numerous clients and their care providers. Moreover, these behavioral staff have provided a significant amount of training to DS staff and Shared Living Providers that has raised their skill levels and improved the overall quality of care for DS clients.

Develop a workgroup to continually monitor/maintain current eligibility requirements/priorities

*a) What did you do?*

We have developed three new groups, specifically for HCRS clients, that meet monthly: Intake Team Meeting, Funding Utilization Review (Funding UR), and Initial New Funding Group (INFG). Similar processes take place at Families First and Lincoln Street. We provide evaluation services as needed for Lincoln Street clients and funding reviews. Funding reviews take place during our Local Funding Committee meetings where representatives from Lincoln Street, Families First, and other stakeholders attend to review all proposals.

**Intake Team Meeting:** Meets monthly to discuss the status of all new clients who have come through the intake process. The team also discusses potential funding priorities available to these individuals along with requested supports. A six month review is presented at these monthly meetings to follow up on clients who have come through intake six months prior to ensure services are secured.

**Funding Utilization Review (Funding UR):** This group consists of representatives from our Funding, Program Development, Clinical, Employment, Intake, and Nursing departments. Area Managers also attend for client oversight. The Funding UR meeting was designed to review cases that are either preparing to present at Local or who have already been presented at Equity, to determine if they meet a funding priority and develop an appropriate budget

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based on the content in the Needs Assessment. This allows the Intake and Funding teams to review eligibility and funding priorities with a larger group, as well as increase the possibility of additional supports that may be available to an individual.

**Initial New Funding Group (INFG):** Reviews Local and Equity decisions and develops a plan for implementation of new monies. All information from both Funding UR and the Initial New Funding Group is captured in spreadsheet format for tracking purposes.

*b) How well did you do it?*

These three monthly meetings have created many opportunities for any potential or approved funding proposals to be reviewed and for teams to begin the necessary coordination of services. This process has worked well to maintain a collaborative effort for providing services and supports. This multidisciplinary group ensures that each aspect of the client's needs are being addressed and is the first step toward developing a strong funding proposal for the Local Funding Committee.

*c) What difference did it make?*

This Funding UR and Initial New Funding Group structure and tracking method provides DS with the ability to have more controlled and concise conversations about the funding needs of our new and existing clients. They have helped to streamline the development of funding proposals and ensure that each core team member has input with regards to the funding proposal to the Local Funding Committee. Our collaborations internally and with external service partners have improved, giving our clients a greater array of service options and opportunities. Making it our goal to provide as many services as possible, regardless of budget restrictions, has generated a lot of creativity in our staff and opened up opportunities for our clients.

Consistent review of how Medicaid monies within waivers are being utilized, or not

*a) What did you do?*

On a monthly basis, a representative from Funding meets 1:1 with each Area Manager and reviews the most recent Medicaid Waiver spreadsheet. A review of each client is captured on another spreadsheet and identifies tasks to be completed, notes changes needed, and notes the completion of such tasks.

*b) How well did you do it?*

This monthly meeting time has been greatly appreciated by both parties. Collaboratively we discuss current events with regards to each client and their funded areas and are able to troubleshoot, make changes as appropriate, and ensure quality services for our individuals.

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c) *What difference did it make?*

Holding ongoing meetings and developing spreadsheet tracking mechanisms has helped to ensure that Medicaid monies are being utilized accurately and appropriately.

**PLAN DEVELOPMENT**

*1. Planning Process. Please solicit information from your region to inform the planning process for the next three years. Briefly identify the sources of information and how you obtained input (e.g. meetings, surveys, public forums, interviews).*

In our planning for the development of the HCRS Fiscal Year 2015 – Fiscal Year 2017 Local System of Care Plan, we sought input from a wide range of stakeholders. We began by analyzing our two most recent client surveys. HCRS conducts an annual agency-wide Client Satisfaction Survey. In the 2012 survey, several service areas were identified as priorities for our clients: Employment, Housing, and Client Choice all featured prominently. We also analyzed the results of the Client Survey Project's 2013 State Survey of Adults Receiving Developmental Services. Similar priorities emerged.

The framework for our operating principles and division goals was developed during an HCRS Developmental Services Retreat. The retreat was led by Human Services consultant, Max Chmura. A cross section of 22 DS staff members assembled to identify the most important goals for our division. Utilizing the 2012 HCRS Client Satisfaction Survey results as a starting point, we identified service priorities including a focus on improving Service Coordination, increased Housing Options for clients, more Employment Opportunities for clients, and the development of a wider variety of Client Activities. Members divided into teams and presented ideas for meeting these goals during break out sessions over the following months.

In early 2014, we held formal System of Care Plan client feedback sessions led by the HCRS Developmental Services Local Standing Committee. The Standing Committee opened up these meetings to all clients and families. The meetings were held in each HCRS Developmental Services office and were connected via video conferencing. Participants discussed the things that were working well and where they would like to see improvements. The most frequent and consistent area of improvement identified by our clients was client choice in activities including opportunities for peer activities. Over 40 clients participated.

We also held a series of Public Forums to elicit input from other programs, agencies, and interested parties. Meetings were held in Springfield, Brattleboro, and Hartford with approximately 58 people in attendance. Participants included representatives from Lincoln Street Inc. (SSA), Families First (SSA), Turning Point Recovery Center, Local Police Departments, Department for Children and Families, local Schools, The Family Place, DAIL Field Director, HCRS DS Supervisors, HCRS Adult Mental Health and Addictions Services team members, and several family members. We broke out into small groups for discussion. Priority areas identified

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focused on Housing, Employment, and Client Choice. This Local System of Care Plan is the culmination of all these efforts. Our plan reflects the priorities identified by a wide range of our stakeholders.

HCRS reached out to both Lincoln Street and Families First to discuss development of the System of Care Plan. Both held their own forums and provided input to HCRS prior to the development of the final plan. Additionally, we are able to collaborate with both SSAs through our mutual participation in the Local Interagency Team (LIT) and in monthly DS Director meetings. We will continue to meet regularly at the LIT and DS Director meetings, and also have discussed the need to regularly meet 1:1 to discuss in a more focused and intimate environment the mutual needs of all three agencies.

*2. Priority Needs. Identify priority needs and resources based on the information that was gathered. Resources may include financial, human resource, coordination and collaboration with other community and state entities, etc. Consider reduction as well as reallocation of resources.*

- a) Identify current and anticipated needs of people with developmental disabilities in the region over the course of the next three years.*
- b) Prioritize the identified needs.*
- c) Specify whether the needs are currently met, under-met, or unmet.*
- d) Identify existing and new resources and strategies necessary to maintain currently met needs and to meet anticipated under-met or unmet needs.*
- e) Consider strategies and resources from both a program and system perspective.*

The letters in parentheses throughout this narrative refer to the following:

(S) = Stakeholder

(C) = Client

(E) = Employee

Priority 1: Housing:

Limited housing options and availability continues to be a significant challenge for our Agency and our region and, therefore, remains a high priority. Subsidized housing is currently unavailable to almost all of our clients. When housing is available there is often a waiting period of up to two years. Through our participation in the Local Housing Task Force it is clear that availability of affordable housing is a region-wide epidemic.

The Shared Living Provider model continues to be the most popular and successful housing model for individuals with developmental disabilities. Housing and Home Support funding in Developmental Services waivers has gradually decreased over the past three years and has diminished our ability to recruit new providers.

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Our Community Placement Program provides individualized support for clients with a higher level of need. These clients have not been successful in traditional housing models. This program is vital in providing safe and sustainable housing. The capacity of this program needs to be increased to meet the increased demands of high risk clients.

We are launching a Children's Respite House initiative which will provide two to three nights of respite for numerous children receiving supports throughout the Agency. This will provide consistent, reliable respite for families throughout our service area.

Supported housing options for clients capable of a higher level of independence are an unmet need. Many of our clients do not require the level of supervision and support of a Shared Living home, but are not able to live alone in their own apartment without supports. Flexibility in the use of waiver dollars to support these individuals is needed to provide a transition to more independent and less restrictive housing. Affordable and sustainable housing is an unmet need for many of our clients. We are working to develop a supported apartment program that will allow qualified clients to live independently with in-home supports. A supervised apartment program will provide a housing option for clients with a higher level of independence who are in need of regular check-ins and oversight. This model will provide a bridge towards fully independent living for up to four clients.

Specific feedback from our stakeholders includes:

- Increase section 8 vouchers, affordable housing, and grant funds. (E)
- Need more housing options. (S)
- Increase natural supports. (E)
- "Allow us to live more independently and with our friends." (C)

Priority 2: Choice:

After reviewing the HCRS 2012 Client Satisfaction Survey, and the 2013 State Survey, it is clear that client choice across all service areas is a priority. Clients communicated that they did not have a choice in selecting their Guardian, Service Coordinator, or their Direct Support Staff. Allowing our clients to have a voice and a choice is critical to the success of our support system. Client health, safety, stability, and quality of life are all significantly diminished when our clients are not given a choice and when their voice is not heard. Client choice is an under-met need at this time.

We are working to create new opportunities for client directed supports such as Self Advocacy. Forums have been held to elicit feedback from clients. We have made changes to our Service Coordination strategies to offer a more direct and accessible connection between the client and Service Coordinator.

A concerted effort and commitment is needed to increase opportunities for choice across our entire service delivery system. Service Coordinators, Home Providers, Guardians, and

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Treatments Teams are responsible for ensuring that clients are given choices in their care, in their services, and in their lives.

Specific feedback from our stakeholders includes:

- SSA's are not being offered IFS funds for children. (S)
- "Choice of guardian/shared living provider/case manager and other supports." (C)
- "MORE CHOICE" (C)

Priority 3: Delivery of Community Supports:

Community Supports are critical for our clients' quality of life and stability. This is an area that has been significantly reduced or cut out of new budgets. Lack of funding in this area jeopardizes the stability of our Shared Living Provider homes and our ability to sustain providers, whose funding is also being reduced. Clients require socialization and a wide variety of community integration opportunities. Our clients thrive when they are given opportunities to work and learn together.

We need to offer a wider variety of supports focusing on skill building, community participation/access, and functional skills. Most of our region is very rural with limited community resources. Recreational and social opportunities are often limited to those that you can create yourself. Windham and Windsor counties are challenged economically with a struggling employment base.

The statewide effort to eliminate group based, direct care services created highly individualized community and employment support systems. Unfortunately, this effort also resulted in more restrictive peer relationships. Clients consistently provide feedback about their desires for more opportunities to be with their peers. They want to take classes, work on projects, attend skills groups, and socialize with one another. Leaving school creates an enormous social void for most of our clients. Offering community support options provides an opportunity for clients to collaborate, foster new relationships, and increase social skills. This is an under-met area of need.

We offer numerous community based programs for our clients. Recurring events include monthly Self Advocacy groups and Standing Committee meetings. A cooking class is offered weekly in Bellows Falls. One group of clients gets together monthly for bowling and a movie in Springfield. Local skills groups offer a variety of interactive educational programs throughout the year such as the gardening group in Bellows Falls. We have organized trips to the ocean for whale watching and for clients to visit the statehouse.

These are the kinds of activities that our clients want and that we need to increase. Feedback from Self Advocates, Standing Committee, and Peer Support groups clearly indicates a need for an increase in peer based supports.

Specific feedback from our stakeholders includes:

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- Expand community service options to have different models. (S)
- Delivery of community services, more flexibility on the time of day, or day of the week. (S)
- Quality community services. (S)
- “Buses don’t run on weekends” (C)
- “Would like to attend Dartmouth and High School games.” (C)
- “More opportunities to do things together.” (C)
- “Community Center apart from the HCRS office.” (C)
- “Longer and more community hours.” (C)
- “More outings.” (C)
- “More groups.”(C)

Priority 4: High Risk Individuals

The complexity of needs for new clients entering our service system is increasing. Clients on the Autism Spectrum make up the majority of new intakes. Clients with co-occurring disorders are becoming increasingly more common. We need to be able to respond to the needs of these challenging situations. A small number of high-risk clients can exhaust the resources of an entire department.

It is critical to have the financial and programmatic flexibility to create unique highly-individualized treatment plans with wrap-around supports. Our Community Placement Program provides structured treatment in a supervised housing environment for clients with the most challenging behavioral needs. This program has dramatically reduced the number of inpatient hospitalization days as well as reduced the impact on local Hospital Emergency Rooms. Without this program, many of these clients would be in the Brattleboro Retreat or another inpatient psychiatric setting. The clients in this program have historically been among the highest users of these hospitals. Continuation of this program along with the ability to increase capacity is essential in order to meet the needs of high risk individuals. This priority is currently under-met.

In addition to the Specialized Residential Program, existing resources to meet the needs of high-risk clients include our Brick by Brick Developmental Services sex offender treatment program, which serves 18 individuals in a variety of settings. The newly developed First Stop program for children provides a vital link to first time users of our services by connecting individuals and families with supports immediately concurrent with the evaluation and placement process. Our Agency’s Inter-Disciplinary Team meets monthly and is open to all teams to make referrals for new and existing clients. The Inter-Disciplinary Team is made up of representatives from each department to provide advice and assistance for clients with unmet needs. We need to evaluate our utilization of the current VCIN crisis bed.

Specific feedback from our stakeholders includes:

- Creating a DCF Residential Treatment (S)

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- Increasing the capacity of the Specialized Residential Program and Community Placement Program. (E)

Priority 5: Clinical Services

Our utilization and execution of clinical services needs to evolve to meet the needs of our developmental services clients. The effectiveness of long term psychotherapy has not proven to be effective for individuals with developmental disabilities. Additionally, the majority of therapists in the field are not experienced in working with DS clients, further reducing effectiveness.

One of the most effective uses of Clinical Services in DS is through the development and implementation of behavioral supports. We have created a Behavioral Supports Team focused on identifying the specific needs of each individual and working with the team to implement strategies.

Alternative therapies have proven to be very effective for clients with developmental disabilities. Clients benefit from alternative therapies such as Therapeutic Horseback Riding, Movement Therapy, Art Therapy, Aquatic Therapy, and other approaches that do not rely totally on verbal communication. We need the flexibility to be able to utilize clinical funds in employing these alternative strategies. We need increased incentives for providers to accept Medicaid. This priority is currently under-met.

We have a very strong behavioral team providing individualized treatment planning for clients and training for teams. The capacity of this team needs to be increased. Additionally, the availability and funding for alternative therapies is very limited.

Specific feedback from our stakeholders includes:

- “We would like to go to Water Therapy and Art Therapy.” (C)
- “Training from the Behavioral Team has been very valuable.” (S)

*3. Regional Outcomes. Based on the prioritized needs, identify the areas that are considered to be the most important for the region to focus on over the next three years. List the top outcomes/goals for your region that are realistic and achievable. Think about what issues are causing the most difficulties and what issues will make the most difference if focused on. For each outcome, identify:*

- a) What you hope to achieve. (What are you going to do?)*
- b) The strategies you will use for each goal. (How are you going to do it?)*
- c) How you know when each goal has been achieved. (What difference will it make and how will you measure it?)*

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Housing

*a) What you hope to achieve. (What are you going to do?)*

HCRS will continue to develop alternative housing models to meet the individualized needs of our clients. Clients will have a high level of satisfaction and choices with their housing.

*b) The strategies you will use for each goal. (How are you going to do it?)*

Currently, HCRS' Community Placement Program provides 24-hour staffing supports to meet the needs of our clients who have not been successful in our traditional housing models (SLP). We expect that this program will expand as our client population increases which will enable the current residences to increase capacity and sustainability.

HCRS will work towards developing a supervised apartment program which will promote independent living for those who have reached this point of success, yet still require regular check-ins and oversight. We will work to identify an apartment building which will house at least three clients and one apartment supervisor, who will be available to provide oversight and guidance to the residents of the apartments. If successful, this too will proliferate.

The Children's Respite House is underway and will provide two to three nights of respite for a child and their family. This initiative will be available to numerous children receiving supports throughout the Agency. This will provide consistent, reliable respite for families throughout our service area. We are collaborating with other departments within HCRS to offer creative housing options based on the Developmental Services model. We will identify homes for emergency and planned respite that can be utilized as hospital diversion.

HCRS is investigating the requirements for obtaining licensure to create a DCF Residential Treatment Program that will house children in state's custody who also require developmental services supports.

Finally, HCRS has developed a group of team members to attend meetings with our Local Housing Authorities on a Local Housing Task Force. Our intent is to provide advocacy for our clients who want to live independently in affordable housing within their communities. Our goal is to provide education to community partners about the DS population and our housing needs. We hope that this level of networking will evolve into new housing initiatives and opportunities.

*c) How you know when each goal has been achieved. (What difference will it make and how will you measure it?)*

This goal will be met when clients have a choice in where they live and when housing is available. This will be measured in the Client Satisfaction Survey with a target rating of 45% of clients saying that they had a say in where they live. The state average is 38%. A supported apartment program will be in place. Capacity will increase for the Community Placement

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Program beyond the current level of six individuals. We will have created a DCF Residential Treatment Program for boys ages 12-18. We will have an established children's respite home with the capacity to support two children per night.

Choice

*a) What you hope to achieve. (What are you going to do?)*

HCRS recognizes that clients and their families need to have more choices available to them when creating and implementing their services. We will develop systems and create a culture that promotes client choice throughout our service delivery system.

*b) The strategies you will use for each goal. (How are you going to do it?)*

HCRS will continue to meet with clients and advocates to discuss and develop ways to provide more choices to our clients and their families. We will also continue to meet quarterly with the Office of Public Guardian to advocate for our clients by addressing their need for more choices in guardianship. The most important venue that Developmental Services has to address the topic of choice is at the monthly Local Standing Committee meetings.

The conversation on choice has already begun based on the feedback from the Client Satisfaction Surveys. This will be an ongoing topic, and we will ensure that clients have choice within each decision we make as a division. We will implement processes across all our programs to ensure that our clients have choices in the services they receive to include: direct support staff, case management, guardianship, housing, and employment.

*c) How you know when each goal has been achieved. (What difference will it make and how will you measure it?)*

This goal will be met when clients are able to have choices and input in all aspects of their supports. The Local Standing Committee will lead and monitor progress. This will be measured by the Client Satisfaction Survey. Clients reporting having choices in their services will exceed the state average in all surveyed areas.

Delivery of Community Support

*a) What you hope to achieve. (What are you going to do?)*

HCRS recognizes that accessing the community is extremely important for the clients we serve. We will develop client directed community-based support programs that provide clients with opportunities for peer networking and education with a focus on client choice.

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*b) The strategies you will use for each goal. (How are you going to do it?)*

Developmental Services will continue to meet and discuss ways to broaden Community Support options for our clients. We will be addressing ways to offer supports during evening hours as well as on the weekend. Clients have expressed their desire to have more group oriented activities. We will work with our Local Standing Committee and Self Advocates to develop programs that meet the needs and wishes of our clients. During the development of this plan, clients expressed the desire to travel to such places as Boston, Disneyworld, Six Flags, and Branson, Missouri. We will explore alternative transportation options for our clients. Fundraising will allow for trips to places outside of our clients' local communities.

Developmental Services staff will also discuss ways to provide a safe and accessible environment, outside the HCRS offices, where clients can cultivate meaningful friendships, be provided with a variety of skill building opportunities, and participate in enriching activities in a supportive environment. HCRS will explore ways to allow flexibility with waiver dollars to reach some of these goals as well.

Additional strategies for this goal include developing local community-based activity locations for clients to meet for peer events throughout our region. We will develop local client-directed educational programs, including opportunities for clients to lead. We will collaborate with the Self Advocacy Group and the Local Standing Committee to develop these programs.

*c) How you know when each goal has been achieved. (What difference will it make and how will you measure it?)*

This goal will be met when organized client based activities beyond traditional one-on-one community supports are available to all clients. This will be measured by obtaining a rating of 95% of clients reporting having choices in their community supports in the Client Satisfaction Survey and by Local Standing Committee reports.

### High Risk Individuals

*a) What you hope to achieve. (What are you going to do?)*

Developmental Services is devoted to meeting the needs of individuals with extraordinary challenges. Our objective is to provide effective specialized programming to increase stability and reduce incidents with our high risk clients.

*b) The strategies you will use for each goal. (How are you going to do it?)*

Developmental Services will continuously seek ways to achieve financial and programmatic flexibility to create unique, highly-individualized treatment plans with wrap-around supports and expand our current treatment models.

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HCRS will expand our Community Placement Programs which will allow for more clients to receive specialized treatment. We will investigate the requirements for obtaining licensure to develop a DCF Residential Treatment Program. We will continue to provide behavioral services on site to the staff and clients. We will identify alternative programming to meet the needs of those who pose a public safety risk and struggle with sexual and/or violent behaviors.

To meet client needs we will continue to create unique highly-individualized treatment plans. This includes providing specialized housing for high risk youth for emergency respite, planned respite, and hospital diversion as well as expanding the Community Placement Program.

*c) How you know when each goal has been achieved. (What difference will it make and how will you measure it?)*

This goal will be met when we have a licensed DCF Residential Treatment Program. We will also have increased the capacity in our Community Placement Program beyond the current level of six.

Clinical Services

*a) What you hope to achieve. (What are you going to do?)*

HCRS is committed to providing the most effective and comprehensive clinical services to all of our clients.

*b) The strategies you will use for each goal. (How are you going to do it?)*

Developmental Services recognizes that individuals with developmental disabilities often require an alternative therapeutic approach to meet their clinical needs. Developmental Services is committed to monitoring the effectiveness of psychotherapy and discontinuing this treatment when appropriate. Developmental Services will seek alternative funding sources to meet the individualized therapeutic needs of our unique population.

We will continuously monitor the effectiveness of psychotherapy through goal setting and discontinue or change treatment when appropriate. We will seek alternative funding sources to meet the individualized therapeutic needs of our unique population. We will utilize Medicaid providers when possible. Developmental Services is committed to maintaining financial stability and will identify billing mechanisms that can increase clients' access to alternative therapies and providers. Behavioral planning and implementation will be an ongoing tool for supporting individuals with challenging behaviors.

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*c) How you know when each goal has been achieved. (What difference will it make and how will you measure it?)*

Developmental Services will maintain its current level of behavioral supports and seek out opportunities to expand as appropriate. Current therapy options include talk therapy, therapeutic horseback riding and movement therapy. This goal will be met when clients have a greater choice in therapy options and those options are funded through waived dollars and Medicaid.

*4. System Outcomes. Based on the prioritized needs, identify 2-3 areas that are considered to be broad-based needs for the region that will expand the current options available for people with developmental disabilities and should be transformed into state-wide-system outcomes.*

### Housing

Housing is the number one broad-based area of need for our region and throughout the State. Through our public forums, a consistent theme of concern for lack of housing options was clearly presented. In our monthly local funding meeting and through communication with other agencies and resources, the need for more housing resources is at the top of everyone's concern.

We have depleted the pool of Shared Living Providers in our region making it increasingly difficult to find new providers capable of providing a high level of support for our clients. Furthermore, funding for Shared Living Providers continues to be decreased in our DS waivers. The lack of day programming and community resources for our clients puts an additional burden on home providers. Funding for Community Supports continues to be decreased through the waiver funding process.

Subsidized housing and Section 8 vouchers are unavailable for the vast majority of our clients. Clients receiving Social Security do not have enough money to afford an apartment. We are limited in how we can use existing Housing and Home Support Funds. Clients often have limited housing choices when they enter our program.

Due to the lack of affordable housing, clients with a higher level of independent skills are often placed in a Shared Living Provider home for lack of less restrictive options. The development of a Supported Apartment program for clients with the ability to live more independently would provide a more financially responsible and less restrictive living option for those clients. Additionally, the development of additional crisis beds beyond the one regional VCIN bed will increase our capacity to respond to client needs.

### High Risk

State and local agencies throughout Vermont are struggling to meet the needs of high risk clients since Tropical Storm Irene destroyed the State Hospital. Increasingly complex clients coming into our system require unique services. Clients on the Autism Spectrum and clients with co-occurring disorders make up a larger percentage of our client base than ever before.

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Since the closing of the Vermont State Hospital, the burden for providing inpatient care for clients with the highest need has shifted to local emergency rooms. The need for inpatient psychiatric emergency hospitalization has increased while the availability of beds has decreased. People experiencing a mental health crisis are spending long periods of time in local emergency rooms due to the lack of available inpatient beds. Clients waiting for a bed often require supervision by the Sheriff's Department in the hospital emergency room. This bottleneck is a public safety concern. Local resources are being exhausted.

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Developmental Services Director

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