VERMONT DEPARTMENT OF MENTAL HEALTH AND DEPARTMENT OF DISABILITIES AGEING, AND INDEPENDENT LIVING - DEVELOPMENTAL DISABILITIES SERVICES
LOCAL COMMUNITY SERVICES PLAN
PREVIOUSLY CALLED THE LOCAL SYSTEM OF CARE PLAN

Instructions for the Three-Year Plan
FY '25 – FY '27

Plan Period: July 1, 2025 – June 30, 2028
Date Due: May 1, 2025

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Purpose

The existence of the Local Community Services Plan is statutorily required: 18 V.S.A. § 8908

The primary purposes of the local system of care plans are to**:**

1. Guide the development of local services, including identifying priority areas of support and use of resources; and,
2. Inform, as applicable:
   - DMH's Vision 2030 work,
   - DDS' State System of Care Plan, and
   - the budget process for your local agency and both state entities.

Current Status

Please provide the following:

- Briefly identify service and support needs, by service category, and which are being met or not met in the region(s) you serve
    a. e.g. for DDS: home supports, work supports, crisis services
    b. e.g. for DMH: all comprehensive services, as described in the Mental Health Provider Manual or CCBHC Requirements, if applicable
- Update the status of each specific outcome identified in your previous Local 'System of Care' Plan. Consider:
    a. What did you do?
    b. How well did you do it?
    c. What difference did it make?

Plan Development

For DMH Designated Agencies:

- Reference the flowchart in Appendix B. If you have developed a community needs assessment in the last three years, such as in preparation for Certified Community Based Integrated Health Centers (CCBHCs), or plan to soon, you may be able to submit that as your plan. It is possible this document can also count for a DS Local Community Services Plan, if the agency's information gathering and analysis was designed to collect and process information on the DS population as well.
- In previous years, DMH required separate plans specific to each program, as well as Quality Improvement and Utilization Review on the same document. This is no longer required.

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

    People and organizations to get input from include:
    a. Individuals who receive services/self-advocacy groups
    b. Local program standing committee(s)
    c. Specialized Service Agencies and other service providers in your region
    d. Staff and contractors, including other programs of the agency
    e. Family members, family advocacy groups and guardians
    f. Advocacy organizations, such as local interagency team
    g. Health care providers or home health agencies
    h. State departments/divisions, as relevant
    i. Your agency's Board of Directors (or equivalent)
    j. Local schools

Other resources to use to inform the planning process include:

a. DDSD and/or DMH Quality Service Reviews and Designation reviews
b. Appeals and grievances, critical incident reports, other relevant reports
c. Individual and family satisfaction survey results
d. Internal quality improvement or assurance processes

2. **Priority Needs.** Identify priority needs and resources based on the information that was gathered. Resources may include financial, human resources, coordination and collaboration with other community and state entities, etc. Consider reduction as well as reallocation of resources.
    a. Identify current and anticipated needs of people with developmental disabilities and/or mental health challenges in the region over the course of the next three fiscal years.
    b. Prioritize the identified needs.
    c. Specify whether the needs are currently met, under-met or unmet.
    d. Identify existing and new resources and strategies necessary to maintain currently met needs and to meet anticipated under-met or unmet needs.
    e. Consider strategies and resources from both a program and system perspective.

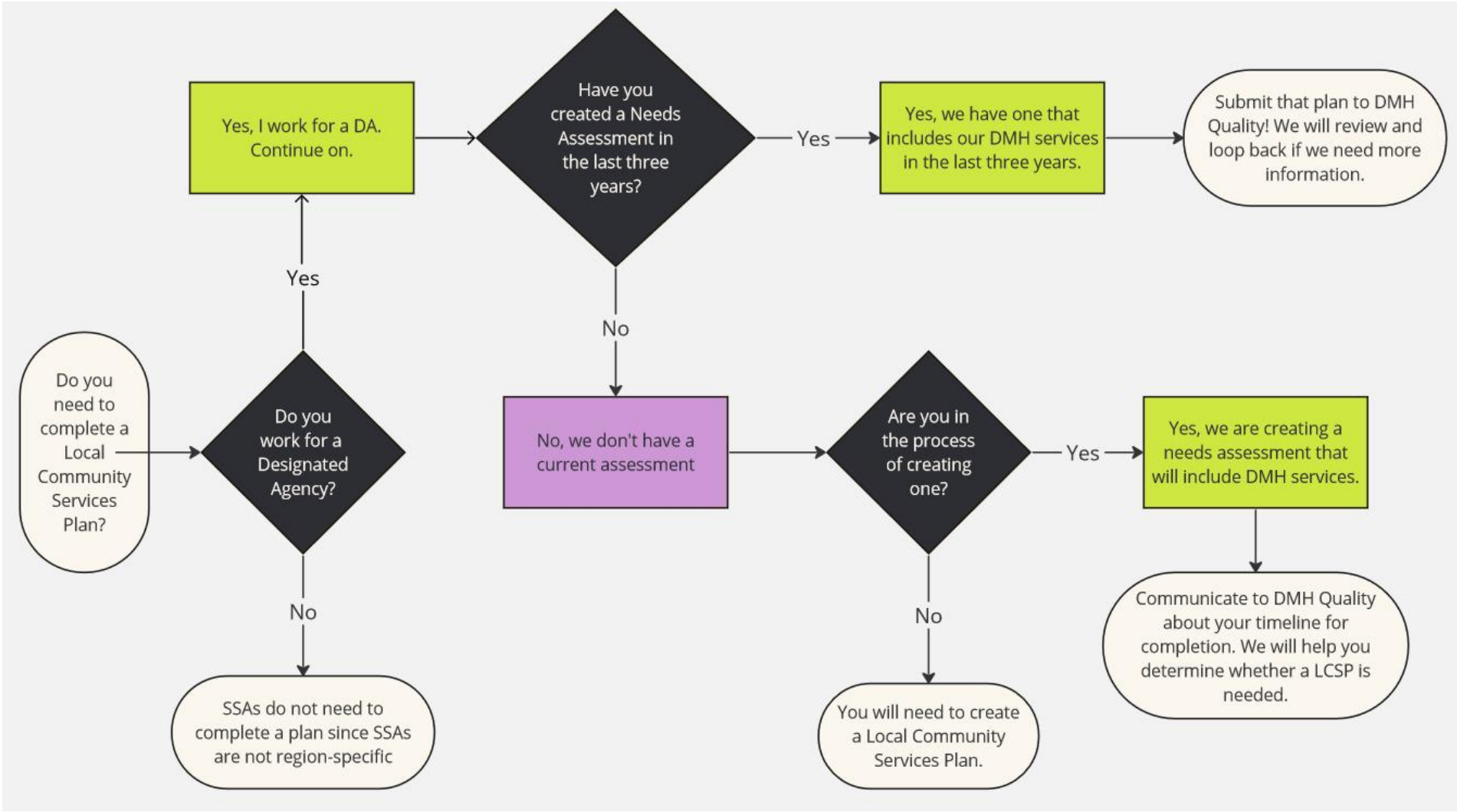
3. **Regional Outcomes.** Based on the prioritized needs, identify the areas that are considered the most important for the region to focus on over the next three years. **List the top outcomes/goals for your region that are realistic and achievable.** Think about what issues are causing the most difficulties and what issues will make the most difference if focused on. For each outcome, identify:
    a. What you hope to achieve. (What are you going to do?)
    b. The strategies you will use for each goal. (How are you going to do it?)
    c. How you know when each goal has been achieved. (What difference will it make and how will you measure it?)

4. **System Outcomes.** Identify 2-3 areas that are considered broad-based needs for the region or state that will expand the current options available for people with developmental disabilities and/or mental health challenges and should be transformed into state-wide-system outcomes.

Appendix A: Questions to consider when gathering and prioritizing information for the Local Community Services Plan:

a. What is working well?
b. What should be changed or improved?
c. Are there additional services that should be available in your region?
d. What do self-advocates and families value about supports?
e. How should things be done differently?
f. What do self-advocates and families want more of and/or less of?
g. What changes or improvements would you want to see in the system of services in three years?
h. Does the current range of types of services provided address, or fail to address, the needs of people with developmental disabilities in your region?
i. In your local area are there age groups or people with types of disabilities that are not addressed through the current types of services provided?
j. In what ways might the process for applying for services be modified to assure people have full information about their options?

Appendix B: DMH Agencies- Do you need to complete a Local Community Services Plan?



Appendix C: (Optional) Template for Local Community Services Plan

Current Status

- Review of Needs in the Region currently

Counseling Services of Addison County completed a comprehensive Community Needs Assessment in August 2025 in alignment with the Certified Community Behavioral Health Clinic (CCBHC) requirements. As outlined in Appendix B, this assessment was conducted through a structured process of data collection, analysis, and stakeholder engagement. The final report fulfills the requirements for submission as the agency's plan and may also serve as the Developmental Services (DS) Local Community Services Plan, as the methodology intentionally incorporated information on and analysis of the DS population.

- Review of Outcomes in previous System of Care Plan**
  **Mental health respondents may choose to skip this component if you choose since the previous plan included outcomes specific to the program level.

Outcome 1	Description: New options for day services and increased socialization
What did you do?	When the COVID-19 pandemic began in March 2020 and the DS workforce declined sharply, the program acted quickly to maintain essential supports in two parallel ways: • **In-Person Critical Supports** A small group of individuals with the most significant needs continued to receive in-person support to ensure their health, safety, and daily functioning. • **Remote Service Options** For the larger group who chose to remain home, CSAC staff created Zoom-based activity groups. Craft supplies and other needed materials were delivered directly to participants' homes so they could fully engage. Service Coordination was conducted by phone and Zoom, ensuring continuity of planning and supports. • **Adaptation to Workforce Challenges** As in-person services resumed, staffing levels remained well below pre-pandemic numbers. The program responded by introducing **consumer-driven group services** in which clients selected topics of interest, shared skills with peers, and helped shape the activities. Each group was staffed by a facilitator alongside two paid peer facilitators, expanding leadership opportunities. • **Ongoing Service Choices** Some families elected to continue supporting their family member at home when in-person services resumed, hiring their own employees under contract rather than returning to agency-based services.

Outcome 1	Description: New options for day services and increased socialization
How well did you do it?	• **Flexibility & Responsiveness:** Staff adapted rapidly to changing conditions—redesigning service models, using Zoom to reduce isolation, and shifting resources to group service formats. • **Sustainability of Innovation:** The group model, launched out of necessity, continues to this day and is **flourishing**. It provides a meaningful use of Community Support funding, directly aligned with client desires for socialization and leadership roles. • **Empowerment of Clients:** Paid peer facilitator roles created genuine opportunities for people to lead, teach, and inspire their peers—building confidence and modeling self-determination. • **Consistency of Service Coordination:** Despite the challenges, coordinators maintained regular contact with individuals and families, preventing lapses in care and compliance. • **Workforce Recovery:** While the program continues to operate with a reduced workforce, there has been **slow but steady progress** in rebuilding staff capacity.
What difference did it make?	• **Reduced Isolation & Sustained Connection:** Remote and later hybrid services provided vital social contact during the pandemic and beyond. For many, Zoom groups remain a lifeline to peers and staff. Currently this platform is used by the Green mountain Self Advocates group and for remote service coordination. • **Preservation of Essential Supports:** Those with the most critical needs never lost access to in-person support, ensuring health and safety and stability of their homes through the crisis. • **Expansion of Social & Leadership Opportunities:** The flourishing group model has become a cornerstone of Community Supports, providing meaningful engagement and opportunities for clients to both participate and lead. • **Increased Family Choice:** Families who chose to contract their own employees had the flexibility to tailor supports to their comfort level, demonstrating the program's responsiveness to diverse needs. • **Enduring Innovation for the Future:** The continuation of consumer-driven groups into the present day illustrates how a crisis-born model can grow into a sustainable practice, enhancing socialization, peer teaching, and leadership in ways that traditional one-to-one services did not always achieve. • **Current Reality:** While innovation has expanded options, the limited workforce continues to mean that **individuals are waiting for agency-staffed Community Supports**, underscoring both the resilience of current services and the ongoing need for workforce development.

Outcome 2	Description: Continue to develop IFS
What did you do?	• CSAC remained an integral member of the local IFS pilot, aligning Youth & Family and Developmental Services programs. • We used the flexibility of IFS funding to serve children with complex needs—including those with Intellectual Disability, Autism, or PDD—without being limited by siloed funding streams. • A shared liaison role bridged Y&F and DS, improving continuity for youth transitioning to adult services. • We tracked DS eligibility and monitored "June grads" to prepare them for adult DS. • During COVID, we adapted services creatively (e.g., shower-curtain barriers to allow in-person groups, expanded home visits, community-based supports). • We supported high-need children using ARIS family-managed respite.
How well did you do it?	• Despite COVID disruptions, families reported continuity of services. Staff were able to keep seeing kids in home, school, and community settings. • The liaison position reduced transition gaps between youth and adult services, and youth with DS diagnoses were less likely to "fall through the cracks." • We successfully maintained high-end services (spec rehab, case management, intensive in-home supports) even with staffing shortages. • Anecdotally, families appreciated that IFS allowed us to support both children and parents/guardians—something not possible before IFS. • Tracking was done more consistently for DS eligibility and case management hours, though survey data and outcome metrics were limited.

Outcome 2	Description: Continue to develop IFS
What difference did it make?	• Children with complex needs remained in community settings rather than higher levels of care. • Families were supported directly at home, reducing stress and increasing stability. • Transitions to adult DS were smoother, with eligibility established earlier and service gaps reduced. • IFS flexibility allowed CSAC to support whole families, not just the child, which improved resilience and family functioning. • During the pandemic, innovative approaches prevented service disruption and reinforced trust between CSAC and families. • Systemically, the IFS model demonstrated that braided funding can break down silos and enable more responsive care.
Next Steps	• As IFS winds down, we are working internally to redesign supports for children with Intellectual Disabilities, Autism, and PDD to ensure that the gains made under IFS (flexibility, whole-family support, smooth transitions) are not lost. • We aim to align these lessons with CCBHC development and our CNA findings, emphasizing least restrictive settings, integrated DS/MH care, and stronger family supports.

Outcome 3	Description: Staff turnover and increase substitute roster
What did you do?	The CSAC DS Program faced already difficult hiring challenges that were further compounded by the Covid-19 pandemic. In response, the agency took multiple actions to stabilize and grow its workforce: • **Staff Compensation Improvements:** In 2022, base pay rates were adjusted, providing a long-needed boost to morale and retention. A year later, substitute staff pay rates were raised by $2.00 per hour to match entry-level DSP wages, making sub work more attractive and equitable. • **Marketing Investments:** Recognizing that traditional recruitment was no longer sufficient, the agency partnered with *Place Creative Company* to develop a professional marketing campaign. This included radio ads, newspaper inserts, visually engaging rack cards and handouts, and digital outreach through sponsored posts on Front Porch Forum, Facebook, and Indeed. • **Substitute Pool Development:** Efforts were also made to expand and stabilize the substitute list. When staff transitioned out of regular employment, they were encouraged to stay engaged as substitutes or provide family respite. **How well did you do it?** • The **rate adjustments** were well-received, with noticeable positive impact on staff morale and a stronger sense of being valued. Staff feedback highlighted appreciation for the agency's willingness to invest in its workforce despite tight budgets. • The **marketing campaign** was implemented strategically and professionally. Materials were designed to be both eye-catching and informative, broadening the agency's reach beyond word-of-mouth recruitment. Multiple platforms were targeted to maximize audience exposure. • As a result of these efforts, the **substitute list grew to four active individuals** at the general level, with three of the four residences also having program-specific subs. This marked an increase over prior years, where the list was frequently at or near zero. The creative practice of keeping former staff engaged as subs or respite providers has been especially successful, maintaining continuity of care and preserving staff relationships with individuals served.
How well did you do it?	

Outcome 3	Description: Staff turnover and increase substitute roster
What difference did it make?	• **Improved Workforce Stability:** While the agency's workforce still lags behind community needs, the measures taken slowed attrition and created slow incremental growth. Staff who might otherwise have left entirely have remained connected through substitute or respite roles. This continues to be an area that needs improvement. • **Increased Morale and Engagement:** Staff pay adjustments reinforced the agency's commitment to valuing employees, improving morale at a time when retention was a major concern statewide. • **Enhanced Community Visibility:** The marketing investment significantly raised the agency's public profile. Families, community members, and potential applicants reported greater awareness of employment opportunities, positioning CSAC as a more visible and competitive employer in the region. • **Sustained Services Through Flexibility:** The expanded substitute pool, though still modest, has provided critical relief coverage for residences and community programs. This flexibility has helped ensure service continuity for individuals with developmental disabilities, particularly during unexpected staff absences.

Planning Process

- People and Organizations

Information Source	Number Involved (People)	Feedback/input method E.g. survey, meeting, public forum, interview, report, etc.
Individuals who receive services, self-advocacy groups	Survey (226), Focus Groups (19), and Interviews (17)	Survey, Focus Groups, and Interviews
Local program standing committee(s)	6	Focus Groups
Specialized Service Agencies and other service providers	Survey (12), Focus Groups (8), and Interviews (16)	Surveys, Focus Groups and Interviews
Staff, contractors, other programs at your agency	Survey (50), Focus Groups (21), and Interviews (3)	Surveys, Focus Groups and Interviews
Family members, family advocacy groups, guardians	Surveys (41, Focus Groups (6), and Interviews (4)	Surveys, Interviews

Information Source	Number Involved (People)	Feedback/input method E.g. survey, meeting, public forum, interview, report, etc.
Advocacy organizations	Surveys (2), Interview (1)	Surveys, Interviews
Health care providers	Survey (1, Focus Groups (13), and Interviews (3)	Surveys, Focus Groups and Interviews
State departments/divisions	Focus Groups (11), and Interviews (1)	Focus Groups and Interviews
DA Board of Directors (or equivalent)	Focus Groups (2) and Interviews (2)	Focus Groups and Interviews
Others	Surveys (9), Focus Groups (11) and Interviews (1)	Focus Groups and Interviews

- Documents and Processes

Information Source	Feedback / Trends to consider
DDSD or DMH Quality Service Review	**Feedback and Trends from Available Data** Analysis of Quality Service Reviews, the Community Needs Assessment, appeals and grievances, critical incident reports, satisfaction surveys, and internal quality improvement processes reveals the following themes: • **Workforce shortages remain the central barrier.** Vacancies, turnover, and an insufficient substitute pool continue to impact access to services, disrupt continuity, and delay progress toward goals. Recruitment strategies and pay adjustments have helped modestly but do not yet close the gap. • **Crisis response needs to be more consistent and IDD-informed.** Families and staff report variability in how crises are managed for individuals with developmental disabilities. There is a need for clearer protocols, stronger collaboration with emergency departments and first responders, and reliable follow-up after crisis events. • **Families and individuals value flexibility and creativity.** Hybrid service models, peer-led groups, and family-hired staff arrangements are well received. These approaches have reduced isolation, built leadership skills, and provided choice in how services are delivered. • **Social connection and employment remain priorities.** Individuals consistently express interest in meaningful work, community participation, and opportunities to build independence. Families highlight the importance of supports that promote belonging and skill development.

	• **Satisfaction survey themes:** Respondents emphasized appreciation for respectful staff, family involvement in planning, and flexibility of supports. Concerns were raised about staff turnover, service delays, and limited opportunities for socialization and employment. Guardians expressed a desire to be more involved in selecting staff to ensure good fit. • **Grievances and complaints:** These most often relate to delays in service initiation, lack of timely communication about changes in staffing or funding, and frustrations with documentation accuracy. Families and guardians want clearer, more proactive communication and faster resolution when concerns are raised. • **Documentation and planning require improvement.** Reviews show gaps in the accuracy and timeliness of medical records, ISAs, and Emergency Fact Sheets. Goals are not always measurable, and progress is not consistently tracked across time. Staff need tools and support to strengthen data collection and outcome measurement. • **Systematic data tracking is underdeveloped.** Current systems make it difficult to evaluate progress across the population or identify trends early. Building stronger analytics capacity will improve planning, compliance, and alignment with CCBHC and DS reporting requirements.
Appeals and Grievances, Agency Complaints	• See above
Critical Incident Reports	• See above
Individual and Family Satisfaction Surveys	*See Community Needs Assessment
Internal quality improvement or assurance processes	• See above
Other sources of information	None

Priority Needs & Regional Outcomes

Only list items your agency can feasibly turn the curve on in the next one-three years. If a larger goal is a priority needed for the region, consider how to split off a piece that is feasible in the timeframe of this plan. Please write needs into this document in rank order of priority.

1. Priority Need / Outcome	Description: **Improving Crisis Response for People with Developmental Disabilities (IDD)** CSAC closes the gap identified by DS residential and community staff who report variable responsiveness from crisis services for clients with IDD—by ensuring every crisis touchpoint is IDD-informed, reliably dispatched, and followed by rapid warm hand-offs into ongoing care
What do you hope to achieve? (outcome)	• A reliable crisis system across the county that understands IDD needs • Fewer emergency room visits for emotional/psychiatric reasons and repeated crises • Fast connection from crisis response to ongoing care including connection with the individual's therapist and increasing the capacity for therapeutic supports to avert ED use.
How are you going to do it? (resources & strategies)	• Use clear procedures for how to help people with IDD during crises (like ways to communicate or calm the person down) • Make sure someone follows up after a crisis (warm handoff), including booking the next appointment and offering peer support. • Work closely with hospitals, police, and housing programs on offering training and formalizing relationships through an MOU so responses are better coordinated • **Train all crisis and DS staff** in Zero Suicide practices/CAMS alignment, trauma-responsive care, and autism/IDD specific needs as part of CSAC's Trauma-Informed Systems effort.
How will you know when you've achieved it? (performance measure)	• 90% of IDD crisis calls get a clinician follow-up within an hour • 95% get a follow-up scheduled within 2 days, and 80% attend a visit within 3 days • ER visits for behavioral crises drop by 10% • Most urgent cases get evaluated within 1 day; routine cases within 10 days

2. Priority Need / Outcome	Description: **Better Care for Adults with Both Developmental Disabilities and Addiction/Mental Health Issues (Dual Diagnosis)** Adults with both IDD and substance use or mental health issues often don't get the care they need, especially after a crisis.CSAC expands integrated dual-diagnosis care tailored for adults with IDD, addressing the county's high gap between SUD and mental health need and treatment received and ensuring smooth pathways from crisis to ongoing co-occurring care.
What do you hope to achieve? (outcome)	• A steady, specialized care program for adults with both IDD and mental health/substance use needs • Care that keeps people engaged and on the path to recovery • Clinicians who are trained in IDD + MH/SUD
How are you going to do it? (resources & strategies)	• Train staff to work with both IDD and addiction/mental health issues • Hire more clinicians with dual licenses (mental health + addiction treatment). Grow the pool off clinicians who can deliver supports to a person with IDD, work with their team if indicated supporting a range of modalities for non-verbal or those with limited communication • Work closely with primary care and medication providers to coordinate care
How will you know when you've achieved it? (performance measure)	• All key teams (mental health, addiction, crisis, etc.) are working together with the IDD team • More staff are trained and licensed to treat both areas IDD+MH/SUD • A fully working program for co-occurring care is in place by January 2027

3. Priority Need / Outcome	Description: **Solving Staffing Problems in Developmental Services (DS)** There aren't enough staff to provide stable services in homes and communities for people with developmental disabilities. This leads to waitlists and burnout.
What do you hope to achieve? (outcome)	• Safe, consistent staffing in homes and community support. Increased availability of Shared Living Homes and a reduction in the waiting period for one. Availability of other residential housing options • Restored support hours for clients • Continued high-quality employment, residential and community programs
How are you going to do it? (resources & strategies)	• Recruit and keep staff with better career paths, schedules, and branding • Train staff in basic mental health, addiction, and trauma care • Train staff in ID specific areas : Communication Challenges, behavioral support, respectful personal care, consumer driven services • Support home settings with extra supervision and backup staff • Promote the work of DS Staff to help with hiring and community awareness
How will you know when you've achieved it? (performance measure)	• Keep DS staff vacancy rate at 10% or lower • Homes are fully staffed every month and overtime is cut by 15% • 90% of staff complete required training each year • Reduce wait time for a shared living provider by 25%

4. Priority Need / Outcome	**Involving Clients and Families More in Services** **What's the problem?** Clients and families often feel left out of important decisions about services and staffing.
What do you hope to achieve? (outcome)	• Clients and families are more involved in planning and decision-making • Better matches between clients and staff • Build stronger communication and trust • Clients are involved in the staff interview process, small pool of clients trained in the process, called on to participate in 2nd interviews
How are you going to do it? (resources & strategies)	• Let families and consumers help choose staff and make it easier to ask for changes • Grow the Parent Advisory Committee and offer family peer support • Train staff to share decisions with clients and honor their preferences
How will you know when you've achieved it? (performance measure)	• 85% of families say they feel heard and involved • 80% clients are happy with their staff, and fewer than 10% ask to switch staff early on • At least 12 active Parent Advisory members and 45% of families take part in at least one activity each year

System Outcomes

What do you hope the region or state can turn the curve on in the next few years? This is a placeholder for items that are broader than your agency's sphere of control alone.

Rank	Regional or State?	Description of Broad Need
1	State: DDSD (DAIL) + DMH + DSU	Adopt one statewide co-occurring practice & financing framework for people with I/DD who also have MH/SUD needs. Align clinical guidelines, access timelines, documentation, and braided payment across DDSD/DAIL, DMH, and VDH DSS, crisis, outpatient, targeted case management, peer support, and care-coordination standards as required under the CCBHC model. Include portable peer certification and shared quality measures.
2	State and Regional: DDSD (DAIL) + DMH + DSU (with housing partners)	Support an integrated supportive-housing pipeline—from shared living/group homes to independent scattered-site units, plus step-up/step-down crisis/stabilization and tenancy supports—so people with I/DD and co-occurring MH/SUD can remain in the community. Standardize care-coordination with housing organizations, unify tenancy-support service definitions, and use joint data/metrics to reduce ED use and institutional days. Measure: new dedicated units/slots; tenancy retention; crisis bed utilization; successful community transitions.
3	State and Regional - DMH + VDH DSU (policy); DDSD/DAIL	Help implement a single “front door” and care pathway across DS, MH, and SUD locally. Routine universal screening for SUD/MH in DS; direct connection to 24/7 crisis and mental health urgent care / walk-in; rapid access to initial & comprehensive evaluations within 10 business days; and warm hand-offs to outpatient MH/SUD, targeted case management, and peer/family supports. Build workforce capacity through dually-credentialed clinicians and cross-training of DS staff in co-occurring care. Measure: % of DS clients screened, % meeting 1-day/10-day access, crisis diversion, and sustained engagement in MH/SUD services.