DEVELOPMENTAL CENTER TASK FORCE IMPLEMENTATION WORKGROUPS 2014
SUMMARY OF MEETINGS

BACKGROUND

To implement recommendations of the Health and Human Services Agency Task Force on the Future of Developmental Centers'(DC Task Force) January 13, 2014, report, "Plan for the Future of Developmental Centers in California," the Department of Developmental Services (DDS) has developed several proposals that were introduced with proposed revisions to the Governor's Budget in May and were signed into law in June as part of SB 856 (Chapter 30, Statutes of 2014), the Developmental Services 2014-15 Budget trailer bill.

GOALS

The intent of organizing stakeholder workgroup meetings was to seek input from a diverse group of individuals throughout California and to move forward with recommendations for regulations where needed, and to gain feedback on the DC Task Force topics included in the 2014-15 Budget.

SUMMARY

Prior to the stakeholder meetings, a listen-only conference call was held on August 25th, open to invited meeting participants as well as any interested public representatives, as a way to share details about the workgroup topics and meeting details. All of the meeting information and materials were posted on the DDS Web site.

A series of three, 2-day stakeholder meetings took place in Fresno on August 27th and 28th in the Hugh Burns State Building; in Los Angeles on September 3rd and 4th in the Junipero Serra Office Building; and in Sacramento on September 10th and 11th at the Department of Health Care Services.

Each meeting was structured the same way, which allowed workgroups to work through five topics:

- Acute Crisis Units at Sonoma and Fairview Developmental Centers
- Community Crisis Homes
- Community State Staff Program Expansion
- Enhanced Behavioral Supports Homes
- Developmental Center Resident Transition Planning

There were four to five workgroups, based upon participation. Each workgroup included representation from organizations representing consumers and consumer advocates, family members, regional centers, clinical representatives, legislative members as well as employee and provider perspectives. One member from each invited organization participated with the workgroups, while others were welcome to listen to the discussion. One hundred and three individuals attended the three meetings (not including DDS representatives and facilitators).

The Department of Social Services was present at each stakeholder meeting to hear input on staffing (structure, qualifications and training) and emergency intervention training and techniques.

Materials and background information about each topic were shared with the workgroups. Also provided to the workgroup were suggested prompts for facilitating discussion through each topic (Program Design, Person Centered Planning, Monitoring, Rates, Transition Process and Staffing).

THEMES FROM WORKGROUPS

A 20-page document titled, "Consolidated Comments from DC Task Force Implementation Workgroups," has been completed and is attached to this document, to summarize the comments from all three meetings regarding the five topics.

The following are topic specific, high-level themes about each of the five topics:

- Acute Crisis Units at Sonoma and Fairview Developmental Centers

    - Housing design should consider a safe, accessible, open floor plan that is home-like and provides individual bedrooms, while providing considerations for sensory needs, exercise options, and learning

    - Consider a capacity of no more than four individuals

    - There should be clear admission guidelines regarding eligibility, priority of admission, quick timeframes, and highly skilled assessments performed by a specialized team

    - Length of stay should be based on individual need and progress, not to exceed one year. Discharge planning should start upon admission to ensure a safe transition back to the community once stabilized

    - Enhanced staffing of well trained, highly qualified staff and a system that allows for an increase or decrease in staffing, based on individual needs

    - Utilize a whole team approach to include a multidisciplinary team with an emphasis on transition and enhanced communication throughout the process to include prior and future providers as well as DC staff

    - Provide evidence-based treatment services while measuring the success of individuals through data collection

- Community Crisis Homes

    - Housing design should provide a home-like, safe and accessible open floor plan environment that has enough space for individuals to have private bedrooms and bathrooms, plenty of room indoors and outdoors, with multiple common areas, made with special materials for safety and sensory needs

    - Homes should utilize a sprinkler system, alarms, technology and sensors with delayed egress, if necessary, however further discussion regarding the use of a secured perimeter is recommended

    - Short-term length of stay to be determined by the planning team through evidence-based outcomes, ranging from 1 month to 2 years

    - Enhanced behavioral, evidence-based treatment model with positive behavioral supports and appropriate medical supports

    - Utilize a whole team approach to include a multidisciplinary team with an emphasis on transition and enhanced communication throughout the process to include prior and future providers

    - Utilize a skilled crisis team throughout the process from admission to discharge to support the individual consistently throughout transition

    - Regional center, DDS and Department of Social Services (DSS) should provide enhanced monitoring

    - Highly trained staff with relevant experience that can provide rich, interactive staffing of 1:1 or more/less, as needed, while implementing plans

    - Emphasis on competency-based training for staff

    - Separating a facility rate and an individualized rate will assist in helping the provider to maintain beds, while having the flexibility to support each individual's specific needs

- Community State Staff Program Expansion

    - Launch a program that educates providers and regional centers about the availability of expertise this program offers, through the use of flyers/brochures, DDS Web site , presentations, and job fairs

- Education efforts should target both employees and providers to address pay, benefits, worker's compensation, disciplinary processes, coordination with unions, the full range of employees available from a DC and differences between job duties in the community and at a DC

- Peer-to-peer outreach and education from employees and providers that have successfully used the program should be available

- Contracting process should be flexible allowing for part-time employment and/or duties at multiple locations

- Incentivize providers and regional centers to participate in the program

- Incentivize people for relocation, various areas of expertise and varying geography

- Use state staff for mobile crisis teams

- Enhanced Behavioral Supports Homes

    - Housing design should have a capacity of 2 - 4 that is tailored to the individual and owned separately from service delivery, that is not in a high-traffic area, is on the greatest amount of land, and allows for duplex living, if appropriate, while also allowing private bedrooms and bathrooms

    - Large, accessible, single-story, open design home that does not have too many walls or barriers, to provide line of sight and plenty of common rooms and inside and outside space, including a sprinkler system for safety, special materials for safety and sensory needs, and incorporates technology where appropriate

    - Ensure admission criteria includes compatibility of individuals with various levels of intellectual disabilities and behaviors

    - Program design should be approved by regional center, then DDS , then DSS

    - Evidence-based behavioral intervention, led by a well-defined planning team with support from various assessments and a behavior support plan

    - Utilize a skilled crisis team from admission to discharge to consistently support the individual throughout the process

    - Have regular medical, behavioral, and psychiatric review by professionals with appropriate expertise

- Include robust monitoring by DSS and DDS

- Collect standardized data and quality indicators for all Enhanced Behavioral Supports Home providers and review weekly

- Administrator and Direct Care Staff should have a more enhanced level of expertise and competency-based training, with the capability of providing acuity staffing that can be increased or faded as needed

- Separating a facility rate and an individualized rate will assist in helping the provider to maintain beds, while having the flexibility to support each individual's specific needs

- <u>DC Resident Transition Planning</u>

  - Transition teams need to keep the team and family informed, while allowing enough time for meetings and transition

  - A thoughtful 1-page summary of the individual that highlights important points, including key medical and behavioral information, would be helpful to the new provider, staff and physicians to help them get to know the person that is in transition before reviewing their entire file

  - A recent whole-person, standardized assessment for the individual should be available, in addition to assessments for living choice options and vocational choices, so as much as possible is known prior to transition

  - Have all supports in place prior to transitioning

  - DC's should ensure that all residents have the documentation (state identification cards, green cards, birth certificates, etc.) needed to transition to the community well before transition starts

  - DDS Regional Project should, at a minimum, visit the new home weekly for 30 days

  - Use outcomes to evaluate the progress of the individual's transition

  - Collaboration of DC medical professionals with community medical professionals should be encouraged prior to, during and after transition

  - Create regional medical clinics and mobile health clinics with specialized services, not always available in the community, for individuals to utilize after leaving the DC

- Provide "Transition Insurance" or some sort of similar mechanism to cover potential costs and address different liabilities encountered by the need to provide services to DC residents while they are visiting residential and day activity options

DDS REPRESENTATION

At each of the meetings, DDS had representatives facilitate the discussions and meeting details. Those that attended the meetings included:

- Santi J. Rogers, Director
- John Doyle, Chief Deputy Director
- Nancy Bargmann, Deputy Director
- Patricia Flannery, Deputy Director
- Brian Winfield, Assistant Deputy Director
- Jim Knight, Assistant Deputy Director
- Dwayne LaFon, Assistant Deputy Director
- Fariba Shahmirzadi, Assistant Deputy Director
- Amy Wall, Assistant Director
- Shelton Dent, Manager
- David Dodds, Special Consultant to the CSD Deputy Director
- Kathy Kinser, Special Assistant to the Director
- Tiffani Andrade, Special Consultant
- Tamara Rodriguez, Emergency Preparedness and Response Officer
- John Schmidt, Special Assistant to the Director

SUB-WORKGROUPS

At this time, two sub-workgroups are meeting to discuss specific details related to some of the topics:

- Rates Sub-Workgroup – This group is made up of 10 members, chaired by DDS. Members include service providers, regional center representatives and ARCA representatives. The group is working through recommendations for the rate structure for the new models of care – Community Crisis Homes and Enhanced Behavioral Supports Homes. The group has met via phone and in person, and expects to deliver recommendations in November.

- Behavioral Focus Workgroup - This group is made up of the 3 Board-Certified Behavior Analysts who attended the DC Task Force Implementation Workgroup meetings. The group is focusing on specific recommendations and timelines associated with behavior programming and planning.

PUBLIC COMMENT

Public comments were collected through September 30th. Clear directions regarding submitting comments were posted on the DDS Web site. Two individuals and three organizations submitted written comments. Primary areas of interest highlighted in the comments were:

- Ensuring the Centers for Medicare and Medicaid Services' criteria is considered for applicable models
- Home design should meet standards for universal and accessible design, while allowing for private bedrooms, plenty of space and appropriate models to the individual being served
- Resources should be available to all consumers in California instead of limited to consumers in one Regional Center area
- There should be a consideration of converting existing homes into the new models of care
- Crisis resources should be available quickly
- Individuals who are medically fragile and behaviorally complex should have managed medical care by professionals with expertise in the field of developmental disabilities
- Individuals with intellectual disabilities and mental illness can be successful in small community-based residential settings with enhanced behavioral supports
- There should be careful risk assessment as well as adequate behavioral and psychiatric support
- Homes should be staffed to allow for 1:1 interventions
- Admission and length of stay should be specific to the type of residential model
- Consideration of maintaining resources for individuals in the community while they are receiving crisis services
- The Department of Public Health recertification should be confirmed prior to use of an acute crisis unit at Sonoma DC
- Restraint and seclusion should not be part of a behavioral support plan
- All assessments should meet the requirements of California's Olmstead plan, while DDS and regional centers should identify unmet needs with a plan to fill in the gaps
- Re-examine and streamline policies and procedures regarding individuals moving out of developmental centers
- Consider development of transitional living facilities on or near developmental centers
- Consider developing regional consortiums to locate residential options for people with challenging behaviors and/or complex medical needs
- Ensure that the Regional Center DC liaisons have small enough caseloads to adequately support the goals and interests of their consumers
- Make all community options available to individuals moving through their IPP process

REGULATIONS

A team at DDS is working on drafting the emergency regulations for the new community models of care, while considering all of the input received from the stakeholder process. DDS anticipates finishing the draft emergency regulations in December 2014 and submitting for public comment no later than January 2015.