CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ACUTE CRISIS UNITS AT SONOMA AND FAIRVIEW DEVELOPMENTAL CENTERS – TOPIC #1	
EFFECTIVE JANURY 1, 2015, A NEW CRISIS CENTER WILL BE ESTABLISHED AT SONOMA DEVELOPMENTAL CENTER AND ADDITIONAL SUPPORTS AND RESOURCES WILL BE PROVIDED TO ENHANCE EXISTING SERVICES AT FAIRVIEW DEVELOPMENTAL CENTER. EACH DEVELOPMENTAL CENTER's CRISIS UNIT WILL BE A SEPARATE RESIDENTIAL UNIT, DISTINCT FROM OTHER RESIDENTIAL UNITS AT THE DEVELOPMENTAL CENTER AND MODIFIED TO INCLUDE A STAND-ALONE KITCHEN. THE CRISIS UNITS SHALL SERVE NO MORE THAN 5 CONSUMERS EACH. THE UNITS ARE INTENDED TO ASSIST CONSUMERS IN CRISIS WITH TRANSITIONING BACK TO THEIR PRIOR RESIDENCE, OR AN ALTERNATIVE COMMUNITY-BASED RESIDENTIAL SETTING WITHIN SPECIFIED TIMEFRAMES. THIS MODEL IS INTENDED AS THE "SAFETY NET" FOR CONSUMERS IN ACUTE CRISIS WHERE COMMUNITY OPTIONS DON'T EXIST, AND WITH THE OVERARCHING GOAL OF SHORT-TERM STABILIZATION. EVALUATIONS OF DC CRISIS CENTERS WILL BE PROVIDED ANNUALLY TO BUDGET AND POLICY COMMITTEES COMMENCING ON JANUARY 10, 2015, FOR FAIRVIEW DEVELOPMENTAL CENTER AND JANUARY 10, 2016, FOR SONOMA DEVELOPMENTAL CENTER.	
PROGRAM DESIGN	<u>Housing design</u> • Safe • Open floor concept • Accessible kitchen • Separate bedrooms • Padded surfaces • Sensory design • Outdoor garden • Exercise room • Noise reduction • Quiet room (not a seclusion room) • Homelike • Inclusion center • Nice lighting • Possible duplex (2 people per environment; 5 is too much) • SLS model <u>Admission</u> • Need a clear definition of a 'crisis' and 'acute' for admission purposes • Decide if there should be a zero reject policy • Have an evaluation center (like a Mental Health 5150) to confirm or deny admission • Define who will be referred population; further definition of "crisis" • Confirm how to triage who is admitted – the priority

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ACUTE CRISIS UNITS AT SONOMA AND FAIRVIEW DEVELOPMENTAL CENTERS – TOPIC #1	
	• If no beds available, need to have a back-up option • Streamline admission process • Specialized statewide team to handle entire process of admission - continuum • Get them moved in ASAP • Highly skilled assessment • Use Regional Project staff to do assessments • Upon admission – full physical, labs, psychiatric, medical, medications • Get as much information as possible at admission and throughout transition • Speed up 6500 process <u>Program</u> • Use uniform standards/policies & procedures across the state (all acute crisis centers) • Capacity of 10 across entire state is not enough; need to create more • Create an acute crisis center at Porterville DC for forensic needs • Use forensic, law enforcement and MH expertise to teach us what works • Learn from other states, including family members with resources in other states • Staff that know how to handle trauma • Length of stay – 90 days minimum to 1 year maximum • Community Care Facility (CCF) or Intermediate Care Facility (ICF) model – confirm what is best due to Sonoma DC ICF decertification issue • Mobile crisis team to be used from start to finish, to follow the individual <u>Staffing</u> • 1:1 well trained staff (consider psych techs as the staff but could be community staff) • Staff time based on individual need – may increase or fade as needed • Ongoing staff training program – and specifically in suicide prevention and Applied Behavior Analysis • Have DC staff train community staff and have community staff train DC staff • Staff need training in special needs areas • Clearly define everyone's roles in regulations

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ACUTE CRISIS UNITS AT SONOMA AND FAIRVIEW DEVELOPMENTAL CENTERS – TOPIC #1	
PERSON CENTERED PLANNING AND QUALITY ASSURANCE/MONITORING	<u>Person Centered Planning</u> • Involve the individual in the entire planning process • Prevention - Identify risks ahead of time • Standardize the 4418 process • Involve eventual community provider in the process from the beginning • Multidisciplinary team – Regional Center Representative (Acute Crisis Unit specific 'low' caseload), Developmental Center Representative, Occupational Therapist, Physical Therapist, Psychologist, BCBA (Board Certified Behavior Analyst)/Behavior Specialist, M.D., speech, pharmacist, sensory, neuropsychologist, Recreation Therapist, etc. (use teleconference if applicable) • Use regional project expertise/team as part of the team • Do a matching process so individuals can co-exist • Whole team approach, including the advocate/Clients Rights Advocate • Treat people behaviorally and medically • Establish person's baseline right away • Develop plan within 10 days • Use/modify existing plan for first 10 days • Sync person's DC programming with their eventual community programming • Manage behaviors – don't just tolerate behaviors • Evidence based services • Immediate access to a physician • Have access to a day program and community integration • Continue the community supports that are working while in crisis center • Overemphasis on good communication <u>Monitoring and Outcomes</u> • Goal of stabilization before exiting • Measure the success of the program – data collection throughout • Statewide, web-based system for all paperwork (referral, admission, transition) • Self-advocacy group within the center • Review increase of behaviors within 24 hours • Define monitoring and quality assurance clearly • Ensure they are truly ready for discharge before leaving

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ACUTE CRISIS UNITS AT SONOMA AND FAIRVIEW DEVELOPMENTAL CENTERS – TOPIC #1	
TRANSITION PROCESS	<u>Transition</u> • Transition process of moving out starts day 1 of moving in • Continuum of care process • Ensure individuals don't get admitted to DCs through Acute Crisis Unit • Make sure community staff get trained at the DC on the floor prior to client moving out • Move into a step down community model from the acute crisis model • Define exit criteria based on stability and ready for the community • Fade restrictions along the way so they are more prepared for community <u>Resources</u> • Have multiple community resources available to prevent re-admission • Give community resource extra/additional behavioral support upon return to home • Pay bed hold rate to community provider to keep resource available to return to • Educate parents, families, RCs, support groups, and all involved about entire process • Have a Resource Developer exploring community options the entire duration of stay • Have resources available as they move out – Psychiatric, medications, pharmacy, etc. • Educate the community about services (i.e. courts) • Have money follow the person so there is no gap in services • Use DC Acute Crisis Center staff to come to the community placement after for transition

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

COMMUNITY CRISIS HOMES (CCH) – TOPIC #2	
DEFINITION OF COMMUNITY CRISIS HOME - FACILITY CERTIFIED BY THE STATE DEPARTMENT OF DEVELOPMENTAL SERVICES…AND LICENSED BY THE STATE DEPARTMENT OF SOCIAL SERVICES…AS AN ADULT RESIDENTIAL FACILITY, PROVIDING 24-HOUR NONMEDICAL CARE TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES RECEIVING REGIONAL CENTER SERVICES AND IN NEED OF CRISIS INTERVENTION SERVICES WHO WOULD OTHERWISE BE AT RISK OF ADMISSION TO THE ACUTE CRISIS CENTER AT FAIRVIEW DEVELOPMENTAL CENTER OR SONOMA DEVELOPMENTAL CENTER, AN OUT-OF-STATE PLACEMENT, A GENERAL ACUTE HOSPITAL, AN ACUTE PSYCHIATRIC HOSPITAL, OR AN INSTITUTION FOR MENTAL DISEASE... A COMMUNITY CRISIS HOME SHALL HAVE A MAXIMUM CAPACITY OF EIGHT CONSUMERS.	
PROGRAM DESIGN	<u>Admission</u> • Decide if there should be a zero reject policy • Multiple Regional Centers should develop and access – not just for one Regional Center • Clearly define entrance and exit criteria • Vacancy needs to be listed on SSRS (Statewide Specialized Resource Service) <u>Housing Design</u> • 8 beds maybe too many • Consider 2 smaller crisis homes instead of 1 large home • Have at least 3 homes across state – north, central and south • Have higher and lower level of crisis homes • Have a portion of home or one home for more suicidal/homicidal individuals • Have specialized crisis homes – i.e. sex offenders; autism • Physical separation of people • Accessible living environment • Private bedrooms • Private bathrooms (doors should open outwards) • Homelike environment • Features – large open floor plan; quiet room; exercise room; separate kitchen • Allow alone time through technology (sensors) • Duplex design • Require a sprinkler system • Plenty of common areas • Spacious – indoor and outdoor • Special substitutes for glass/windows (self-frosting); consider acoustics; soft home if needed • Place these homes in areas where noise is not a problem – more rural but not too rural

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

COMMUNITY CRISIS HOMES (CCH) – TOPIC #2	
	• Delayed egress may be necessary (no secured perimeter) • May need alarms <u>Length of Stay</u> • Short term - 1 month; 2 months; 3 months; 6 months; 1 year; 2 years • Length of stay to be determined by planning team • Make length of stay evidenced based – don't stay longer than needed • Not a 'forever' home • Individual may not want to stay – let them leave if they want to <u>Program Design</u> • Enhanced behavioral and sensory services • Treatment based model – behavioral intervention needed • Evidence based • Positive behavioral supports • Active treatment • Have a mobile crisis unit available at all times – follow them through the process • Use what works from existing adult and children's crisis homes that is successful • Be clear about when to be hands on or hands off • Providers should be expected to have Policies &Procedures • Need to also have crisis homes for children • Have relationships with neighbors, law enforcement, community medical groups and Mental Health • 16 hour training is far too little • Allow family involvement and 'Ronald McDonald' funding for family to visit
PERSON CENTERED PLANNING AND QUALITY ASSURANCE/MONITORING	<u>Person Centered Planning</u> • Intense customized intake assessments before customized treatment plan can be done • Complete as many assessments as the individual needs • Complete a risk assessment prior to admission and after, if necessary • Have a statewide assessment team to assess as quickly as possible • Complete an individualized emergency plan upon admission • Look at what worked and didn't work in previous environment

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

COMMUNITY CRISIS HOMES (CCH) – TOPIC #2	
	• Clearly defined individualized rules for the CCH and individuals • Once individual has progressed, then they discharge • Begin transition planning at the beginning of placement • Have an Individual Behavior Support Plan prior or at admission • IPP meeting should take place in 14 days (not 30 days) • Whole team approach - Psychologist, Psychiatrist, RN, behaviorist/BCBA (Board Certified Behavior Analyst), LCSW (Licensed Clinical Social Worker) • Define the team in regulation • Staff need to know how to implement the plan • Allow for a personalized day schedule • Consultation and services may need to increase/decrease month to month based on need • Have one leader of the team • Allow them to continue their day programming/school they were in prior to moving into CCH • Transition out to transition homes – lower acuity homes • Present clients with an array of living options to return to • Have individual transition out with a comprehensive transition plan • Allow individual to make multiple visits prior to moving out (lunch, overnight, and so on) <u>Monitoring</u> • Department of Social Services – monitor annually • Regional Center – enhanced monitoring monthly • Home should have own internal Quality Assurance system • Regional Center Service Coordinators should have small intensive caseloads (25-30) and have varying education expertise • Regional Centers could 'visit' through technology if necessary (private phone booth) • Use NCI (National Core Indicators) as monitoring indicators • Look at data of discharged client – look at success rate • Human rights committee – to look at SIRs and hands on tactics; debriefing • Access to the Clients Rights Advocate • All professionals need to be identified prior to serving anyone (MD, dentist, etc.) • Outcomes based approach • Form a relationship with community Mental Health

COMMUNITY CRISIS HOMES (CCH) – TOPIC #2	
	• Have RN do the medication administration • Pay attention to change of conditions • Anyone that visits the home should complete a 'snapshot' of their visit (immediate feedback) • Regional Center and Department of Social Services monitoring – more frequent • Make safety in the CCH a concern for all individuals • Work out 'out of area' Medi-Cal problem
STAFFING	<u>Administrator</u> • Manager or QIDP (Qualified Intellectual Disability Professional)? <u>Direct Care Staffing</u> • Prevent a 'watching/fish bowl' mentality where staff just 'watch' clients instead of interacting with them • Highly trained staffing • Staff should have 2 years of experience prior to working in CCH model • Psych tech staffed daily • Pay direct care staff 150% of minimum wage • Constant cross training – allow previous staff to come to CCH and work with individual • Use community state staffing • Rich staffing – 1:1 or more as needed; flexibility with ratio • Constant line of sight staffing • Have transportation teams of staff just to transport (3 staff = 1 driver; 2 staff to supervise) • More restrictions and staffing in the beginning – then fade • Plenty of staff training – competency based training (DSP 1 & 2 is not enough) • Train staff on de-escalation • Have previous (favorite) community staff continue to visit on regular basis <u>Consultants and Supports</u> • BCBA/Board Certified Behavior Analyst (or something similar) on staff daily • Psychologist on staff or available daily

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

COMMUNITY CRISIS HOMES (CCH) – TOPIC #2	
RATES	<u>Facility Rate</u> • Cover bringing staff on early and training; 1:1 staff; environment; Administrator; housing costs • Facility damage • Enough funding for professional level staffing • Include transition period and bed holds in the rate <u>Individual Rate</u> • Justify individual rate based on what they truly need • Give individual 1st and last month's rent when getting discharged from facility • Additional consultation, staffing and supports <u>Other Rate Information</u> • Negotiate rates • Allow for rate adjustments • Use Rate Reform Study Methodology

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

COMMUNITY STATE STAFF PROGRAM EXPANSION – TOPIC #3	
THE EXPANSION OF THE COMMUNITY STATE STAFF PROGRAM WILL ASSIST IN MEETING THE GOAL OF SUCCESSFULLY TRANSITIONING DEVELOPMENTAL CENTER RESIDENTS TO COMMUNITY LIVING OR DEFLECTING THE ADMISSION OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES TO A DEVELOPMENTAL CENTER, AN INSTITUTION FOR MENTAL DISEASE, AN OUT-OF-STATE PLACEMENT, A GENERAL ACUTE CARE HOSPITAL, OR AN ACUTE PSYCHIATRIC HOSPITAL.	
EDUCATION AND AWARENESS	• Launch a program • Educate the providers about the program so it is clear and desirable • Have flyers, brochures and job fairs about the program • Have current community staff tell their peers about program • Make it not so risky for providers/businesses to take on state staff • Have a state staff coordinator at each DC • Put details of program on the DDS website and into RC billings • Present to providers as a pool of expertise • Incentivize the participation for the employer – hear about the advantages of the program • Present at provider groups/associations • Have a registry of state staff • DC staff and community staff should train each other – learn each other's skills/expertise • Show the advantages for the individual served • Allow more opportunities at RCs for state staff • Allow DC staff to visit community setting to see if they are interested • Use state staff to put together a crisis team • Use state staff for a medical clinic/health resource center at RCs

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

COMMUNITY STATE STAFF PROGRAM EXPANSION – TOPIC #3	
CONTRACT PROCESS	• Confirm details about overtime, rate increases, discipline, bargaining unit decisions • Need to fix disparity in rates paid to state staff vs. community staff • Allow part time, as needed or temporary state staff • Allow providers to get rate increase to pay state staff their rate • Cost share with Regional Centers • Spectrum of opportunity – Occupational Therapist, Physical Therapist, Psychologist, MD, Psych Techs, etc. • Allow multiple providers to contract for one state staff so it makes up a full time position • Allow Regional Centers to pool their money to afford a doctor • Use state staff in the day program/vocational model • Allow state staff to be specialists or work in private homes • Change the non-compete clause • Align or re-align jobs to match from Developmental Center to community • If it doesn't work out, allow a 'right to return' clause • Allow to be short term at one vendor then move on to another vendor • Require Developmental Center staff to go through DSP 1 & 2 training as part of the contract (complete at Developmental Center) • Retention bonuses
GEOGRAPHIC CONSIDERATIONS	• Have a statewide database of availability of staff and their expertise – medical, dental, etc. • Give state staff relocation monies • Incentivize people to move from northern to southern and vice versa • May have to pay more for varying areas (Bakersfield vs. San Diego) • Use state staff at Regional Centers in rural areas due to expertise

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ENHANCED BEHAVIORAL SUPPORT HOMES (EBSH) – TOPIC #4	
DEFINITION OF ENHANCED BEHAVIORAL SUPPORTS HOME - FACILITY CERTIFIED BY THE STATE DEPARTMENT OF DEVELOPMENTAL SERVICES ... AND LICENSED BY THE STATE DEPARTMENT OF SOCIAL SERVICES AS AN ADULT RESIDENTIAL FACILITY OR A GROUP HOME THAT PROVIDES 24-HOUR NONMEDICAL CARE TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITES WHO REQUIRE ENHANCED BEHAVIORAL SUPPORTS, STAFFING, AND SUPERVISION IN A HOMELIKE SETTING. AN ENHANCED BEHAVIORAL SUPPORTS HOME SHALL HAVE A MAXIMUM CAPACITY OF FOUR CONSUMERS... AND SHALL BE ELIGIBLE FOR FEDERAL MEDICAID HOME-AND COMMUNITY-BASED SERVICES FUNDING.	
PROGRAM DESIGN	<u>Housing Design</u> • Capacity of 2, 3, or 4 • Separation of the home ownership from the service provider • Tailor home to the individual • BCBA/Board Certified Behavior Analyst to consult with the builder • Allow duplex living • Each person to have their own bedroom • Allow delayed egress • Use some type of tracking mechanism for individuals who present elopement considerations (if person agrees) • Require sprinklers • Tempered glass • Open floor plan • Soft walls • Non-squeaky floors • Specialized lighting • Sensory sensitive design • Specialized furniture that is non-movable (so that it can't be thrown) • Postural supports in the chairs • Plenty of divided common rooms – living room, family room, craft room, etc. • Single story – no stairs • Toilets should be separate from the showers • Roll in showers • Accessible homes • Modify environment for individuals with PICA Disorder • Require flash and fire alarms • Not too many walls/barriers in homes

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ENHANCED BEHAVIORAL SUPPORT HOMES (EBSH) – TOPIC #4	
	• Use technology for doors, windows, etc. • Use Wi-Fi • Use cameras (in common areas only), smart phones, computers, iPads, and communication devices • Home should not be in a busy area • Home should be on the greatest amount of land • Lots of outdoor space • No cul-de-sac <u>Admission Criteria</u> • Confirm admission criteria – including for compatibility of individuals; level of ID; behaviors • Zero rejection policy (confirm how to handle sex offenders) <u>Program Design</u> • Large vehicles for transporting due to size of individuals and plenty of staffing • Program design should be approved by Regional Center, then Department of Developmental Services, then Department of Social Services • Providers to work with neighbor to prevent NIMBY (Not in My Backyard) behavior • All EBSH providers to work together through a network in state • Collaborate between Regional Centers/IP (Integrated Project) • Relationships with law enforcement, fire marshal, etc. • Collect standardized data for all EBSH providers (including behavior and restraint data) • Review data weekly • Department of Developmental Services/Department of Social Services Memorandum of Understanding • Need a statewide system for sharing resources
PERSON CENTERED PLANNING AND QUALITY ASSURANCE/MONITORING	<u>Person Centered Individualized Planning</u> • Positive behavior programming • Whole person assessment • Therapeutic outcomes based • Skills teaching program • Assessment prior to moving in

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ENHANCED BEHAVIORAL SUPPORT HOMES (EBSH) – TOPIC #4	
	• Complete medical assessment • Complete a risk for restraint assessment • Allow restricted health care plans (i.e. diabetes) • Regular medical and psychiatric review • Allow this to be a forever home or a transitional home • Response, intervention, and redirection (RIR) • Evidence based behavioral intervention • Have an interim safety plan for first week • Behavior support plan within 7 days • Functional Assessment within 14 days • Final transition plan in 30-90 days • Visual supports in the home • Decrease of transitions • Allow for an isolation plan for individuals • Allow for in home or community day programming • Positive reinforcement only • Ensure individual's behavior challenges are being isolated possible from medical concerns • Define planning team/circle of support – behaviorist, case manager, staff, facility manager, psychiatrist, MD, RN, pharmacist, family, job coach, advocate/Clients Rights Advocate, friends, church • Decide what the quality indicators are • Every facility needs their own BCBA (Board Certified Behavior Analyst)/behaviorist, pharmacist, dentist, MD • Have relationship with local hospital • Have immediate access to 24/7 healthcare – nursing, psychiatric, MD • Have a change of condition policy • Utilize a specialty pharmacy for coordinated care • No restraints or seclusions • Have access to medications as they leave facility; have them paid for • Fix county to county Medi-Cal issue • Constant transition planning • Allow dental procedures in non-traditional setting, to support the individual

ENHANCED BEHAVIORAL SUPPORT HOMES (EBSH) – TOPIC #4	
	• Goal of placement stability • Provide incentive to Medi-Cal providers to work with our clients • Develop wrap around services at the same time home is being developed <u>Monitoring</u> • 8 hours of BCBA/Board Certified Behavior Analyst supervision per week per client • 1 hour of BCBA/Board Certified Behavior Analyst supervision for every 10 hours of direct intervention • More consultation than 16 hours per person every 6 months • Robust monitoring • Allow Office of Clients Rights to monitor regularly (neutral party) • Department of Social Services should review 2x/year for the beginning then fade • Have a standard weekly meeting • Have a mobile 'intervention' team follow them through entire process • Standardized and quick data collection for all EBSH homes • Need a medication management plan and oversight by licensed professional • Self-advocacy council • Department of Developmental Services BCBAs/Board Certified Behavior Analysts should oversee Regional Center BCBA/Board Certified Behavior Analysts • Have Protection From Harm (PFH) supports in place • Client resident council to advocate for themselves • Regular 'Fidelity Checks' to ensure what is expected from provider is actually happening for the client
STAFFING	<u>Administrator</u> • Consider having a BCBA (Board Certified Behavior Analyst)/Behaviorist/Behavior Management Assistant be the Administrator of the home • Administrator to have a higher level of Administrator Certification than what is expected • Administrator to be proficient in level of the home <u>Staffing Ratios</u> • 24/7 staffing • At least 2 staff at all times; 2 awake overnight staff

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

ENHANCED BEHAVIORAL SUPPORT HOMES (EBSH) – TOPIC #4	
	• Use state staff • Consider staff transitions • Start with 1:1 and fade or increase as needed • Adequate staff to be able to respond to emergencies without others getting neglected • Flexible staffing based on individual need – take space of home into account <u>Staffing Qualifications</u> • Require Psych Tech staff or similar level of expertise • Use registered behavior technicians as direct care staff – 40 hours of competency training • Staff have to demonstrate competence to work with the individuals • Need to pay high enough wages for staff to stay • Language requirements for staff so everyone is understood <u>Staff Training</u> • Staff need to have beyond DSP I and II – competency based • Staff to receive additional monthly behavior training • Annual crisis intervention training and restraint/containment training (if used) • Staff to receive sexuality training, communication training • Staff training specific to the individuals being served • Additional 24-30 hours Continued Education Units on top of current training requirements (16 hours is not enough) • Train staff on medical procedures allowed in restricted health care plans • Provider needs to have a non-retaliation plan, Employee Assistance Program, open door policy and benefits for staff
RATES	<u>Facility Rate</u> • Pay for fixed costs to sustain home • If client improves, don't decrease the rate – allow home to sustain • Allow for geographical cost differences • Allow for Staff Continued Education Units • Property manager and housing developer costs • Facility damage

ENHANCED BEHAVIORAL SUPPORT HOMES (EBSH) – TOPIC #4	
	Individual Rate • Supplemental staffing and ancillary supports • Can fluctuate by need Other Rate Information • Not bound by median rates • Rates need to allow for qualified staffing • Rate should include incentives for staff • Transportation needs to be in the rate • Allow a bed hold rate • Use Rate Reform Study Methodology

CONSOLIDATED COMMENTS FROM DC TASK FORCE IMPLEMENTATION WORKGROUPS

DEVELOPMENTAL CENTER RESIDENT TRANSITION PLANNING – TOPIC #5	
DIFFERENT TRANSITION PROTOCOLS AND PROCEDURES WERE CREATED AND IMPLEMENTED FOR THE CLOSURES OF AGNEWS DEVELOPMENTAL CENTER AND LANTERMAN DEVELOPMENTAL CENTER. WITHOUT A FORMAL CLOSURE PLAN, IT IS RECOGNIZED THAT INDIVIDUALS MOVING FROM DEVELOPMENTAL CENTERS NEED CAREFUL AND THOUGHTFUL TRANSITIONS TO ENSURE THEIR HEALTH AND SAFETY AND TO SUPPORT THE INDIVIDUAL TO BE SUCCESSFUL IN THE COMMUNITY.	
TRANSITION PROCESS AND ACTIVITIES	• Thoughtful summary of the individual (rather than a stack of documents) – single page • Pull out key points of successes and failures of the individual to share • Interview and utilize comments from Direct Support Professionals (DSP) about individual • Need for transparency • Utilize a neutral unbiased person to coordinate entire transition • Transition meeting needs to allow for enough time • Individualized planning process • Cross training for everyone – utilize standard training techniques to prevent changes • Use technology when needed to prevent travel for team members • Make comprehensive assessment standardized • Provide many community options and be clear about what they look like • Whole person thorough assessments • Define various assessments and when you need to use them – goal and criteria based • Complete a vocational assessment • Involve family in considerations of decisions and build trust and relationship with them • Have multiple assessments done – Intermediate Care Facility (ICF), Community Care Facility (CCF), Supported Living Services (SLS), etc. – so there are plenty of options • Make sure individual gets full spectrum of living options • Involve community provider as soon as possible for transition • Plenty of coordination between Regional Centers – including inter Regional Center transfers • Allow individuals to choose details about where they live (near family or not; beach vs. mountains; LGBT (Lesbian; Gay; Bisexual; Transgender); socio; culture) • Keep families informed about entire transition process • Know everything early on so there are no surprises right before transition • Have all supports in place before exiting • If individuals want to leave sooner, allow them to – don't delay the process • Have Developmental Centers get all documents in order prior to moving – birth certificates, identification cards, medical, etc.

	• Utilize many pictures in transition process • Clearly identify behavior needs (ABCs/Antecedent Behavior Consequence) prior to leaving Developmental Center • Developmental Center staff to assist if the community home is not going well • Use Regional Project as efficiently and effectively as possible – valuable resource • Developmental Center /Regional Project to follow up with home weekly for 30 days at least • When pre-move visits take place including overnights, confirm who is 'liable' (insurance) • Have the multiple trips to the new home include visits to parks, doctor office, restaurants, etc. • Evaluation of the process after it is completed – look at outcomes (Special Incident Reports (SIRs), costs, timeframes, health stats, progress) and make public • QMS (Quality Management System) should review all deaths • Have transitioned clients go back to Developmental Centers to share about their transition experience to clients
HEALTH CARE AND OTHER NEEDS	<u>Health Care</u> • All medical concerns need to be known clearly • DME (Durable Medical Equipment); dental; Occupational Therapy; Physical Therapy; speech; HRT (Hormone Replacement Therapy), etc. – all available • Developmental Center doctors and RNs to work with community doctors and RNs to produce seamless transition • Need to be very clear about health risks • Use Psych Techs in new facility to provide nursing support since they know the client • Regional Center funded medical clinics for individuals to go to after leaving Developmental Center • Mobile health clinics • Use nurse throughout the move, especially for more fragile individuals • Have a directory of health providers that can be a resource • Regional Centers should partner with community clinics • Maintain health insurance during transition • Allow team to recommend medical testing (not just the doctor) <u>Other Needs</u> • Have a plan to reduce transfer trauma • Replicate patterns they are used to – i.e. sleeping

	• Have all records go with the client to new setting • Developmental Center database information needs to be shared with Regional Center database information