PART ONE

OVERVIEW OF THE DEVELOPMENT OF THE CLIENT DEVELOPMENT EVALUATION REPORT (CDER)

I. BACKGROUND

The Client Development Evaluation Report (CDER) is the assessment instrument that the Department of Developmental Services (DDS) utilizes to (1) collect data on client diagnostic characteristics; 2) measure and evaluate on an ongoing basis client adaptive skills and challenging behavior; and (3) evaluate personal outcomes and quality of life of persons with developmental disabilities who receive services in the California developmental disabilities services system. The CDER must be completed at least annually on each of these clients who live in Developmental Centers or live in the community and are Waiver eligible.

The CDER was developed in response to the Lanterman Developmental Disabilities Services Act of 1977 (Division 4.5 of the Welfare and Institutions Code). It is based on the Client Centered Evaluation Model (CCEM), which was developed under the direction of the Health and Human Services Agency *(formerly the Health and Welfare Agency)* to meet the following requirements of the State Council on Development Disabilities:

- Be client-oriented
- Track client throughout the service system
- Provide measures of change in client independence in living settings
- Provide measures of change in client productivity in work settings
- Be applicable in all service settings
- Be applicable to all types and levels of developmental disabilities

CCEM underwent extensive field testing during 1976 and 1977. Analysis of the field test findings and input from those who had used CCEM pointed to the need for revisions to that instrument. The necessary revisions were made during 1978 and resulted in the 1979 version of the CDER.

In 1986, substantial changes were made to computerize the instrument. The 1986 Diagnostic Element of the CDER differed from the previous 1979 version in a number of ways. Among these differences were the following: Fields for coding etiology of diagnoses according to ICD-9 nomenclature were added and substantial changes were made to the epilepsy and cerebral palsy items. Items were added to the section to assess the following:

a. Intelligence quotient and name of intelligence test that was used (Developmental Centers only)
b. Adaptive behavior rating
c. Vision and hearing loss, both corrected and uncorrected
d. Types of prescribed medications for challenging behavior (replacing dosage items in previous version)
e. History of prescribed medications for challenging behavior and/or psychiatric disorders
f. Abnormal involuntary movements (Developmental Centers only)

g. Special health care requirements (replacing aids/equipment items in previous version).Special conditions or behaviors such as stealing, fire setting, legal status, and other conditions that can impede community placement

In 2003 work was begun on further revision of CDER. The intent was to address two needs that have become increasingly important as the Department of Developmental Services (DDS) focuses on efficient and effective delivery of services to consumers. The first was the need to provide useful and accurate information to Regional Centers about consumers' skills and challenges so appropriate services and supports could be obtained. The second was the need to assess the outcomes of the services provided to consumers. The 2008 revision formalizes the work begun in 2003. Few changes were made to the Diagnostic Section, the Evaluation Section was substantively revised, and the Personal Outcomes Section was added.

The 2011 changes of the CDER were made for the regional centers to begin using the 10th Revision of the International Classification of Diseases (ICD-10) of diagnostic codes in the CDER. The Centers for Medicare and Medicaid Services (CMS) was changing to require all health care transactions with diagnostic codes to be the ICD-10 version effective in October 2013. The implementation date was later extended by CMS.

The 2014 changes to the CDER enabled the regional centers to begin using the DSM5 codes for diagnosis coding of any psychiatric conditions and this replaced the use of the DSM-IV codes.

The 2015 changes of the CDER are for the developmental centers to begin using the 10th Revision of the (ICD-10) diagnostic codes in the CDER (effective in October 2015) and to begin using the DSM5 codes.

Purpose and Uses of CDER

CDER is primarily a management tool. For management purposes, CDER data are used for: (1) determining the number of persons with developmental disabilities, the types of their disabilities, and their service needs; (2) budgetary purposes, such as assisting in determining developmental center staffing requirements and regional center caseloads; (3) establishing the priority of client services according to unmet needs identified during the assessment of the client; and (4) developing aggregated statistical reports to provide information on the types of disabilities, levels of developmental disabilities, and other measures of client functioning.

For operational purposes, CDER data are used to assist the regional center interdisciplinary team (IDT) in assessing the overall status of individual clients. The data permit the IDT to identify the client's capabilities and needs, and the condition(s) that impede the client's progress. Identification of these attributes is necessary for planning purposes, as well as for developing and initiating specific strategies to enhance independence and quality of life.

CDER Reliability *and Validity*

The revised 2008 CDER is supported by a Reliability and Validity Document. *(See Appendix C for the Reliability and Validity Report)*. The Evaluation Element was completed for 809 consumers to test its reliability and validity. The sample was drawn from six regional centers; participants were randomly selected from consumers scheduled for yearly review. In keeping with instructions for the new form, service coordinators used reliable informants to collect information needed to answer each question. A subset of 368 consumers was randomly chosen for a second administration two to four weeks later.

Data collected in the original administration correlated well with data collected several weeks later. Most correlations were very high, demonstrating strong test-retest reliability. Correlations were lower for the challenging behaviors items than for the daily living skills items. (Specific details may also be found on the DDS website www.dds.ca.gov in The Revised Client Development Evaluation Report: Reliability and Validity of the Evaluation and Personal Outcomes Elements by J. McCreary, PhD, and H. Stanislaw, PhD.)

Confidentiality of CDER Data

The Department utilizes a Unique Client Identifier (UCI) to protect the confidentiality of the clients. The UCI is a seven-digit computer number generated for each regional center to represent each of its clients and is encoded in each of the CDER documents completed for each consumer. The UCI allows the Department to fulfill its responsibilities while further safeguarding the confidentiality of client data.

The Client Master File and the CDER History File contain the UCI as the sole means of identification. Only under certain conditions is the client's name used on a CDER report; for example, to improve the serviceability of CDER reports and to speed the process of filing reports (such as client profiles) in the individual client record at the regional center, and/or at the developmental centers, the name of the client is placed on the reports. To print the client name on these reports, a computer merge links the CDER file with the Client Master File using the UCI as the common variable. This linkage is performed within the computer memory and is printed on the report and not maintained
in machine-readable form. These reports are distributed by registered mail and are made available only to the originating agency. A contract between DDS and the regional centers stipulates that confidentiality safeguards must parallel those used by the Department.

II. THE NEED FOR EVALUATION

There continues to be an increased awareness of the rights and the service needs of persons with developmental disabilities. This awareness has resulted in an increase in both the availability and cost of public-supported human services designed to meet the special needs of these individuals.

The expansion of developmental services has been accompanied by an increased need for accurate and meaningful information about clients and the services they receive. Organizations responsible for statewide planning and budgeting require information on the size, types of disabilities, and the service needs of the client population. Program managers and administrators need information on the cost and relative effectiveness of different types of services. Case managers and other direct service providers need information about the developmental status and needs of individual clients. Clients and their families require information about the services needed.

The need for valid, accurate information about clients and the services they receive is reflected in State and Federal law.

This need has been recognized by the agencies responsible for the provision of developmental services. The Department utilizes the data collected on CDER in conjunction with costs and services information to respond to a wide range of requirements, including the following:

- Chapter 8, Division 4.5 of the Welfare and Institutions Code requires DDS to report to the Legislature on the following:
  - Changes in the independence, productivity, and normality of clients' lives
  - Progress or lack of progress made by the clients
  - Type and amount of services provided to clients to obtain program results
  - State expenditures associated with varying levels of program effectiveness
- DDS requires a wide range of information to administer the Developmental Disabilities Services Program. This needed information includes:
  - The numbers, types and degrees of disability, and the location of clients served by the different programs under the jurisdiction of the Department
  - The types, numbers, capacity, and quality of programs serving the Department's clients
  - The types and amount of unmet service needs
  - The types, amount, and equity of services provided by different types of programs and case management agencies
  - The relative effectiveness of different case management agencies and different types and patterns of services, as measured by the degree of clients' developmental progress

III. CDER USAGE AT THE LOCAL LEVEL

In addition to addressing the various legislative and department requirements, CDER can be used at the local level to assist in improving the delivery of service to the client. Following are ways in which this can be accomplished by making use of CDER data:

- **Appropriate Client Placement**: Client assessment information derived from CDER can aid case managers in the selection of appropriate placement settings and/or the determination of the effectiveness of programming. It may be found that a client has good motor development and high levels of independent living, cognitive, communication, and vocational skills, but is lacking in social and emotional competence. Based on this assessed profile, a placement facility that specializes in behavior management and socialization training can be selected, which will meet the specific needs of the client.

- **Monitoring Program Effectiveness**: CDER client data can be used to determine the effectiveness of program placement. By measuring changes in the client's levels of functioning from one point in time to another point in time as a result of services received, a determination can be made as to whether to continue current programming or develop new strategies and initiate new programming.

- **Planning Prevention Strategies**: The newly revised Diagnostic Element of CDER will be helpful in planning for prevention services. Knowledge of the trends in diagnosis, probable etiology and associated risk factors will enable staff to establish priorities for prevention planning.

- **Resource Development Planning**: CDER data, when reviewed for an entire caseload or for specific subsets of the caseload, can be of great assistance in planning for future services. Knowing that a large group of clients are reaching age 22 and that the clients have certain developmental characteristics can, for example, be helpful in planning for the development of appropriate residential and/or day programs.

IV. DESCRIPTION OF THE CDER INSTRUMENT

The CDER consists of three components: Diagnostic Information, Evaluation Information, and Personal Outcomes Information. These components are described briefly below.

The Diagnostic Element

The Diagnostic Element is the first component of CDER. It is that portion of the instrument on which developmental diagnostic information is recorded. It contains a comprehensive summary of the types, etiologies, and levels of severity of primary disabilities the client has, as well as the impact these conditions have on programming. This element was updated with the 2008 revision. Minor changes were made in the motor dysfunction items, seizure disorder items, and Autism items. The Diagnostic Element must be completed by the attending physician and/or psychologist as appropriate.

The Evaluation Element

The Evaluation Element was substantially revised in the 2008 revision to assure that it provides useful information in a reliable manner. It was also condensed to allow CDER to accommodate new items that assess outcomes of services. The result is a 20 item measure. The first 14 items assess consumers' skills for daily living using a five point scale. A low score indicates less skill and a high score reflects a skill level that allows for independent action by the consumer. The remaining six items assess the frequency and/or intensity of challenging behaviors that make increased supervision or monitoring of the consumer necessary. These behaviors are also rated on a five point scale, with a low score indicating the consumer is not able to control or eliminate challenging behaviors and a high score indicating these behaviors occur rarely or never.

The assessment strategy underlying the new Evaluation Element differs from the previous version. The original items provided response options that described the specific abilities or behaviors of consumers; the number of options ranged from four through nine. The revised items employ a standardized five point scale through which persons who complete the assessment describe the level of ability or behavior. Since all possible behaviors would not be listed in the new format, the scale was developed so that each successive number on the scale indicates a new level of skill or, in the case of the challenging behaviors segment, an increased level of control over behaviors injurious to oneself or others. The new version of the Evaluation Element also encourages the test administrator to interview reliable informants to determine the most frequent behavior shown by the consumer in a specified time period, rather than relying solely on personal observation.

The Personal Outcomes Element

The new element, the Personal Outcomes Element, was developed to assess the outcomes of services and supports. It contains twenty-six (26) items. The first 16 items focus on indicators of integration, inclusion, access to health care, and productivity. The remaining 10 items assess satisfaction and quality of life through an interview with the consumer. The Personal Outcomes Element uses a series of standardized responses through which the level or degree of an attribute is measured. In this portion of the revised CDER, four response options are always offered.

The Personal Outcomes Element (POE) is designed to assess life experiences of consumers in order to measure the degree to which DDS is meeting consumer's needs. The Lanterman Act requires DDS to determine the degree to which the services it provides empower consumers to make choices and lead more independent, productive, and "normal" lives. The POE items were designed to assess well-being in different areas of the consumer's life, thereby conforming to Senate Bill 1383 (which modified the Lanterman Act) and reflecting an increased emphasis within DDS on individualized services and supports.

An early version of the POE was pretested by DDS in a 1997 pilot study of 148 consumers in the San Gabriel/Pomona service delivery area. The results of the pilot study highlighted several issues that were central to the final revision of the POE. First, a system for obtaining quality of life information directly from consumers was developed because the use of informants for those questions posed a threat to both reliability and validity. Second, the revised POE incorporated questions with simple direct wording that asked for specific information regarding observable events or situations; questions that used this format yielded the highest reliability in the pilot study.

A November 16, 1999, report of the Service Delivery Reform Committee on the measurement of personal outcomes also provided guidance in developing questions. This report identified 30 possible outcomes of services and supports, clustered under the headings of Choice, Relationships, Lifestyle, Health and Well-Being, Development, Rights, and Satisfaction. The revised CDER includes questions pertaining to all of the major areas detailed in the 1999 report.

V. GENERAL INSTRUCTIONS

The following are general instructions for completing the CDER Answer Sheet, form DS 3752 and the CDER Booklet, form DS 3753A. The Answer Sheet is the document from which client data recorded on the CDER booklet are entered into the computer. The CDER booklet, form 3753A, contains the client information as well as the codes to be used.

PART TWO

DESCRIPTION OF AND INSTRUCTIONS FOR THE CLIENT DEVELOPMENT EVALUATION REPORT

Basic Instructions for Completing CDER Answer Sheet

1. When completing the Answer Sheet, write legibly with a pen; **DO NOT USE A PENCIL.**

2. On the front side at the bottom of the Answer Sheet, space has been provided for the signature(s) and title(s) of the person(s) completing the form. The appropriate person(s) must sign this form.

3. Space has also been provided for the addressograph imprint, which must be on developmental center clients' CDER's.

4. Refer to the Manual for instructions regarding the specific codes to enter on the form.

Basic Instructions for Completing both Forms (Answer Sheet and Booklet)

1. The data on the CDER booklet and on the Answer Sheet are currently entered into the system. Write legibly with a pen (preferably a fine ballpoint pen); **DO NOT USE A PENCIL.**

2. If there is more than one box for numbers, all of the boxes must be used, unless otherwise instructed, even when the response is a single digit. For example, if there are two boxes and the entry is the number "2," it must be written as "02."

Date of birth, Nov. 22, 1995 | 1 | 1 | 2 | 2 | 9 | 5 |
M M D D Y Y
Correct

Date of birth, June 1, 1901 | 0 | 6 | 0 | 1 | 0 | 1 |
M M D D Y Y
Correct

Date of birth, June 1, 1901 | 6 | | 1 | | 1 | |
M M D D Y Y
Incorrect

3. It is also very important to use the codes provided on the form or in the Manual. Do not create codes, as this will cause the computer to generate an error. For example:

Client takes anticonvulsant medication

|1|	1 = Yes 2 = No Correct	|Y|	1 = Yes 2 = No Incorrect

4. **Do not leave any items unanswered unless instructed to do so.** A careful check should be made to ensure there is an entry for items in each section on the form.

5. In summary, when completing CDER, note the following:

   a. Response must be clearly legible and in ink.
   b. Recorded responses must be a letter or number specified on the form or in the detailed instructions section of the Manual.
   c. The client identifier must be accurate and consistent throughout the form and entered in the appropriate locations.
   d. All pages of the set must be in the package.
   e. All requested responses must be completed.
   f. All entries in the Diagnostic, Evaluation, and Personal Outcomes elements must be correct.
   g. The Answer Sheet must be signed.

Once a number of CDER's have been completed, the user will become familiar with the criteria and methods of rating. Most ratings can then be completed by a quick review of an item or an entry in the manual.

VI. DETAILED INSTRUCTIONS: HOW TO RATE THE CLIENT

The following section presents detailed instructions for completing CDER. It is organized to correspond with the instrument itself. All necessary codes for completing CDER are contained in the instrument and in the Manual.

Each CDER item is presented and explained in the same order that it appears on the document. Under the Diagnostic Element, general explanations followed by more detailed explanation on coding are given for each specific disability and other pertinent information contained in this element. In addition, examples of coding each item are given.

Under the Evaluation Element, the items are presented with a general explanation to clarify criteria for each rating level. The explanations of the levels of achievement contain examples of possible behaviors which may be observed. Those items and levels which are self-explanatory do not have explanations to accompany them. Prior to assessing the client, the person completing CDER should read instructions completely to become familiar with what is expected. When the assessment / evaluation is being completed, the rater can return to specific instructions, as necessary. As raters become familiar with the instrument, it will not be necessary to refer to the detailed instructions each time.

Under the Personal Outcomes Element, the items have very specific directions associated with reporting options. The person completing CDER not only needs to become familiar with the items and the requirements of the items, but also with the services being delivered to the consumer, and with the personal response of the consumer to those services. Occasionally specialized interview techniques may be required to determine consumer response to the services received.

CLIENT IDENTIFYING INFORMATION

OVERVIEW OF CLIENT IDENTIFYING INFORMATION

The purpose of this portion of the Manual is to provide information that identifies the client and allows for the location of the client. It consists of two parts—Report and Client Identifier and Client Locator. The first part provides certain identifying client data; the second part provides data on the specific location of the client.

Client Identifying Information Section includes the following items:

Client Identifying Information

- Overview of Client Identifying Information
- Report and Client Identifier
  - Reporting date
  - Client identifier (UCI)
  - Client birthdate
  - Sex
  - Height
  - Weight
  - Date weighed
- Client Locator
  - Program
  - Section
  - Unit

Following are instructions for completing these items:

1. REPORTING DATE

This is the date on which CDER is completed. In the appropriate boxes, indicate the completion date: month, day, and the last two digits of the year. If the month or date requires only one digit, enter a zero (“0”) before it. For example, an evaluation date of April 5, 1985, would be recorded as

Reporting Date					
0	4	0	5	8	5
M	M	D	D	Y	Y

2. CLIENT IDENTIFIER (UCI)

This is the seven-digit code that uniquely identifies each client. It is assigned to the client by the regional center and follows the client throughout the system for as long as the client receives regional center services. If the client should exit the system at one point in time and reenter the system at a future point in time, the same Unique Client Identifier (UCI) is to be used to identify

the client. The UCI not only uniquely identifies the client, but protects the confidentiality of the client's records.

Client Identifier

3. CLIENT BIRTHDAY

This item is used to record the client's date of birth: month, date, and the last two digits of the year. If the month or day requires only one digit, enter a zero ("0") before it. For example, a birthdate of March 15, 1986, would be recorded as

Client Birthday

0	3	1	5	8	6
M	M	D	D	Y	Y

4. SEX

Enter the appropriate code: "M" for male or "F" for female to record the client's gender.

Sex

M=Male
F=Female

HEIGHT AND WEIGHT

This information is extremely important for assessing the client's care needs. Height and weight must be obtained for all clients in placement because they contribute to supervision needs or staffing calculations. For example, it is more difficult to care for a physically disabled person who is 150 pounds than for a person who weighs 35 pounds. Similarly, certain behaviors, such as temper tantrums, are more problematic if the client is 6 feet tall and weighs over 200 pounds than if the client is 3 feet tall and weighs 35 pounds.

Note: If height and weight information is not available for clients in their own homes, estimate height and weight and leave Item 7, "Date Weighed," blank.

5. HEIGHT

Enter the client's height in inches.

Height in Inches

6. WEIGHT

Enter the client's weight in pounds. If the client's weight is less than 100 pounds, enter a zero ("0") in the first of the three boxes. Do not leave any boxes blank.

Weight in Pounds

7. DATE WEIGHED

Enter the month and last two digits of the year on which the client was last weighed. If this information is not available for clients in their own homes, leave this item blank.

Date Weighed

M M Y Y

CLIENT LOCATOR

8. PROGRAM, SECTION, AND UNIT

These items are developed and used at the discretion of the agency completing the CDER document. Since agencies' organizational requirements vary, standard codes have not been developed, but left blank to be developed by the reporting agency (developmental center or regional center).

Within a regional center, these items may be left blank if they are not used; or, one or all three items may be used to specify which field office is responsible for a client, or which staff person is responsible for a particular client.

Within a state facility, these items are used to specify the facility program and residence to which the client has been assigned. The codes entered in items 8-10 may be numeric, alpha, or alpha-numeric, whichever is internally feasible for the reporting agency.

Program

Section

Unit