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DEPARTMENT OF
DEVELOPMENTAL
SERVICES

REGIONAL CENTER CORE STAFFING STUDY

FINAL REPORT

SEPTEMBER, 1999



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EXECUTIVE SUMMARY

Citygate Associates was engaged by the Department of Developmental Services (DDS) to develop a technical budgeting methodology for funding the staffing and operating expenses of the state's 21 Regional Centers (RCs). In order to develop the method, Citygate was asked to:

Identify the...staff that will enable Regional Centers to meet their state and federal mandates and are consistent with good business practices. This study must determine the staff resources required to effectively monitor and assure that appropriate services are rendered effectively to persons of varying developmental disabilities. (Request for Proposal, DDS)

We reviewed the overall RC system in detail in order to answer three key questions:

- 1) What are RCs supposed to do, based on state and federal mandates?
- 2) What resources do RCs require to perform those functions?
- 3) How should RCs' operations be budgeted?

This Executive Summary first presents the background which led to this project, then describes Citygate's study methodology, and is followed by an overview of the mandates which drive the workload and staffing requirements of Regional Centers (RCs). The Executive Summary then highlights the resources required by Regional Centers, discusses Citygate's proposed budget model for RC operations, and concludes with a listing of suggested system outcomes that the proposed budget model should be expected to generate.

Note: a glossary is included at the end of this report to assist the reader with frequently used but unusual terms and initials contained in this document.

A. STUDY BACKGROUND

This Core Staffing study was initiated out of concern for the usefulness of the currently used Core Staffing Formula. Designed approximately twenty years ago, the existing Core Staffing Formula is obsolete and does not reflect today's RC operating environment.

The approach initially considered for replacing the Core Staffing Formula involved the use of a "time-and-motion" study. However, many challenges made the execution of this study approach difficult. Operations vary widely between the 21 RCs. Various staffing patterns and internal processes are used across the system. Thus, for a variety of reasons the time-and-motion approach to building a new budget model was discounted in favor of the approach employed in this study (our study approach is described below, and presented in more detail in Section I of this report.)

Citygate Associates' approach to this sizeable project involved an extensive number of tasks and analytical processes. Within the constraints of the schedule and budget for this project, Citygate worked to make the study design as comprehensive and rigorous as possible. As a result, the proposed RC budget model is a vast improvement over the existing Core Staffing Formula. Yet with any new budget model—particularly one as complex and detailed as this one—opportunities for validation and refinement of the model exist. In Section IV of this report, Citygate identifies a number

of areas where validation of our proposed model is merited. Within the framework of our proposed budget model, various approaches to workload validation, including time-and-motion analysis, can now be cost-effectively employed within narrowly targeted functional areas.

B. OVERVIEW OF STUDY METHODOLOGY

Citygate conducted extensive qualitative and quantitative data gathering and review in preparing this report. The study began with ten regional forums with RC line staff in consumer service coordination, community services, clinical services, administration, and with executive directors. Four regional forums for vendors, consumers and family members were conducted, and thousands of responses to the state's surveys of consumers, families and vendors were reviewed. Site visits were made to five RCs, in addition to the eight visited in Citygate's prior study of community placement practices. Background interviews with key constituencies were held. A review of academic research on case management, developmental disability services and operational budgeting was performed, along with a review of law, regulation and prior reports on RC budgeting and operations. Twenty of the state's 21 RCs participated in completing a complex and thorough survey of RC operations, staffing and expenditures.

Data cited in this report refer to the most recent period available during the study, 1997-98. Since that time, in recognition of the impact of the unallocated reduction and service requirements in the RCs, substantial increases in staffing and funding have been included in the 1998-99 budget and proposed for 1999-00. Survey-reported results do not necessarily represent appropriate staffing or service levels, but present a common baseline of operations as of that period. Only when the scope and level of service at a specific RC was confirmed as appropriate and effective by qualitative analysis and fieldwork was survey data used to model future staffing levels.

Preliminary findings were reviewed with expert panels comprised of RC staff in consumer service coordination, clinical and community services. A preliminary draft of this report was reviewed in detail by RC teams in consumer service coordination, community services, clinical services and administration; their comments were presented to Citygate in writing and in a meeting with the teams and Project Steering Committee. The final draft was distributed throughout the state to RCs and key stakeholders. Three public hearings were held to solicit public comment. This final report incorporates significant findings and methodological changes as a result of the public comment process. Throughout the study, a Project Steering Committee of DDS, Association of Regional Center Agencies (ARCA), and Department of Finance (DOF) representatives worked closely to oversee the study design and project findings.

C. RC MANDATES

A comprehensive review of state and federal law and regulation identified the diverse mandates of the RCs. In summary, all of the following are specific obligations of the RC system:

- ◆ **Intake and Eligibility** assessment;
- ◆ **Consumer service coordination (CSC)** focused around the Individual Program Planning (IPP) Process for persons with developmental disabilities, and the Individualized Family Service Plan (IFSP) for early intervention children;

- ◆ **Prevention services;**
- ◆ **Casefinding** including outreach and community awareness services;
- ◆ **Developing services and supports** to meet identified needs, including community support and facilitation;
- ◆ **Advocacy** for, and protection of, the civil, legal, and service rights of developmentally disabled persons;
- ◆ **Quality assurance** of purchased services and vendors;
- ◆ **Technical assistance** to vendors; and
- ◆ **Fiduciary financial services** to vendors and consumers.

Purchase of Service (POS) funds comprise almost 80% of the RCs' total budget, exceeding \$900 million in 1997-98, and budgeted at nearly \$1.1 billion for 1998-99. The number of active consumers in RCs has increased by over 50% from 1990 to 1998, while RC total budgets have increased between 7.3% and 19.7% annually, for a total of 143 percent since FY 90-91. This amounts to a 62% increase in expenditures per consumer. The State has struggled to control this expenditure, especially during the fiscal pressures of the early 1990s. However, the volatility of these numbers is substantial, and several RCs have had budget crises triggered by POS overruns in recent years.

With POS representing 80% of an RC's budget, and the demand for POS depending on the outcome of the IPP process, the IPP takes on a much larger meaning than a collaborative process to develop an individualized plan. Fiscal accountability requires that oversight and control be exerted over something so substantial and critical to financial results. Yet nothing in the mandate describes the IPP as a fiscal negotiation between the state and a consumer, and in fact, every element of person-centered planning describes a collaborative process, not the "arms-length" transaction that fiscal standards would consider appropriate.

The Lanterman Act addresses the issue obliquely, specifically requiring that RCs identify and pursue all possible sources of funding, including other public and private sources, and that they use innovative and economical methods to achieve IPP objectives (W & I Code Sec. 4659 & 4651). The other reference is a global requirement that RCs perform their contracts within the provision of the funds appropriated in the Budget Act. These vague and open-ended requirements create a "Catch 22" when weighed with the mandate's emphasis on person-centered planning to address consumer preferences, choices, goals and objectives. While the issue of POS funding and management is not a part of this Citygate study, it heavily impacts RC direct services and resource requirements, and has to be considered as part of the operational context. Specifically, the blended role of the IPP as the centerpiece of the RCs role, yet driving 80% of expenditures in a closed-ended budget, affects CSC and related processes.

D. RESOURCES REQUIRED BY RCs

The RCs provide consumers and their families with case management through an integrated team, of which the consumer service coordinator (CSC) is one key member. Consumer service coordination is only one piece of the total case management process. Other personnel within the RC usually provide the resource development, vendor quality assurance and clinical specialty skills that are essential to effective case management.

The evaluation and monitoring aspect of the Individual Program Plan (IPP) process is both the most critical aspect of consumer service coordination and requires the most judgement. Judgement is a higher cognitive skill that requires synthesizing observations based on experience, training, and interpretations of policy. Consumers' circumstances, rather than mandate compliance, should dictate routine and proactive interactions with consumers and their families. Without this contact, the CSC can neither meet the Lanterman Act's requirements for evaluation and monitoring, nor perform CSC services consistent with good professional practice.

While CSCs are the primary points of direct service for RCs, their accessibility and effectiveness is directly dependent on the type and availability of other personnel resources and support systems. Budgeting and monitoring CSC resources in isolation is not an effective measure of the quality or quantity of RC direct services.

The most frequent complaint cited by consumers and vendors in DDS surveys is the inability to talk to the appropriate person on a timely basis. RCs echoed this frustration during Citygate's fieldwork. Reduction of real caseloads for CSCs enabled in the budget is a key way to improve access and communication. Understated wage rates and insufficient budgeting for essential non-CSC functions were key reasons that RCs could not operate at the CSC levels stated in the core staffing model. In addition to enhanced CSC levels, we recommend resources to fund three specific alternative access routes into RC operations, including a CSC officer of the day, a special incident specialist and a customer service/complaints position.

Clinical services need to incorporate both intake assessment roles and routine, proactive participation in ongoing consumer service coordination, dependent on total consumer volume, consumer complexity and risks. Clinical staff may also contribute to vendor quality assurance and technical assistance. The increased complexity of consumers, and the expansion of supportive and independent living for these consumers, requires increased support of CSCs in order to identify risks and develop appropriate supports or interventions to avoid deterioration in consumer status. We strongly recommend that some minimum portion of clinical expertise be on the RC payroll and in-house. The complex needs of RC consumers benefit greatly from a truly interdisciplinary model of operation.

The community services role of the RCs' mandate is the aspect least addressed by current core staffing and budgetary components. We recommend structuring quality assurance and vendor technical assistance as a function of the total vendors used by RC consumers, and establishing operating standards for assessing service, operational and fiscal compliance of all third-party vendors. Quality assurance for vendors should incorporate continuous improvement process models along with regulatory and fiscal compliance. Furthermore, we recommend that resource development vary by the number of consumers in an RC's caseload.

RCs have substantial infrastructure needs that directly affect the ability of CSCs and others to provide direct services to consumers. Staff training, consumer records management, and information systems training and support are three key areas in which RCs do not currently have sufficient resources. These must be routine investments to enable professional staff to perform effectively.

The detailed input measures and ratios incorporated in this model are not the best long-term approach to planning and budgeting RC direct services, including CSC. Services should be planned and evaluated based on measurable outcomes. DDS and RCs should collaborate on a prospective outcome evaluation of alternative CSC models.

E. BUDGET MODEL FOR RC OPERATIONS

The mechanics of budgeting for RCs over time are a key consideration. As discussed above, the current Core Staffing Model has failed to adapt to shifts in RC operations and compensation. The Core Staffing Formula creates only the operational budget appropriation, and a second distinct process is used to determine the allocation each individual RC receives.

Citygate Associates developed a software model using Excel[®] that is tailored to individual RCs, and summarizes local operational budgets to a statewide total. This model has several layers and easily adjusted assumptions. It can be used to test alternatives, project future requirements, and can be adjusted over time. Variables in the model that adapt over time and to local RC conditions include:

- ◆ workload (intake cases by type, consumers by level of complexity, by residential status, by mental health dual diagnosis, by Early Start and Medicaid waiver eligibility, and paid vendors by type);
- ◆ salary and wage assumptions (currently defined statewide, since no regional correlations were evident in data);
- ◆ number of counties and municipal entities in an RC's area; and
- ◆ total employees.

The allocation will still need customization to individual RCs. No single formula can accommodate all variables in the extremes of size and operating conditions represented in the RCs. Also, certain RCs have functions that support other elements of the RC system, or have unique roles. Contract funding for San Diego RC's operation and support of the SANDIS information system is an example. These are budgeted as lump-sum items after the budget model calculates local RC operations.

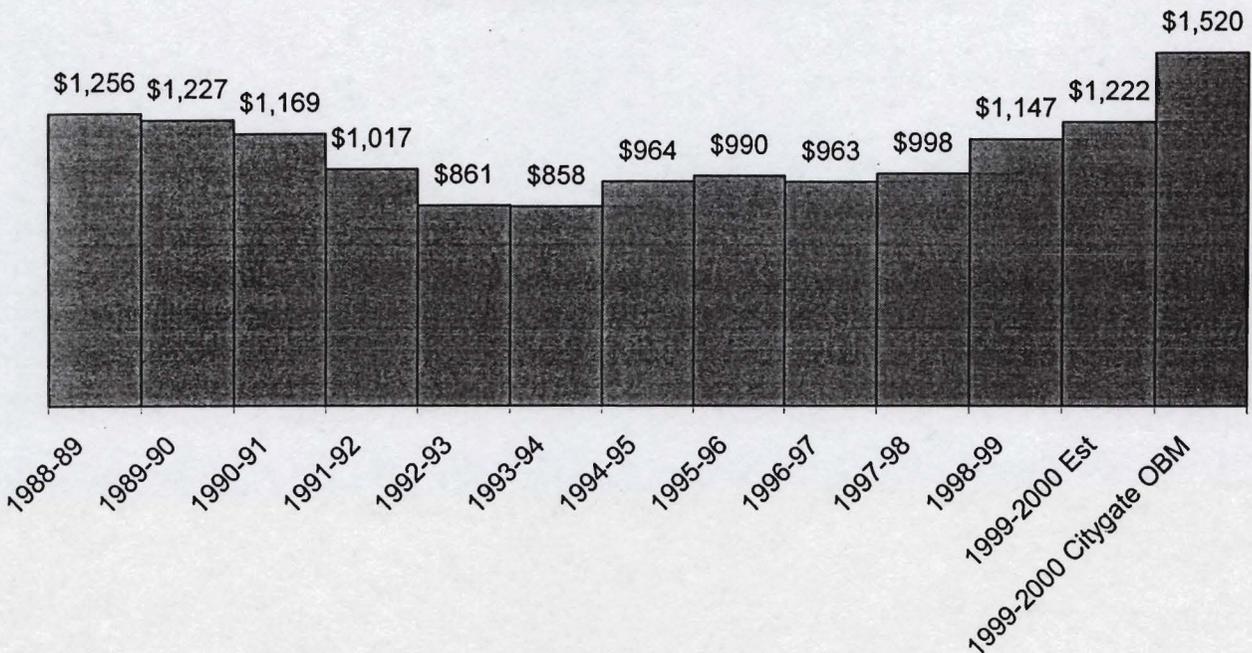
Salary savings (currently at 5.5% except for CSC where it is budgeted at 1% as of the November 1998 update to the 1998-99 budget) should not be deducted from the state appropriation for RCs. Vacancies need to be absorbed through overtime, contract personnel, or other personnel practices; in addition direct costs are associated with turnover and hiring. The funds to address vacancies should remain available to the RC through the elimination of a "salary savings" deduction.

The chart below presents the annual RC operational budget per consumer since 1988-89; it also includes a comparison of the projected budget for 1999-2000 per the May 1999 update using the

Core Staffing Model (1999-2000 Est), and the comparable projection using Citygate's Operating Budget Model (1999-2000 CG). While substantial nominal growth in RC operations has occurred in the past two fiscal budgets, the real dollar operational budget in 1998-99 is nine percent **below** the 1988-89 level (adjusting using the California consumer price index (CPI) for all urban consumers, 1984=100). The proposed increases for 1999-2000 in the state budget would still leave RC operational budgets per consumer three percent below the 1988-89 budget.

RC Operational Budgets Per Consumer, Constant Dollar Value

Adjusted Using California CPI to 1984 Dollars



Citygate's Operating Budget Model (OBM) projects a total budget of \$1,520 per capita in 1984 dollars for 1999-2000, 24 percent higher than the budget proposed in the May 1999 update. In real dollars, the OBM budget is 21 percent higher than the 1988-89 budget. Given the movement of consumers from state developmental centers to the community and the commitment to person-centered planning implemented since that time, this increase in real dollars is intuitively consistent, as well as supported by the complex methodology previously summarized, and presented in our report.

**Comparison of Operating Budget Model to Core Staffing Formula Projections,
FY 1999-2000**

	Operating Budget Model Outcome 1999-2000 (Projected)	Core Staffing Formula 1999-2000, May Revision	Numerical Change from OBM to Core Staffing Formula	Percent Change from OBM to Core Staffing Formula
PERSONNEL				
Salaries	\$261,391,718			
Benefits (at 23.7%)	\$62,472,621			
Total Salaries & Benefits	\$323,864,339			
NON-PERSONNEL				
OPERATING	<u>\$59,467,581</u>			
OPERATING TOTAL:	\$383,331,919	\$304,284,000	\$79,047,919	26%
SPECIAL CASES	19,842,000	19,692,000	150,000	1%
GRAND TOTAL:	\$403,173,919	\$323,976,000	79,197,919	24%
		<small>(See note below)</small>		
Budgeted FTEs	6,492	6,488 est.	4	0%
Average Annual Wage	\$40,266	\$33,800	\$6,466	19%
Total Consumers	153,600	153,600	N/A	N/A
Complex Consumers	32,348	32,348	N/A	N/A

Note: Before unallocated reduction and at 1989-90 salary levels. RCs' surveyed FTEs 1997-98 were 33% below core staffing levels.

F. SYSTEM OUTCOMES

The assumptions used to generate the budget model can reasonably be expected to produce the following service outcomes, assuming operating systems are effective, staff performance is of reasonable quality, and circumstances are routine.

RC Accountabilities under Operating Budget Model	
Mandated Function	Typical Outcomes
Intake	Completing intake, eligibility and the initial IPP/IFSP in 45-120 days, including review of current assessments and completion of needed assessments.
Consumer Service Coordination	In-home, non-complex consumers in a stable situation are seen face-to-face twice a year, and also during the annual review and update of the IPP and Client Developmental Evaluation Report (CDER). The consumer and family have a brief telephone update with the CSC every month that is documented in the consumer's file, and provider contact via telephone and reports also occurs monthly, on average. Consumers, families and providers are able to speak directly with a CSC or supervisor "Officer of the Day" during regular working hours, Monday through Friday, and within two hours on the weekend and holidays. When a message is

RC Accountabilities under Operating Budget Model

Mandated Function	Typical Outcomes
Community Services	<p>left for a specific responsible CSC or supervisor, the call is returned within 24 hours, except during exceptional circumstances, when the Officer of the Day handles follow-up.</p> <p>In crisis situations or for special needs, CSCs may readily access additional support resources from resource specialists (e.g., placement), clinicians (behavioral or medical crisis), or other CSC staff (Officer of the Day or supervisors) to expand the interdisciplinary team actively supporting the consumer and family. Complete and current consumer records facilitate continuity of services.</p> <p>CSCs receive 40 hours or more of continuing education annually.</p> <p>Third-party vendors all receive annual on-site reviews and triennial comprehensive reviews, including training, assistance and follow-up. Fiscal monitors are included in the annual review as appropriate.</p> <p>Consumers, families and vendors are able to reach a special incident coordinator within two hours, seven days a week. Special Incident Reports are tracked by vendor and by functional issues, as are Life Quality Assessments to identify patterns and initiate appropriate interventions.</p> <p>Files on both RC-vendor and generic resources are current and complete. Facilitation and advocacy with generic resources is routine. Resource development specialists routinely support CSCs in identifying and accessing IPP services for individual consumers, and by advocating for consumers with vendors.</p>
Outreach and Advocacy	<p>Consumers and families can reach a consumer advocate or the consumer service representative within 24 hours of initial contact.</p> <p>Compliance for consumers with forensic status, including court guardianship, criminal action, or other issues is coordinated through a forensic specialist, who actively supports CSCs in these areas.</p> <p>RC boards have ongoing training and development, including access to external training programs, along with appropriate facilitation and logistics support.</p>
Clinical Services Monitoring	<p>CSCs may routinely consult with technical support in clinical areas including, but not limited to medicine, psychology, psychiatry, nursing, nutrition, pharmacology and genetics; these resources are actively involved with 30% to 50% of consumers in a given year. A Registered Nurse (RN), or other clinician, as appropriate, participates in IPP updates every three years with every consumer, and in the annual reviews of complex and high-risk consumers.</p> <p>Specific health service indicators are defined, based on consumer needs and risk factors. For example, consumers on psychotropic medication receive a</p>

RC Accountabilities under Operating Budget Model

Mandated Function	Typical Outcomes
Fiscal Services	<p>current psychiatric consult annually; diabetic consumers receive annual HbA1c and cholesterol testing and receive foot exams annually; female consumers over a specified age have annual breast exams, etc. The RC is not responsible for direct provision of these services, but for monitoring access and ensuring provision, unless consumers and families refuse services. POS may be used as a last resort.</p> <p>Clinicians and behaviorists are routinely available, on site if needed, to discuss special needs with families and vendors. CSCs can request clinical consultation and support without POS authorization.</p> <p>RC activities as well as reports by providers are current in the consumer file.</p> <p>Vendors are paid monthly in a consistent cycle for services provided. Representative payee accounts are accurate and readily available.</p> <p>RC internal controls, financial practice, and reporting are consistent with generally accepted accounting principles. The RC receives an unqualified opinion from an independent financial audit each year.</p>

I. INTRODUCTION AND SCOPE

A. BACKGROUND

The State Department of Developmental Services (DDS) served approximately 147,000 consumers (as of 12/31/97) in California through 21 Regional Centers (RCs). The RCs are local, not-for-profit corporations that contract to serve the population of a specified geographic catchment area. The population served is persons with developmental disabilities, and infants under 36 months of age at risk for developmental disability (Early Start, Part C), referred to in this report as consumers. The total appropriation for RCs for 1997-98 was \$1.1 billion, and for 1998-99, \$1.3 billion.

The appropriation is currently built up in two major pieces: operations, and purchase of services (POS). Appropriations for each are presented below:

	1997-98 (May Revision)	1998-99 (November Update)
Operations	\$226,700,000	\$275,800,000
Purchase of Services	<u>910,400,000</u>	<u>\$1,075,700,000</u>
Total	\$1,137,100,000	\$1,351,500,000

POS are expenditures on behalf of specific consumers for services and supports associated with eligibility determination, assessment, and the implementation of a consumer's Individual Program Plan (IPP; Individualized Family Service Plan (IFSP) for Early Start.) The operational budget covers the staff who provide the RCs' direct services to consumers and their families, and the organizational functions (management, human resources, office space, telephones, accounting, etc.) in which they operate. The specific responsibilities and direct services provided by the RCs are discussed in detail below and in the following chapters.

The salary and wage (Personal Services) portion of the operating budget for RCs was originally based on a comprehensive formula commonly referred to as the Core Staffing Formula, developed in 1978. This formula specifies resources by position and calculates the statewide staffing needs and associated salary, wage, and benefits (**Exhibit I-1**). The number of positions is calculated either as one per RC (21 statewide) or using a variety of formulas. The remainder of the operating budget, the Operating Expense portion, covers rent, travel, communications, etc. and is currently budgeted as a base amount unique to each RC, with increments of \$3,400 per professional staff position and \$2,400 per non-professional position for personnel growth.

The Core Staffing Formula has outlived its usefulness. The Lanterman Act (the primary mandate for DDS and RC services) has undergone major changes in the past seven years. The local catchment areas have all had varying levels of growth and change. When originally defined, each of the 21 RCs was intended to serve approximately the same number of consumers. In 1997-98, workload in RCs varied from 2,000 to 13,500 consumers, averaging 6,700. Information systems and automation were unknown in 1978. The Core Staffing Formula budgets for a different operating environment than exists today.

Regional Centers
NOVEMBER 1998 ESTIMATE
OPERATIONS
Personal Services Worksheet
Current Year 1998-99

EXHIBIT I-1

	ADJUSTED FY 1998-99 BUDGET AUTHORITY			NOVEMBER 1998	DIFFERENCE
	Positions	Average Salary	Total Costs	ESTIMATE	
I. CORE STAFFING					
A. ADMINISTRATIVE SUPPORT (Core Staffing Positions)					
Director	21.00	\$60,938	\$1,279,898	\$1,279,898	\$0
Administrator	21.00	48,069	1,009,449	1,009,449	0
Chief Counselor	21.00	48,983	988,643	988,643	0
Fiscal Manager	21.00	45,880	963,480	963,480	0
Transportation Coordinator	21.00	42,793	898,653	898,653	0
Fiscal Monitor	21.00	38,036	798,758	798,758	0
Program Evaluator	21.00	42,793	898,653	898,653	0
Resource Developer	28.00	42,793	1,198,204	1,198,204	0
Office Supervisor	21.00	23,327	489,867	489,867	0
Executive Secretary	52.50	21,878	1,148,490	1,148,490	0
PBX/Mail/File Clerk	63.00	21,878	1,378,188	1,378,188	0
MD/Psych Secretary (1:2)	113.21	21,878	2,476,582	2,476,582	0
Secretary (1:4)	864.78	18,757	16,220,878	16,220,878	0
Account Clerk (1:600)	251.57	18,397	4,628,133	4,628,133	0
Subtotal - Administrative Support	1,541.06		\$34,375,474	\$34,375,474	\$0
Fringe Benefits - 23.7%			8,146,987	8,146,987	0
Salary Savings - 5.5%			(2,338,735)	(2,338,735)	0
TOTAL - ADMINISTRATIVE SUPPORT <i>(Core Staffing Positions)</i>			\$40,183,726	\$40,183,726	\$0
ROUNDED TO:			\$40,184,000	\$40,184,000	\$0
B. DIRECT SERVICES (Core Staffing Positions)					
Physician (1:2000, min. of one)	75.47	\$78,271	\$5,982,582	\$5,982,582	\$0
Prevention Coordinator	21.00	41,752	876,792	876,792	0
Psychologist (1:1000)	150.94	41,754	6,302,349	6,302,349	0
High Risk Infant Case Manager	21.00	40,805	858,905	858,905	0
Client Rights Advocate	21.00	38,036	798,758	798,758	0
Developmental Center Liaison	16.60	38,036	631,398	631,398	0
Genetics Associate	21.00	38,034	798,714	798,714	0
Supervising Counselor (1:8)	352.07	38,036	13,391,335	13,391,335	0
Nurse (1:2000, min. of one)	75.47	37,171	2,805,295	2,805,295	0
Diversion	4.00	31,848	126,584	126,584	0
Intake Worker (1:14)	348.00	31,532	10,910,072	10,910,072	0
Client Program Coordinator (CPC) (1:62)	2,370.15	28,849	67,902,427	67,902,427	0
CPC, Quality Assurance for ARM	36.85	28,849	1,055,718	1,055,718	0
CPC, Title 17 Quarterly Monitoring	63.52	28,849	1,819,784	1,819,784	0
Nutritionist (1:2000, min of one)	75.47	28,130	2,122,971	2,122,971	0
Revenue Clerk (1:400)	58.91	20,617	1,173,313	1,173,313	0
Subtotal	3,707.45		\$117,554,993	\$117,554,993	\$0
Fringe Benefits - 23.7%			27,860,533	27,860,533	0
Salary Savings - 5.5%			(7,997,854)	(7,997,854)	0
Subtotal - Direct Services			\$137,417,672	\$137,417,672	\$0
1. DEDUCT FROM CORE STAFFING (TRANSFER TO OTHER DIRECT SERVICES)					
a. Clients' Rights Advocacy Contract	(26.30)		(1,050,000)	(1,050,000)	0
b. Resource Developer Adjustment	(7.00)		(350,000)	(350,000)	0
c. Developmental Center Liaison Adjustment	(7.00)		(311,000)	(311,000)	0
d. CPC, Title 17 Quarterly Monitoring Adjustment	(80.70)		(2,916,000)	(2,916,000)	0
TOTAL - DIRECT SERVICES <i>(Core Staffing Positions)</i>	(131.00)		132,790,872	132,790,872	0
ROUNDED TO:			\$132,791,000	\$132,974,000	\$0
SUBTOTAL CORE STAFFING	5,117.51		\$172,974,398	\$172,974,398	\$0
ROUNDED TO:	5,118.00		\$172,974,000	\$172,974,000	\$0

EXHIBIT I-1
(continued)

Operations
Personal Services Worksheet, FY 1998-99 (Continued)

Page D-6

	ADJUSTED FY 1998-99 <u>BUDGET AUTHORITY</u>	NOVEMBER 1998 <u>ESTIMATE</u>	<u>DIFFERENCE</u>
II. OTHER DIRECT SERVICES (Non-Core Staffing Positions)			
Medicaid Waiver Operations (See Page D-30 of this Section.)	\$17,985,000	\$17,985,000	\$0
Community Placement Plan (See Pages D-35 to D-45 of this Section.)	12,987,000	12,987,000	0
Quality Assurance/Quarterly Monitoring (See Pages D-31 to D-34 of this Section.)	13,085,000	13,085,000	0
Early Start / Part C (See Pages D-46 to D-55 of this Section.)	9,950,000	9,950,000	0
Clinical Support Teams (See Pages D-56 of this Section.)	6,332,000	6,332,000	0
Targeted Case Management (See Page D-62 of this Section.)	3,510,000	3,510,000	0
Foster Grandparent/Senior Companion Programs (See Pages D-71 to D-72 of this Section.)	196,000	196,000	0
Sherry S. (See Page D-70 of this Section.)	518,000	518,000	0
Regional Resource Development Project (See Page D-73 of this Section.)	398,000	398,000	0
DSS Incidental Medical Care Regulations (See Page D-74 of this Section.)	202,000	202,000	0
Nursing Home Reform (See Page D-75 of this Section.)	176,000	176,000	0
1998-99 Program Change: Restoring Case Management Services (See Pages D-17 to D-29 of this Section.)	26,211,000	26,211,000	0
1998-99 Program Change: Increased Access to Health Care and Quality Services (See Page D-61 of this Section.)	4,220,000	4,220,000	0
Wellness Projects Augmentation (See Page D-67 of this Section.)	731,000	731,000	0
1998-99 Program Change: SB-1039 (See Page D-69 of this Section.)	582,000	582,000	0
TOTAL DIRECT SERVICES (Non-Core Staffing Positions)	\$97,063,000	\$97,063,000	\$0
TOTAL PERSONAL SERVICES (I + II)	\$270,037,398	\$270,037,398	\$0
ROUNDED TO:	\$270,037,000	\$270,037,000	\$0

This excludes the impact of the unallocated reduction.

Increased complexity has affected the benchmark wage levels. The Core Staffing Formula identifies comparable state civil service positions for each RC position in order to establish the comparative wage level. For management positions, where the scope of operations affects the level of position used, the enormous change in RC size has increased managers' scope of responsibility at the RCs. However, Core Staffing positions have not had the benchmarks changed.

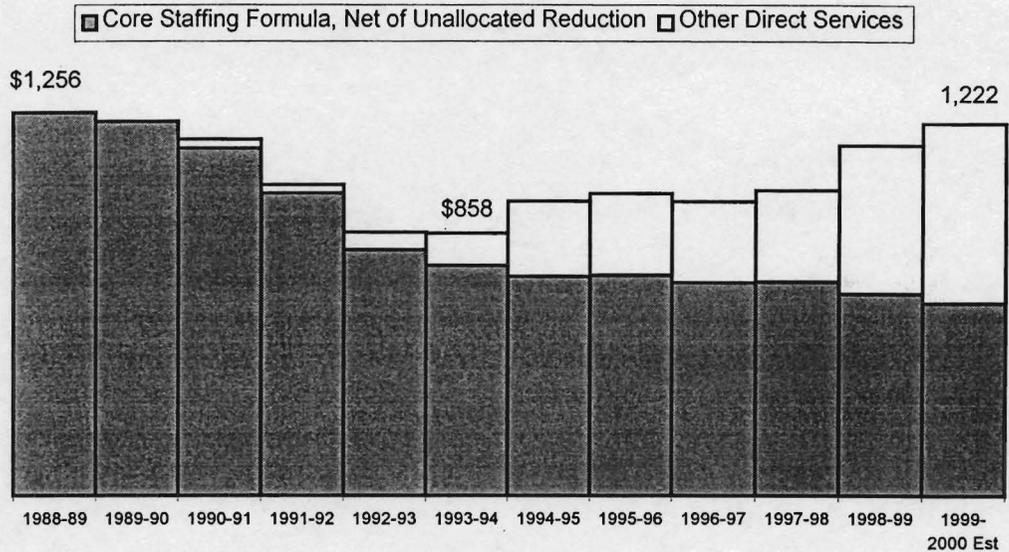
Political factors have also invalidated the Formula. In the early 1990s, a statewide recession triggered significant budget cutbacks at the state level. From 1991-92 through 1994-95, DDS' budget for RC operations had a cumulative reduction of \$40.6 million annually compared to Core Staffing budget levels. Rather than adjusting the formula or designating the functional area of the reductions, these were deducted from the total amount budgeted through the Formula. Another \$6.4 million was reduced by doubling the time for processing intake assessments (from 60 to 120 days), and making a reduction in associated staffing (a provision which sunsets on June 30, 2000, reverting to 60 day assessments.)

Core Staffing salary and wage levels have not changed since 1989-1990 as a matter of policy. In the past nine years, the consumer price index has increased 31 percent, while most RC positions have had no change in the budgeted wage rate. RCs had to absorb unbudgeted wage increases to hire and retain staff.

These factors (change over time, unallocated reductions and wage freezes) have resulted in significant disconnects between RC operational reality and the Core Staffing Formula. Reading the Core Staffing Model creates a very specific image of the number and type of staff, which comprise a Regional Center. Reality is utterly different. Within the constraints of total budget, RC operations attempt to reflect market wage rates, the use of technology, and completely realign the clinical team and role of the RC, etc.

The final complication is supplemental appropriations. In recent years, appropriations for RC operations have been increased to respond to unmet needs and system gaps associated with the unallocated reductions and other factors discussed above. However, these changes have been made as an overlay not only to the Core Staffing Formula but to the retained unallocated reduction. **Table I-1** below presents the per capita RC operational budget from 1988-1989 to 1999-2000 (per the May 1999 estimate). The Core Staffing Formula is shown net of each year's unallocated reduction, with supplemental appropriations included as "Other Direct Services." The portion of the total appropriation generated by Other Direct Services increased from zero to 48 percent.

Table I-1: RC Operational Appropriation per Consumer, Constant Dollars



(Uses California Consumer Price Index with 1984=100 to adjust to constant 1984 dollars; consumers are defined as active consumers plus Early Start consumers)

B. SCOPE

Citygate was engaged to develop a technical budgeting methodology for funding staffing and operating expenses in the state’s 21 RCs. This quantitative outcome, however, required extensive qualitative preparation. In order to develop the method, Citygate was asked to:

Identify the...staff that will enable Regional Centers to meet their state and federal mandates and are consistent with good business practices. This study must determine the staff resources required to effectively monitor and assure that appropriate services are rendered effectively to persons of varying developmental disabilities. (Request for Proposal, DDS)

This study is not a management audit of either the RC system, or any individual RC. RC-specific data were collected and analyzed in order to understand the system, and compare and contrast different operational approaches. We did not, however, assess appropriateness or effectiveness of organizational or staffing practices among individual RCs. We did review the overall system in detail in order to answer three key questions:

- 1) What are RCs supposed to do, based on state and federal mandates and good professional practice?
- 2) What resources do RCs require to perform those functions?
- 3) How should RC operations be budgeted?

We make specific operational recommendations in areas essential to meeting mandates. However, the RC system is designed to maximize local accountability and flexibility, including a high degree of discretion in day-to-day operations. Our report will address **what** should be done,

and identifies examples we consider especially effective. **How** RCs implement and operate was not within the scope of our study.

1. What Are RCs Supposed to Do?

A clear definition of the roles and functions of the RCs was required before resource needs could be determined. This was not readily available, nor subject to general consensus among DDS, the 21 RCs or key stakeholders. We reviewed the mandates and fundamental functions of the RCs. Our conclusions on the RCs' key roles are presented in Chapter II. **Table I-2**, below, summarizes key Regional Center functions across two dimensions: the role, ranging from direct service provider to advocate; and the focus, from the individual with developmental disabilities to the broader population of persons with developmental disabilities and their surrounding community.

Table I-2 Regional Center Roles and Activities

ROLE	Advocate	<ul style="list-style-type: none"> • Help in Obtaining Generic Services • Family Resource Centers • Peer Support Infrastructure 	<ul style="list-style-type: none"> • Interagency Liaison • Advocacy • Public Awareness/ Education • Vendor Technical Assistance
	Direct Service	<ul style="list-style-type: none"> • Eligibility Assessment • IPP • RC Purchased Services • Individual Resource Development • Financial Management • Monitoring & Intervention 	<ul style="list-style-type: none"> • Outreach • Vendor Quality Assurance • Research & Training • Community Resource Development
		Individual	Population
		FOCUS	

2. What Resources do RCs Require?

Quantifying the resources needed to fulfill RCs' roles is a complex challenge. One approach would be to do "time and motion" studies of each task that is required under the entire mandate. With 21 RCs in various settings and no clear model defined, this would require weeks of log keeping by RC staff in 15-minute increments of all activities, plus a validation cycle of on-site observation for several RCs. This would provide a definitive portrait of what RCs are now doing and task level resource requirements. Given the broad range of operational models, however, these 21 distinct detailed pictures would not move us appreciably closer to what resources RCs should have to fulfill their

mandates. (As discussed in Chapter IV, we recommend selective time and motion studies be conducted to evaluate and refine the conceptual model developed in this study.)

Citygate Associates developed detailed functional profiles of the Regional Centers through a combination of forums with RC staff, consumers and vendors, site visits, and a comprehensive survey. These were reviewed and assessed on a functional basis, resulting in what we call "building blocks". Building blocks were developed for Intake, Client Service Coordination, Community Services, Clinical Services and Administration. Since RCs have placed a range of priorities on these activities (discussed in Chapter III), the building blocks produce a broad range of options for level of service for each, and the associated levels of resource requirements.

A literature review and contact with key informants was a second source for "what should be." Appendix C provides a comprehensive summary of the literature review; Chapter III cites specific considerations included in the resource requirement assessment. We interviewed academic and professional sources in California and other states to explore other models for serving persons with developmental disabilities, as well as other human service models in case management. Professional practice standards for case management, human services programs, not-for-profit and governmental administration and operations were also reviewed and considered in the resource definition.

Combining these sources, Citygate developed analytical options for levels of service and associated results in each functional area. Implications of key alternatives were reviewed in detail with Expert Panels comprised of RC operational leadership from the pertinent function. Chapter III reviews the alternatives as well as key conceptual conclusions regarding the level of resources required to fulfill the mandates described in Chapter II, as well as appropriate professional practice. Chapter IV integrates these findings to a set of budgetary recommendations with associated staffing and salary levels.

3. How Should RCs be Budgeted?

The mechanics of budgeting for RCs over time are a key consideration. As discussed above, the current Core Staffing model has failed to adapt to shifts in RC operations and compensation. The Core Staffing Formula creates only the operational budget appropriation, and a second distinct process is used to determine the allocation each individual RC receives. While this process facilitates adaptation to individual circumstances, it does not lend itself to equity and consistency in statewide levels of service, nor does it fully address need.

Citygate Associates developed a software model using Excel[®] that has several layers, each of which can be adjusted over time and tailored to individual RCs. Chapter V describes this model in detail, as well as the recommended set of assumptions and variables that produce the results presented in Chapter IV. Variables in the model that adapt over time and to local RC conditions include:

- ◆ workload (consumers by level of complexity and special conditions, total vendor responsibilities, representative payees);
- ◆ salary and wage assumptions (currently defined statewide, since no regional correlations were evident in data);

- ◆ number of counties and municipal entities in an RC's area; and
- ◆ rent costs indexed to total employees.

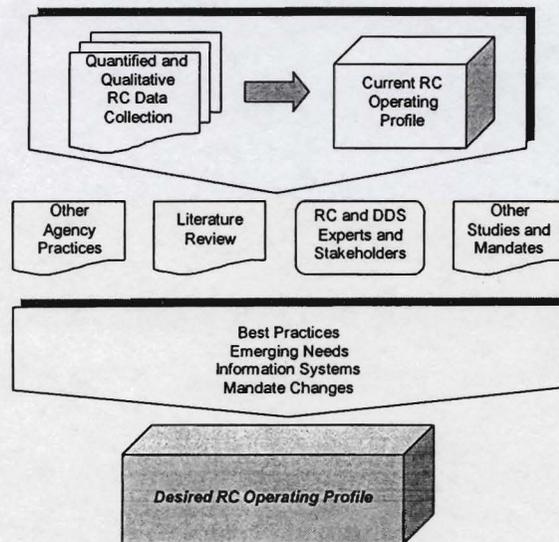
The allocation will still need customization to individual RCs. No single formula can accommodate all variables in the extremes of size and operating conditions represented in the RCs. Also, certain RCs have functions that support other elements of the RC system, or have unique roles. Examples include San Diego RC's operation and support of the SANDIS information system, South Central Los Angeles' lead role in forensic staffing for all RCs in Los Angeles County, and the foster grandparent program.

C. METHODOLOGY

1. Process

Table I-3 summarizes our conceptual approach to the study:

Table I-3: Conceptual Approach to the Study



This project could be described as a collaborative process. The nature of the developmental disabilities system, with its many constituent groups and stakeholders, encouraged collaboration. Citygate Associates recognized very early that a key ingredient to the successful outcome of this study resided in carefully listening to and understanding the concerns of the constituencies and stakeholders, whether they be the state, associations, RCs, legislators, vendors, families, or consumers. A number of study activities were designed to create opportunities for contributions from these and other stakeholders.

A Project Steering Committee assisted in guiding this project and proved to be a rich conduit for gaining qualitative information. The Committee generally met once a month with frequent communication with committee members in the interim. The committee was comprised of

representatives from DDS, the Association of Regional Center Agencies (ARCA), and the Department of Finance.

2. Data Collection

Functional Areas

With the collaboration of DDS, ARCA and the project steering committee, essential functional areas were identified early in the study. These areas were:

- ◆ Case Management—ongoing case management/service coordination including family support, consumer-oriented outcome measurement and quality assurance.
- ◆ Clinical Services—specialty consumer services including intake, clinical teams and related quality assurance.
- ◆ Community Services—RC operations devoted to provider relationships and resource development, vendor-oriented quality assurance and other community services.
- ◆ Operations—internal administration including finance, accounting, human resources, information systems, etc.
- ◆ Executive Management—RC directors concerning issues of governance, planning and community/constituency relations.

These principal functional areas were recognized as the essential building blocks Citygate would work with in designing a budget and staffing model for RCs. However, one of the great difficulties of this study remained in determining what each building block was composed of in a manner that was comprehensive, comparative and standardized.

RC Forums

A total of ten forums were conducted: two for each of the functional areas, one held in Northern California, the other in Southern California. All forums were held at RC sites except one, which was held in conjunction with an ARCA conference of RC directors. Citygate facilitated each forum and dispatched one to three additional team members. A majority of RCs attended the forums for each of the functional areas, and all RCs participated in at least one of the forums or submitted written responses. The forums served to gather preliminary qualitative assessments for each function and initial exposure to the varying models employed by RCs. Forum participants also informed the design of Citygate's comprehensive survey instrument.

Background Interviews

Citygate conducted background interviews with a variety of interested parties in order to learn more about the issues and expectations regarding the developmental disabilities system and the outcome of this study. Interviewees included stakeholder organizations, legislative staff, Department of Finance, employee organizations and representatives from various divisions of DDS including administration, community services, and executive leadership.

Site Visits

Site visits were conducted simultaneously with the release of the survey into the field. Citygate visited five sites: two in the north, and three in the south. Sites were selected with the assistance of the Project Steering Committee and satisfied criteria of size, variation of the models, and urban and rural service areas. The selected sites were:

- ◆ Eastern Los Angeles
- ◆ Inland
- ◆ San Diego
- ◆ Golden Gate
- ◆ Redwood Coast.

Public Forums for Consumers, Families and Vendors

At each of the site visits we attempted to meet with consumers and families selected by local Area Boards. In order to independently obtain consumer and family observations as well as vendor input that represented a broad base, Citygate held two public forums regarding RC direct services for each of these important stakeholder groups: again, one in the north, one in the south. Regrettably, attendance was low at all of the meetings, but those who did attend made pertinent remarks, notably in describing their varying expectations of RCs. Citygate also invited written comment from stakeholders and received approximately thirty responses.

Mid-Contract Review Qualitative Comments

Again, to the end of increasing the contributions of stakeholders, particularly consumers, families and vendors, Citygate reviewed some 40,000 qualitative comments compiled by DDS through the mid-contract review surveys distributed to the clients and vendors of RCs. These comments were categorized, tallied, and analyzed for overall or RC specific patterns.

Literature Review

To perform our review of the literature, Citygate Associates conducted an Internet search and a search of several electronic databases. Publications of interest were then pulled from various sources including libraries, state agencies, associations, and the Internet. We augmented our information through interviews with staff at state agencies, associations, or specialist institutions. During this review, we visited issues surrounding case management/service coordination, quality of life, quality assurance, and health care.

Expert Panels

Citygate Associates' analysis focused on the functional areas that were most subject to high variance and high cost. We identified various models, and then brought together a panel of RC professionals to discuss the respective advantages or disadvantages of each model in terms of meeting mandates, service-level, required resources, and costs. These panels of experts also assisted us in defining the essential components of complex functions such as case management.

Three expert panels were convened for case management, clinical services and community services with approximately 12 participants from RCs in each.

Survey

Citygate Associates, with DDS and steering committee review and input, developed a comprehensive survey that leveraged our past experience studying the RC system, our experience as management and human resources consultants, and the information gleaned from the functional forums held concurrent to the design of the survey. The survey collected data on the following subjects:

- ◆ Staffing
- ◆ Finance
- ◆ Consumers
- ◆ Workload
- ◆ Case Management
- ◆ Community Relations
- ◆ Intake and Clinical Services
- ◆ Human Resources
- ◆ Facilities
- ◆ Information Systems.

The survey also contained open-ended questions, particularly in the area of executive priorities, performance objectives, and description of service models. Organization charts and position descriptions were also requested. The collection of this information was designed to comprehensively account for the operations of each individual RC and supply Citygate Associates with sufficient data to standardize and compare across the RC system. All but one of the 21 RCs provided data via the Survey. At every step of quantitative data collection, Citygate devoted extensive effort to providing technical consultation, follow-up, research of reporting alternatives, and quality control in order to minimize discrepancies.

II. REGIONAL CENTERS' ROLE AND FUNCTIONS

The interpretation of the Regional Centers' (RCs) role and function encompasses thousands of pages of legislation, case law and regulation. Defining RC resource requirements reflecting those details would assume that the mandate is complete and correct, and the best professional practice option. Given the extensive changes in law in the past two legislative sessions, much of the record of mandate is outdated or incomplete. Returning to the fundamentals of the RC model for service to persons with developmental disabilities in California assists in identifying the key functions, required services and associated resource requirements for RCs. **Appendix D** provides a more detailed overview of mandated activities, summarized functionally in **Table II-1** below.

Table II-1: RC Functional Mandates

Function
Intake and Eligibility assessment, including clinical diagnosis and assessment
Consumer Service Coordination focused around the Individual Program Planning (IPP) process for persons with developmental disabilities, and the Individualized Family Service Plan (IFSP) for early intervention children
Prevention services
Casefinding including outreach and community awareness services
Developing Services and Supports to meet identified needs, including community support and facilitation
Advocacy for, and protection of, the civil, legal, and service rights of persons with developmental disabilities (DD persons)
Quality Assurance of purchased services and vendors
Technical Assistance to vendors
Fiduciary Financial Services to vendors and consumers.

RCs were created so that persons with developmental disabilities and their families may have access to services and supports best suited to them throughout their lifetime. It is the intent of the Legislature that the design and activities of RCs reflect a strong commitment to the delivery of direct service coordination. All operational expenditures of RCs must support and enhance delivery of direct service coordination, and services and supports identified in the consumer's Individual Program Plan (IPP) (W&I Code, Sec. 4620). DDS has further interpreted this:

The primary role of the regional centers is to provide **fixed points of contact in the community** for consumers and their families so that consumers may have access to the services and supports best suited to them throughout their lifetimes. (Emphasis added) (Individual Program Plan Resource Manual, DDS, January 1995).

The distinctive aspect of RCs is the legislative intent to rely on a community-based organization (CBO) instead of state or local government. In creating the RC network, the

Legislature found that the service provided to individuals and their families by RCs could not be satisfactorily provided by state agencies (W&I 4620). Legislative intent was in accord with trends in social services and professional observations that locally-based service systems were generally more responsive to the needs of consumers and the local community.

The Lanterman Act specifies that RCs shall provide or ensure needed service and supports are available in a cost effective manner. The IPP is the centerpiece of the service coordination process. In the Act, service coordination includes activities necessary to implement an IPP, including:

- ◆ participation in developing the IPP;
- ◆ assuring that the planning team considers all options;
- ◆ securing services and supports;
- ◆ collecting and disseminating information;
- ◆ monitoring implementation of IPP; and
- ◆ assisting in revising IPP.

Service coordinators are required to identify and pursue all possible sources of funding including other public and private sources, and to use innovative and economical methods to achieve IPP objectives. Models and resource requirements for service coordination are explored in detail in Chapter III.

A. THE IPP AND RELATED ACTIVITIES

In order to interpret the RCs' mandate, we must define "the IPP." The person-centered values associated with the commitment to individual program planning are essential to the integrity of the process and to the intent of the Lanterman Act and the RC system (Individual Program Plan Resource Manual, DDS, January 1995). For the purposes of our report, however, we will focus on the process and activities associated with the IPP, and will discuss values only when they have a specific functional or resource impact.

1. IPP Development and Monitoring

The core value of the IPP process is meaningful choice by consumers or their authorized representative. This has very specific resource requirements and implications. Meaningful choice for persons with developmental disabilities is increasingly complex and has to address cultural competency, varying levels of education, language, etc. It also expands the scope of the service planning process by requiring RCs to identify multiple vendors, where feasible. Ultimately, it affects other direct RC services such as resource development. Process elements of meaningful choice affecting RC direct service resources include:

- ◆ Preparation of special materials communicating at the appropriate level;

- ◆ Use of other communication tools such as site visits and observation to enhance understanding; and
- ◆ Multiple contacts to introduce or explain choice options to provide for assimilation and reflection.

The IPP is functionally a process, not a single document or meeting. The written IPP must contain goals and objectives for the consumer based on the needs, preferences, and life choices of the consumer and family. It includes a schedule of the type and amount of services and supports to be purchased by the Regional Center, or obtained from generic or other resources in order to achieve those goals and objectives. Those responsible for providing services shall also be included, with family and consumer input on the selection of providers. (W&I Code 4646.5 (a)(2-4)).

The IPP process begins with “a process of individualized needs assessment” (W&I Code 4646). Assessment is an ongoing process, and may include specific technical activities, such as psychological or medical testing. Within the IPP process, assessment is also mandated to include a review of social goals and the consumer’s values and preferences. Specific assessment outcomes defined by DDS and the Welfare & Institutions Code (Individual Program Plan Resource Manual, DDS, January 1995) include determining the consumer’s:

- ◆ Life goals
- ◆ Strengths and capabilities
- ◆ Preferences
- ◆ Need for living supports
- ◆ Barriers to meeting goals or preferences
- ◆ Concerns or problems.

Legislation in the 1997-98 session added a review of the consumer’s general health status including medications (W&I Code 4646.5, SB 1038) and referral to medical professionals, as appropriate.

The skills needed to complete the IPP assessment vary depending on the consumer, and may include psychology, medicine, housing development, school programs, employment, legal status, etc. The consumer service coordinator (CSC) may have information needed to address some or all of these issues, but for complex or special needs cases, supplemental resources must be available to support the assessment process.

The IPP, then, is the documented culmination of a complex assessment process in a team-oriented collaboration with the consumer and his/her circle of supports. The intent is to enable the consumer to make meaningful choices about services, options and providers. Such choice may require multiple meetings and other efforts to develop a clear understanding of the alternatives and tradeoffs.

The mandate (and professional practice standards) requires continued monitoring of the consumer's situation in order to reevaluate needs, objective fulfillment, and satisfaction (Code of California Regulations (CCR), Title 17 §56047). So the IPP is never truly 'completed,' but is a relationship and cyclical process (Table II-2). It is repeated at least every three years, and should be modified more frequently as needed. Throughout the process, consumer and family needs and preferences are paramount; the mandate explicitly requires specific advance notice, communication in terms and means appropriate and understandable to the consumer, and the provision for appeal and fair hearing should IPP results not meet their expectations.

Table II-2: IPP Process



2. Consumer-focused Quality Assurance and Monitoring

Assessment and subsequent monitoring and reevaluation of consumers are the most complex level of function for the CSC, who is the primary provider of direct service in RCs. It requires a synthesis of observations, training and experience, and reflects the subjective judgement of the CSC. In personnel terms, this is the 'highest' level of functioning, and is the level that determines the job value in monetary and organizational terms.

Mandate defines specific monitoring activities, including quarterly face-to-face meetings with consumers in residential care (monthly contacts for those consumers dependent for all activities of daily living). To meet DDS goals of "monitoring those individual's health, safety and well-being, and to gather information to determine if the services are effective and to monitor progress toward meeting identified goals (sic)," these contacts must be substantive. They require complex qualitative judgements that consider the consumer's circumstances, history, and potential outcomes, the individual vendor, and all other contextual variables. Throughout this report, we will consider this aspect of monitoring to include consumer-focused quality assurance, specifically, the activities associated with monitoring consumer's health, safety, well-being, and the effectiveness of services and supports being provided to that consumer. Vendor-focused quality assurance, which assesses the compliance and performance of the vendor across multiple consumers, is addressed below as a part of the discussion of community service roles.

3. Fiscal Implications of the IPP Process

The collaborative planning process for the IPP described in mandate and summarized above is clear and explicit. The challenges intrinsic to it, especially in the area of creating



meaningful choice, are responding substantially to preferences and obtaining the services and supports needed to achieve a consumer's goals and objectives. Overshadowing the entire process, however, is the fiscal reality of the operation. The California Supreme Court decision of *Association for Retarded Citizens vs. Department of Developmental Services* established that all services and supports listed in the IPP are a legal entitlement of the consumer. The State is thereby obligated to deliver anything cited in the IPP. While DDS is the payor of last resort, services and supports identified in the IPP that cannot be obtained through other sources must be met through purchased services administered by the RCs.

Purchase of Service (POS) funds comprise almost 80% of the RCs total budget, exceeding \$900 million in 1997-98, and budgeted at nearly \$1.1 billion for 1998-99. POS expenditures in FY 97-98 averaged \$6,200 per consumer. The range is large however, and one-third of consumers receive no POS while others receive over \$100,000 annually. The number of active consumers in RCs has increased by over 50% from 1990 to 1998, while RC total budgets have increased between 7.3% and 19.7% annually, for a total of 143 percent since FY 90-91. This amounts to a 62% increase in expenditures per consumer. The State has struggled to control this expenditure, especially during the fiscal pressures of the early 1990s. DDS uses sophisticated modeling techniques to estimate the overall purchased service budget for a coming year, and allocates a set amount to each RC. However, the volatility of these numbers is substantial, and several RCs have had budgetary crises triggered by POS overruns in recent years.

With POS representing 80% of a RC's budget, and the demand for POS depending on the outcome of the IPP process, the IPP takes on a much larger meaning than the collaborative process described above. Fiscal accountability requires that oversight and control be exerted over something so substantial and critical to financial results. Yet nothing in the mandate describes the IPP as a fiscal negotiation between the state and a consumer. Every element of person-centered planning describes a collaborative process, not the "arms-length" transaction that fiscal standards would consider appropriate.

The Lanterman Act addresses the issue obliquely, requiring RCs to identify and pursue all possible sources of funding, including other public and private sources. It also requires them to use innovative and economical methods to fulfill the IPP (W & I Code Sec. 4649 & 4651). The other reference is a global requirement that RCs perform their contracts within the provision of the funds appropriated in the Budget Act. (W&I Code 4791). These vague and open-ended requirements create a "Catch 22" when weighed with the mandate's emphasis on person-centered planning. While the issue of POS funding and management is not a part of this Citygate study, it heavily impacts RC direct services and resource requirements, and has to be considered as part of the operational context.

B. COMMUNITY AND VENDOR MANDATES

While the IPP and consumer service coordination are repeatedly cited as the purpose of RCs, there are several other major mandates for direct RC services. The largest set relates to the broader community, including vendors. These are discussed below, including resource development, vendor quality assurance, vendor technical assistance, and public awareness and outreach.

1. Resource Development

The mandate that RCs directly support the development of services for persons with developmental disabilities is intrinsic to the effectiveness of the consumer service coordination/IPP process. Successful case management:

requires an accurate assessment and recurring re-evaluation with the consumer of what is needed; *the existence of the needed services*; and the power to ensure that the services are in fact delivered in a timely fashion [emphasis added]. (Dinerman, 1992)

RCs are required to develop needed services and supports (W & I Code 4629), to expand opportunities for consumers to participate in the community (W&I 4688), and to conduct activities to secure needed services and supports (W&I 4648).

Activities RCs are mandated to offer in meeting this obligation include:

- ◆ outreach, training, education to agencies, programs, businesses, and community activity providers;
- ◆ developing a community resources list;
- ◆ providing assistance to families and case managers on expanding integration options in areas of work, recreation, social, community service, education, and public services;
- ◆ developing and facilitating the use of innovative methods of contracting with community members to provide support in natural settings;
- ◆ development of natural supports to enhance community participation; and
- ◆ providing technical assistance and coordination with community support facilitators.

The development of services and supports occurs at three levels: individual, vendor, and community. *Individual service development* is typically triggered by a goal or need identified in a consumer's IPP, with the CSC and/or other RC staff working to develop the services to meet that individual need. An example would be locating a dance class in the consumer's neighborhood that is willing to enroll the consumer. *Vendor development* focuses on recruiting and assisting vendors to fill an identified gap in the service and supports available. Examples include helping a vendor develop an additional residential care facility (RCF), one at a higher service level, or working with a specific opportunity to develop more affordable housing for independent living. *Community development* includes advocacy and facilitation efforts so that existing resources better accommodate the needs of developmentally disabled persons, and include them in their definition of communities served. Examples include working with county mental health departments, local police, transportation agencies, parks and recreation, etc.

The skills and resources required to execute resource development are diverse. Resource development at the individual level is essentially part of the consumer service coordination process and relationship. As a result, the amount of time required to execute this function will vary depending on the availability and accessibility of supports in the community, as well as the ease with which the CSC can access information about those services. In the large, diverse

markets served by most RCs, the breadth of knowledge required to access services on behalf of individual consumers will exceed the capacity of individual CSCs, and require support from specialist staff with focused experience, knowledge, and reference systems.

Technical assistance to vendors requires expertise in the type of program needed, combined with skill in teaching and facilitating (see discussion below). Community-level resource development requires leadership and credibility from the RC as an institution, as well as effective and articulate liaison activity and advocacy. The technical infrastructure needed includes coordinated information about available resources. Analytical, prospective needs assessments should be performed periodically, comparing resources against summary data on needs reflected in consumers' IPPs. Planning should include assessment of future trends and identification of potential gaps.

2. Vendor Quality Assurance

RC mandates require monitoring the effectiveness of purchased services from a consumer-focused perspective, i.e. the extent to which they meet IPP objectives, are consistent with consumer needs and choices, and consumer satisfaction. Vendorization (certifying a provider to participate as a POS vendor) is required to first consider the use of consumers' natural supports; other criteria includes the provider's success in attaining IPP objectives; relevant licensing, certification or accreditation, cost relative to quality and other vendors; and the consumer/representative's preference. Residential care has the most specific mandate and requirements for quality assurance, due to the higher level of vulnerability of the consumers; however, it comprises only 28% of the POS budget for 1997-98.

Specific citations relevant to vendor quality assurance include:

- ◆ Monitor and ensure quality of services and supports provided. This includes adhering to principles of this section, determining whether services and supports in IPP are congruent with choices and needs, whether they are delivered, having the desired effects, and achieving consumer satisfaction (W&I 4689);
- ◆ Increase quality of community services and protect consumers. RCs shall identify ineffective and poor quality services (W&I 4648);
- ◆ Identify providers not in compliance with statutes and regulations and notify appropriate licensing or regulatory authority, or request area board investigation (W&I 4648);
- ◆ RC shall (a) guide and counsel facility staff regarding care and services and supports for each consumer and (b) monitor the care and services and supports provided (W&I 4742);
- ◆ Monitor compliance with program standards for day programs (W&I 4691); and
- ◆ Increase the quality of community services by ensuring adequate services and compliant providers (SB1038; W&I 4648).

RCs are also directed to conduct fiscal reviews and audits of providers as needed.

Specific regulatory requirements exist for monitoring level 2-4 community care facilities (CCFs), including compliance with licensing requirements, and interagency reporting of violations (CCR, Title 17 §56001 et seq., more specifically Articles 8 and 9). When staff identifies a vendor not complying with mandates, a plan of corrective action shall be developed, reviewed with the vendor, and monitored for implementation. Failure to implement the plan shall result in sanctions. This process is accompanied by due-process requirements for appeal and hearing. Legislation in 1998 reversed prior restrictions on unannounced visits to require at least two unannounced visits annually. Unannounced visits were previously restricted to circumstances of immediate danger or substantial inadequacy only (W&I 4648.1). Family Home Agencies (FHAs) are subject to requirements similar to those of RCFs.

The currently mandated facility liaison role encompasses individual consumer monitoring (e.g., quarterly visits and achievement of IPP objectives) at each CCF (a CSC function), technical assistance to the vendor and licensing compliance review (CCR, Title 17 §56048). While this is responsive to vendors' desire to minimize the number of RC staff they have to coordinate with, and improves consistency, it creates other problems and requires that CSCs have specific technical knowledge outside of that required for their direct consumer services.

For supported living services (SLS), mandated quality assurance is less specific as to the content and scope, with the primary activity being quarterly consumer contacts. Since SLS vendors provide service at a one-to-one level in the consumer's own home, this focus on individual consumer quality assurance may be appropriate (CCR, Title 17 §58600 et seq.).

3. Technical Assistance

Technical assistance to existing and potential vendors, including education to other community agencies to facilitate inclusion of developmentally disabled persons, is a component of resource development and quality assurance mandates. It may begin in assisting the planning and startup of a new service. For quality assurance, the extent of technical assistance in developing a plan of corrections, assisting in meeting that plan, and monitoring its compliance varies greatly, but often includes on-site training for vendor staff, etc. The mandate also includes:

To increase quality of community services and protect consumers, the RC shall identify ineffective and poor quality services and supports and provide or secure consultation, training, or technical assistance for the agency or individual provider to upgrade the service. (W&I 4648)

Technical assistance and evaluation skills are required to execute vendorization consistent with local needs and the provision of high quality services (SB1038). Explicit training requirements have been spelled out in regulation to expand access to residential services, including:

At least semi-annual residential service training to those wishing to become vendors. (CCR, Title 17 §56003). DDS, through RCs, shall offer statewide training (in conjunction w/community colleges) for directors or licensees of residential facilities serving DD persons. (W&I 4695)

The RCs are also required to make "systematic use of the findings of the Life Quality Assessment (LQA) [performed by the area boards] to identify training and resource development needs."

4. Advocacy, Public Awareness and Outreach

This mandate has several dimensions. Education and outreach to foster inclusion of developmentally disabled persons in the community and local services is a key part of the advocacy mandate. While "advocacy" is a vague term in many settings, it has a specific meaning for the Lanterman Act in both asserting and facilitating the integration and independence of persons with DD, and in protecting the personal and civil rights of those persons. Advocacy occurs for an individual consumer through consumer service coordination and consumer-focused quality assurance. Advocacy is also an element of resource development, vendor quality assurance and technical assistance. Its broadest application is in public education and outreach on the rights, needs, and opportunities associated with independence and attainment of the highest functional and social potential for persons with developmental disabilities. This function has the potential for decreasing RC purchased service costs as the availability of generic and natural supports for developmentally disabled persons increases.

A more focused education and outreach is associated with the mandate to prevent developmental disabilities, and to find eligible cases (case finding), especially for those at risk of having a child with developmental disabilities. RCs are required to provide services to prevent developmental disabilities for "any potential parent requesting services who is at high risk of parenting a DD infant or to any infant at high risk of becoming DD." This is linked to the explicit legislative intent that "these services shall be given equal priority with all other basic RC services." As with other RC provisions, RC payment for such services should be a last resort after other options are exhausted.

C. FIDUCIARY FINANCIAL MANDATES

RCs are responsible for purchasing services and supports needed to implement consumers' IPPs. Within that role, RC responsibilities include payment to vendors such as community care facilities (CCF), transportation, day programs, etc. Another RC role is to support consumers through representative payee services consistent with advocacy and protection of rights while seeking the most independent setting consistent with consumer and family desires. The RCs are also defined as the payor of last resort. They must first exhaust other options for obtaining needed services supports, including natural supports, other governmental payee, and private sources.

A separate set of operational fiscal mandates pertains to the internal fiscal operations of the Regional Center. They will be considered in the operational models discussed in Chapters 3 and 4. As discussed above, they include the requirement to operate within the appropriation, and general provisions for 'cost-effectiveness'. Annual independent audits, reporting to DDS using the Uniform Financial System (UFS), financial planning reports, and conflict of interest and contracting provisions are all standard operational requirements. This includes appropriate internal controls and documentation in compliance with generally accepted accounting principles.

1. Vendor Payment

Over \$1 billion in POS funds are disbursed annually by the 21 RCs. Many vendors are small or group homes, or local community-based organizations. Cash-flow for these small businesses is

sensitive, and for many, the RC is the sole purchaser of services, making RC payment cycles essential for the continued operation of the home and for reliable services to consumers. Regional Centers reported from 300 to 4,200 monthly checks issued to POS vendors. Payment cycles are subject to the standards of appropriate fiscal administration, including evidence of services provided, of appropriate authorization for the purchase, etc.

In addition to routine payment, RCs are increasingly responsible for contract and rate negotiations with vendors within guidelines set by DDS (CCR, Title 17 §50601 et seq.). POS funds may be used for developing new community resources for consumer needs, including reasonable start-up costs through grant structures. RCs are responsible for developing contract provisions for day programs, consistent DDS rates (currently undergoing revision), specifying service, payment, and units of service. Similarly, for transportation vendors, the RCs perform rate setting, and may contract through competitive and non-competitive procurements (CCR, Title 17 §58530 et seq.). The RCs negotiate rates with supportive living services (SLS) vendors, consistent with regulation and cost-effectiveness standards, requiring a pro forma calculation of costs in alternative settings to compare with the SLS proposal. The RCs are also required to comment on rate change proposals from certain classes of vendors submitted to DDS.

Performance-based contracts are increasingly a preferred approach to improving consumer benefit and service quality, but require a higher level of sophistication and vendor technical knowledge in both contract negotiation and monitoring.

2. Consumer Revenue and Custodial Funds

Consistent with the RCs' role as 'payor of last resort', they are mandated to identify and pursue all public funds to which an RC consumer is entitled, and all private funds the payment of which is legally enforceable (73 Ops.Cal.Atty.Gen.). This includes working with DDS to provide specific training for CSCs in identifying and obtaining services from other governmental agencies and private providers to which the consumer is entitled (generic supports). It extends to facilitating unpaid natural supports, such as friends and family, to help out on incidental matters (a ride to a doctor's appointment, help when a car breaks down) in the same way that the general population does.

For a large number of consumers, the RC administers their personal disabilities monies paid through Social Security (SSI/SSP). These funds are required to be conserved in a separate interest bearing account, available to the consumer on request, with interest accruing to individual consumers' accounts. The RCs may not charge consumers for this service as "representative payee". While the residential care facility (RCF) in which a consumer lives may also serve as representative payee, thus reducing the RCs' costs, many RCs advise consumers to separate the service from their RCF.

At its option, the RC may provide a broader financial service to consumers, encompassing money management such as rent payment, assistance in budgeting, and expenditure monitoring, etc.

III. BUILDING BLOCKS TO REGIONAL CENTER RESOURCE REQUIREMENTS

The breadth and complexity of the mandates for the Regional Center (RC) system makes resource allocation difficult, and potentially open-ended. To facilitate linkage of resources to specific elements of the mandate, we structured our analysis to produce "building blocks." These functional elements address discrete elements of the mandate, or serve to support the operations required to meet mandate. By segregating the mandate elements along the broad concepts discussed in Chapter 2, we facilitate weighing the costs associated with each major element, and setting priorities among them. We sought to clearly define and illustrate the interdependencies among these elements, and the extent to which they have an immediate impact or a long-term effect.

The building block approach lends itself to a review of the different priorities set by individual Regional Centers, and the resulting operational models. The current Core Staffing Formula does not address major elements of the mandate, and is complicated by a \$47 million "unallocated reduction" dating from the fiscal constraints of the early 1990s. This has forced RCs to make local decisions on what elements of the mandate to meet most completely. No single RC has a comprehensive response to each element of the mandate, and the type and level of services provided varies across each functional area. Comparing and contrasting the approaches will enhance the insights on the operational and funding tradeoffs that total state appropriations need to consider and, in some cases, standardize.

Some RCs have protected funding in consumer service coordination (CSC) at the expense of other areas, while other RCs have protected family support, clinical services or quality assurance, all with the intent of best meeting the needs and desires of local consumers. These "protected" resource models for each functional area provide examples of what the RC system might look like if a similar priority were placed on that function statewide. These more comprehensive examples are contrasted with the operational profiles of RCs that placed lower priorities on that function and chose other areas for resource protection.

Comparing resource commitments across Regional Centers is also complicated by the very diverse operational scope of the centers. While they were organized at their inception to serve an approximately even number of constituents, varying growth rates in the ensuing decades has led to very different operations. RCs range from 2,000 to 13,500 active and Early Start consumers, with an average of 6,700. The geographic region served by RCs varies greatly, from 800 to 31,000 square miles, encompassing from one to ten counties (except for Los Angeles County that is served by seven RCs.)

These variances affect overall costs and cost per consumer. For example, the total geographic area served affects both the amount of travel costs for Consumer Service Coordinator (CSC) travel to consumers, and the number of regional offices and overhead a RC might have. More subtly, the area will affect the amount of consumer contact time a CSC may have when travel time stretches into several hours each way, impacting the effective productivity of the CSC. Urban traffic congestion can erode staff productivity to the same extent distance can in a

rural area. **Table III-1**, below, summarizes the range of operational size and service areas for California's 21 Regional Centers.

Table III-1: Regional Center Summary of Operating Profile

As of 12/31/97	Total	Average	Lowest	Highest
Consumers (Active and Early Start)	141,300	6,700	2,000	13,500
Area (Square Miles)	158,000	10,500	800	31,000
Density (Consumers/Square Miles)	0.93		0.14	12.08
Counties Served	58	2.8	1/7	10

Within this complex context, we will profile the functional building blocks common to the Regional Centers and focus our assessment on interactions, along with the implications each has for consumer service coordination and consumer outcomes.

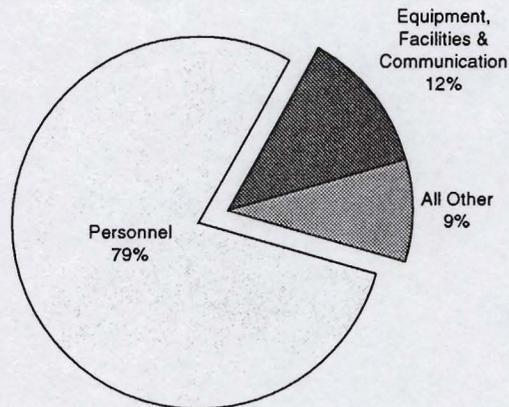
A. SURVEY DATA AND ANALYSIS

As a part of this study (discussed in detail in Appendix A), Citygate conducted a comprehensive survey in August 1998 of RC operations, staffing and expenditures. The most recent year reported was 1997-98. Nineteen of the 21 Regional Centers provided complete fiscal information within the study's demanding time frames, and 20 RCs provided information on staffing patterns reflected in the summary analysis of personnel and hours.

It was a major commitment for Regional Centers to complete the survey, requiring in-depth profiles of all key activities, and data in formats not always readily available. Citygate staff worked closely with each RC to ensure consistency in the technical interpretations of the survey questions and methods. The survey results showed a high level of consistency and validity based on internal and RC-to-RC comparisons. Examples of RC staffing levels and resource allocation patterns cited below are based on survey results, with findings for each RC provided in **Appendix B**. The survey reflects the reality in the field, not the way things "should be." Understanding the strengths and weaknesses of the existing system is essential to establish a foundation for any new recommendations.

Regional Centers are primarily labor-driven organizations. Overall, salary, wage, benefits and contract employee costs comprised 79% of total RC operational expenditures in 1997-98 on average as reported in the Citygate Survey, ranging from 63% to 91% (**Table III-2**, below).

Table III-2: Regional Center Respondents' Expenditure by Line Item, 1997-98



The building blocks will be discussed in terms of personnel resources, with the exception of non-payroll items. The full-time-equivalent (FTE) will be the standard unit of measure. It is comprised of a 2,080 hour work year (40 hours per week, 52 weeks per year) and **includes** the time an employee would be unavailable for routine duties, e.g. vacation, holiday, sick leave, and continuing education.

Productive time, specifically time net of paid hours unavailable to perform primary duties, is explicitly labeled where used, for example, in building up time required for tasks, and then converted to paid hours based on assumed productivity standards. Personnel data are generally reported to include both payroll and contract personnel, but only actual time paid. Unfilled positions (vacancies) and unpaid leaves of absence are not included in the staffing data discussed below.

The number of consumers served by an RC will be the primary unit used to compare RC costs and labor per unit of service. Our analysis and reporting will refer to the state's Client Master File (CMF) data set for consistency, using the midpoint of the fiscal year for comparison (e.g., data as of 12/31/97 for the fiscal year 1997-98). Unless otherwise referenced, the data combine consumers in CMF categories 01 (High Risk Infants) and 02 (Active Consumers), but exclude other categories. High-risk infants are under 36 months of age and eligible under Early Start program criteria. Active consumers have completed assessment and are eligible for services under the Lanterman Act.

Task-level workload estimates are provided as an analytical expansion of Citygate's initial staffing model that defined resource requirements at a programmatic level using high-level indicators, which served as control totals. Task content and frequency were defined based on field work, process reviews in forums and expert panels, defined professional and best practice per the literature and mandate review, and the expertise of project team members. Hours per task were estimated by the project team and compared to the detailed ARCA Personnel Task Force Report. That report detailed hours per task as well as tasks per position for all RC operations.

The ARCA report findings were adjusted by the Citygate team based on project research, professional judgement and experience, field work and expert panels, changes in mandate, operating environment and practices.

As discussed in Chapter IV, we recommended selected evaluation of task specific assumptions.

B. REGIONAL CENTER PRIORITIES

In an attempt to articulate RC priorities and choices made in resource tradeoffs, the Citygate Survey asked RC directors three open-ended questions:

1. What are critical **priority** items (functions or activities) for the RC: those things that “always” get done, despite time or resource constraints?
2. What are **important** priority items for the RC: those things that should always be done, but realistically get done as often as time or resource constraints permit?
3. What are **deferred** priority items for the RC: those things that should be done, but are frequently or usually deferred due to time or resource constraints?

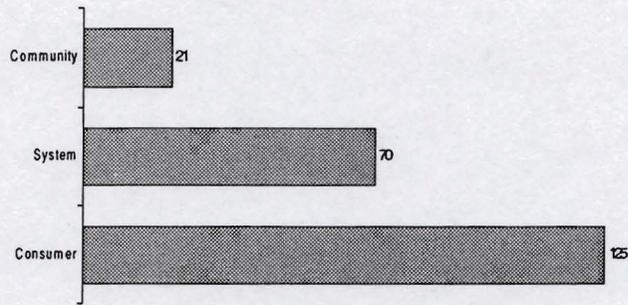
These same questions were explored in site visit interviews and the executive director forums. Survey responses were coded by staff responsible for the field work discussions to improve insight and consistency.

In quantitative analysis, **priority** items (the first question) were weighted by three (3), **important** items (the second question) weighted by one (1), and **deferred** items (the third question) weighted by negative one (-1). We also coded the responses by the general functional area: services or roles directly interacting with **consumers**, those interacting with the **community** including providers, and those that were **system** (operational) issues.

1. RCs Have High Compliance with Life-Safety Consumer Services

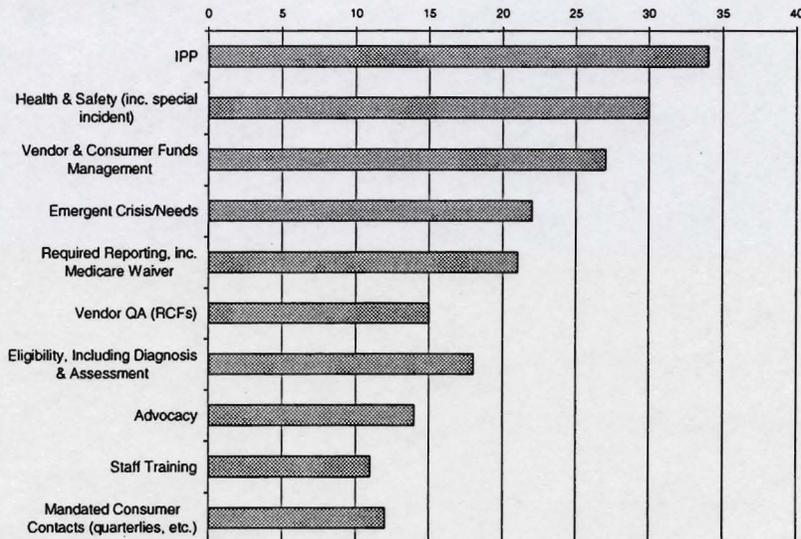
By summary functional area, **Table III-3** below shows the clear priority placed on direct consumer-related activities Individual Program Plan (IPP) completion, health and safety (including special incident follow-up) and responding to emergent crisis were cited most frequently as a priority that is always met, regardless of resource constraints. System issues are the next most important, driven by the high priority given to meeting vendor payment responsibilities, and to compliance with required reporting, including Medicaid waiver documentation.

Table III-3: Total Weighted Points by Functional Area, RC Priorities



The five top items for consumers and system priorities were **never** cited as deferred by any respondent, and only two respondents said that a key consumer service would be **important** (should always be done, but may be constrained by resources.) The top ten scored responses are presented in **Table III-4**, below.

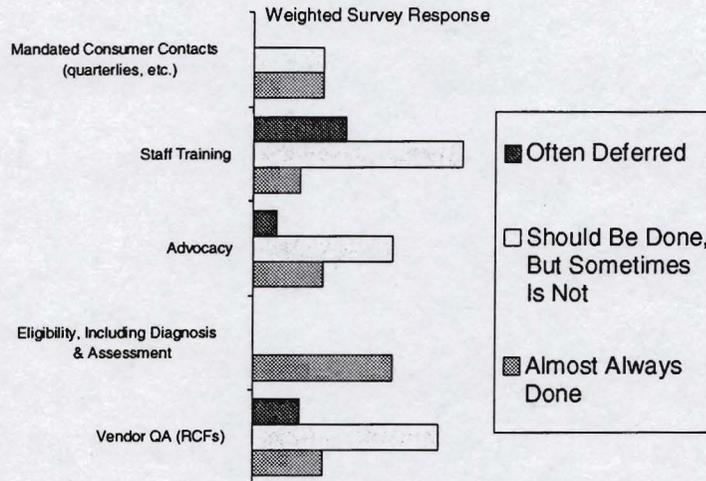
Table III-4: Top Ten Responses to Regional Center Priority Survey Questions



2. Resource Constraints Affect Key Consumer and Community Services

The respondents had less agreement on the priorities of the items ranking five through ten based on the scores in Table III-4. While they aggregate as high priorities, staff training, vendor quality assurance for residential care facilities, and advocacy were all cited as important activities that **often** were deferred due to resource constraints. Mandated consumer contacts (minimum contact levels) were also cited as sometimes impacted by resource constraints (**Table III-5**.)

Table III-5: Number of Responses by Priority for the Second Tier of Five Priorities

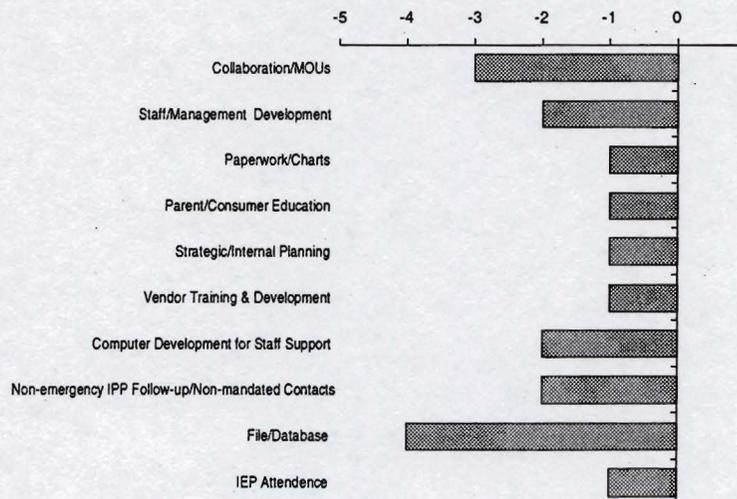


The number eleven item on weighted score, resource development, was also an “always done” for some, “often deferred” for one, and a “should be” for the plurality of respondents. Other items that had a positive net weighted value, but frequently split between “usually done” or “often deferred” for respondents included outreach, routine communication with families, equipment monitoring, and management.

3. Activities Often Deferred Due to Resource Constraints are Important to Achieving Quality Outcomes for Consumers and Families

Consensus re-emerged about items that are sometimes or frequently impacted by resource constraints. Collaboration with generic resources, including inter-agency memoranda of understanding (MOUs), were cited by eleven RCs, followed by staff and management development.

Table III-6: Most Frequently Cited Important Activities That Sometimes or Frequently Are Deferred Due to Resource Constraints



The portrait of the RC system synthesized from the survey, site visits, interviews and other project activities is one currently driven by mandate compliance, but acutely aware of the need for other activities that are critical to the quality of the process. Legislation usually defines the minimally acceptable standard, and often is specific on how to conduct activities only when there is a perception by policy makers that a problem needs correction. Regulation is the usual forum for expanding and defining how the legislative mandate should be executed, but RCs have a higher level of detailed legislation, and a much faster rate of change than other human service vendors we have worked with. The compliance pressure for DDS and the RCs has assumed a higher focus than the professional standards of human services and administrative practice (doing the "right job the right way"). Specific gaps in practice and activities highlighted in this section will be discussed in the relevant functional area of building blocks below.

C. INTAKE AND ASSESSMENT

1. Definitions

The screening call is the public's first contact with the RC. At this time, the caller is briefly profiled to determine whether the call to the RC is appropriate. A referral is made to another agency (e.g., mental health or rehabilitation) as needed. Intake consists of briefing the prospective consumer and their family on the RC's services, roles and process for eligibility determination, and sending information within 15 days of contact (w&l 4646). Where current medical and/or psychological assessments are available from outside sources, these are obtained and reviewed. When appropriate, the RC directly performs medical or psychological assessments.

This process usually entails several meetings with the consumer and family, as well as calls to external providers to obtain records, follow-up, etc. At the conclusion of the assessment, an eligibility determination is made, either as having a developmental disability under the Lanterman Act, or at risk for DD and eligible for RC services under the Early Start program for high risk infants (under 36 months of age). The initial assessment activities are then integrated into the IPP process for the first time.

The data on intake and assessment case load are among the weakest in the system. Three sources for workload data elements exist: category 0 consumers (eligibility determination) per the DDS CMF at 12/31/97; a "budget estimate" workload collected by DDS from the RCs, and Citygate Survey data. For the budget estimate, the RCs report monthly intakes accepted by over and under 36 months of age, which is averaged for the year and then projected. Each case is budgeted at 1:14 over a two-month period, effectively a 1:7 ratio. Category 0 is theoretically a cumulative workload of all cases in the system, not just entrants.

For completeness and internal consistency, we used the budget estimate intake workloads in our analysis. Improved reporting and tracking of intake and evaluation volumes, including reconciliation to CMF data, is an important need.

Standards differ by program. Under current legislation, eligibility for developmentally disabled persons must be determined within 120 days of contact, with preparation of the initial IPP following that period. Eligibility is to include medical, psychological, and social assessments. The period for determination will revert to 60 days as of June 30, 2000. Early Start consumers, however;

must complete both the assessment and the initial IPP (called the Individualized Family Service Plan, IFSP) within the initial 45 days. Definitive eligibility determination is not made for this population until 36 months of age.

Consumer requirements generate a total workload independent of mandated timelines. Intake should be based on the actual intake caseload, not amortized over the number of months. The consumer requires the same services and total staff time whether those services are spread over one, two or four months. The required time frames for assessment affect resource requirements only when they change, increasing or decreasing backlog. When time frame mandates do not change, the equivalent to one month's workload must be completed each month to keep backlog constant as a new set of intake cases arrive.

2. RC Operating Models

RCs vary a great deal in how intake and assessment is performed and organized. They average 114 intake cases per month, but range from a low of 37 to a high of 212. The number of cases active at a single point in time will vary based on backlog (the time between intake and eligibility determination). Data are not collected on actual backlog or length of time to complete the process.

Most RCs have one or more paraprofessional personnel who screen initial phone calls and send out contact packets of information. The intake and assessment process overlaps with ongoing consumer service coordination, with the same skills and knowledge required to assess and plan for the consumer in preparing for the first IPP as for subsequent cycles. Most RCs use CSC personnel to coordinate the intake and assessment process; however, RCs vary substantially in how they staff this function. Most have separate intake units with dedicated CSC personnel, usually with a higher experience or skill level than the case-carrying CSCs. Some integrate intake and assessment CSC with case-carrying CSCs. Still others have dedicated intake for Early Start only, integrating other intakes with case-carrying CSCs.

The use of POS funds in intake and assessment also varies. Three RCs reported using POS monies for social assessments in the intake and assessment process. These differences make resource comparison for intake and assessment difficult, and also complicate evaluating CSC service levels. For consistency, Citygate Survey data were standardized for the six RCs reporting integrated CSC usage that provided detailed resource allocation by reclassifying those resources out of CSC staffing. Another eight RCs reported segregated staffing for social intake and assessment activities and their individual data were used. CSC resources for social intake and assessment for the six RCs reporting integrated CSC usage without providing detailed resource allocation data were estimated and reclassified using data provided by the other 14 RCs. **Table III-7** summarizes each of these respondent categories.

Table III-7: Respondents Models for Intake Coordination and Social Services

Intake and Assessment Social Service Model	Respondents
Dedicated Intake and Assessment Unit Including Consumer Service Coordination	7
Dedicated Administrative Intake with Consumer Service Coordination Provided by CSC Unit	7
Fully Integrated to CSC Operating Unit	6

Data on compliance with mandated timelines were not available. Of the six RCs, which mentioned intake and assessment in priorities, all cited it as consistently being done, regardless of resource constraints. Two RCs indicated that timeline requirements are sometimes compromised by resource constraints.

The average CSC paid hours per intake case was 8.4. Contract personnel were included, except those paid out of POS funds. This is equivalent to 248 cases per FTE per year, or a staffing ratio of 41 active cases per worker, assuming each case lasts two months.¹

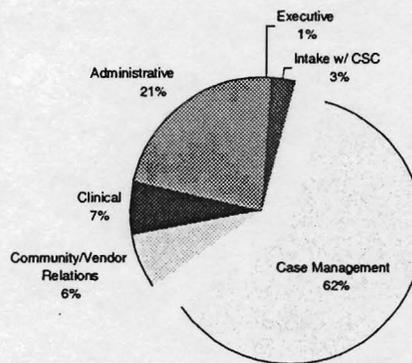
For planning purposes, we define intake to consist of the CSC handling the consumer through the initial IPP or IFSP, materially the same workload for both Early Start and other consumers. Functional build-up by task for social assessment, coordination of other assessments, and preparation of the initial IPP/IFSP are estimated to require nine productive hours per consumer, or 11.25 total paid hours per consumer, equivalent to a 15.4:1 monthly caseload. This is a 33% increase over surveyed levels.

D. CONSUMER SERVICE COORDINATION

For this report, consumer service coordination is addressed as a major element of the overall case management process, but does not include all aspects of case management, as discussed below in **Definitions**. Consumer service coordination is the highest profile service provided by the RCs. It is the primary point of contact for consumers and families and has specific staffing standards defined in appropriations. It is, appropriately, the largest single cost of the RC system, with CSC staff and direct supervision accounting for 62%, on average, of the total salary, wage and contract personnel expenditures in the surveyed RCs in 1997-98. Direct support to consumer service coordination is a substantial portion of the administrative expenditures shown in **Table III-8**.

¹ Calculated as 2080 paid hours per FTE per year/8.4 paid hours per case = 248 cases completed per year; (248 annual cases/12 months) x 2 months duration=41 cases.

Table III-8: Salary, Wage and Contract Expenditures, by Functional Area, Surveyed RCs 1997-98



Services to DD persons have traversed several models from custodial institutions, to a service model, to a developmental model, and currently to a person- and family-centered model. Each shift in model represented a shift in the decision-making center, moving from physicians, to teachers and psychologists, and now to consumers or their families. Accordingly, case management models and institutions have been adapted in an attempt to accommodate new service paradigms. In California, current law defines a service coordination model that embraces the consumer or his family as the ultimate decision-maker to accept or reject proposed services. Planning is described as “a process through which system representatives and consumers come to an agreement” (W&I 4646).

In case management didactic reviews, “restrictiveness” relates to the degree to which system needs take primacy over individual needs and desires. Various methods have been proposed to deal with the restrictions born of interactions between the system and individuals, from posing service coordinators as fiscal intermediaries or gatekeepers, to providing case managers as independent advocates, to the newest model of support brokerage.

1. Definitions

Case Management

Case management has been developed for a wide range of vulnerable populations, and has roots traceable to the beginnings of the social work profession, with a parallel evolution in the field of nursing. Unfortunately, substantial tension exist between the social work and nursing models in many settings, as documented in the professional literature of both groups. Some see the two professions as having mutually exclusive goals, while others have achieved superior programs through collaborative models. Case management models are distinguished by the target population, the auspices under which the manager operates, and the goals of the program (Netting, 1992).

Program goals have been classified into three broad categories: 1) social, 2) primary care, and 3) medical-social. As described by Loomis (1988):

Social goals focus on well people living within the community. The purpose is to provide basic supportive services rather than health care. Case management programs with social goals attempt to empower consumers so that they no longer need case management. Primary care goals based on a traditional medical model approach...are often associated with a gate-keeping function. The case management program's goal is to monitor service use so that resources are used efficiently...The medical-social goal focuses on consumers already at risk and case management programs intervene with vulnerable populations to prevent additional problems and to establish equilibrium.

Clearly defining case management goals is important to the quality of the program. Another perspective on the diversity of case management roles is provided by Weil, et al. (1985) who describes case managers as performing any combination of the roles of "problem solver, advocate, broker, planner, community organizer, boundary spanner, service monitor, record keeper, evaluator, consultant, collaborator, coordinator, counselor, and expeditor." This is specifically a social services driven definition, however, and requires a high level of professional function to effectively encompass this diversity of roles. Netting notes that "balancing the advocacy role with the gatekeeping function may be one of the most difficult tasks that case managers encounter." All authors in discussing case management roles at this level assume professional preparation, including nursing, social work or psychology.

Netting (1992) describes five key challenges facing case management:

- 1) Case management conceals the broader issue, "that the health and human services system is a non-system. Case management is needed only because of system failures (complexity, fragmentation) and needs to "be committed to working themselves out of a job."
- 2) Maintaining a consumer-centered perspective in a cost-focused environment: working toward balancing.
- 3) Quality in brokered systems: the case managers have "limited control over those agencies and their staffs that see consumers on a daily basis. Quality assurance of these brokered services requires macropractice skills. Even with such skills, difficulties arise...there may not be mechanisms in place to assess quality and providers may resent case managers reporting complaints and problems."
- 4) Availability of services to address specific consumer needs: "it is mandatory that case managers identify gaps in the ... system and report ... to policy makers. This requires case managers to see patterns and recognize interrelationships between microneeds and macroissues. This also requires adequate communication with appropriate decision-makers and careful documentation. Documentation may be an added stress to already over-burdened case managers."
- 5) Case management provider qualifications and training: "Currently anyone can become a case manager...advocate for trained people to provide case management but avoid the turf struggles that have pitted social workers and nurses against one another."

The breadth of the case manager role is the justification in literature for the advanced training and frequent licensure of personnel, for example, social workers and registered nurses. Netting specifies, "case management carries an oversight function. Unless it is carried out with quality monitoring, adequate reassessment and evolving care planning, it may set up false hopes. Carried out in a professional manner, [it] will vary by design to meet the needs of a diverse

clientele.” Functional case management activities from several examples are summarized in Table III-9, below.

Table III-9: Comparative Case Management Functions

	Minnesota	Project Continuity (Nebraska)	California
Administrative Roles			
Intake	X	X	RC Function
Eligibility determination	X		RC Function
Service authorization	X		X
Ongoing eligibility reviews		X	N/A
Conciliation and appeals	X		X
Service Roles			
Assessment/Arranging for Assessments	X	X	X
Developing individual service plans	X	X	X
Identifying service options	X	X	X
Identifying providers	X	X	X
Assisting consumers to access services	X	X	X
Coordinating services (including exchange of information among providers and families)	X	X	X
Evaluating and monitoring services	X	X	X
Periodic review of service plans	X		X

The Service Coordination Role

In the literature of the developmental disabilities field and case management profession, a wide range of terms are used to describe this function. Some of the phrases try to capture subtle differences in the scope of administrative or service functions, while a significant part of the variance is intended to describe distinct differences in attitude and approach.

“most likely, few targeted groups relish being called a “case” or being “managed.” Therefore, an assortment of more palatable terms is being used interchangeably with case management: care management, managed care, care coordination, continuity coordination, service integration, and service coordination. ... It is case management of service management and service coordination, as opposed to managing a case.” (Netting, 1992).

Service coordination is considered by many sources as one dimension of case management. However, the scope of case manager involvement in service coordination may range greatly, from simply linking individuals with disabilities to qualified resources, to being very involved including directly locating, coordinating the evaluation and selection with the consumer, negotiating and contracting, coordinating and supervising the service provision. This role variation is reflected in California’s RCs. The involvement of CSCs should vary by the nature of the consumer’s needs, wishes, and natural supports. For RC-purchased POS services, the case manager and the RC (in conjunction with DDS) have responsibility for certifying the vendor as qualified, rate setting, authorizing and executing payment, and providing ongoing quality assurance of the vendor’s continued qualifications and compliance. It extends into training and developing new resources, as discussed in the community services sections. For



generic services, the RC role is more attenuated, and often consists of simply linking the consumer and family with potential sources of services and supports.

The functional position and actual job content is not widely reported in the profession's literature. Our literature review found one program that cited weekly consumer contact, others as needed. Another determined service intensity based on a priority-rating scale, another emphasized work in parent groups. One study found that maintaining consumer contact is the most critical variable in the quality of case management (Shaw, et al., 1988).

Regional Centers Use a Team, Including the CSC, for Case Management

In the California system, the Regional Center as a whole executes the broader case management function. The individual consumer service coordinator is responsible for a discrete subset of case management activities, compared to the comprehensive roles described in the literature discussed above and in **Appendices C and D**. This is reflected in the qualifications and salary assumption for CSCs, and in RCs' need for supplemental support in community and clinical services to complete the case management role.

The case manager role has evolved over the life of the Lanterman Act. The position was originally a master's-level prepared social worker and had a professional counseling relationship with the consumer. By the mid-1990s, the role was defined as service coordination, with a redefined staffing model assuming no master's level prepared professionals. Examples of all steps along this continuum can be found in the RCs' actual practice, with a few RCs still having a staff of only master's prepared social workers, many having a mixture of experience and qualifications, and some where the social work master's degree is extremely rare.

In this report, we will, consistent with current legislation and policy, use the consumer service coordinator (CSC) title and role description, focusing on functional roles as the key defining element. In Citygate forums and other project meetings with RC CSC leadership, we explored the functional definition of the CSC in California, and compared that to other states' models for case management to individuals with developmental disabilities. Key findings from those meetings are summarized below.

Consumer Service Coordination includes:

- ◆ Linking individuals with resources and services from a perspective oriented toward enhancing capabilities and strengths;
- ◆ Accurately assessing and re-evaluating with the consumer what is needed ;
- ◆ Varying the goals and scope of consumer service coordination depending on consumer needs and vulnerabilities;
- ◆ The CSC's job is a qualitative process built around relationships and fueled by interaction at informal and formal points; and

- ◆ The IPP is a product of a larger, ongoing process, not an end unto itself. Fluidity of planning, assessment, etc. should reflect the consumer more than regulation.

Key system characteristics needed include:

- ◆ The rate of change in the program in recent years has made rational management difficult—a period of stability is needed to implement all the accumulated changes and evaluate their effect before new change is imposed;
- ◆ Educational support to the CSC is critical in many areas, including developmental disabilities issues and background, local service system, regulations, etc.;
- ◆ Education needs to be both up-front and ongoing;
- ◆ Case work documentation is an essential tool when working in an interdisciplinary team (ID team) to successfully assess, plan, implement and monitor; however, much of current documentation required does not facilitate team interaction or improve outcomes;
- ◆ Technology is an important support to CSCs to streamline certain tasks; however, it should not interfere with the interpersonal nature of the CSCs job: specifically, production of forms is not the job's basic content;
- ◆ Quality assurance focusing on an individual consumer's circumstances and the services received is a natural part of the CSCs function; and
- ◆ Broad-based quality assurance, including vendor-wide and systemic QA is a non-core function and can create conflicts of interest with the CSCs consumer focused service-facilitation.

Other models are not comparable to California's consumer service coordination:

- ◆ The much lower case management ratios in some states (1:30, 1:25) include a larger level of direct service (skills teaching, counseling, etc) that are distinct from California's RC purchase of services model; and
- ◆ The Developmental Centers' social worker staffing model is not comparable to RC roles and activities.

2. Conceptual Models for Case Management

Models from other regions, while not directly comparable, provide insights and some specific tools for RC operations and budgets. The following examples have specific lessons for inclusion in the budgeting model for RCs.

Project Continuity: Part H Case Management for Extremely Acute Infants: Data on Case Manager Roles, Consumer Factors Affecting Workload and the Impact of Documentation

This program provides rare data on functional job descriptions, resource requirements and activity drivers (Jackson, Finkler, Robinson, 1992, 1995.) As mentioned above, the range of staffing ratios and contact times varies enormously based on the scope of services, the consumer and the case manager/CSC role. Project Continuity is a short-term program (four to eight months) of intensive case management in Nebraska for infants with or at risk for developmental disabilities who also had a combination of acute and chronic medical conditions. Case managers were drawn from several disciplines, including registered nurses, social workers, a child-life specialist and a parent/infant educator. Case management time was tracked functionally and prospectively for each consumer. These are summarized in **Table III-10**, below.

Hours varied by age of child, and with special clarity, by family situation. Families with needs that were retrospectively defined as complex averaged 6.26 hours per month compared to 3.62 per month for non-complex. (These translate, using an 80% productive FTE, into consumer to case manager ratios of 22:1 and 38:1, respectively.) Indicators of complex situations included financial concerns, family problems, and/or lack of identified resources.

RC CSC leadership echoed this finding. Family issues were consistently cited as determinant of CSC resource requirements. Some issues were objective: one and two parent families, health of the other family members, etc., while others were psychological and functional, including the family's adjustment to the consumer's developmental disability.

Table III-10: Distribution of Case Management Functions, Project Continuity

Function	Percent of Hours
Determine eligibility	5%
Identify and arrange evaluations	5%
Provide support to families	45%
Make referrals to outside agencies	5%
Exchange information among service providers and families	20%
Maintain follow-up contact with community providers and family	20%
Determine discharge from project	0%
Total	100%

Service coordination costs varied by medical condition and paralleled the variation of hospitalization. Importantly, given the level of RC concern about documentation and paperwork:

Decreased time spent on exchanging information may reflect several mechanisms implemented by the project to improve communication, that is, team meetings and distribution of report of contracts and progress notes, may have streamlined communication and subsequently helped to reduce costs.

Our model for RC staffing has incorporated functional position tasking, the value of documentation, and the potential for measuring family dynamics cited above.

Self Determination Initiatives: Emerging Models Focus on Consumer Service Coordination

The most current evolution in support for persons with developmental disabilities is in the area of self-determination. This is a continuation on the spectrum of person-centered services, and focuses on increased self-direction of services and funds at the individual level. The movement's vocabulary refers to "brokered supports" and includes seven key functions:

1. Assist consumers to determine their needs and plan supports.
2. Assist consumers to find and arrange resources and supports.
3. Provide education and technical assistance for consumers.
4. Act as a fiscal intermediary.
5. Provider consumer employment administrative support.
6. Facilitate community building.
7. Assure consumer monitoring of quality (*Common Sense, Oregon DDS*).

The system still focuses on a single point of entry, consistency in statewide services and fiscal administration, but articulates increased individualization of services and supports. Financial delegation is a common feature of these models, and advocates cite limited data that self-determination models can decrease total public expenditures. These examples are in states other than California, with funding models that often have expenditure limits, waiting lists, and other features not present in California. In this model, case management is replaced by support brokerage.

Functionally, support brokerage is similar to California's current consumer service coordination. Literature describes the support broker role as requiring that support brokers know the significant issues of every person that they do brokerage with and that they see each person at least twice a year. If less is spent on brokerage, then more is available to buy services and supports. However, if too little is spent on support brokers then the quality of the brokerage and the assurance of quality and safety in the lives of those supported is diminished.

Canadian pilot projects in support brokerage developed professional conflicts and duplication between the social worker (which that model retained) and the new role of support broker. The support broker role is consistent with current Lanterman Act commitments to person-centered planning and the role of the CSC.

Increased Consumer Independence Requires More Individualized CSC Service and Monitoring

The job has changed as consumers are more mainstreamed. CSCs now deal with a larger universe, including day programs or activities. Developing consumer-specific opportunities (supported employment, independent living) means a 'custom product' each time, not just developing enough 'slots' in standardized programs. This can entail additional work for CSCs and support through resource development.

Traditional social models are appropriate for well people living within the community, seeking to empower the consumer so that they no longer need case management. However, the

increasing diversity of consumers also increases the number of consumers at risk. "At risk" encompasses a wide range of situations, e.g. medical frailty, maladaptive behaviors, unstable or unsafe environment, etc., as well as the specific definition of at-risk for placement or movement within placement to a more restrictive environment. Consumers at risk need a blended medical-social goal with the intent to offer appropriate intervention to prevent additional problems and to establish equilibrium. This increases the need for routine support from clinical professionals, as well as for proactive monitoring and evaluation.

3. RC Operating Models for Consumer Service Coordination

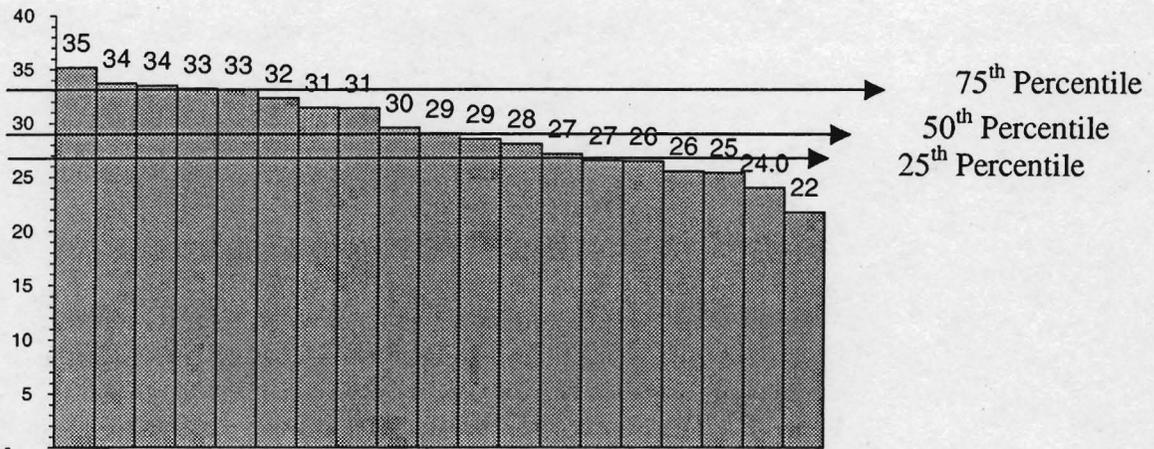
The CSC is the core of the case management team, but, in most RCs, the CSC does not perform all aspects of the role. As discussed in Intake and Assessment (above), the functions of CSCs vary significantly. Defining 'true' consumer service coordination resources, net of other functions, requires normalizing the data. The social and coordination role in intake and assessment were normalized 'out' of CSC numbers for those RCs that use CSCs in that activity, consistent with its separate mandate and budgetary treatment. The skill set requirement and functional content of intake and assessment is essentially the same as other CSC activities, and should not be distinguished on a functional basis. Normalizing the CSC data also required including contract labor and aligning specialty resources that carry ongoing cases (for example, RCs using RNs for Early Start CSCs.) Clerical staff (including clerical case aides) and CSC supervision are not included in the CSC hours, and will be addressed separately.

Consumer Service Coordinator Hours per Consumer Vary Widely

Consumer service hours available annually for ongoing case management of Early Start (CMF category 01) and Active consumers (category 02) are presented in **Table III-11**, below. The average (mean) of the 20 responding RCs was 29.5 with a median of 29.3. The reported hours ranged from 21.7 to 38.8. Statistical analysis by RC size did not find any correlation between overall RC caseload size and CSC hours per consumer. CSC hours per consumer were also not correlated to the number of square miles in an RC's catchment area. Vacancies (budgeted but not filled positions) ranged from three to eight percent of the respondents' total CSC positions. Those hours are not included in this analysis.

The highest reported value is ten percent above the next RC, a substantial difference. The data for this one RC are not based on actual paid hours (as were the other 19 respondents) but are estimates based on budgeted positions. Since vacancy factors are likely to be a minimum of 5%, this high outlier was eliminated from quantitative analysis based on data inconsistency. The lowest reported value was confirmed as accurate and retained.

Table III-11: Normalized Annual Consumer Service Coordination Paid Hours per Active and Early Start Consumer, 1997-98, by Responding Regional Center, with Quartiles



The 87th percentile of data as reported is equivalent to the caseload of 62 consumers per case worker, with three retained respondents (excluding the high-end outlier) reporting at or below this case management ratio. Quartile values are presented in Table III-12, below.

Table III-12: Quartile Values of Normalized Annual Consumer Service Coordination Paid Hours per Active and Early Start Consumer, 1997-98

Quartile	Normalized Annual Consumer Service Coordination Paid Hours per Active and Early Start Consumer	Active and Early Start Consumer per Consumer Service Coordinator FTE
Maximum	35.2	59
75 th Percentile	32.7	63
50 th Percentile	29.0	72
25 th Percentile	26.5	78
Minimum	21.7	96

The wide range of consumer service coordination staffing raises many questions to audiences not intimately familiar with RC operations. Is each RC providing comparable services, and, if so, why are some apparently much more efficient than others? If the consumer service coordination services are not comparable, does the quality directly correlate to the staffing level? Are there other services being provided to consumers by the RC to compensate for a lower staffing level? Are these staffing levels proactive choices by RC boards and management, or the best achievable as a result of local conditions? Analysis showed a slight inverse correlation with the average wage of CSCs, supporting a hypothesis that some centers using fewer CSCs per consumer are paying more per CSC.



Specialist Resources Account for Some of the Variance in CSC Hours/Consumer

One key variable is the extent to which the CSC is directly supported by specialty resources who do not carry cases. The CSC normalized data (above) reflects professional staff with ongoing case-carrying responsibility. In some RCs, the CSC has sole responsibility for individual resource development, monitoring, advocacy, and family support. Other RCs have elected to have focused specialists actively assist the CSC on an individual consumer's needs. In this analysis, we focus on specialty resources that directly substitute for CSC time, using a common-sense test: if the specialty resource doesn't do the task, would the CSC have to do it? Common examples of specialty resources were family support staff and clinical resources in nursing or psychology over and above intake and assessment roles.

The Citygate survey collected and measured the specific specialist support used by CSCs in ongoing direct consumer service. Using a consistent measure, and validating self-reported data by detailed review of personnel staffing patterns, we have allocated staffing resources (excluding clerical) that are: 1) incremental to other core functions, and 2) directly support ongoing case management and substitute for tasks the CSC would otherwise perform. RCs tended to either use a significant level of these resources (eight RCs used specialty resources equivalent to four to nine percent additional CSC resources) or very little (ten RCs had one percent or less). Only two RCs had resources in the two-to-three percent range. The impact these specialty resources have on quartile CSC hours per consumer are presented in Table III-13, below.

Table III-13: Quartile Values of Normalized Annual Consumer Service Coordination Paid Hours per Active and Early Start Consumer, and Adjusted for Specialty Resources, 1997-98

Quartile	Normalized Annual Consumer Service Coordination Paid Hours per Active and Early Start Consumer	Normalized Annual Consumer Service Coordination Paid Hours Consumer Including Specialist Resources	Percent Change with Specialists
Maximum	35.2	36.0	2.2%
75 th Percentile	32.7	33.8	3.4%
50 th Percentile	29.0	29.6	1.9%
25 th Percentile	26.5	26.6	0.6%
Minimum	21.7	23.6	8.3%

The inclusion of specialist hours significantly impacts RCs with relatively low CSC normalized hours per consumer. In the distribution of CSC hours/consumer, the tendency of the distribution towards high (a skew measured as above 0) or low (skew below 0) values, is reduced from (0.22) to (0.04). This supports a model in which RCs with very low CSC staffing have elected to allocate CSC funds to specialist resources that support CSCs in ongoing case management, realizing a higher level of client service than the CSC hours alone would indicate.

any single consumer needed varied greatly, according to both tangible and intangible variables. Intangibles, including family complexity (as discussed above) were cited as very important, but could not be used to evaluate CSC staffing level without a consistent standard. Informants agreed that family complexity was not a function of income, education or ethnicity, so these demographic measures were not appropriate.

Measurable factors included the specific service needs of the consumer. CSC leadership agreed that the higher and more complex the total IPP service and support needs of a consumer, the more CSC time that consumer would require. Other factors cited included residential placement, and age. Residential placement was generally perceived as more resource intensive than consumers residing in their parents or others' homes. However, independent or supportive living consumers in their own homes could generate an even higher workload because of the need for one-on-one planning, monitoring, negotiating with vendors, and other services, as well as a higher level of volatility in the consumer's needs.

The association of consumer age and CSC resource requirements was not perceived consistently. While many felt that extremes of age (at risk infants and the emerging geriatric population) had unique and more intensive needs, others disagreed, and saw that the post-school age, independent and active adult consumer needed more 'custom-tailored' services (e.g., job placement).

A recent DDS study on the sources of variance in POS expenditure patterns by RC identified the effect of many environmental factors. Factors evaluated included service area, per capita income, consumer age, placement and ethnicity. This study also examined data from the Client Developmental Evaluation Record (CDER) used by DDS for all active consumers (high risk infants under 36 months of age do not require complete CDERs.) CDER includes almost 200 individual consumer characteristics as reported by developmental and Regional Center staff. The CDER instrument is analyzed and used to produce several synthetic variables that summarize the implications of many individual variables.

The DDS study focused on one of those summary measures, Preferred Program, in its efforts to determine the impact of individual consumer service costs upon Regional Center expenditure variances. Utilizing only data associated with consumers over 3 years of age who receive POS funding support through DDS, 88,497 in total, a considerable degree of consistency was observed between Regional Centers in the percentage of consumers classified in each of the nine preferred programs. Less consistency was noted in the per capita expenditure arena but certain programs were still quite comparable.

To assign a Preferred Program, consumer characteristics are used to classify them around their key needs and vulnerabilities in a sequential method. The specific elements that drive the preferred program definition tend to be relatively stable over time, and the finding is a composite of several data elements. This makes the Preferred Program measure less vulnerable to becoming outdated or inconsistent across RCs. If Preferred Program is an integral part of RC budgeting, and sufficient staff resources are available, accuracy and completeness of CDERs should improve, consistent with the high level of reliability found by Citygate's validity review of CDERs in the Community Placement Study.



of the IPP and consumer relationship, and cannot substitute for that process. These nine descriptive groups are summarized below, in the same order in which consumers' cases are cascaded.

• Preferred Program Coding Method

1. Medical Care	Consumers with a chronic medical condition that has a significant impact on service provision.
2. Physical Development	Consumers who are non-ambulatory (not including infants) and have a medical condition of a less severe nature than in Medical Care, above.
3. Autism	All consumers with a diagnosis of Infantile Autism.
4. Sensory	Consumers with severe sensory deprivation, not previously classified. Many of these consumers also exhibit maladaptive behaviors but are not included in the Behavior Adjustment category because of the additional impact of sensory problems.
5. Child Development	Any consumer under the age of 15 who does not fall into a previous category. (Early Start consumers are not included in this category since they are not part of the complete CDER data set.)
6. Behavior Adjustment	Any consumer not classified in a previous area with a score that indicates serious behavior problems. A cluster analysis of social-emotional domain items of the CDER to assess the severity of behavioral problems.
7. Habilitation	Consumers who remain unclassified after the prior "decision tree" process (1-6) with high functional skills or potential, with a service focus on enhancing social, cognitive and adaptive behavior skills.
8. Socialization	Consumers who remain unclassified after the prior "decision tree" process (1-6) with moderate functional skills or potential, with service needs emphasizing on enhancing socialization self-care skills.
9. Physical-Social	Consumers who remain unclassified after the prior "decision tree" process (1-6) with profound retardation. While ambulatory and without serious medical conditions, their general health and self-care abilities are a frequent service need.

The Preferred Program variable is also used by the state developmental centers to budget staffing requirements per resident by type of personnel. The Coffelt community placement population is staffed at a lower CSC level (1:45) than the overall state standard of 1:62. Coffelt consumers have a much higher incidence of three preferred program types (01, 02, 06). Citygate's analysis found that while CSC staffing levels reflected so many factors that consumer status alone was a weak correlate, preferred program type (06) behavior adjustment was significantly associated with higher RC operational costs.

RC input and advisory groups agreed that staffing ratios (while inherently not an ideal way to plan services) should vary based on consumer needs, and that the total service level needs of consumers would be expected to vary directly with the CSC needs of the consumer. Preferred program is the best available, consistent measure with data supporting its accuracy in capturing those factors measuring total consumer service needs.

A consumer's preferred program, as currently implemented by the RCs, is not fully consistent with other identified workload drivers, specifically Early Start, Medicaid waiver, out-of-home placement and mental health dual diagnosis. Most Early Start consumers do not have a

independent living), while correlated to complex preferred programs, includes significant numbers of consumers in other preferred programs.

To fully capture the workload implications of the other variables, we have defined Early Start, Medicaid waiver eligibility, out-of-home placement and significant mental health dual diagnosis, along with exceptionally complex preferred programs (medical care (01), autism (03) and behavior adjustment (06)) as “special conditions”. Consumer service coordination resource requirements for RCs will be weighted based on the mix of consumers and number of special conditions.

This budget methodology does not dictate that any individual consumer should be staffed at a specific level due to the presence of one or more special conditions, only that, **on average**, consumers with those conditions require resources at that level. A consumer with none of the identified special conditions may have complex and intense needs, while a consumer with multiple special conditions, who also has a strong circle of support, may have low needs for CSC resources.

DDS and the RCs should continue to monitor preferred program, other CDER variables, and data on other workload drivers to refine the most effective measures of CSC and other resource needs. The method should be refined on an ongoing basis.

The Majority of Difference in CSC Staffing Across RCs Reflect Real Operating Differences

Other attempts at adjustment and normalizing the case management resource utilization considered correlation to RC size (economies of scale), types of consumer (acuity), and urban or rural job markets, and costs of employment. None of this showed a consistent relationship to the net CSC hours per consumer. Interviews and forums held during the study process indicated that RCs in intense job markets (e.g., Los Angeles and San Jose) were perceived to have more difficulties in hiring and retaining CSC and other personnel, with an associated higher cost per CSC and a lower overall level of staffing.

The presence of seven Regional Centers in Los Angeles County provides a comparison population relatively free of variance in the surrounding job market, cost of living, etc. However, these seven RCs are as dissimilar in staffing levels, patterns and salary and wage rates as the 21 statewide RCs. Two of the seven are at or above the 75th percentile of statewide CSC staffing levels, while two others are at or below the 25th percentile.

The overall level of CSC services and associated outcomes do vary by environmental and internal factors. However, internal operating policies and effectiveness appear to be the most influential factors in setting the level of CSC and related staffing. The impact of these internal and external factors probably mitigates some of the variance in staffing to account for comparable outcomes. For example, extremes in overall RC size, geographic density and service patterns



Based on RC site visits, interviews, and group discussion in the forums and expert panels held with RCs, consumers, and vendors, we believe factors unique to individual RCs are extremely influential. One RC with staffing levels consistently at or above the 75th percentile achieves that through a created internal culture that tolerates below average compensation and sub-standard facilities while attaining positive staff morale, retention and performance. While admirable, it is inappropriate to replicate this intangible “best practice,” or to expect other RCs to produce the same quality at this budget level.

Another significant variation was in the actual role and task involvement of the CSC. The level of involvement of the CSC in service coordination varies, as discussed in Definitions, above. We observed variation not just based on the source of payment, or consumer and their natural supports but based by local RC policy or de facto practice. This contributes to variations in the CSC and RC roles that are cited by vendors as a source of confusion. Examples cited in forums, observed in our field work and from interviews include:

- ◆ Some RCs informally or formally delegate service coordination roles to vendors, especially for generic services for consumers in residential placement. For example, the residential provider is responsible for the consumer’s ongoing medical needs and for ensuring appropriate access to health care services. RC involvement has been, in the past, inconsistent and often reactive.²
- ◆ RC participation with and inclusion of service providers in service planning and consumer monitoring varies widely. Day program providers reported that there are RCs that do not recognize providers as qualified to offer observations on a consumer’s needs and behaviors and who are unresponsive to provider requests to directly monitor the consumer. Other RCs actively solicit input from day program providers as an ongoing process; there are those that support consumer intake solely by a passive information packet, and RCs where CSCs routinely attend consumer intakes to new programs.

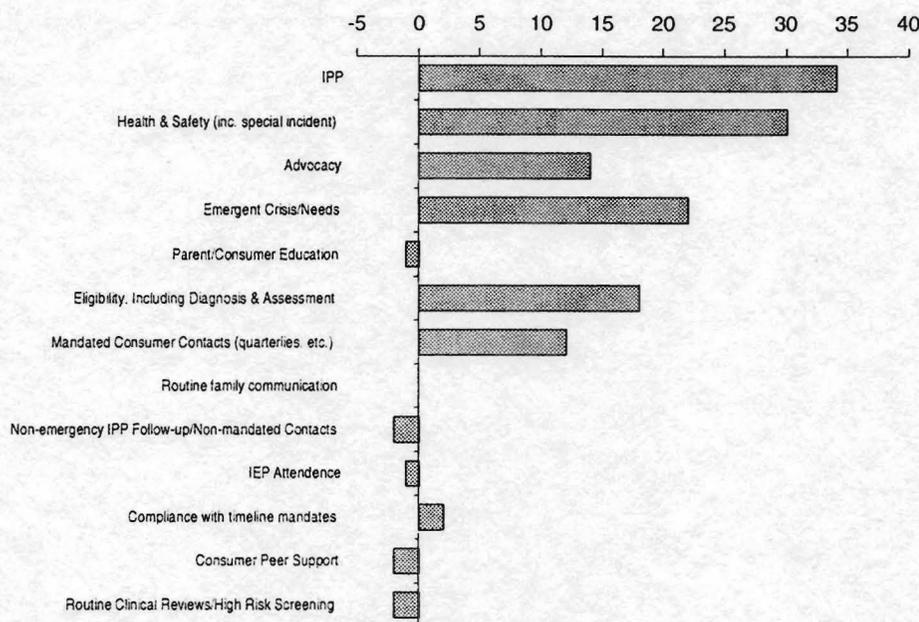
Substantive Gaps in CSC Services Exist for Some RCs That Are Associated with the Level of CSC Staffing

The Citygate Survey asked RC directors about key activities, as discussed above in B Regional Center Priorities. While subjective, responses illustrate some of the function differences among RCs in consumer service activities (**Table III-14**). The most frequently cited, but often deferred activity was family/consumer education. The other cluster of concern was around consumer and family contact. While mandated contacts (quarterlies, etc.) were usually performed, some respondents indicated these were sometimes impacted by resource constraints. Routine family communication and non-mandated consumer contacts were frequently cited as often deferred due to resource constraints.

² Lanterman Act changes from SB 1038 will require a more methodical monitoring and assessment of consumer medical services in the IPP process.

As discussed in the prior review of case management and consumer service coordination models, contact is the most critical tool to execute the function successfully, dictating the ability to monitor, reassess, and support consumers. Without effective monitoring, the IPP is merely a piece of paper, losing its value as a process. Consumer and family education and support are also critical, substantive elements to the mandated system. They are essential to meaningful choice, a keystone of the person-centered planning process, as well as intrinsic to a social model of case management that seeks to empower well-persons living in the community.

Table III-14: Consumer-Related Functions Cited As Priorities, by Weighted Score, Citygate Survey



The RC directors are aware of the need for these functional activities, as indicated in their response to survey questions on what their resource investment priorities were. Decreasing caseload among CSCs was the most frequently cited, followed by improved staff training and technology support to CSCs. The single most cited activity was increasing consumer contact.

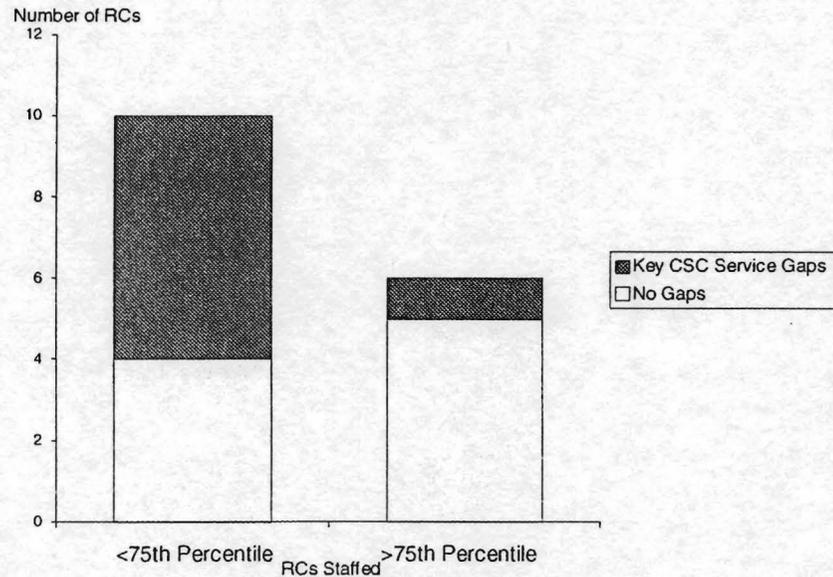
The gaps and resource priorities were correlated to the CSC staffing levels reported in the Citygate Survey (Table III-15). An important service gap (parent education) was reported by only one of six (17%) respondents staffed at the 75th percentile or above. Sixty percent of other respondents reported critical service gaps, including non-mandated consumer contact, timely or universal completion of IPPs and monitoring of IPP services. The 75th percentile was 32 hours per year per consumer, equivalent to an average caseload of 64 consumers per CSC (using the Citygate data and norm discussed previously). However, some RCs appear to be achieving comparable levels of performance with substantially lower staffing.

The perception and reporting of significant gaps in CSC services did not apply to all target populations. RC leadership consistently reported in forums, in expert panels and in field work that the 45:1 staffing levels used for State Developmental Center (SDC) discharges to community placement (so-called Coffelt consumers) was an effective level to address the more complex needs of most of these consumers. All indicated, however, that using Coffelt status to



determine staffing levels was arbitrary, since some Coffelt consumers are not especially complex and, increasingly, consumers with highly complex issues have never entered a SDC.

Table III-15: RCs Reporting Key CSC Service Gaps, By CSC Staffing Percentile, Citygate Survey, 1997-98



4. Actual RC CSC Staffing Is Below Needed Levels on Average, and Support for CSCs is Needed

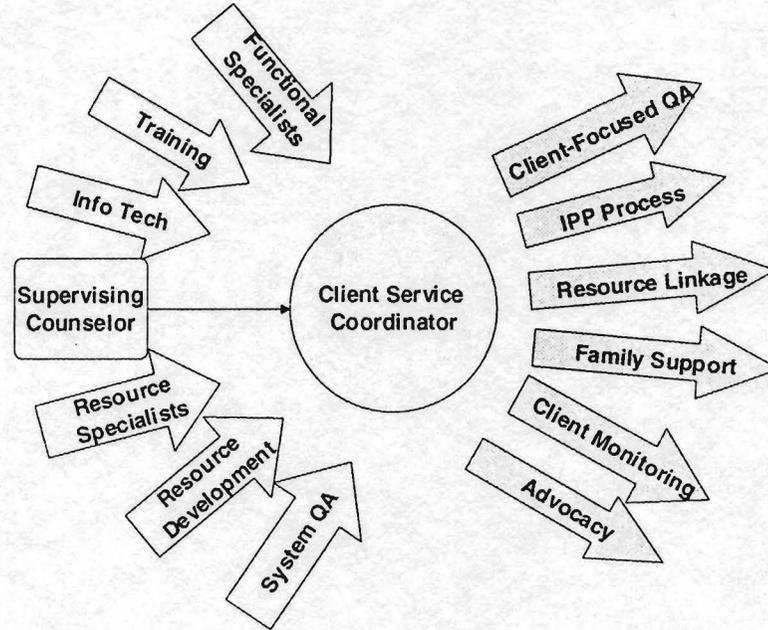
The findings from other case studies and the California RC experience as reported to Citygate via field work, forums and the survey support a hypothesis that for moderate to high risk consumers, 45:1 is reasonable standard. Overall ratios at or below 62:1 (actual paid hours of CSC time, not a threshold level) appear to provide a *minimum* safety net operation for consumer service coordination. Detailed workload assumptions and functional validation of recommended staffing levels by task by consumer type are provided in Chapter IV.

The CSC in the California system is predominately non-licensed. The RC as a team performs the broader case manager function, since some elements of the role require more sophisticated skills and expertise. This requires CSC collaboration with dedicated specialists as well as other RC operations. Therefore defining and maintaining CSC staffing ratios in isolation is not a meaningful indicator of the adequacy of overall case management, unless those positions are staffed and budgeted by a multidisciplinary, professional workforce, such as, social workers, nurses, psychologists and developmental specialists. **Table III-16** below provides a conceptual model of the supportive resources (inputs) to the CSC that are essential to creating the consumer service indicated to the right of the figure.

California is pursuing demonstration projects in self-determination in Tri-Counties, Eastern Los Angeles and Redwood Coast RCs. The California models may include flexible payments, non-traditional service provision, alternative case management models, and individual budgeting. Case

management alternatives may include the consumer, family, legal guardian or conservator arranging for needed services or hiring a service coordinator independent of the RC.

Table III-16: Collaborative Resource Model for Consumer Service Coordination



E. COMMUNITY SERVICES

The seventeen RCs providing detailed vendor data in the Citygate survey averaged 3,700 vendors each. A significant number of these (one-third to one-half) are individual consumer families receiving voucher payments. **Table III-17** below presents the range of vendor numbers for key categories, including Community Care Facilities Level 2-4 (CCF), skilled and intermediate care, intermediate care facilities for DD persons (SNF/ICF/DD), day programs and supportive and independent living contractors (SL/IL).

Table III-17: Vendor Volumes, Citygate Survey, 1997-98

	Level 2-4 Community Care Facility	Skilled Nursing/ Intermediate Care ¹	Day Programs	Supportive/ Independent Living
Maximum	396	180	100	65
Average	191	52	51	15
Minimum	49	11	21	12

¹Not defined as POS vendors, generally paid through MediCal

The range of staff hours for community services per consumer varied greatly, as did the program content and activities.



Table III-18: Paid Community Service Hours per CMF Consumer, Citygate Survey, 1997-98

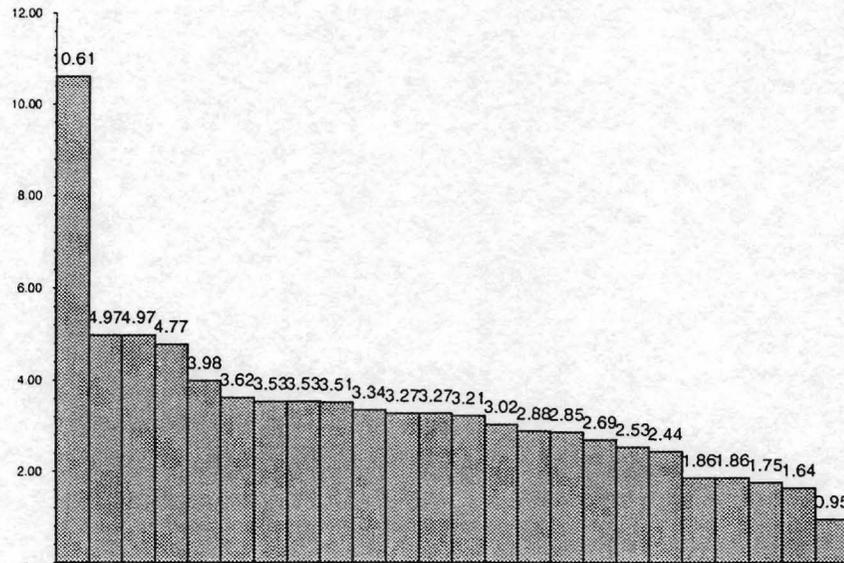


Table III-19: Quartile Values of Community Services/Vendor Relations Paid Hours per Active and Early Start Consumer, 1997-98

Quartile	Annual Community Services/Vendor Relations Paid Hours per Active and Early Start Consumer	Community Services/Vendor Relations Paid Hours Consumer Trimmed to Internal Mean
Maximum	10.61	4.97
75 th Percentile	3.57	3.51
50 th Percentile	3.02	3.02
25 th Percentile	2.48	2.53
Minimum	0.95	1.64

In an attempt to refine the interpretation of community services staffing, we segregated staff functionally based on survey data, position descriptions and staffing reports, including allocation of partial FTEs as appropriate. Facility liaison functions are discussed separately and *not included in the hours and resources cited*, since almost all RCs used CSCs to perform that function at the time of the survey.

1. Quality Assurance

Vendor quality assurance and technical assistance staff were approximately one-third of community service resources for all RCs, averaging about three FTEs per RC.

Extreme ranges of staffing for vendor quality assurance (QA), as well as in specific job content, were reported in the Citygate survey, and confirmed in site visits and forums. Technical assistance (TA) to vendors is included with this area since RCs vary in their approach to vendor

quality between the use of formal process (QA) and less formal coaching and training (TA), and all use some combination of the two in evaluating and monitoring plans of corrective action for vendors. RCs ranged from a low of one FTE to a high of 13 in QA/TA roles. There is a degree of overlap with resource development roles in many RCs, since technical assistance is provided in the beginning phases of resource development as well as through quality assurance, and personnel were allocated between the two functions based on survey data, as appropriate.

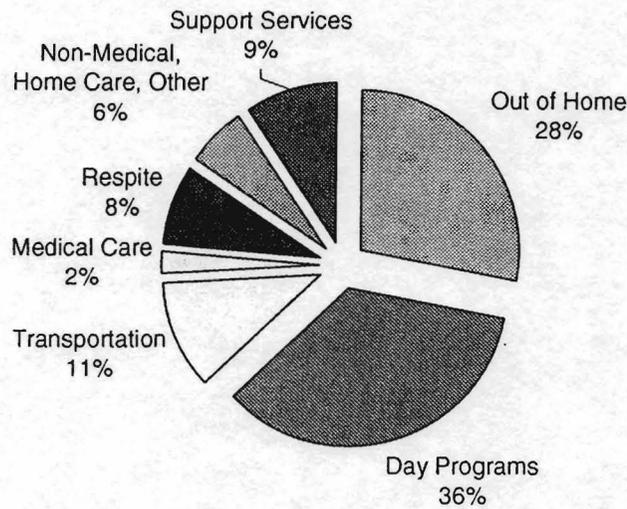
Several RCs have only one to two staff responsible for all quality assurance for all vendors. In interviews, and in the survey, these professionals describe their primary function as consulting and training for CSCs to be effective in facility liaison roles and providing support on monitoring plans of correction in response to problems. RCs at this staffing level indicated severe challenges in conducting the required proactive reviews of RCFs once every three years, and gaps in following up on corrective action plans and in technical assistance to vendors to enhance service quality.

In contrast, other RCs have a structured plan for proactive cycles of quality assurance visitation to all major categories of vendors, including RCFs, day programs, transportation vendors and SL/ILS. Some conduct fiscal audits of vendor personnel and other data to ensure staffing and service levels conform to contract. One RC collects for overpayments when the actual staffing provided is lower than contract.

The nature of the RC-vendor relationship, ranging from collaborative (technical assistance) to more arms length and regulatory (fiscal audits, for example), is partially a function of local market conditions. Some RCs, including those with relatively low local costs of land and personnel, have more than sufficient local applicants for vendors in many key areas of service. Without availability pressures, these RCs may appropriately stress superior quality outcomes without adversely affecting consumers' access to needed supports and services. Other RCs, especially in urban, high cost areas, have much less choice in vendors and may be more actively focused on recruiting, developing, and retaining qualified programs.

However, the extremes of levels of service across the RCs have a substantive difference outside of the local nature of the vendor relationship. RC POS, as discussed in Chapter II, is the majority of the RC total appropriation and expenditure, totaling \$900 million in 1997-98. **Table III-20** breaks expenditures down by programmatic area.

Table III-20: POS Expenditures, California Regional Centers 1997-98, by Program Area



A detailed mandate for RCF quality assurance exists, although they account for only 28% of total expenditures. As detailed in the Citygate survey, a quarter of the Regional Centers (26%) provide proactive quality assurance (scheduled inspections with a standardized review as opposed to responding to problems and complaints) to RCF vendors. Another 20% have proactive QA programs for RCFs and one other service (either SNF/ICF, transportation or day programs.) Just over half (53%) of RCs have structured policies for proactive quality assurance in RCF, day programs, and supportive living/independent living (SL/IL). Infant care programs are quality assured by a few RCs, and only one includes transportation providers on a focused basis. Within programs with a comparable vendor scope, substantial variance exists in the frequency and depth of the QA program. Virtually all RCs indicated that the level of follow-up after inspection and plans of correction was a significant service gap.

Prudent practice in managing state expenditures would dictate a minimal level of quality assurance focusing on contract compliance, and gross indicators of level of service and volume of services provided. The Bureau of State Audits identified gaps in this area last year. The federal Health Care Financing Administration (HCFA) also is requiring fiscal review of vendors as part of the Medicaid Waiver. Proactive quality assurance should encompass any vendor providing consumer services under RC contract in order to protect consumers and deliver on what has been described as the promise of case management in oversight (Netting, 1992).

Table III-21: Scope of Proactive Quality Assurance Reviews

Level of Service	Respondents 1997-98
RCF Only	26%
RCF and Transportation Only	5%
RCF, SNF and ICF Only	5%
RCF and Day Programs	10%
RCF, Day, SL and IL	53%

Table III-22: Quality Assurance Staffing as a Ratio of Vendor or POS Volumes, Citygate Survey, 1997-98

Quartile	RCF Vendors to QA/TA Staffing	Residential and Day Program Vendors to QA/TA Staffing
Maximum	240	144
75 th Percentile	60	35
50 th Percentile	42	23
25 th Percentile	11	7
Minimum	0	0

The CSC Should Not Be Solely Responsible for Facility Liaison Quality Assurance

The facility liaison role specified in the mandate is responsible for coordinating all services and monitoring consumers at a single RCF vendor. This provides a single point of contact for the vendor, and increases efficiency for the CSC responsible for those residents. All but one RC had CSCs as the primary facility liaison in our survey period. Regulation has expanded the facility liaison role to include specific, proactive quality assurance, including inspection, assessment of compliance with regulation, interagency reporting and developing and monitoring compliance plans.

The CSC has primary responsibility, as discussed previously, for consumer-focused quality assurance. We define this as specific monitoring and evaluation of the consumer, their situation, their IPP implementation and the services provided. This individualized approach is consistent with person-centered planning. An appropriate role of the CSC is to facilitate resolution between the vendor and consumer on minor issues and problems, and to resort to formal process (special incident reporting, etc.) when required for quality services or consumer safety. This quality assurance role for CSCs requires an awareness of regulation, consumer rights, and a constant vigilance for both explicit and subtle indicators of consumer status and service quality as experienced by that individual consumer.

Systematized Vendor Quality Assurance is Distinct from CSCs and Critical to Quality Case Management

Systemic quality assurance overlaps with consumer-focused quality assurance, but is different and requires different skills. Vendor QA should focus on management and operational process, considering the individual experiences of consumers as clues to the effectiveness and appropriateness of the vendor's systems. It should seek systemic changes that provide long-term continuous improvement, rather than case-by-case resolution. Special incidents are looked at to provide



indications of what system failures may have occurred, and how the system should be changed to prevent the problem, or provide for quicker intervention. This focus on patterns and systems is appropriately different from consumer-focused quality assurance where the specific incident, in and of itself, is preeminent and the short term resolution is pursued regardless of systemic needs.

Systemic vendor QA requires broad, technical expertise, a specific interest and personality in the staff person, and a different set of skills than consumer service coordination, including more sophisticated process and management skills. We believe that while the CSC should collaborate and contribute to vendor QA, it is inappropriate to add it as a structured accountability to the CSC position. QA staff under community service/vendor relations should perform vendor-oriented quality assurance. A commitment to system-wide QA as a function supplementing CSCs' consumer-focused QA is essential to meet the RC's total case management responsibilities, and to protect and promote consumers' safety and health. Vendor QA is intrinsic to advocacy and protection of consumers' rights. Systematic tracking of special incidence reporting and findings from the Life Quality Assessments (LQA) to identify patterns and integrate with vendor education and corrective action plans should be a key element that links consumer-focused QA to vendor-focused QA.

QA for vendors should consider both continuous improvement process models and regulatory compliance. Furthermore, we believe adequate QA resources should be available to provide technical, contract and fiscal review to all third-party POS service providers. This includes day, transportation, independent and supportive living and infant development, as well as cooperating with the Department of Health Services in QA for SNF and ICF settings serving individuals with developmental disabilities. Fiscal monitoring should include responsibility for parent vendors to ensure compliance with law and regulation. Since the number and type of vendor vary by RC and by complexity of consumer needs, we propose modeling resources for this function as linked to the number of vendors in these categories by RC.

2. Resource Development/ Resource Specialists

Resource Development staff accounted for one-quarter of community services staff and resource coordinators/specialists for about 15 percent. In our survey, resource development staff tended to be a higher paid position, with responsibilities for setting program standards, negotiating contracts with new vendors, coordinating specific services such as transportation, residential placement, etc. Resource coordinators and specialists were, on average, a lower paid position, including paraprofessional community liaisons and drivers for transportation services, with a more focused position responsibility and less requirement for judgement and discretionary decisions. RCs averaged two FTEs in resource development (ranging from one to 6.5 FTEs) and 1.5 in resource coordination (from one to 4 FTEs). RCs in the top 25% of staffing (75th percentile) reported two paid hours per consumer, or a ratio of one resource developer per 1000 consumers.

Resource Development, as cited in Chapter II's discussion of the IPP process and the CSC role review in this Chapter, is an essential part of the overall RC function of case management. Like system QA, the skills required for resource development are more complex than the non-licensed level required for the typical CSC position. These include organizational skills, facilitation, negotiation, program and regulatory knowledge, public speaking, and other

social system capabilities. Resource development should also include quantitative and qualitative planning and needs assessments.

The maturity of local service systems was frequently cited in forums and site visits as a variable in resource development needs, as was independent and supportive living. In short, this referred to the variance in service available between urban areas with sophisticated social services systems and diverse community opportunities for persons with developmental disabilities, and smaller communities with fewer service options. Resource development was seen as more difficult and requiring more focused effort to access even basic supports and services in these less mature markets.

The overall movement towards individualized services and supports was another important factor. As discussed in CSC Models, above, consumers increasingly are living independently or in supported situations on their own. Supported employment in the community is also increasing. Both of these are “custom-built” opportunities that are identified and developed one by one for individual needs. They require broad networking and community relationship skills, facilitation, and other social service capabilities.

Resource development in some areas and services still needed “slots”— the development of comprehensive service programs focusing on one segment or one particular need of persons with developmental disabilities. The diversity of resource availability and needs between different RC service areas is profound, and one of the best reflections of the need to tailor services and programs to local conditions. Services that exist in abundance in one market are scarce and widely sought in another, for a number of reasons, making state standardization inappropriate.

Based on the Citygate forums, field work, and survey, consumer service needs (and associated system resource development requirements) vary directly with the volume of consumer needs. Like QA, resource development staffing should be at a higher skill level than CSC, and is required to complete the case management team within the RC. It should be budgeted in a link to total consumer needs.

3. Advocacy and Outreach

This function includes what has formally been designated the Consumer Rights Advocate (CRA). This position has been contracted to Protection & Advocacy. However, most RCs used the CRA’s expertise in consumer rights for internal, vendor, consumer and family education, for assistance in special incident reviews, and in vendor quality assurance. Some, using a high level of legal training for that position, also used that role in assisting with court processes including In re: Hop, custodial, and forensic cases. These education, advocacy and forensic roles were not eliminated with the CRA contracting, and most RCs include one or more positions for these functions.

Other positions in this area include public information and affairs staff, community outreach, and ethnic constituency specialists. RCs ranged from one to four FTEs for this function.

F. SUPPORT SERVICES: CLINICAL SPECIALISTS

Actual staffing levels of clinical professionals in RCs, as reported in the Citygate Survey, was substantially below the Core Staffing Formula, even when excluding the clinical team supplemental appropriation, and including contract personnel. The use of POS funds for intake assessments also complicates developing a complete picture of clinical resources available for RC operational support. Nurses used for ongoing case management are reported with consumer service coordination staffing, and excluded from the exhibit below.

Table III-23 Clinical Staffing, Citygate Survey and Core Staffing Formula, 1997-98

1997-98 Position	Survey FTEs ¹	Core Staffing FTEs ²	Survey Average Salary & Wage	Core Staffing Wage Rate
Physician	18	94	\$43.17	\$38.11
Psychologist	42	167	\$24.64	\$20.07
Nurse Specialist	64	115	\$18.22	\$17.87
Nutritionist	7	73	\$17.81	\$13.52

1) Nineteen respondents extrapolated to 21 RCs, reflects impact of unallocated reduction

2) Prior to impact of \$47 million in unallocated reductions

The variance in clinical resources across RCs was profound. Two RCs have maintained extensive clinical consulting staff in-house, including several physicians and psychologists, genetics and nutritional consultants. Several RCs had more extensive psychological support services in-house, including behavioral intervention programs or consultation to CSCs. Others had virtually no in-house staff, or less than three FTEs. In response to these gaps, the 1997-98 state budget added 21 clinical teams, supplemented with 14 more in the 1998-99 budget.

The intake process for new clients requires development of a definitive diagnosis (if over 36 months of age) or risk for developing developmental disabilities (if under 36 months old). While many new consumers have recent clinical assessments performed by community physicians, the RC must obtain, review and interpret those findings. For others, no current information is available, and the RC may directly assess the consumer's needs. Physicians and psychologists are the clinicians most actively involved with intake. Resources are budgeted for physicians and psychologists for each assessment.

Clinical monitoring is more complex, and needs to be proactive whenever possible to reduce risk. Risk is defined more broadly than just at risk for institutionalization, but encompasses any risk for deterioration in physical, mental, or social status. The RCs are barred from providing direct services, including ongoing health care. They serve as the payor of last resort, with POS funds purchasing health care services when all other options are exhausted. However, access to needed services is limited in some areas.

Shortages exist in some areas for specialty physicians in neurology, psychiatry, etc. More commonly, the consumer has difficulty finding a primary care physician with the skills and willingness to accommodate the consumer's special needs in addition to their health care needs. Dental care is often hard to find. The RC clinician may work directly with community providers to increase acceptance of consumers, to provide education about clinical and social needs and to

facilitate collaboration and continuity of care. This work may be generic, or to aid an individual consumer meet their personal health care needs.

RCs are required (as of 1998-99) to provide a general health assessment to each consumer at the time of his or her IPP to ensure he or she has access to needed health services, that chronic conditions are being appropriately managed, and that services are effectively coordinated. Where appropriate, this includes a review of prescriptions. For example, Citygate's prior study found significant numbers of Coffelt consumers on psychotropic medications without a current psychological consultation on file.

To precisely estimate the local level of clinical need we recommend using the consumer mix by preferred program along with the number of consumers having significant mental health dual diagnosis, who are Medicaid waiver eligible or Early Start to target staffing for physicians, psychologists, nurses, nutritionists and pharmacists. The specific mix of targeted consumers will vary by clinical specialty. In addition, an overall level of clinical monitoring is budgeted for non-targeted consumers, including the IPP process element of health status monitoring.

This budget methodology does not dictate that any individual consumer should receive focused clinical monitoring due to the presence of one or more special conditions, only that, **on average**, consumers with those conditions are most likely to require those resources. A consumer with none of the identified special conditions may have significant clinical risks, while a client with multiple special conditions may be stable and in good health.

DDS and the RCs should continue to monitor preferred program and other CDER variables to refine the most effective predictors of clinical risk and resource needs. The method should be refined on an ongoing basis.

G. INTERNAL OPERATIONS

The Regional Centers are community-based, not-for-profit organizations. As such, they have a set of professional practice and management standards distinct from governmental or private, for-profit industry. Yet they are dependent on the state for their primary purpose and the vast majority of their funding, and exercise a substantial authority and budget delegated by the state through contract.

1. Governance

The governance function is critical to any organization, but especially important to the RC model. The state's mandate for the RC board is more intrusive than for a typical community not-for-profit, consistent with the high degree of delegated authority the RC holds for implementing a key state program. Board composition is required to be at least 25% consumers, and 50% consumers and families. Composition shall also reflect the types of disabilities served by the RC, and the geographic and ethnic characteristics of the area served. Provider representation is also called for, along with individuals with legal, management, public relations, and developmental disability program skills (w& 4622).

The desire to anchor the board with consumer and family perspectives is consistent with the intent of the Lanterman Act to use RCs as a mechanism to create a more locally accountable and responsive system than would be possible through a state-operated agency. It also imposes a challenge to empower and educate the board participants to make their roles meaningful and contributory. This challenge faces all volunteer boards, where a wide range of motivations and expertise may be represented. The diversity of perspectives is the essential asset that can make community boards a powerful tool for both local control and fiduciary operations. However, it requires a comprehensive, structured approach to board development, education, and process facilitation.

The board's role is to establish strategic direction, goals and policies consistent with those strategies, and monitor the implementation and progress of the organization. The executive director is the board's agent in managing the day-to-day operations of the organization, and serves at the pleasure of the board. Effective examples of board roles also include advocacy, community leadership and facilitation, and complaint and problem resolution. Other key functions are directing the annual independent financial audit, and the performance review of the executive director. Specific additional requirements for RC boards are taking public input on the RC's performance contract objectives and conducting final negotiations on the RC contract with DDS (W&I 4622, 4629, 4634, 4639).

RCs responding to Citygate's Survey reported an average of 10 board meetings per year. These are required to be formal open meetings, with notice, comment and recording procedures, and may extend to three or more hours, with preparation time typically three to four times as long. The executive director, executive secretary, and other lead management members (operations, fiscal and consumer services) typically attend.

The survey respondents also had an average of six board subcommittees, meeting an average of seven times a year, for 42 additional meetings, usually attended by the executive director and secretary, as well as relevant management team members. Almost all RCs reported an executive committee of the board. Common subcommittees included strategic planning, personnel/nominating, legislative affairs, administration/fiscal, and a wide range of other programmatic areas such as consumer services. Some RCs reported formal retreats or training opportunities, typically held twice a year.

Board support and attendance is a primary job function of the executive director. Administrative support is typically the responsibility of the executive assistant or secretary, and could easily account for a quarter to half of a full-time administrative position.

2. Information Systems

The level and effectiveness of, and investment in, automation vary substantially across the RCs. However, the RCs are currently collaborating in a system-wide strategic information systems plan. Capital policies of the state and contracting process complicate this issue. Standard business practice is to budget and accrue funds for periodic expenses such as information systems across several years (at least three). However, RCs can neither accrue funds across several years, nor book assets. This makes major upgrades or investments difficult, resulting in incremental, piecemeal approaches. Investment in information technology in the three years ended 6/30/98 by the RCs ranged

from \$185,000 to \$1.5 million. Per employee (FTE) the investment range was still substantial, from \$885 to \$7,500, and averaged \$2,600.

Many RCs use laptops for CSCs to support ongoing documentation needs for consumer service, appropriate to the mobile nature of the job and conducive to increased field work without adversely affecting need for a complete record. At the other extreme is an RC where CSCs have to share desktop computers. The availability of computers per employee (FTE) ranged from 0.77 to 1.91, and averages 1.12. The effectiveness of the available resources varies, and significant software support appears to be an opportunity for both improved documentation and productivity. (See the discussion of SANDIS, below.)

The State's Uniform Financial System (UFS) is a mandated integrated system that appears to work effectively for tracking and reporting POS data. However, the UFS for operations is not used consistently, nor are the data accessible or usable. Citygate staff spent an extraordinary level of effort working with DDS and RC staff in trying to use the UFS operational data to develop comparative information. While all RCs report to this system, no standardized chart of accounts or departmental classification is used.

Staffing for information systems (IS) operation support is incomplete. IS support was not defined in the original Core Staffing Formula, and has been added through supplemental appropriation. The 20 RCs providing detailed staffing information to the Citygate Survey reported the following information systems support staff for 1997-98. Total wages for the three itemized positions in the survey was \$1.4 million.

Table III-24 Information Systems Staffing, Citygate Survey, 1997-98

Surveyed Position	FTEs	Average Salary & Wage
Information Systems Manager	17	\$22.23
Network Manager	10	\$18.57
Information Systems Assistant/Computer Support Technician	19	\$13.19

Employee training in the use of hardware and software is equally important to the asset value of information systems. Increased recognition of the need for continuous reinvestment in computer software, training and support has been a key theme in information management. Almost all RCs report relatively low levels of training and support, compared to other service industries.

SANDIS

SANDIS was developed as an integrated case management and information and referral system. It runs on an AS400 system, the most common platform in the RC/DDS environment, and uses the RPG4 programming language. SANDIS maximizes flexibility through the use of a system-wide table of codes that allows modification without reprogramming. The system can also be installed in independent modules and now offers a more user friendly graphical interface for use in a Windows® environment via TCP/IP or other connection protocols. It has a number of built-in queries and reports and new queries can be developed by knowledgeable information systems staff. In

addition, SANDIS uses bridge programs to allow it to exchange data with UFS, CMF, CDER and other systems in the RC/DDS environment.

SANDIS is used by some RCs to assist case managers and other staff in one or more of the following areas:

◆ Resources

SANDIS stores and tracks information on providers including insurance, licensing, staff training requirements, special incident reports, quality assurance schedules and program reviews. Non-vendored services can be added to the data base as well. The matching program is a searchable data base using flexible criteria such as geographic area, service provided, and funding accepted.

◆ Consumers

SANDIS gathers and assists in tracking consumer information as well as scheduling annual reviews and referrals to specialists. Demographic, benefit and waiver, service history (including incident reports), and assessment information is stored. Information on health providers, medications, and assessments is also kept. SANDIS integrates the completion of the DDS CMF and CDER.

◆ Purchase of Service and Transportation

Service requests and histories are tracked and include funding source information. Requests entered can be printed as a form for approval.

◆ Reports and Tracking

SANDIS offers a variety of management information reports and report reminders. Annual reviews are automated. Consumer services and placement histories can be reported by consumer or in summary reports. Caseload and agency-wide statistics are available with breakouts according to a variety of criteria. Special incident reports may be tracked by consumer, vendor, or type of incident. SANDIS also tracks resource quality assurance and correction plans, training, vacancies, and automatically develops needs assessment reports.

Over time, the SANDIS program has been adapted to fit changing needs and other organizations, with a number of custom adaptations. San Diego information systems personnel are currently working on integrating Title XIX notetaking capabilities, developing applications to view vendor information via a consumer file, and to enable UFS service authorizations through the SANDIS program.

SANDIS appears to be the most successful attempt at significantly automating a large number of the RCs' tasks. RCs should use it or a comparable resource to move toward an automated, integrated system that includes automation of routine consumer documentation and a tickler system of prompts for meeting consumer service schedules.

3. Management Infrastructure and Clerical Support

The RCs generally reported a more complex management structure than provided for in the original Core Staffing Formula. Seventeen (of nineteen respondents) reported a human resources director with an average wage of \$23.32 per hour, a position not in the original Core Staffing Formula but added through supplemental appropriation. Other positions provided for in Core Staffing are at a significantly higher wage level than the positions identified as equivalent in the survey. Lower level positions, specifically clerical, are staffed in the Core Staffing Formula at triple the actual practice in the RCs, before the impact of the unallocated reduction. **Table III-25** below summarizes administrative staffing per the Citygate Survey compared to Core Staffing assumptions. Note that **all clerical** staffing for the RC are reported in the administrative function. The majority of these resources are integral to direct consumer service and include support for intake and consumer service coordination.

Table III-25 Executive Staffing, Citygate Survey, 1997-98

Position	Survey FTEs ¹	Core Staffing FTEs ²	Survey Average Salary & Wage	Core Staffing Wage Rate
Executive Director	21	21	\$44.42	\$29.30
Director, Administrative Services	20	21	\$34.25	\$23.11
Office Administrator/ Operations Manager	27	21	\$19.15	\$11.21
Administrative Assistant/ Executive Secretary	62	52	\$16.37	\$10.52
Secretary	361	1000	\$11.10	\$9.77
Clerk	131	63	\$10.20	\$10.52

1) Nineteen respondents extrapolated to 21 RCs

2) Prior to impact of \$47 million in unallocated reductions

The low level of two types of resources was notable. Only six RCs reported a director of internal training and development, although many RCs identified the need for staff development as critical. Comments at Citygate forums, site visits, and expert panels, as well as consumer and vendor forums, were consistent about the need for staff education. CSC new hires, in particular, were identified as having little or no direct field experience and limited pertinent training regarding persons with developmental disabilities. Functional knowledge, regulatory, policy and procedure training, and RC-specific information on resources, systems and infrastructure available for consumers needs are all needed by the CSC. In addition, as mentioned above, the capital expenditure on information systems is of limited value unless matched by investment in staff training for continued software skill development.

The professional, systematic maintenance of consumer records was also a low staffing priority. Only a few RCs identified consumer record management as a discrete function or with specific support. This is distinct from simply using clerical staff to file paperwork by consumer. Social services has no professional tradition of standardized documentation comparable to clinical services. Documentation standards for clinical programs are designed to support transfers of patient accountability across shifts in a seven-day a week, 24-hour a day format, and across practitioners in a fragmented specialized system. There is a medical records profession and consistent standards for



each member of the clinical team. While this clinical standard may exceed what is needed in social services, there are some beneficial lessons. Specifically, as cited in the research by Project Continuity, discussed in Consumer Service Coordination, above, the consistent use of interdisciplinary notes and contact reports, combined with team meetings appeared to significantly reduce the amount of time case managers spent in exchange of information functions.

Citygate Associates' prior study on community placement reviewed almost 1,000 consumer records of the most complex consumers, those placed in the community from a State Developmental Center (SDC) or residing in a SDC. We found that RC documentation in consumers' files was inadequate for ongoing consumer monitoring and evaluation. Frequently, there was no information on medical care, current physician or psychological consultations, etc. since the consumer's SDC discharge records. We also found that some RCs, and some residential care providers, had outstanding, highly automated documentation. The Health Care Financing Administration (HCFA) review of DDS' Medicaid Waiver was also very critical of documentation.

CSCs expressed concern in the course of this study that documentation, especially for Medicaid waiver cases, was an 'end unto itself' without specific benefit to consumers. However, the high level of turnover in CSC positions alone would support enhanced standards of documentation to ensure a consistent record is available. This would also make staffing more flexible when documentation on issues is readily available to staff aside from the CSC in the event of absence, etc.

H. FISCAL ADMINISTRATION

1. Vendor

RCs responding to the Citygate Survey averaged 2,300 checks monthly to vendors for services purchased on behalf of RC consumers. The number of vendors in key programs was presented in **Table III-22**, above. In addition, a large number of transportation vendors are often used, along with voucher checks to families for in-home respite and other direct supports. Frequency of payment (a direct workload driver for fiscal staff) varied significantly, from bimonthly to weekly.

Table III-26 Frequency of POS Checks, Citygate Survey, 1997-98

Frequency of POS Checks	Percent of Responding RCs
Monthly	37%
Twice a Month	32%
Three Times a Month	21%
Weekly	11%

RC reported staffing per vendor at the following levels:

Percentile	Vendors per FTE
100%	130
75%	261
50%	297
25%	336
0%	1,342

Fiscal staffing was a significant portion of RC operational budgets based on the Citygate Survey. It was, like overall management and administration (below), more sophisticated and at a higher functional level and wage than provided for in the Core Staffing Formula.

Table III-27 Fiscal Staffing, Citygate Survey, 1997-98

Position	Survey FTEs ¹	Core Staffing FTEs ²	Survey Average Salary & Wage	Core Staffing Wage Rate
Controller/Accounting Director	21	21	\$26.48	\$22.06
Accounting/Fiscal Supervisor	23	None	\$19.66	NA
Accountant II/Bookkeeper	65	None	\$13.18	NA
Accountant I/Accounting Clerk	64	49	\$11.73	\$9.91
Associate Accountant	54	243	\$13.93	\$8.84

1) Nineteen respondents extrapolated to 21 RCs

2) Prior to impact of \$47 million in unallocated reductions

2. Consumer Custodial Funds

Sixteen RCs provided detailed data on representative payee and money management functions. They served 1,200 consumers each, on average, as representative payee with three FTEs and an average wage of \$15.02 per hour. Staffing levels per participating consumer were fairly consistent, ranging from 315 to 490 with an average of 354 consumers per FTE.

Representative payee functions, adjusted for contract personnel, averaged 305 cases per FTE for 1997-98 survey respondents, with an average wage of \$13.74 per hour. The variance in workload was large, from 156 cases to 550 cases per FTE. The cluster around 300 cases per FTE was very strong, however, with an average wage of \$14.28. Forty-six percent of respondents were within 6% of 300, and only three were below that. Five others were higher, with three exceeding 400. RCs in the 300 range included those with satisfactory levels of service as observed in fieldwork.

Percentile	Caseload per FTE
100%	156
75%	283
50%	305
25%	349
0%	550

We recommend budgeting representative payee functions at the variable rate of 300 cases per FTE.

Approximately half of RCs actively participate in consumer money management functions, although the degree varies. RCs with active money management roles reported from 300 to 800 consumers participating, at a staffing rate of approximately 300 to 500 consumers per FTE. Some RCs use POS funds for this role.

For one RC with an exceptionally large program, ten FTEs were responsible for representative payee and money management roles, and checks cut on consumers' behalf through these programs was one-third of the RC's total monthly payments. This compares to RCs who minimize this role, preferring RCF vendors or other supports to the consumer to assume that role for the consumer.

Consistent with mandate definitions, the Citygate budget model will include funding for representative payee functions, but **not** for money management.

IV. REGIONAL CENTER OPERATING BUDGET MODEL

The primary purpose of this project is to develop a model for the Department of Developmental Services' (DDS) appropriations for the Regional Centers' operating budget. This statewide number is currently developed using the 20 year old Core Staffing Formula as adjusted in the DDS budget package. The appropriation is the first of a two step process that yields a Regional Center's annual operating contract. The second step, the allocation process, begins with the Core Staffing Formula, and then modifies this extensively. The model presented by Citygate is our recommended replacement to the Core Staffing Formula, reflecting the analyses detailed in prior chapters.

The Citygate model is a dual product: a software tool for ongoing analysis and planning, and a specific scenario for resource and cost. The model's software uses utilization, resource requirement, and unit cost relationships to produce individual and summary expenditure and staffing estimates for Regional Center (RC) operations. It can be used to evaluate scenarios and choices, with a readily adjusted set of assumptions that drive specific expenditure and staffing calculations.

The base Operating Budget Model (OBM) presented below provides Citygate's recommendations as to the most appropriate set of assumptions, given the roles, functions, and services described in prior sections. These assumptions can be readily modified and refined over time, and ongoing monitoring and updating of the model is built-in. Chapter V presents the results of the model using the recommended assumptions detailed below, as well as a sensitivity analysis of the impact of changes in key assumptions.

The recommended Regional Center operating budget model is designed to:

- ◆ Promote equity and statewide consistency in service levels provided to consumers;
- ◆ Provide flexibility to meet changing conditions;
- ◆ Better match the realities of Regional Center operations;
- ◆ Reflect the unique conditions in each Regional Center service area; and,
- ◆ Provide a means of measuring the efficiency of Regional Center operations through improved correspondence between the budgeting method and actual operations.

In reviewing the proposed model, the inherent trade-offs between simplicity and accuracy must be kept in mind. In order to meet the needs and expectations of the interested stakeholders, the model, as presented, is a detailed build-up, including numerous earmarked positions. This may hamper the ability of the model to "age gracefully," since changing circumstances and roles will make these specifics obsolete over time. Other variables, especially the fundamentals, will keep pace with changes in the size and mix of consumers served by the RCs. However, the tradeoff for enhanced feasibility for implementation outweighed the value of long-term flexibility, resulting in the model's level of detail.

The model was designed around the mandated functions of Regional Centers outlined in Chapter II. If there are major changes in function or role, the model may need to be revisited.

However, the model is sufficiently robust to accommodate legislative or regulatory fine-tuning of existing functions when updated routinely as described.

A. OPERATING BUDGET MODEL

The budget model is structured into four components:

1. **Mandated Services**, which include:
 - Eligibility assessment;
 - Consumer service coordination (CSC);
 - Community services, including communications and customer service;
 - Clinical support services;
 - Fiscal administration (of vendor and consumer custodial payments).
2. **Support Functions**, which include:
 - Executive/Administrative personnel;
 - Human Resources;
 - Internal Finance;
 - Information Systems Support;
 - Consumer Records Management;
 - Communications and Logistics.
3. **Non-Personnel Costs**, which include:
 - Facilities;
 - Governance Development and Facilitation;
 - All other administrative costs.
4. **Special Case Add-ons**, which include:
 - Items applicable to only certain RCs, e.g., Foster Grandparents;
 - Items contracted via RC budgets statewide, e.g., the Life Quality Assessments.

The budget for each of these components is driven by one or more variables that, in general, capture the common factors that create variance among RCs, such as caseload volume, consumer characteristics, the number and type of vendors, etc. In the majority of areas, this model successfully quantifies common relationship factors, usually with a specific function that effectively reflects the needs of individual RCs and budgets each RC accurately, as well as creates a statewide-summary for appropriation.

The significant exception to this is the area of “other administrative costs.” These non-personnel costs did not show a consistent pattern around any underlying workload variable (consumers, employees, area, etc.) or RC characteristic (rural, urban, large, small, etc.). The measure with the least internal variance (standard deviation around an average) was cost per full-time equivalent employee; however, this deviation is still so large that the model’s value for each RC is typically well above or below their actual experience. While the model’s number is appropriate for statewide appropriations, it will require individualized allocation of other administrative costs to each RC, consistent with the current allocation method.

The salary costs per full-time equivalent (FTE) in the Operating Budget Model use State of California positions identified as being equivalent to RC positions based on this study. The mid-point of the identified salary range as of July 1999 was used in the model. The fringe benefit rate used (23.9 percent) was the current state average benefit rate, and is materially the same as the DDS budget and the actual level per RC.

The budget model is determined by the following data elements:

- ◆ Number of intake consumers (using monthly figures from DDS, annualized);
- ◆ Number of representative and complex consumers served, where representative and complex are defined in the OBM as follows;

Representative Consumers	Complex Consumers
Preferred Program =	Preferred Program =
<ul style="list-style-type: none"> • Physical Development (02) • Sensory Deprivation (04) • Child Development (05) • Habilitation (07) • Physical Social (08 and 09) 	<ul style="list-style-type: none"> • Medically Needy (01) • Autistic (03) • Behavioral (06)

- ◆ Number of consumers in out-of-home placement, Medicaid Waiver eligible, Early Start, or with significant mental health dual diagnoses;
- ◆ Number of total vendors per the paid vendor file for the prior year, and broken out into subsets for community care facilities and other third party vendors (excluding in-home respite and other in-home payments);
- ◆ Number of counties served;
- ◆ Total full-time equivalent (FTE) positions budgeted by the model.

There were many other possible variables that were considered but not used in the model, including: urban/rural; unionization; service area population size; service area geographic size, service area population density; local service system maturity; and consumer age (other than Early Start). Many of these showed no consistent correlation with cost or operational considerations. Others had such slight effects that they made the model unduly complicated without improving its accuracy. Consumer residential status does drive specific workload elements of the consumer service coordinator and quality assurance process, and is discussed in each section. For quality assurance, this is addressed by a workload assumption per residential facility.

There is potential for further refinement with better data on the factors used. This would include a data set of all authorizations including direct Purchase of Service (POS) purchases and so-called "\$0" authorizations for services under lump-sum contracts. While not currently available from all RCs, these may be a more accurate measure of the fiscal workload associated with vendor payment. Similarly, these data, correlated to consumer characteristics in the Client Development Evaluation Record (CDER), would evaluate and refine the method for identifying "complex consumers".

The specific elements of the Regional Center Operating Budget Model within each component are described below, and summarized in **Exhibit IV-1** on the following pages. **Exhibit IV-4** at the end of this section provides a cross-reference of the current functions detailed in the RC operational budget to the relevant Citygate OBM element.

EXHIBIT IV-1

(Consists of a total of 9 pages)

Recommended Operating Budget Model

FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL				BUDGET MODEL																																												
Mandated Functions																																																		
<p>1. Intake and Eligibility Assessment</p>	<ul style="list-style-type: none"> The length of calendar time for completion does not affect the hours per case required to perform the function. Both Early Start and other consumers are budgeted to include completion of the initial IPP/IFSP with comparable workload. 	<p>Estimated Productive Hours by Task:</p> <ul style="list-style-type: none"> Social Assessment 2 Coordination of Other Assessments 1 Initial IPP/IFSP 6 Subtotal 9 				<ul style="list-style-type: none"> 185 intake cases per FTE per year Caseload equivalent, assuming two-month case duration 31 per 1 CSC Position Specification per Senior CSC 																																												
<p>2. Consumer Service Coordination (CSC)</p>	<ul style="list-style-type: none"> Includes routine consumer contacts, IPP monitoring and updates and ongoing family support. Family support and other specialists who support CSCs are funded in Community and Clinical service, below. Family Resource Centers are funded via other contracts, not RC operating budget. In-home cases assumed to have two annual face-to-face visits. Annual updates are in addition to face-to-face visits. Early Start has semi-annual updates. Out-of-Home Placements (e.g. Residential, SNF/ICF and SL/IL) require quarterly (two more than in-home) face-to-face visits (2 unannounced). 1.5% of placed consumers require monthly visits due to ADL limitations. Workload for ongoing case load broken into two components: <ol style="list-style-type: none"> Compliance per varies by placement and reflects meeting minimum standards; Needs-Driven depends on consumer circumstances, and varies more than compliance. Special conditions include mental health dual diagnosis, Medicaid waiver eligible, out-of-home placement or consumers with Preferred Programs are Medical Care (01), Autism (03) or Behavior Modification (06). 	<p>Annual Productive Hours by Task per Consumer:</p> <p>Ongoing Caseload</p> <table border="1" data-bbox="974 691 1562 919"> <thead> <tr> <th>Compliance (varies by placement)</th> <th>At Home</th> <th>Out-of-Home/IL/SL</th> <th>Weighted Average</th> </tr> </thead> <tbody> <tr> <td>Visitation</td> <td>6</td> <td>11</td> <td>7.5</td> </tr> <tr> <td>Annual Review</td> <td>6-12</td> <td>6-12</td> <td>6.6</td> </tr> <tr> <td>Provider Report Review</td> <td>1</td> <td>2</td> <td>0</td> </tr> <tr> <td>Subtotal</td> <td>14-20</td> <td>19-25</td> <td>15.6</td> </tr> </tbody> </table> <table border="1" data-bbox="974 924 1562 1208"> <thead> <tr> <th>Need-Driven (varies by consumer needs)</th> <th>Low</th> <th>High</th> <th>Weighted Average</th> </tr> </thead> <tbody> <tr> <td>Provider Communication/Advocacy</td> <td>2</td> <td>10</td> <td>4.5</td> </tr> <tr> <td>Consumer/ Family Contact</td> <td>2</td> <td>12</td> <td>5.5</td> </tr> <tr> <td>Interdisciplinary Consultation</td> <td>2</td> <td>6</td> <td>3</td> </tr> <tr> <td>Subtotal</td> <td>2</td> <td>28</td> <td>13</td> </tr> <tr> <td>Total</td> <td>20-26</td> <td>47-53</td> <td>29</td> </tr> </tbody> </table>				Compliance (varies by placement)	At Home	Out-of-Home/IL/SL	Weighted Average	Visitation	6	11	7.5	Annual Review	6-12	6-12	6.6	Provider Report Review	1	2	0	Subtotal	14-20	19-25	15.6	Need-Driven (varies by consumer needs)	Low	High	Weighted Average	Provider Communication/Advocacy	2	10	4.5	Consumer/ Family Contact	2	12	5.5	Interdisciplinary Consultation	2	6	3	Subtotal	2	28	13	Total	20-26	47-53	29	<p>Consumer to CSC ratios by status:</p> <ul style="list-style-type: none"> Five or more special conditions: 34:1 Four special conditions: 36:1 Three special conditions: 40:1 Two special conditions: 45:1 One special condition: 54:1 No special condition: 69:1 CSC "Officer of the Day": 2.2 FTEs per RC 292 third party vendors per CSC for quality assurance support 8 CSCs per Supervising CSC 1 CSC Manager (assistant director) per 8 Supervising CSC in excess of eight 1 Director, Consumer Services per RC
Compliance (varies by placement)	At Home	Out-of-Home/IL/SL	Weighted Average																																															
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Recommended Operating Budget Model			
FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL	BUDGET MODEL
	<ul style="list-style-type: none"> ▪ Additional staffing for emergency response and coverage for out-of-office CSCs. ▪ CSCs are not responsible for Title 17 annual reviews of facilities but they do: <ol style="list-style-type: none"> 1. participate in triennial reviews of facilities in which they do <u>not</u> have consumers; 2. serve as sources of information for annual reviews and triennial reviews of sites in which they have consumers. 	<p>Officer of the Day</p> <ul style="list-style-type: none"> ▪ Ten hours per day, seven days a week (other hours covered by on-call supervisors and management) <p>Other CSC Responsibilities</p> <ul style="list-style-type: none"> ▪ Participation in annual/triennial vendor reviews 5.7 hrs/vendor/year ▪ Continuing Education 40 hours per CSC (budgeted in non-productive time) 	
<p>3. Community Services-Resource Development</p>	<ul style="list-style-type: none"> ▪ Excludes quality assurance and monitoring roles, described below. ▪ Includes mandated specialists for: <ol style="list-style-type: none"> 1. Special education; 2. Family support; 3. Housing; and 4. Community integration. <p><i>(Ongoing family support provided via CSC budgets, above. Family Resource Centers funded via other contracts, not RC operating budget.)</i></p> ▪ Other mandated skills, including quality assurance and criminal justice, addressed below. ▪ Includes transportation coordination. ▪ Includes placement specialist for DC liaison. ▪ Includes other resource specialist functions used by some RCs including community living options. ▪ Adds focused support for Employment/Daily Activities including liaison with Department of Rehabilitation. 	<ul style="list-style-type: none"> ▪ Top 25% of RCs averaged 1 per 1000 consumers, or 1.7 productive hours/consumer/year, and report a high level of compliance with key service priorities ▪ Scale matters: RCs with small caseloads, when responsible for wide geographic area, need additional resources. ▪ Minimum of one FTE per county, budgeted at the higher resource developer position, benefits two RCs in 1999-2000 ▪ Formula results in a minimum of 4.0 FTEs per RC (one per mandated functional specialty) that also would be responsible for other areas such as transportation, DC placement and employment/daily activities, an average of 7.6 FTEs and maximum of 14.3 for 1999-2000 ▪ For operations over the minimum, staffing mix is at: <ul style="list-style-type: none"> 20% resource developers 80% resource specialist 	<ul style="list-style-type: none"> ▪ The greater of 1000 consumers to 1 Resource Development staff or minimum 1 per county served, staffed at <ul style="list-style-type: none"> 20% resource developers 80% resource specialist ▪ 1 Director, Community Services per RC

EXHIBIT IV-1

(Consists of a total of 9 pages)

Recommended Operating Budget Model

FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL	BUDGET MODEL																																												
<p>4. Community Services- Community Outreach and Advocacy</p>	<ul style="list-style-type: none"> ▪ Advocacy, protection of consumer rights and public education and outreach are specific RC mandates. ▪ RCs have significant responsibilities for consumers' court-related (forensic) issues and are mandated to have specialty skills in criminal justice. RCs are also mandated to advocate for consumers' rights with vendors, etc. ▪ RC Boards are an important element of community accountability; RCs reported an average of 52 board and board committee meetings a year. ▪ New legislation requires employment of a consumer advocate. 	<ul style="list-style-type: none"> ▪ Provides for a forensic legal specialist position ▪ Adds consumer advocate and facilitator ▪ Adds public information and customer service positions to enhance access by the community, families and consumers and to provide a separate path for expediting problem resolution ▪ Includes dedicated administrative support for Board of Directors ▪ For very large RCs (over 10,000 consumers) supplemental positions are needed to backfill positions budgeted at 1 per RC. 	<ul style="list-style-type: none"> ▪ 1 Forensic Specialist per RC ▪ 1 Public Information Officer per RC ▪ 1 Consumer Advocate per RC ▪ 1 Customer Service/Complaint Coordinator per RC ▪ 0.75 Facilitator (Consumer Advocate support) per RC ▪ 1.0 Administrative Assistance (Secretary to the Board) ▪ For RCs with more than 10,000 consumers, 0.5 Resource Developer FTEs per 600 consumers 																																												
<p>5. Community Services – Vendor Quality Assurance (QA) and Technical Assistance (TA)</p>	<ul style="list-style-type: none"> ▪ Meets mandate for specialized skills in quality assurance. ▪ All personal service vendors except parent vouchers and in-home respite and other services should have annual monitoring and triennial comprehensive reviews. ▪ Other team members participating in QA reviews include CSC and clinical, budgeted separately. ▪ Performance contracting with vendors is increasing and requires expertise in program content to negotiate and monitor. ▪ Fiscal monitoring is an increasing emphasis for Medicaid Waiver, and is needed for all vendors, including family vouchers. ▪ Coordination and facilitation of vendor training included along with vendor orientation and technical assistance, however, testing, credentialing or formal training programs are not. 	<p>Annual Productive Hours by Task:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #cccccc;">QA Community Care Facilities</th> <th>Annual CCF</th> <th>Triennial CCF</th> <th>Annual Average per CCF</th> </tr> </thead> <tbody> <tr> <td>Preparation</td> <td style="text-align: center;">1</td> <td style="text-align: center;">4</td> <td style="text-align: center;">2</td> </tr> <tr> <td>On-Site</td> <td style="text-align: center;">6</td> <td style="text-align: center;">8</td> <td style="text-align: center;">9</td> </tr> <tr> <td>Write-up</td> <td style="text-align: center;">2</td> <td style="text-align: center;">6</td> <td style="text-align: center;">4</td> </tr> <tr> <td>Exit Interview w/Vendor</td> <td></td> <td style="text-align: center;">3</td> <td style="text-align: center;">1</td> </tr> <tr> <td>CAP Review</td> <td style="text-align: center;">2</td> <td style="text-align: center;">4</td> <td style="text-align: center;">3</td> </tr> <tr> <td>Follow-up/Technical Assistance</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> <td style="text-align: center;">5</td> </tr> <tr> <td>Total</td> <td style="text-align: center;">13</td> <td style="text-align: center;">33</td> <td style="text-align: center;">24</td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #cccccc;">QA Other Third-Party Service Vendors</th> <th>Annual Other Vendors</th> <th>Triennial Other Vendors</th> <th>Annual Average</th> </tr> </thead> <tbody> <tr> <td>Preparation</td> <td style="text-align: center;">1</td> <td style="text-align: center;">4</td> <td style="text-align: center;">2</td> </tr> <tr> <td>On-Site</td> <td style="text-align: center;">4</td> <td style="text-align: center;">8</td> <td style="text-align: center;">7</td> </tr> </tbody> </table>	QA Community Care Facilities	Annual CCF	Triennial CCF	Annual Average per CCF	Preparation	1	4	2	On-Site	6	8	9	Write-up	2	6	4	Exit Interview w/Vendor		3	1	CAP Review	2	4	3	Follow-up/Technical Assistance	2	8	5	Total	13	33	24	QA Other Third-Party Service Vendors	Annual Other Vendors	Triennial Other Vendors	Annual Average	Preparation	1	4	2	On-Site	4	8	7	<ul style="list-style-type: none"> ▪ Staffing mix: 20% Quality Assurance Coordinator; 80% Program Evaluator --1 per 69 RCFs --1 per 83 Other 3rd-party service vendors ▪ 1 Fiscal Monitor FTE per 555 vendors (all types) ▪ 1 Quality Assurance Manager per 8 Program Evaluators/Fiscal Monitors ▪ 1 Vendor Training Coordinator per RC ▪ Special Incident Tracking and Follow-up 2.2 FTE per RC
QA Community Care Facilities	Annual CCF	Triennial CCF	Annual Average per CCF																																												
Preparation	1	4	2																																												
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Recommended Operating Budget Model

FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL				BUDGET MODEL
	<ul style="list-style-type: none"> Includes special incidence response, follow-up and tracking integrated with LQA tracking and integration with QA/TA planning. 	Write-up	2	6	4	
		Exit Interview w/Vendor		3	1	
		CAP Review	1	2	2	
		Follow-up/Technical Assistance	2	8	5	
		Total	10	31	21	
		<ul style="list-style-type: none"> Fiscal Auditor 3 productive hours per vendor Special Incident Reporting and Follow-up seven days a week, ten hours per day Vendor Training Coordinator 				
<p>6. Clinical Services</p>	<ul style="list-style-type: none"> Includes medical and psychological assessment, or review of recent external reports for each intake case. RN consultation during intake for consumers with specific chronic or acute conditions and ongoing care needs. Ongoing clinical support targeted by specialty based on consumer characteristics and risk (At Risk) Triennial RN participation in IPP for all consumers for health status/medication assessment, with MD, psych, pharmacist and/or nutritionist consultation available for follow-up as needed (see right). Ongoing RN support for all Early Start, medically needy, and Medicaid waiver eligible consumers as part of ongoing consumer service team with focused physician consultation as needed. Physician support for internal consultation, advocacy in the community or support in 	Assessment per Intake	Monitoring: Consumers not at risk	Monitoring per At Risk Consumers	Annual Productive Hours per Consumer Served & Percent of Consumers Served	<ul style="list-style-type: none"> Minimum 1 each Physician, Psychologist, RN, Pharmacist and Nutritionist per RC 1 Physician per 7,289 non- at risk consumers and 1 per 2,912 at risk consumers 1 RN per 2,521 non- at risk consumers and 1 per 416 at risk consumers 1 Psychologist per 7,280 non- at risk consumers and 1 per 364 at risk consumers 1 Pharmacist per 7,280 non- at risk consumers and 1 per 1,456 at risk consumers 1 Nutritionist per 4,118 non- at risk consumers and 1 per 832 at risk consumers 1 Director, Clinical Services per RC
		MD	3	1 for 20%	1 for 50%	
		RN	2	2 for 33%	4 for 100%	
		Psychologist	4	2 for 10%	4 for 100%	
		Pharmacist	N/A	1 for 20%	1 for 100%	
		MD Target Population=All Medicaid Waiver eligible, all Early Start and consumers with preferred programs of Medical Care (01) or Physical Development (02)				
		RN Target Population=All Medicaid Waiver eligible, all Early Start and consumers with preferred programs of Medical Care (01) or Physical Development (02)				
		Psychologist Target Population=All mental health dual diagnosis cases and consumers with preferred programs of Sensory Deprivation (02), Autism (03) or Behavior Modification (06)				
		Pharmacist Target Population=All Medicaid Waiver eligible, all mental health dual diagnosis and consumers with preferred programs of Medical Care (01), Autism (03) or Behavior Modification (06)				

EXHIBIT IV-1

(Consists of a total of 9 pages)

Recommended Operating Budget Model						
FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL			BUDGET MODEL	
	obtaining services <ul style="list-style-type: none"> Psychologist/behaviorist support for internal consultation, assessment and intervention planning. At risk defined as all mental health dual diagnosis cases and consumers with preferred programs of Sensory Deprivation (02), Autism (03) or Behavior Modification (06). Nutritional and pharmaceutical consultation available for both intake and ongoing consumer service teams. Pharmacy at risk targets are Medicaid Waiver eligible, mental health dual diagnosis and consumers with preferred programs of Medical Care (01), Autism (03) or Behavior Modification (06). Nutrition at risk targets are all Early Start consumers. RNs or other clinical specialists with routine consumer service coordination caseloads are addressed in CSCs, above.	Nutritionist	N/A	2 for 20%	2 for each Early Start consumer	
7. Fiscal Administration	<ul style="list-style-type: none"> Includes representative payee function but does not provide for consumer money management functions beyond that level. Assumed to pay vendors once a month. Includes POS budgeting and monitoring. 	<ul style="list-style-type: none"> 6.4 productive hours/vendor/year (30 minutes per month) reflecting RCs at the 75th percentile or above 5.5 paid hours/representative payee/year reflecting RCs at the 75th percentile or above Staff mix: <ul style="list-style-type: none"> 25% Accountant II/Bookkeeper 50% Accountant I/Assistant Bookkeeper 25% Associate Accountant I/Account Clerk 			<ul style="list-style-type: none"> 260 vendors per accountant 300 rep payees per accountant 1 Controller FTE per RC 1 Accounting Supervisor per eight accounting staff 	

Recommended Operating Budget Model			
FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL	BUDGET MODEL
Support Functions Infrastructure			
8. Executive/ Administrative Support			<ul style="list-style-type: none"> ▪ 1 Executive Director per RC ▪ 1 Director, Administration/ Chief Financial Officer per RC ▪ 1 Administrative Assistant per RC (other administrative assistants budgeted in Communications & Logistics)
9. Human Resources (HR)	<ul style="list-style-type: none"> ▪ Coordinates hiring, personnel relations, benefits, occupational safety and compliance; administers class, position and salary structure, along with annual performance reviews; validates time reporting, manages payroll and benefits accounting and inquiries. ▪ CSCs budgeted for 40 hours of continuing education (CE) annually as effectiveness is linked to both knowledge in technical areas and in customer service and operating skills, clinical staff have mandated CE requirements as part of licensure requirements. ▪ Inclusion of director for staff continuing education does not reflect line assignment but functional focus on human resources. 	<ul style="list-style-type: none"> ▪ HR Assistant staffing level consistent with DC staffing model for human resources ▪ Provides for 1.4 productive human resource hours per employee per month exclusive of education and training support 	<ul style="list-style-type: none"> ▪ 1 Human Resources Manager per RC ▪ HR Assistant (1 per 100 RC employee FTEs, less 1 for director position) ▪ 1 Education & Training Administrator per RC
10. Internal Finance	<ul style="list-style-type: none"> ▪ Performs operational budgeting and monitoring as well as executive oversight to consumer/vendor fiscal services. ▪ Manages internal operations accounts payable. 	<ul style="list-style-type: none"> ▪ Primary staff activity is internal vendor payments, therefore tied to volume of operational expenditures excluding payroll (handled via human resources) ▪ Accountant I staffed at 35 hours per month per million in non-payroll operations 	<ul style="list-style-type: none"> ▪ 1.0 Accounting Supervisor ▪ 0.25 Accountant I per \$1 million non-personnel operating budget (Chief Financial Officer and Controller positions detailed above)

EXHIBIT IV-1

(Consists of a total of 9 pages)

Recommended Operating Budget Model			
FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL	BUDGET MODEL
11. Information Systems (IS) Support	<ul style="list-style-type: none"> ▪ Overall IS budget should be 3-4% of gross operating revenue based on common industry standards. ▪ Equipment, systems and applications support are all ongoing requirements. ▪ Budget for IS hardware and software, and personnel training included in Non-Personnel costs, below. 	<ul style="list-style-type: none"> ▪ Support is a function of total operating staff, the variable that drives both total hardware and need for individual support, therefore technicians budgeted relative to total employed FTEs ▪ Provides for 16.6 productive hours per FTE per year in data technician support 	<ul style="list-style-type: none"> ▪ 1 Manager, Information Systems per RC ▪ 1 Network Manager per RC ▪ 1 Data Technician per 100 FTEs
12. Records Management	<ul style="list-style-type: none"> ▪ Incorporates Medicaid Waiver and other categorical program reporting and compliance, CDER abstracting and reporting, CMF updating. ▪ Social work does not have a consistent tradition in documentation, however, effective documentation decreases time spent in interagency communication tasks, continuity of services across team and supports continuous improvement and internal quality assurance. ▪ Prior study on Community Placement found severe gaps in documentation making evaluation of RC effectiveness difficult. ▪ Function defined for consumer record management, including transcription of assessments, integration of interdisciplinary notes, obtaining and issuing documentation with outside vendors and agencies, etc., working with all consumer-support staff and most closely with CSC. 	<p>Productive Hours Assumptions</p> <ul style="list-style-type: none"> ▪ Records specialist (including transcription) budgeted at 1 hr/intake case + 6 minutes/consumer/month. ▪ Records technicians budgeted at 15 minutes per consumer per month ▪ Documentation and compliance specialist including Early Start, TCM and Medicaid waiver reporting and documentation ▪ Abstract and reporting specialist includes preparation of CDER and CMF updates from CSC notes 	<ul style="list-style-type: none"> ▪ 1 Consumer Records Director per RC ▪ 1 Documentation & Compliance Specialist per RC ▪ 1 Abstract & Reporting Specialist per RC ▪ Records Specialist (1 per 1,387 active consumers and 1 per 1,664 intake cases) ▪ Records Technician (1 per 555 consumers)
13. Communications & Logistics	<ul style="list-style-type: none"> ▪ Provides central telephone and mail support as well as distributed support for telephone and calendar management. ▪ Human resources staff, consumer record support, data base management and applications support budgeted in separate areas. 	<ul style="list-style-type: none"> ▪ General secretarial/clerical support based on professional FTEs, averaging 4 productive hours per FTE per week or 208 per year ▪ Support mix budgeted at 20% administrative assistants; 50% secretarial; 30% clerks ▪ Consumer records are budgeted for and staffed separately from this item 	<ul style="list-style-type: none"> ▪ 1 Office Supervisor per RC ▪ General secretarial/clerical support at one per eight professional FTEs



Recommended Operating Budget Model

FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL	BUDGET MODEL
Non-Personnel Costs			
<p>14. Governance</p>	<ul style="list-style-type: none"> ▪ Community boards with substantial consumer and family participation are a distinguishing feature of California's RC system. ▪ Board access to education and development should be earmarked and dedicated independent of RC budget. 	<ul style="list-style-type: none"> ▪ Boards average 10 meetings per year, plus 42 committee meetings per year ▪ Facilitation includes assistance in both preparing for meetings and during meetings, at eight hours per committee meeting and 16 per board meeting ▪ \$500 per board member for development and education, with an average board size of 30 	<ul style="list-style-type: none"> ▪ \$15,000 per RC for governance ▪ 0.30 Facilitator FTE per RC ▪ 6% Cost of Living Adjustment (COLA) to these numbers to roll forward 1997-98 to 1999-00
<p>15. Facilities</p>	<ul style="list-style-type: none"> ▪ Actual facility costs did not vary by geography (urban vs. non-urban, high cost vs. low cost markets, large vs. small service areas). ▪ Facility costs are interchangeable with other mechanisms for access, including transportation, travel and information systems. 	<ul style="list-style-type: none"> ▪ Actual facility cost consistently varied by FTE in a linear function ($R^2=.794$) around a base of \$147,000 and an increment of \$3,000 per FTE (Facilities=$147000+3000(\text{FTEs})$) ▪ A power function (Facilities=$6,110(\text{FTEs})^{0.9079}$) had a higher predictive value ($R^2=.832$) but is less intuitively understandable to users 	<ul style="list-style-type: none"> ▪ \$147,000 fixed ▪ \$3,000 per FTE
<p>16. Information Systems</p>	<ul style="list-style-type: none"> ▪ Expenditures for equipment tend to be sporadic year to year, and a mechanism to carry forward funds in this category is needed since the current annual model supports higher cost options such as leasing rather than direct purchase. ▪ The potential of equipment expenditures loses much of its value if personnel training is not invested in concurrently. 	<ul style="list-style-type: none"> ▪ Assumes a \$2,250 base system cost per employee and a three year replacement cycle ▪ Current cost, no COLA required 	<ul style="list-style-type: none"> ▪ IS Equipment at \$750 per FTE ▪ Staff Training in IS area at one-third of IS Equipment, or \$250 per FTE
<p>17. All Other</p>	<ul style="list-style-type: none"> ▪ Includes communications, insurance, legal. ▪ Creates a statewide budget total requiring individual RC allocation 	<ul style="list-style-type: none"> ▪ System-wide average was \$184 per consumer per year in 1997-98 ▪ 6% COLA to these numbers to roll forward 1997-98 to 1999-00 	<ul style="list-style-type: none"> ▪ \$195 per consumer per year

EXHIBIT IV-1

(Consists of a total of 9 pages)

Recommended Operating Budget Model			
FUNCTIONS	ASSUMPTIONS	WORKLOAD DETAIL	BUDGET MODEL
18. Special Case Add-ons	<p>The Citygate Model does not integrate two types of costs included in the RC operational appropriation. These are special case items, and added as lump-sums after the model calculates the RC operational budget for each RC and summarizes that to a state-wide RC operational budget. Costs handled as special cases include:</p> <ul style="list-style-type: none"> ▪ Contract costs that fund special services outside of RC direct operations, e.g., Mediation, Consumers' Rights Advocate (CRA), Movers Evaluation Contract, etc.; and ▪ Unique costs applying to only certain RCs, e.g., support of SANDIS by the San Diego RC, the Foster Grandparents program, South Central Los Angeles Court diversion project, etc. 		
		1999-2000 May 1999 Update/Budget Model	
	Budget Model Monitoring and Evaluation		\$150,000
	CCF Staff Training Contact		\$ 6,339,000
	CRA Contract		\$ 3,734,000
	Foster Grandparent/Senior Companion		\$856,000
	LQA Contract		\$ 2,862,000
	Mediation Contract		\$806,000
	"Movers" Evaluation Contract		\$500,000
	RRDP		\$504,000
	SANDIS Information System		\$325,000
	Self-Determination Pilot Projects		\$500,000
	Sherry S. Court Case		\$766,000
	Wellness Projects		<u>\$2,500,000</u>
	Subtotal		\$19,842,000

1. MANDATED SERVICES

Eligibility Assessment

The eligibility assessment function is defined for the model to include:

- ◆ the processes of initial screening prior to intake,
- ◆ formal assessment (diagnosis) and determination of eligibility, and
- ◆ the initial Individual Program Plan (IPP; Individualized Family Service Plan (IFSP) for Early Start).

The length of calendar time for completion does not affect the hours per case required to perform the function, but does spread the same hours/consumer over different periods, creating different backlogs (consumers in process). Only when the backlog is changed (increased from 90 to 120 days, or decreased from 90 to 45, for example) is there a differential, **one-time** cost.

An analogy would be that the distance to drive from Sacramento to San Francisco does not change whether the trip is completed in two hours or eight hours. But if the first half of the trip is at an eight hour pace, in order to finish the trip in a total of two hours, the pace in the second half will have to exceed the two hour pace.

The variable cost is based on the following ratio of Intake consumers (taken from those shown in DDS' budget) to consumer service coordination staff. Administrative support to intake is included in Support Functions, below.

Intake Consumers	
Intake CSCs	185:1 Annually
Intake CSCs	15.4:1 Monthly

The return to a 60-day model for non-Early Start consumers (assuming they are currently completed in 120 days) will trigger a **one-time** workload impact of:

- Days in backlog reduction (x) average daily intake (x) 11.25 hours per case

If 1997-98 workloads are used in an example of this calculation, backlog reduction would require a temporary staff increase of approximately six FTEs, statewide. After reducing the case backlog from four to two months, the intake staffing requirements would be stable at the same level as prior to the reduction in backlog, independent of any change in the number of monthly cases.

- Days in backlog reduction (120 days-60 days)=60 day reduction
- Average daily intake caseload: 1,090 cases per month (excluding early start)/30=36.4 cases per day
- 60 days (x) 36.4 cases per day (x) 11.25 hours per case = 24,570 paid hours one-time need.

Reducing intake backlog (or creating savings due to backlog extension) are one-time costs/savings only and usually accomplished through overtime or temporary staffing. Another alternative for reducing backlog would be a gradual phase-in over an extended period, but attrition would be required to ultimately balance staffing and need at the new level.

The staffing for the formal assessment and eligibility determination is included in Clinical Services, below.

Consumer Service Coordination

There are two main processes under consumer service coordination: development and implementation of the Individual Program Plans (IPP), or Individualized Family Service Plan (IFSP) for Early Start consumers, and the ongoing process of assessment and evaluation. Since these two processes are inextricable, they were entered into the OBM as a single factor. RCs should provide seamless integration of key specialty resources with day-to-day case management, including nursing, behavioral health and forensic experts. Using personnel with professional training and experience in these disciplines as consumer service coordinators for high-risk consumers is a best practice. Where done, these specialty CSCs should be integrated in the same operational unit as CSCs with social work or other backgrounds. The complex needs of RC consumers benefit greatly from a truly interdisciplinary model of operation.

The top 13% percent of RCs in 1997-98 (the 87th percentile) were staffed at CSC levels equivalent to 62:1 for most consumers and 45:1 for highly complex consumers. These RCs were more consistently able to provide mandated consumer services as well as to initiate the proactive contacts essential to a good quality of service. RC consumer service coordinators reported that staffing at 45:1 was effective in meeting the needs of complex consumers placed in the community through the Coffelt settlement, who have preferred programs highly correlated with those identified as complex in our analysis.

Task level estimates, below, provide an illustration of the level of effort associated with key compliance and need-driven activities performed by CSCs.

Annual Productive Hours by Task per Consumer:

Ongoing Caseload

Compliance (varies by placement)	At Home	Out-of-Home/ IL/SL	Weighted Average
Visitation	6	11	7.5
Annual Review	6-12	6-12	6.6
Provider Report Review	<u>1</u>	<u>2</u>	<u>1.5</u>
Subtotal	13-19	19-25	15.6
Need-Driven (varies by consumer needs)	Low	High	Weighted Average
Provider Communication/ Advocacy	2	10	4.5
Consumer/ Family Contact	2	12	5.5
Interdisciplinary Consultation	<u>2</u>	<u>6</u>	<u>3</u>
Subtotal	6	28	13
Total	19-25	47-53	29

To capture the array of consumer needs in an effective budget model, we needed to accommodate the wide variances of consumer mix among the RCs. To do this, we adjusted CSC staffing levels using special conditions as a weighting factor. Consumers (as of February 1999) by special condition are presented below in **Table IV-1**.

Table IV-1 Consumers by Special Condition

Consumers as of 2/99	Early Start	Complex Preferred Program	Non Complex Preferred Program	Total
Out of Home, Waiver, and Dual Diagnosis	0	693	3,154	3,847
Out of Home and Waiver	4	2,665	17,621	20,290
Out of Home and Dual Diagnosis	0	290	1,494	1,784
Waiver and Dual Diagnosis	0	179	828	1,007
Out of Home only	1,809	1,738	17,467	21,014
Waiver only	93	2,188	14,725	17,006
Dual Diagnosis only	0	355	2,283	2,638
None	13,190	8,151	59,233	80,574
Total	15,096	16,259	116,805	148,160

Early Start cases are subject to specific additional federal regulation and intensive family support is critical at this first contact. The RC is accountable for education for this group, unlike other consumer groups. The Lanterman act mandates focused effort on prevention and early intervention for persons at risk for developmental disabilities. Early intervention can enable an at-risk infant to live a normal life without further need for RC support. These cases are also in rapid transition due to their development stage. Finally, their transition at 36 months of age from Early Start status to either consumer (Category 02) or out of eligibility for RC services requires focused support. These factors combine to result in Early Start status being assigned a two-fold weight as a special condition. For example, an Early Start infant, living at home who is not waiver eligible and does not have a dual diagnosis would be coded as having two special conditions.

Examples of consumer profiles and their associated count of special conditions include:

<ul style="list-style-type: none"> Consumer with a complex preferred program (Medically Needy (01), Autistic (02) or Behavioral (05)) who also lives independently and is Medicaid waiver eligible 	<ul style="list-style-type: none"> Three special conditions
<ul style="list-style-type: none"> Representative consumer living independently 	<ul style="list-style-type: none"> One special condition
<ul style="list-style-type: none"> Representative consumer living independently with a significant mental health dual diagnosis 	<ul style="list-style-type: none"> Two special conditions

• Early Start infant with complex preferred program (e.g., Autism) living at home	• Three special conditions
• Consumer with complex preferred program (e.g., Medically Needy) placed in a SNF or ICF with a significant mental health dual diagnosis	• Three special conditions
• Waiver eligible consumer with complex preferred program (e.g., Medically Needy) placed in a CCF with a significant mental health dual diagnosis	• Four special conditions
• Waiver eligible Early Start infant living at home	• Four special conditions

The proposed staffing levels are based on the hours required for both mandated (compliance activities) and discretionary (need based) services. Recommended **average** staffing for each level of special conditions are presented in **Table IV-2**, below.

Table IV-2 Recommended Average Staffing for Each Level of Special Conditions

Consumer Profile	Total Consumers	Percent Of Total	Recommended CSC Ratio	Annual Productive CSC Hours per Consumer
All 5 Special Conditions	-	0%	34	49
Any 4 Special Conditions	697	0%	36	46
Any 3 Special Conditions	8,190	6%	40	42
Any 2 Special Conditions	37,414	25%	45	37
Any 1 Special Condition	42,626	29%	54	31
None	59,233	40%	69	24
Total	148,160	100%		

These assumptions result in an overall CSC staffing level of 53:1 given the projected 1999-2000 consumer volume and mix of special conditions. CSCs in this model are not responsible for CCF facility liaison. The staffing assumes strong specialty support in resource development, vendor quality assurance and medical and psychological monitoring, as well as staff training, records management and information systems support.

The OBM provides 2.2 CSC FTEs to each RC in addition to ongoing consumer service coordination to provide consistent availability and accessibility seven days a week, ten hours a day. This function is referred to as "Officer of the Day." While 24-hour coverage is required, we have assumed the hours beyond the ten paid per day at full wage would be addressed via on-call staff rotated across CSC supervisors and management.

RCs also have a variable assumption for CSC participation in the annual and triennial quality assurance for vendors. While Community Services, below, leads that function, CSCs will participate as sources of information prior to reviews, and as team members on triennial reviews. This involvement was modeled at 5.7 productive CSC hours per third party service provider.

Training and development are essential to effective consumer service coordination. CSC budgets assume 40 hours of continuing education per year as an element of non-productive time.

Supervision for CSCs includes first line supervisors (one per eight CSCs including CSCs performing intake functions) and the Director of Consumer Service. Supervisors have both administrative and line responsibilities (supervision, internal quality assurance, training and development), and provide "overflow" capacity for peak workloads and crisis situations in the CSC caseload. Some RCs report success in using self-managed work team models, and we strongly endorse efforts to "flatten" the organization. In this implementation scenario, the CSC Supervisor role would shift to increased technical support, coaching, problem solving and supplementing the consumer service team in crisis situations.

In large RCs, where more than 15 CSC supervisors report to the Director of Consumer Services, an intermediate position, CSC Manager, is defined to improve span of control. While instituting additional layers of management is not desirable, the sizes of some RC operations make this a required support to ensure effective management and supervision. For the 1999-2000 projections, this increases to 19 RCs with 0.5 to 3.5 FTEs in CSC Managers.

The cost for CSC consumer service was based on the staffing ratios in Exhibit IV-2 and below:

CSC Officer of the Day	2.2 per RC
CSC QA Participation	5.7 productive hours per third party vendor per year
CSC Supervisor Ratio	8 CSCs:1 (Includes CSCs performing eligibility assessment)
CSC Manager	8 CSC Supervisors:1 when CSCs exceed 96
Director of Consumer Services	One per Regional Center

Community Services

There were four processes identified under community services:

- ◆ Resource development and generic advocacy (which includes specialist functions);
- ◆ Outreach, casefinding, and community relations;
- ◆ Vendor quality assurance (QA) including fiscal monitoring; and,
- ◆ Vendor technical assistance (TA).

In the OBM, the resource development process is combined with outreach to generic resources, including casefinding, and vendor QA is combined with vendor TA. Specific positions for

general public communications and events, a consumer advocate and a forensic specialist (responsible for supporting CSCs in court-related consumer issues and fair hearings) are functionally described in this section, but may be placed in other organizational relationships at the discretion of each RC. Each RC was allocated one Director of Community Services position.

Resource development, as discussed in Chapters II and III, is an essential part of the overall RC function of case management. The IPP development and implementation is dependent on the availability of appropriate services and supports. Resource development is also an explicit mandate. The *minimum* cost for resource development was set at 1.0 senior staff (resource developer) full-time equivalent (FTE) per county. The assumption is that resource development is locally specific, and increases as the number of local entities and jurisdictions increase. Each Los Angeles County RC was allocated a minimum 1.0 FTE. Based on 1997-98 workload, three RCs would be staffed based on this minimum, since it yields a higher staffing level than the variable staffing model. In the 1999-2000 projections, only two RCs are staffed using the minimum. For most RCs, the staffing for resource development is a function of the number of consumers. In these larger operations, resource development and resource specialists provide a mix of skill levels assuming that the larger size provides for lead roles by more expert personnel, i.e., the resource developer position.

The "maturity" of local service systems was frequently cited as a variable in resource development needs, as was independent and supportive living. This referred to the number and type of generic resources available in the community independent of the RC, with 'mature' settings having more robust infrastructures. It was impossible to develop a standard, consistent measure of maturity of local service systems; accordingly, this factor is not incorporated into the model.

Another important consideration identified was consumers in independent and supportive living. This required a higher level of one-on-one resource identification, as well as quality assurance and technical assistance. However, in the current data set, the number of consumers in independent/supportive living yielded numbers that were too small to impact model outcomes, and too small to clearly differentiate resource needs. This could change as they increase as a portion of the RC consumer population.

The variable cost for resource development is based on one thousand representative and complex consumers per resource developer FTE, consistent with reported RC staffing at the 75th percentile, adjusted for quality assurance. Additional staff in this area is provided for at the rate of 0.5 FTE per 600 clients over 10,000. This provides size-sensitive resource specialist support as needed for the approximately 8 FTEs in seven positions budgeted as fixed.

Position	Staffing Ratio
Resource Development/Specialists	1 FTE/1000 Consumers
Resource Development/Specialists	1 FTE/1200 Consumers over 10,000 Base
Staffing Mix: 33% Resource Developers—67% Resource Specialists	

The resource development staff will require a mix of skills and specialties to perform effectively. Mandated specialties included in this specific staffing element are:

- ◆ special education;
- ◆ family support;
- ◆ housing; and
- ◆ community integration.

The other two mandated specialties, quality assurance and criminal justice, are addressed in other budget items, including Vendor Quality Assurance, below. The consumer forensic specialist is budgeted as an additional position for each RC.

Resource development staff incorporate the transportation coordinator and developmental center placement specialist called for in the Core Staffing Formula, as well as the community living options specialists used by some RCs. The mixture of minimum and variable staffing produced by the model yields from 4 to 14 FTEs per RC, with an average of 7.6 per RC in the 1999-2000 model. For RCs staffed above the minimum level, the position mix is set at 33 percent resource development and 67 percent resource specialist.

Adequate quality assurance (QA) staff should be available to provide technical, contract and fiscal review to all third-party POS vendors. A system-wide QA function is essential to meet the RCs' total case management responsibilities, and to protect and promote consumers' safety and health. QA is intrinsic to advocacy and protection of consumers' rights. The complexity of the vendor system and the scale of funding moving through the RCs dictate a prudent oversight process. The increased use of vendor performance contracts and RC responsibility for rate setting and contract oversight also requires meaningful oversight. Systemic vendor QA requires broad, technical expertise, a specific interest and personality in the staff person, and a different set of skills than consumer service coordination, including more sophisticated process and management skills. It should operate as a supplement to CSCs' consumer-focused QA.

In addition to residential care facilities (already with extensive specific QA requirements), system quality assurance should include: day programs; transportation; independent and supportive living; infant development vendors; and cooperation with the Department of Health Services in QA for skilled nursing facilities (SNF) and intermediate care facilities (ICF) serving individuals with developmental disabilities. Quality assurance for vendors should incorporate continuous improvement process models along with regulatory and fiscal compliance. Special incident reports (SIR) and complaints should be systematically tracked for quality assurance and technical assistance implications. This recommendation is consistent with recent federal requirements for Medicaid Waiver compliance. Since the number and type of vendors (the workload driver for this operational unit) vary by RC and by complexity of consumer needs, we propose linking resources for this function to POS budgeted for each RC. This includes community services absorbing the vendor QA.

component of the facility liaison role and other regulatory vendor QA currently performed by CSCs, as discussed below.

The annual quality assurance of residential care facilities is currently integrated with the facility liaison role, and is typically a consumer service coordinator responsibility. While the CSC is the right liaison for the consumer-focused monitoring of IPP services, supports, needs, and satisfaction, comprehensive, vendor-focused reviews of compliance, plans of corrective action and follow-up should be performed by quality assurance staff, with the CSC liaison participating as a team member. We believe that while the CSC should collaborate and contribute to vendor QA, it is inappropriate to add a structured accountability role to the CSC position. QA staff under community service/vendor relations (see above) should perform it.

The variable cost for vendor QA and TA was set based on specific hours per vendor, by type of vendor (Exhibit IV-1). Each third-party vendor is assumed to receive an annual on-site review by a program evaluator, plus a comprehensive, multi-disciplinary review once every three years. Fiscal monitors were also budgeted per third party vendor, as was CSC participation (discussed above). Supervision through the Quality Assurance Coordinator position was budgeted at 1:8 program evaluators.

In addition, two other fixed positions were included in quality assurance and technical assistance. The first is responsible for monitoring special incident reporting, assisting in response to SIRs including monitoring of corrective action plans (CAPs), and evaluating patterns in SIRs and Life Quality Assessments to be addressed in vendor training and technical assistance. This position is budgeted at ten productive hours per day, seven days a week (2.2 FTEs), to expand access and support beyond routine working hours. The second position is Vendor Training Coordinator, responsible to conduct basic orientation, and assist in facilitating vendor training and technical assistance. Large RCs may require additional resources in these or other fixed positions. The staffing ratio for resource developers and specialists is structured to provide sufficient staff to meet those needs.

Position	Productive Hours per Year		
	Community Care Facilities	Other Third-Party Service Vendors	All Other Vendors
Program Evaluators	24	20	0
Fiscal Monitors	3		
QA Manager	8 Program Evaluators: 1		0
Special Incidence Reporting and Follow-up	2.2 FTEs per RC		
Vendor Training Coordinator	1.0 FTE per RC		

Outreach and Advocacy

Advocacy, protection of consumer rights, public education, and outreach are specific RC mandates. RCs have significant responsibilities for consumers' court-related (forensic) issues, and particularly, are mandated to have specialty skills in criminal justice. As an adjunct to CSC and other staff, one FTE is funded as a forensic specialist with knowledge in consumer rights, regulation, mandate and due process, including consent, court, and custodial areas required for successful RC

operation. Other forensic specialists may be needed, depending on size and local needs. These would be developed from the pool of staff provided for community services relative to RC size.

Consumer advocate and facilitator positions are needed, as new legislation requires employment of a consumer advocate. The model also adds public information and customer service positions to enhance access by the community, families and consumers, and to provide a separate path for expediting problem resolution.

Grouped with these roles is an executive secretary dedicated to supporting the RC Board of Directors. RC Boards are an important element of community accountability; RCs reported an average of 52 board and board committee meetings a year.

Overall, baseline staffing for Outreach and Advocacy consists of:

- ◆ Consumer Forensic Specialist (1 per RC);
- ◆ Consumer Advocate (1 per RC);
- ◆ Facilitator for Consumer Advocate (0.75 per RC);
- ◆ Public Information Officer (1 per RC);
- ◆ Customer Service/Complaints (1 per RC); and
- ◆ Board Secretary (1 per RC).

Large RCs that require additional resources in these areas will be able to draw on added resource development staffing that is sized to overall RC size, discussed above.

Clinical Support Services

Clinical support services include the necessary services of professional personnel including physicians, psychologists, registered nurses (RN), pharmacists, nutritionists, etc. There are incremental staff budgeted for physician, RN, psychologist, pharmacist, and nutritionist. These funds may be spent by individual RCs over a broader set of specialists, including speech, occupational and behavioral therapists, depending on local conditions. Clinical services incorporate both intake assessment roles and routine, proactive participation in ongoing consumer service coordination, dependent on total consumer volume and consumer complexity and risks. Clinical staff will also contribute to vendor quality assurance and technical assistance. The increased complexity of consumers and the expansion of supportive and independent living for these complex consumers require increased support to CSC in order to identify risks and recommend appropriate supports or interventions to avoid deterioration in health, psychological or social status.

We strongly recommend that some minimum portion of clinical expertise be on RC payrolls (in-house). While contract personnel are valuable—especially community-based physicians—it is important to integrate clinical perspectives with RC operations, policy, and management, and to make informal consultation and interaction available to CSCs on a day-to-day basis. We do not believe this can be fully implemented with only contract or part-time clinical personnel. We would recommend that in-house (i.e., employed) clinical staffing cover a spectrum of disciplines, including

psychological, medical, and nursing, at a minimum. Specific expertise in genetics, nutrition, pharmacology, psychiatry, neurology, and other pertinent areas should be available but are amenable to contract models.

The minimum cost is five licensed professional full-time equivalent personnel per RC, plus a separate position budgeted for Director, Clinical Services:

- ◆ One Physician;
- ◆ One Registered Nurse;
- ◆ One Psychologist;
- ◆ One Nutritionist; and
- ◆ One Pharmacist.

The variable staffing for ongoing review and evaluation of consumer needs and issues is based on specific hours per consumer by type for both intake and monitoring roles (see Exhibit IV-1), resulting in differing ratios of representative and complex consumers to clinical personnel, as shown below. It includes health reviews as a routine part of IPPs with RN participation and consultation with physicians and psychologists. As a point of reference, a common health care workload ratio for primary care physician per population is one per 2000 to 3000, providing for comprehensive personal health care. This model is intended to provide assessment and ongoing monitoring and support, not direct care.

Specialty	Target Population	Non-Targeted Consumers	Targeted Consumer
Physician (MDs)	All Medicaid Waiver eligible, all Early Start and consumers with preferred programs of Medical Care (01) or Physical Development (02)	1:7,280	1:2,912
Nurses (RN)	All Medicaid Waiver eligible, all Early Start and consumers with preferred programs of Medical Care (01) or Physical Development (02)	1:2,521	1:416
Psychologists	All mental health dual diagnosis cases and consumers with preferred programs of Sensory Deprivation (02), Autism (03) or Behavior Modification (06)	1:7,280	1:364
Pharmacist	All Medicaid Waiver eligible, all mental health dual diagnosis and consumers with preferred programs of Medical Care (01), Autism (03) or Behavior Modification (06)	1:7,280	1:1,456
Nutritionist	All Early Start	1:4,118	1:832

Under these assumptions, the average RC would be budgeted for 26 clinical FTEs in addition to the director, including 11 RNs, 6.5 psychologists, three physicians and 2.5 each in pharmacy and nutrition.

Fiscal Administration

The mandated portion of fiscal administration consists of processing vendor payments and consumer custodial payments. Each RC is budgeted for a chief financial officer/administrator plus the following:

- ◆ A fiscal director at the controller level (1 per RC)
- ◆ Accounting Supervisors (one per eight accountants)
- ◆ Accountants.

Accountants are budgeted at 1 per 260 vendors (assuming one check per vendor per month) and 1 per 300 representative payees (based on workload hour assumptions detailed at Exhibit IV-1). The Accountant FTEs are budgeted as a mix of three positions: 25 percent Accountant II/Bookkeeper, 50 percent Accountant I/Assistant Bookkeeper and 25 percent Associate Accountant I/Account Clerk.

2. SUPPORT FUNCTIONS

The budget for support functions provides for the organization's executive functions and administrative support of all direct service functions, such as consumer service coordination or community services. It includes the internal infrastructure required by appropriate business practice. RCs have substantial needs that directly affect the ability of CSCs and others to provide direct services to consumers. Staff training, consumer records management, and information systems training and support are three key areas in which RCs do not currently have sufficient resources. These areas need to be routine investments to enable professional staff to perform their jobs effectively.

Executive and Administrative Personnel

Each RC is assumed to require a minimum set of administrative personnel:

- ◆ Executive Director;
- ◆ Chief Financial Officer/Director, Administration; and
- ◆ Administrative Assistant.

Human Resources

Positions included in this area are:

- ◆ Human Resource Administrator;
- ◆ Education and Training Administrator; and
- ◆ Human Resources Assistant.

This function coordinates hiring, personnel relations, benefits, occupational safety and compliance; administers class, position and salary structure, along with annual performance reviews;

validates time reporting, manages payroll and benefits accounting and inquiries. The overall staffing model provides for an average of 1.4 productive human resource hours per employee per month. In smaller RCs, the 1.0 FTE Director of Human Resources will fulfill all of these functions. Where required, supplemental support is provided through the Human Resources Assistant position.

The model includes one FTE as director for staff continuing education. Its placement here does not reflect line assignment but the position's functional focus on internal human resources. CSCs and other professional staff are budgeted for 40 hours of continuing education annually as their effectiveness is linked to their knowledge in technical areas, customer service, and operating skills. Clinical staff have specific mandates for continuing education as part of their licensure requirements.

Internal Finance

This functional area performs operational budgeting and monitoring as well as executive oversight to consumer/vendor fiscal services, described above. It includes monitoring of POS expenditures, management and executive reporting, coordination of external audit, etc. The primary staff function is management of internal operations accounts payable. Positions in this area include

- ◆ Chief Financial Officer and Controller positions (discussed above);
- ◆ Accounting Supervisor (1 per RC); and
- ◆ Accountant I.

The Accountant I primary activity is internal vendor payments, therefore it is budgeted relative to the volume of operational expenditures excluding payroll (which is handled via human resources). The position is budgeted at 35 hours per month per million dollars in non-payroll operations, or 0.5 FTEs per million dollars of non-payroll operations.

Information Systems

Overall budgets for information systems (IS) are generally targeted at 3-4 percent of gross operating revenue based on common industry standards. Data intensive businesses may spend up to 8 percent of revenue, while expenditures below two percent are questionable and may create vulnerability in an industry or company. Equipment, systems, and applications support are all ongoing requirements of effective operations. The budget for IS hardware and software, assuming a three-year replacement cycle, and personnel training are included in Non-Personnel, below.

A network manager, who is also responsible for the server, currently the AS400, assists the director of information systems. Support is a function of total operating staff, the variable that drives both total hardware and need for individual support; therefore technicians are budgeted relative to total employed FTEs. The model provides for one FTE per 100 employees in PC and software support.

The model provides for the following resources:

- ◆ Director, Information Systems (one per RC)
- ◆ Network/Server Administrator (one per RC)
- ◆ Data Support Technicians (1 per 100 FTEs)

Records Management

The profession of social work does not have a consistent tradition in documentation; however, effective documentation decreases time spent in interagency communication tasks, improves continuity of services across teams, and supports continuous improvement and internal quality assurance, as cited in Chapter III. Citygate's prior study on Community Placement found severe gaps in documentation that made evaluation of service effectiveness difficult. A structured, professional process for consumer record management is essential for continuity of services, evaluation and planning, and will enhance consumer service while decreasing record keeping time for CSCs and other staff.

The function defined for consumer record management extends beyond simple filing and includes:

- ◆ transcription of clinical and other assessments;
- ◆ integration of interdisciplinary notes;
- ◆ obtaining from and issuing documentation to outside vendors and agencies, etc., including copies of reports from other providers; and
- ◆ working with all consumer-support staff and most closely with CSCs.

The function incorporates Medicaid Waiver and other categorical program (Early Start, Targeted Case Management (TCM)) reporting and compliance, CDER abstracting and reporting, and client master file (CMF) updating. Abstract and reporting specialist roles include preparation of CDER and CMF updates from CSC notes. By using documentation specialists in this area, CSC time is freed for consumer service while the quality of documentation and compliance with internal and external standards improves.

Budgeting for the positions includes the following positions, with workload assumptions detailed in Exhibit IV-1:

- ◆ Consumer Records Director (1 per RC);
- ◆ Documentation & Compliance Specialist (1 per RC);
- ◆ Abstract & Reporting Specialist (1 per RC);
- ◆ Records Specialist (1:1,387 for active consumers + 1:1,664 intake cases); and
- ◆ Records Technician (1:555 consumers).

For the average RC, these assumptions result in 18.5 FTEs devoted to creating and maintaining the records needed to support the collaborative RC models in consumer service. A byproduct of this approach will be better compliance with Medicaid Waiver and other external documentation standards. However, the primary benefit will be to direct consumer service through enhanced integration and continuity within the RC and with external members of the consumer's circle of support and service providers.

Communications and Logistics

This addresses RC operational needs for central telephone and mail support as well as distributed support for telephone and calendar management. Specific administrative support to human resources, consumer records, information systems and applications are budgeted in their individual areas. Positions are budgeted at one per eight FTEs. Fifty percent of the positions are budgeted as secretaries, 20 percent as administrative assistants/executive secretaries and 30 percent as PBX/mail/filing clerks. This staffing item is in addition to the consumer record support described above. Under these assumptions, the average RC will have 30 FTEs, including the resources required for receptionist and mail service. Of these positions, on average, eight will be at the administrative assistant level.

3. NON-PERSONNEL OPERATING EXPENSES

Non-personnel operating expenses for the RCs entered the budget model in four categories:

- ◆ Governance;
- ◆ Facilities;
- ◆ Information Systems Equipment and Training; and,
- ◆ All Other Operating Expenses.

Each of these is discussed below.

Governance

A key feature of the Regional Centers is that they are organized as non-profit corporations, which means they are legally controlled by local boards of directors. In recognition of the important role played by the local RC boards, the OBM includes a minimum amount of \$15,000 per year for board-related education and development.

Facilities

Facility costs were modeled separately, since they were one of the few cost categories that were positively correlated with FTEs. Every RC was assumed to need a central location for administration, consumer services, etc. The use of facilities or other substitutes (transportation, technology) to address access in larger service areas is an option for RCs, but budgeted through this formula. Actual facility cost consistently varied by FTE in a linear function ($R^2=.794$) from a base of \$147,000 with an increment of \$3,000 per FTE (Facilities= $147000+3000(\text{FTEs})$). A power function (Facilities= $6,110(\text{FTEs})^{0.9079}$) had a higher predictive value ($R^2=.832$) but is less intuitively understandable to users.

Information Systems Equipment and Training

RC expenditures for information systems equipment and software tend to be sporadic year to year. RCs' actuals were very inconsistent both RC to RC, and year to year. A mechanism to carry-forward funds in this category is needed, since the current annual model supports higher cost options such as leasing rather than direct purchase. The average level per RC FTE is budgeted at \$750 per FTE per year, but this is likely to fluctuate substantially from year-to-year. The value assumes replacement of the computer hardware every three years and an estimated system cost of \$2,000 per person. Additional budget for software purchase and replacement constitutes the rest of the budgeted amount.

The investment in IS equipment and software loses much of its value if personnel skills are not developed concurrently. Consequently, training is budgeted at one-third of equipment expenditures each year per FTE.

All Other Operating Expenses

There are several other categories of operating expenses that are modeled as a single sum. As discussed above, this area had the weakest base for budgeting at the individual RC level due to extreme internal variance. While the model is accurate in predicting the overall dollar total, allocation to individual RCs is problematic, and will require individual allocation. These expenses total to 12.5 percent of the RC operational budget as surveyed, and include: 50 percent of equipment (assuming 50 percent is information systems, above); communications; general expenses; insurance; data processing; fees; board expenses; and legal fees. These operating expenses are modeled as a variable cost of \$195 per consumer, a number that should be updated annually.

B. SPECIAL CASE ADD-ONS

No model can accommodate all the variances in the RC system. Several budget items are unique to individual RCs, or are not truly a part of RC operations. Other items are allocated specifically to a single RC on behalf of several RCs in the area, to whom it provides a centralized service. We have moved these on a lump-sum basis, at the level in the May 1999 budget estimate. This category should be used only for unique items. *Future changes to the budget model intended to affect all RCs consistently should be implemented by changing the OBM itself, not through use of a Special Case Add-on.* Special Case Add-ons in 1997-98 and projected for 1999-2000 based on the May 1999 update are listed, below:

Special Case Add-Ons	1997-98	1999-2000 May 1999 Update
Community Services for Defendant RCs	\$1,229,000	\$ -
CRA Contract	\$376,000	\$ 1,887,000
Foster Grandparent/Senior Companion	\$648,000	\$733,000
RRDP	\$504,000	\$504,000
"Movers" Evaluation Contract	\$1,300,000	\$500,000
LQA Contract	\$220,000	\$ 2,862,000
Mediation Contract	\$-	\$806,000
CCF Staff Training Contact	\$-	<u>\$ 6,339,000</u>
Subtotal	\$4,277,000	\$13,631,000

C. SALARY AND WAGE ASSUMPTIONS

Data from RCs and from the state were reviewed in developing salary and wage models. The actual information from RCs was critical to "reality" testing the positions and ranges used from the state compensation system for RC modeling. While RCs have been constrained in compensation by the Core Staffing Formula's static assumptions, they have also had to remain relevant to hire and retain staff. They also have a wide range of personnel positions not included in the Core Staffing Formula.

The model identifies appropriate state positions and costs the positions at the middle of the current (July 1999) compensation range for that position. In executive positions, two ranges have been identified, one for very large RCs (defined as those with caseload more than one standard deviation above the mean) and one for the rest of the RCs. These are summarized in **Exhibit IV-2**, along with the actual wage rates paid by RCs for the comparable positions in 1997-98. The overall state wage level is less than two percent below a market-based estimate for RCs using their actuals adjusted with CPI updates.

Compensation differentials for regional markets were evaluated as an optional method to better match local conditions. The diversity of wage rates even within a common market such as Los Angeles/Long Beach Standard Metropolitan Statistical Area resulted in a lack of internal correlation within the RC historical data, and no regional adjustments are included in the OBM at this time.

We reviewed the Federal Medicare wage index data to assess local patterns. If local wage differentials are incorporated in future model adjustments, we recommend the use of the Health Care Financing Administration (HCFA) wage differentials for local markets. While designed to apply to health care providers, the RCs are a parallel service institution. Their mix of nursing will be lower than the hospital model; social workers and other service workers will comprise a large portion of the work force. However, the HCFA wage index data would be used to differentiate among markets rather than set an absolute standard. As a human-services based index using a standardized methodology, it represents the best available option to regionally adjust wages.

D. MODEL EVALUATION, UPDATE AND MANAGEMENT

The model is extremely flexible as a software tool. Single field edits can be made to any of the variables listed in **Exhibit IV-3**, and the model will flow these throughout to quantify the impact of changes or evaluate alternatives for planning. Several RC-specific data sets (see Exhibit IV-3) are used in the model, with information for each variable by RC. Updating these with actuals or projected data for the modeled year will recalculate throughout the model. The model needs to be viewed as a dynamic set of assumptions, and modified both as better information is available and as circumstances change. Without a process for updating the model, it will rapidly become obsolete and burdensome, reminiscent of the Core Staffing Model it is designed to replace.

The assumptions recommended in this report are the best possible at this time, based on the judgment of the Citygate Associates team and supported by extensive participation by many organizations and institutions. Within the focused framework established by the model, further select data collection and analysis is needed to evaluate and refine key assumptions. The evaluation efforts can be broken into two areas: implementation planning and ongoing management of the model.

1. Evaluation and Implementation Planning

Key assumptions that remain open to validation include the time required for specific tasks, and refinement of the model for classifying representative and complex consumers. While workload specifications in the model reflect the team's best estimates and reflect extensive work on site and in discussion with RC personnel, they have not been validated against a task-specific workload analysis. Based on the degree of ambiguity and consensus, we recommend workload evaluation be conducted in the following areas:

- ◆ Quality assurance and technical assistance tasks, specifically for out-of-home vendors;
- ◆ Intake CSC & clinical including the interdisciplinary (ID) team process;
- ◆ Workload levels for out-of-home consumer placements relative to CSC staffing;
- ◆ IPP/IFSP process including preparation, ID team, and meeting(s); and
- ◆ Fiscal administration for vendor payment and contract management.

The impact of monolingual/multiethnic cultures on these workload elements should be explicitly addressed.

Evaluation should also pursue the potential to standardize consumer authorization data and compare vendor numbers as the best determinant of internal fiscal workload. Authorizations should also be correlated to preferred program findings to assess the measure's accuracy and completeness in defining the intensity of consumer needs.

2. Management of the Model Over Time

Evaluation of the OBM assumptions needs to continue over time to avoid the extreme disconnect between reality and budget model that occurred in the Core Staffing Formula. We

recommend that each RC complete a core personnel survey at least every three years. This would include reporting paid hours by standardized position, along with salary and wage, benefits and contract hours and costs. Consistency in the instrumentation and method will assist RCs in anticipating the data request and make completion of the survey easier than with the more comprehensive and complex Citygate survey. Survey results should be analyzed to identify overall patterns including:

- ◆ Use of positions outside the standard classifications;
- ◆ Significant shifts in resources away from the OBM model;
- ◆ Significant changes in salary, wage, or benefits for individual positions compared to the OBM and state benchmark positions.

The intent of the survey would not be to evaluate individual RC operations, but to calibrate the OBM for continued relevance and identifying and monitoring gaps before they become acute. RCs should be identified in the survey to enable correlation analysis, for instance, emergence of consistent patterns in wages by high and low cost markets, etc.

At the same time, three additional data points should be collected, again using standardized accounting definitions:

- ◆ Facilities costs (rent, utilities and communications);
- ◆ Information Systems Costs (equipment and other contract services);
- ◆ All Other Non-Personnel Costs.

The analysis would be similar to that intended for the general classification and compensation survey of positions: seeking patterns across all RCs and among RCs.

Changes in salary and wage rates, as well as other cost factors such as rent are inevitable. The base OBM uses the state wage model. This model will track the overall market only when the state budget is able to generate sufficient funds. However, this pattern is likely to be mimicked in the overall RC appropriation: circumstances that restrict state salary increases will likely restrict overall RC appropriations. Assuming a purely market-driven wage model would ignore this reality and create another kind of irregularity in the OBM. The wage survey should enable consistent tracking of actual paid wages, and significant discrepancies for comparable positions should be addressed by adjusting the OBM wage model, even where it departs from state standards.

Under no circumstances should an across-the-board approach to individual wage levels be used, such as a "cost of living adjustment." Factors used to adjust the OBM's average wage rates are not to be interpreted as a pass through to wage rates at the individual level. Just as staffing levels are averages and RCs will need to exercise discretion based on specific circumstances and practice, the wage range for a specific position in an RC should be set for that RC based on the local position's duties, requirements, and competitive labor market. The wage rate for an individual employee should be set based on the local conditions and the individual performance and capabilities of the incumbent.

As indicated above, any systematic changes needed for RCs due to extrinsic (environmental) changes or intrinsic (system) changes should be implemented through explicit modification of the OBM, rather than the use of special case add-ons or other adjuncts to the model. This would include budget reductions through categorical allocations. Individual adjustment may be called for when an RC has a major step-up in rent cost, for example, whereas market-wide increases in rent cost should be addressed through adjusting the OBM formula for all RCs.

Focused validation on the preferred program analysis of CDER data is important, especially with the implementation of the new CDER. Cross tabulation to key consumer characteristics, including the potential for a new cluster analysis is appropriate as a part of ongoing maintenance of the model.

E. OPERATING OUTCOMES

The assumptions used to generate the budget model, can reasonably be expected to generate the following service outcomes, detailed below in **Table IV-3**, assuming operating systems are effective, staff performance is of reasonable quality, and under routine circumstances.

Table IV-3: RC Accountabilities under Operating Budget Model	
Mandated Function	Typical Outcomes
Intake	Completing intake, eligibility and the initial IPP/IFSP in 45-120 days, including review of current assessments and completion of needed assessments.
Consumer Service Coordination	<p>In-home, non-complex consumers in a stable situation are seen face-to-face twice a year, and also during the annual review and update of the IPP and Client Developmental Evaluation Report (CDER). The consumer and family have a brief telephone update with the CSC every month that is documented in the consumer's file, and provider contact via telephone and reports also occurs monthly, on average.</p> <p>Consumers, families and providers are able to speak directly with a CSC or supervisor "Officer of the Day" during regular working hours, Monday through Friday, and within two hours on the weekend and holidays. When a message is left for a specific responsible CSC or supervisor, the call is returned within 24 hours, except during exceptional circumstances, when the Officer of the Day handles follow-up.</p> <p>In crisis situations or for special needs, CSCs may readily access additional support resources from resource specialists (e.g., placement), clinicians (behavioral or medical crisis), or other CSC staff (Officer of the Day or supervisors) to expand the interdisciplinary team actively supporting the consumer and family. Complete and current consumer records facilitate continuity of services.</p> <p>CSCs receive 40 hours or more of continuing education annually.</p>

Table IV-3: RC Accountabilities under Operating Budget Model

Mandated Function	Typical Outcomes
Community Services	<p>Third-party vendors all receive annual on-site reviews and triennial comprehensive reviews, including training, assistance and follow-up. Fiscal monitors are included in the annual review as appropriate.</p> <p>Consumers, families and vendors are able to reach a special incident coordinator within two hours, seven days a week. Special Incident Reports are tracked by vendor and by functional issues, as are Life Quality Assessments to identify patterns and initiate appropriate interventions.</p> <p>Files on both RC-vendor and generic resources are current and complete. Facilitation and advocacy with generic resources is routine. Resource development specialists routinely support CSCs in identifying and accessing IPP services for individual consumers, and by advocating for consumers with vendors.</p>
Outreach and Advocacy	<p>Consumers and families can reach a consumer advocate or the consumer service representative within 24 hours of initial contact.</p> <p>Compliance for consumers with forensic status, including court guardianship, criminal action, or other issues is coordinated through a forensic specialist, who actively supports CSCs in these areas.</p> <p>RC boards have ongoing training and development, including access to external training programs, along with appropriate facilitation and logistics support.</p>
Clinical Services Monitoring	<p>CSCs may routinely consult with technical support in clinical areas including, but not limited to medicine, psychology, psychiatry, nursing, nutrition, pharmacology and genetics; these resources are actively involved with 30% to 50% of consumers in a given year. A Registered Nurse (RN), or other clinician, as appropriate, participates in IPP updates every three years with every consumer, and in the annual reviews of complex and high-risk consumers.</p> <p>Specific health service indicators are defined, based on consumer needs and risk factors. For example, consumers on psychotropic medication receive a current psychiatric consult annually; diabetic consumers receive annual HbA1c and cholesterol testing and receive foot exams annually; female consumers over a specified age have annual breast exams, etc. The RC is not responsible for direct provision of these services, but for monitoring access and ensuring provision, unless consumers and families refuse services. POS may be used as a last resort.</p> <p>Clinicians and behaviorists are routinely available, on site if needed, to discuss special needs with families and vendors. CSCs can request clinical consultation and support without POS authorization.</p> <p>RC activities as well as reports by providers are current in the consumer file.</p>

Table IV-3: RC Accountabilities under Operating Budget Model	
Mandated Function	Typical Outcomes
Fiscal Services	<p>Vendors are paid monthly in a consistent cycle for services provided. Representative payee accounts are accurate and readily available.</p> <p>RC internal controls, financial practice, and reporting are consistent with generally accepted accounting principles. The RC receives an unqualified opinion from an independent financial audit each year.</p>

EXHIBIT IV-2
(Consists of 6 pages)

<i>Personnel Positions and Wage Rates</i>				
Generic Title	Description	RC Survey, 1997-98 Annualized	Benchmark State Position	State Compensation Midpoint July 1999
Executive Director - Large RCs (more than one standard deviation above other RCs on weighted consumer size)	Serves as the CEO of the RC, responsible for management and operations. Reports to the Board and participates in policy development.	\$92,394	Exempt Category E	\$102,020
Executive Director	Plans and directs policy implementation. Represents the RC in external forums.	\$92,394	CEA IV	\$94,848
Consumer Forensic Specialist	Has an expert familiarity with law and regulation especially as it pertains to consumers' rights and RC responsibilities. Assists case managers and other RC personnel in complying with regulation, educating vendors and protecting consumers' rights. Assists in court interactions including public guardian, juvenile and criminal court jurisdictions.	\$53,705	Community Program Specialist III	\$56,129
Consumer Advocate	Serves as an advocate for consumers and their families to facilitate solutions to problems, concerns and unmet needs. May cross departmental lines and engage in cooperative endeavors with consumer service coordinators, staff and vendors to identify problems and expedite resolutions.	\$34,160	Social Work Associate	\$31,955
Public Information Officer	Coordinates the RC's public information program to meet the specific needs of the public and interested parties, including preparation of materials in a variety of media suitable for both consumers and the general public. Supports advocacy through enhanced public awareness of the needs and opportunities associated with inclusion of the developmentally disabled. Established and maintains a community information program and liaison with media, governmental and community organizations.	\$40,639	Community Program Specialist II	\$49,833
Customer Service/Complaints	Serves as an advocate for consumers, families, vendors and other interested parties to facilitate solutions to problems, concerns and unmet needs. May cross departmental lines and engage in cooperative endeavors with consumer service coordinators, staff and vendors to identify problems and expedite resolutions.	\$40,639	Community Program Specialist II	\$49,833
Consumer Services Director / Chief Counselor (Large RCs)	Directs program/regional managers, responsible for operating the RC's case management program. Implements board and executive policy. Serves as a member of executive management team.	\$73,241	CEA II	\$82,206
Consumer Services Director / Chief Counselor		\$73,241	CEA I	\$71,585
CSC Manager	Provides management of several CSC units where needed in larger RCs. Reports to CS Director and supervises CS Supervisors.	\$64,446	20% Range Differential from CSC Supervisor	\$55,352

<i>Personnel Positions and Wage Rates</i>				
Generic Title	Description	RC Survey, 1997-98 Annualized	Benchmark State Position	State Compensation Midpoint July 1999
Program/ Regional Manager / Supervising Case Manager	Supervises case managers, including workload assignment, scheduling and performance reviews. Ensures that case managers obtain appropriate support from other RC resources. Ensures services are provided within the established standards and guidelines.	\$53,705	20% Range Differential from CSC	\$46,127
Senior CSC/Case Manager	Citygate defined as Social Worker II described in Appendix E.	\$37,576	Social Worker II per Citygate Survey	\$44,408
Service Coordinator / Case Manager / Consumer Program Coordinator	Provides ongoing case management to individual consumers. Assesses needs and coordinates services through the IPP process. Identifies and resolves consumer, family and vendor concerns for all services needed by the consumer, including RC, POS & generic.	\$34,160	Survey using Citygate defined benchmarks at 40% Social Worker I, 40% Social Worker II and 20% Social Worker III. Includes 5% Bilingual differential for 50%	\$38,439
Community Services Director (Large RCs)	Directs resource development and vendor relations programs, including quality assurance	\$57,697	CEA II	\$82,206
Community Services Director,		\$57,697	CEA I	\$71,585
Resource Developer	Plans and initiates the development of community services through community outreach and interagency coordination. Directs development and maintenance of resource lists for consumer referrals. Reviews new vendor applications.	\$40,639	Community Program Specialist II	\$49,833
Resource Specialist	Under direction of Resource Developer, implements community outreach and interagency coordination plans, maintains resource list for consumer referrals, and processes new vendor applications.	\$37,576	Community Program Specialist I	\$41,371
Quality Assurance Coordinator	Coordinates evaluations of community programs and services. Provides consultations and/or training to programs and RC staff to improve service quality and compliance with standards. Develops procedures for evaluations.	\$38,158	Community Program Specialist II	\$49,833
Special Incidence Follow-up/On Call	Identifies problem areas in consumer services by compiling, analyzing and summarizing information gathered from incident reports, review of consumer records and other relevant sources. Reports critical impact incidents to appropriate personnel and may act as first respondent and liaison in intervention to ensure consumer safety.	\$38,158	Community Program Specialist II	\$49,833
Vendor Training Coordinator	Responsible to conduct basic orientation, assist in facilitating vendor training and technical assistance.	\$38,158	Community Program Specialist II	\$49,833

EXHIBIT IV-2
(Consists of 6 pages)

<i>Personnel Positions and Wage Rates</i>				
Generic Title	Description	RC Survey, 1997-98 Annualized	Benchmark State Position	State Compensation Midpoint July 1999
Program Evaluator	Schedules and performs evaluations of community programs and services using standardized methods. Analyzes findings, develops recommendations and prepares reports. Consults with programs to improve program quality and compliance.	\$35,336	Community Program Specialist I	\$41,371
Fiscal Monitor	As a function of quality assurance, evaluates fiscal affairs of vendors.	\$29,963	Acct Officer/ Supervisor	\$42,407
Director, Clinical Services, (Large RCs)	Responsible for planning & coordinating services that promote and ensure health & well being of RC consumers. May include supervision of intake services. Oversees health enhancement and monitoring services.	\$71,162	CEA II	\$82,206
Director, Clinical Services, Centers		\$71,162	CEA I	\$71,585
Physician	Perform medical evaluations and diagnosis consistent with DDS law and regulation. Assess consumer needs, participate in preparing consumer's program plan, consult with and coordinate activities with RC, vendor and external professional personnel as needed.	\$93,353	Physician & Surgeon, Range D	\$107,078
Psychologist	Perform psychological evaluations and diagnosis consistent with DDS law and regulation. Assess consumer needs, participate in preparing consumer's program plan, consult with and coordinate activities with RC, vendor and external professional personnel as needed.	\$56,542	Psychologist (Senior)	\$59,729
Pharmacist	Consulting pharmacist with expertise in psychotropic medication, drug interactions and experience with neurology including seizure medication management (Pharmacy II/I).	\$53,040	Pharmacy Services Manager	\$64,752
Nurse Specialist	Consulting Registered Nurse with expertise in needs relevant to the RC consumer population. Specialty areas may include chronic health needs, specific conditions such as neurology, diabetes, or developmental disabilities, long term care, facilities and licensing. Consults to RC personnel, vendors, consumers and families. Works directly with consumers and prepares nursing assessments, consults with other providers and assists in ensuring consumers have access to needed health promotion and medical services consistent with their needs.	\$38,364	Nurse Consultant I	\$50,195
Nutritionist	Assess consumer needs, advise on nutrition and feeding issues.	\$35,021	Public Health Nutrition Consultant I	\$39,986

<i>Personnel Positions and Wage Rates</i>				
Generic Title	Description	RC Survey, 1997-98 Annualized	Benchmark State Position	State Compensation Midpoint July 1999
Administrative Assistant / Executive Secretary	Coordinates, screens and refers contacts/issues as appropriate. Supports management in executing responsibilities. Prepares special reports, maintains documentation, follows up on assignments on behalf of superior.	\$34,007	Executive Secretary II	\$37,022
Secretary	Responsible for calendar, coordination and scheduling meetings, and processing related paperwork. Compiles, tabulates and verifies data and prepares routine reports. Coordinates centralized filing and ensures availability of information on a timely basis.	\$22,762	Office Assistant, Typing	\$25,665
PBX/Mail/File Clerk	Includes receptionist, telephone operators, mail room, computer data entry, word processing and filing.	\$21,182	Office Assistant, General	\$25,665
Director, Administrative Services/Chief Financial Officer (Large RCs)	Manages finance, accounting, data processing, personnel, and office operations, including external reporting.	\$71,635	CEA II	\$82,206
Director, Administrative Services/Chief Financial Officer	Designs and supervises implementation of internal controls. Manages liquidity and treasury accounts. Controls purchasing, property and supply.	\$71,635	CEA I	\$71,585
Office Administrator / Operations Manager	Oversees office operations including facility, space, supplies, telephone, equipment and furnishings. Oversees supplies and equipment purchasing and office support staff. Develops office procedures and provides internal training.	\$39,836	Office Services Supervisor II	\$32,454
Consumer Record Administrator	Designs, initiates and coordinate methods for collecting, analyzing, storing, retrieving and reporting accurate consumer case information and statistics in compliance with federal, state and local laws, professional standards and the data needs of case managers, clinicians, consumers, administrators and governmental agencies.	\$46,379	Medical Records Director	\$41,583
Documentation & Compliance Specialist	Maintains expert familiarity with special regulatory requirements of DDS, HCFA and other key regulatory agencies affecting RC consumers. Consults with RC management and staff to ensure consumer record systems are efficient and meet specific standards. Designs and executes quality assurance procedures to monitor compliance and reporting for these systems.	\$34,007	Health Records Technician III	\$36,910

EXHIBIT IV-2
(Consists of 6 pages)

<i>Personnel Positions and Wage Rates</i>				
Generic Title	Description	RC Survey, 1997-98 Annualized	Benchmark State Position	State Compensation Midpoint July 1999
Abstract & Reporting Specialist	Compiles statistics for use in reports and surveys. Maintains expert familiarity with DDS and other consumer data systems including criteria and standards. Consults with RC personnel to ensure compliance with data system standards and effective utilization of summary data available from these sources.	\$34,007	Health Records Technician III	\$36,910
Record Specialist II	Under general supervision, assembles consumer records, evaluates them for completeness, works with professional personnel to ensure completeness and timeliness of entries. Prepares charts for fair hearings and other special reviews. Has expertise in clinical terms and vocabulary and ability to transcribe clinical dictation.	\$22,762	Office Assistant, Typing	\$25,665
Record Specialist I	Under close supervision, assembles consumer records, evaluates them for completeness and works with professional personnel both inside the RC and POS vendors to ensure completeness and timeliness of entries. Abstracts and reports specific information from records in response to authorized requests. Obtains authorized information on consumers from external parties including clinicians.	\$21,182	Office Assistant, General	\$25,665
Controller/ Accounting Director	Directs accounting from recording transactions through financial statement and report preparation. Responsible for the general ledger (UFS); supervises posting, reconciling, preparation of schedules reports. Monitors budget and reports variances.	\$55,605	Accounting Administrator II	\$61,632
Accounting / Fiscal Supervisor	Supervises accounting functions. Reviews and/or prepares specialized entries. Resolves accounting, consumer trust and vendor issues. Interprets policy, regulation & procedure. Reviews and approves purchase & payment authorizations.	\$40,220	Acct Officer/ Supervisor	\$42,407
Accountant II/Bookkeeper	Processes transactions including payroll, accounts payable and receivable. Verifies authorizations, prepares checks and reconciles accounts. May include consumer revenue coordination.	\$29,963	Accounting Technician "II"	\$32,280
Accountant I/Assistant Bookkeeper	Processes transactions including payroll, accounts payable and receivable. Verifies authorizations, prepares checks and reconciles accounts. May include consumer revenue coordination & accounting.	\$27,239	Accounting Technician	\$29,721

<i>Personnel Positions and Wage Rates</i>				
Generic Title	Description	RC Survey, 1997-98 Annualized	Benchmark State Position	State Compensation Midpoint July 1999
Associate Accountant I/Account Clerk	Performs routine transaction posting, processing and verifying, following established procedures. May include consumer revenue coordination and accounting.	\$24,392	Account Clerk II	\$26,639
Director, Human Resources	Under executive direction, supports RC managers and staff in recruitment, benefits, wages, personnel records and employee relations. Plans, develops and implements programs. May include responsibility for volunteer programs.	\$48,666	Staff Services Manager I	\$56,129
Human Resources Specialist	Under the direction of the Director, Human Resources, administers employee files and records, coordinates and schedules interviews, answers employee inquiries and assists the Director.	\$32,429	Personnel Services Specialist I	\$32,429
Information Systems Manager	Manages the RC's computer systems, including AS 400 and supervision of networks. Plans for system requirements including employee training. Coordinates and integrates functions and enhancements with user departments, including management reporting.	\$46,266	Staff Services Manager III	\$71,386
Network Manager	Responsible for local and remote area networks for personal computers, including internal and external e-mail, security and backup. Establishes procedures for maintaining network, software and related hardware.	\$38,620	Associate Information Systems Analyst	\$52,322
IS Assistant/ Computer Support Technician	Provides hand-on user support for software and hardware PC issues, including network operations and backup. Performs maintenance and repairs, and coordinates with external vendors and technicians as needed.	\$27,106	IS Tech Specialist I	\$39,499
Internal Development and Training	Plans and coordinates RC employee training and development, including needs assessment, program design and obtaining/providing instruction as appropriate. Facilitates professional development for RC personnel and board members.	\$46,379	Training Officer I	\$49,833
Facilitator	Provides assistance to consumers serving on the RC Board or as consumer advocates.	\$21,888	Support Services Assistant, Interpret/HWA	\$34,932

BUDGET MODEL VARIABLES

Global Assumptions

1. Productive Hours/FTE, Executive/Physicians/Psychologist
2. Productive Hours/FTE, Staff
3. Fringe Benefits as Percent of Salary & Wage
4. Salary Model Used (State or RC Actuals)
5. Wage Increase over Salary Model Base (%)
6. Workload Increase over Model Base (%)

Non-Personnel Expense

1. Facilities Fixed Cost/RC
2. Facilities Variable Cost/FTE
3. Facilities Rate Increase over Base
4. Data Processing Equipment Dollars/FTE
5. Governance Development Fixed Dollars/FTE
6. Board Facilitator FTE/RC
7. Governance Rate Increase over Base
8. Other Non-Personnel Operating Cost/FTE
9. Other Non-Personnel Operating Cost Rate Increase over Base

Staffing Ratios

1. Intake Cases/CSC/Year: Early Start
2. Intake Cases/CSC/Year: All Other
3. Consumers/CSC: Representative
4. Consumers/CSC: Complex
5. CSCs/Supervisor
6. CSC Supervisors/CSC Manager
7. Third Party Vendors/CSC
8. Consumers/Physician/Year: Representative
9. Consumers/Physician/Year: Complex
10. Consumers/RN/Year: Representative
11. Consumers/RN/Year: Complex
12. Consumers/Psychologist/Year: Representative
13. Consumers/Psychologist/Year: Complex
14. Consumers/Nutritionist/Year: Representative

15. Consumers/Nutritionist/Year: Complex
16. Consumers/Pharmacist/Year: Representative
17. Consumers/Pharmacist/Year: Complex
18. Intake Cases/Physician/Year: Early Start
19. Intake Cases/Physician/Year: All Others
20. Intake Cases/RN/Year: Early Start
21. Intake Cases/RN/Year: All Others
22. Intake Cases/Psychologists/Year: Early Start
23. Intake Cases/Psychologists/Year: All Others
24. Consumers/Resource Developer: Complex
25. Consumers/Resource Developer: Representative
26. Average Paid QA Hours/RCF Vendor
27. Average Paid QA Hours/Other Third Party Service Vendor
28. Average Paid Fiscal Monitors/Vendor
29. Average Paid Account Clerk Hours/Vendor
30. Average Paid Account Clerk Hours/Representative Payee
31. Account Clerks per Fiscal Supervisor
32. Secretary/Clerk/PBX/Mail Room FTE ratio to Professional FTEs
33. Data Processing FTE per employed FTE
34. Human Resources FTE per employed FTE
35. Consumers/Records Specialist
36. Intake Cases/Year/Records Specialist
37. Consumers/Records Clerk

RC-Specific Data Sets In Model

1. Consumers by CMF Status 01
2. Consumers by CMF Status 02
3. Consumers by CDER Preferred Program—
by Dual Diagnosis
by Early Start Status
by Residential Placement
by Waiver Eligible Status
4. Average Monthly Intake/Early Start (DDS Survey)
5. Average Monthly Intake/All Others (DDS Survey)
6. Vendors by Type (Paid Vendors File)

EXHIBIT IV-4 November 1998-99 RC Operating Budget Cross Reference to Recommended Operational Budgeting Model		
<u>Budget Item</u>		<u>Citygate Model</u>
A	Restoring Case Management Services	
1	Restoration of unallocated reduction for case management staff	There is no unallocated reduction in our model, therefore this is not a separate funding issue
2	Update of case management (CM) salaries to recommended state equivalents	Model uses current (as of 7/1/99) salaries
3	Salary savings reduction from 5.5% to 1.0% for CM	Model has no salary savings assumption (0%)
4	Additional Essential Positions	Included in Model Staffing
	21.0 Information Services Manager	Information Systems position
	21.0 Personal Computer Systems Manager	Information Systems position
	21.0 Training Officer	Human Resources position
	21.0 Special Incident Coordinator	Community Services: Quality Assurance position
	51.5 Vendor Fiscal Monitor	Community Services: Quality Assurance position
	21.0 Human Resources Manager	Human Resources position
	21.0 Information Systems Assistant	Information Systems positions (model provides more than this)
	44.4 Secretary (1:4)	Human Resources Assistant: Information and Logistics
5	Impact of 1-3-775 new case management teams (CPC+supervisor)	Via CSC Staffing
B	Medicaid Waiver	
	Operations costs	Included in Clinical; Records Management; CSC
C	QA/Quarterly Monitoring	
	Staff to monitor consumers 4x year in CCF, S/IL, SNF/ICF & FHA settings	Included via CSC
	CCF 22755 x 6 hour visit to 6 person facility + 9 hour follow-up = 2.5 per person x 4	Accommodates 2.5 hrs x 4
	SL/IL 13069 x 1.5 per person visit + 2 hr per person follow-up = 3.5 per person x 4	Accommodates 3 hrs x 4
	SNF/ICF 8180 x 6 hrs/6 person facility + 9 hr follow-up = 2.5 per person x 4	Accommodates 2.5 hrs x 4
	FHA: 100 x 6 hrs/6 person facility + 9 hr follow-up = 2.5 per person x 4	Accommodates 2.5 hrs x 4

EXHIBIT IV-4

(Consists of a total of 3 pages)

D	Community Placement Plan	
	21.0 Resource Developers for DC placement	Included in Resource Development along with other specialist (minimum of 4.0 FTEs/RC)
	Case management enhancement (1:88 to 1:79)	Included in CSC
	DC Liaison (6 month pre-placement work w/ DC residents & face-to-face every 30 days for 90 day post placement) (1:25 cases)	
	DC Liaisons Assessment Staff (Outplacement planning 1:70)	
	Ongoing case management (1:62 to 1:45) 21.4 CPC FTEs	Included in CSC
	LQA	Liaison included in quality assurance
	Community services for defendant RCs (\$100 K/per RC for DC screening, 2.0 CPCs/RC case management, 1.0/ RC resource development, 0.5/FTE training in flexible living arrangements & \$75K/per consultant evaluation of CLO)	Included as Special Case
E	Early Start/Part C	
	Case Management Enhancement (1:83 to 1:62) + salary update	Duplicates CM restoration, Item 1-4, above
	Case Management differential for different federal requirements (17,285 children funded at 1:45)	Included in model CSC at 45:1
	45 day assessment & IFSP preparation	In intake: No staffing impact on ongoing basis
	Interdisciplinary participation in IFSP	Minimum performance standard for all consumers at 62:1 and below
	IFSP periodic review every six months	Included in model CSC at 45:1
	Transition at 30-36 months to exit Part C	Included in model CSC at 45:1
	Administrative Support (lump sum) tracking Part C funds, audit act, data collection & reporting, appeals	Included in Records Management, Community Services, QA
	Clinical Support (lump sum) 45 day intake & assessment compliance	In clinical intake: Length of time to complete has no impact on ongoing basis
F	Clinical Teams: annual reviews of medical, health care plans & behavioral plans for CCF & S/IL residents & review all mortalities	In clinical monitoring
	21 Pharmacists	In clinical monitoring
	21 MD	In clinical monitoring
	21 RC	In clinical monitoring
	21 Psychologists	In clinical monitoring
G	CCF Training	Included as Special Case
H	Increase Access to Health & Quality Services	In clinical monitoring
	Supplement to F, plus consultation to other populations, prevention & access & advocacy	In clinical monitoring

EXHIBIT IV-4
(Consists of a total of 3 pages)

	14 Pharmacists	In clinical monitoring
	14 MD	In clinical monitoring
	14 RC	In clinical monitoring
	14 Psychologists	In clinical monitoring
I	Targeted Case Management: 5.8% of TCM reimbursements	Included in CSC, Consumer Records Management
J	LQA Contract	Included as Special Case
K	CRA Contract	Included as Special Case
L	Mediation	
	1.8 Supervision CPC (1 hr prep, 3.5 meeting)=4.5 per mediation	Included in CSC Officer of the Day Support
	0.2 Clinical Staff (2 hrs/per 25% of mediations)	Included in Clinical Monitoring Role
	0.9 CPC (4.5 hrs per mediation)	Included in CSC Officer of the Day Support
	Training for RC staff	Included in 40 hour continuing education for CSC (nonproductive time assumption)
	Mediation Contract personnel	Included as Special Case
M	Wellness Project	Included as Special Case
N	Movers Evaluation Contract	Included as Special Case
O	SB 1039 Program Change (0.5 Admin Analyst + Clerical support/RC)	Included in Outreach & Advocacy, Logistics & Communications staff
	Rights notices to all consumers in community living	Included in Outreach & Advocacy, Logistics & Communications staff
	Complaints follow-up for those not resolved by CRA	Included in Outreach & Advocacy, Logistics & Communications staff
	Written notice of complaints rights	Included in Outreach & Advocacy, Logistics & Communications staff
P	Sherry S Court Cases	Included as Special Case
Q	Foster Grandparents/Senior Companion	Included as Special Case
R	RRDP	Included as Special Case
S	DSS Incidental Medical Care Regulations (3.4 CPCs + supervision & clerical)	Monthly monitoring of 350 CCF ADL dependent 6hrs/6 people facility; 9 hr follow-up; 2.5 hr/consumer for 8 incremental visits over quarterly requirement

V. OPERATING BUDGET MODEL OUTCOMES

Using the baseline Operating Budget Model (OBM) described in Chapter IV, the statewide total Regional Center (RC) budget outcomes are presented in this section, along with alternative scenarios and a sensitivity assessment.

A. BASE CASE RESULTS

Based on common workload levels, **Table V-1** shows the total dollar amount of the RC operating budget for 1999-2000 as projected by the OBM model. The Department of Developmental Services (DDS) budget proposal for the same period, based on the May 1999 update, is shown adjacent.

Table V-1: Comparison of Operating Budget Model to Core Staffing Formula Projections, FY 1999-2000

	Operating Budget Model Outcome 1999-2000 (Projected)	Core Staffing Formula 1999-2000, May Revision	Numerical Change from OBM to Core Staffing Formula	Percent Change from OBM to Core Staffing Formula
PERSONNEL				
Salaries	\$261,391,718			
Benefits (at 23.9%)	<u>\$62,472,621</u>			
Total Salaries & Benefits	\$323,864,339			
NON-PERSONNEL				
OPERATING	<u>\$59,467,581</u>			
OPERATING TOTAL:	\$383,331,919	\$304,284,000	\$79,047,919	26%
SPECIAL CASES	19,842,000	19,692,000	150,000	1%
GRAND TOTAL:	\$403,173,919	\$323,976,000	79,197,919	24%
Budgeted FTEs	6,492	6,488 est.	4	0%
Average Annual Wage	\$40,266	\$33,800	\$6,466	19%
Total Consumers	153,600	153,600	N/A	N/A
Complex Consumers	32,348	32,348	N/A	N/A

The modeled budget is 24 percent higher than the 1999-2000 proposed budget (May 1999 Update). An exact comparison of full-time equivalents (FTEs) for the 1999-2000 budget is not possible since portions of the budget are lump-sum amounts, and the Core Staffing Formula estimate of 6,488 FTEs overstates the funded FTEs due to low wage assumptions. The May update calls for approximately 6,488 FTEs at an average annual wage of \$33,800. This compares to the 1999-2000 OBM projection of 6,492 FTEs with an average annual wage of \$40,266. The May update did not reflect a four percent cost of living adjustment to all state salaries effective June 1, 1999, but this is included in the OBM.

Staffing by functional area is shown in **Table V-2** below (before Special Case Add-ons). The greatest increase is in community services in both raw numbers and percent. Clinical

services saw the second largest percent increase. The slight increase in average salary between the actual paid and the 1997-98 OBM is primarily due to the concentration of the model's FTE increases in skilled and professional positions with higher individual compensation than the overall average.

Table V-2: Full-Time Equivalent Positions Budgeted by OBM

Position Categories	1999-2000 OBM Total FTEs	1997-98 Citygate Survey FTEs	Percent Change
Intake Consumer Service Coordination	165	62	165%
Consumer Service Coordination & Supervision	3,348	2,321	44%
Clinical Services	561	151	272%
Community Services	756	235	222%
Fiscal Services and Administration	<u>1,661</u>	<u>1,027</u>	<u>62%</u>
TOTAL	6,490	3,796	71%

A functional representation of the FTEs generated by the budget model is presented as **Table V-3**. Note this is not a recommended organizational or operational model, but a schematic presentation of budgeted positions by functional area. Individual RCs will arrange operations and line relationships at their discretion.

Table V-4 details the modeled full-time equivalent (FTE) positions, by position type, generated by the OBM. The salary amounts used are the midpoints of the salary range of equivalent State of California positions as of June 1, 1999, per Table V-4, with the exception of the Consumer Service Coordination (CSC) series and supervisors, where a compensation survey of California's ten largest counties was used (**Appendix E**). Again, individual RCs will determine the actual personnel mix and staffing to implement in operations.

**Table V-3: Full-Time Equivalent Positions Modeled by Functional Organization
1999-2000 Projection Before Special Case Add-Ons**

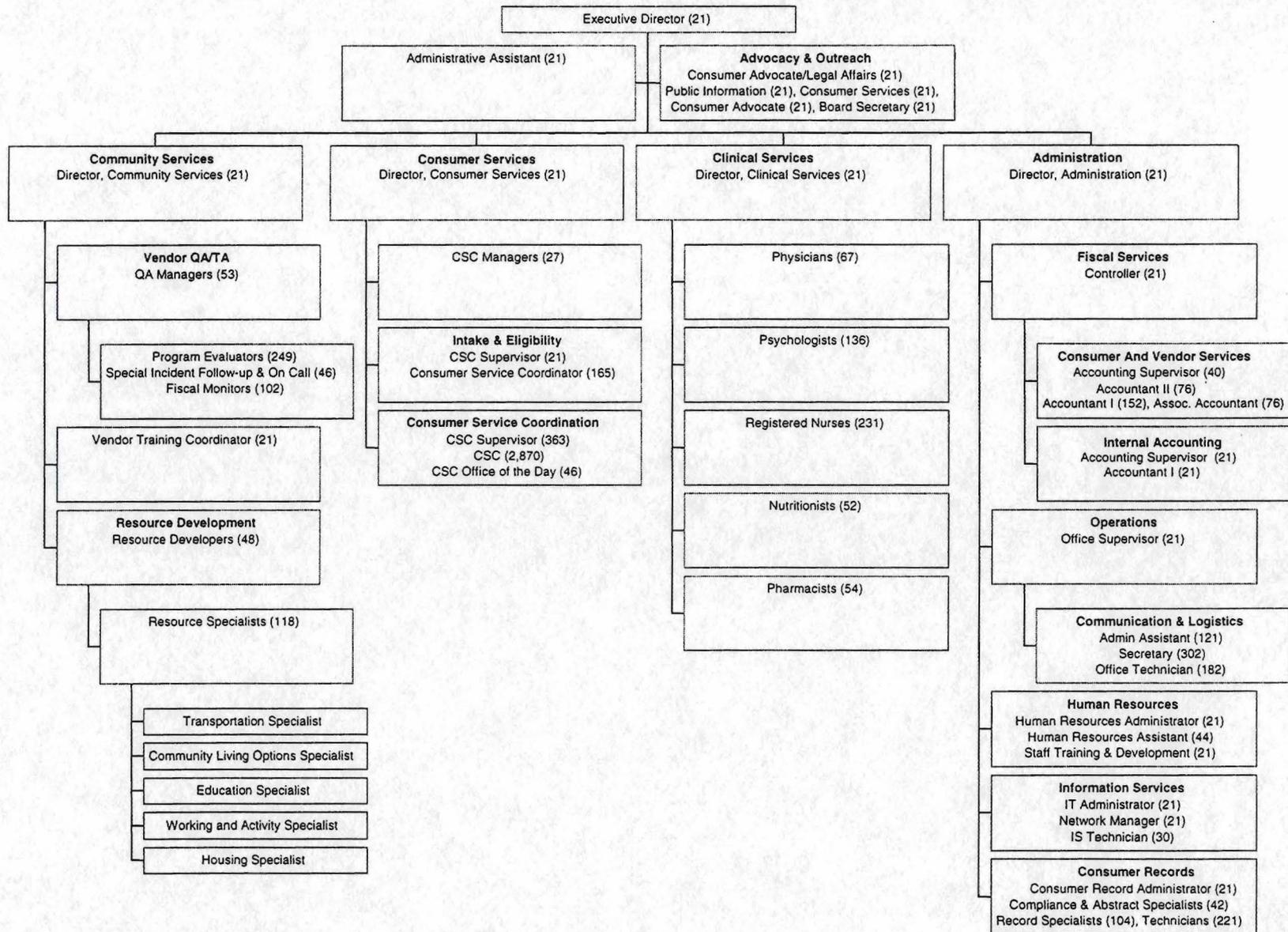


Table V-4: Operating Budget Model Full-time Equivalents by Position

Projected 1999-2000

Position	FTEs	Annual Salary	Total Salary Cost
1. MANDATED SERVICES			
Director, Consumer Services	21.0	\$73,102	\$1,535,152
CSC Manager	27.0	\$55,228	\$1,491,165
Supervising Counselor	384.5	\$46,024	\$17,696,074
Intake Workers-CSC	164.5	\$40,435	\$6,651,595
Consumer Service Coordinators (CSC)	2802.5	\$38,353	\$107,484,283
Quality Assurance Participation	67.0	\$38,353	\$2,569,651
CSC Officer of the Day/On Call	45.9	\$38,353	\$1,761,841
Director, Clinical Services	21.0	\$73,102	\$1,535,152
Physician	67.0	\$107,078	\$7,171,905
Psychologist	135.9	\$59,729	\$8,115,656
Pharmacist	54.2	\$64,752	\$3,512,465
Nurse (Other than CSC)	231.0	\$50,195	\$11,594,943
Nutritionist	52.3	\$39,986	\$2,089,620
Director, Community Services	21.0	\$73,102	\$1,535,152
Public Information Officer	21.0	\$49,833	\$1,046,485
Consumer Forensic Specialist (formerly CRA)	21.0	\$56,129	\$1,178,705
Customer Service/Complaint	21.0	\$49,833	\$1,046,485
Consumer Advocate	21.0	\$31,955	\$671,056
Facilitators (Consumer Advocate)	15.8	\$34,932	\$550,171
Quality Assurance Coordinator	52.5	\$49,833	\$2,616,214
Program Evaluator	248.5	\$41,371	\$10,280,743
Fiscal Monitor	102.0	\$42,407	\$4,325,518
Vendor Training Coordinator	21.0	\$49,833	\$1,046,485
Special Incident Follow-up and On Call Support	45.9	\$49,833	\$2,289,187
Resource Developers	47.9	\$49,833	\$2,388,369
Resource Specialists	<u>117.7</u>	<u>\$41,371</u>	<u>\$4,869,854</u>
Subtotal	4830.1	\$42,867	\$207,053,927
2. FISCAL MANDATES & ADMINISTRATIVE SUPPORT			
Executive Director	21.0	\$95,873	\$2,013,324
Administrator/Chief Financial Officer	21.0	\$73,102	\$1,535,152
Controller	21.0	\$61,632	\$1,294,282
Accounting/Fiscal Supervisors (Trust, POS and Contracts)	60.5	\$42,407	\$2,565,626
Accountant II	75.8	\$32,280	\$2,445,174
Accountant I	173.0	\$29,721	\$5,141,754
Associate Accountant I (Also see Accountant I & II, above)	75.8	\$26,639	\$2,017,871
Office Manager	21.0	\$32,454	\$681,539
Executive Secretary/Administrative Asst/Office Supervisor	162.8	\$37,022	\$6,027,169
PBX/Mail/File Clerk	181.2	\$25,665	\$4,650,520

Position	FTEs	Annual Salary	Total Salary Cost
Secretary/Clerical	302.0	\$25,665	\$7,750,866
Human Resources Administrator	21.0	\$56,129	\$1,178,705
Human Resources Assistant	43.5	\$32,429	\$1,410,674
Information Technology Administrator	21.0	\$71,386	\$1,499,098
Network/Server Manager	21.0	\$52,322	\$1,098,770
IS/PC Technician	30.5	\$39,499	\$1,203,333
Internal Education & Training Administrator	21.0	\$49,833	\$1,046,485
Consumer Record Administrator	21.0	\$41,583	\$873,251
Documentation & Compliance Specialist	21.0	\$36,910	\$775,102
Abstract & Reporting Specialist	21.0	\$36,910	\$775,102
Record Specialist (Including Medical Transcription)	104.0	\$25,665	\$2,669,172
Record Technician	<u>221.5</u>	<u>\$25,665</u>	<u>\$5,684,824</u>
Subtotal	1661.5	\$32,704	\$54,337,791
TOTAL STAFFING	6491.6	\$40,266	\$261,391,718

B. SENSITIVITY ANALYSIS

The software spreadsheet used to produce the budget estimate for each RC and the state as a whole can be easily used to evaluate potential changes in policy and funding. The following examples test the sensitivity of the model to changes in key assumptions. **Table V-5** summarizes the impact of those changes.

Table V-5: Sensitivity of Model Outcome to Assumption Variances

Change	Dollar Impact	Change in Salary & Benefits	Total Change
Wage Rate Up 5%	\$16.2 million	5.0%	4.0%
CSC Wage Only Up 5%	\$8.5 million	2.6%	2.1%
Staff Productive Hours at 70% of Paid Hours (vs. 80% in base)	\$7.9 million	2.3%	2.0%

The model is most sensitive to changes in wage rates, with a linear impact of over 80 percent of the wage rate increase to the operational budget total. CSC wages are the most important element of this, accounting for 52 percent of the effect of an across-the-board increase in salary and wage. Bottom line impact for CSC wage changes is 42% of the raw percent change (e.g., a 5 percent CSC increase translates into a 2.1 percent bottom line increase).

A key assumption is the percent of paid hours (the full time equivalent of 40 hours a week, 52 weeks a year) that are available for productive work. A certain portion (vacation, holiday and sick leave) is by necessity not available. Another increment of time is spent in related but indirect activity, including continuing education and staff development. The base model assumes staff positions are available to serve consumers 80% of the time (1,664 hours per year). If productive time was only

70% of paid hours (1,456 hours per year, or 12.5% less than in the base case), overall cost would increase two percent.

The productive time standards at 80% and 70% (professional positions) are based on the following assumptions:

Annual Hours/Employee	Staff	Executive/Professional
Non-Productive Time:		
Vacation	80	120
Holiday	88	88
Sick Leave	40	40
Continuing Education	40	80
Incidental Administrative Activities Outside of Core Duties	137	263
Other	<u>31</u>	<u>33</u>
Subtotal	416	624
Productive Hours	1,664	1,456
Total Paid Hours (52 weeks x 40 hours/week)	2,080	2,080
Productivity Assumption	80%	70%

APPENDIX A

APPROACH AND METHODOLOGY

APPENDIX A: APPROACH AND METHODOLOGY

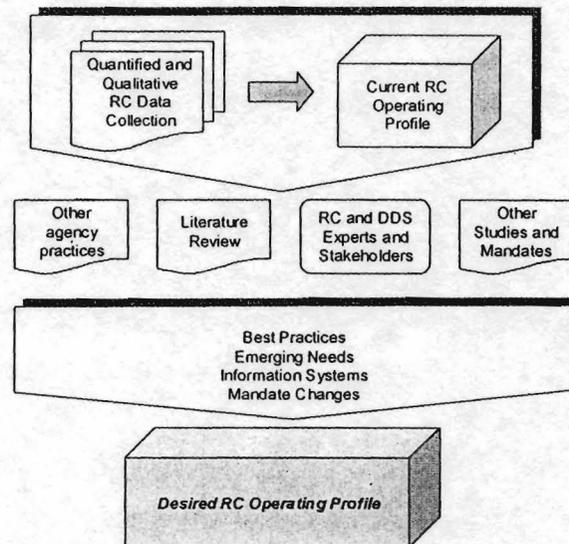
This study sought to answer two distinct but overlapping questions:

1. *What staff and operating resources are required for RCs to meet their mandates and client needs, including monitoring and quality assurance?*
2. *What budget methodology credibly and fairly allocates resources to the RCs while incorporating quantitative and qualitative standards; quality measurement capability; consideration of current and future technology; and flexibility?*

The questions are distinct from one another in that the first asks ‘what *should* be’ and the second asks ‘*how*’. The question, “what *should* the resources be,” required an in-depth understanding of the Department of Developmental Services (DDS), the Regional Center (RC) model, clients’ needs and service delivery models, along with expertise in human resources. The first stage of the study entailed the development of a comprehensive, comparable profile of RC operations. This was essential to understanding the strengths and weaknesses of the current environment. The profile was a key deliverable of the Request for Proposals and was also highlighted in background interviews with the Department of Finance (DOF), DDS and legislative leadership. Effective description of needed changes has been hampered because state policy makers lacked a common basis and understanding of RC operations. One key source said, “We need to be able to get beyond arguing about what ‘is’ to get to what should be.”

If the ‘status quo’ of operations were accepted as the best approach, this study could have focused almost exclusively on quantified data collection and modeling. However, to answer “should,” the historical base was only a starting point, from which critical RC functions, best practices and their associated resources were identified. A desirable model for RC staffing and operations consistent with client needs, good business and professional practice, and current system mandates was defined and reflected in an easy to use formula, incorporating desired flexibility, delivering consistent and reliable allocations. **Table A-1** summarizes our conceptual approach to the study:

Table A-1: Conceptual Approach to the Study



This project could be described as a collaborative process. The nature of the developmental disabilities system, with its many constituent groups and stakeholders, encouraged collaboration. Citygate Associates recognized very early that a key ingredient to the successful outcome of this study resided in the careful attention given to listening and understanding the concerns of the constituencies and stakeholders, whether they be the state, associations, RCs, legislators, vendors, families or consumers. A number of study activities were designed to create opportunities for contributions from these and other stakeholders.

The Project Steering Committee assisted in guiding this project and proved to be a rich conduit for gaining qualitative information. The Committee generally met once a month with frequent communication with committee members maintained in the interim. The Committee was comprised of representatives from the following entities (regular committee members names follow):

- ◆ Department of Developmental Services (DDS)
 - Paul Carleton–Deputy Director of Administration
 - Eileen Richey–Deputy Director of Community Services
 - Al Brown–Project Consultant
 - Ken Buono–Chief, Financial Services
 - Dale Sorbello–Branch Manager, Regional Center Branch
- ◆ Department of Finance (DOF)
 - Walt Schaff–Senior Program Review Analyst
- ◆ Association of Regional Center Agencies (ARCA)
 - Robert Baldo–Executive Director
- ◆ Regional Centers
 - Diane Anand–Executive Director, Lanterman Regional Center

At each Steering Committee meeting, Citygate Associates reported its progress, discussed study issues and priorities, and solicited guidance on the best means to execute project tasks. The Committee proved an invaluable resource assisting with the success of the project at every stage. Their contributions facilitated data collection and analysis and helped us avoid a number of pitfalls.

A. DATA COLLECTION AND ANALYSIS ACTIVITIES

The primary research methods for collecting accurate and meaningful data in an environment as complex as the RC system are multi-sourcing, ratio analysis and trend analysis.

- ◆ **Multi-sourcing** uses several different data sources to confirm and refine key data.
- ◆ **Ratio analysis** examines the relationship across key data elements over time and across sites to find inconsistencies that need validation, as well as consistent patterns that support projections.
- ◆ **Trend analysis** examines patterns over time in the same data set or ratios, again identifying either inconsistencies for validation or reliable patterns.¹

Citygate employed these techniques and others across a large array of data sources in completing the Core Staffing Study. Ratio and trend analysis was utilized to validate or reconcile numerous data points collected through our survey instrument and other means. The use of multiple sources served to augment, refine and cross-validate our information. **Exhibit A-2**, on the following page, presents some of the major data collection activities undertaken. These will be discussed in more detail below.

B. DATA COLLECTION

Citygate Associates concurrently executed quantitative and qualitative data collection. In designing our research method this way, we heightened our ability to collect consistent and valid information. This association of both qualitative and quantitative methods rendered each data element more probing and provided greater comprehension.

Although the collection of qualitative and quantitative data was conducted concurrently, their respective emphases sometimes alternated. This was indicative of our process of iterative analysis that preceded reaching a point of fully integrated consideration of all data.

¹ Guide for Prospective Financial Statements, American Institute of Certified Public Accountants, Chapter 14.

EXHIBIT A-1

Data Collection Activities

Data Collection	Discussion	Quantity
Document Review	Review of internal DDS and RC documentation, including prior studies, audits, agency and RC responses, RC contracts, mandates, budget proposals, etc.	
Leadership Interviews	Orientation interviews held with DDS, ARCA, legislative staff, key stakeholders and other key informants to explore issues and criteria for the project	Over 16 interviews
Literature Review	Literature review of the clinical, professional and business journals and publications on budgeting, management, and case management practices for the developmentally disabled	Over 30 publications reviewed
RC Forums	Facilitated discussions with five sets of RC professionals with a meeting for each held in northern and southern California to gather qualitative information and to explore issues for the methodology, data sources, criteria and best practices <ul style="list-style-type: none"> Executive Management Operations including finance, information systems and human resources Case Management Clinical Services Community Services, including resource development and quality assurance 	Ten meetings at five different RCs
RC Survey of Resource Allocation, Staffing, Positions, Salary & Operations	Preset template spreadsheet was developed based on meetings with RC groups, review of documents and our knowledge of systems to provide a common reporting matrix for operating expense and staffing. Templates were distributed to all 21 RCs on disk. Follow-up data collection and data cleaning ensured consistency in reporting across RCs.	20 data sets, with follow-up and standardization
Site Visits	Visits to five RCs not visited in Citygate's prior study or in the RC Forums, above, in order to observe operations, interview key personnel and clients, and explore specific practice issues identified in the Forums	Five site visits
Consumer & Family Forums Vendor Forums	Public forums for vendors and consumers and their families were held in both northern and southern California. These forums provided an additional opportunity for contributions to the study effort from these key stakeholder groups in a setting independent of RCs or DDS.	Four public forums
Expert panels	Three teams of consulting RC professionals assisted in evaluating options and implications for their functions, with representation determined by the RCs, ARCA and DDS <ul style="list-style-type: none"> Case Management Community Services Clinical Teams 	Four meetings

Qualitative Data Collection

Functional Areas

With the collaboration of DDS, ARCA and the Project Steering Committee, essential functional areas were identified very early in the study. These areas were:

- ◆ Case Management—ongoing case management/service coordination including consumer-oriented outcome measurement and quality assurance
- ◆ Clinical Services—specialty consumer services including intake clinical teams and related quality assurance
- ◆ Community Services—RC operations devoted to provider relationships including resource development, vendor-oriented quality assurance and other community services
- ◆ Operations—internal administration including finance, accounting, human resources, information systems, etc.
- ◆ Executive Management—RC directors concerning issues of governance, planning and community/constituency relations

These principal functional areas were recognized as the essential building blocks Citygate would work with in designing a budget and staffing model for RCs. However, one of the great difficulties of this study remained in determining what each building block was composed of in a manner that was comprehensive, comparative and standardized.

RC Forums

A total of ten forums were conducted: two for each of the functional areas, one of which was held in Northern California, the other in Southern California. All forums were held at RC sites except one, which was held in conjunction with an ARCA conference of RC directors. Citygate facilitated each forum and dispatched one to three additional team members. A majority of RCs attended the forums for each of the functional areas and all participated in at least one of the forums or submitted written responses.

The forums served to gather preliminary qualitative assessments for each function and initial exposure to varying models employed by RCs. Forum participants also informed the design of Citygate's comprehensive survey instrument.

Background Interviews

Citygate conducted background interviews with a variety of interested parties in order to learn more about the issues and expectations regarding the developmental disabilities system and the outcome of this study. Interviewees included stakeholder organizations, legislative staff, Department of Finance as well as representatives from various divisions of DDS including administration, community services and executive leadership.

Site Visits

Site visits were conducted simultaneously with the release of the survey into the field. Citygate visited five sites: three in the north, two in the south. Sites were selected with the assistance of the Project Steering Committee and satisfied criteria of size, variation of the models, and urban and rural service areas.

- ◆ Eastern Los Angeles
- ◆ Inland
- ◆ San Diego
- ◆ Golden Gate
- ◆ Redwood Coast.

Citygate used the functional areas to guide our interview activities at each of the sites. A typical program for a one-day site visit, where each interview lasted approximately one hour, is shown in **Table A-2** below. These site visits were yet another means of multi-sourcing to supplement and validate the survey, while gaining qualitative insight to the operating environment of particular RCs.

Table A-2: Site Visit Interview Tracks

Track 1	Track 2	Track 3
Operational Overview	Operational Overview	Operational Overview
Executive Director	Chief Counselor	Designated Citygate Survey Coordinator
Director, Quality Assurance	Supervising Counselors (up to four)	Director, Management Information Systems
Quality Assurance Staff (up to five)	Case Managers (up to five)	Director, Financial/Accounting Services
Director, Clinical Services	Case Managers (up to five)	Director, Human Resources
Clinical Services Specialist (up to five)	Families & Consumers (Area Board)	Director, Resource Development
Exit Interview with Executive Team	Families & Consumers (Area Board)	Exit Interview with Executive Team

Public Forums for Consumers and Families and Vendors

In order to independently obtain consumer and family observations as well as vendor input that represented a broad base, Citygate held two public forums regarding RC direct services for each of these important stakeholder groups: again, one in the north, one in the south. Regrettably, attendance was low at all of the meetings, but those who did attend made pertinent remarks, notably in describing their varying expectations of

RCs. Citygate also invited written comment from stakeholders and received approximately thirty responses.

Mid-Contract Review Qualitative Comments

Again, to the end of increasing the contributions to this study of stakeholders, particularly consumers, families and vendors, to this study, Citygate reviewed some 40,000 qualitative comments compiled by DDS through the mid-contract review surveys distributed to the clients and vendors of RCs. These comments were categorized, tallied and analyzed for overall or RC specific patterns.

Literature Review

To perform our review of the literature, Citygate Associates conducted an internet search and a search of several electronic databases. Publications of interest were then pulled from various sources including libraries, state agencies, associations, and the internet. We augmented our information through interviews with staff at state agencies, associations, or specialist institutions. During this review, we visited issues surrounding case management/service coordination, quality of life, quality assurance, and health care.

Expert Panels

Citygate Associates' analysis focused on the functional areas that were most subject to high variance and high cost. We then identified the various models and brought together a panel of RC professionals to discuss the respective advantages or disadvantages of each model in terms of meeting mandates, service-level, required resources and costs. These panels of experts also assisted us in defining the essential components of complex functions such as case management. Three expert panels were convened for case management, clinical services and community services with approximately 12 participants from RCs in each.

Quantitative Data Collection

Survey

Citygate Associates, with DDS and Steering Committee review and input, developed a comprehensive survey instrument that leveraged our past experience studying the RC system, our experience as management and human resources consultants, and the information gleaned from the functional forums held concurrent to the design of the survey.

The instrument consisted of a template spreadsheet with designated cells available for responses. The survey collected data on the following subjects:

- ◆ Staffing
- ◆ Finances
- ◆ Clients
- ◆ Workload
- ◆ Case Management
- ◆ Community Relations

- ◆ Intake and Clinical Services
- ◆ Human Resources
- ◆ Facilities
- ◆ Information Systems.

The survey also contained open-ended questions, particularly in the area of executive priorities, performance objectives, and description of service models. Organization charts and position descriptions were also requested. The collection of this information was designed to comprehensively account for the operations of each individual RC and supply Citygate Associates with sufficient data to standardize and compare across the RC system.

The survey was pre-tested at Lanterman RC and subsequently modified prior to distribution to all 21 RCs. Significant project delays were experienced to complete the survey but concern for achieving participation from all 21 RCs led to extensions of the deadline. The last survey file was received on November 3rd, 1998. Of 21 RCs, all but one provided data via this instrument.

Citygate Associates expended considerable effort to reconcile data and enhance its quality. However, we identified potential gaps and inconsistencies in reporting early in the quality control stages and sometimes even prior to the return of the survey. In response, Citygate engaged in the pursuit of alternative data sources. The most intensive effort was dedicated to obtaining consistent and reliable financial data.

Alternative Financial Data

Twenty-one different operations with different accounting created a major challenge. Although RCs' financial data must be reported through the Uniform Financial System (UFS), the chart of accounts is only partially uniform. Certain account codes are fixed, but there is considerable room for adaptation to individual circumstances or preferences, and none of the codes are mandatory. Uncertainty regarding the manner in which RCs rolled up to the fixed account codes paired with data gaps, prompted Citygate to request alternative data sets. The difficulties in reconciliation precluded a comprehensive summary data run from UFS, and required individual 'roll-ups' for each RC, using standardized management reporting. RCs were asked to run a computerized report using the raw financial data reported to UFS. Reconciling and standardizing that data to make analysis and interpretation meaningful was very difficult.

Two-thirds of the RCs responded to this request which either complemented or replaced the request for financial data via the survey. Generally, comparative analysis of this new data showed material consistency with RC reported data. Where significant differences were found, the UFS data was considered more reliable and therefore preferred.

Survey Follow-up/Discrepancies

At every step of quantitative data collection, Citygate devoted extensive effort to providing technical consultation, follow-up, research of reporting alternatives, quality

control, and minimization of the impact of any discrepancies. As project delays and data collection difficulties accumulated, we determined and prioritized the minimal data set an RC could submit. Most RCs experiencing difficulty were able to achieve minimum compliance, and if not, we integrated any data submitted where doing so was congruent and feasible.

C. DATA ANALYSIS

The preceding pages described study activities related to data collection. However, data analysis was performed concurrent to its collection. As data became available from the multiple sources, it was analyzed and integrated to develop key deliverables or the comprehensive tools needed to build up conceptual models and perform statewide costing.

Comparable RC Profile

The first key deliverable from the historical data analysis was a comprehensive table profiling resource utilization by each RC. By functionally standardizing the data, we were able to report on resource commitments and the ratios to consumers and other key variables for each RC. We also created a personnel summary of the key positions in use, along with functional position descriptions and specifications that included compensation ranges and trends. We subsequently performed variance analysis, a statistical technique used to “control for” characteristics which vary between compared groups, seeking to identify variables that reliably accounted for key differences across RCs.

Functional Areas Profile

Citygate maintained its conceptual approach of critical functional areas replicated in one form or another throughout the RC system. The initial identification and refinement of the principal functional areas was relatively easy. Determining the specific components of each function presented a much greater challenge. We completed this task by thorough analysis of survey data from individual RCs compared with aggregate data, and integrated with qualitative information gained throughout the study period. We then defined each functional area in overall terms and in terms of the components derived, mandates, and organizational models.

Mandate Review

Citygate reviewed the legal mandates in the RC environment. Our review comprised federal, state, and contractual requirements while focusing particular attention on state mandates. Our approach consisted in identifying major mandated components within functional areas, to assist in the functional building block approach to modeling the budget and staffing of RCs. In designing this study, we opted for a review of mandates integrated into both field observations of RC professional standards and good practice, and qualitative and quantitative data. Citygate deemed this a more appropriate method to budget for and staff the central functions of regional centers and the necessary operations support. This was preferred to a methodology primarily relying on mandates that recently, have been subjected to frequent change. Our selected methodology better

protects RCs' operational independence and, by the absence of extensive direct linkage to mandates, it better protects the budget and staffing model from the unpredictable changes in mandates.

Conceptual Models

Once the analysis of the functional areas was completed, we undertook the development of conceptual models for both the functional areas themselves and their interactions within the entire RC organization. This process was further informed by survey analysis, our review of mandates and the literature, panels of RC experts, and the project steering committee.

Preferred Cost Model

The Steering Committee selected preferred models that Citygate Associates built up functionally at a total state-wide level with costing detail drawn from the diverse RC models already in operation. These provided case studies of virtually all options, including historical data on staffing and expenditures. The preferred statewide model was finalized and refined based on steering committee review and comment. The model sought to maximize RC flexibility by using generic or broad functional definitions whenever possible.

Operational Variables

The identification of the preferred cost model included all essential RC functions in its design but did not yet include the support services necessary to its viability. The contents of the box were known, but the box itself needed to be built. The operational variables identified through the survey and other statistical data served as the starting point for this final resource analysis that included items such as office space and technology, etc.

A spreadsheet formula calculating the preferred model at the RC level, using local operational variables was finalized with DDS. This model will support the individual allocation process, but will continue to be adapted to each RC by DDS staff during the allocation process.

APPENDIX B

REGIONAL CENTER RESOURCE PROFILE, 1997-98

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC M	RC M % of total	RC N	RC N % of total	RC U
Salaries & Wages	\$ 8,181,298	64.02%	\$ 7,537,000	62.65%	\$ 7,891,906
Benefits	\$ 2,081,628	16.29%	\$ 2,107,167	17.52%	\$ 1,892,653
Temporary and Contractual Services	\$ 76,188	0.60%	\$ 194,512	1.62%	\$ 690,129
Equipment	\$ 463,644	3.63%	\$ 333,677	2.77%	\$ 231,782
Facilities	\$ 927,060	7.25%	\$ 717,080	5.96%	\$ 873,333
Travel--In State	\$ 227,567	1.78%	\$ 363,652	3.02%	\$ 243,923
Communication	\$ 301,895	2.36%	\$ 297,974	2.48%	\$ 238,705
Expenses	\$ 305,589	2.39%	\$ 287,061	2.39%	\$ 189,674
Insurance	\$ 107,907	0.84%	\$ 58,383	0.49%	\$ 54,868
Data Processing	\$ -	0.00%	\$ 31,251	0.26%	\$ 100,280
Fees	\$ 55,883	0.44%	\$ 84,968	0.71%	\$ 444,433
Board of Director's Expenses	\$ 26,610	0.21%	\$ 12,988	0.11%	\$ 14,193
Legal Fees	\$ 23,768	0.19%	\$ 4,687	0.04%	\$ 165,266
Total Operations Expenses	\$ 12,779,037		\$ 12,030,400		\$ 13,031,142
Total FTEs	235.15		204.52		231.47
Total Active Clients (CMF 1 &2)	9784.00		8632.00		9254.00

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC U % of total	RC A	RC A % of total	RC O
Salaries & Wages	60.56%	\$ 4,889,106	66.37%	\$ 4,415,286
Benefits	14.52%	\$ 1,022,627	13.88%	\$ 1,237,099
Temporary and Contractual Services	5.30%	\$ 112,312	1.52%	\$ 73,203
Equipment	1.78%	\$ 217,994	2.96%	\$ 143,981
Facilities	6.70%	\$ 506,206	6.87%	\$ 451,101
Travel--In State	1.87%	\$ 45,085	0.61%	\$ 191,701
Communication	1.83%	\$ 169,410	2.30%	\$ 179,996
Expenses	1.46%	\$ 135,895	1.84%	\$ 80,910
Insurance	0.42%	\$ 53,243	0.72%	\$ 43,642
Data Processing	0.77%	\$ 72,245	0.98%	\$ 898
Fees	3.41%	\$ 118,644	1.61%	\$ 86,007
Board of Director's Expenses	0.11%	\$ 1,439	0.02%	\$ 31,506
Legal Fees	1.27%	\$ 22,135	0.30%	\$ 22,715
Total Operations Expenses		\$ 7,366,341		\$ 6,958,045
Total FTEs		151.00		128.25
Total Active Clients (CMF 1 &2)		4782.00		4161.00

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC O % of total	RC P	RC P % of total
Salaries & Wages	63.46%	\$ 6,375,661	66.02%
Benefits	17.78%	\$ 1,646,365	17.05%
Temporary and Contractual Services	1.05%	\$ 20,749	0.21%
Equipment	2.07%	\$ 167,762	1.74%
Facilities	6.48%	\$ 714,181	7.40%
Travel--In State	2.76%	\$ 133,267	1.38%
Communication	2.59%	\$ 174,671	1.81%
Expenses	1.16%	\$ 156,759	1.62%
Insurance	0.63%	\$ 47,918	0.50%
Data Processing	0.01%	\$ 15,308	0.16%
Fees	1.24%	\$ 107,774	1.12%
Board of Director's Expenses	0.45%	\$ 5,219	0.05%
Legal Fees	0.33%	\$ 90,898	0.94%
Total Operations Expenses		\$ 9,656,531	
Total FTEs		186.00	
Total Active Clients (CMF 1 &2)		5440.00	

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC B	RC B % of total	RC C	RC C % of total	RC D
Salaries & Wages	\$ 5,753,885	60.84%	\$ 13,084,036	63.72%	\$ 4,212,036
Benefits	\$ 1,137,909	12.03%	\$ 3,875,467	18.87%	\$ 1,109,526
Temporary and Contractual Services	\$ 51,662	0.55%	\$ 90,572	0.44%	\$ 18,120
Equipment	\$ 50,669	0.54%	\$ 573,328	2.79%	\$ 119,946
Facilities	\$ 1,013,330	10.71%	\$ 1,106,553	5.39%	\$ 602,328
Travel--In State	\$ 86,415	0.91%	\$ 460,768	2.24%	\$ 253,524
Communication	\$ 273,532	2.89%	\$ 365,768	1.78%	\$ 94,714
Expenses	\$ 545,845	5.77%	\$ 383,173	1.87%	\$ 224,378
Insurance	\$ 53,078	0.56%	\$ 473,288	2.31%	\$ 62,998
Data Processing	\$ -	0.00%	\$ 18,059	0.09%	\$ 7,058
Fees	\$ 449,820	4.76%	\$ 77,218	0.38%	\$ 106,374
Board of Director's Expenses	\$ 16,297	0.17%	\$ 13,568	0.07%	\$ 8,789
Legal Fees	\$ 24,699	0.26%	\$ 11,062	0.05%	\$ 19,422
Total Operations Expenses	\$ 9,457,140		\$ 20,532,860		\$ 6,839,213
Total FTEs	165.50		323.63		122.30
Total Active Clients (CMF 1 &2)	6888.00		14094.00		4052.00

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC D % of total	RC E	RC E % of total
Salaries & Wages	61.59%	\$ 4,340,403	56.80%
Benefits	16.22%	\$ 869,983	11.38%
Temporary and Contractual Services	0.26%	\$ 149,590	1.96%
Equipment	1.75%	\$ 247,681	3.24%
Facilities	8.81%	\$ 464,359	6.08%
Travel--In State	3.71%	\$ 74,074	0.97%
Communication	1.38%	\$ 328,145	4.29%
Expenses	3.28%	\$ 181,289	2.37%
Insurance	0.92%	\$ 43,150	0.56%
Data Processing	0.10%	\$ 93,070	1.22%
Fees	1.56%	\$ 782,073	10.23%
Board of Director's Expenses	0.13%	\$ 9,482	0.12%
Legal Fees	0.28%	\$ 58,703	0.77%
Total Operations Expenses		\$ 7,642,002	
Total FTEs		108.46	
Total Active Clients (CMF 1 &2)		4856.00	

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC F	RC F % of total	RC G	RC G % of total	RC Q
Salaries & Wages	\$ 4,573,991	59.25%	\$ 7,692,492	59.32%	\$ 7,377,597
Benefits	\$ 941,154	12.19%	\$ 1,156,762	8.92%	\$ 1,390,807
Temporary and Contractual Services	\$ 71,344	0.92%	\$ 37,665	0.29%	\$ 499,215
Equipment	\$ 468,976	6.07%	\$ 513,952	3.96%	\$ 1,068,621
Facilities	\$ 521,591	6.76%	\$ 879,355	6.78%	\$ 859,221
Travel--In State	\$ 143,379	1.86%	\$ 138,000	1.06%	\$ 95,995
Communication	\$ 567,527	7.35%	\$ 311,000	2.40%	\$ 378,933
Expenses	\$ 71,534	0.93%	\$ 1,630,881	12.58%	\$ 436,564
Insurance	\$ 46,734	0.61%	\$ 95,000	0.73%	\$ 136,299
Data Processing	\$ -	0.00%	\$ 44,565	0.34%	\$ 437,453
Fees	\$ 229,827	2.98%	\$ 447,626	3.45%	\$ 622,227
Board of Director's Expenses	\$ 6,717	0.09%	\$ 20,000	0.15%	\$ 7,794
Legal Fees	\$ 77,367	1.00%	\$ -	0.00%	\$ 282,954
Total Operations Expenses	\$ 7,720,142		\$ 12,967,298		\$ 13,593,681
Total FTEs	122.90		219.55		228.00
Total Active Clients (CMF 1 &2)	4979.00		8628.00		9636.00

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC Q % of total	RC H	RC H % of total	RC I
Salaries & Wages	54.27%	\$ 2,118,064	57.23%	\$ 7,252,240
Benefits	10.23%	\$ 601,365	16.25%	\$ 1,811,621
Temporary and Contractual Services	3.67%	\$ -	0.00%	\$ -
Equipment	7.86%	\$ 216,266	5.84%	\$ 292,027
Facilities	6.32%	\$ 205,244	5.55%	\$ 626,856
Travel--In State	0.71%	\$ 100,535	2.72%	\$ 172,806
Communication	2.79%	\$ 138,545	3.74%	\$ 249,866
Expenses	3.21%	\$ 79,695	2.15%	\$ 202,371
Insurance	1.00%	\$ 18,305	0.49%	\$ 149,970
Data Processing	3.22%	\$ 10,327	0.28%	\$ 98,280
Fees	4.58%	\$ 168,993	4.57%	\$ 371,647
Board of Director's Expenses	0.06%	\$ 37,927	1.02%	\$ 11,497
Legal Fees	2.08%	\$ 5,675	0.15%	\$ 99,058
Total Operations Expenses		\$ 3,700,941		\$ 11,338,239
Total FTEs		70.13		166.19
Total Active Clients (CMF 1 & 2)		2040.00		7059.00

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC I % of total	RC S	RC S % of total
Salaries & Wages	63.96%	\$ 10,715,330	65.87%
Benefits	15.98%	\$ 2,839,576	17.45%
Temporary and Contractual Services	0.00%	\$ 236,892	1.46%
Equipment	2.58%	\$ 234,780	1.44%
Facilities	5.53%	\$ 1,111,407	6.83%
Travel--In State	1.52%	\$ 84,150	0.52%
Communication	2.20%	\$ 246,146	1.51%
Expenses	1.78%	\$ 502,940	3.09%
Insurance	1.32%	\$ 111,387	0.68%
Data Processing	0.87%	\$ -	0.00%
Fees	3.28%	\$ 145,313	0.89%
Board of Director's Expenses	0.10%	\$ 16,785	0.10%
Legal Fees	0.87%	\$ 23,886	0.15%
Total Operations Expenses		\$ 16,268,591	
Total FTEs		379.67	
Total Active Clients (CMF 1 &2)		11577.00	

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC J	RC J % of total	RC T	RC K	RC K % of total
Salaries & Wages	\$ 6,919,430	65.49%		\$ 6,528,604	65.68%
Benefits	\$ 1,482,012	14.03%		\$ 1,518,468	15.28%
Temporary and Contractual Services	\$ 231,411	2.19%		\$ 417,077	4.20%
Equipment	\$ 364,984	3.45%		\$ 411,750	4.14%
Facilities	\$ 671,686	6.36%		\$ 643,863	6.48%
Travel--In State	\$ 105,584	1.00%		\$ 16,898	0.17%
Communication	\$ 264,362	2.50%		\$ 133,103	1.34%
Expenses	\$ 206,889	1.96%		\$ 145,789	1.47%
Insurance	\$ 81,949	0.78%		\$ 36,506	0.37%
Data Processing	\$ 23,429	0.22%		\$ -	0.00%
Fees	\$ 161,011	1.52%		\$ 49,235	0.50%
Board of Director's Expenses	\$ 22,002	0.21%		\$ 9,313	0.09%
Legal Fees	\$ 30,413	0.29%		\$ 29,091	0.29%
Total Operations Expenses	\$ 10,565,162		\$ -	\$ 9,939,696	
Total FTEs	208.90		0.00	198.22	
Total Active Clients (CMF 1 &2)	7090.00		6882.00	6286.00	

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	RC L	RC L % of total	Grand Totals	Grand Totals % of total
Salaries & Wages	\$ 4,657,600	60.75%	\$ 124,515,964	62.24%
Benefits	\$ 970,395	12.66%	\$ 29,692,585	14.84%
Temporary and Contractual Services	\$ 166,138	2.17%	\$ 3,136,780	1.57%
Equipment	\$ 527,117	6.88%	\$ 6,648,936	3.32%
Facilities	\$ 414,350	5.40%	\$ 13,309,103	6.65%
Travel--In State	\$ 52,254	0.68%	\$ 2,989,577	1.49%
Communication	\$ 171,791	2.24%	\$ 4,886,082	2.44%
Expenses	\$ 381,124	4.97%	\$ 6,148,361	3.07%
Insurance	\$ 19,615	0.26%	\$ 1,694,239	0.85%
Data Processing	\$ 14,056	0.18%	\$ 966,277	0.48%
Fees	\$ 202,566	2.64%	\$ 4,711,639	2.36%
Board of Director's Expenses	\$ 6,524	0.09%	\$ 278,650	0.14%
Legal Fees	\$ 83,572	1.09%	\$ 1,075,371	0.54%
Total Operations Expenses	\$ 7,667,102		\$ 200,053,563	
Total FTEs	92.00		3,542	
Total Active Clients (CMF 1 &2)	4603.00		140,723	

Regional Center Financial Expenditures, 1997-98 per Survey

Line Item	Min	Max	Median	Std Dev	-1 Std Dev	+ 1 Std Dev
Salaries & Wages	54.27%	66.37%	62.65%	3.39%	58.85%	65.64%
Benefits	8.92%	18.87%	15.28%	2.72%	12.13%	17.56%
Temporary and Contractual Services	0.00%	5.30%	1.05%	1.45%	0.12%	3.02%
Equipment	0.54%	7.86%	2.96%	1.91%	1.41%	5.24%
Facilities	5.39%	10.71%	6.48%	1.23%	5.42%	7.88%
Travel--In State	0.17%	3.71%	1.38%	0.95%	0.55%	2.44%
Communication	1.34%	7.35%	2.36%	1.33%	1.11%	3.77%
Expenses	0.93%	12.58%	2.15%	2.56%	0.51%	5.64%
Insurance	0.26%	2.31%	0.63%	0.44%	0.41%	1.29%
Data Processing	0.00%	3.22%	0.18%	0.75%	-0.26%	1.23%
Fees	0.38%	10.23%	1.61%	2.30%	0.06%	4.66%
Board of Director's Expenses	0.02%	1.02%	0.11%	0.22%	-0.08%	0.36%
Legal Fees	0.00%	2.08%	0.29%	0.53%	0.01%	1.07%
Total Operations Expenses	<hr/>					
Total FTEs	<hr/>					
Total Active Clients (CMF 1 &2)	<hr/>					

Regional Center Financial Expenditures, 1997-98 per Survey, per FTEs

Line Item	RC M \$ per FTE	RC N \$ per FTE	RC U \$ per FTE	RC A \$ per FTE
Salaries & Wages	\$ 34,791	\$ 36,852	\$ 34,094	\$ 32,378
Benefits	\$ 8,852	\$ 10,303	\$ 8,177	\$ 6,772
Temporary and Contractual Services	\$ 324	\$ 951	\$ 2,981	\$ 744
Equipment	\$ 1,972	\$ 1,632	\$ 1,001	\$ 1,444
Facilities	\$ 3,942	\$ 3,506	\$ 3,773	\$ 3,352
Travel--In State	\$ 968	\$ 1,778	\$ 1,054	\$ 299
Communication	\$ 1,284	\$ 1,457	\$ 1,031	\$ 1,122
Expenses	\$ 1,300	\$ 1,404	\$ 819	\$ 900
Insurance	\$ 459	\$ 285	\$ 237	\$ 353
Data Processing	\$ -	\$ 153	\$ 433	\$ 478
Fees	\$ 238	\$ 415	\$ 1,920	\$ 786
Board of Director's Expenses	\$ 113	\$ 64	\$ 61	\$ 10
Legal Fees	\$ 101	\$ 23	\$ 714	\$ 147
Total Operations Expenses	\$ 54,344	\$ 58,823	\$ 56,297	\$ 48,784
Total FTEs	235.15	204.52	231.47	151.00
Total Active Clients	9784	8632	9254	4782

Regional Center Financial Expenditures, 1997-98 per Survey, per FTEs

Line Item	RC O \$ per FTE	RC P \$ per FTE	RC B \$ per FTE	RC C \$ per FTE
Salaries & Wages	\$ 34,426	\$ 34,278	\$ 34,767	\$ 40,429
Benefits	\$ 9,646	\$ 8,851	\$ 6,876	\$ 11,975
Temporary and Contractual Services	\$ 571	\$ 112	\$ 312	\$ 280
Equipment	\$ 1,123	\$ 902	\$ 306	\$ 1,772
Facilities	\$ 3,517	\$ 3,840	\$ 6,123	\$ 3,419
Travel--In State	\$ 1,495	\$ 716	\$ 522	\$ 1,424
Communication	\$ 1,403	\$ 939	\$ 1,653	\$ 1,130
Expenses	\$ 631	\$ 843	\$ 3,298	\$ 1,184
Insurance	\$ 340	\$ 258	\$ 321	\$ 1,462
Data Processing	\$ 7	\$ 82	-	\$ 56
Fees	\$ 671	\$ 579	\$ 2,718	\$ 239
Board of Director's Expenses	\$ 246	\$ 28	\$ 98	\$ 42
Legal Fees	\$ 177	\$ 489	\$ 149	\$ 34
Total Operations Expenses	\$ 54,252	\$ 51,917	\$ 57,143	\$ 63,446
Total FTEs	128.25	186.00	165.50	323.63
Total Active Clients	4161	5440	6888	14094

Regional Center Financial Expenditures, 1997-98 per Survey, per FTEs

Line Item	RC D \$ per FTE	RC E \$ per FTE	RC F \$ per FTE	RC G \$ per FTE
Salaries & Wages	\$ 34,440	\$ 40,018	\$ 37,217	\$ 35,038
Benefits	\$ 9,072	\$ 8,021	\$ 7,658	\$ 5,269
Temporary and Contractual Services	\$ 148	\$ 1,379	\$ 581	\$ 172
Equipment	\$ 981	\$ 2,284	\$ 3,816	\$ 2,341
Facilities	\$ 4,925	\$ 4,281	\$ 4,244	\$ 4,005
Travel--In State	\$ 2,073	\$ 683	\$ 1,167	\$ 629
Communication	\$ 774	\$ 3,025	\$ 4,618	\$ 1,417
Expenses	\$ 1,835	\$ 1,671	\$ 582	\$ 7,428
Insurance	\$ 515	\$ 398	\$ 380	\$ 433
Data Processing	\$ 58	\$ 858	-	\$ 203
Fees	\$ 870	\$ 7,211	\$ 1,870	\$ 2,039
Board of Director's Expenses	\$ 72	\$ 87	\$ 55	\$ 91
Legal Fees	\$ 159	\$ 541	\$ 630	-
Total Operations Expenses	\$ 55,921	\$ 70,458	\$ 62,816	\$ 59,064
Total FTEs	122.30	108.46	122.90	219.55
Total Active Clients	4052	4856	4979	8628

Regional Center Financial Expenditures, 1997-98 per Survey, per FTEs

Line Item	RC Q \$ per FTE	RC H \$ per FTE	RC I \$ per FTE	RC S \$ per FTE
Salaries & Wages	\$ 32,358	\$ 30,201	\$ 43,639	\$ 28,223
Benefits	\$ 6,100	\$ 8,575	\$ 10,901	\$ 7,479
Temporary and Contractual Services	\$ 2,190	\$ -	\$ -	\$ 624
Equipment	\$ 4,687	\$ 3,084	\$ 1,757	\$ 618
Facilities	\$ 3,769	\$ 2,927	\$ 3,772	\$ 2,927
Travel--In State	\$ 421	\$ 1,434	\$ 1,040	\$ 222
Communication	\$ 1,662	\$ 1,975	\$ 1,504	\$ 648
Expenses	\$ 1,915	\$ 1,136	\$ 1,218	\$ 1,325
Insurance	\$ 598	\$ 261	\$ 902	\$ 293
Data Processing	\$ 1,919	\$ 147	\$ 591	\$ -
Fees	\$ 2,729	\$ 2,410	\$ 2,236	\$ 383
Board of Director's Expenses	\$ 34	\$ 541	\$ 69	\$ 44
Legal Fees	\$ 1,241	\$ 81	\$ 596	\$ 63
Total Operations Expenses	\$ 59,621	\$ 52,771	\$ 68,226	\$ 42,850
Total FTEs	228.00	70.13	166.19	379.67
Total Active Clients	9636	2040	7059	11577

Regional Center Financial Expenditures, 1997-98 per Survey, per FTEs

Line Item	RC J \$ per FTE	RC K \$ per FTE	RC L \$ per FTE	Grand Totals \$ per FTE
Salaries & Wages	\$ 33,123	\$ 32,936	\$ 50,626	\$ 35,156
Benefits	\$ 7,094	\$ 7,660	\$ 10,548	\$ 8,383
Temporary and Contractual Services	\$ 1,108	\$ 2,104	\$ 1,806	\$ 886
Equipment	\$ 1,747	\$ 2,077	\$ 5,730	\$ 1,877
Facilities	\$ 3,215	\$ 3,248	\$ 4,504	\$ 3,758
Travel--In State	\$ 505	\$ 85	\$ 568	\$ 844
Communication	\$ 1,265	\$ 671	\$ 1,867	\$ 1,380
Expenses	\$ 990	\$ 735	\$ 4,143	\$ 1,736
Insurance	\$ 392	\$ 184	\$ 213	\$ 478
Data Processing	\$ 112	\$ -	\$ 153	\$ 273
Fees	\$ 771	\$ 248	\$ 2,202	\$ 1,330
Board of Director's Expenses	\$ 105	\$ 47	\$ 71	\$ 79
Legal Fees	\$ 146	\$ 147	\$ 908	\$ 304
Total Operations Expenses	\$ 50,574	\$ 50,144	\$ 83,338	\$ 56,483
Total FTEs	208.90	\$ 198	92.00	3541.845842
Total Active Clients	7090	6286	4603	140723

Regional Center Financial Expenditures, 1997-98 per Survey, per FTEs

Line Item	Minimum	Maximum	Std Dev	Mean +1 StDev	Mean -1 StDev
Salaries & Wages	\$ 28,223	\$ 50,626	\$ 4,936	\$ 30,220	\$ 40,092
Benefits	\$ 5,269	\$ 11,975	\$ 1,680	\$ 6,703	\$ 10,063
Temporary and Contractual Services	\$ -	\$ 2,981	\$ 834	\$ 51	\$ 1,720
Equipment	\$ 306	\$ 5,730	\$ 1,360	\$ 518	\$ 3,237
Facilities	\$ 2,927	\$ 6,123	\$ 735	\$ 3,022	\$ 4,493
Travel--In State	\$ 85	\$ 2,073	\$ 536	\$ 308	\$ 1,380
Communication	\$ 648	\$ 4,618	\$ 897	\$ 483	\$ 2,276
Expenses	\$ 582	\$ 7,428	\$ 1,598	\$ 138	\$ 3,334
Insurance	\$ 184	\$ 1,462	\$ 290	\$ 188	\$ 768
Data Processing	\$ -	\$ 1,919	\$ 451	\$ (178)	\$ 724
Fees	\$ 238	\$ 7,211	\$ 1,590	\$ (259)	\$ 2,920
Board of Director's Expenses	\$ 10	\$ 541	\$ 115	\$ (36)	\$ 193
Legal Fees	\$ -	\$ 1,241	\$ 341	\$ (37)	\$ 644
Total Operations Expenses	\$ 42,850	\$ 83,338	\$ 8,856	\$ 47,627	\$ 65,339
Total FTEs					
Total Active Clients					

Regional Center Financial Expenditures, 1997-98 per Survey, per Client

Line Item	RC M	RC N	RC U	RC A	RC O	RC P	RC B	RC C	RC D
Salaries & Wages	\$ 836	\$ 873	\$ 853	\$ 1,022	\$ 1,061	\$ 1,172	\$ 835	\$ 928	\$ 1,039
Benefits	\$ 213	\$ 244	\$ 205	\$ 214	\$ 297	\$ 303	\$ 165	\$ 275	\$ 274
Temporary and Contractual Services	\$ 8	\$ 23	\$ 75	\$ 23	\$ 18	\$ 4	\$ 8	\$ 6	\$ 4
Equipment	\$ 47	\$ 39	\$ 25	\$ 46	\$ 35	\$ 31	\$ 7	\$ 41	\$ 30
Facilities	\$ 95	\$ 83	\$ 94	\$ 106	\$ 108	\$ 131	\$ 147	\$ 79	\$ 149
Travel--In State	\$ 23	\$ 42	\$ 26	\$ 9	\$ 46	\$ 24	\$ 13	\$ 33	\$ 63
Communication	\$ 31	\$ 35	\$ 26	\$ 35	\$ 43	\$ 32	\$ 40	\$ 26	\$ 23
Expenses	\$ 31	\$ 33	\$ 20	\$ 28	\$ 19	\$ 29	\$ 79	\$ 27	\$ 55
Insurance	\$ 11	\$ 7	\$ 6	\$ 11	\$ 10	\$ 9	\$ 8	\$ 34	\$ 16
Data Processing	\$ -	\$ 4	\$ 11	\$ 15	\$ 0	\$ 3	\$ -	\$ 1	\$ 2
Fees	\$ 6	\$ 10	\$ 48	\$ 25	\$ 21	\$ 20	\$ 65	\$ 5	\$ 26
Board of Director's Expenses	\$ 3	\$ 2	\$ 2	\$ 0	\$ 8	\$ 1	\$ 2	\$ 1	\$ 2
Legal Fees	\$ 2	\$ 1	\$ 18	\$ 5	\$ 5	\$ 17	\$ 4	\$ 1	\$ 5
Total Operations Expenses	\$ 1,306	\$ 1,394	\$ 1,408	\$ 1,540	\$ 1,672	\$ 1,775	\$ 1,373	\$ 1,457	\$ 1,688
Total Paid Hours	50	49	52	66	64	71	50	48	63
Total Active Clients	9,784	8632	9254	4782	4161	5440	6888	14094	4052

Regional Center Financial Expenditures, 1997-98 per Survey, per Client

Line Item	RC E	RC F	RC G	RC Q	RC H	RC I	RC S	RC J	RC K
Salaries & Wages	\$ 894	\$ 919	\$ 892	\$ 766	\$ 1,038	\$ 1,027	\$ 926	\$ 976	\$ 1,039
Benefits	\$ 179	\$ 189	\$ 134	\$ 144	\$ 295	\$ 257	\$ 245	\$ 209	\$ 242
Temporary and Contractual Services	\$ 31	\$ 14	\$ 4	\$ 52	\$ -	\$ -	\$ 20	\$ 33	\$ 66
Equipment	\$ 51	\$ 94	\$ 60	\$ 111	\$ 106	\$ 41	\$ 20	\$ 51	\$ 66
Facilities	\$ 96	\$ 105	\$ 102	\$ 89	\$ 101	\$ 89	\$ 96	\$ 95	\$ 102
Travel--In State	\$ 15	\$ 29	\$ 16	\$ 10	\$ 49	\$ 24	\$ 7	\$ 15	\$ 3
Communication	\$ 68	\$ 114	\$ 36	\$ 39	\$ 68	\$ 35	\$ 21	\$ 37	\$ 21
Expenses	\$ 37	\$ 14	\$ 189	\$ 45	\$ 39	\$ 29	\$ 43	\$ 29	\$ 23
Insurance	\$ 9	\$ 9	\$ 11	\$ 14	\$ 9	\$ 21	\$ 10	\$ 12	\$ 6
Data Processing	\$ 19	\$ -	\$ 5	\$ 45	\$ 5	\$ 14	\$ -	\$ 3	\$ -
Fees	\$ 161	\$ 46	\$ 52	\$ 65	\$ 83	\$ 53	\$ 13	\$ 23	\$ 8
Board of Director's Expenses	\$ 2	\$ 1	\$ 2	\$ 1	\$ 19	\$ 2	\$ 1	\$ 3	\$ 1
Legal Fees	\$ 12	\$ 16	\$ -	\$ 29	\$ 3	\$ 14	\$ 2	\$ 4	\$ 5
Total Operations Expenses	\$ 1,574	\$ 1,551	\$ 1,503	\$ 1,411	\$ 1,814	\$ 1,606	\$ 1,405	\$ 1,490	\$ 1,581
Total Paid Hours	46	51	53	49	72	49	68	61	66
Total Active Clients	4856	4979	8628	9636	2040	7059	11577	7090	6286

Regional Center Financial Expenditures, 1997-98 per Survey, per Client

Line Item	RC L	Grand Totals	Minimum	Maximum	Std Dev	Mean +1 StDev	Mean -1 StDev
Salaries & Wages	\$ 1,012	\$ 885	\$ 766	\$ 1,172	\$ 99	\$ 913	\$ 983
Benefits	\$ 211	\$ 211	\$ 134	\$ 303	\$ 49	\$ 162	\$ 260
Temporary and Contractual Services	\$ 36	\$ 22	\$ -	\$ 75	\$ 21	\$ 15	\$ 44
Equipment	\$ 115	\$ 47	\$ 7	\$ 115	\$ 31	\$ 84	\$ 78
Facilities	\$ 90	\$ 95	\$ 79	\$ 149	\$ 19	\$ 71	\$ 113
Travel--In State	\$ 11	\$ 21	\$ 3	\$ 63	\$ 16	\$ (4)	\$ 37
Communication	\$ 37	\$ 35	\$ 21	\$ 114	\$ 21	\$ 16	\$ 56
Expenses	\$ 83	\$ 44	\$ 14	\$ 189	\$ 38	\$ 44	\$ 82
Insurance	\$ 4	\$ 12	\$ 4	\$ 34	\$ 6	\$ (2)	\$ 18
Data Processing	\$ 3	\$ 7	\$ -	\$ 45	\$ 11	\$ (8)	\$ 18
Fees	\$ 44	\$ 33	\$ 5	\$ 161	\$ 36	\$ 8	\$ 70
Board of Director's Expenses	\$ 1	\$ 2	\$ 0	\$ 19	\$ 4	\$ (3)	\$ 6
Legal Fees	\$ 18	\$ 8	\$ -	\$ 29	\$ 8	\$ 10	\$ 16
Total Operations Expenses	\$ 1,666	\$ 1,422	\$ 1,306	\$ 1,814	\$ 138	\$ 1,528	\$ 1,559
Total Paid Hours	42	52	42	72	9	32	61
Total Active Clients	4603	140723	2,040	14,094	2,902	1,701	143,625

Regional Center Staffing Mix per Survey
See Notes on Page 31

RC Detail		Paid Hours 1997-98	1997-98 FTEs(1)	Salary & Wage (Total) 1997 98
Case Management (Excluding Intake CSC)	RC A	175,760	85	2,752,240
Case Management (Excluding Intake CSC)	RC B	229,906	111	3,577,960
Case Management (Excluding Intake CSC)	RC C	392,847	189	8,460,789
Case Management (Excluding Intake CSC)	RC D	132,080	64	2,282,704
Case Management (Excluding Intake CSC)	RC E	120,466	58	2,473,741
Case Management (Excluding Intake CSC)	RC F	151,840	73	2,506,778
Case Management (Excluding Intake CSC)	RC G	281,827	135	4,806,301
Case Management (Excluding Intake CSC)	RC H	76,362	37	1,156,871
Case Management (Excluding Intake CSC)	RC I	226,772	109	5,190,425
Case Management (Excluding Intake CSC)	RC J	258,960	125	5,011,563
Case Management (Excluding Intake CSC)	RC K	227,849	110	3,706,057
Case Management (Excluding Intake CSC)	RC L	126,880	61	2,560,188
Case Management (Excluding Intake CSC)	RC M	305,729	147	5,216,176
Case Management (Excluding Intake CSC)	RC N	301,600	145	5,236,436
Case Management (Excluding Intake CSC)	RC O	139,992	67	2,348,420
Case Management (Excluding Intake CSC)	RC P	241,904	116	4,409,201
Case Management (Excluding Intake CSC)	RC Q	245,440	118	3,787,817
Case Management (Excluding Intake CSC)	RC R	181,824	87	3,597,892
Case Management (Excluding Intake CSC)	RC S	413,920	199	5,972,552
Case Management (Excluding Intake CSC)	<u>RC T</u>	<u>184,475</u>	<u>89</u>	<u>-</u>
Case Management (Excluding Intake CSC)	Total	4,416,432	2,123	75,054,109
Community/Vendor Relations	RC A	16,640	8 \$	352,578
Community/Vendor Relations	RC B	16,640	8 \$	310,629
Community/Vendor Relations	RC C	53,852	26 \$	1,086,412
Community/Vendor Relations	RC D	39,940	19 \$	764,053
Community/Vendor Relations	RC E	13,520	6 \$	332,694
Community/Vendor Relations	RC F	14,560	7 \$	239,513
Community/Vendor Relations	RC G	27,040	13 \$	463,981
Community/Vendor Relations	RC H	9,360	5 \$	206,976
Community/Vendor Relations	RC I	21,580	10 \$	452,147
Community/Vendor Relations	RC J	22,880	11 \$	529,509
Community/Vendor Relations	RC K	16,380	8 \$	322,376
Community/Vendor Relations	RC L	4,160	2 \$	94,884
Community/Vendor Relations	RC M	22,880	11 \$	416,424
Community/Vendor Relations	RC N	14,560	7 \$	291,073
Community/Vendor Relations	RC O	14,040	7 \$	276,875
Community/Vendor Relations	RC P	18,720	9 \$	370,698
Community/Vendor Relations	RC Q	45,760	22 \$	828,910
Community/Vendor Relations	RC R	10,272	5	284,818
Community/Vendor Relations	RC S	20,520	10 \$	361,314
Community/Vendor Relations	<u>RC T</u>	<u>18,720</u>	<u>9 \$</u>	<u>-</u>
Community/Vendor Relations	Total	422,024	203 \$	7,985,864

Regional Center Staffing Mix per Survey
See Notes on Page 31

RC Detail		Contract/ Temporary Labor Hours 1997-98	Contract/ Temporary Labor Cost 1997-98	Average Salary & Wage /Hour	Average Salary & Wage /Annual
Case Management (Excluding Intake CSC)	RC A	-	67,884	\$ 15.66	\$ 32,571
Case Management (Excluding Intake CSC)	RC B	-	-	\$ 15.56	\$ 32,371
Case Management (Excluding Intake CSC)	RC C	-	-	\$ 21.54	\$ 44,797
Case Management (Excluding Intake CSC)	RC D	-	-	\$ 17.28	\$ 35,948
Case Management (Excluding Intake CSC)	RC E	2,493	61,530	\$ 20.53	\$ 42,712
Case Management (Excluding Intake CSC)	RC F	-	-	\$ 16.51	\$ 34,339
Case Management (Excluding Intake CSC)	RC G	-	-	\$ 17.05	\$ 35,473
Case Management (Excluding Intake CSC)	RC H	-	10,000	\$ 15.15	\$ 31,512
Case Management (Excluding Intake CSC)	RC I	-	-	\$ 22.89	\$ 47,608
Case Management (Excluding Intake CSC)	RC J	14,400	210,960	\$ 19.35	\$ 40,254
Case Management (Excluding Intake CSC)	RC K	-	-	\$ 16.27	\$ 33,832
Case Management (Excluding Intake CSC)	RC L	-	-	\$ 20.18	\$ 41,970
Case Management (Excluding Intake CSC)	RC M	-	-	\$ 17.06	\$ 35,488
Case Management (Excluding Intake CSC)	RC N	-	-	\$ 17.36	\$ 36,113
Case Management (Excluding Intake CSC)	RC O	-	-	\$ 16.78	\$ 34,893
Case Management (Excluding Intake CSC)	RC P	-	-	\$ 18.23	\$ 37,912
Case Management (Excluding Intake CSC)	RC Q	-	-	\$ 15.43	\$ 32,100
Case Management (Excluding Intake CSC)	RC R	-	139,628	\$ 19.79	\$ 41,159
Case Management (Excluding Intake CSC)	RC S	-	-	\$ 14.43	\$ 30,013
Case Management (Excluding Intake CSC)	<u>RC T</u>	-	-	\$ -	\$ -
Case Management (Excluding Intake CSC)	Total	16,893	490,003	\$ 17.74	\$ 36,889
					\$ -
Community/Vendor Relations	RC A	\$ -	\$ -	\$ 21.19	\$ 44,072
Community/Vendor Relations	RC B	-	\$ -	\$ 18.67	\$ 38,829
Community/Vendor Relations	RC C	-	\$ -	\$ 20.17	\$ 41,962
Community/Vendor Relations	RC D	-	\$ -	\$ 19.13	\$ 39,790
Community/Vendor Relations	RC E	-	\$ -	\$ 24.61	\$ 51,184
Community/Vendor Relations	RC F	-	\$ -	\$ 16.45	\$ 34,216
Community/Vendor Relations	RC G	-	\$ -	\$ 17.16	\$ 35,691
Community/Vendor Relations	RC H	-	\$ -	\$ 22.11	\$ 45,995
Community/Vendor Relations	RC I	-	\$ -	\$ 20.95	\$ 43,580
Community/Vendor Relations	RC J	-	\$ -	\$ 23.14	\$ 48,137
Community/Vendor Relations	RC K	-	\$ -	\$ 19.68	\$ 40,936
Community/Vendor Relations	RC L	-	\$ -	\$ 22.81	\$ 47,442
Community/Vendor Relations	RC M	-	\$ -	\$ 18.20	\$ 37,857
Community/Vendor Relations	RC N	-	\$ -	\$ 19.99	\$ 41,582
Community/Vendor Relations	RC O	-	\$ -	\$ 19.72	\$ 41,019
Community/Vendor Relations	RC P	-	\$ -	\$ 19.80	\$ 41,189
Community/Vendor Relations	RC Q	-	\$ -	\$ 18.11	\$ 37,678
Community/Vendor Relations	RC R	0	0	\$ 27.73	\$ 57,673
Community/Vendor Relations	RC S	-	\$ -	\$ 17.61	\$ 36,624
Community/Vendor Relations	<u>RC T</u>	-	\$ -	\$ -	\$ -
Community/Vendor Relations	Total	-	\$ -	\$ 19.80	\$ 41,186
					\$ -

Regional Center Staffing Mix per Survey
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RC Detail		Paid Hours 1997-98	1997-98 FTEs(1)	Salary & Wage (Total) 1997 98
Clinical	RC A	2,080	1	\$ 52,908
Clinical	RC B	16,640	8	\$ 401,399
Clinical	RC C	35,360	17	\$ 848,296
Clinical	RC D	6,240	3	\$ 159,545
Clinical	RC E	6,570	3	\$ 189,960
Clinical	RC F	14,352	7	\$ 352,520
Clinical	RC G	17,984	9	\$ 342,654
Clinical	RC H	7,280	4	\$ 94,991
Clinical	RC I	18,720	9	\$ 428,675
Clinical	RC J	19,344	9	\$ 542,466
Clinical	RC K	15,953	8	\$ 551,020
Clinical	RC L	4,160	2	\$ 129,060
Clinical	RC M	22,533	11	\$ 499,673
Clinical	RC N	14,560	7	\$ 372,272
Clinical	RC O	31,832	15	\$ 639,434
Clinical	RC P	19,968	10	\$ 600,629
Clinical	RC Q	12,480	6	\$ 324,461
Clinical	RC R	18,720	9	\$ 501,963
Clinical	RC S	51,584	25	\$ 1,216,834
Clinical	<u>RC T</u>	-	0	-
Clinical	Total	<u>336,360</u>	<u>162</u>	<u>\$ 8,248,760</u>

Regional Center Staffing Mix per Survey
See Notes on Page 31

RC Detail		Contract/ Temporary Labor Hours 1997-98	Contract/ Temporary Labor Cost 1997-98	Average Salary & Wage /Hour	Average Salary & Wage /Annual
Clinical	RC A			\$ 25.44	\$ 52,908
Clinical	RC B	-	\$ -	\$ 24.12	\$ 50,175
Clinical	RC C	-	\$ -	\$ 23.99	\$ 49,900
Clinical	RC D	-	\$ -	\$ 25.57	\$ 53,182
Clinical	RC E	418	\$ 18,698	\$ 28.91	\$ 60,141
Clinical	RC F	-	\$ -	\$ 24.56	\$ 51,090
Clinical	RC G	-	\$ -	\$ 19.05	\$ 39,632
Clinical	RC H	-	\$ -	\$ 13.05	\$ 27,140
Clinical	RC I	-	\$ -	\$ 22.90	\$ 47,631
Clinical	RC J	48	\$ 1,440	\$ 28.04	\$ 58,330
Clinical	RC K	-	\$ -	\$ 34.54	\$ 71,843
Clinical	RC L	-	\$ -	\$ 31.02	\$ 64,530
Clinical	RC M	-	\$ -	\$ 22.18	\$ 46,124
Clinical	RC N	-	\$ 86,095	\$ 25.57	\$ 53,182
Clinical	RC O	-	\$ -	\$ 20.09	\$ 41,783
Clinical	RC P			\$ 30.08	\$ 62,566
Clinical	RC Q	-	\$ -	\$ 26.00	\$ 54,077
Clinical	RC R	0	\$ 0	\$ 26.81	\$ 55,774
Clinical	RC S	-	\$ -	\$ 23.59	\$ 49,066
Clinical	RC T	-	\$ -	\$ -	\$ -
Clinical	Total	466	\$ 106,233	\$ 24.52	\$ 51,009

Regional Center Staffing Mix per Survey
See Notes on Page 31

RC Detail		Paid Hours 1997-98	1997-98 FTEs(1)	Salary & Wage (Total) 1997 98
Admin	RC A	109,200	53	\$ 1,398,682
Admin	RC B	63,440	31	\$ 773,242
Admin	RC C	168,208	81	\$ 2,541,245
Admin	RC D	69,888	34	\$ 1,010,839
Admin	RC E	79,150	38	\$ 1,405,241
Admin	RC F	68,640	33	\$ 919,434
Admin	RC G	115,648	56	\$ 1,807,938
Admin	RC H	43,264	21	\$ 517,191
Admin	RC I	67,080	32	\$ 1,310,691
Admin	RC J	125,016	60	\$ 1,759,099
Admin	RC K	127,595	61	\$ 1,636,308
Admin	RC L	43,680	21	\$ 475,734
Admin	RC M	119,602	58	\$ 1,591,794
Admin	RC N	69,720	34	\$ 1,201,092
Admin	RC O	69,888	34	\$ 932,907
Admin	RC P	104,208	50	\$ 1,384,094
Admin	RC Q	133,120	64	\$ 1,826,056
Admin	RC R	80926	39	\$ 1123568
Admin	RC S	237,120	114	\$ 2,712,296
Admin	<u>RC T</u>	<u>62,400</u>	<u>30</u>	<u>\$ -</u>
Admin	Total	1,957,793	941	\$ 26,327,450
Total	RC A	314,080	151	\$ 4,786,522
Total	RC B	344,240	166	\$ 5,389,591
Total	RC C	673,147	324	\$ 13,386,353
Total	RC D	260,628	125	\$ 4,355,140
Total	RC E	225,599	108	\$ 4,567,398
Total	RC F	255,632	123	\$ 4,107,529
Total	RC G	458,736	220	\$ 7,638,234
Total	RC H	145,874	70	\$ 2,190,094
Total	RC I	345,670	166	\$ 7,622,831
Total	RC J	434,520	209	\$ 8,060,410
Total	RC K	412,302	198	\$ 6,760,110
Total	RC L	191,360	92	\$ 3,421,710
Total	RC M	489,118	235	\$ 8,105,447
Total	RC N	425,400	205	\$ 7,537,000
Total	RC O	266,768	128	\$ 4,415,284
Total	RC P	386,880	186	\$ 6,857,154
Total	RC Q	474,240	228	\$ 7,294,380
Total	RC R	295,902	142	\$ 5508241
Total	RC S	743,944	358	\$ 10,716,487
Total	<u>RC T</u>	<u>278,720</u>	<u>134</u>	<u>\$ -</u>
Total	Total	7,422,760	3569	\$ 122,719,913

Regional Center Staffing Mix per Survey
See Notes on Page 31

RC Detail		Contract/ Temporary Labor Hours 1997-98	Contract/ Temporary Labor Cost 1997-98	Average Salary & Wage /Hour	Average Salary & Wage /Annual
					\$ -
Admin	RC A			\$ 12.81	\$ 26,642
Admin	RC B	7,800	\$ -	\$ 12.19	\$ 25,352
Admin	RC C	-	\$ -	\$ 15.11	\$ 31,424
Admin	RC D	-	\$ -	\$ 14.46	\$ 30,084
Admin	RC E	3,528	\$ 55,665	\$ 17.75	\$ 36,929
Admin	RC F	-	\$ -	\$ 13.40	\$ 27,862
Admin	RC G	-	\$ -	\$ 15.63	\$ 32,517
Admin	RC H	1,308	\$ 12,575	\$ 11.95	\$ 24,865
Admin	RC I	-	\$ -	\$ 19.54	\$ 40,642
Admin	RC J	1,908	\$ 11,976	\$ 14.07	\$ 29,268
Admin	RC K	-	\$ -	\$ 12.82	\$ 26,674
Admin	RC L	-	\$ -	\$ 10.89	\$ 22,654
Admin	RC M	-	\$ 76,188	\$ 13.31	\$ 27,683
Admin	RC N	4,644	\$ 51,553	\$ 17.23	\$ 35,833
Admin	RC O	-	\$ -	\$ 13.35	\$ 27,765
Admin	RC P	-	\$ -	\$ 13.28	\$ 27,627
Admin	RC Q	-	\$ -	\$ 13.72	\$ 28,532
Admin	RC R	0	\$ 0	\$ 13.88	\$ 28,878
Admin	RC S	9,122	\$ 130,000	\$ 11.44	\$ 23,792
Admin	RC T	-	\$ -	\$ -	\$ -
Admin	Total	28,310	\$ 337,957	\$ 13.89	\$ 28,892
					\$ -
Total	RC A	-	\$ -	\$ 15.24	\$ 31,699
Total	RC B	7,800	\$ -	\$ 15.66	\$ 32,566
Total	RC C	-	\$ -	\$ 19.89	\$ 41,363
Total	RC D	-	\$ -	\$ 16.71	\$ 34,757
Total	RC E	6,499	\$ 135,893	\$ 20.25	\$ 42,111
Total	RC F	-	\$ -	\$ 16.07	\$ 33,422
Total	RC G	-	\$ -	\$ 16.65	\$ 34,633
Total	RC H	1,708	\$ 22,575	\$ 15.01	\$ 31,228
Total	RC I	-	\$ -	\$ 22.05	\$ 45,869
Total	RC J	16,356	\$ 224,376	\$ 18.55	\$ 38,584
Total	RC K	-	\$ -	\$ 16.40	\$ 34,104
Total	RC L	-	\$ -	\$ 17.88	\$ 37,192
Total	RC M	-	\$ 76,188	\$ 16.57	\$ 34,469
Total	RC N	4,644	\$ 137,648	\$ 17.72	\$ 36,852
Total	RC O	-	\$ -	\$ 16.55	\$ 34,426
Total	RC P	-	\$ -	\$ 17.72	\$ 36,866
Total	RC Q	-	\$ -	\$ 15.38	\$ 31,993
Total	RC R	5018	\$ 139,628	\$ 18.62	\$ 38,719
Total	RC S	9,122	\$ 130,000	\$ 14.40	\$ 29,962
Total	RC T	-	\$ -	\$ -	\$ -
Total	Total	51,147	\$ 866,308	\$ 17.18	\$ 35,730

Regional Center Staffing Mix per Survey
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RC Detail						
Percent of Total, All Positions		Paid Hours 1997-98	1997-98 FTEs(1)	Salary & Wage (Total) 1997-98	Contract/ Temporary Labor Hours 1997-98	Contract/ Temporary Labor Cost 1997-98
Executive	RC A	1%	1%	2%		
Executive	RC B	1%	1%	2%	0%	
Executive	RC C	0%	0%	1%		
Executive	RC D	1%	1%	2%		
Executive	RC E	1%	1%	2%	0%	0%
Executive	RC F	1%	1%	0%		
Executive	RC G	0%	0%	0%		
Executive	RC H	1%	1%	3%	0%	0%
Executive	RC I	1%	1%	1%		
Executive	RC J	1%	1%	2%	0%	0%
Executive	RC K	1%	1%	2%		
Executive	RC L	1%	1%	0%		
Executive	RC M	0%	0%	1%		0%
Executive	RC N	0%	0%	1%	0%	0%
Executive	RC O	1%	1%	2%		
Executive	RC P	1%	1%	1%		
Executive	RC Q	0%	0%	-		
Executive	RC R	1%	1%	0%	0%	0%
Executive	RC S	0%	0%	1%	0%	0%
Executive	<u>RC T</u>	1%	1%			
Executive	Total	1%	1%	1%	0%	0%
Intake w/ CSC	RC A	3%	3%	3%		
Intake w/ CSC	RC B	5%	5%	4%	0%	
Intake w/ CSC	RC C	3%	3%	2%		
Intake w/ CSC	RC D	4%	4%	5%		
Intake w/ CSC	RC E	2%	2%	1%	1%	0%
Intake w/ CSC	RC F	2%	2%	2%		
Intake w/ CSC	RC G	3%	3%	3%		
Intake w/ CSC	RC H	5%	5%	7%	23%	0%
Intake w/ CSC	RC I	3%	3%	2%		
Intake w/ CSC	RC J	1%	1%	1%	0%	0%
Intake w/ CSC	RC K	5%	5%	7%		
Intake w/ CSC	RC L	5%	5%	5%		
Intake w/ CSC	RC M	3%	3%	3%		0%
Intake w/ CSC	RC N	5%	5%	4%	0%	0%
Intake w/ CSC	RC O	3%	3%	3%		
Intake w/ CSC	RC P			0%		
Intake w/ CSC	RC Q	7%	7%	7%		
Intake w/ CSC	RC R	1%	1%	0%	100%	0%
Intake w/ CSC	RC S	3%	3%	3%	0%	0%
Intake w/ CSC	<u>RC T</u>	<u>4%</u>	<u>4%</u>			
Intake w/ CSC	Total	3%	3%	3%	19%	0%
Case Management Exc. Intake	RC A	56%	56%	57%		
Case Management Exc. Intake	RC B	67%	67%	66%	0%	
Case Management Exc. Intake	RC C	58%	58%	63%		
Case Management Exc. Intake	RC D	51%	51%	52%		
Case Management Exc. Intake	RC E	53%	53%	54%	38%	45%

Regional Center Staffing Mix per Survey
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RC Detail						
Percent of Total, All Positions		Paid Hours 1997-98	1997-98 FTEs(1)	Salary & Wage (Total) 1997-98	Contract/ Temporary Labor Hours 1997-98	Contract/ Temporary Labor Cost 1997-98
Case Management Exc. Intake	RC F	59%	59%	61%		
Case Management Exc. Intake	RC G	61%	62%	63%		
Case Management Exc. Intake	RC H	52%	52%	53%	0%	44%
Case Management Exc. Intake	RC I	66%	66%	68%		
Case Management Exc. Intake	RC J	60%	60%	62%	88%	94%
Case Management Exc. Intake	RC K	55%	55%	55%		
Case Management Exc. Intake	RC L	66%	66%	75%		
Case Management Exc. Intake	RC M	63%	63%	64%		0%
Case Management Exc. Intake	RC N	71%	71%	69%	0%	0%
Case Management Exc. Intake	RC O	52%	52%	53%		
Case Management Exc. Intake	RC P	63%	63%	64%		
Case Management Exc. Intake	RC Q	52%	52%	52%		
Case Management Exc. Intake	RC R	61%	61%	65%	0%	100%
Case Management Exc. Intake	RC S	56%	56%	56%	0%	0%
Case Management Exc. Intake	<u>RC T</u>	<u>66%</u>	<u>66%</u>			
Case Management Exc. Intake	Total	59%	59%	61%	33%	57%
Community/Vendor Relations	RC A	5%	5%	7%		
Community/Vendor Relations	RC B	5%	5%	6%	0%	
Community/Vendor Relations	RC C	8%	8%	8%		
Community/Vendor Relations	RC D	15%	15%	18%		
Community/Vendor Relations	RC E	6%	6%	7%	0%	0%
Community/Vendor Relations	RC F	6%	6%	6%		
Community/Vendor Relations	RC G	6%	6%	6%		
Community/Vendor Relations	RC H	6%	6%	9%	0%	0%
Community/Vendor Relations	RC I	6%	6%	6%		
Community/Vendor Relations	RC J	5%	5%	7%	0%	0%
Community/Vendor Relations	RC K	4%	4%	5%		
Community/Vendor Relations	RC L	2%	2%	3%		
Community/Vendor Relations	RC M	5%	5%	5%		0%
Community/Vendor Relations	RC N	3%	3%	4%	0%	0%
Community/Vendor Relations	RC O	5%	5%	6%		
Community/Vendor Relations	RC P	5%	5%	5%		
Community/Vendor Relations	RC Q	10%	10%	11%		
Community/Vendor Relations	RC R	3%	3%	5%	0%	0%
Community/Vendor Relations	RC S	3%	3%	3%	0%	0%
Community/Vendor Relations	<u>RC T</u>	<u>7%</u>	<u>7%</u>			
Community/Vendor Relations	Total	6%	6%	7%	0%	0%
Clinical	RC A	1%	1%	1%		
Clinical	RC B	5%	5%	7%	0%	
Clinical	RC C	5%	5%	6%		
Clinical	RC D	2%	2%	4%		
Clinical	RC E	3%	3%	4%	6%	14%
Clinical	RC F	6%	6%	9%		
Clinical	RC G	4%	4%	4%		
Clinical	RC H	5%	5%	4%	0%	0%
Clinical	RC I	5%	5%	6%		
Clinical	RC J	4%	4%	7%	0%	1%

Regional Center Staffing Mix per Survey
See Notes on Page 31

RC Detail						
Percent of Total, All Positions		Paid Hours 1997-98	1997-98 FTEs(1)	Salary & Wage (Total) 1997-98	Contract/ Temporary Labor Hours 1997-98	Contract/ Temporary Labor Cost 1997-98
Clinical	RC K	4%	4%	8%		
Clinical	RC L	2%	2%	4%		
Clinical	RC M	5%	5%	6%		0%
Clinical	RC N	3%	3%	5%	0%	63%
Clinical	RC O	12%	12%	14%		
Clinical	RC P	5%	5%	9%		
Clinical	RC Q	3%	3%	4%		
Clinical	RC R	6%	6%	9%	0%	0%
Clinical	RC S	7%	7%	11%	0%	0%
Clinical	RC T	0%	0%			
Clinical	Total	5%	5%	7%	1%	12%
Admin	RC A	35%	35%	29%		
Admin	RC B	18%	18%	14%	100%	
Admin	RC C	25%	25%	19%		
Admin	RC D	27%	27%	23%		
Admin	RC E	35%	35%	31%	54%	41%
Admin	RC F	27%	27%	22%		
Admin	RC G	25%	25%	24%		
Admin	RC H	30%	30%	24%	77%	56%
Admin	RC I	19%	19%	17%		
Admin	RC J	29%	29%	22%	12%	5%
Admin	RC K	31%	31%	24%		
Admin	RC L	23%	23%	14%		
Admin	RC M	24%	24%	20%		100%
Admin	RC N	16%	16%	16%	100%	37%
Admin	RC O	26%	26%	21%		
Admin	RC P	27%	27%	20%		
Admin	RC Q	28%	28%	25%		
Admin	RC R	27%	27%	20%	0%	0%
Admin	RC S	32%	32%	25%	100%	100%
Admin	RC T	22%	22%			
Admin	Total	26%	26%	21%	55%	39%
Total	RC A	100%	100%	100%		
Total	RC B	100%	100%	100%	100%	
Total	RC C	100%	100%	100%		
Total	RC D	100%	100%	104%		
Total	RC E	100%	100%	100%	100%	100%
Total	RC F	100%	100%	100%		
Total	RC G	100%	100%	100%		
Total	RC I	100%	100%	100%	100%	100%
Total	RC J	100%	100%	100%		
Total	RC K	100%	100%	100%	100%	100%
Total	RC L	100%	100%	100%		
Total	RC M	100%	100%	100%		
Total	RC N	100%	100%	100%		100%
Total	RC O	100%	100%	100%	100%	100%
Total	RC P	100%	100%	100%		

Regional Center Staffing Mix per Survey
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RC Detail						
Percent of Total, All Positions		Paid Hours 1997-98	1997-98 FTEs(1)	Salary & Wage (Total) 1997-98	Contract/ Temporary Labor Hours 1997-98	Contract/ Temporary Labor Cost 1997-98
Total	RC Q	100%	100%	100%		
Total	RC R	100%	100%	100%		
Total	RC S	100%	100%	100%	100%	100%
Total	RC T	100%	100%	100%	100%	100%
Total	Total	100%	100%	100%	108%	108%

NOTES

(These pages show reclassifications, for purposes of consistency, of Intake Workers and associated Case Management.)

Footnotes to Staff Consolidation

- 1) Calculated at 2,080 paid hours, FTEs reported by RCs varied from that model
- 2) Tri-Counties did not provide salary & wage information, only estimated FTEs
- 3) Golden Gate staffing based on positions in organization chart and wage set at mid-point of salary range. Actual paid hours and wages were not provided.

Definitions

Generic (pre-defined on the survey instrument) positions were grouped according to the following:

Management: supervising positions, specifically Survey Positions Nos. 1, 2, 4, 17, 18, 19, 20, 24, 25, 29. Staff: all others

Executive: Position No. 29; Case Management/Intake: Position Nos. 1-3 (allocated between Intake and CSC per detailed reporting), Intake: Allocated portion of 3, and 8; Community/Vendor Relations: Nos. 4-7; Clinical: Nos. 9-13; Administration: Nos. 14-28 (including all clerical support even though these may work directly with other areas, including case management)

RC-Specific Positions (itemized individually by RCs) varied but were grouped consistent with the generic model. Frequent examples included client rights advocates, transportation and other specialty service coordinators, all of whom were grouped into community/vendor relations, and a variety of administrative positions.

APPENDIX C

LITERATURE REVIEW

APPENDIX C: LITERATURE REVIEW

To perform our review of the literature regarding case management and developmental disabilities service systems, Citygate Associates conducted an internet search and a search of several electronic databases, such as Medline and Biomednet, that provided us with abstracts of pertinent publications. Publications of interest were then pulled from various sources including libraries, state agencies and the Internet. Over 30 documents were reviewed. A bibliography is attached. We augmented our information through interviews with staff at state agencies, associations, or specialist institutions. During our review of the literature, we visited issues surrounding case management/service coordination, quality of life, quality assurance, and health care. This appendix presents a summary of the salient information we gathered from this review.

Services to the developmentally disabled have traversed several models from custodial institutions, to a service model, to a developmental model, and currently to a person- and family-centered model. Each shift in model represented a shift in the decision-making center, moving from physicians, to teachers and psychologists, and now to consumers or their families. A consumer remarked "...finally, we are beginning to be treated as people; at first, we were treated like plants, fed and taken care of; next, we were trained like pets; now for the first time, we are being recognized as people."¹

Accordingly, case management models and institutions have been adapted in an attempt to accommodate new service paradigms. Restrictiveness has been one of the most significant criteria in evaluating quality of life and services. This concept can also be applied to examine system rigidity facing varying consumer needs.

A. CASE MANAGEMENT/SERVICE COORDINATION

In California, current law defines a service coordination model that embraces, through the Individual Planning Process, the consumer or his family as the ultimate decision-maker to accept or reject proposed services. Planning is described as a process through which system representatives and consumers come to an agreement (W&I 4646). In case management, restrictiveness relates to the degree to which system needs take primacy over individual needs and desires. Various methods have been proposed to deal with the restrictions born of interactions between the system and individuals, from posing service coordinators as fiscal intermediaries or gatekeepers, to providing case managers as independent advocates, to the newest model of support brokerage.

The literature commonly identifies a number of functions which case managers fulfill both in response to a "dysfunctional system" and to best meet client goals. The range of functions unique to case management are connecting with clients, planning for services, linking clients with services, and advocating for services. Other functions are related but not unique to case management such as assessment, crisis intervention,

¹ California Department of Developmental Services. *Strategic Plan, Fiscal Year 1998/99*. pp. 2-4.

monitoring or skills teaching. Another article described service coordination (focusing on children) as having seven critical functions: determining eligibility; identifying and arranging assessments; supporting families; referring for services; exchanging information among service providers and families; maintaining follow-up contact with community providers and the family; and determining discharge.² A service monitoring function can be added to this general list for persons receiving out-of-home services. The differences between case management (social work) and service coordination are shades of gray and depend on the intimacy of social interaction and the capacity for clinical assessment. A social worker will seek greater intimacy and involvement and generally, will have some clinical training. (Case management will be used throughout as a generic term covering both "case management" and service coordination, which is our primary interest.)

A great deal of effort has been devoted to demonstrating the value of case management services. What was intuitively evident has been shown to be true; specifically, that case management intervention is useful and appreciated, and that clients who have used the planning and linking process had more service needs identified and received more referrals and services than those who did not go through the process. "The overall goals of consumers (e.g. a decent place to live) rather than the overall goals of system planners (e.g. service utilization) are the reason case management is needed. Case management provides an intervention that is not duplicated by a well-designed system of service."³ Although this quote referred to social workers, it is very likely true of service coordinators.

The models of service coordination observed in this review varied in terms of their mobility, intensity of client contact, their organization and focus. Several offered mobile case management services, seeing clients in their homes, or in their community activities such as school or work. Mobile services were often paired with more intense client, family or service provider contact. One program cited weekly contact, others as needed, one determined service intensity based on a priority-rating scale, another emphasized work in parent groups. One study determined that maintaining client contact is the most critical variable in the quality of case management.⁴

The most uncommon organization for a case management strategy was found in the United Kingdom. Interagency, multidisciplinary client teams with a "named person" contact were organized around transitioning children. This organization ideally would empower service coordinators with recognition from each agency as the primary negotiator with a family.

² Jackson, Barbara, Finkler, Deana, Robinson, Cordelia. (1995) A Cost Analysis of a Case Management System for Infants with Chronic Illnesses and Developmental Disabilities. *Journal of Pediatric Nursing*, 10(5) 304-310.

³ Anthony, William A., Cohen, Mikal, Farkas, Marianne, Cohen, Barry F. (1988) Clinical Care Update: The Chronically Mentally Ill, Case Management—More than a Response to a Dysfunctional System. *Community Mental Health Journal*, 24(3), 219-228.

⁴ Shaw, R., Hargreaves, W., & Surber, R. (1988). *Keeping in touch: Case management of the severely and persistently disabled*. San Francisco: University of California Department of Psychiatry in Rife, John C. et al. (1991).

Hospital-based coordination services were also encountered in this review. Not surprisingly, services tended to focus on health care continuity, community integration and avoidance of rehospitalization.

Supported employment through an individual placement model was presented as having a greater likelihood of achieving independence, empowerment, self-determination, and integration. Case management in this scenario embraces individual choice of services and supports, fulfills the other common functions and avoids focusing on one aspect of a person's life.

“The goal of case management is client empowerment—that is, teaching needed skills so that clients and families develop the self-efficacy that enables them to be in control of their own service and habilitation program.”⁵ The person-centered planning process has been an important step in empowering consumers and families. Empowerment refers to increased control over various aspects of one's life and participation in the community. Self-determination is viewed by some as a step beyond. It refers to consumer and family choice (within resource constraints), with the assumption that the person or family will know best what is needed to accomplish their goals.

It is possible that person-centered planning, empowerment and self-determination are part of a cyclical process. Person-centered planning leads to empowerment leading to self-determination. Ultimately, self-determination should influence subsequent person-centered planning processes. Consumers should greatly benefit from such a cycle, achieving desirable outcomes and their personal goals, as well as obtaining preferred services and supports from preferred providers.

Support brokerage is the model commonly proposed to achieve self-determination. A support brokerage agency ideally is local, independent of providers and government, accountable to meeting the goals of individuals, with maximum flexibility in expenditure based on meeting the criteria of quality of both services and brokerage activity.⁶ A broker learns how a person wants to live, the supports needed, then implements the supports and subsequently reduces involvement to monitoring at a minimum of twice a year. Support brokerage should lead to completely individualized supports and differentiate between providing support and providing programs. The state of Oregon has moved toward brokered supports by linking it to the Family Support model already in place.

Parents as case managers is another concept gaining greater acceptance. Parents receive training and support to carry out the functions of case management. Informed families can better hold service providers accountable and better decide what services correspond to their needs. Parents as case managers shifts from “reliance on over-worked, under-trained staff with a high rate of turnover to reliance on the lifelong

⁵ Fiene, Judith Ivy, Taylor, Patricia. (1991) Serving Rural Families of Developmentally Disabled Children: A Case Management Model. *Social Work* 36(4), 323-327.

⁶ Smull, Michael W. Moving to a System of Support: Using Support Brokerage. *Common Sense*, 1(1&2).

commitment of individuals and families to their own lives.”⁷ Parent case managers is an option for service coordination currently available in California authorized by W&I 4647.

B. QUALITY OF LIFE

With practically no exceptions, the more support is individualized, the higher the achievement of life quality and outcomes. Institutions generally represent the lowest quality of life; although services are coordinated, they rarely correspond to a consumer's desires and their insertion into a consumer's routine may appear arbitrary. Deinstitutionalization is a concept attached to service organizations, not clients. Moving a client is not sufficient to modify an organization's interactions with individuals. In developing programs, the objective is to create learning environments suited to clients and reflecting relatively normal routines of participation in one's community and living arrangement.⁸ A British study of four residential service models concluded that the specialized community group home exceeded other settings in service quality and resident lifestyle. This model offered high levels of structured activities, staff assistance, and positive staff contact to encourage constructive activity on the part of residents.⁹ This model appears to have approximated individualized services.

As another example of change in organizational thinking, hospitals and managed care organizations have moved toward offering after-care coordination of services that seek to support families and increase the success of community integration. The Morristown Hospital Developmental Disabilities Center has taken the health care component a step further by providing comprehensive, coordinated and continuing health care services long after hospitalization. Services include case management by nurse practitioners, outreach, frequent informal consultation, and coordination of inpatient and outpatient care.¹⁰

Quality of life or quality of programs is difficult to assess objectively. During our review, we encountered two useful tools. The Lifestyle Satisfaction Scale assesses client satisfaction with residential and related services. The instrument corrects for acquiescence bias using statistical methods. The Program Analysis of Service Systems' Implementation of Normalization Goals (PASSING) was designed to evaluate human service programs. Social Role Valorization (SRV) principles underlie this quality assurance tool. SRV reconceptualizes normalization on the basis that the occupation of valued social roles increases the chances for achieving other desirable ends including high life quality and social value. An evaluation of 213 programs found that “in practice,

⁷ Minnesota Governor's Planning Council on Developmental Disabilities. (1992) *Shifting Patterns*. pp. 9-11.

⁸ Wetzel, Ralph J. (1992) Behavior Analysis of Residential Program Development. *Research in Developmental Disabilities*, 13 73-79.

⁹ Hatton, Chris, Emerson, Eric, Robertson, Janet, Henderson, Dawn, Cooper, Janet. (1995) The Quality and Costs of Residential Services for Adults with Multiple Disabilities: A Comparative Evaluation. *Research in Developmental Disabilities*, 16(6) 439-460.

¹⁰ Ziring, Philip R., Kastner, Ted, Friedman, Debra L., Pond, William S., Barnett, Michael L., Sonnenberg, Edward M., Strassburger, Kathryn. (1988) Provision of Health Care for Persons with Developmental Disabilities Living in the Community. *Journal of the American Medical Association*, 260(10), 1439-1444.

many human service programs fall considerably short of the verbal assent...give[n] to normalization and SRV-inspired legislation and policies aimed at enhancing clients' social image, competencies, access to valued social roles, and valued social participation."¹¹

C. HEALTH CARE

In addition to the Morristown model previously mentioned, two articles regarding health care were of particular interest. The first discussed the possibilities of managed care effectively serving the developmentally disabled. Managed care could improve access to health care compared to the fee-for-service system. A hypothetical cost model was proposed showing a return to baseline spending in the third year with significant redistribution of resources and cost containment in many areas. "In managed care, reductions in funding are not necessarily related to reductions in levels of service."¹² The advantages of this model are, 1) integration increasing efficiency, 2) reduced duplication through care coordination, 3) elimination of cost shifting between health and long-term care, 4) elimination of categorical eligibility which increases opportunity for new home and community service options. Practice guidelines can be used prospectively (utilization) and retrospectively (quality), and are essential to bringing the uncontrolled practices of fee-for-service systems under management control. Care coordination can obviate the need for negative practices in utilization review because it is associated with reduced utilization. A demonstration project of interest is Health Services for Children. This program provides all acute and long-term care services, and has a care coordination component, updated every six months, to integrate all health, long-term and social services provided by the HMO. Care coordination is one of the major cost centers. In this particular case, out-of-home placements were causing a disproportionate amount of resources to be consumed by a minority of recipients. This voluntary program's success depends on the HMO's ability to convince families to bring children home and create savings that will fund community-based services.

The second article described performance or quality-based compensation models which have been effective in a managed care organization. The goal of these models is to reward service providers who offer greater value. This organization has developed case-mix and severity adjustments for a variety of health care settings along with criteria of effectiveness, appropriateness, etc. to evaluate its providers. This type of compensation model can be used to make explicit an organization's expectations from payers or providers. "Although there is considerable cost for these methodologies and the resources required to develop and maintain the data sets, basing payments on objective performance should ultimately provide greater value."¹³

¹¹ Flynn, Robert J., LaPointe, Nancy, Wolfensberger, Wolf, Thomas, Susan. (1991) Quality of Institutional and Community Human Service Programs in Canada and the United States. *Journal of Psychiatry & Neuroscience*. 16(3) 146-153.

¹² Kastner, Theodore A., Walsh, Kevin K., Criscione, Teri. (1997) Technical Elements, Demonstration Projects, and Fiscal Models in Medicaid Managed Care for People with Developmental Disabilities. *Mental Retardation*, 35(4), 270-285.

¹³ Hanchak, Nicholas A., Schlackman, Neil, Harmon-Weiss, Sandra. (1996) U.S. Healthcare's Quality-Based Compensation Model. *Health Care Financing Review*, 17(3) 143-159.

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APPENDIX D

MANDATES

APPENDIX D: MANDATES

Citygate's review of the legal mandates of the RC environment constituted a complex and significant study activity. This review considered federal and state laws and regulations, RC contracts, case law, administrative manuals and documentation, prior compilations of mandates, and was augmented with various other contributions from DDS and RCs. A list of some of the texts considered in performing this review follows:

- ◆ Lanterman Act and Related Developmental Disability Laws
- ◆ Federal Part C of IDEA Regulations
- ◆ Poindexter Paperwork Reduction Report
- ◆ Health Care Financing Administration's Home and Community Based Services Waiver Monitoring Protocol
- ◆ Coffelt Settlement
- ◆ Title 17 Code of California Regulations
- ◆ RC Contract Language
- ◆ Developmental Disabilities Assistance Act and Bill of Rights
- ◆ Title XIX Targeted Case Management State Plan Amendment
- ◆ Other Monitoring Protocols
- ◆ Home and Community Based Services Waiver
- ◆ Nursing Home Reform Documentation
- ◆ Preadmission Screening and Annual Review (PASARR) Documentation

The following pages contain an example of the work performed on California statutes. The category columns were checked off according each particular mandate's effect on that function of an RC's operations. These were not necessarily a definitive assessment but rather an analytical tool to inform and assist the conduct of other study activities. Consequently, various declinations of this table were utilized throughout the study.

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4512	(b) Def: Specialized services and supports. Determination must be made through IPP with consideration of needs and preferences and must offer range of service options proposed by IPP participants. (j) Def: IPP Planning team members	x	x								
W&I Code	Sec. 4515	Separate patient consent for each release of information										
W&I Code	Sec. 4519	Report requirements for placing a client out-of-state documenting efforts for in-state placement. Must be reviewed and updated every six months		x				x		x		
W&I Code	Sec. 4593	RC may notify area board when RC believes publicly funded program is failing to meet its obligations										
W&I Code	Sec. 4596	(d) RC or DDS to provide list with certain information of consumers to area boards for purposes of LQA (g) Life quality assessment by Area Board to be conducted 90 days prior to consumer triennial IPP (h) RC and Area Board shall meet to exchange information for LQA and follow-up on violations of rights (j) RC shall review information from LQAs systemically to identify training and resource development needs	x	x	x					x		
W&I Code	Sec. 4620	RC created so DD and families may have access to services and supports best suited to them throughout their lifetime. Leg. Intent that design and activities of RC reflect a strong commitment to delivery of direct service coordination and that all operational expenditures of RC are necessary to support and enhance delivery of direct service coordination and services and supports identified in IPP	x	x	x	x	x	x	x	x	x	
W&I Code	Sec. 4622	RC governing board composition and representativeness, including minima for DD and parent, etc. membership on the board. (a) (5) (F) RC to provide training and support to DD (or parent?) board members										
W&I Code	Sec. 4622	RC governing board composition and representativeness, including minima for DD and parent, etc. membership on the board. (g) RC to provide training and support to DD (or parent?) board members										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4629	RC and state five year contracts, including compliance with state laws and regulations clause (c) (1) (A) Annual performance objectives that are specific, measurable and designed to 1) assist consumers achieve life quality outcomes, 2) achieve meaningful progress above current baselines, and 3) develop services and supports to meet identified needs. (c) (1) (B) Annual Performance objectives to be developed through a public process, including 1) informing the community about RC services and supports and operations, including budget and baseline data 2) conducting a public meeting for public input 3) using focus groups or surveys to collect information from the community and 4) circulating a draft of the objectives prior to presentation to the board at a meeting where additional input shall be considered. (c) (2) DDS may specify additional areas of service and support to be developed or enhanced (f) Contract renewal contingent on compliance including compliance with performance objectives.	x	x	x	x	x	x	x	x	x	x
W&I Code	Sec. 4630	(b) Contract shall not prevent RC from employing innovative programs techniques or staffing arrangements expected to enhance program effectiveness.										
W&I Code	Sec. 4631	(a) UFS (accounting, budgeting and encumbrancing, reporting, and systematic approach to admin practices and procedures) shall include number and costs of diagnostic services provided by RC, number and costs of services by service category purchased, all other administrative costs (b) Contract shall require strict accountability and reporting regarding revenues and expenditures and effectiveness of RC in carrying out its program and fiscal responsibilities					x		x			
W&I Code	Sec. 4633	Material change in policy affecting State contract at least 30 days notice of intent										
W&I Code	Sec. 4634	Presentation of State contract to governing board 90 days prior to effective date										
W&I Code	Sec. 4638	RC shall not use state funds to influence employees about unionization or to litigate the National Labor Relations Act. RC may use funds for assistance in collective bargaining or handling employee grievances										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4639	RC board shall annually contract with an accounting firm for independent audit					x		x			
W&I Code	Sec. 4640.6	RC Staffing and 1:62. (a) RC staffing pattern shall demonstrate direct service coordination is the highest priority		x								
W&I Code	Sec. 4640.6	RC Staffing and 1:62. (b) 24 hour, 365 emergency response system ensuring response within two hours of time call was placed		x	x	x			x			
W&I Code	Sec. 4640.6	RC Staffing and 1:62. (c) Contract shall require case mgmt. consumer/staff ratios with overall average of 1:62. RC to have or contract for expertise in: Criminal justice, to assist in providing services and supports to consumers who are victims, defendants, inmates, or parolees. Special education, to assist in providing advocacy and support to families seeking appropriate educational services from a school district. Family support, to assist in maximizing the effectiveness of support and services provided to families. Housing, to assist in accessing affordable housing for consumers in independent or supportive living arrangements. Community integration, to assist consumers & families to access integrated services & support and opportunities to participate in community life. Quality assurance, to assist in providing necessary coordination and cooperation with the area board in conducting quality-of-life assessments and coordinate the RC quality assurance efforts. Each RC shall employ one consumer advocate who is DD. Other service delivery staffing arrangements DDS finds necessary to ensure max. cost effectiveness and that service needs are met.		x	x	x	x	x	x	x	x	
W&I Code	Sec. 4640.6	(d) Proposed RC staffing arrangements which substantially deviate from 1:62 shall be submitted to DDS for approval. Proposal must describe why it is in best interest of consumers and families and demonstrate public support.										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4640.7	(a) Leg. Intent that RC assist DD and families in securing those services and supports which maximize opportunities and choices for living working , learning, and recreating in the community (b) RC designed for maximum cost-effectiveness and based on service coordination model. Each consumer shall have a CSC responsible for providing or ensuring need services and supports are available. RC shall examine differing levels of coordination services to establish varying caseload ratios within the RC to best meet consumer needs		x						x	x	
W&I Code	Sec. 4640.8	Task force or advisory group: RC best efforts to be representative										
W&I Code	Sec. 4641	Casefinding activities including multilingual notification and outreach services	x								x	
W&I Code	Sec. 4642	Intake eligibility. Initial intake to be performed with in 15 working days following request for assistance and shall include certain information and advice. Intake shall include a decision to provide assessment.	x									
W&I Code	Sec. 4643	(a) Assessment to be performed within 120 days of initial intake. Performed in 60 days or less if delay would expose client to health risk, significant developmental delay or placement in more restrictive environment	x									
W&I Code	Sec. 4643	(a) Assessment to be performed within 60 days with possible 30 day extension for circumstances if approved by DDS in writing.	x									
W&I Code	Sec. 4643.5	(a) Cross center eligibility (b) Eligibility shall continue unless after comprehensive reassessment DD determination was clearly erroneous (c) Transfer: same services & supports pending new IPP. If same services do not exist new IPP within 30 days. Prior to approval of new IPP RC shall provide alternative services that best meet IPP objectives in least restrictive setting.	x	x								x
W&I Code	Sec. 4644	(a) In addition to intake eligible persons, RC may cause to be provided preventive services to any potential parent requesting services who is at high risk of parenting a DD infant or to any infant at high risk of becoming DD. Leg. Intent these services shall be given equal priority with all other basic RC services. RC payor (from POS) of last resort for preventive services.	x	x		x						x

Citation	Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code Sec. 4646	<p>(b) DD person and legal representative shall have the opportunity to actively participate in the development of the IPP</p> <p>(c) IPP to be completed w/in 60 days of completion of assessment. RC to inform consumer and others of services of the area board and protection and advocacy agency and provide address and telephone</p> <p>(d) IPP shall be prepared jointly by planning team. Decisions shall be made by agreement between RC representative and the consumer or others at the program plan meeting.</p> <p>(e) RC shall comply with request that a designated representative receive written notice of all meetings to develop or revise IPP and pursuant to Sec. 4710 (Fair hearings)</p> <p>(f) If final agreement on IPP cannot be made, subsequent IPP meeting w/in 15 days unless requested by consumer or agreed to by team. Additional IPP meeting may be held if agreed to.</p> <p>(g) RC rep. And consumer shall sign program plan prior to implementation. If disagreement in whole or part, RC shall send written notice of fair hearing rights. Disagreements on specific points of program plan should not prohibit implementation of services/supports for the remainder of the plan.</p>	x	x								

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4646.5	<p>(a) IPP process to include:</p> <p>(1) Gathering information and conducting assessments for DD person. For children review should consider child and family unit as a whole.</p> <p>(2) Statement of goals and specific measurable objectives</p> <p>(3) IPP for child: RC guided by parameters of Sec 4685 (Services and Supports for Persons Living in the Community)</p> <p>(4) Schedule for POS services or generics to achieve objectives and goals.</p> <p>(5) When agreed to, a review of the general health status of the adult or child, including discussion of current medications. Concerns shall trigger referrals to RC clinicians or consumer's physician. Documentation of health status and referrals in record by CSC.</p> <p>(6) Regular periodic review and reevaluation of provision of services and objective fulfillment and satisfaction</p> <p>(b) IPP shall be reviewed and modified by planning team in response to person's achievement, changing needs or triennially. Consumer may request IPP review which must be conducted within 30 days or submittal.</p> <p>(c) (2) RC shall use IPP training materials and format prepared by the DDS</p>	x	x		x				x		
W&I Code	Sec. 4647	<p>(a) Service coordination includes activities necessary to implement an IPP including, but not limited to, participation in IPP process, assurance planning team considers all appropriate options, securing services and supports, collection and dissemination of information, monitoring implementation of IPP and assist in revising IPP</p> <p>(b) RC to assign service coordinator for overseeing, implementing & monitoring each IPP. May be RC employee or contracted. All parties must agree the person should continue to serve as CSC.</p> <p>(c) Where appropriate, consumer or other may perform all or part of CSC duties if RC director agrees and it is feasible.</p> <p>(e) If CSC alternative, subsection (c), RC shall information and support to alternative service coordinators</p>	x	x	x				x	x	x	
W&I Code	Sec. 4648	Services and supports: (a) RC shall conduct activities to secure needed services and supports.		x						x		

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4648	Services and supports: (a) (1) RC to secure services and supports that meet the needs of the consumer. The planning team shall give highest preference to services and supports which allow minors to live with their families, adults to live as independently as possible in the community and allow all to interact with persons without disabilities in positive meaningful ways.		x				x		x		
W&I Code	Sec. 4648	Services and supports: (a) (2) Implementing individual program plans: RC planning team to first consider services/supports in natural settings, services and supports shall be flexible and tailored to the consumer and family		x				x		x		x
W&I Code	Sec. 4648	Services and supports: (a) (3) (b) RC may reimburse of individual or agency for services or supports if vendorized or an emergency vendorization. Regulations shall be adopted.					x	x	x			
W&I Code	Sec. 4648	Services and supports: (a) (3) (d) RC may vendorize a licensed facility at a capacity equal to or less than the licensed capacity. A facility already licensed on Jan. 1, 1999 shall continue to be vendorized at their full licensed capacity until the facility agrees to vendorization at a reduced capacity.						x	x	x		
W&I Code	Sec. 4648	Services and supports: (a) (4) RC may contract or issue a voucher for services and supports up to max. amount set by DDS. If a rate has not been established, RC may establish an interim rate for any service needed to implement an IPP.		x			x	x	x			
W&I Code	Sec. 4648	Services and supports: (a) (6) RC and consumer shall consider following in selecting a provider: (A) provider's ability to deliver quality services and supports (B) provider's success in achieving IPP objectives (C) provider's licensing, accreditation or professional certification (D) cost of providing services and supports of comparable quality by different providers, if available (E) the consumer's choice of providers.			x			x	x			
W&I Code	Sec. 4648	Services and supports: (a) (8) RC funds not to supplant the budget of agencies to service the general public										

Citation	Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code Sec. 4648	Services and supports: (a) (9) (A) RC may provide placement in, purchase of, or follow-along services to DD persons in, appropriate living arrangements (a) (9) (B) RC shall make available at a minimum the rights information prepared by DDS and in alternative formats (other languages, Braille, audio) when necessary (a) (9) (C) Consumers are eligible to receive supplemental services including additional staffing. Additional staff should be periodically reviewed by planning team. RC shall monitor programs ensuring additional staff is provided and utilized appropriately.		x	x			x	x		x	x
W&I Code Sec. 4648	Services and supports: (a) (10) RC may provide emergency and crisis intervention services to maintain client in living arrangement of choice. If possible, avoid dislocation.		x								
W&I Code Sec. 4648	Services and supports: (a) (11) Planning teams shall consider use of paid roommates or neighbors, personal, technical and financial assistance and other options that would result in greater self sufficiency and cost effectiveness for the state.		x				x	x	x		x
W&I Code Sec. 4648	Services and supports: (a) (12) When IPP specified facilitation is needed, facilitator shall be of consumer's choosing		x								
W&I Code Sec. 4648	Services and supports: (a) (13) Community support may be provided to assist DD person to fully participate in community and civic life. Facilitation shall include: outreach and education to community programs; direct support to individuals; developing unpaid natural supports.		x						x	x	
W&I Code Sec. 4648	Services and supports: (a) (14) Other services and supports may be provided as set forth in Sec. 4685, 4686, 4687, 4688, 4689.		x						x	x	
W&I Code Sec. 4648	(b) (1) RC shall conduct activities to provide advocacy for, and protection of, the civil, legal, and service rights of DD persons		x	x			x			x	
W&I Code Sec. 4648	(c) RC may assist consumers and families directly or through a provider in identifying circles of support within the community		x						x	x	

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4648	(d) (1) To increase quality of community services and protect consumers RC shall identify ineffective and poor quality services and supports and provide or secure consultation, training, or technical assistance for agency or individual provider to upgrade service (d) (2) To increase quality of community services and protect consumers RC shall identify providers not in compliance w/statutes and regulations and notify appropriate licensing or regulatory authority, or request area board investigation		x	x			x		x		
W&I Code	Sec. 4648	(e) Actions for expanding needed services: RC may solicit services and supports by RFP, may request program development funds or community placement plan funds for startup costs, or may use creative and innovative service delivery models.								x		
W&I Code	Sec. 4648	(f) RC payor of last resort: Except in emergency, RC shall not provide direct treatment and therapeutic services, but shall use appropriate public and private community agencies and providers to obtain services for consumers		x			x					x
W&I Code	Sec. 4648.1	(a) RCs may monitor services purchased for consumers w/o prior notice. At least two unannounced visits per year. (b) RC monitoring and auditing staff access to records, etc. (c) DDS and RC to ensure providers of services and supports are informed of their rights and responsibilities and laws governing DD (d) RC may terminate POS payments for non-compliance. RC shall avoid unnecessary disruptions of service, when terminating payments. (e)(2) RC may recover funds from provider. Recovered funds remitted to the department (f) RC shall report licensing violations to appropriate state agency (g) RC may use volunteer teams to conduct monitoring activities (h) In providing technical assistance, RC shall use "Looking at Service Quality-Provider's Handbook"			x		x	x		x	x	
W&I Code	Sec. 4649	Joint effort w/area board to inform public of services available to DD. RC to provide materials and education to community groups and if necessary develop resource materials about local resources.									x	
W&I Code	Sec. 4650	Annual plan and program budget submitted no later than Sept. 1					x		x			
W&I Code	Sec. 4651	(a) RC shall find innovative and economical methods of achieving objectives in the IPP		x						x		

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4652	RC shall investigate every appropriate and economically feasible alternative for care w/in region. If suitable care unavailable, services may be obtained outside the region		X						X		
W&I Code	Sec. 4655	(a) RC director or designee may consent to client treatment under certain circumstances with limitations										
W&I Code	Sec. 4656	(b) RC maintain record of every DD person under 18 referred to the RC, whether or not services are provided	X						X			
W&I Code	Sec. 4657	RC required to collect following information for new cases & at review of all clients in out-of-home placement--SS# of parents, birthday of parents, DD status of parents, parents living or deceased.										
W&I Code	Sec. 4659	(a) RC identify & pursue all possible sources of funding for consumer services, including government programs and private entities with liability (b) Private funding not result in reduction of RC POS budget, except in fed. SSI & state supplementary program (d)(2) To best use generic resources, fed funding and private insurance, RC to be trained by DDS and to train and inform CSC on generic, Fed. Funded, and private insurance programs at local level		X			X		X			
W&I Code	Sec. 4660	RC board meetings scheduled, open, and public. Time for public comment to be allowed.										
W&I Code	Sec. 4661	(a) RC to mail seven days in advance notice of board meetings if requested (b) RC shall maintain all recordings and written comments submitted as testimony on agenda items, keep open/available to public							X			

Citation	Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code Sec. 4669.2	<p>(a) RC may, w/o reduction in direct services and w/ DDS approval and consultation with stakeholders, explore and implement service delivery alternatives for consumers living in the community as follows:</p> <p>(1) Alternative service coordination</p> <p>(2) Technical & financial support to consumers or families to provide or secure own services in lieu of RC coordinated services. To be cost effective in aggregate and limited to consumers at risk of more restrictive setting.</p> <p>(3) Negotiated levels of payment to providers for specific services for consumers through contract</p> <p>(4 & 5) Reduced RC reporting & recording requirements, recommendations and proposals may be made to DDS in consultation with certain entities</p> <p>(6) RC leasing and contracting of facility and provision of services in facility</p> <p>(7) Sharing admin resources with other public & private agencies serving DD.</p> <p>(8) Proposals for RC to purchase office space, if cost-effective. No POS funds</p> <p>(b) Consultation in sub (a) to occur prior to public hearing in Sec. 4669.75</p> <p>(c) RC shall report annually on any alternative used under this section</p>		x		x	x	x	x	x		
W&I Code Sec. 4669.75	<p>(a) Prior to submission of proposal under Sec. 4669.2 to the DDS, RC shall conduct a public hearing w/ 10 days notice to receive comments</p> <p>(c) Written comments and a summary of verbal testimony shall be considered by the RC and submitted in the proposal to the DDS</p> <p>(d) Alternatives must be implemented w/in existing RC allocation and be cost-effective</p> <p>(e) Proposals to meet freedom of choice requirements of HCBW</p>										
W&I Code Sec. 4677	<p>(a) Parental fees collected should be remitted to State Treasury for the Program Development Fund</p> <p>(b) State Council on Dev. Disabilities shall, not less than triennially, request from RCs information on types/amounts of services and supports needed but unavailable</p>					x			x		

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4681.4	(c) To reduce direct care staff turnover and improve quality of care in ARM facilities, funding increase to be used only to increase staff salaries and benefits, provide coverage while attending training (d) ARM providers to report to RC, in format and frequency determined by DDS, information necessary to monitor compliance with subdivision (c)			x		x					
W&I Code	Sec. 4681.5	(e) (2) DDS to adopt emergency regulations for enforcement of direct care staff training and testing requirements			x			x				
W&I Code	Sec. 4684	RC pays cost of service authorized for AFDC-FC recipients but are not allowable under State or Fed. AFDC-FC requirements. RC shall accept referrals for evaluations of AFDC-FC eligible children & assist county welfare and probation departments in identifying appropriate placement resources for children eligible for RC services	x									
W&I Code	Sec. 4685	(b) Family support services: (1) respect decision making authority of family (2) flexible and creative in meeting evolving family needs (3) build on family strengths & natural supports and community resources (4) be designed to meet cultural preferences, values, lifestyles (5) focus on entire family and promote inclusion of DD children in all aspects of school and community	x	x					x	x		x
W&I Code	Sec. 4685	(c) Maintaining child at home: (1) DDS and RC shall give very high priority to development and expansion of services and supports to help families caring for children at home (2) IPP to include family plan when child at home. RC to consider every possible way to assist family to keep child at home. When RC first aware family considers placement or needs additional services, RC meet w/ family, discuss needs, and provide if possible (3) RC may utilize innovative service-delivery mechanisms, e.g. vouchers, respite options, supplemental support to generic child care (6) RC may only pay cost of child care that exceeds that of providing day care to child w/o disabilities, unless proven financial need (7) RC provide voucher for diapers, children 3 or older; under 3 if proven financial need and will enable child to stay in home	x	x			x		x	x		x

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4685.1	(a) When out of home placement, RC to make every effort to locate, consistent w/ IPP in reasonably close proximity to family home (b) When placement cannot be close to home, RC to document efforts to locate, develop or adapt services and supports; and what steps RC take to develop the services at home or close to home; updated every 6 months or as agreed to by family		x						x		
W&I Code	Sec. 4685.5	Self determination pilot programs										
W&I Code	Sec. 4686	(f) Physician to provide assurances to RC of patient's stable condition prior to purchasing in-home gastrostomy care (g) Prior to purchase of in-home gastrostomy care, RC to ensure nursing assessment of client and home performed by registered nurse.				x						
W&I Code	Sec. 4687	Support & counseling to assist DD to make informed decisions may be made available, e.g. sexuality training; parenting skills training; supported living for DD parents w/ children; advocacy assistance; family counseling; & Sec. 4685 services when DD parent in family		x					x			
W&I Code	Sec. 4688	(b) RC responsible for expanding opportunities for full/equal participation of consumer in community through activities including, but not limited to: (1) outreach, training, education to agencies, programs, businesses, and community activity providers (2) developing community resources list (3) Providing assistance to family and case manager on expanding integration options in areas of work, recreation, social, community service, education and public services. (4) Developing and facilitating use of innovative methods of contracting w/community members to provide support in natural settings (5) Development of natural supports to enhance community participation (6) Providing technical assistance & coordination w/community support facilitators		x					x	x	x	

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4689	(a) For DD adults, DDS and RC shall ensure that supported living arrangements adhere to following principles: (1) Consumers shall be supported in living arrangements which are typical of those in which persons w/o disabilities reside. (2) Support changes as needs change w/o moving consumer (3) Consumer preferences guide where and w/whom person lives (4) Consumer control over the environment w/in own home (5) Purpose of services and supports assist individual to exercise choice in his/her life while building relationships (6) Services and supports are flexible and tailored to consumer's needs and preferences (7) Services and supports are most effective where a person lives, w/in context of day-to-day activities. (8) Consumer shall not be excluded from supported living arrangements based on severity or nature of disability		x				x	x	x		
W&I Code	Sec. 4689	(b) RC may contract w/agencies to assist consumers in securing own home or to provide consumers support to live in own home (c) Range of supported living services and supports available: a list (d) RC to provide information and education to consumers & families about supported living principles/services (e) RC to monitor & ensure quality of services & supports provided. Includes adherence to principles of section, whether services & supports in IPP are congruent w/ choices & needs, whether they are delivered, having desired effects, and consumer satisfaction	x	x	x			x	x	x	x	
W&I Code	Sec. 4689.1	(d) DDS to develop regulations on FHA and family homes including among others, selection criteria for RC to apply in vrending FHA, monitoring, program design, records, procedures for enforcing, investigating, sanctioning, appeals (d) (8) Under regs, DDS and RC monitoring of FHA and homes designed to ensure compliance w/ law and provide for health and well-being, assist consumer in understanding rights, consistency w/ FHA design and IPP, maximize consumer choices, home environment		x	x			x	x	x		
W&I Code	Sec. 4690.1	(b) DDS may develop alternative procedures, both competitive and non competitive, for use by RC to establish rates for transportation services										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4691	(f) RC to monitor compliance with program standards for day programs.		x	x							
W&I Code	Sec. 4695	DDS, through RCs, shall offer statewide training (in conjunction w/community colleges) for directors or licensees of residential facilities serving DD persons. Training at college level for college credits.						x	x			
W&I Code	Sec. 4696.1	(b) In order to achieve outcomes of sub (a) (re: cooperation between county mental health and RC), by July 1, 1999 RC and county mental health to develop MOU addressing following: crisis intervention for clients of both systems, case conference for dually diagnosed after admission to inpatient mental health facility, collaborative planning for dual diagnosis, RC and MH collaborate to train community providers (training to include day programs and crisis prevention), RC and MH to work on agreement on a consumer-by-consumer basis on diagnosis and medical necessity, (d) Director of RC and county MH to meet at least annually to review effectiveness, direction and priorities of interagency collaboration				x			x	x		
W&I Code	Sec. 4705	(a) All service agencies shall have an agency fair hearing procedure, for resolving conflict between agencies and recipients, DDS to promulgate regulations by July 1, 1999 (c) RC mediation and fair hearing procedure shall be stated in writing in English and other languages and prominently displayed with provision of this chapter (d) All recipients and applicants shall be informed, verbally and in writing in appropriate language, of the fair hearing and mediation procedures when applying, when being denied, or notified of modification of (Sec. 4710), services.						x	x		x	
W&I Code	Sec. 4707	mediation process for resolving conflicts between RCs and recipients of services implemented by July 1, 1999							x			
W&I Code	Sec. 4710	"Adequate notice" shall be sent by RC when RC decides w/o mutual consent to reduce terminate or change services in IPP or that individual is no longer eligible, denies initiation of service requested for inclusion in IPP; if lack of funds is reason, RC to notify DDS; if person found ineligible for services, RC to send adequate notice										
W&I Code	Sec. 4710.6	(a) Upon receipt of the hearing request form, the RC director shall notify, in writing, the claimant, parent or guardian, and the authorized representative of claimant's fair hearing rights										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4710.7	Fair hearing process: (a) Immediately upon receipt of the hearing request form, RC director shall offer in writing to meet informally w/claimant & family. Mtg. may be declined (c) RC director to render decision										
W&I Code	Sec. 4710.8	Fair hearing process: Informal meeting: convenient, and RC to pay for interpreter if needed							x			
W&I Code	Sec. 4712	(a) Fair hearing: held w/in 50 days of postmark date on the request form or date received by RC. RC may also request continuance not to exceed the 90 day time period for rendering a final administrative decision (e) Fair hearing at time and place convenient to claimant. Claimant and RC shall agree on location. (k) RC to pay cost of recording (m) Fair hearing open to public							x			
W&I Code	Sec. 4714	For each appeal request, RC shall submit information to DDS on case resolution through informal meeting or mediation, issues involved, and outcome of fair hearing.							x			
W&I Code	Sec. 4728	Each RC shall adopt procedures for granting of requests for records by authorized persons within 3 business days							x			
W&I Code	Sec. 4729	Access to records requested, RC to provide at minimum information on types of records, official responsible for maintaining records, right of access and policies and cost										
W&I Code	Sec. 4731	(a) Any consumer who believes any right has been abused or denied, may pursue a complaint. Initial referral to CRA of RC. CRA to investigate within 10 working days and send written proposed resolution to parties. If consumer dissatisfied elevate to director of RC. All consumers notified in writing in appropriate language of right to file complaint when applying for RC services and at IPP meetings.			x				x			
W&I Code	Sec. 4741	Except for immediate danger to health and well-being of client, RC shall not remove consumer from residential care facility against consumer's wishes unless court action or parental consent for minor										
W&I Code	Sec. 4742	RC shall (a) guide and counsel facility staff regarding care and services and supports for each consumer and (b) monitor care and services and supports provided		x	x			x	x	x		
W&I Code	Sec. 4742.1	Statements made by RC representative when discharging obligation to monitor shall be a privileged communication, unless knowledge of falsity or reckless disregard for truth.										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4743	One person assigned by RC to be principal liaison to monitor provision of care and services provided in accordance w/individual program plans. If more than one is needed, one person shall be assigned primary responsibility for directions to administrator and monitoring of care and services.		x	x			x				
W&I Code	Sec. 4744	RC to provide facility administrator all information concerning any history of dangerous propensity of consumer prior to placement. No confidential information shall be released w/o consent										
W&I Code	Sec. 4745	During each visit, RC staff shall inform administrator of any substantial inadequacies and the specific corrective action necessary and deadline for completion and confirm in writing w/in 48 hours.		x	x							
W&I Code	Sec. 4746	Severity of deficiencies and quality of care provided shall determine how long RC will work with facility administrator to resolve inadequacies. If unacceptable, after reasonable period RC staff to recommend disposition to supervisor and licensing agency and administrator. RC to develop sufficient documentation to sustain corrective action.		x	x			x	x	x		
W&I Code	Sec. 4747	If a consumer requests relocation, RC shall schedule an IPP meeting as soon as possible to assist in locating and moving to another residence		x								
W&I Code	Sec. 4750.5	To gather data relevant to ensuring safety and well-being DDS to ensure client master file entry updated w/in 30 days of change of residence.		x					x			
W&I Code	Sec. 4776	On or before Aug. 1 each year RC shall submit a program budget plan to DDS and the state council					x		x			
W&I Code	Sec. 4782	Parents of consumers under 18 receiving 24 hr. out-of-home care through RC shall pay a fee depending on ability to pay but not to exceed cost of caring for normal child at home or cost of services provided whichever is less. Parents shall not be charged for diagnosis or counseling services from RC.										
W&I Code	Sec. 4787	Community Placement from DC: (c) RC able to exceed projected placements w/in the fiscal year shall be allocated additional funding for that purpose in that fiscal year. (d) If DDS determines a RC will not make all of the projected placements during the fiscal yr., those funds shall be made available to those RCs who have exceeded projected placements.										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4791	(b) RCs shall administer contracts w/in level of funding available w/in the annual Budget Act (e) In the event of an unallocated reduction in RC budget, (1) DDS provides RC w/guidelines & tech. Assistance for reducing operations and purchase of service costs; (2) RC to submit plan to absorb and save sufficiently to provide services (k) DDS may require use of operations funds to reduce deficiency of POS funds					x		x			x
W&I Code	Sec. 4800	Persons committed, right to judicial review (b) RC employee to convey request for release to facility director (c) (1) person may be released to RC if willing and able (d) Court may order RC to initiate, or cause to be initiated, conservatorship proceedings for DD adult										
W&I Code	Sec. 4803	Commitment: If RC recommends a consumer be admitted to a community care/health facility, the RC employee shall certify in writing that neither the consumer nor guardian have objected. RC to provide certificate to facility prior to admission.										
W&I Code	Sec. 4825	Any DD adult who is competent may apply for and receive RC services										
W&I Code	Sec. 4843	To accomplish goals of Sec. 4833 (community living continuum) (a) DDS may develop a continuum training model and provide technical assistance to providers through state and county agencies and RC professional collaboration						x	x	x		
W&I Code	Sec. 4846	Interagency agreements shall be established between RCs and the community living continuums to assure clear roles and responsibilities for delivery of services and may include the Dept of Rehabilitation Independent Living Programs.										
W&I Code	Sec. 4847	DDS shall coordinate or require each RC to coordinate a meeting w/in each catchment area between RC, local health facility providers, Dept of Health Services from local office and DDS. Meeting shall be held at least annually to better coordinate services and supports to RC consumers in licensed health facilities.							x			

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
Govt. Code Title 14	Sec. 95002	The purpose of this title is to provide a statewide system of coordinated, comprehensive, family-centered, multidisciplinary, interagency programs, responsible for providing appropriate early intervention services and supports to all eligible infants and toddlers and their families.										
Govt. Code Title 14	Sec. 95002	It is the intent of the Leg. That agencies which possess the greatest expertise in providing early intervention services to infants and their families in the past continue to provide these services.										
Govt. Code Title 14	Sec. 95003	Intent of Leg that DDS among other agencies work together to provide coordinated interagency services to high-risk and disabled infants and their families.										
Govt. Code Title 14	Sec. 95004	Early intervention services provided as follows (a) Direct services for eligible infants and toddlers and their families shall be provided pursuant to the existing RC system and the existing local education agency system and Part H of IDEA (b) Services shall be provided by family resource centers (c) Existing obligations of the state to provide these services at state expense shall not be expanded.	x	x					x		x	
Govt. Code Title 14	Sec. 95007	DDS lead agency for EI, responsibilities: (h) (2) Monitoring shall be conducted by interagency teams that are sufficiently trained to ensure compliance. Interagency teams shall consist of DDS, Dept. of Education., the interagency coordinating council, or a local family resource center or network parent, direct service provider, or any other agency responsible for providing EI services. (j) Ensuring the provision of appropriate EI services to all infants eligible			x				x		x	

Citation	Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
Govt. Code Title 14 Sec. 95014	<p>(a) "Eligible infant or toddler" means birth through 2 years of age for whom a need is documented by means of assessment and evaluation and meet one of following criteria (1) Infants and toddlers w/ a developmental delay, (2) Infants and toddlers w/ established risk conditions have a high probability of leading to developmental delay, (3) Infants and toddlers who are at high risk of having substantial developmental disability due to a combination of biomedical risk factors</p> <p>(b) (1) DDS and RC shall be responsible for provision of appropriate EI services for all infants except for those w/ solely visual hearing or orthopedic impairment or a combination thereof</p> <p>(c) RC shall be agency responsible for providing or purchasing appropriate EI services that are beyond the mandated responsibilities of local education agencies. Education agency shall provide to funded capacity.</p> <p>(d) RC and local education shall coordinate intake, evaluation, assessment and individualized family service plans for infants and toddlers and their families who are served by an agency.</p>	x	x					x			
Govt. Code Title 14 Sec. 95016	<p>(a) Referred infant/toddler shall have a timely, comprehensive multidisciplinary evaluation. In determining eligibility, an assessment shall be conducted and shall include a family interview to identify child's needs for services, resources and concerns of family and services and supports necessary to enhance family's capacity to meet developmental needs of their child. Evaluations shall be shared between agencies. Families shall have opportunity to participate in all decisions regarding eligibility and services.</p> <p>(b) RC and education agencies shall be responsible for ensuring the requirements of section are implemented.</p>	x	x	x				x			
Govt. Code Title 14 Sec. 95018	Eligible infant/toddler & family shall be provided a service coordinator, responsible for family service plan & coordination w/other agencies/persons. Qualifications, responsibilities and functions of service coordinators to be consistent w/ statutes and regs under Part H and this title. Service coordinator caseloads shall be an overall average of 1:62. Service coordination is not subject to any fees.		x								

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
Govt. Code Title 14	Sec. 95020	(a) Each infant/toddler shall have an IFSP in place of individual program plan (b) A meeting to share results of evaluation, determine eligibility and develop initial IFSP shall be conducted w/in 45 days. RC or LEA to initiate and conduct meeting. Families to be afforded opportunity to participate in decisions re: eligibility and services (c) Parent shall be fully informed of rights. Referral may be made to FRC (d) IFSP in writing shall address: (1) present levels of development, (3) statement of major outcomes, (4) criteria, procedures and timelines used to evaluate progress, (5) a statement of the specific EI services needed, (8) steps to be taken to ensure transition at 3 years (e) Each service identified as one of 3 types: (1) an EI service. EI services identified on IFSP that exceed funding, statutory, and regulatory requirements of departments shall be provided by RC or LEA, (2) any other service subject to eligibility, (3) a referral to a nonrequired service (f) An annual review and other periodic reviews of IFSP shall be conducted to evaluate progress against outcomes.	x	x					x			
Govt. Code Title 14	Sec. 95024	(b) Increased costs to RCs for early intervention should be funded by Part H (d) If federal funds remain after mandatory components, state Depts. May (1) designate local interagency coordination areas statewide and contract w/ RC or LEA, (2) allocate funds to support family resource services (e) If plan developed under subdivision (d) lead agency shall give high priority to family resource services										
H&S Code	Sec. 416.8	Conservatorship: Court shall be provided by RC with complete evaluation of the DD person. Report shall include a current diagnosis of physical, mental conditions and social adjustment each prepared by appropriate qualified person	x			x						
H&S Code	Sec. 416.95	Conservatorship: DD person shall be informed of right to counsel										
H&S Code	Sec. 416.14	Conservatorship: Director of DDS shall (a) consult w/ DD person s and their families w/ respect to services, (b) Act as adviser when requested, (c) Accept conservatorship of person and/or estate of DD who needs his assistance		x					x			

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
H&S Code	Sec. 416.15	Conservatorship: Director of DDS may advise and guide w/o court appointment										
H&S Code	Sec. 416.16	Conservatorship: Director shall have same powers and duties as conservators and guardians as in Probate Code										
H&S Code	Sec. 416.17	Conservatorship: When director acting through RC as conservator shall maintain close contact w/ DD person, act as wise parent and permit and encourage self-reliance.		x					x			
H&S Code	Sec. 416.18	Conservatorship: Director shall provide for at least an annual review in writing of DD person's condition	x	x	x	x			x			
H&S Code	Sec. 416.19	Conservatorship: The services to be rendered by the director of DDS as adviser or as guardian or conservator of the person shall be performed through the RC or by other agencies or individuals designated by the RC.		x					x			
Prob. Code	Sec. 1827.5	In limited or general conservatorship proceedings, with consent of conservatee, RC may assess as provided in W&I Sec. 4620 et seq. RC shall submit findings and recommendations to the court. (c) RC report to include description of specific areas, nature and degree of disabilities. RC may also, in certain circumstances, make a recommendation on suitability of petitioners	x			x						
Prob. Code	Sec. 1955	Sterilization proceeding: (a) Court shall request RC to coordinate an investigation and prepare and file a report. Report shall be based on comprehensive medical, psychological, and sociological evaluations and shall address factors listed in Prob. Sec. 1958 (summary follows) (b) Person to be examined personally by two physicians. Examinations at county expense. (c) Each examiner shall prepare a comprehensive report. (e) RC to compile, maintain lists of persons competent in such examinations. Reference to Sec. 1958: incapability to consent to sterilization; fertility and capability of procreation; capability and likelihood to engage in sexual activity and likelihood to result in pregnancy; incapability of caring for child even with training or high risk to mother; less invasive methods unworkable; proposed method entails least invasion; current knowledge does not suggest reversible sterilization will be available shortly or that advancement in treatment of disability is near; person has not made knowing objection to sterilization.										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 6502	RC may request petition for commitment to DDS under Sec. 6500 standard of danger to self or others										
W&I Code	Sec. 6504.5	Commitment: RC to examine the alleged mentally retarded person and within 15 days submit a report on evaluation with recommendation of facilities in which person may be placed. Report to include description of least restrictive residential placement necessary for treatment. If DC is recommended a report must be submitted to director of DC. RC's report also to address interim placements.	x	x								
W&I Code	Sec. 6506	Commitment: RC to recommend a suitable person or facility to care for mentally retarded person in least restrictive setting.										
Penal Code	Sec. 1370.1	Mental Incompetence: (a) (1) (B) (1) RC shall make recommendation for placement (a) (1) (C) Court shall determine conditions, levels of supervision and security for absences from placement for medical treatment, social visits and other activities (a) (2) The court shall order RC to evaluate defendant and submit recommendation whether defendant should be committed (d) If RC concludes that behavior related to defendant's criminal offense has been eliminated, the court may, upon recommendation by RC, dismiss the charges.	x	x								
Penal Code	Sec. 1370.4	If, in the evaluation under Sec. 1370.1, the RC opines defendant is not a danger while on outpatient treatment and will benefit from treatment and has obtained the agreement of the residential facility director and agreement of defendant to submit to outpatient treatment and the director of facility will designate a supervisor for defendant, the court may order outpatient treatment. The provisions of Title 15 (commencing with Section 1600) of Part 2 (Penal Code) (Outpatient Status) except that RC director shall be substituted for community program director and the director of DDS for director of Mental Health and residential facility for treatment facility.	x	x					x			
W&I Code	Sec. 4417	DDS may organize and maintain community mental hygiene clinics for prevention, early diagnosis and treatment of retardation, such may be maintained only for persons not requiring institutional. DDS may regulate.										

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
W&I Code	Sec. 4418.3	Transition from DC to community: (c) consumer shall be afforded opportunity to visit a variety of community living arrangements (e) RC shall schedule face-to-face reviews no less than once every 30 days for the first 90 days. Following the first 90 days, the RC may conduct reviews less often as specified in IPP	x	x								
W&I Code	Sec. 4418.7	Transition from DC to community: (a) If RC determines or is informed that community placement is at risk of failing, RC shall notify DDS (b) DDS shall arrange for an assessment of the situation to determine if additional or different services and supports. DDS shall ensure that RC provides those services and supports on an emergency basis. IPP meeting shall follow.		x					x			x
W&I Code	Sec. 4433	(a) (3) Leg. Finds clients' rights advocacy services provided by RC may have conflict of interest (b) DDS shall contract for clients' rights advocacy services in single statewide contract. (g) This section shall not prohibit RC from advocating for rights including the right to generic services		x					x			
W&I Code	Sec. 4433.5	Notwithstanding Sec. 4433, DDS may contract with the Organization of Area Boards to provide clients' rights advocacy services to DD individuals who reside in DC or state hospitals.										
W&I Code	Sec. 4434	(b) DDS shall take all necessary actions to support RC to successfully achieve compliance and provide high quality services and supports to consumers and their families. (d) As part of its responsibility to monitor RC, DDS shall collect and review printed materials issued by RC. Within a reasonable period of time, DDS shall review new or amended POS policies prior to implementation by RC to ensure compliance with statute and regulation.		x			x		x			x
Penal Code	Sec. 1001.22	Diversion: Court shall consult with prosecutor, defense counsel, probation department, and RC to determine whether defendant may be diverted. RC shall submit a report with determination whether defendant is mentally retarded and eligible for RC diversion-related treatment and habilitation services. RC shall also submit a proposed diversion program as derived from the defendant's IPP.	x	x								
Penal Code	Sec. 1001.23	Diversion: RC to submit progress report at least every six months		x								

Citation		Description of mandate	Intake & Assessment	Ongoing Case Mgmt	Quality Assurance	Clinical Services	Fiscal	Vendor Relations	Other Admin	Resource Development	Outreach & Education	POS
Penal Code	Sec. 1001.28	Diversion: Diversion period not to exceed two years.										
Penal Code	Sec. 1001.34	Diversion: Notwithstanding any other provision of law, the diversion-related IPP shall be fully implemented by RC upon court order and approval of the diversion-related treatment and habilitation plan.	x	x					x			x
Penal Code	Sec. 1602	Outpatient: (a) (2) One of three conditions prior to placing on outpatient status: community program director (RC) advises the court that defendant will not be a danger to the health and safety of others while on outpatient status, will benefit from such status, and identifies an appropriate program of supervision and treatment. (b) The community program director (RC) shall submit the evaluation and the treatment plan specified in (a) (2) within 15 calendar days except in the case of a person who is an inpatient, the plan shall be submitted within 30 calendar days. (c) Evaluations and recommendations shall include review and consideration of the circumstances of the criminal offense and prior criminal history.	x	x					x			
Penal Code	Sec. 1604	Outpatient: (b) Community program director (RC) shall submit a recommendation regarding the defendant's eligibility for outpatient status and the recommended plan for outpatient supervision and treatment. The plan shall set forth specific terms and conditions to be followed during outpatient status.	x	x								
Penal Code	Sec. 1606	Outpatient: Hearing at end of outpatient period, community program director (RC) shall furnish a report and recommendation.										

APPENDIX E

CONSUMER SERVICE COORDINATOR: COMPENSATION AND CLASSIFICATION SURVEY RESULTS



APPENDIX E:

Consumer Service Coordinator: Compensation and Classification Survey Results

The importance of the Consumer Service Coordinator (CSC) position to both RC operational outcomes and budgets required better perspective on the positions' classification and compensation than available solely through state and RC sources. The wide range of CSC qualifications made it particularly difficult to compare compensation levels without developing benchmark classes. To improve the study results in CSC, CSC supervisor and manager classification and compensation, we conducted a limited scope review of comparable positions and career tracks. Since this was not a part of the DDS Core Staffing Study scope, the timing and funds for the survey were extremely restricted. However, the high quality of Internet personnel resources made the results far better than could have been created by this approach even a year ago.

Citygate Associates reviewed all web site postings for California's top ten counties, as well as for the State, pulled position specifications and slotted them based on requirements, role, and associated compensation ranges. Thirty-four positions from nine employers were obtained, and included career tracks in social work from several counties. We were assisted by the existing information we had on 20 RCs' CSC positions, including position descriptions, minimum qualifications and actual compensation averages as well as ranges.

The number of comparisons obtained with this method is reasonable for validation of the limited positions reviewed, given the very large number of employees in the positions. The data from Southern California counties reflects the degree of automation among counties. Santa Clara, Sacramento, and Contra Costa counties were reviewed but did not have sufficient on-line information to acquire data on this short notice.

Benchmark positions relevant to RC CSCs for the survey were defined as:

Social Worker I: Providing journey-level case management under general supervision with a moderately difficult case load, minimum requirement is Bachelors' and one to two years experience beyond first year training (5 comparisons)

Social Worker II: Select or difficult case load, providing comprehensive case management, minimum requirement is Master in Social Work; or Master's and 1-2 years related experience or two years experience equivalent to a Social Worker I with Bachelors degree (8 comparisons)

Social Worker III: Professional practice; case management differentiates from Social Worker II due to the high risk, and shorter time frames in case load, e.g. crisis intervention; usually requires Master's with experience, license in clinical social work or counseling required for many positions) (9 comparisons)

We also defined positions bracketing these benchmarks above and below: Social Work Trainee (typically baccalaureate with no experience) and Social Worker IV (independent clinical practice). Data for these are included in the detailed exhibits that follow.

The current CSC funding used by the state is a 50% / 50% blend of the Social Work Associate and the Psychiatric Social Worker positions. Comparing these and other State of California positions to the surveyed social work positions we found:

- Social Work Associate corresponds to benchmark positions as Social Worker I. The state's compensation midpoint is 6.6 percent below the benchmark internal average.
- Psychiatric Social Worker corresponds to the benchmark position of Social Worker II. The state's compensation midpoint is 0.1 percent below the benchmark internal average, or essentially comparable.
- The state did not have a position comparable to Social Worker III.

The findings below use the internal mean (excluding high and low).

Position	Survey Midpoint (Internal Average)	State Comparison
Social Worker I	\$33,724	\$31,494
Social Worker II	\$39,449	\$39,408
Social Worker III	\$40,742	N/A
Core Staffing Blend		\$34,590

Based on our extensive field work including site visits and interviews with dozens of CSCs and CSC supervisors, review of staffing models and personnel position descriptions for all RCs, and review of consumer case load data, we believe a reasonable staffing assumption reflecting known case mix for the RCs would be 40% Social Worker I, 40% Social Worker II and 20% Social Worker III. This provides an internal career path for CSCs; addresses differential consumer needs, and supports retention of experienced personnel in direct consumer service. This position mix has an average midpoint of \$37,418 using the survey data. Bilingual differentials, where offered in surveyed sites, were typically five percent of compensation. If applied to 50% of CSCs, this would bring the blended midpoint to \$38,353.

We also surveyed social work supervisory levels and obtained six benchmarks. Internal comparison found that differential from subordinate compensation ranged from three percent to 20%, with four of the six between 10-15%. Roles and functions of the surveyed positions were consistent with CSC supervisors based on our fieldwork. We propose a 20% differential to enable broader retention ranges in the CSC position, or a compensation midpoint of \$46,024.

Position	Criteria	Survey Midpoint (Internal Average)
Consumer Service Coordinator	40% Social Worker I	\$33,724
	40% Social Worker II	\$39,449
	20% Social Worker III	<u>\$40,742</u>
	Blended Midpoint	\$37,418
Bilingual Differential	5% of Base for 50%	\$38,353
First Line Supervisor (CSC Supervisor)	20% Differential	\$46,024
Second Line Supervisor (CSC Manager)	20% Differential	\$55,229

EXHIBIT E-1: DDS Public Sector Social Work Compensation Survey Position Descriptions and Banding

Posted Positions as of 9/1/99

Study Benchmark	Position Title	Employer	Minimum Degree/Experience
1 Social Work Trainee	Social Worker I	San Diego Co	BA & No experience or 2 yrs as eligibility worker
2 Social Work Trainee	Children's Services Social Worker I	Ventura Co	BA in Social Work or BA + 1 year
3 Social Work Trainee	Child Social Worker Trainee	LA County	Relevant BA or BA+1 year case work w/ vendor
4 Social Work Trainee	Social Worker I	Riverside	30 semester units of relevant coursework
5 Social Worker I	Social Worker II	San Diego Co	BA & 1 year or Masters
6 Social Worker I	Social Work Associate	State	BA
7 Social Worker I	Social Worker II	Riverside Co	1 year or grad level education & six months
8 Social Worker I	Child Social Worker I	LA County	1 year as trainee or Relevant BA+1 year Or BA+2 years
9 Social Worker I	Health Care Social Worker	Riverside Co	BA & 1 year
10 Social Worker II	Hospital Social Worker II	State	
11 Social Worker II	Clinical Social Worker I	Orange County	Masters in Social Work (MSW) 6 mo as Ventura Co SW I or MSW or Bachelor's in Social Work (BSW) + 1 year relevant experience
12 Social Worker II	Children's Services Social Worker II	Ventura Co	Social work BA + 1 year related experience (RE) or 2 year as Riverside County SW II
13 Social Worker II	Social Service Worker III	Riverside Co	MA
14 Social Worker II	Psychiatric Social Worker	State	MA
15 Social Worker II	Child Social Worker II	LA County	Master or Related BA+2 closely relevant experience MSW or MA & 2 years RE or BA & 2 yrs as San Bernardino SWII
16 Social Worker II	Social Work Practitioner-Children's Services	San Bernardino County	MSW or MA& 2 years RE or BA & 2 yrs as San Bernardino SWII
17 Social Worker II	Social Work Practitioner	San Bernardino County	MSW or MA& 2 years RE or BA & 2 yrs as San Bernardino SWII
18 Social Worker III	Social Worker III	San Diego Co	BA & 3 years RE or MA & 2 years
19 Social Worker III	Sr. Psychiatric Social Worker	San Diego Co	MA & 2 years RE
20 Social Worker III	Social Worker V	San Diego Co	MA & 2 years RE
21 Social Worker III	Children's Services Social Worker III	Ventura Co	MSW+2 years RE or BSW + 3 years RE MSW or masters in psych or 3 years as Riverside Co SW III
22 Social Worker III	Social Service Worker IV	Riverside Co	SW III
23 Social Worker III	Clinical Social Worker II	Orange County	Licensed Clinical Social Worker (LCSW)
24 Social Worker III	Medical Social Worker II	Riverside Co	MA plus one year directly relevant

EXHIBIT E-1: DDS Public Sector Social Work Compensation Survey Position Descriptions and Banding

Posted Positions as of 9/1/99

25 Social Worker III	Senior Social Worker	Orange County	Masters or BA and five years RE or Credits and six years Masters Social Welfare or Masters/MFSS and 2 yrs RE or 3 years in-house experience as CWWI LCSW/MFT
26 Social Worker III	Child Welfare Worker II	Alameda County	License as CSW 1 yr in-house as SWIII or 2 yrs SW II or equivalent
27 Social Worker IV	Psychiatric Social Worker	San Francisco	
28 Social Worker IV	Psychiatric Social Worker II	Riverside	MA & 2 years as CA Psych SW or 4 years external RE
29 First Line Supervisor	Social Work Sup I	Riverside	
30 First Line Supervisor	Psych Social Work Supervisor I	State	MA & 1 yr supervisory experience or Riverside SW5 Promotion from Alameda CWW II
31 First Line Supervisor	Psych Social Work Supervisor II	State	
32 First Line Supervisor	Social Work Sup II	Riverside	MFCC/LCSW + 2 years post grad RE
33 First Line Supervisor	Child Welfare Supervisor	Alameda County	
34 First Line Supervisor	Sr. Psych Social Worker	San Francisco	



EXHIBIT E-2: DDS Public Sector Social Work Compensation Survey: Position Compensation and Averages

Posted Positions as of 9/1/99

	Benchmark	Employer	Bottom Step	Top Step	Midpoint	
1	Social Work Trainee	San Diego Co	\$ 24,461	\$ 29,744	\$ 27,103	3%-6% Bilingual Differential
2	Social Work Trainee	Ventura Co	\$ 27,720	\$ 38,844	\$ 33,282	5% Bilingual Differential
3	Social Work Trainee	LA County	\$ 26,556	\$ 32,976	\$ 29,766	
4	Social Work Trainee	Riverside	\$ 26,980	\$ 33,426	\$ 30,203	
Social Worker I						
5	Social Worker I	San Diego Co	\$ 25,730	\$ 31,283	\$ 28,507	
6	Social Worker I	State	\$ 28,176	\$ 34,812	\$ 31,494	
7	Social Worker I	Riverside Co	\$ 30,996	\$ 38,412	\$ 34,704	
8	Social Worker I	LA County	\$ 31,248	\$ 38,700	\$ 34,974	
9	Social Worker I	Riverside Co	\$ 32,705	\$ 40,518	\$ 36,612	
Average			\$ 29,771	\$ 36,745	\$ 33,258	
Internal Average (Excluding High and Low)			\$ 30,140	\$ 37,308	\$ 33,724	
Social Worker II						
10	Social Worker II	State	\$ 28,764	\$ 35,712	\$ 32,238	
11	Social Worker II	Orange County	\$ 34,152	\$ 45,864	\$ 40,008	
12	Social Worker II	Ventura Co	\$ 30,000	\$ 42,048	\$ 36,024	5% Bilingual Differential
13	Social Worker II	Riverside Co	\$ 34,500	\$ 42,744	\$ 38,622	
14	Social Worker II	State	\$ 35,088	\$ 43,728	\$ 39,408	
15	Social Worker II	LA County	\$ 36,516	\$ 45,240	\$ 40,878	MA starts @ \$38,700
16	Social Worker II	San Bernardino County	\$ 36,691	\$ 46,821	\$ 41,756	
17	Social Worker II	San Bernardino County	\$ 38,172	\$ 48,696	\$ 43,434	
Average			\$ 34,235	\$ 43,857	\$ 39,046	
Internal Average (Excluding High and Low)			\$ 34,491	\$ 44,408	\$ 39,449	
Social Worker III						
18	Social Worker III	San Diego Co	\$ 29,786	\$ 36,213	\$ 33,000	
19	Social Worker III	San Diego Co	\$ 33,072	\$ 40,206	\$ 36,639	
20	Social Worker III	San Diego Co	\$ 34,902	\$ 42,411	\$ 38,657	
21	Social Worker III	Ventura Co	\$ 32,112	\$ 45,024	\$ 38,568	5% Bilingual Differential
22	Social Worker III	Riverside Co	\$ 35,652	\$ 44,160	\$ 39,906	
23	Social Worker III	Orange County	\$ 36,924	\$ 49,776	\$ 43,350	
24	Social Worker III	Riverside Co	\$ 37,596	\$ 46,572	\$ 42,084	
25	Social Worker III	Orange County	\$ 39,168	\$ 52,812	\$ 45,990	4% Bilingual Differential
26	Social Worker III	Alameda County	\$ 45,552	\$ 52,280	\$ 48,916	
Average			\$ 36,085	\$ 45,495	\$ 40,790	
Internal Average (Excluding High and Low)			\$ 35,632	\$ 45,852	\$ 40,742	
27	Social Worker IV	San Francisco	\$ 50,726	\$ 61,646		
28	Social Worker IV	Riverside	\$ 41,616	\$ 51,564		
First Line Supervisor						
29	First Line Supervisor	Riverside	\$ 38,418	\$ 47,590		Difference from Subordinate 11%
30	First Line Supervisor	State	\$ 39,624	\$ 48,156		10%
31	First Line Supervisor	State	\$ 43,452	\$ 52,824		10%
32	First Line Supervisor	Riverside	\$ 42,744	\$ 52,978		20%
33	First Line Supervisor	Alameda County		\$ 60,164		15%
34	First Line Supervisor	San Francisco	\$ 52,104	\$ 63,310		3%
Average			\$ 43,268	\$ 54,170	\$ 48,719	
Internal Average (Excluding High and Low)			\$ 41,940	\$ 53,531	\$ 47,735	



APPENDIX F

GLOSSARY OF TERMS

APPENDIX F: GLOSSARY OF TERMS

Annualized—A statistical technique by which data for part of a year are converted to their yearlong equivalent.

ARCA—Association of Regional Center Agencies

Association of Regional Center Agencies—(ARCA) The organization of Regional Centers which coordinates many of their legislative activities.

CAP—Corrective Action Plan.

Case Management—(CM) The process of insuring that a consumer receives the necessary services.

Case Manager—(CM) A role used in social, human and medical services with a variety of meanings. Usually describes an individual responsible for assessing a consumer/patient's needs, developing a plan for services, obtaining and integrating those services, evaluating their effectiveness and quality, and mediating between the consumer/patient and the service system.

Casefinding—The processes and tools used by Regional Centers to identify potential consumers.

Catchment Area—Geographic area whose residents are served by a given Regional Center.

CBO—Community Based Organization.

CCF—Community Care Facility.

CDER—Client Developmental Evaluation Record.

Client—Traditional term for an individual qualified to receive services from Regional Centers through The Lanterman Act or Early Start. See Consumer.

Client Developmental Evaluation Record—A standard data set for tracking defined measures profiling active consumers in the Regional Center system.

Clinical Services—Specialty consumer services including intake clinical teams and related quality assurance. Clinical teams include such specialty positions as doctors, nurses, psychologists, etc.

CM—Case Management or Case Manager depending on the context.

CMF—Client Master File.

Coffelt—A court order directing the state to move most consumers from state developmental centers into community placement. Defined target numbers for compliance, standards for the placement process and other detailed implementation steps and requirements.

Community Based Organization—(CBO) Global term for local voluntary agencies characterized by 'grass-roots' support, representative boards of directors for governance, and local accountability and commitment. Usually a not-for-profit agency focused on a specific population and/or need.

Community Care Facility—(CCF) A licensure category for group homes administered by the State Department of Social Services. Frequently paid through Regional Center POS on behalf of consumers residing in these facilities. A Level 1 CCF requires less intensive staffing because consumer needs are not as demanding.

Community Services—Regional Center operations devoted to developing and maintaining relationships with vendors and other sources of services and supports to consumers. Includes advocacy directed at increasing opportunities for consumers to live and participate in settings with persons without developmental disabilities. Other activities include resource development and vendor-oriented quality assurance.

Consumer—The preferred term for an individual qualified to receive services from Regional Centers through The Lanterman Act or Early Start. See Client.

Consumer Rights Advocate—(CRA) Position previously in the Regional Center responsible for representing consumers in appeals and fair hearing processes. Positions and associated budgets realigned to a contract directed by area boards to increase independence.

Consumer Service Coordination—(CSC) Consumer evaluation, collaborative planning for consumer services. Supports preparation of the IPP, facilitates access to IPP services and monitors the effectiveness of those services in meeting the consumer's needs.

Consumer Service Coordinator—(CSC) The most frequent title of the primary staff member responsible for consumer service coordination. Carries a defined, ongoing caseload of consumers, responsible as their primary point of contact with the Regional Center.

Core Staffing Formula/Model—A legislatively mandated model developed in 1978 used to determine the state's appropriation for Regional Centers' operations.

Corrective Action Plan—(CAP) A plan issued by the RC quality assurance teams to vendors who are out of compliance. The plan prescribes steps for vendors to correct deficiencies.

CRA—Consumer Rights Advocate.

CSC—Consumer Service Coordination or Consumer Service Coordinator depending on the context.

Day Program—A structured daily activity for six to eight hours per day for consumers in a group setting, with a variety of levels of activities and supportive services depending on the consumer's abilities, needs and interests.

DC—Developmental Center. See SDC below.

DDS—Department of Developmental Services.

Department of Developmental Services—A department of the California Health and Welfare Agency charged with administering services and funds for persons with developmental disabilities. Operates the state developmental centers and contracts with 21 Regional Centers for community-based programs.

Direct Service—Services provided by the Regional Center directly to a consumer and his circle of support, as differentiated by services purchased by the Regional Center through POS. The primary direct service is consumer service coordination. Regional Centers are prohibited from providing direct services in residential services, medical care and many other areas.

DOF—California State Department of Finance.

Early Intervention—Program to provide services to children at risk for developmental disabilities under the age of three (36 months). Funded by the US Department of Health and Human Services (also known as Part C (formerly Part H) funding).

Early Start—See Early Intervention.

Executive Management—Regional Center directors who handle issues of governance, planning and community/constituency relations.

Family Home Agency—(FHA) A private, not-for-profit agency that assists adults with developmental disabilities in moving into family homes.

FHA—Family Home Agency.

Fiduciary Financial Services—Regional Center activities related to insuring that vendors receive payment for services they provide to Regional Center consumers.

Forensic—Literally, “court related”, including any consumer interactions with the judicial system in custody, protective services, etc., as well as in civil or criminal or other related status such as parole and probation.

FTE—Full-time equivalent.

Full-time Equivalent—(FTE) A standardized unit of employees based on the number of hours paid per year. One FTE equals a standard full time position, 2080 hours in a year (52 weeks a year, five days a week, eight hours a day).

Generic Services—Consumer services and supports identified in the IPP and obtained with the Regional Center’s facilitation, but paid by a third party, not POS funds. Examples include health care paid for by insurance or MediCal, Department of Rehabilitation services and local school district services.

HCFA—Health Care Financing Administration.

Health Care Financing Administration—(HCFA) A federal agency within the US Department of Health and Human Services responsible for Medicare and Medicaid (MediCal in California) financing. Administers and oversees Medicaid waiver programs.

ICF—Intermediate Care Facilities.

ID Team—Interdisciplinary Team.

IFSP—Individualized Family Service Plan.

ILS—Independent Living Services.

Independent Living Services—(ILS) Same as SLS, except that the consumer purchases the in-home support.

Individual Program Plan—(IPP) This plan reflects consumer’s choices in how to structure his life within his abilities. Focuses on defining necessary services and supports to maximize independence. Developed collaboratively with the consumer and his circle of supports.

Individualized Family Service Plan—(IFSP) This process is functionally equivalent to the IPP, except that it is for consumers in the Early Start program, and subject to specific regulations. Focuses on the family unit and maintaining at risk children in a natural home setting.

Information Systems—(IS) The use of computers in communication, data collection, reporting, monitoring and work.

Intake and Eligibility—Initial process used to determine what (if any) developmental disabilities a potential consumer has, and whether those disabilities qualify him for participation in the Regional Center system. At the end of this process, the eligible consumer and his CSC will have developed the initial IPP or IFSP.

Interdisciplinary Team—(ID Team) A team of professionals with different specialties who collaborate to serve Regional Center consumers.

Intermediate Care Facilities—(ICF) Licensure status for nursing homes issued by the California Department of Health, dictating specific staffing and services. Less clinical staff is required than in a skilled nursing facility (SNF). Variations include ICF/DD (Developmental Disability), ICF/DD-H (Developmental Disability-Habilitation) and ICF/DD-N (Developmental Disability-Nursing).

IPP—Individual Program Plan.

IS—Information Systems.

Life Quality Assessment—(LQA) A standardized interview survey of consumer satisfaction encompassing all aspects of a consumer's services, including living arrangements, daily activities, relationships, etc. Conducted at least once every three years for each consumer in a residential placement in California by a third party under contract to the local area board.

LQA—Life Quality Assessment.

Medicaid Waiver—A program by which Medicaid (MediCal in California) funds are available for skilled nursing and supportive services for consumers living in a CCF. As an exception to standard Medicaid policy, operating under a waiver requires a specific application by the state, is subject to specific terms and conditions defined by HCFA.

Memorandum of Understanding—A legally binding document between two bargaining groups that substitutes for a contract or legal decision.

MOU—Memorandum of Understanding.

Multi-sourcing—This research technique involves gathering information from multiple sources.

OBM—Operating Budget Model.

Operating Budget Model—(OBM) Citygate's proposed model for determining the operating budget of Regional Centers. It replaces the Core Staffing model, and excludes the POS portion of a Regional Center's budget.

Operations—Operations funds pay for the day to day costs of the direct services provided by Regional Centers to consumers, as well as necessary administration and overhead. See also POS.

Outliers—Responses to a survey which are at the either extreme end of the spectrum.

Part C—Regulations describing the Federal Early Intervention programs serving developmentally disabled and at risk infants 0-36 months old.

Payor—The entity that actually pays for services provided to Regional Center consumers.

POS—Purchase of Services.

Prevention Services—Activities that reduce the occurrence of developmental disabilities. Includes population-focused activities, such as education on risks associated with maternal behaviors, the need for good nutrition and early prenatal care as well as interventions for at risk individuals.

Project Steering Committee—Committee of officials from DDS, ARCA and DOF overseeing Citygate's study design and project findings.

Purchase of Services—(POS) Funds administered by Regional Centers and appropriated through the State Department of Developmental Services to purchase services and supports for consumers as identified in the IPP. Regional Centers are required to use POS funds as a last resort for services and support, seeking to obtain services through other funding mechanisms whenever possible. See also Operations, and Generic Services.

QA—Quality Assurance.

Quality assurance—(QA) This function allows the Regional Center to insure that vendors are providing adequate service to the consumers. It is an important part of consumer service coordination and case management. See also Consumer Service Coordination.

Ratio Analysis—This analytical technique examines the relationship across data elements over time and across sites to find inconsistencies that need validation, as well as consistent patterns that support projections.

RC—Regional Center.

RCF—Residential Care Facility. See community care facilities (CCF).

Regional Center—(RC) Twenty-one locally controlled not-for-profit agencies that coordinate and administer the state's services to persons with developmental disabilities.



Each agency has a local board of directors, and contracts with the State through the Department of Developmental Services.

Residential Placement—A living arrangement where the consumer resides outside of his parent's or guardian's home.

Restrictiveness—The degree to which system needs take precedent over individual needs and desires.

SANDIS—San Diego Information System. Developed by the San Diego Regional Center, this software package integrates case management, information and referral systems. It also can bridge between these functions and other Regional Center/DDS reports.

SDC—State Developmental Center.

Sensitivity Analysis—An analytical assessment of how much the results of a model change if a specific variables changes.

SIR—Special Incident Report.

Skilled Nursing Facility—(SNF) Licensure status for nursing homes issued by the California Department of Health, dictating specific staffing and services. More nursing and clinical staff is required than in an intermediate care facility (ICF).

SLS—Supported Living Services. A living arrangement where vendors provide one-to-one service in the consumer's home.

SNF—Skilled Nursing Facility.

State Developmental Center—One of five residential centers operated by the State Department of Developmental Services. Prior to the 1990s, these housed consumers on a long-term basis, with many living there for decades. Today, they are primarily focused on short-term stabilization of special needs. See also Coffelt.

TA—Technical Assistance.

Technical Assistance—(TA) Service provided by RC to improve vendors' quality of service. Services may range from staff training to assistance with program design.

The Lanterman Act—The common name for the legislation establishing California's system to serve consumers with developmental disabilities. Refers to the initial legislation's author, Frank D. Lanterman.

UFS—Uniform Financial System.

Uniform Financial System—(UFS) Accounting reporting system used by Regional Centers and mandated by state law.

Vendorization—Certifying a provider to participate as a POS vendor.