

**Community Developmental Services**

**A program of**

**Washington County Mental Health**

**Vermont Developmental Services**

**Local System of Care Plan**

**FY' July 1, 2017-June 30, 2020**

**Submitted: March 2017**

## **Purpose**

Community Developmental Services' Local System of Care Plan (LSOCP) is similar to that of the Individual Support Agreement (ISA). Like the ISA, the LSOCP serves as a framework for developing services; it identifies areas of support or desired outcomes, and illustrates the resources and strategies necessary for implementation. Along with other state-wide Designated Agencies, CDS's LSOCP also assists with informing the State System of Care Plan so that a unified and cohesive plan can be developed; a plan that allows growth and aims to improve services areas, a plan that generates positive outcomes, and a plan that will ultimately be driven by person-centered planning.

## **Current Status**

CDS provides a variety of supports and services to individuals with Developmental Disabilities. Programmatically, the CDS umbrella covers several service areas including: United Employment Services, Communication, Training, and Resource Program, Supervised Apartment Program, Residential Programs/Staffed Living, Developmental Home Coordination, the Learning Network, Specialized Treatment and Rehabilitation Team (START), to name a few. CDS staff have commonly been described as knowledgeable, friendly/welcoming, dedicated/committed, creative, enthusiastic, accepting/open, and as "genuinely wanting to make a difference in the lives of the individuals they support."

In examining CDS's FY 2015-2017 LSOCP, four areas were identified as a focus or "priority need." While we have made significant strides in many areas, we continue to explore opportunities for growth and improvement. The priority needs from the previous plan are outlined below:

### **Integrated Family Services and Children Services**

#### **a) What did we do?**

We transitioned to a single-intake process for children by developing a children's navigation system. We established a Utilization Review Committee (UR), comprised of various agency and DS representatives, that meets weekly to review children's cases and to determine how they will best be served. We've participated in meetings with our community partners, such as the Family Center and Youth Services Bureau to discuss the outcomes and implications of IFS. Senior Leadership meets monthly to determine how non-categorical funding will be implemented. A county-wide committee, comprised of reps from various regional service providers, also meets every other month to discuss topics related to improved system delivery and concepts of IFS. Lastly, the Child and Adolescent Needs and Strengths (CANS) comprehensive assessment tool is utilized for all children in order to support care planning, level of care decision making, to assist with quality and improvement initiatives, and monitoring of service outcomes.

**b) How well did we do it?**

The development of several different committees has helped to create thoughtful discussion and debate on issues related to the IFS model. The implementation of children's navigation system has helped to streamline the intake process and speed up services. Overall, the discussions of IFS have had a positive impact and the changes that have been made as a result are going well.

**c) What difference did it make?**

The single intake process has allowed us to offer services to more people. The various committees have provided valuable input and oversight regarding the allocation of resources and funding, such as the monitoring of Family Managed Respite and distribution of Flexible Family Funding. Non-categorical funds have been used to provide after school classes and respite. Although progress has been made with IFS, there are lingering concerns around funding and disbursement. For example, once PCA/transition funds end for a consumer, non-categorical funding is quite often not enough to meet their needs. Lastly, in exploring the IFS model, CDS has increasingly collaborated with the Children Youth and Families division and various community partners to provide cross services.

## **Developmental Home Provider Trainings and Increased Stipends**

**a) What did we do?**

We've required Home Providers to complete an *online* Pre-service training before contract signing. We also continue to make all of our trainings open and accessible to Home Providers and encourage them to attend if there is an area or skill they would like help with. CDS's Resident Nurse is accessible and open to working with home providers around medication/medical issues, questions, or concerns. We continue to explore the budget and funding options to support increased stipends for Home Providers.

**b) How well did we do it?**

Home providers now receive mandatory *online* Pre-Service trainings that provide them with fundamental knowledge of areas such as: abuse reporting requirements, health and safety, emergency protocols, critical incident reporting, individual rights, confidentiality, and more. Previously, Pre-Service trainings were conducted one on one, rendering the process time consuming and disorganized. Home Providers received a 2% increase on their contracts. CDS continues to work on bringing DH levels into alignment with the state-wide level of care document.

**c) What difference did it make?**

Home providers, along with newly hired staff, now complete Pre-Service training *online* which has made the process much more efficient and systematic. As a result,

100% of new Home Providers are receiving Pre-Service training. Additionally, there has been an influx in contractors attending trainings beyond Pre-Service, specifically with our Communication, Training, and Resource program's Facilitated Communication Training. Compared to other agencies and community providers in Vermont, the stipend offered to CDS home providers is significantly lower. The inability to offer competitive stipends, especially for consumers with unique and challenging support needs, effects placement and presents challenges in finding/recruiting qualified and experienced providers.

## **Transitional Apartment Housing**

### **a) What did we do?**

We've formed a committee to discuss and brainstorm solutions for transitional housing options and we've looked at various funding options that would support alternative/non-traditional models of residential living. We established "Sierra House", a staffed living/transitional house that has been modified into three apartments. Two consumers share a staffed apartment while two other consumers live in their own apartment with staff support.

### **b) How well did we do it?**

The committee continues to work towards finding solutions and exploring various housing options for our consumers. Currently, there is limited funding for transitional living apartments or alternative housing. Sierra House continues to function as our only transitional apartment.

### **c) What difference did it make?**

Access to transitional apartment housing is a model of supported/assisted living that requires a substantial amount of planning and what's more, *funding*. Although there has not been significant progress or gains in this identified area of need, there are still avenues to explore, such as grants or partnering with local housing agencies, etc. Sierra House is an example of how this model of living can be achieved. In examining issues related to housing, it has made a difference in our collective understanding and effort in embracing a *Supported Decision Making* approach to services. Consumers should be provided with supports to make decisions about where they want to live and furthermore, various housing options need to be accessible and affordable.

## **Expand In-House Clinical Options**

### **a) What did we do?**

CDS has hired a full time Licensed Clinical Mental Health Counselor, who assists with supporting the behavioral needs of our consumers, meets with teams to provide consultation, conducts individual and group therapy, which includes resuming the Dialectical Behavioral Therapy program at CDS. CDS's Mental Health Counselor also oversees our Behavioral Oversight Committee and performs Guardianship Evaluations.

### **b) How well did we do it?**

In-house clinical supports have been re-established and expanded through hiring a full time licensed clinician. CDS previously has not had a full time licensed clinician on staff.

### **c) What difference did it make?**

CDS is more equipped to meet its clinical needs. Instead of relying on external contractors with limited availability and high costs, we can utilize in-house services with more ease of access. This has further decreased the amount of time that consumers need to wait to start receiving the services. It also has the added benefit of increased clinical consultation being available to programs and teams within the division.

## **Plan Development**

### **1. Planning Process**

CDS continues to work towards a planning approach that reflects the ideology of "Results Based Accountability" (RBA). Representatives from various CDS programs collect RBA data which is presented and reviewed once a month at our Leadership meetings. Along with other WCMH divisions, the RBA information is compiled into an annual report.

Information for the LSOCP was solicited and gathered from several sources and although the scope of analysis was somewhat limited due to logistical matters and time constraints, the input received was valuable and provided insight for informing the LSOCP process.

As outlined in the Developmental Disabilities Act of 1996, individuals with developmental disabilities have certain rights and opportunities, such as making choices that will affect their lives. Supporting individuals in the everyday decision making process is an integral component in "person centered planning." Information from the individuals we serve, listening to their voices, empowering them to make their own choices, should be the very first step in plan development and service coordination. CDS obtained input from several consumers and self-advocates through verbal interviews,

pulling information from Individual Support Agreements, and through disseminating the Vermont Consumer Satisfaction Survey.

Feedback from families, guardians, and home providers offers a unique perspective, often based on familial and environmental factors and experiences that traditional day staff, Case Managers, Coordinators etc. are not cognizant of. Information from families, guardians, and home providers was gathered through individual interviews, information from ISA reviews, Satisfaction Surveys, and during the QSR process.

Input from direct support staff, Case Managers, and Coordinators is another important area when examining the supports and services we provide to our consumers. Through interviews, employee surveys, and exit interview data, information was gathered to help us determine what we've done well, what needs improvement, and what our focus should be for the next three years.

Vital information was also obtained from Washington County Mental Health's internal quality assurance reviews. Quality assurance data is obtained for our "Centers of Excellence", much of which applies to the work we do at CDS. Information related to sexual offenders and consumers indication of where they would like to live was pulled from various sources including 2014-2015 data from the National Core Indicators (NCI), Adult Consumer Survey Outcomes, Public Safety Risk Assessments (PSRA), DAIL Risk Assessments, Sex Offender Treatment Intervention and Progress Scale intake forms, ISAs, Consumer Logs (completed by staff and home providers), and progress notes.

## **2. Priority Needs**

For nearly 20 years, CDS has developed our LSOCP with the input from consumers, families, home providers, self-advocates, schools, local providers, and community partners. We want to emphasize that *all* service areas are valued and part of the fundamental fabric that enables us to provide quality, person-centered support with positive outcomes. However, when considering the feedback and input from all the sources, there were three areas of support that emerged as priority needs:

### ***Wage Compensation***

- a) Current and Anticipated Need: Recruiting and retaining experienced and qualified staff is an essential component in the delivery of quality supports and services. Consumers rely on the support of dedicated and motivated staff to help them achieve their individual goals and outcomes outlined in their ISAs. Over the past several years, we have seen a number of long term staff

leave their jobs at CDS for one with a higher and more appealing wage compensation. The number of open/unfilled positions at CDS has grown exponentially. CDS's inability to offer competitive salaries and base pay increases has impacted our ability to find staff that are willing to work with a population that have challenging behaviors and needs, specifically we are seeing an increase in numbers of young adults with Autism who have a history of aggression and violence. Although some positions at CDS offer a "difficulty of care" stipend, feedback indicates this is not sufficient compensation to attract qualified staff not to mention helping to prevent burnout and retain seasoned staff in those unique positions.

- b) Prioritize Need: Recruiting and retaining experienced and qualified staff is becoming increasingly more difficult. The amount of compression that has occurred due to lack of salary specific funding increases, restrictions or "caps" on funding categories (the true costs of services that are needed for consumers, but exceed funding limits) and "level funding", which actually serves as a "budget cut" due to that same amount of money needing to be spread out across the growing consumer population, has caught up to mental health services as a whole, but even more so for developmental services. Increasing compensation for staff is the primary goal for CDS over the next three years.
  
- c) Status of Goal: Compensating our employees a competitive, and often livable wage, is an area that has been increasingly under-met. Data gathered from staff satisfaction surveys and exit interviews demonstrate that time and time again, the wages and salaries paid at CDS are not adequate for the growing expectations of the work.
  
- d) Resources and Strategies: In order to recruit qualified staff and to *retain* experienced, dedicated staff, the development of a compensation plan that addresses the severely under-met need of adequate salary compensation is crucial.
  
- e) Programmatic/Systematic Resources and Strategies: A compensation plan needs to be developed and implemented not just at CDS, but across the agency as well as state-wide. We have seen progress with other DA's who have increased their compensation for employees. Increasing salaries and wages is not only in-line with other State agencies, but aligned with National and State

initiatives to raise the minimum wage to \$15.00/hr. Additionally, the development of a plan should not only address salary compensation, but should be organized in a manner that allows for continued allocation of cost of living increases while also competing at “market rate.”

### ***Transitional Housing/Alternative Housing Models***

- a) Current and Anticipated Need: CDS currently has several housing options for individuals with residential needs: staffed living residences, group homes, developmental homes, and supervised apartments. Although these options exist, what we are finding is that individuals in transition (typically those who are aging out of school or young adults wanting more independence) are expressing a desire to live in an apartment or shared-living situation but do not have the skills or supports to do so. Many young adults entering services as well as those currently receiving supports have voiced that living in a DH feels like they are a “guest living in someone’s home” and would like to experience the autonomy a young person might feel when transitioning into adulthood.
- b) Prioritize Need: Similar to the previous LSOCP, due to funding and logistical matters, access to transitional housing remains at a medium priority level.
- c) Status of Goal: This is currently an under-met goal. Although CDS has a Supervised Apartment Program, individuals who pose a health and safety risk cannot access the program. Currently, CDS only has one transitional house and three staffed living residences.
- d) Resources and Strategies: In order to provide this model of living as an option to consumers, CDS needs to acquire more buildings/spaces/apartments, etc. to accommodate the need. Additionally, it would be beneficial to explore housing resources, programs, vouchers, and grants to assist with funding.
- e) Programmatic/Systematic Resources and Strategies: CDS would benefit by collaborating with other divisions and agencies who have implemented transitional living programs and alternative residential models. In exploring and examining how others have implemented these models of living and moreover, how the projects were funded, CDS could strategize how to make

this “dream” (as described by many young adults and consumers in their ISAs) a reality.

### ***Increased DH stipends and Trainings***

- a) Current and Anticipated Need: Currently, all consumers who have residential funding are evaluated by a 3 level system which allows for increased stipends to home providers. However, this does not address the need for increasing stipends for *existing DHs*. As mentioned in the current status section of this year’s LSOCP, DHs are required to complete an online pre-service training *prior* to signing contracts. While this requirement has helped to ensure that 100% of new home providers receive the training, it does not address the significantly low numbers of respite providers who complete the training. Although there has been a slight increase in DHs attending other agency trainings, more attendance and consistency would be a helpful and productive allocation of resources.
  
- b) Prioritize Need: Due to the influx of other competing agencies in the Washington County area, increasing existing DH stipends is a higher priority need. All too often, DHs are contracting with competing agencies who offer higher stipends. Increased training remains at a medium level priority in that while some progress has been made making trainings more accessible to DH providers, there is more work to be done.
  
- c) Status of Goal: While this is a met need for new DHs, increasing stipends for existing DHs is an under-met need. Similarly, Pre-service training for DHs is a met need, but for respite staff it is an un-met need. Lastly, expanding the field and scope of trainings for DHs is currently under-met.
  
- d) Resources and Strategies: In order to increase DH stipends, there needs to be funding to do so. Through advocacy, creativity, and collaboration, CDS aims to work with our fiscal staff to determine current market demand for DHs in our area and move towards adjusting rates to ensure they are equitable across the region. Increased technological resources and access to online training programs can be an effective and efficient way to address training issues. More DHs have internet access and with continued collaboration between agency administrative staff and the CDS Leadership team, online training can be a valuable training tool. Peripheral and on-sight trainings need to be made more accessible and attractive for home providers. Collaboration between DH

recruitment, coordinators, home providers, and case managers can assist with devising methods and plans for increased trainings.

- e) Programmatic/Systematic Resources and Strategies: CDS will continue to work with providers in our area to assess market demand and explore funding options in order to increase stipends to match competitive rates. Collaboration with ARIS could be a strategy to restructure, manage, and track DH/Respite trainings—not only making trainings accessible to DHs/Respite staff, but *mandatory*. Online training is now common and used by many agencies across Vermont. CDS can continue to work with other agency providers in an effort to learn what they have accomplished with this format and also partner in trainings when possible.

### ***Increased Staff Trainings***

- a) Current and Anticipated Need: Although CDS requires a range of trainings for new hires and offers a number of supplemental trainings to existing employees, there is a growing need for increased trainings for staff.
- b) Prioritize Need: Since CDS offers a number of trainings, this is a medium-level need. Modifying the delivery of trainings and expanding access to include a wider scope of staff would assist with a cohesive and consistent delivery of services that is in line with state wide standards and protocols.
- c) Status of Goal: In conjunction with the agency at large, CDS offers a number of trainings to staff; however the bulk of these trainings, especially at entry level positions, are required and do not expand beyond the first few months of employment. CDS holds an annual “All Staff Training” that aims to inform staff on an area of significance for the DS population. We also have increased our Case Manager trainings from 4 times a year to 12 times a year (for staff hired after 2010) and 6 times a year (for staff hired before 2010). These “workshops” provide important information and impart knowledge about the DS system and delivery of services.
- d) Resources and Strategies: In order for CDS to increase trainings available to staff, it is necessary to plan and develop a training system that is organized and structured in a thoughtful manner. Exploration of various funding sources combined with careful collaboration both within and outside the agency is required for designing a quality training program.

- e) Programmatic/Systematic Resources and Strategies: CDS will continue to partner with local and state agencies in an effort to diversify its trainings. We will work with our administration and fiscal programs to locate funding for increased trainings and explore options for training coordination. We will also continue to advocate at the state level the ongoing need for establishing an “informed” network of staff through proper and consistent training.

### **3. Regional Outcomes**

#### **Transitional Housing/Crisis Beds**

- a) *Outcome*: The lack of emergency placement—or “crisis beds”—in our region is of growing concern. CDS will work towards acquiring more crisis and transitional housing for our consumers in need of housing and support critical, often unsafe, moments in their lives.
- b) *Strategies*: CDS will continue to advocate at a local and state level the serious need for crisis beds and transitional housing in our Region. Whether a crisis situation or change in life circumstance—we will partner with other local and regional agencies, businesses, providers etc. to acquire the networking, resources, and funding necessary for procuring buildings, apartments, or properties for the use of crisis/transitional purposes.
- c) *Assessment & Measurement*: CDS will evaluate progress made with the acquisition and success of transitional housing through a variety of measures that include statistical data (or numerical data), interviews and input from consumers, parents/guardians, staff, etc., relevant data from health care providers or crisis facilities, analysis of incident reports related to crisis, surveying, gathering information from ISAs (“where do I want to live?”), consumer satisfaction surveys, etc.

#### **Caseload Sizes**

- a) *Outcome*: Caseload sizes for Coordinators and Case Managers have been increasing for some time. It is not unusual for a Case Manager at CDS to have nearly (or over) 20 consumers on their caseload. This trend is having an impact on the quality of services we provide for our consumers and contributes to staff burnout. Large caseloads are not only affecting Case Managers-- who are finding themselves overloaded with work and little to no compensation or “incentive” to

keep them going—but also the individuals and families we serve who are entitled to, and deserve, comprehensive and dedicated service coordination.

b) *Strategies*: CDS will continue to work towards decreasing case load sizes by developing and implementing a compensation plan. Increased wages and salaries will provide incentive to recruit and retain experienced and qualified Case Managers. CDS will progress with exploring ways to decrease caseload sizes through reallocation, reducing hours where needed, and through hiring additional staff.

c) *Assessment & Measurement*: CDS will examine the progress of caseload sizes through data collection and analysis of various information gathering methods, including comparing service coordination hours to actual Medicaid billed hours, interviews and input from Case Managers, consumers, parents/guardians, etc., QSR data, RBA scorecards, and more.

### **One Time Funding**

a) *Outcome*: One time funding is a crucial component in the delivery of person centered planning. Our consumers utilize this funding avenue for a multitude of purposes ranging from acquiring technology/equipment to proving the means for a self-advocate to attend and present—locally and nationally-- at disability related events. CDS will continue to work towards preserving and maintaining this important funding stream for our consumers.

b) *Strategies*: CDS will continue to advocate at a local and state level by maintaining a consistent voice and presence with the state legislature. We will continue to educate the DS community, administrative staff, and fiscal departments on the importance of one time dollars and how much it assists our consumers in such a variety of ways.

c) *Assessment & Measurement*: CDS will assess the availability and access of one time dollars by gathering and analyzing fiscal data, information from one-time funding forms, interviews and input from consumers, parents/guardians, families, DHs, staff etc.

## **4. System Outcomes**

### **Compensation**

Compensation and wage issues are not problems that are unique to CDS. As discussed in the priority needs section, adequate wage compensation for staff is imperative for the future of the DS system. Adequate and competitive

compensation contributes to overall job satisfaction, motivation, low absenteeism, low turnover, provides peace of mind to our staff and increases self-esteem. The individuals who access our services rely on consist staff and supports. Consistency, mingled with the benefits listed above, translates into a better quality of services provided and *expands options* by allocating resources to areas of need as opposed to investing in--not to mention costs of--recruitment and training. The nationwide movement towards a \$15 minimum wage has become a part of the political platform for Vermont; it would be beneficial for the DS system to adopt a cohesive plan that not only aligns with the state plan, but addresses areas of compression. A proactive approach to compensation demonstrates a state-wide commitment and value to employees and consumers.

### **Budget Caps**

The issue of “budget caps” on Medicaid waivers *severely limits* the options of supports and services for many of the individuals we serve. As mentioned earlier, there has been an increase of consumers entering services who have specific needs related to health and safety. Often, these consumers have violent or aggressive behaviors that require a substantial amount of support (e.g. 2:1 and in some cases, 3:1 staffing). For many of these individuals, the costs to support them exceed the \$250,000 “budget cap.” With limited access to crisis beds, locked facilities, or other state residential options, all we have left is staffing and alarms to ensure community safety. The individuals that we support in this range have high needs and multiple, complicated issues. Although we have well trained and dedicated staff working with these folks, the lack of compensation and limited resources makes this increasingly difficult. Despite numerous consultations from all over Vermont and New England, there have been no “real” solutions on how to simultaneously reduce costs while maintaining adequate supports. The needs of our individuals do not change when our fiscal budget does, so in establishing “budget caps” to save money is a tremendous risk to the community, our staff, and the individuals we support.