

Vermont

State System of Care Plan

for Developmental Disabilities Services

FY 2015 – FY 2017

Three Year Plan

Effective: July 1, 2014

Developmental Disabilities Services Division
Department of Disabilities, Aging and Independent Living
Agency of Human Services
State of Vermont

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**For additional information, or to obtain copies of this report in this or other
formats, please contact:**

**Developmental Disabilities Services Division
103 South Main Street, Weeks Building
Waterbury, VT 05671-1601
Phone: 802-871-3065
Fax: 802-871-3052
www.dail.vermont.gov**

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SECTION ONE – INTRODUCTION

I. Background

A. History

The closure of Brandon Training School in 1993 was a significant milestone in the history of Vermont’s system of care for individuals with developmental disabilities. It marked the end of reliance on an institutional model of care and underscored the commitment to create those supports and services necessary for people to live with dignity, respect and independence outside of institutions.

In 1996, the Vermont State Legislature embedded in law the process by which the state continues that commitment. The Developmental Disabilities Act of 1996 (DD Act) requires the Department of Disabilities, Aging and Independent Living (DAIL), through the Developmental Disabilities Services Division (DDSD), to adopt a plan known as the *State System of Care Plan* that describes the nature, extent, allocation and timing of services that will be provided to people with developmental disabilities and their families. The *State System of Care Plan*, (from here on called the “*Plan*”), along with the *Regulations Implementing the Developmental Disabilities Act of 1996* and the *Developmental Disabilities Services Annual Report*, cover all requirements outlined in the developmental disabilities statute.

In 2013, Vermont marked the 20th anniversary of the closing of the Brandon Training School (BTS). This major milestone in the history of Developmental Disabilities Services (DDS) created an opportunity for us not only to remember the past and celebrate our accomplishments to date, but to begin thinking about the future of Developmental Disabilities Services and what we want the system of care to look like 10 – 20 years in the future. To assist in this effort the Commissioner of DAIL created the DDS *Imagine the Future* Task Force to help create the future vision. The Task Force is made up of consumers, families, individuals who were involved in the closing of the BTS 20 years ago, providers, advocates and other stakeholders. At the time of the writing of this *Plan*, the Task Force is continuing to meet and develop the vision. As part of this process, the Task Force will be reviewing the DD Act as it is currently written and will make recommendations regarding any necessary changes to the Act in order to achieve the vision for DDS in Vermont. Some of the Task Force’s ideas, as well as the ideas from a DDS Legislative Policy Work Group, are reflected in this *Plan* (the DDS Legislative Policy Work Group met in 2013 and was tasked with coming up with innovative and cost-effective ways of

providing services). Any additional recommendations from the Task Force will be reviewed for inclusion in future updates to the *Plan*.

The Division also anticipates that over the next 3-year *Plan* period we will be working to develop a plan to implement new rules for Home-and Community-Based Services (HCBS) that have been issued by the Centers for Medicare and Medicaid Services (CMS). The primary intent of the CMS rules is to ensure that individuals receiving long-term services and supports through various CMS HCBS programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate. The rules are designed to enhance the quality of home and community-based services (HCBS) and provide protections to participants. The rules also emphasize the importance of access, person-centered planning and individual choice. The *Plan* also reflects our beginning efforts to move towards implementation of the new rules.

The *Plan* reflects the Division's commitment to the health, safety and well-being of people with developmental disabilities and their families as well as to our principles and values. The principles, which can be found on page 5 of this *Plan*, emphasize our commitment to maximizing individual choice and control in designing and implementing this *Plan*.

B. Creation of the *Plan*

Gathering information about the needs of people with developmental disabilities in Vermont and the effectiveness of our services and supports is an ongoing endeavor. The *Plan* builds on experience gained through previous plans and is developed every three years and updated annually, as needed, with input from a variety of individuals interested in services and supports for people with developmental disabilities. Input is obtained by the State through a process of gathering information from conversations with stakeholders, Local System of Care Plans, public hearings, written comments, online survey and satisfaction surveys of individuals receiving services (see Section Five). One of the key groups consulted during the development of this *Plan* is the Developmental Disabilities Services State Program Standing Committee. In accordance with the Developmental Disabilities Act, specifically 18 V.S.A. §8733, this Governor appointed body is charged with advising DAIL on the status and needs of people with developmental disabilities and their families and advising the Commissioner on the development of the *Plan*. All these methods of input provide the perspective of a wide range of individuals.

C. Intention of the *Plan*

The *Plan* is intended to help people with developmental disabilities, their families, advocates, service providers and policy makers understand how resources for individuals with developmental disabilities and their families are managed. It lays out criteria for determining who is eligible for developmental disabilities services and prioritizes the use of resources. It is specifically intended to spell out how legislatively-appropriated funding will be allocated to serve individuals with significant developmental disabilities. The *Plan* guides the appropriate use of this funding to help people achieve their personal goals and to continuously improve the system of supports for individuals with developmental disabilities within available resources.

This *Plan* does not substitute for the State of Vermont's Medicaid State Plan. It does not guide or direct the allocation of resources for all Medicaid State Plan services, or other services administered by the Agency of Human Services or other state agencies.

This three-year *Plan* is effective as of July 1, 2014 and will be updated on a yearly basis, as needed. Feedback on the *Plan* is welcome.

II. DAIL Mission Statement

The mission of the Department of Disabilities, Aging and Independent Living (DAIL) is to make Vermont the best state in which to grow old or to live with a disability; with dignity, respect and independence.

Core Values and Principles of DAIL

1. **Person-centered:** We help people to make choices and to direct their own lives; pursuing their own choices, goals, aspirations and preferences.
2. **Natural Supports:** We recognize the importance of family and friends in people's lives. We respect the unique needs, strengths and cultural values of each person and each family.
3. **Community participation:** We support consumers' involvement in their communities, and recognize the importance of their contributions to their communities.
4. **Effectiveness:** We pursue positive outcomes through effective practices, including evidence-based practices. We seek to develop and maintain a trained and competent workforce, and to use staff knowledge, skills and abilities effectively.
5. **Efficiency:** We use public resources efficiently; avoiding unnecessary activities, costs, and negative impact on our environment.
6. **Creativity:** We encourage progress through innovation, new ideas, and new solutions. We accept that creativity involves risk, and we learn from mistakes.
7. **Communication:** We communicate effectively. We listen actively to the people we serve and to our partners. We are responsive.
8. **Respect:** We promote respect, honesty, collaboration and integrity in all our relations. We empower consumers, staff and partners to achieve outcomes and goals. We provide opportunities for people to grow, both personally and professionally.
9. **Leadership:** We strive to reach our vision and to demonstrate our values in all our work. We collaborate with consumers and other partners to achieve outcomes, goals and priorities. We are accountable.

III. Principles of Developmental Disabilities Services

The Developmental Disabilities Act of 1996 states that services provided to people with developmental disabilities and their families shall foster and adhere to the following principles:

1. **Children's Services:** Children, regardless of the severity of their disability, need families and enduring relationships with adults in a nurturing home environment. The quality of life of children with developmental disabilities, their families and communities is enhanced when the children are cared for within their own homes. Children with disabilities benefit by growing up in their own families; families benefit by staying together; and communities benefit from the diversity provided when people of varying abilities are included.
2. **Adult Services:** Adults, regardless of the severity of their disability, can make decisions for themselves, can live in typical homes, and can contribute as citizens to the communities where they live.
3. **Full Information:** In order to make good decisions, people with developmental disabilities and their families need complete information about the availability and choice of services, the cost, how the decision making process works, and how to participate in that process.
4. **Individualized Support:** People with disabilities have differing abilities, needs, and goals. Thus, to be effective and efficient, services must be individualized to the capacities, needs, and values of each individual.
5. **Family Support:** Effective family support services are designed and provided with respect and responsiveness to the unique needs, strengths, and cultural values of each family and the family's expertise regarding its own needs.
6. **Meaningful Choices:** People with developmental disabilities and their families cannot make good decisions unless they have meaningful choices about how they live and the kinds of services they receive. Effective services are flexible so they can be individualized to support and accommodate personalized choices, values and needs and assure that each recipient is directly involved in decisions that affect that person's life.
7. **Community Participation:** When people with disabilities are segregated from community life, all Vermonters are diminished. Effective services and supports foster full community participation and personal relationships with other members of the community. Community participation is increased when people with disabilities meet their everyday needs through resources available to all members of the community.

8. **Employment:** The goal of job support is to obtain and maintain paid employment in regular employment settings.
9. **Accessibility:** Services must be geographically available so that people with developmental disabilities and their families are not required to move to gain access to needed services, thereby forfeiting natural community support systems.
10. **Health and Safety:** The health and safety of people with developmental disabilities is of paramount concern.
11. **Trained Staff:** In order to assure that the purposes and principles of this chapter are realized, all individuals who provide services to people with developmental disabilities must have training as required by section 8731 of the Developmental Disabilities Act.
12. **Fiscal Integrity:** The fiscal stability of the service system is dependent upon skillful and frugal management and sufficient resources to meet the needs of Vermonters with developmental disabilities.

SECTION TWO – ELIGIBILITY

I. Overview

Using national prevalence rates, it is likely that roughly 15,650 of the state’s 626,011¹ citizens have a developmental disability as defined in the Vermont Developmental Disabilities Act of 1996. Given the birth rate in Vermont of about 5,687 live births per year², it is expected that approximately 142 children will be born each year with developmental disabilities³.

Not everyone with developmental disabilities needs or wants services. Most individuals with developmental disabilities in Vermont are actively involved in home and community life, working and living along with everyone else. Of those who do need support, many people have only moderate needs. Those with more intense needs usually require long term, often life-long support. As part of the 2013 Legislative Task Force, Designated Agencies (DAs) were surveyed concerning their role in intake and eligibility determination of people applying for services. The data from this survey show the following:

- 57% of applicants are found to meet clinical eligibility criteria. This means 43% of people applying for services are not clinically eligible.
- Of those who meet clinical eligibility, 55% are found to meet a system of care funding priority. This means almost 45% of those who are clinically eligible for services do not receive home and community-based services funding.
- Almost 30% of all individuals seeking DD services have a funding application reviewed by the State funding committees.
- Of those reviewed and approved at a local funding committee, 5% are funded locally and 95% are referred to the State funding committees.

In enacting the Developmental Disabilities Act, the Legislature made clear its intention that developmental disabilities services would be provided to some but not all of the state’s citizens with developmental disabilities. It gave responsibility for defining which individuals would have priority for funding and supports to the Division through *Regulations Implementing the Developmental Disabilities Act of 1996* and the *State System of Care Plan*.

¹ Based on national census figures for 2012 obtained from the U.S. Census Bureau and national prevalence rates of 1.5% for intellectual disability and 1.0% for Pervasive Developmental Disorders.

² Based on 2012 calendar year data from the Vermont Department of Health Vital Statistics.

³ Based on prevalence rates of 1.5% for intellectual disability and 1.0% for Pervasive Developmental Disorders.

There were 4,245 people who received developmental disabilities services in FY 2013, which is about 27% of Vermonters who are estimated to meet clinical eligibility for developmental disabilities services. The number of people served each year increases by approximately 100 individuals taking into account the people who die or leave services annually. Services are determined through an individual planning process and designed to be based on the needs and strengths of the individual, the individual's goals and the availability of naturally occurring supports.

II. Eligibility Determination

The *Regulations Implementing the Developmental Disabilities Act of 1996* explain clinical eligibility and recipient criteria, financial requirements and ability to pay for services.

Individuals with developmental disabilities who wish to receive services must first be found eligible. There are three parts to determine eligibility.

1. Financial eligibility – In order to receive funding, an individual must be determined financially eligible for Vermont Medicaid.
2. Clinical eligibility – In order to receive funding, an individual must be determined to have a developmental disability by a formal, professional evaluation. A developmental disability is defined as having either an intellectual disability or a pervasive developmental disorder; deficits in adaptive functioning; and an onset of the disability prior to age 18.
3. Criteria to access funding – each funding source has its own criteria (see below for home and community-based services criteria and Section Three).

To access funding for home and community-based services, it must be determined:

1. The individual has an unmet need related to his or her developmental disability; and,
2. The individual's unmet need meets a funding priority as outlined in the *Plan* (see Section Four).

III. Intake Process and Choice of Provider

Any individual who believes he or she has a developmental disability or is the family member or guardian of such a person may apply for developmental disabilities services. The individual applies at the Designated Agency (DA) for the geographic region where the individual with the developmental disability lives.

Within five (5) working days of receiving an application for services from an individual, an individual's family member or guardian, the Designated Agency will:

1. Explain the application process to the applicant including the information required, potential service options, how long the process will take, how and when the applicant will be notified of the decision, and the rights of applicants, including the right to appeal decisions concerning the application.
2. Notify the applicant of the rights of recipients of services, including the procedures for filing a grievance or appeal.
3. Discuss options for information and referral.
4. Determine whether the individual with a developmental disability or the individual's family is in crisis or will be in crisis within 60 days. If the Designated Agency determines that the individual or family is facing an immediate crisis, the Designated Agency shall make a temporary or expedited decision on the application.

At the beginning of the assessment phase of intake, the Designated Agency (DA) will identify and explain to the eligible applicant his or her right to choose a provider. In addition to receiving services from the DA in the county where the individual lives, an applicant may choose to receive services from a Specialized Service Agency (SSA) or another DA. Specialized Service Agencies are organizations that provide a distinctive approach to services and/or services that are designed to meet the needs of individuals with distinctive needs. There are five SSAs who provide services in select regions around the state. The other DA/SSAs have the option to decline to provide services in which case the person may receive services from their DA or choose to self- or family-manage their services.

The Designated Agency will clearly explain and provide contact information for the applicant to learn about each of the following options.

- **Agency-Managed Services:** Agency-managed services are when a Designated Agency or Specialized Service Agency (DA/SSA) manages all services and supports provided to the individual. Even when the DA/SSA contracts through another entity, such as a home provider or other service organization that hires or contracts for support workers, the DA/SSA remaining responsible for management and quality oversight of all developmental disabilities services.
- **Shared-Managed Services:** Shared-managed services are when a Designated Agency or Specialized Services Agency (DA/SSA) manages some, but not all, of the services, and the individual or a family member manages some of the services and is responsible for the quality oversight of those services. For example, a DA/SSA may provide service planning and coordination and

arrange for other services, such as home supports, while the individual or a family member manages supports such as respite, community and/or work supports. The Fiscal Employer/Agent (FE/A) must be used by individuals and family members who share-manage their services to help with many of the bookkeeping and reporting responsibilities of the employer. Shared-managed services is not defined as a DA/SSA contracting with a shared living provider and/or other contracted entity who hires support workers because in those situations the DA/SSA is still responsible for the management and quality oversight of those services.

- **Self-Managed⁴:** Self-managed services are when an individual manages all of his or her developmental disabilities services. The individual is responsible for hiring his or her own staff, administrative responsibilities and quality oversight associated with receiving developmental disabilities services funding. However, no more than eight (8) hours per day of paid home supports may be self-managed. The Fiscal Employer/Agent (FE/A) must be used by individuals who self-manage their services to help with many of the bookkeeping and reporting responsibilities of the employer.
- **Family-Managed Services⁵:** Family-managed services are when a family member manages all of an individual's developmental disabilities services. The family member is responsible for hiring staff, administrative responsibilities and quality oversight associated with receiving developmental disabilities services funding. However, no more than eight (8) hours per day of paid home supports may be self/family-managed. The Fiscal Employer/Agent (FE/A) must be used by family members who family-manage their services to help with many of the bookkeeping and reporting responsibilities of the employer.

When an individual or family chooses to self/family-manage services, the individual or family member is also responsible for ensuring that the approved funding is used in compliance with the *State System of Care Plan*, the *Regulations Implementing the Developmental Disabilities Act of 1996* and all other relevant policies and guidelines. The Supportive Intermediary Service Organization (Supportive ISO) must be used by individuals and family members who self/family-manage their services to help them understand their role and responsibilities as an employer, such as assuring workers are trained, supervised and monitored. The Fiscal Employer/Agent (FE/A), must be used by individuals and family members to help them do many of the bookkeeping and reporting responsibilities of the employer.

⁴ For more information, see the [Self/Family Management Guide](#) for a comprehensive guide for people who are self/family-managing their developmental disabilities services funded through Medicaid, and the [Regulations Implementing the Developmental Disabilities Act of 1996](#)

⁵ Ibid.

IV. Individualized Budgets and Authorized Funding Limits

If an applicant has been found financially and clinically eligible, an Individualized Needs Assessment will be completed to determine if the individual meets a funding priority as defined within the current State System of Care Plan (see Section Four). If the individual is found to meet a funding priority, the DA is responsible for preparing a funding proposal requesting specific types and amounts of service based upon the individual's needs. The DA then presents it to the Local Funding Committee for approval and then the appropriate statewide funding committee for final review and recommendation to DAIL for a final decision as described in Section Three.

The DA must notify the applicant, within forty-five (45) days of receipt of the application, of the financial and clinical eligibility determination and, if the applicant has been approved for services, the amount, types and costs for these services in the form of the individual's Authorized Funding Limit (AFL). The AFL will be determined based upon an Individual Needs Assessment and shared with the applicant. All individuals with home and community-based services funding have an individualized budget and must be given an Authorized Funding Limit. The AFL needs to be reflective of identified need, funded areas of support and must include only allowable Medicaid expenses.

Attachment A lists allowable developmental disabilities services and definitions. Additional guidance is provided in *Attachment B* regarding the ability to move home and community-based services funding within individualized budgets, as well as who is responsible when an individual's services are self-managed, family-managed or shared-managed and the budget is overspent.

Within 30 days of written notification of funding approval and AFL determination, the chosen DA/SSA will begin funded services. During the 30 day period, the DA/SSA will work with the applicant to initiate person-centered planning and the Person's Story and develop an Individual Support Agreement. The DA/SSA may begin some or all services before the 30 day timeframe depending on individual circumstances. For individuals who choose to self/family-manage their services, the DA will transfer the approved budget and AFL to the Supportive ISO. The individual or family may then arrange to implement services with the assistance of the Supportive ISO.

If the applicant is found ineligible for services, the DA is responsible to provide the individual information and referrals to other services. If the applicant is found ineligible to receive funding for some or all services based on the Developmental

Disabilities State System of Care Plan Funding Priorities, the DA will, as soon as possible, notify the applicant and provide information to the individual about the basis for the decision, the process for appeal and where to obtain legal assistance. The applicant's name will be placed on a waiting list maintained by the DA/SSA. The applicant will be informed that his or her name has been placed on the waiting list, and will be given information about the periodic review of the waiting list.

SECTION THREE – FUNDING AUTHORITY AND SOURCES

I. Overview

The role of the developmental disabilities services system is to support individuals and families to live as independently as possible in their communities. Family and other natural supports play a key role in supporting individuals; developmental disabilities services funding is intended to meet needs that families cannot meet or are not met by Medicaid State Plan services, Medicare, private insurance or other sources of funding. The contribution of family and other natural supports must be considered when determining the amount and scope of developmental disabilities services funding.

The Agency of Human Services (AHS) is committed to providing high quality, cost-effective services to support Vermonters with developmental disabilities within the funding available and to obtain good value for every dollar appropriated by the Legislature. To help achieve this goal, the Developmental Disabilities Services Division allocates these appropriated funds to its network of Designated Agencies and Specialized Service Agencies (DA/SSAs) as well as the Supportive Intermediary Service Organization (Supportive ISO) on behalf of people self/family-managing services. Agencies' allocations may be adjusted based on their ability to meet specific outcomes as outlined in their grant agreement with AHS.

People who self/family-manage their services are ultimately choosing to take responsibility for hiring, training and directing their support workers. This gives them flexibility for making the day-to-day decisions about how services are provided. The Supportive ISO is available to assure that people understand their options and meet their responsibilities as the employer. The Fiscal/Employer Agent (F/EA) helps with many of the bookkeeping and reporting responsibilities that people who self/family manage have as employers.

This *Plan* is based on the terms and conditions in Vermont's Global Commitment to Health 1115 waiver. The Global Commitment waiver is an agreement between Vermont and the federal government which includes some specific federal requirements related to developmental disabilities home and community-based services funding. The Division provides additional guidance for allocating funding and changing an individual's budget through regulations, policies and guidelines, including but not limited to the following:

- *The Developmental Disabilities Act of 1996*
- *Regulations Implementing the Developmental Disabilities Act of 1996*
- *Administrative Rules on Agency Designation*

- *The Vermont State System of Care Plan for Developmental Disabilities Services – FY 2015 – FY 2017*
- *DAIL Adult Services Division & Developmental Disabilities Services Division Services: Medicaid Claims Codes and Reimbursement Rates*
- *Individual Support Agreement Guidelines*
- *Guidelines for the Quality Review Process of Developmental Disabilities Services*
- Vermont State Medicaid regulations

II. Home and Community-Based Services Funding Appropriated for Developmental Disabilities Services

The Legislature appropriates home and community-based services (HCBS) funding for developmental services on an annual basis. This appropriation includes a base allocation used by DA/SSAs and Supportive ISO for individuals currently receiving services and may include additional funding for individuals who are new to services or who currently receive services and have an increase in needs. This funding is known as New Caseload Funding and is allocated to the Equity Fund and Public Safety Fund⁶. A summary of the new funding available in FY 2015 is shown in *Attachment C*.

Funds from the DS/SSAs base allocation that are no longer needed are reallocated in two ways:

1. Agencies reassign funding to individuals who meet the funding priorities.
2. Funds may be returned to the Division to be used as a statewide resource. These funds are known as Returned Caseload Funding (see Section Four, II.A.1 and Section Four, II.C.4).

To ensure the highest value is obtained from funding, services must be of high quality and cost effective. To that end, the Division requires agencies to continually reassess the use of developmental disabilities HCBS funding to assure funding is used to:

1. Address unmet needs of individuals who apply for, or are currently receiving, developmental disabilities services when those needs meet a funding priority.
2. Provide services and supports consistent with the individual's strengths and needs that prevent the need for more costly services and are the most cost-effective method of meeting the individual's goals.

⁶ See pages 18 – 21 for descriptions of Equity Funding and Public Safety Funding.

3. Meet outcomes identified in Individual Support Agreements.
4. Provide services based on current Individualized Needs Assessment or periodic review. A periodic review of needs is conducted at least annually for all individuals receiving services. The intent of this process is to reallocate funding to where it is most needed. Funding is adjusted on an individual basis so that services are reduced where they are no longer needed and increased where there are new needs, as funds are available⁷.
5. Recalculate service and support costs annually and update individuals' budgets accordingly by reallocating (known as "re-spreading") costs across individuals' budgets, as appropriate.
6. Address gaps in services identified in the Local System of Care Plans with available funds.

III. Responsibility for Funding Decisions

A. Role of the Division in Funding

The Division maintains an active role in the allocation, review and approval of developmental disabilities services funding. The Division will:

1. Prepare budget recommendations for the Administration's review, including analysis of emerging trends, changes in best practices, pressures, and opportunities for cost-reduction and system-delivery improvements
2. Issue instructions for any budgetary rescissions.
3. Provide funding guidelines and technical assistance to agencies and local funding committees.
4. Lead the Equity and Public Safety Funding Committees; establish operating procedures for each committee; take recommendations from the committees; assure that each funding proposal is in compliance with this *Plan*, the DDS Regulations Implementing the DD Act of 1996, and all other relevant policies and guidelines; make final funding decisions and track funding requests for current and new recipients.
5. Review representative samples of individuals' services to determine whether the supports currently funded are of high quality, cost effective, meet people's needs and achieve their desired goals.
6. Approve all Unified Services Plans. Unified Service Plans blend different funding sources (such as developmental disabilities home and

⁷ See Attachment D for further guidance on *Moving Funds in Individualized Budgets*.

community-based services funding, Children's Personal Care Services and/or High Technology Home Care Services⁸) into a unified funding approach with one coordinated service plan for individuals with complex and intensive medical and/or behavioral support needs.

7. Assist agencies to fill vacancies in group homes that are considered statewide resources, including the Intermediate Care Facility, for people with Developmental Disabilities (ICF/DD). Agencies must notify DDS of a group home opening. The Division then sends a notice to the statewide provider network. Agencies receive referrals and consult with DDS staff to review viable candidates and come to a mutual agreement as to the best match for the home. In the event that a mutual agreement cannot be reached, the DA/SSA will make the final decision.
8. Assist agencies to negotiate and facilitate arrangements for eligible individuals when the Department for Children and Families (DCF), Department of Mental Health (DMH), Department of Corrections (DOC) or other state agencies and/or out-of-state organizations are contributing payment for an individual's home and community-based services. Provide final funding approval in conjunction with other departments.
9. Prior authorize requests for any out-of-home placements supported by developmental disabilities home and community-based services funding for children under age 18.
10. Resolve the issue of which agency is the Designated Agency when it is not clear which agency has the Designated Agency responsibilities for a particular individual in accordance with DDS guidance.
11. Manage the budget within available funding.

B. Role of the Funding Committees

The Local and Statewide Funding Committees for home and community-based services and their respective roles and responsibilities are outlined below.

⁸ Children's Personal Care Services and High Technology Home Care Services for children are managed by Vermont Department of Health/Children with Special Health Needs. High Technology Home Care Services for adults are managed by Department of Disabilities, Aging and Independent Living/Adult Services Division.

Funding Committee	Decision-making Authority
Local Funding Committees	Review requests to be submitted to Equity and Public Safety Funding Committees
Statewide Equity Funding Committee	Review requests for New Caseload Fund and Returned Caseload Fund – Division makes final decisions
Statewide Public Safety Funding Committee	Review requests for Public Safety Fund – Division makes final decisions

Local Funding Committees

Each Designated Agency must maintain a local funding committee that meets at least monthly and is comprised of staff from the Designated Agency, representatives from local Specialized Service Agencies, people receiving services and/or family members or guardians. Members must also include one or more individuals representing local community resources (e.g., Vocational Rehabilitation, schools, Department of Corrections, Area Agency on Aging, Department for Children and Families) and other interested stakeholders.

The Supportive Intermediary Service Organization (Supportive ISO) for people who choose to self/family-manage services) must maintain a local funding committee that meets on a regular basis and is comprised of staff from the Supportive ISO and people receiving services and/or family members. Members must also include one or more individuals representing local community resources (e.g., Vocational Rehabilitation, schools, Area Agencies on Aging) and other interested stakeholders.

The local funding committee will review proposals for all new funding on behalf of individuals for whom they are the Designated Agency. The same expectations pertain to the Supportive ISO funding committee. The committee will:

1. Confirm that the individual meets clinical (see Attachment C) and financial (Medicaid) eligibility criteria for developmental disabilities services;
2. Determine whether the individual’s needs meet a funding priority;
3. Determine if the supports and services described are needed by the individual and are the most effective and cost-efficient means of providing the service;
4. Ensure all other funding options and resources have been explored, including developing, nurturing and reinforcing natural supports; and,

5. Confirm that each individual funding proposal is in compliance with this *Plan*, the DDS Regulations and all other relevant policies and guidelines; and revise the *Plan* as necessary prior to sending the proposal onto the relevant statewide funding committee.

If the committee determines that all criteria are met, the proposal is submitted to either the Equity Funding Committee or Public Safety Funding Committee, as appropriate, for funding consideration.

Equity Funding Committee

The Equity Funding Committee will follow the membership, management, and operating procedures established by the Division. The committee is comprised of the following membership.

Number of Members	Representation	Selected by
2	Developmental Disabilities Services Division	Developmental Disabilities Services Division
3	Designated Agency and/or Specialized Service Agency	Designated Agencies and Specialized Service Agencies
2	Individual(s) receiving services and/or family member(s)	Recommendations from DA/SSAs, Green Mountain Self-Advocates and others – Division makes final decisions

The Equity Funding Committee assists in the management of New Caseload Funding allocated by the Legislature to meet the needs for individuals whose circumstances are described in the funding priorities – with the exception of the Public Safety funding priority which is managed through the Public Safety Funding Committee. The Equity Funding Committee also assists in managing Returned Caseload Funding that comes back to the Equity Fund when those dollars are no longer needed by an individual. If necessary, New and Returned Caseload Funding may be used to fund the needs of individuals who meet a Public Safety funding priority. Alternatively, it is permissible to use Public Safety funding, when necessary, to fund the needs of individuals who meet funding priorities other than the Public Safety priority. The decision to transfer funds is made by the Division.

The Equity Funding Committee will confirm:

1. The individual’s needs meet a funding priority;
2. The supports and services described are needed by the individual and are cost-efficient and the most effective means of providing the service;
3. All other funding options and resources have been explored, including developing, nurturing and reinforcing natural supports; and,
4. Each individual funding proposal is in compliance with this *Plan*, the DDS Regulations and all other relevant policies and guidelines.

Public Safety Funding Committee

The Public Safety Funding Committee will follow the membership, management, and operating procedures established by the Division. The committee is comprised of the following membership.

Number of Members	Representation	Selected by
1	Developmental Disabilities Services Division	Developmental Disabilities Services Division
2	Designated Agency and/or Specialized Service Agency	Designated Agencies and Specialized Service Agencies
2	Other interested individuals (e.g., people receiving services/family members; Department of Corrections staff, public safety professionals)	Recommendations from DA/SSAs, Green Mountain Self-Advocates and others – Division makes final decisions

The Public Safety Fund is comprised of funding allocated by the Legislature to specifically address the needs of adults with developmental disabilities who pose a risk to public safety. If Public Safety Funding is insufficient for individuals who meet the criteria below, the individual may have access to the New Caseload Fund or the Returned Caseload Fund, depending on the funding availability. The decision about whether to access New Caseload or Returned Caseload funds is made by the Division.

The Public Safety Funding Committee will confirm:

1. The individual's needs meet a funding priority;
2. The supports and services described are needed by the individual and are the most effective and cost-efficient means of providing the service;
3. All other funding options and resources have been explored; and,
4. Each individual funding proposal is in compliance with this *Plan*, the DDS Regulations and all other relevant policies and guidelines.

Individuals Eligible for Public Safety Funding:

1. For new applicants, the public safety risk must be identified at application and they must meet the Public Safety Funding priority criteria in #4 below.
2. For individuals currently receiving services, the public safety risk must be newly identified and they must meet the Public Safety Funding priority criteria in #4 below.
3. The DAIL Public Safety Risk Assessment must be completed or updated for each individual who applies for Public Safety Funding in accordance with the *Protocols for Evaluating Less Restrictive Placements and Supports for People with I/DD who Pose a Risk to Public Safety*.
4. An individual must have proposed services that reflect offense-related specialized support needs and meet at least one of the following criteria:
 - a. Committed to the custody of the DAIL Commissioner under Act 248 because of being dangerous to others. Services are legally mandated.
 - b. Convicted of a sexual or violent crime, has completed his or her maximum sentence and there is evidence that the individual poses a substantial risk of committing a sexual or violent re-offense⁹.
 - c. Substantiated by DAIL or DCF for sexual or violent abuse, neglect, or exploitation of a vulnerable person and there is evidence that the individual poses a substantial risk of committing a sexual or violent re-offense.

⁹ Examples of "evidence" may include; recent clinical evaluations and/or recent treatment progress reports which indicate a continued risk to the public; recent critical incident reports which describe risks to public safety; and/or new criminal charges or DCF substantiations which involve harm to a person. Additional supporting evidence may be taken into account.

- d. In the custody of DCF for committing a sexual or violent act that would have been a crime if committed by an adult, is now aging out of DCF custody, and there is evidence that the individual poses a substantial risk of committing a sexual or violent re-offense.
- e. Not charged with or convicted of a crime, but the individual's risk assessment contains evidence that the individual has committed an illegal act and poses a substantial risk of committing a sexual or violent re-offense.
- f. Convicted of a crime and under supervision of DOC (probation, parole, pre-approved furlough, conditional re-entry) and DOC is actively taking responsibility for supervision of the individual for public safety. Public Safety Funding only pays for supports needed because of the individual's developmental disability. Offense-related specialized support needs, such as sex offender therapy, cannot be funded by DAIL for an individual who is under the supervision of DOC.

Individuals Not Eligible for Public Safety Funding:

1. It is not a priority to use Public Safety Funding, New Caseload Funding, Returned Caseload Funding or DA/SSA base allocation funding to prevent an individual who has been charged with or convicted of a crime from going to or staying in jail or to prevent charges from being filed.
2. Public Safety Funding will not be used to fund services for individuals believed to be dangerous to others but for whom there is no clear evidence they pose a risk to public safety, and who have not committed an act that is a crime in Vermont. These individuals may be funded through New Caseload Funding or Returned Caseload Funding if the individual meets another funding priority.
3. Public Safety Funding will not be used to fund services for individuals who have committed an offense in the past, and:
 - a. Whose proposed services do not reflect any offense-related specialized support needs, or
 - b. Who do not pose a risk to commit a sexual or violent re-offense.

Individuals determined not eligible for Public Safety Funding may be funded through New Caseload Funding or Returned Caseload Funding if the individual meets another funding priority.

IV. Other DDS Resources

In addition to DDS home and community-based services, DDS oversees the following services that may be available to people who are financially and clinically eligible for developmental disabilities services.

A. One-Time Funding

When new funding is approved, 100% of the annualized amount needed to support a full fiscal year of services for the individual is committed. This assures that funds to pay for a full fiscal year of services are built into the DA/SSA's base budget. When 365 days of funding are not required because the individual's newly funded services began after the start of the fiscal year (July 1st), the unused balance creates one-time funding.

One-time funding is created through three funds:

1. New Caseload Fund
2. Returned Caseload Fund
3. Public Safety Fund

One-time funding may be distributed and used by DDS, DA/SSAs and Supportive ISO for temporary or short-term expenditures that directly assist people with disabilities and their families. It may not be used for ongoing needs. Individuals may be eligible for one-time funding if they are clinically and financially eligible for services regardless of whether the individual is currently receiving services. Requests for one-time funding are limited to a maximum of \$5,000 per person per year. The Division may use one-time funding to support specific activities, pilot projects and special initiatives. One time funding may be distributed through the DAs/SSAs and Supportive ISO or by the Division as described below.

The Division determines how one-time funding is used by DA/SSAs and Supportive ISO, including the timing and allocation of these funds to agencies. Any one-time funding distributed to agencies must be allocated according to one-time funding guidance listed below and reported to the Division. If there is a question about an allowable use of one-time funding, the Division makes the final decision.

Allowable Uses for One-Time Funding by DA/SSAs and Supportive ISO:

1. **One time funding must be prioritized for use as Flexible Family Funding.** One-time allocations used as Flexible Family Funding for individuals with disabilities and families waiting for Flexible Family Funding are not to exceed the Flexible Family Funding maximum allocation of \$1,000 per person per year, regardless of source.
2. One-time allocations to address personal health or safety or public safety issues for individuals with developmental disabilities.
3. Short-term increases in supports to individuals already receiving services to resolve or prevent a crisis.
4. Assistive technology, adaptive equipment, home modifications to make the individual's home physically accessible, and other special supports and services not covered under the Medicaid State Plan.
5. Supports that may not meet funding priorities but are proactive and short-term in nature.
6. Transitional support to assist an adult to become more independent in order to reduce or eliminate the need for services.
7. Small grants to self-advocates, families and others; that promote the Principles of Developmental Disabilities Services; for innovative programs that increase consumer ability to make informed choices, promote independent living, and offer mentorship and career building opportunities.
8. Funding for people receiving developmental disabilities services to attend a training or conference that increases consumer ability to make informed choices, promote independent living, offer mentorship and career building opportunities. One time funds can only be used to cover the costs of training/conference registration fee and/or transportation costs for the individual, if needed, to attend a training or conference.

B. Pre-Admission Screening and Resident Review (PASRR) Funding

Individuals age 18 and over who live in nursing facilities may qualify for Nursing Home Day Rehabilitation Services (known as specialized services in a nursing facility) necessary to meet their unique needs related to their developmental disabilities. These services are prior authorized on an individual basis by the Division. Allocations for individuals currently receiving services are reviewed on an annual basis by the Division. Funding for specialized services is allocated from the revolving PASRR fund unless the individual was receiving home and community-based services funding prior to admission to

the nursing facility, in which case a portion of his or her home and community-based services funding is converted to Nursing Home Day Rehabilitation funding to pay for specialized services. The Division is legally mandated to provide these services, therefore, if the PASRR Fund is depleted, funding is allocated through New Caseload Funding or Returned Caseload Funding. Specialized services funded from the revolving PASRR Fund are limited to 5 hours per week.

If an individual receiving specialized services moves out of a nursing facility, the individual's specialized services funding is converted to home and community-based services funding to support the individual's community-based services. Any additional home and community-based services funding approved for an individual moving from a nursing facility to a community placement comes from the New Caseload Funding or Returned Caseload Funding.

If an individual dies or stops receiving specialized services, the funds are returned to the revolving PASRR Fund or to the Returned Caseload Fund if there are sufficient resources to cover current and anticipated specialized services needs.

C. Flexible Family Funding

Flexible Family Funding (FFF) provides funding for respite and goods for children and adults who live with their biological or adopted family or legal guardian. These funds are used at the discretion of the family for services and supports that benefit the individual and family. Families apply for FFF through the Designated Agency which is responsible for determining eligibility for FFF and makes the allocations accordingly. In order to make this resource available to as many individuals as possible, the maximum FFF allocation is \$1,000 per person per year including when using one time dollars for FFF and FFF that is carried over by DAs into the next fiscal year. The program is described in the [Flexible Family Funding Guidelines](#). FFF is available at designated agencies in all counties (IFS pilot and non-pilot regions).

D. Targeted Case Management

Targeted Case Management (TCM) is a Medicaid State Plan service that provides assessment, care planning, referral and monitoring. Services are provided by the DA/SSA and designed to assist adults and children to gain access to needed services.

E. The Bridge Program: Care Coordination for Children with Developmental Disabilities

The Bridge Program is an Early Periodic Screening, Diagnosis and Treatment (EPSDT) service that provides support to families in need of Care Coordination to help them access and/or coordinate medical, educational, social or other services for their children with developmental disabilities under the age of 22. On an annual basis, the Division will negotiate and approve funding allocations for Designated Agencies for the Bridge Program. Designated Agencies will determine clinical and financial eligibility and approve individuals to receive this service. The Bridge Program Guidelines provide details regarding eligibility, scope of service provision and overall management of services. The Bridge Program is available in non-pilot IFS regions. Care Coordination is available through IFS in IFS pilot regions (starting with Addison and Franklin/Grand Isle counties).

V. Integrated Family Services through AHS

Integrated Family Services (IFS) is an Agency of Human Services (AHS) initiative intended to streamline and integrate services currently provided to children and families through multiple AHS departments with the goal of creating a holistic, seamless system of service delivery. When fully operational, children with developmental disabilities, as well as children with other disabilities or needs, will have access to a range of services through IFS. In two regions of the state, (Addison and Franklin/Grand Isle counties), AHS has begun piloting the integration of certain services previously provided to children and families through the Department for Children and Families (DCF), Department of Mental Health (DMH) and DAIL. All services determined to be medically necessary, which were previously available to children and families through DAIL, including Flexible Family Funding (FFF), Family Managed Respite (FMR), Bridge Program Care Coordination and Home and Community-Based Services will be available in the IFS pilot regions. Those children and families residing in non-pilot regions will continue to have access to FFF and Bridge Program (as described above), FMR (as described below) and to home and community-based services (as described in Section Four).

Children under 22 residing in the IFS pilot regions will have access to a range of treatment and services. Young adults age 18 – 21, residing in the pilot regions, may be eligible for services through DDS or IFS. If the agency believes the individual meets a DDS system of care funding priority, an application for DDS home and community-based services may be submitted. If the agency has the capacity to continue to fund a young adult with developmental disabilities age 18 – 21 through IFS, they may continue to do so. For a young adult with developmental disabilities

age 18 – 21 who does not meet a State System of Care funding priority, IFS services through the local DA may be appropriate and will be provided, if medically necessary and as required by federal law.

A. Children’s Personal Care Services

Children’s Personal Care Services (CPCS) is a Medicaid State Plan service available to children under the age of 21 who have a significant disability or health condition that substantially impacts care giving needs and/or the development of self-care skills. Eligibility and amount of support are defined in the Children's Personal Care Services Program Guidelines. They are managed by the Department of Health. See list of programs for children and families on page 27.

B. High Technology Home Care

High Technology Home Care (HTHC) is a Medicaid State Plan service that provides skilled nursing care to adults and children who are dependent on technology. Services include coordinating treatments, medical supplies and sophisticated medical equipment. These services are managed by the Department of Health for children and youth under the age of 18, though sometimes services continue until age 21. See list of programs for children and families on page 27.

High Technology Home Care services for adults age 18 and older are administered by Adult Services Division at DAIL.

Adult Services Division
Department of Disabilities, Aging and Independent Living
103 South Main Street
Waterbury, VT 05671
1-802-871-3044

C. Family Managed Respite

Family Managed Respite (FMR) funding is allocated to Designated Agencies to provide families with a break from caring for their child with a disability, up to age 22. This includes children with mental health or developmental disabilities who do not receive home and community-based services funding. Respite can be used as needed, either planned or in response to a crisis. It may be used to allow the caregiver to attend to his or her own needs or the needs of other family members. Respite may also be used to create a break from the normal routine for the child with a disability. It is intended to promote the health and

well-being of a family by providing a temporary break, not child care to enable employment. Eligibility for FMR, determined through a needs assessment with a Designated Agency, is defined in the FMR guidelines. Families are given an allocation of respite funds that they will manage. Families are responsible for recruiting, hiring, training and supervising the respite workers. Agencies may provide assistance with these responsibilities. The workers are paid through the Fiscal/Employer Agent who processes the payroll and conducts background checks for these employees.

Information about other resources for children and families in Vermont:

Children's Integrated Services

Child Development Division
Department for Children and Families
103 South Main Street
Waterbury, VT 05671-5500
1-800-649-2642

Children's Personal Care Services

Vermont Department of Health
Children with Special Health Needs
108 Cherry Street, Box 70
Burlington, VT 05401
1-800-660-4427

Pediatric High Tech Nursing

Vermont Department of Health
Children with Special Health Needs
108 Cherry Street, Box 70
Burlington, VT 05401
1-800-660-4427

Children's Mental Health

Department of Mental Health
Child, Adolescent & Family Unit
329 Harvest Lane, Suite 300
Williston, VT 05495
1-888-212-4677

Vermont Agency of Education

219 North Main Street, Suite 402
Barre, VT 05641
1-802-479-1030

For additional information about supports for children and family, contact:

Vermont Family Network
600 Blair Park Road, #240
Williston, VT 05494
1-800-800-4005
www.vermontfamilynetwork.org

VI. Developmental Disabilities Services Division – Special Funds

A. Public Guardianship Fund

This fund pays for unanticipated services and for small expenses directly related to the well-being of individuals receiving public guardianship services.

B. Specialized Services Fund

This fund covers dental services for adults and adaptive equipment and other one-time ancillary services needs that families cannot meet or are not covered by Medicaid State Plan, home and community-based services funding, Medicare, private insurance or other funding sources.

VII. Special Initiatives

A. Proposed Projects

The Developmental Disabilities Services Division may use funding to support initiatives that will enhance choice, control and increased opportunities for individuals receiving developmental disabilities services and their families. The timing and amount of funding for any of the following initiatives will be dependent on the availability of funding and capacity to manage each project.

1. Post-secondary education and career building for transition age youth.
2. Innovative community-based independent living options, including support to transition more people to independent living options and use of technology.
3. Re-invigorated focus on person-centered planning processes.
4. Peer mentorship to support individuals to learn and practice new skills.
5. Effective statewide workforce training.
6. Exploration of new approaches to support for families who have adult children living at home.

B. Employment Conversion Initiative

The Employment Conversion Initiative is intended to support people to convert their community supports funding to work supports. This will offset the increased cost of work supports. Beginning in FY 15, an amount equal to \$50,000 of caseload funding is allocated for support needed to maintain an employer-paid job for individuals who have transferred at least 50% of their existing community supports funding to work supports. The maximum amount available to add to work supports from this initiative for each individual is \$5,000, which will be annualized in their individual budget. Requests for these funds are made through the Equity and Public Safety Funding Committees. Continuation of funding this initiative in FY 16 and FY 17 will be considered depending upon effectiveness, use and demand for this support in FY 15.

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SECTION FOUR – FUNDING GUIDANCE

I. Funding Priorities for Home and Community-Based Services

Within the funds available, any individual whose needs meet the funding priorities and who is clinically and financially eligible for developmental disabilities services, has access to funding. The determination that an individual meets a funding priority is made through a comprehensive process that involves the individual and his or her circle of support and includes a needs assessment and takes into consideration the specific level of support needed, natural supports and other resources available to meet the individual's needs. Services and supports are then designed to most effectively meet the individual's needs based on the individual's strengths and personal goals. Services and supports must also be cost effective.

Funding priorities focus on an individual's unmet needs and circumstances that require support from the developmental disabilities services system to address personal health and safety, public safety, keeping people from being institutionalized, keeping transition age youth/young adults employed and supporting parents with developmental disabilities. Circumstances that may result in an individual meeting a funding priority may include the loss of a caregiver; aging caregiver or inability of caregiver to provide care due to mental or physical limitations; caregiver unable to work without support; homelessness of the individual; or abuse, neglect or exploitation.

Although, an individual may have needs that meet more than one funding priority, it is only necessary to meet one of the six funding priorities to access funding. However, the type and level of service may be dependent on the funding priority or priorities the individual meets.

Funding Priorities¹⁰

1. **Health and Safety:** Ongoing, direct supports and/or supervision are needed to prevent imminent risk to the individual's personal health or safety. [Priority is for adults age 18 and over.]
 - a. "Imminent" is defined as presently occurring or expected to occur within 45 days.
 - b. "Risk to the individual's personal health and safety" means an individual has substantial needs in one or more areas that without paid supports put the individual at serious risk of danger, injury or harm (as determined through the needs assessment; see *Attachment D*).
2. **Public Safety:** Ongoing, direct supports and/or supervision are needed to prevent an adult who poses a risk to public safety from endangering others. To be considered a risk to public safety, an individual must meet the Public Safety Funding Criteria (see Section Three). [Priority is for adults age 18 and over.]
3. **Preventing Institutionalization – Nursing Facilities:** Ongoing, direct supports and/or supervision needed to prevent or end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). Services are legally mandated. [Priority is for children and adults.]
4. **Preventing Institutionalization – Psychiatric Hospitals and ICF/DD:** Ongoing, direct supports and/or supervision needed to prevent or end stays in inpatient public or private psychiatric hospitals or end institutionalization in an ICF/DD. [Priority is for children and adults.]
5. **Employment for Transition Age Youth/Young Adults:** Ongoing, direct supports and/or supervision needed for a youth/young adult to maintain employment. [Priority for adults age 19 through age 26 who have exited high school.]
6. **Parenting:** Ongoing, direct supports and/or supervision needed for a parent with developmental disabilities to provide training in parenting skills to help keep a child under the age of 18 at home. Services may not substitute for regular role and expenses of parenting; maximum amount is \$7,800 per person per year. [Priority is for adults age 18 and over.]

¹⁰ Please refer to Section Three, V. regarding Integrated Family Services and funding for services for children up to age 22.

II. Guidance for Management of Developmental Disabilities Services Funding

A. Timeframes for Funding

1. New funding must be used to meet an individual's needs and goals related to the identified funding priority. Changes in a funded area of support must continue to meet the needs related to the identified funding priority. For up to one calendar year after approval of new funding, any reductions to an individual's budget, including both existing and new funding, up to the amount newly funded must be returned to the appropriate statewide fund (Equity and Public Safety). After one calendar year, these funds are available to the DA/SSA to reallocate.
2. An individual's home and community-based services funding may be suspended for up to a maximum of 6 months. If a suspension exceeds 6 months, services must be terminated and the funding returned to the appropriate fund (Equity and Public Safety). A notification must be sent to the individual informing him or her of the right of appeal. The same provision applies to services approved and funded, but not implemented within 6 months of receiving funding. The Division may grant additional time for exceptional circumstances. Services, in whole or in part, must be suspended for the following reasons:
 - a. Incarceration – When an individual enters a correctional facility (pre- or post-sentencing) and is expected to stay no more than 6 months – all HCBS has to be suspended.
 - b. Nursing Facility – When an individual enters a nursing facility and is expected to stay no more than 6 months – all HCBS has to be suspended. With approval of the state, some funds may be shifted to Nursing Facility Day Rehabilitation Services.
 - c. ICF/DD – When an individual admitted to an ICF/DD and is expected to stay no more than 6 months – all HCBS has to be suspended.
 - d. Psychiatric Hospitalization – Level 1: When an individual is admitted to a Level 1 psychiatric bed – all HCBS has to be suspended¹¹.

¹¹ Vermont facilities that provide Level 1 inpatient psychiatric care are the Brattleboro Retreat, Rutland Regional Medical Center, Fletcher Allen Health Care and Vermont Psychiatric Care Hospital. Note that not all "beds" used for psychiatric care in these facilities are considered to be Level 1.

- e. Other Hospitalization – When an individual is temporarily hospitalized in other than an inpatient Level 1 psychiatric bed¹², HCBS funding can be used to provide personal care type services. Agencies can be reimbursed for an individual’s daily rate for home supports, service planning and coordination and administration for up to 30 days of hospitalization.
 - f. Gap in Service Provision – When there is a gap in some or all of an individual’s HCBS that exceeds 14 days – billing for those HCBS services that are not being delivered must be suspended until services are resumed. Exceptions may include services that are provided on an intermittent basis, such as daily respite and crisis services. Billing for home supports may continue when an individual is temporarily away from home for no more than 30 days, such as when visiting family, on vacation, at respite or at camp. In most instances, a home provider is considered to be on-call and may be expected to be available in the event of an emergency. It is at the discretion of the DA/SSA to determine under what circumstances they continue to pay a home provider.
 - g. Visits outside of Vermont – When an individual leaves Vermont temporarily but continues to need services, home and community-based services funding may be continued for a period not to exceed 6 months¹³. Those services that are not being delivered during this time must be suspended.
 - h. Leaves Services – When an individual drops out of services without notice and is unable to be contacted – all HCBS has to be suspended.
 - i. Other circumstances – When an individual is not expected to receive services within a 6 month period – all HCBS has to be suspended.
3. An individual’s home and community-based services funding must be terminated for the following reasons.
- a. Incarceration – When an individual’s stay in a correctional facility exceeds, or is expected to exceed, 6 months.

¹² Vermont facilities that provide Level 1 inpatient psychiatric care are the Brattleboro Retreat, Rutland Regional Medical Center, Fletcher Allen Health Care and Vermont Psychiatric Care Hospital. Note that not all “beds” used for psychiatric care in these facilities are considered to be Level 1.

¹³ For further information about the impact on Medicaid funding and Social Security Benefits when leaving the State of Vermont on a temporary or permanent basis, see Maintaining Vermont Medicaid Eligibility when Living Out of State.

- b. Nursing Facility – When an individual’s stay in a nursing facility exceeds, or is expected to exceed, 6 months.
 - c. ICF/DD – When an individual’s stay in an ICF/DD exceeds, or is expected to exceed, 6 months.
 - d. Extended Visit Out of State – When an individual’s temporary visit out of state exceeds 6 months¹⁴.
 - e. Moved Out-of-State – When an individual makes a permanent move out of state. Exceptions for people who are living out-of-state for the purposes of receiving treatment (shared living in a NH, MA or NY border town)¹⁵
 - f. Declines Services – When an individual voluntarily chooses to no longer receive services.
 - g. Prolonged Suspension – When a suspension exceeds 6 months.
 - h. Death – when an individual dies. Termination of funding date is the day after the individual died.
4. If the start date for newly approved HCBS (in whole or in part) is delayed, the start date for each delayed service must reflect (or, if previously submitted to DAIL, be amended to) the actual date services were started.
 5. If an individual in a group living situation moves out or dies, the funding allocated to that individual may be spread across the budgets for the remaining people in the home for up to 30 days without prior approval. Requests to extend the funding beyond 30 days must be made to the Equity Funding Committee or Public Safety Funding Committee and cannot extend beyond 90 days in total.

B. Access to and Eligibility for Funding

1. All services that can be funded under Medicare, Medicaid State Plan and/or private insurance must be accessed before using developmental disabilities HCBS funding. This includes but is not limited to; personal care services; clinical services; durable medical equipment; nutrition; High Technology Home Care; Early Periodic Screening, Diagnosis and Treatment; Medicaid transportation and

¹⁴ For further information about the impact on Medicaid funding and Social Security Benefits when leaving the State of Vermont on a temporary or permanent basis, see Maintaining Vermont Medicaid Eligibility when Living Out of State.

¹⁵ Ibid.

interpreter services when used for accessing Medicaid funded services. This also includes any treatment as specified in Act 158 (an act relating to health insurance coverage for early childhood developmental disorders, including autism spectrum disorders). Private insurance must be considered for children and young adults up to age 26.

2. Home and community-based services funding may not duplicate or substitute for services and supports that are the responsibility of other support systems. Other support systems may include services such as; Vocational Rehabilitation through the use of Impairment-Related Work Expenses (IRWE) and Plans to Achieve Self-Support (PASS plans); early intervention services through DCF; free and appropriate public education through the school system; home health services; meals on wheels, etc.
3. HCBS employment funding is available for ongoing support to maintain employment. Vocational Rehabilitation Grant funding may be used for job development and training. In addition, individuals who participate in post-secondary education opportunities may receive job placement assistance. Other employment related services may also be available through Vocational Rehabilitation.
4. Guidance on Flexible Family Funding can be found in the FFF Guidelines. Individuals who are receiving FFF or Family Managed Respite (FMR) through IFS who move to HCBS are no longer eligible for FFF or FMR. One-time funding can be used for FFF, but under no circumstances can FFF exceed \$1,000 per person per year, regardless of funding source.
5. If an individual's HCBS funding is terminated, including an individual whose eligibility is based upon Part 3.4 of the Regulations (grandfather clause for individuals who were receiving services on July 1, 1996), he or she retains clinical eligibility for services for up to one year, but must reapply for funding and have needs that meet the funding priorities in order to receive services.
6. If an individual's HCBS funding has been terminated for more than one year, the individual must complete the full application process, which includes determination of clinical eligibility, financial eligibility and if needs meet a funding priority.

C. Administrative Guidance for Funding

1. Each individual receiving services must receive at least an Annual Periodic Review of existing services by the DA/SSA providing services, or the Supportive ISO, to assure the level of funding is consistent with the individual's needs. A more frequent review is required if there is a significant change in the individual's needs. The Periodic Review must include an examination of the actual utilization of services in the past year as compared to the authorized funding limit.
2. Movement of funding within an individual's budget:
 - a. Moving of funds between already funded areas of support within an individual's budget is allowable without an updated needs assessment.
 - b. Moving funding to a currently unfunded area of support is allowable if a new needs assessment reveals a serious unmet need in that new area (see Attachment B). However, within the first year of being funded, movement of funds to a previously unfunded area of support is allowable only if it continues to meet the needs related to the originally identified funding priority (see Section Four, 11.A.1.).
3. Before requesting new funding:
 - a. DA/SSAs must reallocate their base allocation funding that is no longer needed by individuals currently receiving services.
 - b. The cost of services to meet the individual's new or increased needs must exceed \$4,500.
 - c. For individuals who are already receiving services, the DA/SSA must complete a new needs assessment to verify a change in need.
4. Funds are returned as Returned Caseload Funding when an individual has:
 - a. Had their services terminated (see Section Four, II.B.A.3).
 - b. Moved into a statewide group home.
 - c. Received new funding and there are any reductions to an individual's budget during the 12 months after receiving funding, including both existing and new funding, up to the amount newly funded. Any amount reduced that is more than the newly funded amount is retained by the DA/SSA or Supportive ISO and is reallocated to others who have a new or increased need.

5. Administration is authorized at 5% for all newly authorized funding rather than at the DA/SSA or Supportive ISO administration rate.
6. In the event of funding allocation reductions, DA/SSAs and Supportive ISO must inform individuals of their due process rights prior to reducing individual budgets or services as required by Part 8 of the Regulations Implementing the Developmental Disabilities Act. Individuals, families and guardians must be included in the budget reduction decision-making process.
7. Costs for broad-based services, as approved by the Division, include local and statewide crisis capacity (Vermont Crisis Intervention Network), local respite beds and the Fiscal Employer/Agent, and are spread across all individuals' home and community-based services budgets.
8. Payroll taxes such as Social Security and Medicare (FICA), State unemployment taxes (SUTA) and worker's compensation insurance costs must be calculated for payments to direct caregivers. DA/SSAs may adjust for rate changes according to the Regulations (Part 4.10(b)(2)). However, if rates increase, DA/SSAs are encouraged to absorb the increase in cost rather than reduce services.
9. All services must be budgeted at the actual cost or prevailing State-set rate, whichever is lower.
10. If the individual decides to move to a different provider or method of management within a calendar year from the date of service implementation, savings must be returned to the appropriate caseload fund (Equity and Public Safety).
11. If an individual chooses to receive services from a provider other than the DA, the provider submits a budget to the DA and the DA determines its costs to serve the individual and submits the lower of the two budgets to the funding committee. If the SSA is not able to provide the services at the lower approved budget, the DA must do so at that lower rate.
12. For new applicants who choose to self/family-manage their services, the Designated Agency determines its costs to serve the individual, and the individual self/family-managing works with the Supportive ISO to plan how best provide the services using the approved budget.
13. For individuals already self/family-managing services who have a new need as determined by a new needs assessment, the Supportive ISO develops and submits proposals to the Supportive ISO funding committee and then to the appropriate statewide funding committee.

14. When an individual transfers from one DA/SSA to another, all funding related to the individual's services, including the administration amount, is transferred to the new DA/SSA. Funding for local crisis services, local respite homes, the Fiscal Employer/Agent and statewide communication resources (through HowardCenter and Washington County Mental Health) are not transferred.
15. Agencies should use Bridge Funding for children in need of case management/care coordination prior to accessing Targeted Case Management.
16. Increases in Targeted Case Management allocations may be achieved by converting DD HCBS funding to a DA/SSA's TCM allocation. This may also be done when an individual's whole HCBS budget has been suspended to provide transition services for the individual when he or she is moving from a hospital.
17. Joint funding arrangements for home and community-based services involving other state agencies (e.g., VDH, DCF, DOC, DMH) and/or out-of-state organizations must involve the DDS in negotiation and receipt of funding. The Division does not contract with local schools; however, schools may contract directly with local developmental disabilities services providers. These contracts do not involve DDS funding and are not managed by the Division.

D. Limitations for Funding

1. Funding is allocated to meet an individual's unmet needs related to the funding priorities, and based on the most cost effective method of providing services and ensures the funding is targeted to support the individual in making progress toward personal goals. When reviewing a proposal for an individual already receiving funding, the committee may consider the individual's whole budget for consideration of the best way to meet the individual's new needs.
2. The maximum HCBS funding per person per year is \$200,000. Requests will be reviewed through the funding committee process. The Division makes the final decision to approve funding.
 - a. Under extraordinary circumstances, the Division may grant an exception to the maximum on a time-limited basis. Under no circumstances shall exceptions exceed \$250,000¹⁶.

¹⁶ Individuals with a budget between \$250,000 and \$300,000 as of September 27, 2013 may continue with that budget amount consistent with their needs which are subject to six month review.

- b. All existing and new budgets over \$200,000 will be reviewed by the Division at least every 6 months to verify the funded level of support is still needed. Depending on individual circumstances, the Division may decide to review an individual's budget more frequently than every 6 months. In order to verify that the level of support is needed, the review process shall include a review of relevant information including, but not limited to, the most recent assessment and ISA and consultation with the individual's support team. In those instances when the Division review process does not result in a finding that the level of need is verified, the Division Director will make a final decision regarding the amount of funding based upon the information gathered during the review process and, if necessary, further consultation with the individual's support team.
3. Funded services will not duplicate or substitute for natural supports and DA/SSAs will actively develop opportunities to increase natural and unpaid supports.
4. New funding may be authorized for a time-limited period, when appropriate, with the intention to reduce funding based on a review of needs.
5. The maximum cost for service coordination managed through a DA/SSA shall be published in the DAIL Medicaid Claim Codes and Reimbursement Rates¹⁷. If actual costs are less than the published rate, the actual cost must be used. The maximum cost for service coordination for individuals who self/family-manage shall also be published by DAIL. When an individual transfers from a DA/SSA to self/family-managed, the difference between the DA/SSA's service coordination rate and the rate for individuals who self/family-manage is transferred to the Supportive ISO to pay their administrative costs.
6. Reasonable transportation expenses to provide access to the community may be funded, including payments toward the cost of accessible vehicles when used as the primary means of transportation for the individual with developmental disabilities. The maximum per person payment for accessible vehicles shall be published in the DAIL Medicaid Claim Codes and Reimbursement Rates¹⁸.
7. A provider may not bill HCBS for an individual on the same day as

¹⁷ For more information go to DAIL Adult Services Division & Developmental Disabilities Services Division Services: Medicaid Claims Codes and Reimbursement Rates.

¹⁸ Ibid.

Clinic Services, Rehabilitation Services, Bridge Program, Targeted Case Management, PASRR Specialized Services or ICF/DD services.

8. Home and community-based services can only be billed through one HCBS program on the same day (e.g., DDS, TBI, Choices for Care, DMH). If an individual qualifies for more than one HCBS program, the individual can be evaluated to determine the package of supports available and then make an informed decision about which program to choose. Where services administered by either DMH and/or DDS are concerned, funding from one department may be transferred for use under one HCBS program according to the current interdepartmental agreement between DMH and DAIL.
9. Home and community-based services funding may not pay for room and board costs. These costs are typically paid for through the individual's SSI/SSDI.
10. Shared living homes must meet the housing safety and accessibility standards.
 - a. The home provider, or applicable landlord, is responsible for all costs to be in compliance with the housing standards.
 - b. Home and community-based services funding may help pay for home modifications for physical accessibility, not to exceed \$10,000. The costs of ramps, widening doorways and accessibility modifications to bathrooms may be appropriate costs to reimburse.
 - i. Physical accessibility modifications that do not add to the value of the home may be paid for, when necessary, using DA/SSA base allocation, new funding or one-time funding. Once a modification is paid for, the additional allocation must be deducted from the individual's budget.
 - ii. Only the modifications that improve the value of the home that are made for meeting physical accessibility needs of an individual, may be funded up to 50% of the cost, not to exceed the \$10,000 cap. For example, if a new bedroom is needed to allow the individual to live in the home, the home provider should pay for the addition of the bedroom. However, additional cost to make that bedroom accessible may be paid for with HCBS funding.

- iii. Two or more bids are required when construction work is needed to provide the modification. Funding is allocated based on the most cost effective bid.
 - iv. Home modifications under \$5,000 may be paid in a lump sum. Home modifications that cost from \$5,000 to \$10,000 will be paid on a monthly payment basis which ends if the individual moves.
11. Funding for work supports is to maintain an employer-paid job. The following limits apply to new funding for community supports and work supports:
- a. Community supports and work supports are limited to individuals age 19 and older.
 - b. Individuals receiving work supports only: work support hours may not exceed 25 hours per week, including transportation hours. Developing and executing a transportation plan is part of work supports. Individuals should be assisted, as needed, in learning to use public transportation or in working out rides from natural supports, including co-workers.
 - c. Individuals receiving community supports only: community support hours may not exceed 25 hours per week (community support hours include transportation time).
 - d. Individuals receiving both work supports and community supports: may not exceed a total of 25 hours per week of community supports and work supports (including work support transportation hours). An individual is not eligible for new funding for community supports if he or she is already receiving 25 hours per week of work supports.
12. Individuals who chooses to self/family-manage or share-manage cannot manage 24-hour home supports (i.e., shared living, staffed living, group living). Individuals may self/family-manage up to 8 hours per day of paid home supports. However, individuals who need 24-hour home supports may receive them from their local DA, or an SSA of their choice.
13. Developmental disabilities HCBS services funding cannot be used to:
- a. Increase the availability of residential settings that provide supports to more than four adults (age 18 and over). Any exceptions to this limitation must be approved by the Division.

- b. Fund residential settings that provide supports to three or more children (under the age of 18). Any exceptions to this limitation must be approved by the Division.
- c. Fund placements in residential schools or treatment centers; or in-state or out-of-state nursing facilities¹⁹, correctional facilities, psychiatric hospitals or ICF/DDs.²⁰
- d. Fund out-of-state placements for adults unless they pose a risk to public safety and there are no appropriate treatment options in Vermont and the cost is less than the cost of community-based supports in Vermont. Involvement and approval by the Division is required.
- e. Pay for room and board²¹, including costs of vacations. Home and community-based services funding may be used, however, to cover costs incurred by a paid caregiver to support an individual on vacation (e.g., hotel and food expenses).
- f. Fund sheltered workshops or enclaves (segregated work environments within an employer's worksite).

¹⁹ Home and Community-Based Services funding may be converted to pay for PASRR Nursing Facility Day Rehabilitation for individuals living in nursing facilities.

²⁰ Exceptions to this limitation that involve a post-secondary educational experience may be considered but require approval by DAIL.

²¹ Other sources of funding to assist with room and board costs include SSI, Section 8 subsidies, wages and public assistance (e.g., fuel assistance program, General Assistance vouchers, 3Squares VT).

III. Approaches to Manage Home and Community-Based Services Funding

To effectively manage funding for home and community-based services:

1. The Equity Funding Committee and Public Safety Funding Committee will make funding recommendations for both new applicants and individuals with new needs in accordance with the roles of the Equity and Public Safety funding committees described in Section Three. The Division will establish monthly funding targets and will manage statewide funding based on the monthly targets.
2. The needs of each individual currently receiving services will be re-assessed annually by the DA/SSA, or Supportive ISO, using the needs assessment and level of care assessment to assure the individual's budget reflects current needs, strengths and progress toward personal goals. An Annual Periodic Review will take place as part of the planning for the individual's next Individual Support Agreement (ISA) or ISA review. The individual's budget will be adjusted to reflect current needs.

In the event of fiscal pressures (e.g., an appropriation less than projected need, rescission), the Division may reduce DA/SSAs and Supportive ISO base allocations. The Division will issue instructions and provide guidance. Options include, but are not limited to, using one or more of the following approaches.

1. DA/SSAs and Supportive ISO make reductions in administrative costs.
2. DA/SSAs and Supportive ISO make an across the board reduction to individuals' budgets. Each individual's budget is reduced by the same percentage. Individuals and guardians must be involved in the process of determining what services are reduced.
3. DA/SSAs and Supportive ISO are given flexibility to determine how to fund the reduction through efficiencies, administrative and/or non-direct service reductions, and/or reductions in individual's budgets. Individuals and guardians must be involved in the process of determining what services are reduced.
4. The Division identifies specific services that can and/or cannot be reduced.

If services are reduced, individuals and guardians will be provided with notice of the right to appeal²² the reduction.

²² See Regulations Implementing the Developmental Disabilities Act of 1996 for information on the right to appeal.

IV. Waiting List

Each Designated Agency maintains a waiting list that includes:

1. Individuals eligible for home and community-based services based on their developmental disability, including those already receiving services, but whose request for services is denied, in whole or in part, because the individual's needs do not meet a funding priority.
2. Individuals eligible for Flexible Family Funding but for whom there are insufficient funds (including people who receive partial funding and/or one-time funding).
3. Individuals eligible for Targeted Case Management but for whom there are insufficient funds.
4. Individuals eligible for Family Managed Respite funds but for whom there are insufficient funds²³.

Each Specialized Service Agency and Supportive ISO maintains a waiting list that includes individuals already receiving services, but whose request for services is denied, in whole or in part, because the individual's needs do not meet a funding priority.

Each Designated Agency, Specialized Service Agency and Supportive ISO shall notify individuals when they have been placed on a waiting list and review needs of all people on the waiting list:

1. At least annually; and
2. When there are changes in the home and community-based services funding priorities;

to see if the individual meets a funding priority, and if so, to submit a funding proposal and/or refer the individual to other resources and services.

Each Designated Agency, Specialized Service Agency and Supportive ISO shall conduct or arrange for a reassessment of needs of an individual on a waiting list when notified of significant changes in the individual's life situation. Each DA, SSA and Supportive ISO shall submit a funding proposal if the individual meets a funding priority and/or refer the individual to other resources and services, as needed.

²³ Family Managed Respite funds are available to children under age 22 with developmental or other disabilities.

Each Designated Agency, Specialized Service Agency and Supportive ISO shall submit waiting list data according to instructions established by the Division. The waiting list for Flexible Family Funding and Family Managed Respite are reviewed by the Division annually, as well as the utilization of allocation, and resources are redistributed as needed.

SECTION FIVE – PLAN DEVELOPMENT

This section highlights the contributors to the *Plan*. Preparation of the State System of Care Plan includes the following:

1. Obtain written information from a variety of sources, including individuals and organizations that provide, receive, advocate for, and are influenced by, developmental disabilities services and supports;
2. Review local system of care plans from DAs;
3. Hold public hearings;
4. Discuss with the DDS State Program Standing Committee and other statewide advisory groups;
5. Analyze trends in the quality review process and satisfaction surveys; and
6. Adherence to the Developmental Disabilities Act of 1996.

I. Local System of Care Plans

All designated agencies under contract with the Division must submit a Local System of Care Plan that covers the three year period of FY 2015 – FY 2017 for the review and approval by the Division. The purpose of the plans is two-fold:

1. Guide the development of local services, including identifying priority areas of support and use of resources to meet specific regional needs; and
2. Inform the *State System of Care Plan* and the annual budget process.

Local System of Care Plans include sections on plan development, priority needs and resources, and outcomes. Designated Agencies identify regional and statewide issues, some of which require focused planning and change in process to achieve, while others require additional funding. The DA's followed a Results-Based Accountability (RBA) approach to outlining their goals for the 3-year plan period. For each goal, agencies described: *what they are going to do* (the goal), *how they are going to do it* (strategies to achieve the goal) and *what difference it will make* (how will they know if each goal was achieved and to what extent). Each plan was carefully reviewed and analyzed to determine the applicable contributions and feedback to the *State System of Care Plan*. The following page lists a summary of all local plans. *Attachment E* provides a detailed summary of each plan²⁴.

²⁴ Each Local System of Care Plan provides detail about the resources available and those needed to realize the priority needs and meet specific goals of the identified outcomes. Readers are encouraged to review the local plans in their entirety to understand and appreciate the full scope and focus of the plans. They are posted on the DAIL website at www.dail.vermont.gov.

FY 2015 – FY 2015 Local System of Care Plans Summary – Priority Outcomes		
Service/ Support Area	Frequently Mentioned (by 3 or more local plans)	Occasionally Mentioned (by 2 local plans)
Clinical Services	<ul style="list-style-type: none"> - Short term crisis resource - Clinical expertise / training - Alternative therapies 	
Communication – Internal/External	<ul style="list-style-type: none"> - Information and Referral - Accurate / timely information sharing - Marketing strategies 	
Community Supports	<ul style="list-style-type: none"> - Flexible / PLAN - Group supports - Transportation 	
Employment Services	<ul style="list-style-type: none"> - Self-employment / job share - Micro business enterprise - Project Search site - Network with schools 	
Flexible Family Funding (FFF)	<ul style="list-style-type: none"> - Increase maximum payment 	
Health Care Reform	<ul style="list-style-type: none"> - Medical model concern - Advocacy for DD services / safeguards 	
High Risk		<ul style="list-style-type: none"> - Public safety options - Inpatient psychiatric / emergency hospitalization
Housing Options/ Independent Living	<ul style="list-style-type: none"> - Vouchers / rental assistance - Skill development / assessment - Use of technology - Alternative / transitional housing - Peer mentoring - Partnership / networking 	
Integrated Family Services (IFS)	<ul style="list-style-type: none"> - Respite resources - Need clarity / guidance - Improve integration 	
System Sustainability	<ul style="list-style-type: none"> - Funding appropriate to needs - Competitive compensation 	
Training		<ul style="list-style-type: none"> - Vermont Training Consortium - Coordination / flexible
Transportation		<ul style="list-style-type: none"> - Network / Collaborate - Public transportation / car pool

II. On-Line Survey

The Division posted an on-line survey to get input on key questions concerning developmental disabilities funding and services. Ninety-nine (99) individuals responded to the survey. The survey was long (17 questions) and reoccurring themes developed. The following list is a summary of some of the most frequently mentioned comments. A detailed summary is in *Attachment F*.

What is working well?

- Caring, hardworking, responsive, educated staff
- Guiding principles/values
- Person-centered planning – individualized support plans/budgets – choice
- Self-advocacy
- Technology

What is not working well?

- Attitude of State administration
- Budget cuts
- Congregate day settings
- Funding priorities
- Housing options
- Quality of services
- Roadmap to services
- Training and education of support staff/shared living providers
- Transportation options

Family Support

- Early intervention and prevention planning
- Family advocacy and outreach
- Housing/home support options
- Information and referral
- Listen to what families need
- Peer navigators – peer-to-peer mentor program
- Respite
- Training/education for families

Supervised Living – Support to Live in Own Home

- Choice
- Communication skills/technology
- Community supports
- Housing/home support options
- Independent living skills development
- Peer support
- Staff consistency
- Technology to promote independence
- Transportation

High School Graduates/Employment

- Plan ahead – quality transition planning
- Post-secondary education
- Teach independent living/life skills
- Coworker mentors
- Good job matches
- Promote/train independence at work

Technology

- Access resources/try-out centers/DAIL Assistive Technology Program
- Computers, mobile devices, telecommunications
- Multiple uses/benefits of technology
- Network/training/conferences in use of technology
- Recycle equipment
- Increase independent living
- Social networking

Funding

- Agreement with funding priorities
- Lower eligible age of all priorities to age 18
- Broaden eligibility for employment funding priority
- Reinstate previous priorities
- Include children in priorities #1 and #2
- Priorities force crisis in order to obtain services
- Proactive access to funding before situations become emergencies
- System based on emergency situations only

III. Green Mountain Self-Advocates

Members of the Green Mountain Self-Advocates' Board of Governors brainstormed a list of suggestions for the *Plan* based on the on-line survey questions. Green Mountain Self-Advocates feedback is in *Attachment G*.

IV. Consumer Survey

The Consumer Survey Project conducted 603 interviews of adults who receive developmental disabilities services over the course of the past three years (2011, 2012 and 2013). Overall, individuals expressed general satisfaction with where they lived, worked, what they did during the day, and with the individuals who provide them support. A high percentage of individuals who responded to the survey said they:

- Are happy with where they live.
- Are happy with how they spend their free time at home.
- Feel safe at home and in their neighborhoods.
- Have a say in how they spend their money.
- Like their jobs and are treated with respect by their coworkers.
- Like their community activities and the people with whom they spend time.
- Have opportunities to meet new people.
- Are happy with their guardian and get to see their guardian when they want.
- Are happy with their case manager and service agency.
- Get to learn new things/skills.

Survey results also indicated individual's satisfaction was lower in regard to their autonomy. For example, a high percentage of individuals who responded to the survey said they:

- Do not have a choice in where they live or who they live with.
- Do not decide when friends or family can come over to visit.
- Do not have privacy when friends and family visit.
- Cannot stay home alone when others go out.
- Do not have a key to their home.
- Do not work enough hours at their job.
- Do not have a job but want to work.
- Do not have enough community activities.
- Have not voted in an election.
- Feel lonely and wish they had more friends.

V. Quality Reviews

The Division's Quality Management Reviewers conduct bi-annual on-site reviews to assess the quality of services provided by agencies and services that are self/family-managed. Services for a total of 307 individuals were reviewed in the most recent two-year cycle²⁵. This increase in total number of individual services reviewed was due to the addition of a part time Quality Management Reviewer position being added to the team allowing an increased sample size from 10% to 15% of individuals receiving HCBS funded supports.

Areas of Strength – The following trends were noted as areas of strength during this review cycle:

- Communication among the individual's team members.
- Individualized supports across all funded areas.
- Knowledgeable and well-trained service coordination staff.
- Successful, creative employment supports – individualized to meet needs and increased support for consumer businesses and self-employment.
- Well trained direct service staff, including shared living providers.
- Positive family supports.
- Individuals supported to make healthy meal choices & exercise regularly.
- Clinical supports available and used as appropriate.

Areas of Importance to Improve the Quality of Services – The majority of agencies had no areas of importance noted during this review cycle. Of those that did have areas identified, the following trends were noted. Agencies have submitted plans of correction to address these areas.

- Documentation required by the health and wellness guidelines (missing information on emergency fact sheets; missing documentation of prescriptions, annual physical exams, need for follow-up appointments, or other required medical information).
- Lack of consistency and thoroughness in the ISA documents (e.g., no clear method for documenting or tracking progress toward accomplishing the outcomes).
- Inconsistent knowledge of available clinical supports and use across agency including assessment and writing of needed Comprehensive Behavior Support Plans to foster positive behavior supports.
- Inconsistent knowledge of required Guidelines, Regulations and Requirements (i.e., Health & Wellness Guidelines, Behavior Support Guidelines, Critical Incident Reporting Requirements).

²⁵ The 307 individuals were reviewed between June 2011 and May 2013.

VI. Public Hearings

Public hearings on the DRAFT Developmental Disabilities Services State System of Care Plan were held. The first public hearing took place on Thursday, May 8, 2014 at the DAIL Advisory Board meeting from 2:00 p.m. – 3:00 p.m. at the Comfort Inn and Suites in Barre, Vermont. The second public hearing took place on Thursday, May 15, 2014 at the State Program Standing Committee meeting from 9:30 a.m. to 12:30 p.m. at the Comfort Inn and Suites in Berlin, Vermont. The third public hearing took place on Monday, May 19, 2014 from 5:30 p.m. to 7:30 p.m. via Vermont Interactive Technologies (VIT) at the following locations: Brattleboro, Montpelier, Newport, Rutland, White River Junction and Williston. Interpreter services were available at the Williston VIT location. The locations of each VIT site can be found on the VIT website at: www.vitlink.org.

Written comments were **required to be received at the Division no later than 4:00 p.m. on Friday, May 30, 2014**. Written comments were submitted to*:

Tina Royer, Executive Staff Assistant
E- mail: tina.royer@state.vt.us
For inquiries, call: 802-871-3065

U.S. Mail:
Department of Disabilities, Aging and Independent Living
Developmental Disabilities Services Division
103 South Main Street – Weeks Building
Waterbury, Vermont 05671-1601

****Due to possible delays with the mail system, it was strongly encouraged that comments be submitted by e-mail.***

A summary of the feedback received from the public input process was incorporated into the final *Plan*.

VII. Advisory Groups

The Developmental Disabilities Services State Program Standing Committee (SPSC) provided initial input into the development of the draft *Plan* at their March 20, 2014 and April 17, 2014 meetings. Feedback on the DRAFT *Plan* was provided as part of the public hearings scheduled during the DAIL Advisory Board on May 8, 2014 and the SPSC meeting on May 15, 2014.

VIII. Regulations Implementing the Developmental Disabilities Act of 1996

The Developmental Disabilities Services Division's Regulations Implementing the Developmental Disabilities Act of 1996 were updated in 2011. The Regulations provide the following guidance for developmental disabilities services.

- Part 1 – Defines terms used in the Regulations
- Part 2 – Provides the definition of developmental disability and criteria for eligibility
- Part 3 – Provides the criteria of who is a recipient
- Part 4 – Describes process for application, assessment, notification, support planning and periodic review of needs and reassessment of eligibility
- Part 5 – Describes self-managed and family-managed services
- Part 6 – Describes the financial requirements of recipients
- Part 7 – Provides the definition for special care procedures
- Part 8 – Defines the grievance and appeal procedures
- Part 9 – Outlines the standards for training
- Part 10 – Describes certification requirements of providers

SECTION SIX – DDS SYSTEM DEVELOPMENT ACTIVITIES

I. DDS Strategic Plan

The goals and objectives listed below follow a Results Based Accountability approach. They are part of the DAIL Strategic Plan and are consistent with the Agency of Human Services Strategic Plan and the Governor’s priorities for all Vermonters.

	Results	Performance Measures	What we are going to do to Improve Performance	Turning the Curve (updated annually)
Goal 1: Decrease the Lasting Impacts of Poverty on Individuals, Children and Families in Vermont and Create Pathways out of Poverty. [AHS Strategic Plan Goal]				
1	People with intellectual and developmental disabilities are employed.	Percentage of working age adults (age 18 – 65) supported by developmental disabilities services who are employed. <u>FY 15 Target:</u> 45% working age adults employed statewide.	1.a. DDSD will collaborate with the Division of Vocational Rehabilitation (DVR) to provide training and technical assistance to providers to enhance employment outcomes and meet the target. 1.b. DDSD will support and expand opportunities for transition age youth to participate in post-secondary education which will support their career goals. 1.c. DDSD will collaborate with DVR, Agency of Education and the National Project Search to implement Vermont Project Search which provides transition-age youth industry-based training	

	Results	Performance Measures	What we are going to do to Improve Performance	Turning the Curve (updated annually)
			to support their employment opportunities and career goals. 1.d. DDS/D will provide technical assistance to support the option for self-employment.	
Goal 2: Promote the Health, Well-Being and Safety of Individuals, Families and our Communities. [AHS Strategic Plan Goal]				
2	Adults receive effective public guardianship services.	Percent of individuals under guardianship who received an in-person contact each month. <u>FY 15 Target:</u> Establish a baseline <u>FY 16 – FY 17 Target:</u> The percent of individuals under guardianship who received an in-person contact is maintained or increases over baseline in 8 out of 12 months.	2.a. The Office of Public Guardianship (OPG) will track the frequency of in-person contacts. 2.b. OPG supervisors will work with guardians to ensure adequate frequency of visits based upon the individual needs of those under guardianship.	
Goal 3: Enhance AHS’s focus on program effectiveness, accountability for outcomes, and workforce development and engagement. [AHS Strategic Plan Goal]				
3	Stakeholders are easily able to find the information they need on the new DDS/D website.	Percentage of satisfaction from feedback from website users regarding usefulness of content, ease of navigation and accessibility. <u>FY 15 Target:</u> 80% of users will report satisfaction with being able to find the information they needed, ease of navigation and accessibility.	3.a. DDS/D will work with website developers to develop new website format and content. 3.b. DA/IL will solicit feedback from stakeholders using the website and make improvements based on feedback.	

	Results	Performance Measures	What we are going to do to Improve Performance	Turning the Curve (updated annually)
Goal 4: All Vermonters Have Access to High Quality Health Care. [AHS Strategic Plan Goal]				
4	People receiving developmental disabilities home and community-based services will have access to health care.	Percent of people receiving developmental disabilities HCBS services who access preventive care: (recipients age 20 and older with one or more annual preventive/ambulatory health services visits during the measurement year) <u>FY 15 Target: 96%</u>	4.a. The goal is included in DA/SSA Master Grant Agreements with AHS and includes incentives for meeting targets. 4.b. DDS Quality Management Unit also monitors the requirement for annual physicals as part of each DA/SSA biannual quality services review. Corrective feedback and technical assistance is provided as needed.	

II. DDS Work Plan – SFY 2015 – SFY 2017

Over the next three years (FY 15 – FY 17), the Developmental Disabilities Services Division (DDSD) will focus on the following activities in partnership with other stakeholders to help people with developmental disabilities achieve their personal goals and to improve the system of supports. The system development activities from the previous System of Care Plan covering FY 11 – FY 14 are summarized in Attachment H.

#	Activity / Actions Taken	Timeline Target (Fiscal Year)	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Goal #1</u>			
Disability Long Term Services and Supports (DLTSS) use person-centered and inclusive processes and provide comprehensive and integrated services that improve health and quality of life.			
1.a.	Developmental Disabilities Services Division (DDSD) will advocate for participation by individuals and families in Vermont’s health reform initiative.	FY 15 – FY 17	
<u>Actions Taken</u>			
1.b.	DDSD will participate in the development of health reform models to ensure they meet the needs of people with developmental disabilities and are consistent with the Principles of Developmental Disabilities Services.	FY 15 – FY 17	
<u>Actions Taken</u>			
<u>Goal #2</u>			
People interested in self/family-management are informed about how to manage developmental disabilities services.			
2.a.	DDSD will update the <i>Handbook for People who Self- and Family-Manage Medicaid Wavier Services</i> .	FY 15	
<u>Actions Taken</u>			

#	Activity / Actions Taken	Timeline Target (Fiscal Year)	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
Goal #3			
People receiving services have voice and choice in their life.			
3.a.	DDSD will work with stakeholders to develop a plan to assure AHS is in compliance with Centers for Medicare and Medicaid Services (CMS) home and community-based services rule changes (e.g., person-centered planning, consumer choice and control).	FY 15 – FY 17	
<u>Actions Taken</u>			
Goal #4			
The design of Integrated Family Services (IFS) meets the needs of families and children.			
4.a.	DDSD will advocate for participation by families and children in the development of Integrated Family Services.	FY 15 – FY 17	
<u>Actions Taken</u>			
4.b.	DDSD will continue to participate in the design and implementation of Integrated Family Services to support the needs of children with developmental disabilities and their families.	FY 15 – FY 17	
<u>Actions Taken</u>			
Goal #5			
Developmental disabilities services are effective, cost efficient and are provided in a way consistent with the DD Act Principles of Service.			
5.a.	DDSD will develop a work plan and timeline to provide updates to policies and guidelines (e.g., DDS Medicaid Manual, Pre-Admission Screening and Resident Review [PASRR], Health and Wellness Guidelines.)	FY 15	
<u>Actions Taken</u>			
5.b.	DDSD will explore the feasibility of implementing automated processes for applying for services and tracking funding authorization.	FY 16	

#	Activity / Actions Taken	Timeline Target (Fiscal Year)	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Actions Taken</u>			
5.c.	DDSD will support improvement of statewide workforce performance via enhanced training and supervision through support of, and investment in, the Vermont Training Consortium.	FY 15 – FY 16	
<u>Actions Taken</u>			
5.d.	DDSD will finalize the Critical Incident Reporting (CIR) requirements to: 1) reflect changes in electronic reporting, and 2) provide clarity in the definitions of critical incidents (e.g., when and how CIRs are reported; internal process for handling CIRs; data review, analysis and reporting).	FY 15	
<u>Actions Taken</u>			
5.e.	DDSD will streamline the current Critical Incident Reporting (CIR) process by working with AHS/DAIL Information Technology (IT) to enable providers to submit CIR reports electronically.	FY 15 – FY 16	
<u>Actions Taken</u>			
5.f.	DDSD will examine the use and quality of group community services and report to the State Program Standing Committee.	FY 16	
<u>Actions Taken</u>			
5.g.	DDSD will examine how DDSD addresses services to people who pose a risk to public safety in a respectful and equitable manner.	FY 15 – FY 16	
<u>Actions Taken</u>			

#	Activity / Actions Taken	Timeline Target (Fiscal Year)	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Goal #6</u> People with developmental disabilities have expanded service and support options and opportunities.			
<u>Actions Taken</u>			
6.a.	DDSD will work to expand post-secondary education supports for people eligible for developmental disabilities services when additional funds are available.	FY 15 – FY 17	
<u>Actions Taken</u>			
6.b.	DDSD will review recommendations from the Residential Alternatives work group (formed in response to the 2013 DDS Summer Legislative Work Group) and work with providers to transition more people: 1) from Shared Living to Supervised Living, and 2) to more independent living arrangements.	FY 16 – FY 17	
<u>Actions Taken</u>			
6.c.	DDSD will review recommendations from the Residential Alternatives work group (formed in response to the 2013 DDS Summer Legislative Work Group) and work with providers to expand the use of technology to help people live in Supervised Living/more independent living arrangements (similar to Safety Connections). Focus specifically on areas outside of Chittenden County.	FY 15 – FY 17	
<u>Actions Taken</u>			
6.d.	DDSD will review recommendations from the Employment Work Group (formed in response to the 2013 DDS Summer Legislative Work Group) and review and work with providers to pilot the paying of employers/coworkers to support an individual on the job.	FY 15 – FY 17	
<u>Actions Taken</u>			

#	Activity / Actions Taken	Timeline Target (Fiscal Year)	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Goal #7</u>			
The process for allocating home and community-based services resources will be equitable, transparent and uniform across the state.			
7.a.	DDSD will explore various approaches/enhancements to the process of resource allocation to sustain increased service demands while ensuring efficiency and effectiveness in DDS home and community-based services. DDSD will report to stakeholders on findings and involve them in developing recommendations and strategies for enhancement.	FY 16	
<u>Actions Taken</u>			
7.b.	DDSD will implement an improved resource allocation process.	FY 17	
<u>Actions Taken</u>			

ATTACHMENTS

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ATTACHMENT A

DEVELOPMENTAL DISABILITIES SERVICES CODES AND DEFINITIONS

EFFECTIVE: OCTOBER 15, 2012

All services and supports are provided in accordance with the person's Individual Support Agreement (ISA) and applicable State and Federal requirements, including health and safety, training and emergency procedures. Services and supports are funded in accordance with the guidance outlined in the Vermont State System of Care Plan for Developmental Disabilities Services.

Individual budgets may comprise any or all of the services and supports defined in this document and are included in an all inclusive daily rate that combines all applicable services and supports provided to the individual. The daily rate may include:

<u>Code</u>	<u>Service</u>
A01	Service Coordination
B01	Community Supports
C01 – C04	Employment Supports
D01 – D02	Respite
E01 – E07	Clinical Services
G01 – G02	Crisis Services
H01 – H06	Home Supports
I01	Transportation

Some services and supports may be managed by individuals or family members who would fulfill the responsibilities of the employer (e.g., arrange background checks, hire, train, supervise/monitor, fire) as the employer of record. In these situations where the agency is not the employer, a fiscal ISO is responsible for the bookkeeping and reporting responsibilities of the employer. A supportive ISO is also available to assist individuals and families who self/family-manage services with other administrative responsibilities. The parameters of self/family-managed services are outlined in the Regulations Implementing the Developmental Disabilities Act of 1996.

Some services and supports (i.e., Community Supports, Employment Supports and Respite) may be arranged by a home provider who would fulfill the responsibilities of the employer (e.g., arrange background checks, hire, train, supervise/monitor, fire) as the employer of record. In these situations where the agency is not the employer, a fiscal ISO is responsible for the bookkeeping and reporting responsibilities of the employer.

Service Coordination

A01 Service Coordination assists individuals in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. The role of service coordinators is quite varied and individualized, and often can be instrumental in helping individuals get and maintain services. Service Coordination responsibilities include, but are not limited to, developing, implementing and monitoring the Individual Support Agreement; coordinating medical and clinical services; establishing and maintaining a case record; reviewing and signing off on critical incident reports; and providing general oversight of services and supports.

Some responsibilities of the services coordinator must be done by a Qualified Developmental Disabilities Professional (QDDP) who must either work for the provider agency or must have an endorsement by the State of Vermont.

Community Supports

B01 Community Supports are provided to assist individuals to develop skills and social connections. The supports may include teaching and/or assistance in daily living, supportive counseling, support to participate in community activities, collateral contacts (i.e., contact with professionals or significant others on behalf of the individual), and building and sustaining healthy personal, family and community relationships. Community Supports may involve individual supports or group supports (2 or more people). Supports must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within the natural settings of home and community.

Employment Supports

Employment Supports are provided to assist transition age youth and adults in establishing and achieving work and career goals.

Environmental modifications and adaptive equipment are component parts of supported employment and, as applicable, are included in the daily rate paid to providers. Transportation is a component part of Employment Supports that is separately identified and included in the total hours of Employment Supports.

C01 Employment assessment involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the development of personal work goals.

C02 Employer and Job Development assists an individual to access employment and establish employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.

C03 Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

C04 Ongoing Support to Maintain Employment involves activities needed to sustain paid work by the individual. These supports and services may be given both on and off the job site, and may involve long-term and/or intermittent follow-up.

Employment Supports do not include incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs;
or,
3. Payments for vocational training that are not directly related to individuals' supported employment program.

Respite Supports

Respite Supports assist family members and home providers/foster families to help support specific individuals with disabilities. Supports are provided on a short-term basis because of the absence of or need for relief of those persons normally providing the care to individuals who cannot be left unsupervised.

D01 Respite Supports provided by the hour.

D02 Respite Supports provided by the day/overnight.

Clinical Services

Clinical Services include assessment, therapeutic, medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist or nurse. Clinical Services are medically necessary clinical services that cannot be accessed through the Medicaid State Plan.

E01 Clinical Assessment services evaluate individuals' strengths; needs; existence and severity of disability(s); and functioning across environments. Assessment services may include evaluation of the support system's and community's strengths and availability to the individual and family.

E02 Individual Therapy is a method of treatment that uses the interaction between a therapist and the individual to facilitate emotional or psychological change and to alleviate distress.

E03 Family Therapy is a method of treatment that uses the interaction between a therapist, the individual and family members to facilitate emotional or psychological change and to alleviate distress.

E04 Group Therapy is a method of treatment that uses the interaction between a therapist, the individual and peers to facilitate emotional or psychological change and to alleviate distress.

E05 Medication and Medical Support and Consultation Services include evaluating the need for and prescribing and monitoring of medication; providing medical observation, support and consultation for an individual's health care.

[E06 intentionally missed – used by DMH]

E07 Behavioral Support, Assessment, Planning and Consultation Services include evaluating the need for, monitoring and providing support and consultation for positive behavioral interventions/emotional regulation.

E08 Other Clinical Services are services and supports not covered by Medicaid State Plan, including medically necessary services provided by licensed or certified individuals (such as therapeutic horseback riding) and equipment (such as dentures, eyeglasses, assistive technology).

Crisis Services

Crisis Services are time-limited, intensive, supports provided for individuals who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Crisis Services may be individualized, regional or statewide.

G01 Emergency/Crisis Assessment, Support and Referral include initial information gathering; triage; training and early intervention; supportive counseling; consultation; referral; crisis planning; outreach and stabilization; clinical diagnosis and evaluation; treatment and direct support.

G02 Emergency/Crisis Beds offer emergency, short-term, 24-hour residential supports in a setting other than the person's home.

Home Supports

Home Supports provide services, supports and supervision provided for individuals in and around their residences up to twenty-four hours a day, seven days a week (24/7).

An array of services are provided for individuals, as appropriate, in accordance with an individual planning process that results in an Individual Support Agreement (ISA). The services include the provision of assistance and resources to improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include support for individuals to acquire and retain life skills and for maintaining health and safety.

Support for home modifications required for accessibility for an individual with a physical disability may be included in Home Supports. When applicable, these supports are included in the daily rate paid to providers. The daily rate does not include costs for room and board.

H01 Supervised Living are regularly scheduled or intermittent hourly supports provided to an individual who lives in his or her home or that of a family member. Supports are provided on a less than full time (not 24/7) schedule.

H02 Staffed Living are provided in a home setting for one or two people that is staffed on a full time basis by providers.

H03 Group Living are supports provided in a licensed home setting for three to six people that is staffed full time by providers.

H04 Shared Living (licensed) supports are provided for one or two children in the home of a shared living provider/foster family that is licensed. Shared living providers/foster families are contracted home providers and are generally compensated through a "Difficulty of Care" foster care payment.

H05 Shared Living (not licensed) supports are provided to one or two people in the home of a shared living provider/foster family. Shared living providers/foster families are contracted home providers and are generally compensated through a "Difficulty of Care" foster care payment.

H06 ICF/DD (Intermediate Care Facility for people with Developmental Disabilities) is a highly structured residential setting for up to six people which provides needed intensive medical and therapeutic services.

Transportation Services

I01 Transportation Services are accessible transportation for an individual living with a home provider or family member and mileage for transportation to access Community Supports. Transportation is a component part of Employment Supports that is separately identified and included in the total hours of Employment Supports.

ATTACHMENT B

MOVING FUNDS IN INDIVIDUALIZED BUDGETS

Applies to ALL
Self-Managed / Family-Managed / Shared-Managed/ Agency-Managed
Services and Supports

Moving funds between funded areas of support is allowable without an updated needs assessment. A move to an unfunded area is allowable if a new needs assessment reveals a serious unmet need in that area. Only individuals and/or their guardians and the agency may make decisions to move funds between funded areas. Home providers or other employers may not move funds. Moving funds requires a team decision. In all cases the agency or Supportive ISO must be notified of the decision. Moving funds must comply with the DS State System of Care Plan.

Applies to Self-Managed and Family-Managed Services

The individual/family:

- Makes the decision to move funds within funded areas of support with his or her team
- Notifies the Supportive ISO prior to implementing any change
- Is responsible for any overspending in the funded areas of support/authorized funding limits
- Must personally pay their employee(s) or other bills if the overall authorized funding limit is exceeded

The Supportive ISO:

- May or may not be part of the team
- Notifies the Fiscal ISO of any changes in the budget/authorized funding limits
- May determine the individual or family cannot manage services if overspending is repeated

The Fiscal ISO:

- Will enforce the limits on funded areas of support/authorized funding limits
- Will not pay the employee(s) or bills if overall authorized funding limit is exceeded

Applies to Shared-Managed Services

The individual/family:

- With the agency, discuss moving funds; come to agreement prior to moving the funds between funded areas of support and before implementing any change
- Is responsible for any over-spending in the funded areas for those services that they manage

The Agency:

- Notifies the Fiscal ISO of any changes in the budget
- Is responsible for any overspending in the funded areas it manages
- May determine the individual/family cannot manage services if overspending is repeated

The Fiscal ISO:

- Will enforce the limits on funded areas of support and the authorized funding limits
- Will not pay the employee(s) or bills if overall authorized funding limit is exceeded

Applies to Agency-Managed Services

The individual/family:

- Is involved in the team decision about moving funds between funded areas of support

The Agency:

- Manages the individualized budget and is responsible for any overspending in funded areas of support/ authorized funding limits.
- Does not use the Fiscal ISO for their employees

OVERSPENDING IN FUNDED AREAS OF SUPPORT AND AUTHORIZED FUNDING LIMITS

Applies to Self-Managed / Family-Managed and Shared-Managed Services and Supports

If an individual or family exceeds the money available in a funded area of support, but there are still funds in another funded area of support, the Fiscal ISO will pay the worker for that payroll period only. The Fiscal ISO will not continue to pay workers after they have notified the individual or family and the agency or Supportive ISO of the overspending, unless directed by the agency or Supportive ISO. The team must address the issue before the next payroll period. The agency or Supportive ISO must notify the Fiscal ISO of any changes in the budget before the next payroll period. Otherwise, timesheet and Requests for “Goods” Payments will not be processed by the Fiscal ISO. Also, the Fiscal ISO will not process timesheets or Requests for “Goods” Payments that exceed the overall authorized funding limits for “goods” and services.

Applies to Self-Managed and Family-Managed Services

The individual/family:

- Is notified of the overspending by the Fiscal ISO and the team decides how to address the issue
- Notifies the Supportive ISO how they addressed the issue and the changes to existing funded areas of support
- Is responsible for personally paying his or her employee and other bills if the overall authorized funding limit is exceeded

The Supportive ISO:

- Discusses how the issue will be addressed with the individual or family. The Supportive ISO may make contact if the individual or family does not contact them.
- Notifies the Fiscal ISO of the new changes in the funded areas of support
- Is not responsible for any overspending caused by the individual or family
- May determine the individual or family cannot manage services if overspending is repeated

The Fiscal ISO:

- Enforces spending limits in each funded area of support
- Notifies the individual or family and the Supportive ISO of any overspending in funded areas of support
- Pays the worker if there are unspent funds in another funded area of support
- Will not pay the worker if the overall authorized funding limit is exceeded

Applies to Shared-Managed Services

The individual/family:

- Is notified of the overspending by the Fiscal ISO
- The team decides how to address the issue and whether any money can be shifted between funded areas of support
- Is responsible for the services he or she manages
- Is personally responsible for paying his or her employee and other bills if funding cannot be moved or if overall authorized funding limit is exceeded

The agency:

- Discusses how the issue will be addressed with the individual or family. The agency may make contact if the individual or family does not contact them.
- Notifies the Fiscal ISO of the new changes in the funded areas of support
- Is not responsible for overspending by the individual or family
- Is responsible for any overspending in the area it manages
- May determine the individual or family cannot manage services if overspending is repeated

The Fiscal ISO:

- Enforces spending limits in each funded area of support
- Notifies the individual or family and the DA/SSA of any overspending in funded areas of support
- Pays the worker if there are unspent funds in another funded area of support
- Will not pay the worker if the overall authorized funding limit is exceeded

ATTACHMENT C
DEVELOPMENTAL DISABILITIES SERVICES
FUNDING APPROPRIATION – FY 2015

New Caseload Projected Need [334 individuals (includes high school graduates) x \$29,984 avg]	10,014,656
Minus Returned Caseload Estimate (3 year average)	(4,166,960)
Public Safety/Act 248 (40 individuals x \$70,326 average)	2,813,040
TOTAL FY '15 ESTIMATED NEW CASELOAD NEED	8,660,736
1.6% Medicaid Rate Increase for 6 months	1,394,598
Annualization of FY14 Medicaid Rate Increase	1,449,401
TOTAL DDS APPROPRIATION - AS PASSED FY 15	180,588,711

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ATTACHMENT D

Vermont Council of Developmental and Mental Health Services
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NEEDS ASSESSMENT

Name:

D.O.B.:

Recorder (name & title):

Date:

Informant(s) (name(s) & relationship to consumer):

Supports requested:

- Housing & Home Supports:** Supports related to current or needed living arrangements.
- Community Supports:** Supports related to being an included and contributing member of the community such as volunteer, recreational, and self-advocacy activities, board member responsibilities, establishing/maintaining friendships.
- Work Supports:** Supports related to obtaining or maintaining employment.
- Service Planning & Coordination:** Supports related to coordination and monitoring of services.
- Respite Care:** Supports to give breaks to caregivers in order to maintain living situation/placement.
- Crisis Supports:** Supports that aid in the prevention of crisis and that assist people in crisis situations.
- Clinical Interventions:** Supports needed to meet therapeutic needs such as individual and group therapy, occupational therapy, physical therapy, speech and language therapy, consultation, psychiatric, and team training.
- Transportation:** Specialized transportation:
- Other:** Please specify:

NEEDS ASSESSMENT

COMMUNICATION: Level of support needed to express wants and needs and to understand ideas from others (e.g., verbal prompts, cueing, communication devices, gesture dictionaries, sign language, interpreters).

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No support

Minimal. Some support

Moderate. Ongoing support and/or uses alternative means of communication and/or requires interpreter

Significant. Uses maximum level of support to understand communication or be understood

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

SELF-CARE: Level of support needed to complete self-care tasks such as bathing, dressing, toileting, eating, etc.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Some physical assistance and/or verbal prompting

Significant. Total physical assistance to complete most tasks

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

INDEPENDENT LIVING: Level of support needed to complete independent living tasks such as home care, budgeting, cooking, etc.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Some physical assistance and/or verbal prompting

Significant. Total physical assistance to complete most tasks

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

WORK: Level of support needed to obtain or maintain employment.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Some assistance and/or verbal prompting

Significant. Total assistance to complete most tasks

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
Job development:	Select Level	Select Level
On-the-job support & supervision:	Select Level	Select Level
Job follow-up:	Select Level	Select Level
Transportation:	Select Level	Select Level
Supports related to being safe:	Select Level	Select Level
Accessibility issues/adaptations:	Select Level	Select Level
Communication:	Select Level	Select Level
Legal concerns:	Select Level	Select Level
Health/physical needs:	Select Level	Select Level
Personal care needs:	Select Level	Select Level
Psychological/emotional/ behavioral:	Select Level	Select Level

NEEDS ASSESSMENT

RESPITE: Level of support needed to give breaks to caregivers in order to maintain living situation/placement.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No respite

Minimal. Occasional respite

Moderate. Consistent ongoing respite

Significant. Regular, frequent respite

Current Level of Support

Level of Support Needed

At Home:

Select Level

Select Level

NEEDS ASSESSMENT

PARENTING: Level of support needed to provide training in parenting skills to help keep a child under 18 at home.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring and periodic support

Moderate. Regular intervention and support

Significant. Intense intervention and support

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
At Home:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

HEALTH CARE/MEDICAL/MOBILITY: Level of support needed in the following areas: taking medications; making and getting to medical/dental appointments; using special equipment such as a wheelchair, Hoyer lift, etc.; addressing chronic medical conditions such as diabetes, seizures, etc.; addressing special care procedures such as tube feedings, colostomy bag, etc.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Monitoring or periodic support / Routine health care; stable

conditions **Moderate.** Ongoing assistance / Serious and/or multiple conditions

Significant. Total assistance / Substantial health issues

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
Taking medication:	Select Level	Select Level
Making medical/ dental appointments:	Select Level	Select Level
Getting to medical/ dental appointments:	Select Level	Select Level
Using specialized equipment such as wheelchair, Hoyer lift, etc.:	Select Level	Select Level
Chronic medical conditions such as diabetes, seizures, etc.:	Select Level	Select Level
Special care procedures such as tube feedings, colostomy bag, etc.:	Select Level	Select Level
Other:	Select Level	Select Level

NEEDS ASSESSMENT

SLEEPING: Level of support needed as a result of sleep disruption during the night.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No intervention

Minimal. Occasional assistance; monitoring of medium or short duration

Moderate. Frequent assistance; monitoring of extended duration on an episodic basis

Significant. Nightly assistance of long duration

Current Level of Support

Level of Support Needed

At Home:

Select Level

Select Level

NEEDS ASSESSMENT

BEHAVIORAL/MENTAL HEALTH: Level of support/supervision needed throughout the day to manage emotions and/or behavior.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No assistance

Minimal. Periodic or ongoing intervention

Moderate. Planned support and skilled intervention and/or 24-hour support and/or monitoring

Significant. Extensive skilled intervention and/or 24-hour supervision in close proximity

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
At Home:	Select Level	Select Level
At Work:	Select Level	Select Level
In Community:	Select Level	Select Level

NEEDS ASSESSMENT

CLINICAL: Level of support needed to meet therapeutic needs.

Description of Support:

What are other resources for these supports (including natural supports)?

What will happen if these supports are not put in place?

Levels of Support:

None. No support

Minimal. Infrequent intervention

Moderate. Ongoing intervention

Significant. Intervention more than once a week

	<u>Current Level of Support</u>	<u>Level of Support Needed</u>
Psychotherapy:	Select Level	Select Level
Psychiatry:	Select Level	Select Level
Occupational Therapy:	Select Level	Select Level
Physical Therapy:	Select Level	Select Level
Speech Therapy:	Select Level	Select Level
Communication:	Select Level	Select Level
Behavior Consult/Support:	Select Level	Select Level
Offender Treatment:	Select Level	Select Level
Other:	Select Level	Select Level

NEEDS ASSESSMENT

Additional Comments:

ATTACHMENT E

SUMMARY OF LOCAL SYSTEM OF CARE PLANS

ADDISON COUNTY

Counseling Service of Addison County Local System of Care Plan

Priority Outcomes – Regional

1. New options for day services and increased socialization

- a. CA shall investigate our ability to develop and potentially implement an alternate respite option that shall be made available to interested consumers which shall include opportunities for social interaction, education, and community involvement.
- b. CA will meet with and document all consumers / families to determine level of interest.
- c. CA will develop necessary fiscal plan and determine whether or not option is feasible within current funding.
- d. In order to determine effectiveness of initiative, CA will create a pilot program in order to determine effectiveness and ensure best practice utilization.

2. Continue to develop IFS

- a. CA will continue to be an integral active member of our local IFS pilot.
- b. CA will track numbers of hours of spec rehab and case management for children with a primary diagnosis of Intellectual Disability, Autism or PDD.
- c. CA will utilize client satisfaction surveys to IFS families.
- d. CA will strive to expand opportunities for the provision of specialized services within the DS program while at the same time teaming with mental health providers to ensure appropriate services.

3. Staff turnover and increase substitute roster

- a. CA will review and improve upon its staff recruitment process.
- b. CA will offer additional training opportunities as well as community education on the DS services.
- c. CA will consider altering advertising practices. CA will also continue to advocate for improving living wages.
- d. Goal is to have sufficient number of trained substitute staff with low staff turnover.
- e. Continue search for innovative respite options for offender group and persistent challenging behaviors.

Priority Outcomes – System

1. Maintain DS Values in system reforms

- a. CA is committed to continuing to advocate for the respectful inclusion of system values and consumer voice in the all change processes.
- b. CA shall revitalize its Local Standing Committee to empower a stronger voice. CA shall also work with the larger DS system to determine whether or not a statewide consumer/family voice could be promoted.
- c. If successful, system changes will be provided the benefit of having consumer voice considered early in the change process.

2. Health Care Reform

- a. CA shall remain informed and active in ongoing discussions regarding pending changes in Health Care Reform.
- b. CA shall expend administrative resources to ensure participation at ongoing discussions and participate where needed. CA shall keep Local Standing Committee and staff apprised of pending changes so as consumer voice will hopefully direct changes.
- c. DS services shall be well represented in the change process of Health Care Reform.

3. Continue to develop IFS

- a. CA shall participate in the collection of data to drive outcome based decision making within IFS.
- b. Establish data collection to capture numbers of DS children served; numbers of hours of service provided; types of services provided; numbers of crisis interventions provided; review of high utilizers with DS diagnosis; and client satisfaction.
- c. Services provided under the CA umbrella shall increase to children with DS, autism and PDD diagnoses.

**BENNINGTON COUNTY
United Counseling Services, Inc.
Local System of Care Plan**

Priority Outcomes – Regional

- 1. Continue to promote consumer employment as well as volunteer options**
 - a. 49% or more of the qualifying adults served will be employed.
 - b. Increase the number of individuals engaged in activities that “give back” to the community.

- 2. Explore and develop a variety of cost effective residential options**
 - a. Increase the number of people living in less restrictive residential options.
 - b. Consumers will indicate satisfaction in their chosen residence.
 - c. Crisis bed resources will be developed.

- 3. Promote health and wellness for individuals**
 - a. Individuals will have a variety of opportunities to participate in that promotes their health and wellness.
 - b. Individuals will receive, at a minimum, annual health care.

Priority Outcomes – System

- 1. Sustainability of the system**
 - a. Adequate funding is needed to maintain a system of supports, ensuring that consumer voice is heard and respected in system redesign and decision making and that the values of the system are upheld.
 - b. The IFS initiative needs to be structured to ensure that the respite needs of the DS children and their families are met.
 - c. The DOL rule needs to be addressed, ensuring that contracted employees do not convert to becoming agency employees in 2015.

- 2. Development of cost effective residential models to meet the needs of individuals, including those with complex needs**
 - a. Increase the # of housing subsidies, ensuring affordable housing and making the move to an apartment viable for someone on a limited income.
 - b. Development of - and funding for – on-going technology resources that will increase the number of individuals who can reside in a less restrictive environment, while maintaining safety; access to one-time funding on a regular basis to meet technology needs.

**CHITTENDEN COUNTY
HowardCenter
Local System of Care Plan**

Priority Outcomes – Local

- 1. Clinical – Develop a short-term therapeutic residential crisis resource**
 - a. A team will be developed to support individuals with varying acute mental health symptoms.
 - b. An accessible therapeutic space will be made available for individuals to receive short-term and interim stabilization supports.

- 2. Housing – Develop an alternative model of affordable residential housing for up to six individuals with intellectual disabilities.**
 - a. Develop a memorandum of understanding with the Burlington Housing Authority with the provision that individuals who successfully complete the transition program will have access to Section 8 housing.
 - b. Pair affordable housing through a tenant based Non Elderly Disabled Housing Choice Voucher with individual services and supports provided by HowardCenter.

- 3. Employment – Establish a Project Search site in Vermont**
 - a. Partner with Vocational Rehabilitation, local school districts and a large employer within Chittenden County.
 - b. Work with students and a team, including their family, a special education teacher, a job coach and a business representative, to create an employment goal and support the student in the important transition from school to work.

- 4. Outreach – Provide some level of minimal support and information to individuals with ID/DD and their families in Chittenden County who are potentially eligible for services but who do not qualify for funding**
 - a. Contract with a Social Media Strategist to complete an assessment of how HowardCenter can become more dynamic in outreach to the community.
 - b. Build an internal team of content builders to keep the messages to the community current and interesting.
 - c. Integrate with overall HowardCenter development and communication outcomes.

Priority Outcomes – Regional

- 1. Meet the clinical support needs of individuals with acute mental health symptoms**
 - a. Increase access to appropriate psychiatric care for individuals diagnosed with a co-occurring (non-ASD) mental health disorder.

- 2. Develop strategies for alternative models of support for independent living**
 - a. Address the need for affordable housing including access to housing vouchers.
 - b. Expand access to Safety Connection-type programs that incorporate technology to support more independent living in existing models of home support or in the creation of new service options.

LAMOILLE COUNTY

Lamoille County Mental Health Services, Inc. Local System of Care Plan

Priority Outcomes – Regional

1. Increase Housing Options

- a. DS Director will meet with local housing authority to explore options
- b. Advocate and discuss concerns with DDAS, AHS, and Legislators.
- c. LCMHS will work on recruiting a provider to do transitional housing and look to secure individuals who can respond for safety connections.
- d. DS Director will speak with the local field director about lack of affordable housing.

2. Increase use of Public Transportation

- a. LCMHS will advocate and discuss concerns with DDAS, AHS, and Legislators
- b. Improve collaboration between LCMHS, RCT, and public transportation.
- c. Consumer's teams will develop knowledge of route schedules and this will be incorporated into ISA goals.

3. Increase Parent Support for people with Intellectual Disabilities that are parenting

- a. Advocate for additional funding and discuss concerns with DDAS, AHS, and Legislators.
- b. LCMHS will look into curriculum material we can purchase through one time dollars that would support parents with intellectual disabilities.

4. Increase Flexible Family Funding

- a. Continuing to advocate and discuss concerns with DDAS, AHS, Legislators, and Governor.

5. Increase Children's Services

- a. Advocating for additional funding and discussing concerns with DDAS, AHS, and Legislator.
- b. Collaborate with other agencies on the needs of the DS children who are referred for their services.

6. Continue to Improve Post -Secondary Options

- a. LCMHS will advocate for additional funding with DDAS, AHS, and Legislators.

7. Increase Clinical Training for Support Staff

- a. LCMHS will explore internally for resources of skilled staff to provide training in this area to Service Coordinators, CIS, and Shared Living Providers.
- b. Each year we will have training for all staff that is clinically orientated.

Priority Outcomes – System

1. Integrated Family Services (IFS)

- a. Advocate and discuss concerns about having adequate respite resources for children with DDS, AHS and Legislators. Let them know the impact to consumers if there is not enough respite to meet children and family's needs.

2. Greater flexibility of HCBS to pay for housing

- a. Advocate and discuss concerns with DDS, AHS and Legislators about having the ability to use waiver dollars to help support consumer obtaining and maintaining their own housing.

3. Create a funding priority for Post-Secondary.

- a. Advocate and discuss concerns to help ensure there will be a funding priority for any individual with an intellectual disability that wants to participate in a post secondary program can.

FRANKLIN/GRAND ISLE COUNTIES

Northwest Counseling and Support Services, Inc. Local System of Care Plan

Priority Outcomes – Local

- 1. Sustainable and affordable housing continues to be an almost insurmountable barrier to independence. With an emphasis on developing skills building for Independent Living individuals with Intellectual Disabilities are often forced to continue supported living models due to the cost of housing.**
 - a. Alternative housing models are sought through our residential program that include minimal in home living supports in attached housing units.
 - b. New programming to support roommate skills training to make housing more affordable.

- 2. Needs of aging consumers continues to exacerbate safe and accessible community integrated home placements.**
 - a. It is critical to have strong collaborations with community partners like Home Health, Visiting Nurses Association, and local PCP's, yet there is a limited capacity to meet the increasing needs as a larger demographic number of individuals with Intellectual Disabilities continue to age living longer lives.
 - b. There is an increased need for home providers with specialty training to support this aging group in their communities, yet there are no additional resources or funding to support a higher rate of pay for specially trained care providers.

- 3. Increased Clinical and Crisis Supports that would include a quality review of therapeutic needs for individuals with Intellectual Disabilities and secondary diagnosis. Including Mental Health Diagnosis, Substance Abuse, Criminal and Offender history, and extensive behavioral challenges.**
 - a. NCSS is developing a Quality Clinical Utilization Review position to provide an intense case by case review and summary of the clinical needs for individuals with Intellectual Disabilities that have dual diagnosis or significant behavioral challenges.
 - b. The summary of the clinical review will be presented to the clinical review team comprised of 5 MA level clinicians and individual support plans will be developed, including training needs of staff across environments.
 - c. The clinical review team will work closely with Crisis in developing therapeutically sound supports on an individual basis.

- 4. Continued increase in the need for contracted services with rescission of funding compromises the ability to effectively monitor and train staff and provide reasonable respite breaks to service providers.**
 - a. NCSS is developing monthly trainings specific to home providers. The facilitated meetings will be a forum for support. Home provider, contracted staff and natural family caregivers will all have access.
 - b. NCSS has instituted a transitional home model that allows for emergent placements for individuals in services that have been displaced from their home preventing the unexpected overuse of respite funds.

- 5. Transitioning from High School and children’s services to Adult Services continues to be a challenging area. It is only through relentless reaching out and collaborative thinking that high schools in the designated areas are beginning to work more closely with Intake, Employment, and Transitional services at the NCSS**
 - a. There are no new resources to allow this under met need. NCSS has developed a strong collaboration with local VR and CWS to involve more community partners in taking on the strain of meeting this funding priority. Transitional fairs are being held at as many high schools as possible to educate parents on the transition to adult services and the need to find competitive employment for graduating youths. Peer Advocacy is stepping in to make the transition less stressful for the individuals and their families.

Priority Outcomes – Regional

- 1. Increase the ability of individuals to live outside the home provider model and/or to move consistently to a more independent home model.**
 - a. The preferred living model will be captured through the Independent Living Assessment (ILA). The assessment will help the Services Coordinator and the team to identify the particular living situation the individual would prefer to transition to. The assessment will determine strengths and areas of potential growth to move the individual closer to their goal.
- 2. Increase the number of twenty four hour home providers with specialized training for an increasing elder population with significant medical needs**
 - a. NCSS will provide trainings through an experienced onsite LPN to assist in identifying medically appropriate care addressing individual needs.
 - b. NCSS will continue its collaboration with VNA and Home Health to provide Special Care Procedures and Medication Delegation trainings.
 - c. NCSS will start a home provider training and support group the 2nd quarter of 2014 to assist in the education of home providers and to gain inside knowledge of the challenges that are being faced tracking the elder concerns.
- 3. Increasing clinical oversight and utilization review of identified Individuals with dual diagnosis e.g. significant Mental Health and substance abuse issues. Clinical review of individuals with .aggressive and self injurious behaviors as well as, high utilization of crisis and ER services.**
 - a. The new position will start in the spring of 2014. The Quality Reviewer will begin with those individuals identified as highest utilizes of DS crisis services. Once the review is complete the summary will become part of the individuals EMR and the clinical review team’s recommendations and trainings will be noted
- 4. Increase in supports for transitioning youths to meet the funding priority of competitive employment.**
 - a. Work closely with intake to identify graduates at least 6 months prior to transitioning to adlt services. Present cases that may not meet funding priorities to weekly VR meetings and begin transition planning on potential work sites and supports.
 - b. Continue working closely with schools on contracting services to provide supported employment where needed.

Priority Outcomes – System

- 1. Alternative Residential Models**
- 2. Needs of Aging Consumers**
- 3. Increased Clinical Oversight**
- 4. Collaboration for Transitioning Youths**
- 5. System Sustainability**

ORANGE COUNTY

Upper Valley Services, Inc. Local System of Care Plan

Priority Outcomes – Regional

- 1. Develop Strategies for Enhancing Inclusion**
 - a. Develop a process for implementing a focused plan for increasing natural supports
 - b. Define a training plan for staff and home providers
 - c. Begin training activities
 - d. Initiate beginning process in each UVS program area
 - e. Define and develop a documentation system
 - f. Define and document baseline levels of natural supports
 - g. Broaden the number of people involved in the process in each area such that all consumers have the potential to benefit.
 - h. Revise process as indicated by data
 - i. Continue training staff and home providers

- 2. Increase the percentage of people supported by UVS who are employed**
 - a. Evaluate capacity for supporting people in employment
 - b. Organize and implement training on generating and supporting employment outcomes for UVS staff and home providers
 - c. Begin with the formation of a pilot “Employment Focus Group” organized around a sample of individuals not employed
 - d. Implement formal Supported Employment training within each program area
 - e. Continue to evaluate capacity and refine and provide employment training
 - f. Broaden and refine “Employment Focus Group”

- 3. Provide and participate in regular training opportunities for staff and home providers on a local, regional and Statewide basis**
 - a. Continue participation with the newly formed Vermont Training Consortium
 - b. Working with the Consortium assist in the planning and delivery of two conferences on topics of interest to Vermont’s DS system
 - c. Increase the use of technology in order to make training opportunities more readily available
 - d. Facilitate making the Pre-Service Training available on-line
 - e. Work toward the expansion of higher education opportunities focusing on developmental disabilities.
 - f. Work with the DS Directors to increase the number of on-line training options.
 - g. Work towards having a degree program available within the Vermont College System having a focus on community-based services for persons with a developmental disability.

- 4. Select and implement an Electronic Record System in conjunction with other organizations using a consortium model that maximizes efficiency and versatility.**
 - a. Purchase and begin the process of installing an Electronic Health Record (EHR) at UVS
 - b. Develop and provide ongoing training in the use of the EHR

5. Develop more residential options that promote independence

- a. Work with DAIL to identify ways to access rent assistance to facilitate access to housing
- b. Identify Persons who are interested in living in a more independent model
- c. Develop an individualized support plan to maximize chances for the individual to live successfully in an independent model
- d. Develop the use of technology where appropriate to enable people to live independently
- e. Coordinate this initiative with Goal 1 to assure that independent living does not equate to isolation within one's home
- f. During Year 1 develop independent living plans for 5 people (a plan defines the resource and support needs necessary for a person to be successful)
- g. Include this residential option as a potential model at intake.
- h. Develop independent living plans for people

6. Implement an organized and comprehensive children's service program as part of Vermont's Integrated Family Services (IFS) initiative.

- a. Continue coordination with Clara Martin Center (CMC) for the development of a comprehensive service approach as part of IFS. Join with CMC and the State of Vermont to implement the goals of IFS as they continue to emerge.

Priority Outcomes – System

1. Rental Assistance Availability

- a. It is recommended the State of Vermont develop a mechanism and a funding source to provide rent subsidies to enable individuals to afford a move into their own apartment.

2. Health Care Reform

- a. It is recommended that the State (DAIL) work to inform health care planners of the importance of avoiding a return to a medical model as a consequence of health care reform. It is important that the current principles, values and safeguards need to prominently guide the shaping of any new configurations that emerge through the health reform discussions.
- b. It is recommended that DAIL promote the adoption of Quality of Life indicators as the primary outcome indicators of the long term care system responsiveness and effectiveness.
- c. It is recommended that DAIL consider holding a monthly or bi-monthly meeting of stakeholders to keep these individual's informed on the emerging changes (structurally and programmatically) that the health care reform process will have on the service delivery system that currently supports people with developmental disabilities.

3. Consumer Feedback – Specific feedback from consumer groups:

- a. With regard to employing people with disabilities there was a strong request that the State set an example for Vermont by hiring more people with disabilities as part of the State workforce.
- b. With regard to fiscal resources, to encourage the State to include in its budget process adequate funding to meet the essential needs of people who are in need of services and supports.

**ORLEANS/ESSEX/CALEDONIA COUNTIES
Northeast Kingdom Human Services, Inc.
Local System of Care Plan**

Priority Outcomes – Regional

1. **Communication** – Communications to all self advocates, employees, contractors and other stakeholders will be consistent, complete and in a timely manner.
 - a. Specific groups identified will meet to continue discussing areas that we need to work on for better communication.
 - b. Self Advocates/Individuals and local standing committee will have input on our communications.
 - c. A survey is being developed for Shared Living Providers to give specific input on what their needs are for better communication, support and training from NKHS DS Program.
 - d. DS employees will follow the Code of Conduct developed by them in February 2014 in order for all communications to be shared respectfully. This document was just accepted as an agency wide Code of Conduct.

2. **Independent Living Options** – Provide support and assistance to individuals who want to live independently and/or learn the skills to be more independent while living with others.
 - a. Individuals with experience living independently will mentor their peers.
 - b. Groups and/or support to enhance independent living skills will be offered by self advocates, families, employees, contracted workers and community members.
 - c. Discussions with stakeholders around the need for affordable housing.
 - d. Researching what other areas in the State are doing around independent living.

3. **Electronic Medical Record** – Continue to work with NKHS EMR Core Group to have Developmental Service record completely electronic.
 - a. EMR core group will continue to develop and train DS staff on implementation of our EMR record. Training will be provided in each new phase of EMR.
 - b. Paper records will be scanned into electronic file.
 - c. Individuals will be trained and supported in accessing their records once NKHS has completed this implementation.

4. **Transportation** – Support and coordinate travel with individuals to meet their needs.
 - a. Support more individuals to utilize RCT (Rural Community Transportation) by Peer mentoring and practice with individuals to feel more comfortable with public transportation.
 - b. Work with large local business on transportation i.e.: Jay Peak Resort van from Newport to Jay Peak for all their employees.
 - c. Utilize agency transportation when available.
 - d. Look at carpooling when appropriate.

Priority Outcomes –System

- 1. Independent Living Options.**
 - a. The need for financial assistance for individuals to acquire and maintain an apartment.
 - b. More flexibility in the way supports are provided.

- 2. Funding appropriate to individual needs instead of based on a budget cap.**
 - a. Many individuals require more funding than the \$200,000 cap.
 - b. Options for serving individuals who pose a risk to public safety and agencies liability.

- 3. Increase Flexible Family Funding**
 - a. An increase in Flexible Family Funding will keep many individuals living at home longer hence avoiding a more expensive Medicaid Waiver funding source.

- 4. Sustainability of existing Developmental Services funding.**
 - a. Developmental Services consistently has taken budget cuts and the worry of individuals, stakeholders and employees are the sustainable of the services currently in place.
 - b. With the increase need in people meeting the funding priorities currently the concern is for existing people needing to take cuts in their limited services.
 - c. Department of labor rules are adding to the worries of sustainability of current and future services.

**RUTLAND COUNTY
Rutland Mental Health Services
Local System of Care Plan**

Priority Outcomes – Regional

- 1. Employment** – The number of individuals employed will increase and the employment options available for the individuals we serve will expand.
 - a. Participate in DS Taskforce employment workgroup.
 - b. Volunteer to be a pilot agency for the initiative.
 - c. Expand micro business enterprises.
 - d. Explore job carve out and job share options.
 - e. Utilize the “think tank” strategy to creatively brainstorm employment options for individuals, in particular for individuals who currently have staffed community supports.

- 2. Children and Family Services** – Unify services to more effectively and responsively serve children and families in Rutland County
 - a. 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.
 - b. 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.
 - c. 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.
 - d. Brochures will be developed to inform the community of the resources available and to assist families to access resources.
 - e. 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.
 - f. In collaboration with Rutland Family Network a resource guide and recruitment strategies will be shared with families.
 - g. 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.

- 3. Housing Options** – Expand housing options to more responsively meet current and anticipated needs of individuals and promote independent and interdependent living.
 - a. Build partnerships in the community and state to develop affordable and accessible housing.
 - b. Explore, design, and evaluate supported living options that will promote independence and interdependence.

- 4. Community Connections** – Promote/improve community awareness, understanding, and partnerships with CAP.
 - a. Develop marketing and outreach strategies to increase public awareness and support.
 - b. Develop a communication plan to publicize information and community education about CAP.
 - c. Enhance CAP’s presence in the community and reputation through collaborative efforts, enhanced community partnerships, and co-sponsoring community events.
 - d. Additional strategies will be developed with key stakeholder input, including our Local Standing Committee.

Priority Outcomes – System

- 1. Sustainability of Vermont’s developmental disabilities services system**
 - a. The system’s values need to be sustained.
 - b. 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.
 - c. 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)**
 - a. Concern 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**
 - a. 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”.
- 4. Advocacy for services and resources for children and adults who do not meet current eligibility criteria and/or funding priorities for services**
 - a. Concern and frustration about the lack of resources available for children and adults who “fall between the cracks” but would benefit from services.

WASHINGTON COUNTY

Washington County Mental Health Services, Inc. Local System of Care Plan

Priority Outcomes – Regional

1. Integrated Family Services

- a. Work with providers in our area to support IFS being implemented in our county over the next year.
- b. Work to disseminate all information in a timely fashion so families know what's available and how to access services.
- c. Track this through satisfaction survey and with data we collect for our Results Based Accountability scorecards.

2. Personal Care Attendants

- a. Attend trainings and be represented at as many workgroups and meeting as possible to gain as much knowledge to support families through these changes.
- b. Participate in local non-categorical utilization review committee to help families navigate through this process.

3. One-time dollars

- a. Advocate for one-time dollars with the state and legislature.
- b. Educate people who make the budget decisions on the importance of one-time dollars and how much it helps people we support.
- c. Support self-advocates through training and education on how to advocate and have a voice in policy making not just around one-time dollars but all areas of funding that could be cut.

Priority Outcomes – System

1. Post-secondary Options – Continue to promote higher education options.

2. Supports for High Risk Offenders – Change the new capitated rate for waiver budgets.

**WINDHAM/WINDSOR COUNTIES
Health Care and Rehabilitation Services of Southeastern
Vermont Local System of Care Plan**

Priority Outcomes - Regional

- 1. Housing** – Develop alternative housing models to meet individualized needs of our clients.
 - a. Expand 24-hour staffing supports to meet the needs of our clients who have not been successful in our traditional housing models (Shared Living).
 - b. Develop 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.
 - c. Provide consistent, reliable respite for families through the Children’s Respite House
 - d. Investigate 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.
 - e. Attend meetings with our Local Housing Authorities on a Local Housing Task Force to provide advocacy for our clients who want to live independently in affordable housing within their communities.

- 2. Choice** – Develop systems and create a culture that promotes client choice throughout our service delivery system.
 - a. Meet with clients and advocates to discuss and develop ways to provide more choices to our clients and their families.
 - b. Meet quarterly with the Office of Public Guardian to advocate for our clients by addressing their need for more choices in guardianship.
 - c. 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.

- 3. Delivery of Community Support** – Develop client directed community-based support programs that provide clients with opportunities for peer networking and education with a focus on client choice.
 - a. Discuss ways to broaden Community Support options for our clients.
 - b. 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.
 - c. Develop local community-based activity locations for clients to meet for peer events throughout our region.

- 4. High Risk Individuals** – Provide effective specialized programming to increase stability and reduce incidents with our high risk clients.
 - a. 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.
 - b. Expand Community Placement Programs which will allow for more clients to receive specialized treatment.
 - c. Create unique highly-individualized treatment plans.

- 5. Clinical Services** – Provide the most effective and comprehensive clinical services to all of our clients.
 - a. Seek alternative therapeutic approach to meet individual’s clinical needs.
 - b. Monitor the effectiveness of psychotherapy through goal setting and discontinue or change treatment when appropriate.

Priority Outcomes - System

- 2. Housing**
 - a. 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.
 - b. The development of additional crisis beds beyond the one regional VCIN bed will increase our capacity to respond to client needs.
- 3. High Risk**
 - a. The need for inpatient psychiatric emergency hospitalization has increased while the availability of beds has decreased.

ATTACHMENT F
VERMONT STATE SYSTEM CARE PLAN
ON-LINE SURVEY SUMMARY
SPRING 2014

An on-line survey was sent to all stakeholders in January 2014 looking for input on key issues for consideration in the development of the new three-year State System of Care Plan for people with developmental disabilities. There was a very good response with a total of 99 individuals commenting (not all respondents answered each question).

Respondents shared offered very thoughtful suggestions for improving services and supports. The survey was long (17 questions) and it turns out there were reoccurring themes that much of the feedback tended to overlap from one question to another; themes developed. It appeared the best and least redundant way to summary and collate the responses was not by survey question but by certain topic areas. Ideas that were mentioned most frequently are highlighted.

The questions asked on the survey are listed first²⁶; the response summary of responses follows after the questions.

1. What is the one thing about individual developmental disabilities services (for you or someone you know) that you think is great? (70)
2. If you could change one thing about individual services (for you or someone you know) what would you like to see? (67)
3. Please tell us what you think is working well with developmental disabilities services in Vermont? (59)
4. Please tell us what you think is not working well with developmental disabilities services in Vermont and how it could be better? (68)

Family Support

Individuals may be funded to receive services and supports in both home and community settings.

5. What ideas do you have to better support families? (58)

²⁶ The number following each question is the total number of respondents for each question.

6. What ideas do you have to support aging caregivers as they find it harder to care for their family members with developmental disabilities? (52)

Home Support and Independent Living

The most common home support that we fund is called Shared Living. That is when an individual lives in the home of another person who is paid to support the individual. There are also small group homes where 3 to 6 people live (with paid staff) and apartments where 1 or 2 people live (with paid staff or more independently).

7. In addition to the types of home supports described above, what ways can we support people to live in their own homes or with others? (47)

8. What other types of services and supports can help someone to live more independently on their own or with others? (44)

School and Work

Some people receive help to go to college while others receive supports to find and keep a job. There are also people who receive supports to learn new skills and be successful in their community.

9. How can we best support young adults leaving high school? (58)

10. Do you have ideas on how to help people to be more independent at their jobs and not rely as much on paid support? (48)

Extra Supports

Some people need extra supports to keep them safe or to keep those around them safe. For example, some people need to have more than one worker supporting them at a time; technology to provide assistance when no one is around; or a place to live that keeps them and others safe. Others may need workers specially trained in medical procedures because of their health care needs.

11. How can we better support people who have special medical needs? (40)

12. How can we better support people who are a danger to others and/or themselves? (43)

13. What ideas do you have to increase the use of technology to help people be more independent, safe and supported? (43)

Spending money on developmental disabilities services:

A person with a developmental disability may ask their local designated agency for help and apply for services. Because we don't have enough money to serve everyone, we try to figure out who needs the services the most. We use "Funding Priorities" to help us make that decision.

14. Do these Funding Priorities make sense? Which priorities do you think are the most important? (55)

15. If you were to change the Funding Priorities, what changes would you make? (47)
16. In order to use the funding we have the best way possible, what ideas do you have on how we can save money? (48)
17. Do you have any other comments you wish to share? (38)
-

What one thing is great – What is working well?

- **Community-based services**
- **Guiding principles/values**
- **Individual supports focus on needs and independence/strengths of person**
- **Person-centered planning** – individualized support plans / individual budgets and choice/options
- **Self-advocacy**
- **Staff – good, caring, hardworking, responsive, educated**
- **Supported employment**
- **Technology**
- Self/family management
- No institution
- Designated Agency provider system
- Flexible, creative problem solving
- Shared living
- Case management
- Post-secondary education
- Peer assistance
- In-home support – respite
- Living a self-determined life

What one thing should change – What is not working well?

- **Attitude of State administration** – fiscal philosophy/lack of collaborative decision-making/systemically destroying excellence/erosion of values
- **Budget cuts** – fear of services being cut
- **Congregate day settings – groups of 3+ entering community**
- **Family support** – respite too limited or not available
- **Funding / Funding priorities** – based on values, not state budget process
- **Housing options**
- **Quality of services** – move from proactive approach to reactive/less focus on moving toward independence/quality slipping
- **Roadmap to services** – need easy to understand information on how to access/navigate services and supports
- **Shared living** – over reliance – more supported living/housing vouchers

- **Technology** – better access/recycling
- **Training and education of support staff/shared living providers**
- **Transportation options** – increase
- Peer-to-peer advocacy/supports
- Oversight of providers
- Self/family management – increase
- Isolation – being a member of one’s community (community supports)
- High caseloads
- Services to people who are Deaf and hard of hearing
- Transition – post-secondary education – increase access to work supports
- Flexibility in funding – restore “Goods” line in budgets
- Alignment with values
- Behavior challenges – respite – unique interventions and supports
- Children needing nursing care
- Better integration of services with school system
- High turnover of staff, loss of staff with experience, finding quality workers
- Refugee population
- Representative payees needed
- Medicaid application process – confusing/repetitive

Family Support – Aging Caregivers

- **Budget cuts / budgetary stability**
- **Children Personal Care Services**
- **Early intervention and prevention planning** – know options ahead of time, lifelong supports without cut-offs, life planning, guardianship/trusts
- **Family advocacy and outreach** – networking/sharing ideas
- **Flexible Family Funding**
- **Housing/home support options** – assisted living alternatives, subsidized housing, supported community homes, aging in place for whole family
- **Information and referral** – one-stop shop, all-inclusive website, options counseling
- **Listen to what families need**
- **Peer navigators / peer to peer mentor program** – family support groups, aging network
- **Respite** – qualified pool, emergency respite, structure respite program, statewide respite
- **School/Individual Education Plan advocacy**
- **Training/education for families** – advocacy, support options, new models of support, family management, programs, best practices, planning tools/circle of supports (MAPS, PATH), conferences, retreat
- Independent living skills – teach person to become self-supporting

- Self-advocacy – adequately fund
- High Tech Nursing Program for children
- Self/family management – increase
- Community supports – increase quantity and quality
- Choice of providers
- Paying parents/family members
- Social options
- Case management, choice/consistency, help to plan/develop/access services
- Funding – flexible use – greater transparency
- Augmentative communication devices
- Individual Support Agreement – include needs of family
- Family management of 24-hour home supports
- Group homes/community options
- Eligibility – increase IQ cut-off
- Future planning – graduated changes in supports
- Shared parenting
- Natural safety nets

Supervised Living – Support to Live in Own Home

- **Choice** – individually focused supports, individualized planning (MAPS, PATH)
- **Communication skills/technology**
- **Community supports** – inclusive/coordinated community supports
- **Flexible hours of support**
- **Housing/home support options** – affordable/vouchers – independent living models, supported apartments, multiple apartment complex, home ownership, Home Share/Project Home, companionship
- **Independent living skill development** – daily living activities
- **Intentional community model**
- **Peer support** – build networks of support
- **Roommate options** – Peers living with peers, mentoring relationships, not group living
- **Social outreach / learning opportunities**
- **Staff consistency – good salary, training and support**
- **Technology to promote independence** – adaptive living equipment and training, expand “Safety Connections” model, on-call staff, “Skype”
- **Transportation**
- Accessible housing – work with housing providers
- Nursing supports
- Mainstreaming in school – facilitate goals that lead to independence
- Post-secondary programs

- Natural supports – engage and involve extended family
- Relationships
- Parenting skills for parents with disabilities
- Work supports and incentives
- Safety

High School Graduates

- **Employment services** – school strengthen vocational programs, job training
- **Plan ahead – quality transition planning** – assure a plan of action is in place, collaboration between school and adult service providers, transition mentor
- **Peer Mentors** – peer supports
- **Post-secondary education**
- **Teach independent living/life skills**
- **Technology**
- Community-based programs
- Trained/skilled staff
- Encourage responsible/informed sexuality
- Transportation
- Housing

Employment – Job Independence

- **Apprenticeship** – learning a profession from someone who knows job
- **Coworker mentors – peer mentors**
- **Educate employers** – benefits of hiring workers with disabilities, providing natural supports
- **Good job matches** – job must be relevant, desirable and doable and tailored to person’s strengths and interests, allow change of jobs if not a good match
- **Incentives for employers** – hire workers with disabilities
- **On-the-job training by qualified job coach** – train and fade model
- **Promote/train independence at work** – teach problem solving, job coach that supports multiple people at one site
- **Technology**
- Create culture of support at work – social relationships
- Use existing relationships in the community
- Reasonable expectations – set obtainable/realistic goals
- Educate employers about the ADA/ provide reasonable accommodations
- Training for job coaches, use task analysis and graphic instruction
- Not enclaves
- Opportunities for job experiences while still in school
- Vocational training and development that continues after high school

Special Medical Needs

- **Don't provide service in isolation** – need peer support, social interactions, people who care
- **Shortage of nurses/substitutes** – better wages and advertising
- **Training/education/oversight for people providing medical supports**
- **Technology**
- **Workers do not need to be nurses/medical professionals** – use shared living providers/ trained peers
- Understand how to effectively advocate/navigate medical system
- Medical provider to coordinate all services
- Work with medical community – Community Health Team
- Collaborate with DAIL aging programs – home health, meals on wheels
- Respite for primary caregivers
- Special Care Procedures done by trained professionals only
- Prevention – put time/money/expertise upfront to reduce long term needs
- Budget cuts – funding and supports have eroded over the past few years

Public Safety Needs

- **Adequate staffing and funding**
- **Alternatives to costly community inclusion with high ratio staffing**
- **Education of police and medical professionals**
- **Safe place to live/spend time** – rural/farm communities, treatment center, safe beds, group living models, economy of scale, secure facility
- **Strategies to reduce dangers** – risk management, self-manage, problem solving, anger management, positive behavior supports, support groups
- **System willing to take more risks** – not assume all liability, not be responsible for public safety forever
- Trained, qualified, educated, well paid support workers
- Help offenders learn to be responsible and accountable for consequences
- Build capacity/adequate funding
- Plan of care that addresses psychological, emotional, biological and medical
- Psychiatric medication – involuntary administration
- Department of Corrections collaboration – develop lower cost models, cover cost of public safety
- Safety for all is paramount
- Supervision of staff
- Reassessment of risks/support needs
- Identify and treat public safety issues earlier in life

Technology for Independence / Safety / Support

- **Access resources/try-out centers/DAIL Assistive Technology Program**
- **Computers, internet, mobile devices, telecommunications**
- **Multiple uses/benefits of technology** – on-call support, life skills, safety, communication, independent living, supervision/monitoring, better/more interesting lives
- **Network/training/conferences in use of technology** – understand best practices and new technology
- **Recycle equipment**
- **Increase independent living** – reproduce “Safety Connections”
- **Research use of technology** – think outside the box, pilot projects
- **Social networking** – balance of privacy/safety and independence
- Consider low-tech alternatives – does not always need to be expensive
- Affordability – increase funding for technology – save money in long run
- Technology does not replace need for relationships/human contact
- Support animals

Funding Priorities / Best use of Funding

- **Adequate, accessible housing/living options**
- **Agreement with funding priorities** – all are important
- **Change eligible age of all priorities to age 18 (not age 19)** – employment funding priority specifically
- **Discretionary funds set aside for non-priority/noncritical life issues** – short term funding to promote independence
- **Broaden eligibility for employment funding priority** – change to not need to be employed and/or support to maintain employment at any age
- **Expand priorities / reinstate previous priorities** – support person to become independent of services within two years or move to limited services, support to prevent regression, more specificity, etc.
- **Funding priorities have eroded over the years** – does not allow for growth, simply allows for base level existence
- **“Imminent risk”** – not clear what this means, too much emphasis, leads to mentality of scarcity
- **Include children in priorities #1 and #2** (Health & Safety, Public Safety)
- **Increase budget to fund all needs**
- **Priorities force crisis in order to obtain services** – have to declare child “homeless”, hard to obtain community support to replace lost school hours
- **Priorities reflect dumping of responsibilities by DMH and DOC** (Public Safety and Preventing Institutionalization)
- **Proactive access to funding before situations become emergencies** – people become stuck at home due to lack of supports

- **System based on emergency situations only** – ignore general needs and it becomes a crisis and costs more to support
- **Technology and computers**
- **What do priorities exclude** – person must be employed for employment priority, definition of “prevention”, transition assistance for people who don’t meet funding priorities
- Delay in getting supports for graduates that do not meet funding priority and who do not graduate with a job but then end up needing supports years later
- Individuals should not be graduating at the age of 18
- Employment requirement puts a lot of pressure on schools/families/ providers – excludes students yet ready to obtain competitive employment
- What about people who are not “at risk” and don’t/can’t work?
- Reduced funding leads to less agency staff and more caregivers hiring staff – increased risk of poor training, supervision and oversight (risk of abuse, neglect, and exploitation and Medicaid fraud)
- Over reliance on family members without sufficient support/funding/respite
- Eliminate priorities – not a good measure of who needs services – change eligibility to be based on individual functioning
- Focus on post-secondary education, community-based learning options
- Reinstate the “goods” budget line
- Greater alignment with our values

Ideas for Saving Money

- **Eliminate redundant background checks**
- **Look for efficiencies** – simplify reporting/paperwork, less travel/meetings
- **DA/SSA infrastructure** – lower costs, share administrative costs/resources
- **Proactive system of care** – focus on prevention/early intervention
- **Reassess funding over time** – at highest level of service, address low level needs to keep costs down, be better at reassessing needs/closer scrutiny
- **System has lost its focus** – only concern is money and not services – there are no remaining savings to be had, need to be more interested in keeping people safe and maintain/improve reasonable quality of life, a viable system must have enough funding to function effectively
- **Technology** – reduce staff and other supports, recycle/reuse
- Limit budgets to \$200,000
- Adjust budgets when person does better
- Funding priorities need to change with the times – need the ability to support individuals who are more abled who need acute support/especially during transitions
- Public forums to exchange ideas for better and economic services
- Competition across providers – build in incentives

- Limit clinical eligibility to only people with intellectual disabilities
- Graduate people from services
- More assisted/supervised living, roommate models, shared living alternative
- Assure services are actually being received
- Double up people in shared living
- Increase training and wages to retain staff/reduce turnover
- Support parents and home providers as investment in low cost services
- Medicaid funding should not go toward lobbying legislature
- Concern how workers spend time providing community supports/respite
- Concern about using results based accountability as measure of what government should pay for
- Office of Public Guardian case ratio is too high
- Change “Equity Committee” name to “Funding Distribution Committee”
- Severely Functionally Impaired (SFI) should not be in DDS budget

ATTACHMENT G

GREEN MOUNTAIN SELF-ADVOCATES RESPONSE TO VERMONT STATE SYSTEM OF CARE PLAN ON-LINE SURVEY

A focus forum was conducted during a statewide Green Mountain Self-Advocates meeting. Close to 50 people who receive developmental disabilities services and their support staff participated. They represented 10 local self-advocacy groups:

1. Capital Advocates Together of Montpelier
2. Next Step Self-Advocacy of St. Albans
3. Vermont Choices of St. Johnsbury
4. Getting Acquainted Through Self-Advocacy of Lamoille County
5. Advocates for Action of Bellows Falls
6. Speak Up Addison County
7. Randolph Area Peer Support
8. Friends Helping Friends of Barre
9. Communication Alliance of Washington County
10. Strong Advocacy Voices and You of Morrisville

Some relevant comments were also taken from quality assurance focus forums conducted by GMSA in 2013 at agencies being reviewed. We also included SOCP comments we submitted last year that were not acted on for further consideration. Similar comments stated by different people are grouped together

1. What is the one thing about individual developmental disabilities services (for you or someone you know) that you think is great?

Self-advocacy

- Self-advocacy! We are working on educating our society and community about presumption of competence and inclusion for everyone.
- The peer advocacy supports that are available to me.
- Our agency hires people with developmental disabilities to work as professional staff to promote self-advocacy and provide peer support.
- Speaking up for ourselves; Making sure our needs are met; Making sure we are listened to.
- Listening to others' questions and concerns or even feedback or comments from others
- Agency support of self-advocacy and groups:
 - They are behind us for whatever decision we all make and they give us support and input.
 - No one tells us what to do in peer support. The allies help out but actually it is really our group we support ourselves.
 - I would not be at this meeting without staff support.

Individualized

- One thing great about individual services... is that they are individual! Individual services are the way to go to support people. We do not agree with group setting type of services.
 - Do not fund center based day programs
 - Do not open sheltered workshops or fund enclaves
 - Do not allow more than 2 people to live in a shared living arrangement
- I got to interview new staff. I got to know her before she got to know me, before she got hired.
- They matched me with the right person.
- In September I got my own apartment. At first it was scary.

Employment

- Having vocational supports in order to pursue my passion to advocate, individual services allow me pursuit of my goals to educate others.
- Working at an advocacy job and getting paid fits my individual needs.
- Without services, we would not have any jobs.
- They helped me figure out how I do things best, to get a job.

Emotional Support and Crisis response

- Staff are always there for you.
- I get to spend time with my respite person whom I get along with very well.
- There is help for people in crisis, this is a safety net for parents when they can no longer take care of their sons/ daughters.
- I think the agency is doing well, in the fact that they are supporting us in the way they should. Looking forward instead of backward. They are always looking for our futures, not looking in the past.
- I like to have someone (staff) check in with me.
- If we are feeling bad, we have something we can't get off our chest, can't control anger for example, we go to a person for help.
- Services keep us stable when we are going through periods of anxiety or chaos.
- If it weren't for services we wouldn't get any help.
- When my staff and team work together and collaborate.
- Having a home provider.
- Like getting along with my workers.

Life-long Learning

- I think they're great because staff works with you to get your goals done.
- The freedom they offer.
- I like having someone to help me with my budget and making sure my bills get out on time.
- I like going to taking college classes because I like to learn skills and spend time with my friends and other people.
- I like it that I am more disciplined after having independent living services.
- If we don't get services we won't learn the skills; We need to be independent and successful; ISA goals.

Community Involvement and Inclusion

- We would not have any homes or be in the community with other people or families that we know.
- It's all about community inclusion; without support I would be sitting at home on the couch.
- Having friends.

4. If you could change one thing about individual services (for you or someone you know) what would you like to see?

Funding Issues

- Increase the number of hours (staff support) so I have more time to present my ideas of inclusion to schools and other groups.
- Many people said they want more time in the community.
- More funding to improve alternative communication programs and the communication alliance.
- Change (increase) the allocated amount of money I receive annually. I need more time to build social life outside of home.
- Higher wages for staff.
- They cut the mileage. Get more mileage for workers. Sometimes they use their own money to pay for gas to take us places.
- We have lost some people. You get to know a person real well that you work with and all of sudden they are gone. After they leave here they find a better job, a little bit more money.
- Don't cut community hours because this helps us to be integrated.
- Without respite, I wouldn't be here today (at GMSA meeting).
- More people should be getting helped.
- Many people said more money should be in a person's budgets so they get more staff time.

Employment Issues

- More hours of services for work.
- Last Wednesday I was supposed to go to work but there was nobody to give me a ride.
- I used to have people checking up on me. Now they don't check up with you they call on your day off to see how many days you did work. I had 3 people, then 2 checked up on me, now it is nothing. I think it is better to have ones in the community to check up on you instead of leaving you to do it on your own.
- Sometimes you might want to change your job but can't because of lack of transportation.
- Thinking about opening up a business. Need help doing that.
- More help finding jobs. I don't have one yet. I got help to put in applications at places and haven't heard back yet. Probably due to economy and government shutdown.

Policy Issues

- Be proactive not crisis-based.
- Adopt Employment First policy.
- Support peers living with peers independently but without staff.
- Change HOW people received personal care. I think some are getting lost in the system.
- Services should be MORE individualized.

- I am going to be dating a new person. Could use some support.
- Staff and teams need to be better coordinated and better organized.

Attitudinal

- Attitudes should be changed; Being respected as a human being – respected for who we are not what we are or not.
- More moral support.
- Staff need to be more attentive to what the person says they need.
- I would rather be called a person than my disability. They need training to treat me as a person instead of as disability.
- Schedules should be more conducive to work with what the person wants.
- Staff talking (maintaining confidentiality is something self-advocates consistently say needs improvement).

Communication

- Better communication between staff and clients.
- Consistency and communication is poor between my shared living provider and my case manager.
- Better communication, not letting us know until the last minute.
- One person says one thing, another person says another thing.

Staff Turnover

- It's kind of hard when you get someone new and they leave.
- Frustrating when you get used to somebody and you don't have them anymore. I had a case manager I had for a while and then I had a new one – that was frustrating.
- I had a new staff person and they had to leave. I didn't want them to leave. There were money budget issues.
- If you lose a worker, they quit, (the agency has) difficulty finding another worker, I still haven't got a new one.

5. Please tell us what you think is working well with developmental disabilities services in Vermont? ALL OF THE ANSWERS WE GAVE IN #3 ALSO ANSWER THIS QUESTION.

- **Support for self-advocacy** has improved people's lives by making people feel accepted for who they are instead of wishing they were always "Normal". It Teaches us life skills like how to speak up at our ISA meetings, learn life skills for independent living, sex education, how to achieve our dreams and survive "low expectation syndrome". Here are a few comments about what people get out of belonging to a self-advocacy group.
 - *I feel better about myself. I make better decisions*
 - *We help each other. We make things better for others in the community*
 - *We are educating others about disability*
 - *Knowing about myself, my body, knowing how to protect myself*
 - *I am developing my own skills & helping others*
 - *I didn't have a life before, was very isolated*
 - *I have plans for the future*
 - *I know myself better. I respect myself more because we give each other respect*
 - *I know how to speak up for disability rights and services*
 - *It helps me speak my mind and tell it like it is. Before I would go to meetings about my kids with DCF and not say anything*

- *I feel good about having the skills to make responsible choices*
- *We push for Social Change by going to meetings and the Statehouse (i.e. Walk with Your Class, Safety in School. Respectful Language, Funding For Services)*
- *We are making a difference through our local community activities and volunteer work.*

Other Misc. Comments

- Getting employment and job supports.
- Support people taking us to medical appointments.
- Be able to speak out.
- Have options to self and family manage.
- Agency support clients and support staff to go to conferences.
- System responsive to new needs of people and their families.
- Respite works well.
- I got the best staff in the world, a new respite person. She and I have so many things alike. She helped with the internet and took me to see a concert I really wanted to see. We are cooking together and she was impressed that my apartment was spotless. She loves me to death and treats me like I am her daughter. She took me to hockey games and we made cookies for all the players. The other staff is new but he is following the goals after I told him he had too.
- Support to go to college!
- Having a case manager works because they are the ones you can count on when your direct support isn't there for you. And they can help in the event of no or very limited staff.
- I like the services because they've helped me grow emotionally and in terms of being responsible.
- I think community services are working well. It gets people out (several people said this).
- I have so much more freedom.
- When I almost lost my case manager, they let me know I was within my rights to ask for who I want.

6. Please tell us what you think is not working well with developmental disabilities services in Vermont and how it could be better?

ALL OF THE ANSWERS WE GAVE IN #4 ALSO ANSWER THIS QUESTION.

Funding Issues

- Staff not paid a livable wage – we need trained staff to STAY.
- It is not working how people get their services cut due to funding. We need to stay on the legislature to let them know we need services.

Policy Issues

- Attitude of public officials on budget cuts – why was no other program in state government cut? Cut programs more equally and fairly across the board.
- The legislature needs to have oversight of the DS system of care plan.
- I think we are doing well but need more help in the political arena.
- Vermont must keep its commitment to individual services.

Quality Assurance

- There needs to be better communication. Staff need to talk with other staff and case managers more.
- Sometimes staff are too cautious about decisions.
- Staff need to call the clients more and keep them informed of what is going on.
- We need more staff and people who are willing to go about their work with respect and dignity. To improve this they need more sensitivity training.
- Staff needs to be held more accountable and work better with clients. One way to have this happen is with better communication.

Lack of accountability because of Wrap Services

Overall, to save money in response to pressure from budget cuts, many providers have reduced the number of people they employ and directly supervise. An increasing number of independent contractors are paid to provide services. This can be problematic because there is a greater degree of training, support and supervision with employees. In a number of situations agencies use what is referred to as “wrap” services. This means an agency sub-contracts with a shared living provider who then is responsible for hiring and supervising support workers. We worry about agencies moving farther away from directly supervising the people who are actually providing services. This trend seems to be the opposite from recent calls from AHS for more accountability. We need more checks and balances in the system.

More strategic approach to serving victims of abuse/crimes

A critique of the system held by many advocates is that the system is designed to do a better job serving offenders than it does supporting victims. We need parity. People with intense needs and those experiencing challenging behaviors should be given the same access to funding and a dedicated systemic approach as is already provided to offenders. DDAS needs a plan of action for providing increased monitoring and technical assistance to ensure that the state’s Behavior Management Policy is implemented.

ISAs need to be written every year and increase accountability

Another overall system concern is that ISAs were historically written every year and now the state is allowing them to be written every 2 years. In an age when agencies have less in-person contact with the people they serve, reducing the number of meetings to discuss, plan and evaluate how services are provided seems like a bad idea.

Do not fund center based day programs.

The agencies running “learning centers” mean well, but the ones we have seen tend to look childish and are run by staff – not people with disabilities. DAIL quality assurance staff need to do unannounced visits of these “learning programs”. The state needs to make sure that agencies clearly explain that attending a day program is just an option and that all people are told they have the option for individualized services.

7. What ideas do you have to better support families?

- GMSA needs to reach out to students with disabilities.
- Families should be involved immediately for conflict resolution.
- It would take some problem solving and knowledge to create more resources. Please involve self-advocates.
- We appreciate our families but need others in our lives to go to when solving problems. Help our parents understand that and respect our privacy.

- More financial support.
- Better communication.
- Be proactive and avoid crises – it ultimately costs less.
- Have families support other families.
- Show more trust to families.
- I think it is important that families receive information and communication about their son or daughter's program. Home providers also need to be up to date.
- We need to establish an initiative to increase the use of natural supports. Begin with a group receiving training from folks in NH who teach a process for developing natural supports in people's lives.

8. What ideas do you have to support aging caregivers as they find it harder to care for their family members with developmental disabilities?

- Introduce the person to self-advocacy.
- I think if the caregivers know they are the individuals' lifetime "support staff" they need to start looking for natural support or services of some kind once they hit middle age to take over for them when they pass.
- Increase respite budget.
- Support the person with a disability and their family to do lifelong planning.

9. In addition to the types of home supports described above, what ways can we support people to live in their own homes or with others?

- With respite or natural supports.
- Find one person who receives services who is more independent and pair them with another person who receives services is newer to independent living, so there can be peer support
- People need to be with peers to they can learn from each other to develop goals and independence. But this does not mean with staff. The rules for no more than 2 people in a shared living situation much remain. If an organization wants to have more than 2 people living together with shift or live in staff they must follow the existing rules for group living so we can protect our rights.
- The rules for Section-8 housing only allow one person to use a voucher. As we understand it, two friends living together as roommates cannot both receive Section-8. (Reportedly some agencies keep individuals with vouchers from sharing a household to avoid someone having to give up their voucher.) GMSA is concerned that it may set someone up for failure if they have to live alone. Most people without disabilities avoid living alone for both social and financial reasons. We need to develop a peer support residential option where two people with complementary skills can share an apartment. The shared living stipend is given to one or both of them depending on support provided. The stipend would make up for the loss of financial support from Section-8. But more importantly, the shared living stipend would promote using a peer support model for independent living.
- Establish supervised apartment programs but contract with people with disabilities who have strong independent living skills to live in one of the apartments and provide support to peers learning how to live on their own. A few providers have talked about doing this but for a variety of reasons it did not work out. Involve peers and their organizations in the development and running of this type of initiative.
- Consider training and hiring talented shared living providers who know that once someone comes to live with them that they have 2 years to teach the person how to live

more independently. This could also include a situation where two people who eventually want to be roommates begin by living with a shared living provider who teaches them independent living skills.

10. What other types of services and supports can help someone to live more independently on their own or with others?

- Skill building (ex. Cooking, independent living).
- Transportation.
- Case management.
- Budgeting and money management.
- Public transportation that goes more places; maybe that has less commotion and more polite drivers.
- Invest in an initiative to use technology to support independent living. There are many more options than just Safety Connections.
- Support ways for peers to get together and make friends. Support community membership and making of friends.

11. How can we best support young adults leaving high school?

- Better communication about what to expect.
- Peer mentors.

12. Do you have ideas on how to help people to be more independent at their jobs and not rely as much on paid support?

- Matching the right job to the right person means less support is... needed.
- As people learn their jobs better, make sure staff drop back.
- Staff should be professional, trained to set up, support, and FADE from the job site.
- More training for staff and more confidence in the person with a disability.
- Agencies should be given incentives for hiring and supporting people with intellectual disabilities to work for the agency in professional jobs (not just janitorial or clerical tasks).
- Take a closer look at how technology can increase a person's ability to stay organized on the job. Keep track of what it is exactly that staff do to support someone then work with assistive technology project to identify what type of devices and software could be used to increase independence.

13. How can we better support people who have special medical needs?

- Make sure all team members are in the know.
- Help with financing supplies.

14. How can we better support people who are a danger to others and/or themselves?

- More investment in staff training to use positive supports. Use philosophical approach of taught by Al Vechionne and Pat Frawley. The lack of resources to support staff training is unacceptable.
- Have that person with supportive staff.
- Providing training is complicated by the fact that many providers of direct service are contracted. In an increasing number of situations, shared living providers are hiring, training and supervising direct support workers. There needs to be a task force looking into the training and supervising of contracted workers.

- When someone is in crisis or challenging the system we need to be at our very best. Several years ago, DAIL eliminated their training position during the first round of budget cuts. We understand that training is the responsibility of agencies but in light of quality assurance reductions and an increase in contracted workers, we feel the state needs to address this training need.

15. What ideas do you have to increase the use of technology to help people be more independent, safe and supported?

- Adopt National Core Indicator that people receiving services must have access to the internet if they want it.
- DAIL needs to make sure that people receiving residential services have access to a telephone. Shared Living Providers must have a land-line telephone placed in an area where the person receiving services has access. Many Shared Living Providers only have cell phones which significantly limits access for the person receiving services.
- Increase support for use of devices to help communicate.
- Increase training of staff to use technology to increase a person's independence.
- More access to speech recognition software.

16. Do these Funding Priorities make sense? Which priorities do you think are the most important?

- Health and Safety.
- Employment.

17. If you were to change the Funding Priorities, what changes would you make?

- More support for employment.
- Support for job security.
- Support priority for social isolation.

18. In order to use the funding we have the best way possible, what ideas do you have on how we can save money?

- More funding for peer support options – they provide a unique service and are much more cost effective.
- Watch for fraud.
- Families getting involved to decrease the budget.
- We need more open-source text-to-speech software solutions available and in use.
- Do not pay parents to provide services to their adult children. This is a major conflict of interest. A parent should never be a person's service coordinator. People need a neutral independent source for information. Parents typically are a person's guardian and payee for SSI benefits. DAIL does not allow a shared living provider to be a person's guardian or payee so why would this be okay for parents. Many people with developmental disabilities are abused or exploited by their families. For women without disabilities, studies show that 1 in 5 have been physically or sexually assaulted in their lifetime. For women with disabilities, the rate is 4 to 10 times greater. Studies report that 97% to 99% of women with developmental disabilities know their perpetrator. 32% of those abusers are family. People need regular contact with advocates and providers for safety reasons.
- One of the least expensive ways of providing support to people with developmental disabilities is the support the self-advocacy movement. As services are decreased, people rely more on their friends for natural support. The dollars that DAIL invests in self-advocacy enables GMSA to maintain local self-advocacy groups that are available across

the state. Local and state self-advocacy events provide unique support options for people with developmental disabilities including:

- Access to a “safe person” who can provide safety advice without being a mandated reporter
 - Training on essential independent living skills, problem solving skills, social skills, job skills, advocacy skills, healthy relationship skills and support to fully participate in your community
 - Opportunities to learn about self-determination and speaking up for your rights
 - Opportunities to learn from a peer mentor
 - Opportunities to provide community service
- The state should set up a toll-free number so people can call in and give suggestions on how to save money. Support staff have a lot of first-hand information but they do not feel free to speak up. And sometimes when they do speak up agencies do not take them seriously. Many of the support staff that attend our meetings continue to tell us that there are people who get way too much support and others who do not get enough.

19. Do you have any other comments you wish to share?

- One striking inconsistency is that AHS is asking for more accountability yet the state employees responsible for quality assurance have been reduced approximately 75% over the past few years. The decrease in the state’s capacity for quality assurance began around 2006 when the Division of Developmental Services was eliminated and the focus broadened to become DDAS. In the past, each agency had a primary state contact that just focused on one or two agencies. The Quality Assurance Specialist (QAS) assigned to an agency was very familiar with the staff who worked there, knew many if not all of the people who received services, read all of the incident reports, maintained regular contact, provided on-going technical assistance and lead the annual review of the agency. In the past, many self-advocates had a personal relationship with the QAS assigned to their agency and would use the 800 number at the Division to contact this person with concerns about their agency. Today that does not happen because the 800 number was reassigned to another program and the remaining 3 QAS staff are doing the work of 12 which reduces their availability.
- In the past agency reviews were done once a year. Now they have gone to once every two years. The review process states that DDAS will take a close look at the services provided to approximately 5% to 10% of individuals receiving services. (I’ve heard in some agency it is less than 5%). A person receiving services could go more than 20 years before their services go through a quality review conducted by the state. GMSA advocates for more QAS staff.
- In the past service coordinators were required to make in-person home visits once a month for individuals receiving residential services. DDAS has allowed this to be reduced to once every 2 months. Consider that many people have “wrap” services which means all of their staff are contracted workers (home providers, respite workers, community support staff). Our concern is that in situations where a person has no direct staff employed by their agency it increases vulnerability since they may only meet with their service coordinator 6 times a year.
- The state needs to increase monitoring of the Policy on Education and Support of Sexuality. Reportedly there are Shared Living Providers who prohibit people receiving services from expressing their sexuality.

ATTACHMENT H

SYSTEM DEVELOPMENT ACTIVITIES FOR FY 2012 – FY 2014

#	Activity / Actions Taken	FY	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Activity #1</u>			
Offer individuals more choices for home supports by increasing the variety and types of home support options throughout the state and expanding alternatives to support people in more independent and interdependent living.			
1.a	Explore ideas and get input from stakeholders on home supports	12	Completed
<u>Actions Taken</u> Met with a group of family members to hear their issues and concerns about housing and home support needs for their family members and brain stormed viable alternatives. Meet with Green Mountain Self-Advocates (GMSA) to learn about their ideas and concerns about home supports. Met with DDS Directors to discuss ideas and their involvement with an initiative to explore housing and home support statewide. Discussed the idea of a large Creative Home Support forum. Determined this would be a difficult time to devote the necessary energy and resources given other pressing issues.			
1.b	Apply for Housing and Urban Development (HUD) housing grant to secure special Section 8 vouchers	12	Completed In Progress
<u>Actions Taken</u> Partnered with Agency of Human Services (AHS), Department of Vermont Health Access (DVHA), Department of Mental Health (DMH), Money Follows the Person (MFP) and the Vermont Housing Finance Agency (VHFA) to submit a HUD housing grant designed to secure targeted Section 8 vouchers to be used with specified consumers throughout the state – focus on people who have outside supports to help make the housing successful and liaison with the landlords. Vermont did not receive grant. Partnered with AHS, DVHA, DMH, MFP and VT Housing Finance Agency (VHFA) to update and resubmit a second HUD housing grant designed to secure targeted Section 8 vouchers to be used with specified consumers throughout the state – focus on people who have outside supports to help make the housing successful and liaison with the landlords. Notice of Funding Available (NOFA) was released and DDSD is working with VHFA to finalize grant.			
1.c	Explore use of Global Commitment funding for rent	14	Completed
<u>Actions Taken</u> Requested information from the business office. Learned it was possible to convert home and community-based services funding but it would need to come from the new caseload allocation. This may be something for future consideration but the workgroup looking at this issue did not feel it was politically expedient at this time.			
1d	Department of Labor (DOL) change in definition of companionship exemption	14	In Progress

#	Activity / Actions Taken	FY	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Actions Taken</u> Convened Vermont Companionship Committee and participated in national conversations/exploration into what options may be available.			
1.e	Pilot new approaches to providing home supports	13/14	In Progress
<u>Actions Taken</u> A number of providers tested and implemented new approaches to providing home supports including matching consumers moving to supervised living with peer mentors who have experience living in supervised apartments or other settings.			
1.f	Convene Legislative Summer Policy Work Group	13/14	Completed In Progress
<u>Actions Taken</u> Summer study work group met four times and published report of recommendations. One key recommendation for short-term ideas was to move more people from shared living into supervised living. Smaller work group has been meeting to further explore how to move this idea forward; in particular using monitoring and other technology solutions.			
Activity #2 Expand crisis capacity to respond to and support individuals experiencing significant crisis.			
2.a	Consider adding third VCIN bed	12/13	Completed
<u>Actions Taken</u> Considered partnering with adult mental health and had discussions about who would be eligible to use the bed and where the funding would come from. It was determined that it was not financially feasible to pursue adding a crisis bed at this time.			
2.b	Evaluate the need for regional respite bed(s) (e.g., for people with autism)	13/14	Completed
<u>Actions Taken</u> Found that some of the Designated Agencies/Specialized Services Agencies (DA/SSAs) have developed regional respite options.			
2.c	Expand consultation and training component of Vermont Crisis Intervention Network (VCIN)	12/14	Ongoing
<u>Actions Taken</u> Participated in meetings with stakeholders (e.g., VCIN, GMSA, DA/SSAs).			
Activity #3 Enhance workforce development by assessing what training is critical to facilitate the best outcomes for people and work with stakeholders to prioritize, plan, redesign, and automate training so it can be sustained.			
3.a	Explore what and how to enhance professional development of the work force	12-13	Completed
<u>Actions Taken</u> Convened DDSD training workgroup to assess training needs and methods. Surveyed DA/SSAs to see what training/technical assistance was available and needed. Partnered with Center for Disability and Community Inclusion (CDCI) to develop and provide training to providers.			

#	Activity / Actions Taken	FY	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
3.b	Create Vermont Training Consortium training advisory group	14	Ongoing
<u>Actions Taken</u> Participated as a member of the newly established Vermont Training Consortium and collaborated on some statewide training initiatives.			
3.c	Provide relevant statewide training	12-14	Completed
<u>Actions Taken</u> Collaborated with CDCI to plan and convene a yearly Conversion Institute and Association of Persons in Supported Employment (APSE) conference.			
3.d	Health Care Reform workforce development initiative	12-14	Completed
<u>Actions Taken</u> Participated with other Department of Disabilities, Aging and Independent Living (DAIL) and DDS stakeholders in a special subcommittee that specifically focused on work force development in long term services and supports.			
<u>Activity #4</u> Modernize system administration and oversight by implementing improved reporting of service and financial data to improve service quality.			
4.a	Enhance Medicaid data collection for developmental disabilities services	14	In Progress
<u>Actions Taken</u> Worked with DVHA and other AHS departments on drafting the Request for Proposal (RFP) for procurement of new Medicaid Management Information System (MMIS). Worked with AHS and other departments on drafting a new "data dictionary" (similar to what's in the Monthly Service Report [MSR]) for collecting demographic data from DA/SSAs. Update the funding request form.			
4.b	Effectively encapsulate information to make equitable funding decisions	14	Completed
<u>Actions Taken</u> Updated the funding request proposal form for Equity and Public Safety funding.			
<u>Activity #5</u> Improve the system of supports for individuals with Autism Spectrum Disorders (ASD) by implementing the goals of the Interagency Autism Plan to coordinate and increase access to services, promote awareness and develop resources to support people with ASD.			
5.a	Children in Vermont are screened and diagnosed for developmental disabilities, including autism spectrum disorders (ASD), as early as possible	12-14	Completed Ongoing

#	Activity / Actions Taken	FY	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<p><u>Actions Taken</u> Expanded Vermont Child Health Improvement Program (VCHIP) developmental screening training to interested primary care practices through a federal grant secured by the Vermont Department of Health (VDH) and DAIL. Training in developmental and autism screening significantly expanded, from 40 practices initially, to 89 practices receiving training (out of a total of 103 practices statewide.) The percentage of practices performing developmental screenings continues to increase, from 41.3% in 2009 to 79.2% in 2013, particularly at the 9 and 18 month well child visits. There continues to be a significant increase in primary care practices performing autism screening since 2009 when 58.5% indicating screening for autism, to 2013 at almost 90%.</p>			
5.b	Professionals who provide services to individuals with ASD will demonstrate competencies that reflect the experience needed when working with individuals on the spectrum. Training will be available to all professionals for building capacity to meet the needs of individuals with ASD and their families	12-14	Completed
<p><u>Actions Taken</u> DAIL provided \$90,000 in federal grant funds to five Designated Agencies for children with mental health and developmental disabilities to train additional Board Certified Behavioral Analysts. VDH and DAIL received a three year federal grant for improving services to children and youth with ASD. Training is a major component of this grant including: intensive training and coaching in evidence-base practices for Early Essential Education (EEE) and Children’s Integrated Services – Early Intervention (CIS-EI) staff; training for primary care practices in developmental screening, including ASD specific screening; training for physicians regarding the recommended care of children and adults with ASD; and raising awareness of ASD issues for the public.</p>			
5.c	Coordinated autism resource dissemination should be created to act as an information clearinghouse and promote collaboration among school staff, families, state agencies and community service providers and build capacity in all areas of Vermont to address the needs of individuals with ASD and their families	12-14	Completed
<p><u>Actions Taken</u></p> <ul style="list-style-type: none"> • Vermont Family Network (VFN) was provided a three year grant through DAIL to serve as a clearinghouse for autism information dissemination and support to families, including the development of a website with ASD information and having a part-time person dedicated to providing phone line support for information and systems navigation. The website includes a comprehensive list of resources to meet the needs of individuals with ASD and their families. Activity on the ASD website has been steady over the past three years. On average, the site is being visited 3,313 times by 1,219 unique visitors per six month period. VFN has received funding via a grant from the Vermont Developmental Disabilities Council (VTDDC) to expand resources on the website for other developmental disabilities and to maintain the ASD information. 			
5.d	Track legislation requiring insurers to cover certain services to children with autism	12-14	Completed Ongoing

#	Activity / Actions Taken	FY	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Actions Taken</u> Analyzed the impact of the legislation passed in 2012 and provided summary report to legislature with AHS partners. Participated with AHS partners in developing recommendations for implementation of the legislation. Assisting AHS in developing service options within Medicaid.			
Activity #6 Expand capacity to support individuals who pose a high risk to public safety by providing the most appropriate and cost effective services and supervision for people through the use of the public safety risk assessment and protocols.			
6.a	Evaluate the risk in relation to the cost of services of individuals who are a risk to public safety	12	Completed Ongoing
<u>Actions Taken</u> Conducted public safety risk assessments on all individuals who are considered to be a risk to public safety and adjusted budgets based on the results. Conducted Less Restrictive Placement Reviews annually and perform newly funded Comprehensive Behavior Support Plans reviews after six months. Coordinated \$200,000 reviews every 3 months of individuals supported with public safety funding. Implemented a continuous process of evaluating recidivism risk for all persons who receive approved funding under a public safety funding priority.			
6.b	Create Public Safety Protocols	13	Completed
<u>Actions Taken</u> Created protocols which included the “least restrictive environment” annual review. Created and maintain a list of people who receive public safety funding.			
6.c	Ensure effective and cost efficient services	13-14	In Process
<u>Actions Taken</u> Revised the process for reviewing individual budgets over \$200,000.			
Activity #7 Increase employment outcomes in partnership with Creative Workforce Solutions by increasing the employment rate of adults and enhancing methods to support people at their job and to be more independent at work.			
7.a	Increase employment rate	13-14	Ongoing
<u>Actions Taken</u> Provided technical assistance to programs related to their staffing structures to increase job development time.			
7.b	Explore options for increase independence on the job	14	Completed
<u>Actions Taken</u> Facilitated work group on employer paid supports pilot to explore to increase independence from agency staff.			
7.c	Increase employment opportunities for high school graduates	13-14	Completed

#	Activity / Actions Taken	FY	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
<u>Actions Taken</u> Participated on Project Search Task Force to implement a Vermont Project Search aimed at increasing employment for high school graduates.			
<u>Activity #8</u> Create flexible supports and services for children and families in partnership with AHS Integrated Family Services (IFS) as follows:			
<ul style="list-style-type: none"> a. Create better coordinated and integrated services packages for children who need support for health, personal care and case management needs through Children’s Health and Support Services (CHASS). b. Create flexible family support and treatment services based on family functioning and needs through Enhanced Family Services (EFS). 			
8.a	Coordinated and integrated services through CHASS	12	Completed
<u>Actions Taken</u> Moved High Tech Nursing and Children’s Personal Care Services programs to Children with Special Health Needs at the Vermont Department of Health.			
8.b	Flexible Family Support and Treatment Services	12-13	Completed
<u>Actions Taken</u> Planned and launched IFS pilot at Counseling Service of Addison County (CSAC) in Addison County.			
8.c	Flexible Family Support and Treatment Services	13	Completed Ongoing
<u>Actions Taken</u> Provided non-categorical funding to Designated Agencies to increase services to children and families regardless of disability, including family managed respite. Promoted the concept of “One Door”/“No Wrong Door” to increase collaboration across Designated Agencies’ developmental disabilities services and children’s mental health services. Continued planning and collaboration across AHS programs – increased participation and involvement in the Case Review Committee, State Interagency Team, High End System of Care Team, and Integrated Family Services (IFS) Implementation Team. Continued planning to implement Northwestern Counseling and Support Services (NCSS) pilot in Franklin/Grand Isle Counties.			
<u>Activities #9</u> Alternative activities created, developed and/or explored by DDSD			
9.a	Increase post-secondary options for youth	13-14	Completed Ongoing
<u>Actions Taken</u> Worked with DAs to use the Think College model for college campus based post-secondary education. Supported Rutland Mental Health Services (RMHS) and			

#	Activity / Actions Taken	FY	Status (In Progress, Pending, Ongoing, Reevaluate, Dropped, Completed)
	<p>United Counseling Services (UCS) to help open the Castleton State College and Southern Vermont College Post-Secondary Education (PSE) programs. Continued support at Lamoille County Mental Health (LCMH) for Johnson State College and at HowardCenter (HC) for SUCCEED. Created standard procedures for taking the model statewide. Negotiated with Global Campus to expand opportunities to individuals who do not currently have access to other community supports.</p>		
9.b	Increase post-secondary options in Vermont	14	In Progress
	<p><u>Actions Taken</u> Convened Employment Work Group in response to the DDS Summer Legislative Work Group to explore the option of paying employers/coworkers to support a person on the job.</p>		