

Attachment A to the Porterville Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
<p>with a client.</p> <p>3. PDC will ensure that a Qualified Intellectual Disability Professional (QIDP) is assigned to every client; monitors the implementation of each client's IPP; monitors the client's responses to the plan on an ongoing basis and initiates changes to the plan as indicated.</p> <p>4. PDC will provide staff with initial and periodic training on appropriate interaction skills with clients in order to respect the dignity of the clients at all times.</p> <p>5. PDC will ensure that client clothing is properly fitted and maintained in a condition (clean, untoned) that enables clients to dress in a manner consistent with the general community.</p> <p>6. PDC will screen all clients for the need for a comprehensive physical therapy assessment and any therapies indicated as a result of the assessments will be incorporated into the IPP and implemented.</p>	<p>Initially, by August 1, 2016 and quarterly thereafter thereafter Immediately</p> <p>Screenings initiated by August 1, 2016. Completed no later than the next IDT annual assessment for each client.</p>	<p>PDC</p> <p>PDC</p>
C. Comprehensive Assessments and Needs Identification		
<p>1. PDC will complete a comprehensive assessment on every client in the facility to identify the client's needs for support services and training programs during their current placement at PDC and to include the appropriate post discharge setting and necessary preparations for that relocation.</p> <p>2. PDC will update the comprehensive assessments when there are changes in the client's needs.</p> <p>3. PDC/CDDS will identify community resources that are currently available that may meet the PDC clients' needs as identified in their comprehensive assessments.</p> <p>4. PDC/CDDS will develop a plan to create the additional community resources needed to meet the clients' needs as identified in their comprehensive assessments and transition plans.</p> <p>5. PDC/CDDS will prioritize the development of community resources to support individuals who have significant and intense support needs, to ensure careful and timely development and transition planning.</p> <p>6. CDDS will identify the additional community resources needed to meet clients' needs in the community as identified in their comprehensive assessments and transition plans, such as residential services, outpatient clinics, medical providers, supportive living arrangements, employment opportunities, and other supportive services.</p>	<p>As IPP is completed (with annual update through placement)</p> <p>Ongoing</p> <p>Immediately and ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>	<p>PDC</p> <p>PDC</p> <p>PDC/CDDS</p> <p>PDC/CDDS</p> <p>PDC/CDDS</p> <p>CDDS</p>

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D. Individual Program Plan (IPP), Transition Plan (TP) and Activities		
<p>1. Individual Program Plan</p> <p>As required by Sections 4418.3, 4646, and 4646.5 of the California Welfare and Institutions Code an IPP is developed for every individual using a person-centered planning approach by making decisions regarding where a person with developmental disabilities will live and the kinds of services and supports that may be needed. In person-centered planning, everyone who uses regional center services has a planning team that includes the person utilizing the services, family members, regional center staff and anyone else who is asked to be there by the individual. This team is referred to as the Interdisciplinary Team (IDT). The IDT joins together to make sure that the services that people are getting are supporting their choices in where they want to live, how and with whom they choose to spend the day and their plans for the future.</p> <p>2. Exploration and Identification of Living Options</p> <p>The transition process begins with the already existing IPP as mandated in the Lanterman Act and continues as IDTs meet to identify each person's goals and objectives, and services and supports based upon their assessed needs, preferences and choices. PDC will work with individuals, family, IDT, and where appropriate other participants, to review transition options using the clients' IPPs.</p> <ul style="list-style-type: none"> a. PDC will develop and implement a Facility plan to increase opportunities for more individuals to take community tours and experience community living options, in accordance with State policy that each individual is afforded these opportunities. b. PDC will coordinate "meet & greet" introductions to potential providers where clients, families and providers meet to see if a specific option identified through exploration activities has the potential for success. c. The IDT will consider currently available alternative placements for any clients at PDC whose post-discharge needs match the services available and transfers are made as appropriate. <p>3. Transition Planning Meetings</p> <ul style="list-style-type: none"> a. Once a client has had a successful "meet and greet" and identifies a specific living option they want to pursue, a Transition Planning Meeting (TPM) will be held with the IDT to start an Individual Transition and Health Transition Plan for the client. b. The Individual Transition and Health Transition Plan documents the process of planning and implementing transition activities and specific transition health services. <p>4. Familiarization (Cross-training) Activities</p>	<p>IPP completed or amended annually or more frequently, as needed.</p> <p>August 1, 2016</p> <p>As potential options are identified.</p> <p>As potential options are identified</p> <p>Immediately and ongoing</p> <p>Within 30 days of IDT identifying a specific living option</p>	<p>PDC staff complete the IPP while the individual resides at PDC and regional center staff complete once the individual moves to the community.</p> <p>PDC</p> <p>PDC</p> <p>CDDS PDC</p> <p>CDDS PDC</p> <p>CDDS PDC</p>

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<p>a. The IPP will include specific activities for familiarization of new provider staff with the details of the Comprehensive Assessment, Individual Program Plan, Specialized Support Plans and any informal or personalized knowledge from the PDC staff who know the client best. This may include, but is not limited to, activities such as:</p> <ul style="list-style-type: none"> i. Integrated meetings with IDT and new provider staff for transition of plan information. Includes transition of Residential, Day Services/Vocational, Health Care, Behavioral Health and any other plans as identified in the transition plan. ii. Cross training of new provider staff and PDC staff is accomplished via visits by PDC staff to the community providers or vice versa, simulated training situations, or actual observation of daily activities and programming across support settings. 	As transition plans are developed and implemented	CDDS PDC
<p>5. Individualized Health Transition Plans (IHTPs)</p> <p>a. As part of the transition planning process, an IHTP is developed by the ID team to include the client's health history and current health status by the client's medical staff. The client, involved family members, conservator, authorized representative, and/or advocate may participate in the development of the IHTP. The IHTP provides specific information on how the client's health needs will be met and the health transition services that will be provided, such as occupational therapy, respiratory therapy and other specialized health procedures</p>	Upon identification of a specific appropriate living option and ongoing	CDDS PDC
<p>6. Specialized Behavior Plans and Safety Plans</p> <p>a. As part of the transition planning process, the ID Team will develop Specialized Behavior Plans that include components related to client safety for clients who have significant behavioral support needs, many who currently have rights restrictions or the use of highly restrictive methods such as psychoactive medications. Where indicated by the Comprehensive Assessments, specialized behavior plans will be developed to assist new service providers in understanding the needs of the individual and to adequately provide the needed behavioral supports in the new settings.</p>	Upon identification of a specific appropriate living option and ongoing	CDDS PDC
<p>7. Transition Review Meeting (TRM)</p> <p>a. A TRM is held to review and finalize a client's Individual Transition and Health Transition Plan and to ensure that all members of the IDT Team are satisfied that all arrangements agreed on in the planning process have been implemented and that the client is prepared to move. TRM's are held at the conclusion of the transition process and is when the IDT Team sets a move date. An individual's TRM must occur no less than 15 days prior to a planned move date to better inform current quality assurance efforts, meet the</p>	Upon identification of a specific appropriate living option and ongoing	CDDS PDC

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<p>expectations of CMS, and provide information to CDDS.</p> <p>8. Porterville Certified Unit Population Projections</p> <p>The projections below establish the maximum permissible client census eligible for federal funding in the PDC certified units as of the first calendar day of the listed month. Federal Financial Participation is only permissible for clients on the Client List as of June 27, 2016. No Federal Financial Participation can be sought for the number of clients that exceed the projections below, even if the clients that exceed the census limits below are on the Client List as of June 27, 2016.</p> <p style="text-align: center;">Census</p> <p>July 2016105 July 2017.....82 July 2018.....61 July 2019.....39 July 2020.....18 July 2021.....0</p>		
E. Post-Move Monitoring		
<p>1. The California Department of Developmental Services' Porterville Developmental Center Closure Plan will detail the process and mechanisms the Department, regional centers and other oversight entities will employ for monitoring the health, safety and well-being of individuals who transition from Porterville Developmental Center to the community.</p> <p style="padding-left: 20px;">a. Expectations and a clear process will be established for post-move monitoring and required documentation.</p> <p style="padding-left: 20px;">b. State employees, regional center staff and providers will share responsibility in assuring identified outcomes are met while providing and accessing resources to make community living successful</p> <p>2. The Department will maintain an active Quality Management System, in conjunction with the Regional Centers, to monitor consumers' quality outcomes and satisfaction and to identify areas where interventions and improvements may be needed through the use of:</p> <p style="padding-left: 20px;">a. The National Core Indicators (NCI)</p> <p style="padding-left: 20px;">b. Onsite visits and interviews.</p> <p style="padding-left: 20px;">c. Consistent with ongoing CDDS and Regional Center operations, existing systems and databases.</p> <p style="padding-left: 20px;">d. Review of IPPs.</p> <p>3. The California Parties will meet the obligations set forth in Attachment B, which relates to the discharge of PDC clients and requires development of a plan for enhanced oversight of client transitions from developmental centers to the community.</p>	<p>April 1, 2016</p> <p>Continuous and ongoing</p> <p>Immediately and ongoing</p>	<p>CDDS PDC</p> <p>CDDS PDC</p> <p>CDDS PDC</p>

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<p>4. PDC will perform on-site post-move monitoring at residential settings for up to one year after each individual transitions to the community. The monitoring will occur on the following intervals – 5 days, 30 days, 90 days, 180 days, and 360 days. This post-move monitoring shall include feedback obtained from client family members or responsible parties regarding the transfer process to the new community setting.</p> <p>5. Once the individual transitions to the community, regional center staff performs at least quarterly face-to-face visits for anyone residing in out-of-home placement to ensure health, safety and quality services.</p> <p style="margin-left: 40px;">a. In addition, anyone moving from a developmental center to the community receives enhanced (1:45) regional center case management services for at least two years.</p> <p style="margin-left: 40px;">b. Individuals who move from the developmental center to an Adult Residential Facility for Persons with Special Healthcare Needs or to Enhanced Behavioral Supports Home, receive enhanced clinical staffing in the home and oversight by the regional center and CDDS.</p> <p>6. CDDS shall use the National Core Indicators (NCI) to measure the outcomes for individuals who have transitioned to the community. Annually, CDDS will review the outcome measures with the CDDS Quality Management Advisory Group that consists of parents and families, representation from the State Council on Developmental Disabilities, protection and advocacy organizations, DC clients and Regional Center representatives.</p>	<p>At 5, 30, 90, 180 and 360 days from transfer from PDC</p> <p>At least quarterly following move</p> <p>Annually</p>	<p>CDDS PDC</p> <p>CDDS PDC</p> <p>CDDS</p>
F. Monitoring by Independent Monitor		
<p>1. Subject to CMS’s approval, the CDDS will employ at its own expense an independent external organization with proven capabilities in quality assurance systems in the ICF/IID environment (“Independent Monitor”) to develop a monitoring plan and implement the quality assurance performance indicators and conduct the following tasks:</p> <p style="margin-left: 40px;">a. The Independent Monitor will conduct frequent monitoring of conditions at PDC with an emphasis on provision of Active Treatment, quality Health Care outcomes, Behavioral Health outcomes and Client Protections.</p> <p style="margin-left: 40px;">b. Additional specialized monitoring of the transition process and outcomes will be developed by the Independent Monitor based on information gained during the transition process and post move monitoring by PDC and CDDS.</p> <p style="margin-left: 40px;">c. The independent monitor will provide reports based on the data regarding the status of compliance with the provisions and requirements of this Attachment A, Statement of Tasks, data obtained pursuant to Attachment B and data obtained by F91)(a) and (b) to CMS, CDPH, and California Parties beginning on September 1, 2016, and every month thereafter, or more frequently if requested by CMS. The reports shall at a minimum include the items identified in</p>	<p>Monitor to be submitted to CMS for approval no later than August 1, 2016</p> <p>As needed</p> <p>As needed</p> <p>September 1, 2016 and every and every month thereafter</p>	<p>CDDS and monitor</p> <p>Independent Monitor</p> <p>Independent Monitor</p> <p>Independent Monitor</p>

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<p>paragraph E.3-6 and G.1.a-b, updated data on the client census each month, verification of CDDS activities pursuant to Attachment A as described in F.1.d below, and may include other items that the Independent Monitor deems material.</p> <p>d. The independent Monitor's reports will also include verification that CDDS has met its obligations pursuant to Attachment A, including, but not limited to:</p> <ul style="list-style-type: none"> i. Providing trainings in the detection and management of abuse, neglect and mistreatment and the recognition and elimination of environmental and /or situational factors that may result in such mistreatment pursuant to § A.3 of Attachment A ii. Providing familiarization/cross-training activities to facilitate transfer of PDC clients pursuant to § D.4 of Attachment A. iii. Participating in Transition Review Meetings pursuant to § D.7 of Attachment A. iv. Ensuring that Quality Assurance activities are undertaken and monitored for effectiveness pursuant to § G.1 of Attachment A. v. Providing competency evaluations and trainings as necessary for PDC staff and management pursuant to § G. 3 of Attachment A. vi. Ensuring that the monitoring plan is reviewed and revised as necessary pursuant to § G.6 of Attachment A. vii. Ensuring that QMS activities were conducted, including the factors listed in § E.2 of Attachment A. viii. Maintaining a list of clients transitioned to Adult Residential Facility for Persons with Special Healthcare Needs or to Enhanced Behavioral Supports Homes, to which CDDS has an obligation to provide enhanced oversight pursuant to § E.5(b) of Attachment A. 	<p>September 1, 2016 and every and every month thereafter</p>	<p>Independent Monitor</p>
G. Quality Assurance		
<p>1. CDDS will develop and implement a detailed QA plan and maintain the plan over the life of the PDC closure/transition. The QA system will include:</p> <ul style="list-style-type: none"> a. A quality oversight and internal monitoring system with tools and a data system for monitoring. This will be applied by both internal and external reviewers to ensure the timely discovery and investigation of all incidents and injuries, the thorough conduct of investigations, the maintenance of quality of investigative reports and the effectiveness of any required corrective actions. b. Monitoring the effectiveness of incident management, investigations, and corrective actions. c. A process to monitor abuse, neglect, and mistreatment of clients, and revise as identified. d. Quality measurement tools for both internal and external reviewers to use to conduct observations and compare 	<p>August 1, 2016 and ongoing</p>	<p>CDDS</p>

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<p>various records to ensure that all incidents and injuries are reported and appropriate related actions undertaken.</p> <p>e. Unannounced visits on all shifts, including the continuation of CDPH performing unannounced visits to observe for situations that may indicate safety concerns.</p> <p>2. Review competency of PDC and other staff as required in Person Centered Planning in accordance with the Lanterman Act and relevant CMS requirements</p> <p>PDC will continue the development of its integrated Person Centered and Planning (PCP) and Interdisciplinary team (IDT) process, including:</p> <p>a. Increasing IDT members' understanding of the basic PCP concepts and gaining commitment to the underlying values;</p> <p>b. Improving the assessment process to increase identification of client's personal desires/goals in addition to needs/strengths, while maintaining the rights of the clients;</p> <p>c. Increasing involvement of the individual/family members/direct support staff in the IDT and transition planning process;</p> <p>d. Including goals/desires that will assist for a successful transition in each client's IPP and implement a "discovery log" to identify additional individual interests/desires throughout the year that will assist in matching the person to the most appropriate setting.</p> <p>e. A monitoring process to perform ongoing competency evaluation of both individual staff and IDT function will be incorporated in the quality assurance plan.</p> <p>f. When indicated by the monitoring results, competency-based training/retraining will occur.</p>	<p>August 1, 2016 and ongoing</p>	<p>CDPH</p> <p>PDC</p>
<p>External quality reviewer will perform quality assurance on a representative sample of comprehensive assessments.</p>	<p>September 1, 2016 and ongoing</p>	<p>Independent Monitor</p>
<p>3. Determine competencies and train/re-train PDC/RC staff in transition planning. Provide IDT members with training related to the general identification of barriers to successful transition and the consequent design and implementation of strategies to reduce those barriers. The training will focus specifically on the role and responsibilities of the Interdisciplinary team in identifying family/guardian concerns that may serve as a barrier to placement and in the development of strategies to resolve those concerns. Often these concerns are based on the perceived lack of protections, services, and supports in the community. Obstacles and concerns should be defined with sufficient detail to allow the State to identify and address issues related to the current community system.</p>	<p>August 1, 2016 and ongoing</p>	<p>CDDS PDC</p>
<p>4. IDT members in all disciplines will visit community programs on a regular and ongoing basis. Facilitators/PCs, in particular, should begin visiting community programs immediately to become familiar with options and services.</p>	<p>August 1, 2016 and ongoing</p>	<p>PDC</p>

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<p>5. Identify Outcome and Process measures to be monitored, tracked and trended to assure successful transitions and achievement of closure plan objectives.</p>	<p>August 1, 2016 and ongoing</p>	<p>CDDS, PDC</p>
<p>6. The CDDS will review and revise the monitoring plan previously provided during the PIP by developing a two-pronged quality assurance approach. The primary concentration of this approach will be to: 1) assure that clients of PDC achieve the <i>outcomes</i> specified in their IPPs; and 2) that the policies, procedures, and practices employed at PDC support the achievement of these outcomes.</p>	<p>As needed</p>	<p>CDDS</p>