FUNDING THE WORK OF CALIFORNIA'S REGIONAL CENTERS

Prepared by the
Association of Regional Center Agencies

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EXECUTIVE SUMMARY

The Lanterman Act (Division 4.5 of the Welfare and Institutions Code) mandates the Department of Developmental Services (DDS) to "contract with an appropriate private nonprofit corporation or corporations to operate regional centers…"[i] The regional center system has grown and evolved from two regional centers in 1969 serving fewer than a thousand clients to 21 regional centers serving more than 259,000 consumers and their families. Regional center staff perform outreach and community education, intake and assessment, eligibility determination, resource development, and on-going case management services. They also vendor and pay the thousands of organizations and individuals who provide services to regional center consumers.

The regional center budgets are divided into two parts, Purchase of Service (POS), which provides funding to pay the many service providers in the community, and Operations (OPS), which provides funding to pay the regional center staff and all the expenses associated with operating a multi-million dollar business.

Over the past years the types of services purchased for consumers have expanded greatly. The recordkeeping requirements have also expanded as more reliance has been placed on capturing federal funds to operate the regional centers. As this expansion occurred, there have also been several fiscal crises in California which has resulted in cut-backs to the regional center budgets. Both the Purchase of Service and Operations budgets have been affected. This paper focuses on problems caused by the concurrent expansion of workload requirements and Operations budget reductions.

These problems can be categorized into four groups: (1) actions leading to a direct reduction in the OPS budget without a corresponding decrease in operations workload, (2) actions imposing additional workload for which no additional, or inadequate, funding

was added to the OPS budget, (3) inaction with respect to updating the OPS budgeting formula, and (4) design flaws inherent in the OPS budgeting formula.

1. Actions Leading to a Direct Reduction in the OPS Budget Without a Corresponding Decrease in Operations Workload

This is exemplified by unallocated reductions to the OPS budget. The Administration will arbitrarily reduce the budget to meet the state's overall budget requirements and leave the regional centers to determine how they will absorb those reductions and still meet the many mandated requirements for which regional centers are responsible.

2. Actions Imposing Additional Workload for Which no Additional, or Inadequate, Funding was Added to the OPS Budget

Over the past thirty years there have been numerous legislative and regulatory changes which have increased the workload to regional center staff, both in case management and in administration, without any increase (or an inadequate increase) in the OPS budget. These have ranged from increased data gathering from consumers and their families to increased monitoring of facilities and programs, to increased reporting to DDS.

3. Inaction with Respect to Updating the OPS Formula to Keep Pace with the Increasing Costs of Doing Business.

The core staffing formula is the basis for the OPS budget allocations to the regional centers. It was originally designed with the salaries in the core staffing formula comparable to State salaries for similar positions. As State salaries increased, the salaries in the core staffing formula had increased. Then in FY 1991-92, as part of the state's response to a budget crisis, the salaries in the core staffing formula ceased to be adjusted as state salaries increased. Therefore, the salaries in the core staffing formula today, with some minor adjustments, remain at the 1991 levels.

The Lanterman Act specifies that regional centers must adhere to certain caseload ratios (ratios of Consumer Program Coordinators [CPCs] to consumers served).

However, since salaries have been frozen at 1991 levels, regional centers are unable to hire sufficient CPCs to meet the required caseload ratios and, consequently, puts over $1 billion in federal funds at risk.

4. Design Flaws in the OPS Formula

There are many design flaws in the core staffing formula that further complicates the problem. When the core staffing formula was designed, regional centers served on the average about 2,000 consumers each. Now the average number of consumers served by regional centers is about 7,000. As with any organization, as it grows in size there is an increased need for middle managers. The core staffing formula does not adequately allow for middle management and support staff to properly operate the larger organizations regional centers have become.

Another design flaw in the core staffing formula is the Fringe Benefit rate of 23.7%. This is wholly inadequate since the Department uses a rate of 41.6% for the Developmental Center staff. The average fringe benefit rate for regional centers is 34%.

Over the years there have been a number of studies conducted to update the core staffing formula, most notably the Citygate study of 1999. The Department used the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal was supported within the Administration, but is not included in the Governor's budget because of a severe economic downturn.

CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[ii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the

primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has “accepted a responsibility” is directly threatened.

I. INTRODUCTION

Regional centers are a critical publicly-funded safety net for 259,000 of California's most vulnerable citizens. Regional centers provide Californians who have a developmental disability with community-based services and supports to allow children to remain in their family homes and adults to reach the highest level of independence possible. However, chronic underfunding is undermining the regional centers' ability to meet their mandate under the Lanterman Act and the needs of these individuals and to comply with their statutory and contractual responsibilities. Therefore, the Association of Regional Center Agencies (ARCA) believes it is essential that those who influence and make public policy understand the seriousness of this issue, particularly as the state's improving economic situation begins to allow for fiscal restoration of vital public programs.

This paper is designed to: (1) provide information on the existing budgeting methodology used by the state to fund regional center operations, (2) identify the reasons and extent to which the regional center operations budget is underfunded, and (3) alert the public and policy makers that this situation cannot continue without directly threatening the health and well-being of consumers, and the continued receipt of over $1 billion in federal funds to the state.

This paper's focus on the operations side of the budget should not be construed as diminishing the serious underfunding that also exists in the purchase of services budget. ARCA addresses the purchase of service funding issue in its position statement titled "The Budget Crisis Affecting California's Regional Centers."

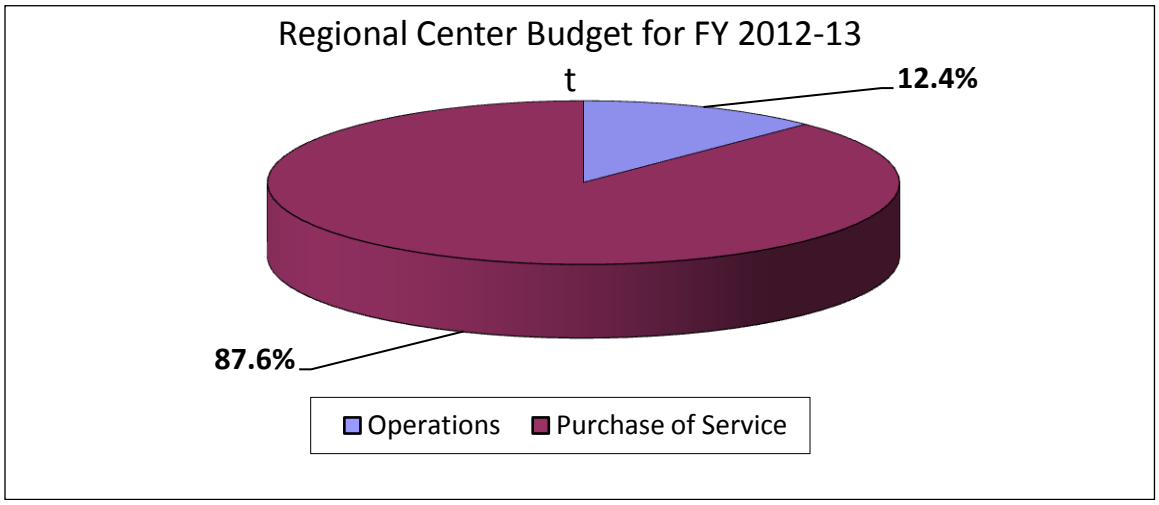
II. BACKGROUND

A. Budget Overview - The state will provide regional centers approximately $4.2 billion in the FY 2013-14. This funding is budgeted and allocated in two distinct categories: purchase of services (POS) and operations (OPS).

Funds allocated for POS are used to purchase services and supports from community-based service providers. These services and supports are needed by consumers and their families to implement consumers' individual program plans (IPPs), or for consumers under the age of three, their individualized family service plans (IFSPs). These IPPs and IFSPs are plans developed by a planning team that include the consumer, the consumer's parents (for a minor), regional center representatives, service providers, and others as appropriate or as invited by the consumer. These plans describe the services required by the consumer to improve or ameliorate their condition, identify who will provide those services, and who will pay for the services.

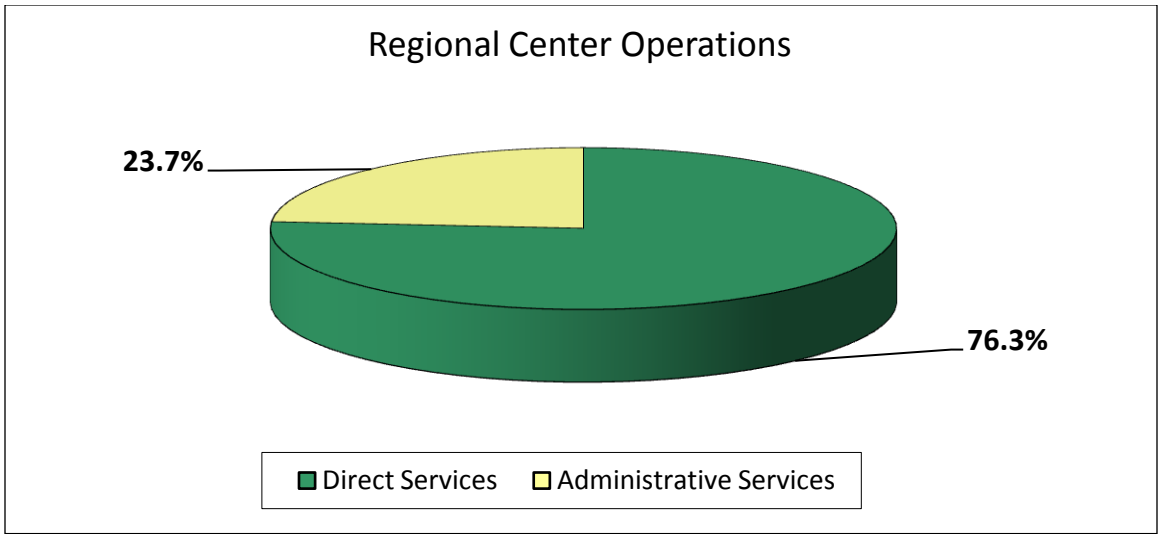
The OPS budget funds a regional center's costs related to personnel and benefits, insurance, leases, equipment, information technology, accounting/payment functions, personnel management, consultant services, independent financial audits, consulting/legal services, board support, travel, office facilities, and other administrative/managerial expenses. Chart 1 shows the relative percentages of the total budget allocated for OPS and POS.

Chart 1



The following chart (Chart 2) shows how the descriptor “OPS budget” is misleading, in that it connotes administrative costs, whereas more than three-fourths of the regional center OPS budget actually funds direct services to consumers and their families.

Chart 2

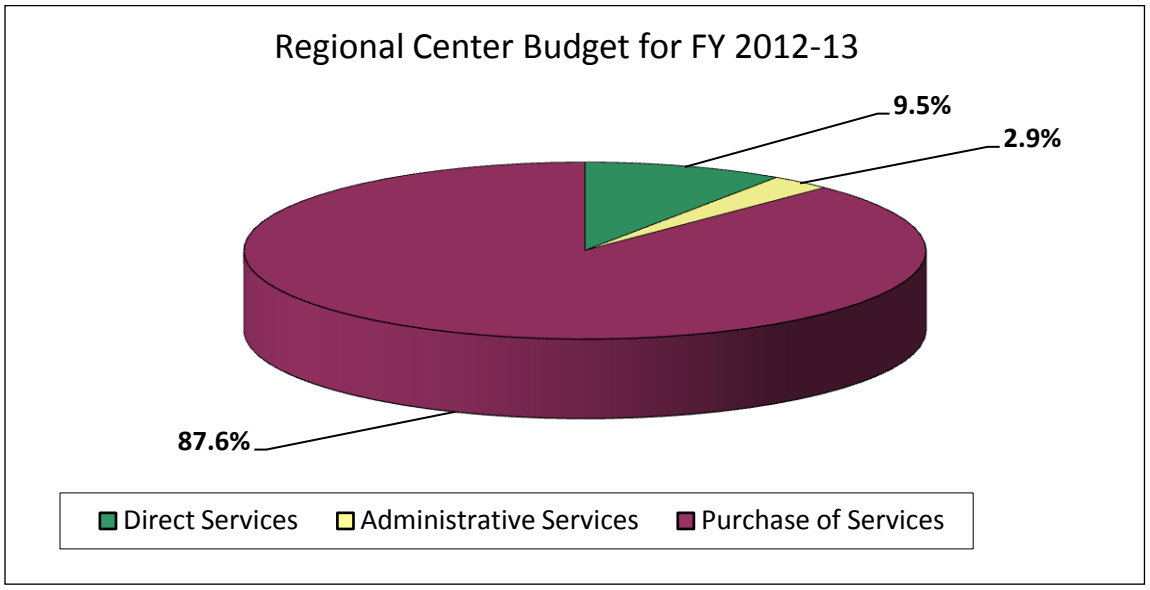


Direct services funded through the OPS budget include service coordination, assessment/diagnosis, individual program planning, consumer money/benefits management, clinical services, 24-hour emergency response, quality assurance,

advocacy, intake/assessment/referral, family support, training, special incident reporting/investigation, etc. Therefore, reductions in the regional-center OPS budget impact the provision of direct services to consumers. An attached publication prepared by Frank D. Lanterman Regional Center describes, in greater detail, the range of important direct services provided by regional centers.[iii]

The balance of the OPS budget (23.7%), funds all the regional centers' administrative costs and operating expenses, and represents just 2.9% of the total (OPS and POS) regional center budget.[iv] Chart 3 shows the OPS budget for the current fiscal year and how the funds are apportioned.

Chart 3



B. Budgeting and Allocation Methodology - Prior to 1979-80, each regional center developed its own staffing pattern and budget through negotiations with the Department of Developmental Services (DDS). Each staffing pattern was based on a program-budget methodology, and the budget-allocation methodology for compensation was based on projected actual salaries and benefits. While this approach addressed local variation and provided for flexibility and innovation, there was also argument for a less

subjective and more equitable method for allocating staffing resources to regional centers taking into account the size of the regional center (based on caseload) and the resources necessary to accomplish the regional centers' statutory and contractual mandates. This led to the development of the current methodology for funding the regional centers' personnel and related operational costs, which is commonly referred to as the "core staffing formula." This formula, developed in 1978, was crafted by DDS personnel based on their knowledge of existing regional center staffing patterns that had previously been approved by DDS, and other standards that were available at the time. For example, the case management ratio of one service coordinator to 62 consumers was based on what county welfare offices used for the Absent Parent Program to receive federal funding. This 1978 formula was arguably an improvement over the initial approach to budgeting and allocating OPS funding, but the formula was still an *ad hoc* creation developed without the benefit of the specialized study that such an important and complex statewide publicly-funded service system needed. There is no written analysis, justification, or documentation supporting the 1978 base formula, which is the same formula used today, except for some "add-ons" and minor changes.

The 1978 formula established specific positions, salaries, benefits, and operating expense assumptions/standards associated with the regional centers' mandates at the time. Salaries for various regional center staff positions were based on equivalent state classifications, with the assumption that as state salaries increased the formula salaries would increase at a similar rate. It also was assumed that benefit and operating expense assumptions would be periodically updated. See Attachment A for a copy of the current core staffing formula.

DDS and ARCA jointly develop the methodology for apportioning budgeted funds to the regional centers, with DDS retaining authority for the final allocation. The percentage of the total regional center funds budgeted to support regional center operations is 12.8 % in the current fiscal year, as shown in Chart 4. Charts 5 and 6 show the steady decline since FY 1988-89 in the proportion of operations funding compared to the total regional center budget.

CHART 4

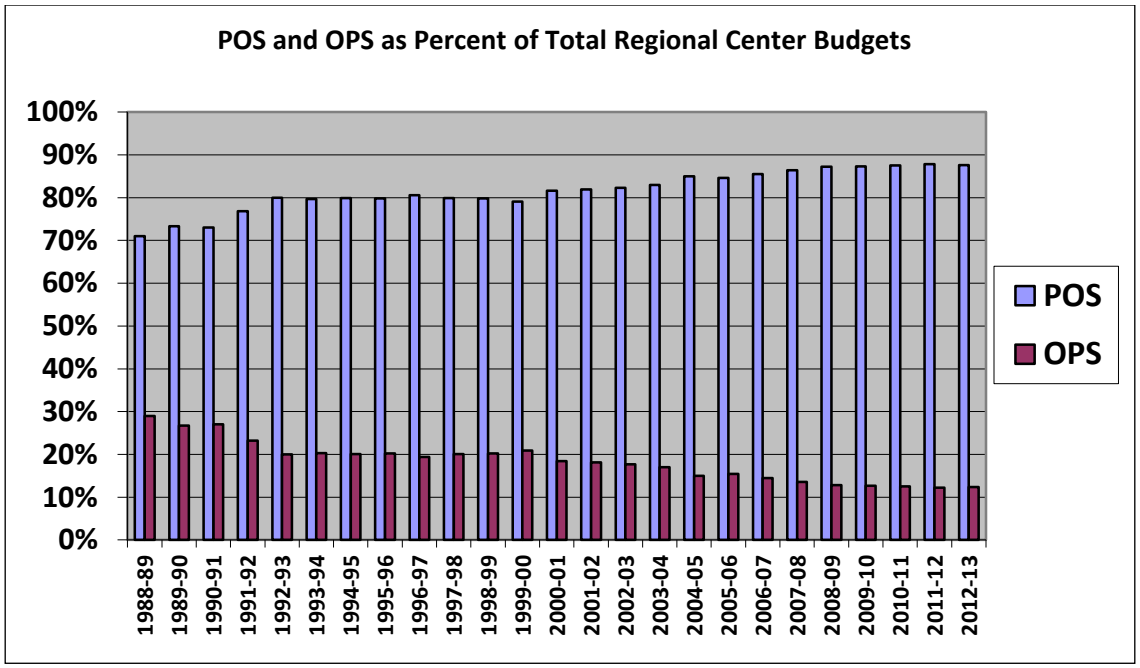
CATEGORY	FY 2013-14 MAY REVISION FY 2012-13 BUDGET *(Dollars in thousands)*	% OF TOTAL BUDGET
Operations	$537,415	12.8
Purchase of Services	3,647,976	86.7
Early Intervention and Prevention Programs	22,384	0.5
TOTAL	**$4,207,775**	**100.0**

CHART 5

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]			
FISCAL YEAR	**TOTAL BUDGET** *(Dollars in thousands)*	**% POS**	**% OPS**
1988-89	458,620	71.0	29.0
1989-90	558,237	73.3	26.7
1990-91	581,532	73.0	27.0
1991-92	647,799	76.8	23.2
1992-93	668,223	80.0	20.0
1993-94	740,511	79.7	20.3
1994-95	804,571	79.9	20.1
1995-96	905,416	79.8	20.2
1996-97	1,009,755	80.6	19.4
1997-98	1,145,438	79.9	20.1
1998-99	1,376,132	79.8	20.2
1999-00	1,584,201	79.1	20.9
2000-01	1,830,955	81.6	18.4
2001-02	2,027,554	81.9	18.1
2002-03	2,218,303	82.3	17.7
2003-04	2,397,486	83.0	17.0
2004-05	2,620,686	85.0	15.0

PERCENTAGE OF TOTAL REGIONAL CENTER BUDGET ALLOCATED FOR POS AND OPS[v]			
FISCAL YEAR	**TOTAL BUDGET** *(Dollars in thousands)*	**% POS**	**% OPS**
2005-06	2,784,773	84.6	15.4
2006-07	3,167,170	85.5	14.5
2007-08	3,512,929	86.4	13.6
2008-09	3,861,302	87.2	12.8
2009-10	3,886,591	87.3	12.7
2010-11	3,909,604	87.5	12.5
2011-12	3,958,227	87.8	12.2
2012-13	4,162,793	87.6	12.4

CHART 6



C. Factors Leading to OPS Underfunding – The factors that have led to the diminution of regional centers' operating capacity and to the current regional center OPS funding crisis fall within four primary categories: (1) actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in

operational workload, (2) actions imposing additional workload for which the regional centers received no additional - or inadequate - funding, (3) inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business, and (4) design flaws in the OPS formula. While not an exhaustive list, these factors, broken out by category, are as follows:

CATEGORY I: ***Actions leading to a direct reduction in the regional center OPS budget without a corresponding reduction in operational workload.***

- Eliminating Hospital Liaison Positions: The FY 1983-84 budget transferred case management services for consumers residing in state developmental centers from regional center employees to developmental center employees, and the regional center OPS budget was reduced accordingly. Prior to this time, regional centers were funded to regularly attend individual program plan meetings and to visit consumers residing in state developmental centers. At one time, regional centers were allocated one position for every 60 consumers residing in the developmental centers. This allocation was later changed to one position for every 120 consumers. In FY 1983-84, regional center staffing for state developmental center consumers was eliminated. A small number of similar positions (one position for every 400 developmental center consumers) were subsequently reestablished in the core staffing formula and continue to the present. This minimal allocation, however, did not compensate regional centers for the workload they continue to incur for state developmental center consumers, including the significant probate and criminal court demands developmental center residents generate. In FY 2009-10, as a result of the settlement in the Capitol People First, et. al. v. Department of Developmental Disabilities (DDS), funding was restored to provide a caseload ratio of one position for every 66 consumers residing in the developmental centers.

- Extending Regional Center Assessment Timelines: Regional centers have mandated timelines for completing their assessment of prospective consumers and for developing an individual program plan or individualized family service plan for those found eligible for services.[vi] The timeline for completing the assessment phase

of the process for consumers over age three has intermittently been extended from 60 to 120 calendar days to justify reducing the regional center OPS budget. This change was first enacted in FY 1992-93 through an urgency statute (Senate Bill 485, Chapter 722, Statutes of 1992) which sunset July 1, 1996. This action was implemented again in FY 2002-03 and, through subsequent legislative actions, has continued into the current fiscal year, and became permanent in FY 2008-09. The savings associated with this action derive from the reduced number of regional center clinical personnel needed for performing the required assessments. The justification for the estimated savings was valid the first year of implementation, but is not valid beyond the first year because intake workload is independent of mandated timelines. As one researcher observed, *"The consumer requires the same services and total staff time whether those services are spread over one, two or four months. The required time frames for assessment affect resource requirements only when they change, increasing or decreasing backlog. When time frame mandates do not change, the equivalent to one month's workload must be completed each month to keep backlog constant as a new set of intake cases arrive."*[vii] Thus, this policy change amounts to a funding reduction since the basic workload requirements remain after the first year.

- Imposition of Unallocated OPS Budget Reductions and Developing/Implementing Expenditure Plans: Unallocated reductions are reductions or offsets to a program's budget that are not specific to, or earmarked against, an individual program or line item. Such reductions are applied to, or offset, the bottom line of the budget. The budget for regional center OPS has sustained numerous unallocated reductions over the years, some of which have been restored and others not. The first unallocated reduction in the regional centers' OPS budget occurred in FY1982-83 ($2.2 million). Budget Act language required DDS to establish expenditure priorities for regional centers to ensure they maintained expenditures within the amount budgeted.[viii] These DDS-developed priorities for controlling costs were invalidated by the state Supreme Court in their 1985 ruling in *Association for Retarded Citizens v. Department of Developmental Services*.

The next unallocated reduction occurred in FY 1991-92. This reduction was followed by unallocated reductions in each fiscal year thereafter through 1995-96. Unallocated reductions were again instituted in FY 2002-03, 2003-04, and 2004-05. Regional centers achieved their OPS budget unallocated reduction target in FY 1991-92 and following through a variety of means including, but not limited to:

- Increasing service coordinator-to-consumer caseload ratios
- Reducing qualifications for new service coordinator employees
- Employee layoffs
- Temporary regional center closures of seven to fourteen days annually with the provision of only on-call emergency services
- Relinquishing money management or representative payee services for consumers receiving SSI/SSP benefits
- Reducing work hours
- Furloughing employees
- Reducing employee training
- Increasing employees' benefit premiums
- Renegotiating lease/rental costs
- Consolidating/closing offices
- Contracting out additional services
- Reducing travel, communication, consultant, legal, and other general administrative expenses
- Stopping hiring
- Discontinuing cost-of-living/salary adjustments

The regional centers' proposals for achieving the required reductions were incorporated into expenditure plans that DDS was required to review and approve, as appropriate.

Another round of reductions to regional center budgets began again in 2009 with the passage of ABX4 9 and continued through 2012. Though many of these budget

reductions used euphemisms such as “cost containment,” “operational efficiencies,” and “General Fund savings,” they were, in effect, unallocated reductions.

Some of these reductions were temporary, in the guise of across-the-board “payment reductions” which began in February 2009 as a 3% payment reduction, was increased to 4.25% in July 2010, and then reduced to 1.25% in July 2012. These reductions came to an end on July 1, 2013.

Unallocated reductions made to the regional center OPS budget since FY 1991-92 that continue to reduce regional center budgets in the current year and future years amount to $44.0 million.[ix] This is an effective budget reduction of 7.6%. These reductions are:

- Change in Intake and Assessment timeline $4.5 million
- FY 2001-02 unallocated reduction $10.6 million
- FY 2004-05 “Cost Containment” $6.0 million
- FY 2009-10 “Savings Target” $14.1 million
- FY 2011-12 “Cost Containment” $3.4 million
- FY 2011-12 unallocated reduction $5.4 million

<u>Category II</u>: *Actions imposing additional workload for which the regional centers received no additional - or inadequate - funding.*

Numerous legislative actions since the early 1980s have placed significant unfunded requirements upon regional centers. Also, many other new requirements have been added, with some funding attached, but frequently the funding is insufficient to comply with the new requirements. Since the adequacy of funding may be seen by some as a disputable matter, the following identify only some of the more significant unfunded requirements or mandates that have been imposed.

- <u>Managing/Implementing the New Uniform Fiscal System</u>: During 1984, DDS implemented the statewide Uniform Fiscal System to provide for uniform accounting procedures and centralized collection of client and fiscal data. There were numerous

implementation issues and unfunded workload related to maintaining this new system.

- Performing New Vendorization Activities: DDS delegated additional vendorization workload to regional centers in FY 1985-86 through the issuance of the 'Vendor Procedures Manual.' New workload involved regional centers reviewing and approving vendor applications, and reviewing rate applications for specified programs before submission to DDS for rate setting.

- Following Up on Specialized Residential Service Facility Reviews: During FY 1985-86, DDS required the regional centers to follow up on DDS evaluations of specialized residential service facilities. Regional centers were required to absorb this additional workload.

- Change to Person Centered Planning: Passage of Senate Bill 1383 in September 1992 (effective January 1, 1993), mandated a new approach to developing individual program plans for regional center consumers. This new approach, called person centered planning, moved away from the traditional approach to service planning, guided by the professionals in the interdisciplinary team, to one where consumers and families assumed a primary role in the planning process, and where the needs and preferences of consumers and families were given much greater consideration. While this approach is preferable, developing an individual program plan using a person centered planning approach takes much longer than using the traditional approach, yet regional centers were not provided any additional resources to accommodate this increased workload.

- Administering Vouchers: In 1991, the Department adopted new regulations establishing a voucher mechanism for paying for specified services. This new approach gave families and adult consumers a direct role in procuring nursing, day care, respite, transportation, diapers and nutritional supplements. While beneficial for many who choose to obtain their services through this purchasing mechanism,

the processing of billings and payments for individual families is very staff-intensive, which includes training family members on record keeping and payroll tax requirements, and for which regional centers received no additional resources to perform the increased workload.

- Collecting and maintaining information on consumers' potential eligibility for Old Age Survivors Disability Insurance and referring such individuals to the Social Security Administration and conducting triennial continuing disability reviews. The law also required that individuals residing out of home be reviewed for such eligibility at the time of every review [Wel. & Insti. Code §4657 and §4658].

- Maintaining an emergency response system that must be operational 24 hours per day, 365 days per year [Wel. & Insti. Code §4640.6(b)].

- Annually preparing and submitting service coordinator caseload ratio data to DDS [Wel. & Insti. Code §4640.6(e)].

- Having or contracting for expertise in the following areas [Wel. & Insti. Code §4640.6(g)(1) through (6)]:
    1. Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.
    2. Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.
    3. Family support expertise to assist the regional center in maximizing the effectiveness of supports and services provided to families.
    4. Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supported living arrangements.

5. Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.
6. Quality assurance expertise to assist the regional center in providing the necessary coordination and cooperation with the Area Board in conducting quality-of-life assessments and coordinating the regional center quality assurance efforts.

- Employing at least one consumer advocate who is a person with developmental disabilities [Wel. & Insti. Code §4640.6(g)(7)].

- Annually conducting four monitoring visits, of which at least two are unannounced monitoring visits, of every licensed long-term health care facility, licensed community care facility, and Adult Family Home Agency home [Wel. & Insti. Code §4648(a)].

- Adding the Adult Family Home Agency program as a new living option and requiring regional centers to engage in specific activities related to selecting, monitoring, and evaluating such programs [Wel. & Insti. Code §4689.1].

- Contracting annually with an independent accounting firm for an audited financial statement, including reviewing and approving the audit report and accompanying management letter, and submitting this information to DDS before April 1 of each year [Wel. & Insti. Code §4639

- During the individual program planning process, reviewing and documenting each consumer's health status, including his/her medical, dental, and mental health status and current medications [Wel. & Insti. Code §4646.5 (a)(5)].

- Developing and updating every six months, as part of the individual program plan, a written statement of the regional center's efforts to locate a living arrangement for minor children placed out of the family home for whom the parents or guardian have requested closer proximity to the family home [Wel. & Insti. Code §4685.1 (a)].

- Developing, implementing, and reviewing annually a "memorandum of understanding" with each (as appropriate) county mental health agency to perform specified activities related to planning, coordinating, and providing services to dually-diagnosed consumers [Wel. & Insti. Code §4696.1].

- Annually preparing and submitting to DDS: (1) a current salary schedule for all personnel classifications used by the regional center, and (2) a listing of all prior fiscal year expenditures from the OPS budget for all administrative services, including managerial, consultant, accounting, personnel, labor relations, and legal services [Wel. & Insti. Code §4639.5].

- Transferring responsibility for conducting initial consumer/family complaint investigations, as required pursuant to Wel. & Insti. Code §4731, from the clients' rights advocate to the regional center director [Wel. & Insti. Code §4731(b)].

- Responsibility for monitoring and paying Habilitation Services Program providers. This $150 million program, which was transferred from the Department of Rehabilitation to DDS, involves about 500 providers.

- Implementing the Family Cost Participation Plan (FCPP) and the Annual Family Program Fee (AFPF), wherein staff assesses fees to families based on specific criteria [Wel. & Insti. Code §4783 and §4785 respectively].

- Every two years screening all vendored service providers against federal and state databases to ensure vendors have not been disqualified from participating

in the Home and Community Based Services (HCBS) Waiver program [Wel. & Insti. Code §4648.12].

- Implementing electronic billing for all vendored service providers [Govt. Code §95020.5 and Wel. & Insti. Code §4641.5].

- Requiring regional centers to post specific information on their internet websites [Wel. & Insti. Code §4629.5].

- Responsibility for reviewing audit reports of medium-sized and large vendors conducted by independent certified public accountants [Wel. & Insti. Code §4652.5].

- Developing Transportation Access Plans for certain consumers [Wel. & Insti. Code §4646.5(a)(6)].

- Completing comprehensive assessments for residents of developmental centers and consumers placed in settings ineligible for Federal Financial Participation and developing appropriate resources in the community [Wel. & Insti. Code §§4418.25(c)(2)(A), 4519(a), and 4648(a)(9)(C)(iii)].

- Verifying individual or family income in order to determine a consumer's eligibility for financial assistance with funding health insurance copayments and coinsurance [Wel. & Insti. Code §4659.1].

- Changing accounting firms to ensure that no accounting firm completes a required financial audit more than five times in ten years [Wel. & Insti. Code §4639(b)].

- Complete a standardized questionnaire upon a consumer's entry into supported living services and at each IPP review thereafter [Wel. & Insti. Code § 4689(p)(1)].

- Completing transition plans for all regional center consumers residing out-of-state and conduct statewide search for in-state services and development of appropriate services as needed [Wel. & Insti. Code § 4519(e)].

- Notifying the Client Rights Advocate of IPP meetings for developmental center residents [Wel. & Insti. Code § 4418(c)(2)(D)], IPP meetings for consumers to be placed in an IMD [Wel. & Insti. Code § 4648(a)(9)(C)(iv)] or who are residing in an IMD [Wel. & Insti. Code § 4648(a)(9)(C)(v)], and of writs of habeas corpus [Wel. & Insti. Code § 4801(b)].

- Completing referrals to Regional Resource Development Projects and Statewide Specialized Resource Service.

- Increased need to do Health and Safety waiver requests due to the freezing of service provider rates.

Category III: ***Inaction with respect to updating the OPS formula to keep pace with the increasing costs of doing business.***

- Failure to Update Salaries in the Core Staffing Formula

  The model for budgeting regional centers' personnel costs is formula driven. The model calculates the number and type of personnel or positions theoretically needed for a regional center to comply with its mandated obligations. A position's salary in the formula is linked to the mid-range state salary for the equivalent state position based on when the regional center position was added to the formula. Until FY 1991-92, whenever state employees received a cost-of-living adjustment, the formula was updated in the formula to maintain salary equivalency with comparable state positions. This policy of indexing regional centers' personnel budget increases to state employee cost-of-living adjustments continued through FY 1990-91. In FY 1991-92, the policy changed when the

state ceased providing regional centers cost-of-living adjustments for their personnel costs. **This policy change, which has continued through the current fiscal year, is the action that has impacted the OPS budget most significantly**.

Illustrating the fiscal impact of this policy change is the regional center "Revenue Clerk" position, which is linked to the state equivalent position classification of "Accounting Technician." The annual mid-range salary for the state Accounting Technician position is currently $35,082, whereas the formula uses an annual mid-range salary of $18,397, which reflects the Accounting Technician annual mid-range salary as of FY 1990-91. Based on caseload and other factors, the budgeting formula calculates the number of positions a regional center needs to perform the specified function(s) for which the Revenue Clerk positions are allocated. The number of positions is then multiplied by the salary in the formula. In this instance, the salary remains equivalent to the state's Accounting Technician in FY 1990-91, or $18,397, which is barely half of the current annual mid-range salary for the state Accounting Technical position. Except for new positions added to the formula since it was developed, and adjustments made in the late 1990s to service coordinator salaries in response to federal audit issues, salaries in the formula have not been adjusted for 23 years. This has the same impact of not receiving a cost-of-living adjustment for 23 years.

The impact of this policy change is enormous, resulting in underfunding the OPS budgeting formula by about $288 million annually. Consequently regional centers are budgeted for their staff at only 58% of what they would be if the core staffing salaries had kept up with inflation.

- <u>Failure to Fully Fund Mandated Caseload Ratios</u>

  According to Wel. & Insti. Code § 4640.6, regional centers are required to maintain certain caseload ratios. For consumers on the HCBS Waiver or in Early

Start, the mandated caseload ratio is one Client Program Coordinator (CPC) for every 62 consumers and for those not on the HCBS Waiver or in Early Start, the required ratio is one CPC for every 66 consumers. However, due to the drastic underfunding of the core staffing formula, as discussed above, it is impossible for regional centers to hire sufficient CPCs to meet these ratios. According to the Core Staffing Schedule in the FY 2013-14 regional center budget, regional centers should have 4,148 CPCs to meet the mandated caseload ratios. However they are funded at only $34,032 per CPC. The actual mid-range salary for CPCs that the regional centers pay is $46,121. At that salary level, the regional centers can afford only 3,061 CPCs, over a thousand less than the formula indicates. This means the average caseload ratio regional centers can afford is one CPC for every 87 consumers. Had the CPC salaries in the core staffing formula kept pace with State salary increases, the budgeted salary would be about $50,340, and if it had kept pace with the Consumer Price Index it would be about $61,200.

The ability of regional centers to hire a sufficient number of CPCs to meet the required caseload ratios is further hindered by the unallocated budget reductions (discussed above), the imposition of a salaries savings factor and a fringe benefit rate of only 23.7% (discussed later).

Category IV: *Design flaws in the OPS formula.*

The existing core staffing formula was developed when the regional center operating environment was far different. In 1978, regional centers were relatively small organizations, their mandates far fewer, and funding streams less diverse. Regional centers have grown tremendously in size and complexity, and their responsibilities have expanded greatly, yet the formula has remained much the same. Those who developed the formula never contemplated a regional center managing, on average, over $196 million annually in state and federal funds, which is a greater amount than the entire regional center budget was for FY 1979-80, nor did they anticipate the average center having about 350 employees.

Specific examples of some of the deficiencies in the core staffing formula include the following:

- The organizational model embodied in the formula did not envision regional centers with hundreds of employees, therefore, staffing for the management and supervision structure for such large organizations is not provided. This problem is exacerbated at large regional centers. The formula does recognize the need for more of certain positions where the number of consumers drives the workload significantly; however, there are other positions, such as the Human Resources Manager and the Training Officer, that every regional center is allocated only one position, regardless of size. Also, large regional centers have need of additional senior and middle management personnel who are not provided for in the formula.

- The "equivalent" state positions used in the formula were determined apart from any review or input from regional centers and, therefore, lack comparability with actual regional center position responsibilities. This lack of comparability has only increased over time as regional centers have grown in size and complexity. This specific problem was identified in a 1984 DDS/ARCA-sponsored study performed by Cooperative Personnel Services, which found that the positions used in the formula were undervalued by approximately 12% on average at that time.

- The formula imposes a 5.5% salary savings requirement on all regional center positions, except for service coordinator positions, where the salary savings is 1%. The imposition of a salary savings requirement fails to account for the need to fill vacancies through overtime or contract personnel, or for the additional costs related to turnover (e.g., advertising, recruiting, and training of staff). Due to mandates and contract requirements, few regional center responsibilities can simply be postponed or neglected.

- In many instances, the use of “one per” positions (e.g., allocating funding for certain positions to every regional center regardless of size and/or programs and/or large and widespread geographic boundaries) fails to generate the appropriate number of personnel required for those positions where regional center size, demographics, and/or number of vendored programs drive the workload. Again, this reflects an assumption in the original formula, which presumed each regional center would serve approximately the same number of consumers in generally the same manner, which, at the time, were about 2,000 per center. Today the largest regional center serves about 22,000 active and high-risk consumers, whereas the smallest center serves about 3,000 consumers in a geographically large and widespread area.

  One example is the Resource Developer. Each regional center is budgeted for only one regardless of the number of consumers served or the number of service providers vendored by the regional center.

- The formula uses a standard 23.7% figure for budgeting total fringe benefits. This figure has not been adjusted to account for increases in such areas as workers’ compensation, health benefits, FICA, etc. By comparison, the current fringe benefit percentage used by DDS for its Headquarters personnel is 41.6%.[x]

- The state equivalent positions used in the formula are budgeted at the midpoint of what is typically a five-step state salary range. This methodology results in underfunding for every employee who remains with the regional center more than three years since there is no allowance for seniority or merit salary adjustments after the third year of service (assuming the individual was initially hired at the lowest step of the salary range).

- The formula does not recognize or account for the very significant regional variations in prevailing salary levels.

- The amount provided for regional center operating expenses and equipment per position has not been updated since FY 1985-86, when it was set at the amount used by DDS for its Headquarters employees.

The core staffing formula, therefore, suffers from a variety of deficiencies which, when combined with all the other the issues noted above, has created an enormous OPS budgetary shortfall that continues to worsen.

D. History of Efforts to Remedy OPS Underfunding - Concerns about underfunding in the regional center OPS budget are not new. ARCA has given this matter considerable attention over the years. Unfortunately, these efforts have yielded little success. The following summarizes the most significant past efforts to address the inadequacies of the OPS budgeting methodology:

1. 1981 – *Staffing Standards Task Force*. ARCA forms a Staffing Standards Task Force to *"study and prepare a 'core staffing' formula that more closely approximates the Regional Center staff responsibilities as directed in law and legal contract."* The Task Force surveys regional centers, reviews current regional center activities, and develops a "core staffing" plan. ARCA adopts the Task Force report and forwards it to DDS. DDS takes no action due to budgetary concerns.

2. 1983 – *Personnel Task Force Report*. ARCA establishes a Personnel Task Force to (1) pursue a core staffing study, and (2) coordinate a study comparing the state's classification and pay plan with that of the regional center core staffing formula. Cooperative Personnel Services (at that time an entity within the State Personnel Board) conducts the comparison classification study and issues its report in February of 1984. The report finds that the regional center position salaries lag the state equivalent positions by 12.4%. The Task Force develops a recommended staffing allocation formula reflecting the resources needed for regional centers to comply with their contractual and statutory obligations. The Personnel Task Force releases its report in February 1984, including a copy of the CPS study as an

appendix. DDS, while sympathetic, is not able to gain support within the Administration to implement the report's recommendations.

3. 1989 – *Personnel Task Force Report*. Another ARCA Personnel Task Force convenes and: (1) reviews and updates information on current regional center mandates, (2) engages Cooperative Personnel Services to revise their prior compensation study with some updates, and (3) develops a report that includes a historical perspective, a task analysis for each position in the core staffing formula, a comprehensive model staffing and allocation plan using a *"slightly less than average regional center"* construct, and findings and recommendations. The report is issued in January 1990. The Cooperative Personnel Services study finds that regional center positions are underfunded by approximately 10% in comparison to comparable state positions. The ARCA Board of Directors approves a motion by the Executive Committee to prepare and submit an Executive Summary of the Task Force report to Senator Dan McCorquodale to be considered in the Senate Resolution 9 hearings. The Executive Summary and a copy of the second study conducted by Cooperative Personnel Services are transmitted to Senator McCorquodale and key legislative committee consultants. No action is taken.

4. 1999 - *Citygate Associates Study* – DDS, acknowledging serious flaws in the core staffing formula and concerned about OPS underfunding, engages a contractor to *"Identify the . . . staff that will enable Regional Centers to meet their state and federal mandates and are consistent with good business practices."* The Legislature, in the FY1998-99 Budget Act, adopts control language requiring DDS to *". . . provide the Fiscal and Policy Committees of the Legislature with the Findings of the Regional Center Core Staffing Study by no later than March 1, 1999. This study is to address the type of classification, number, qualification, and compensation required for Regional Centers to meet their state and federal mandates and to be consistent with good professional and business practices."*

A contract is awarded to Citygate Associates in June 1998 and, with two subsequent contract amendments, the state expends $402,000 for the study. ARCA, the Department of Finance, and DDS oversee the study design and project findings. Citygate's study methodology includes a qualitative and quantitative analysis, including: ten regional forums with regional center line staff representing the range of regional center personnel; four regional forums for vendors, consumers and family members; site visits to five regional centers; background interviews with key constituents; a research literature review; a survey of regional centers; review of the draft report by regional center teams representing a cross-section of regional center personnel; and three public hearings. Citygate delivers a final report to DDS in September 1999 unveiling a new methodology for budgeting regional center staffing and operating expenses. The report identifies numerous problems with the existing budgeting formula, resulting in 24% less funding than needed to appropriately meet state and federal mandates.

The Legislature adopts additional Budget Act language in FY 1999-2000 requiring DDS, by December 15, 1999, to *". . . make recommendations to the Legislature and the Governor regarding the core staffing formula used to allocate operations funding to regional centers. These recommendations shall include consideration of, and public comments related to, the Regional Center Core Staffing Study, and shall include, but not be limited to, all of the following: (1) Salary and wage level for positions deemed necessary to retain and maintain qualified staff. (2) Regional center staff positions that should be mandated. (3) Staffing ratios necessary to meet the requirements of this chapter, including a service coordinator-to-consumer ratio necessary to appropriately meet the needs of consumers who are younger than three years of age and their families. (4) Funding methodologies. (5) Indicate the impact of staffing ratios implemented pursuant to subdivision (c) . . ."*

DDS uses the report, with some modifications, to propose a new budgeting methodology and a four-year phase-in plan and, beginning in FY 2001-02, to fully fund the regional center OPS budget. The DDS proposal is supported within the

Administration, but is not included in the Governor's budget because of a severe economic downturn.

5. 2001 – *ARCA Position Paper.* ARCA prepares and transmits a position paper to the director of DDS detailing regional center OPS and POS budget issues. The paper is based on a survey of all 21 regional centers. The paper and attending transmittal letter highlight the OPS underfunding issue confronting the centers and identifies the need for "serious and immediate attention." Again, no action is taken.

E. Changes in the Budgeting Formula - The original "core staffing formula" has been adjusted intermittently throughout the years, as shown in the next chart. Not included are increases associated with Community Placement Plan (CPP) efforts to move people from state developmental centers into the community, since this is a state priority that has generally been well-funded. The following are non-CPP related changes since FY 1990-91 that resulted in additional OPS funding and the reasons for these increases:

CHANGES IN THE OPERATIONS BUDGETING FORMULA

YEAR	CHANGE	FUNDING (Millions)	REASON
90-91	Funding to perform activities required by the Sherry S./Violet Jean C. Court cases.	$1.0	Court-required workload.
97-98	Establishing 21 regional center clinical teams to enhance the centers' clinical capacity.	6.1	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
97-98	Requiring regional centers to conduct quarterly monitoring for all consumers living out of home.	14.8	Same as above
98-99	Updating budgeted salaries for quarterly monitoring staff, clinical teams, and case management staff serving consumers placed from developmental centers.	5.0	Same as above
98-99	Updating base staffing levels to ensure	3.5	Same as above

YEAR	CHANGE	FUNDING (Millions)	REASON
	sufficient staffing for performing quarterly monitoring visits.		
98-99	Establishing 14 additional regional center clinical teams.	4.5	Same as above
98-99	Increasing monitoring frequency of consumers with health conditions living in CCFs. Regional center are provided addition staff for new activities.	5.3	New DSS Title 22 regulatory requirements.
98-99	Reducing CPC caseloads to 1:62 (included reduction of CPC salary savings requirement; updating CPC salaries; restoration of unallocated reduction for CPCs; and funding other essential positions). (Half-year funding)	27.9	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
99-00	Additional funds to fully implement the above reduction of CPC caseloads to 1:62.	27.9	Same as above
98-99	Establishing a consumer complaint process in statute. Regional centers each provided ½ position for new workload.	0.7	Legislation (SB 1039) establishing a consumer complaint process, i.e., Wel. & Insti. Code 4731.
98-99	Fund Essential Regional Center Positions – Information Systems manager, Personal Computer Systems Manager, Training Officer, Special Incident Coordinator, Vendor Fiscal Monitor, Human Resources Manager, and Information Systems Assistant (half-year funding)	6.7	Fund essential positions previously not included in the core staffing formula
99-00	Additional funds to fully implement the above new positions.	6.7	Same as above
99-00	Performing health status reviews of consumers during a part of the IPP process.	3.2	Adverse federal (CMS) audit of the HCBS Waiver; intense media coverage of consumer care issues; publication of controversial mortality studies
00-01	Establishing 1:45 maximum caseload ratios for service coordinators for consumers placed out of state developmental centers.	0.6	Same as above
01-02	Implementing a statewide risk management system, including regional center risk management committees.	6.7	Same as above
02-03	Establishing Federal Program Coordinators and providing unfunded rent relief.	15.2	State initiative to increase and maintain federal financial participation.
03-04	Establishing Federal Compliance Specialists and fiscal/contract documentation staff.	4.4	Same as above
03-04	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	1.4	State initiative to increase federal financial participation.
03-04	Complying with requirements of the federal	1.4	Congressional enactment

YEAR	CHANGE	FUNDING (Millions)	REASON
	Health Insurance Portability and Accountability Act (HIPPA)		of HIPPA legislation.
04-05	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	2.8	State initiative to increase federal financial participation.
04-05	Funding for regional center administrative activities associated with implementing the Family Cost Participation Program.	.6	Enactment of legislation establishing the Family Cost Participation Program.
05-06	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.8	State initiative to increase federal financial participation.
06-07	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.3	Same as above
07-08	Funding to accelerate and increase the number of consumers enrolled in the Waiver **(one-time-only funding)**.	2.1	Same as above
06-07	Funding for expansion of Autism Spectrum Disorder Initiative	1.7	State initiative to better serve consumers with autism spectrum disorder
07-08	Additional funds to implement the expansion of the Autism Spectrum Disorder Initiative.	1.8	Same as above
08-09	Funding to accelerate and increase the number of consumers enrolled in the Waiver (one-time-only funding).	.9	State initiative to increase federal financial participation.
09-10	Fund additional case managers to participate in IPP meetings of consumers residing in state developmental centers	3.1	Pursuant to the Capitol People First lawsuit settlement

The above chart illustrates that, with a few relatively minor exceptions, all the positive adjustments to the OPS budget since FY1990-91 have been driven by actions related to preventing/minimizing the loss of federal funding, and initiatives to increase federal funding. While helpful, these increases or positive adjustments are dwarfed by the losses suffered in the OPS budget highlighted in the previous section on *Factors Leading to OPS Underfunding*.

III. THREAT TO FEDERAL FUNDING

In a 1992 oversight hearing before a Senate Budget Subcommittee, the DDS Director testified that *"the Department believes that regional centers have sustained the most serious and damaging budget reductions of all entities in the developmental services system. The Department is concerned that two years of unallocated reductions to*

regional centers' operations budget has severely impaired their ability to meet their existing statutory and contractual requirements . . . [and that the reduction had] . . . reduced [the] ability of the regional centers to monitor client services and care. The Department is also concerned that the diminished ability of regional centers to monitor the health and safety of vulnerable clients placed in residential care facilities, particularly for clients who do [not] have an involved parent, may lead to an increase in health and care problems."[xi] The concerns expressed by Mr. Amundson were prescient and later confirmed when noted in a December 2007 Department report to the Legislature. In this report, the Department stated that, *"In 1997, the federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services (CMS)) conducted its first major review of the state's Waiver and found serious deficiencies . . . In response to these findings, the state negotiated with the federal government to implement a series of initiatives necessary to continue in the Waiver program . . . The new initiatives were designed as permanent infrastructure improvements targeted at improving the overall quality of the service system. The federal government, however, froze Waiver enrollments as of December 1997 until the state demonstrated each regional center had implemented these changes. . .* ***The cumulative impact of this enrollment freeze cost the state an estimated $933 million in lost federal funds****.*[xii] [Emphasis added] *This significant funding loss underscores the importance of meeting federal quality assurance standards in the developmental services system lest the savings achieved through cost-containment measures is dwarfed by subsequent losses in federal reimbursement."*[xiii] The CMS freeze on enrolling new people in the Waiver was not fully lifted until January 2004, or nearly six years later. Due to the Department's and the regional centers' successful efforts in recent years to significantly increase federal funding, the state now has considerably more federal funding at stake should sanctions again be imposed.

One of the key issues identified by CMS during its review were the inordinately high caseloads of regional center service coordinators, which is a situation directly related to insufficient resources, since service coordinators, and their associated costs, comprise about 60% of the entire regional center OPS budget.[xiv] The CMS review noted that

"Case management activities are deficient . . ." and that there *". . . is a decreasing level of expertise and experience among case managers caused by high turnover rates and high case loads."*[xv] The state's corrective action plan to CMS involved setting a maximum limit on Waiver caseloads and providing additional funding for regional center operations. However, regional centers now find themselves in perhaps an even more compromised position, with respect to caseload ratios and the ability to ensure consumers' health and safety, than when CMS conducted their review in 1997. For example, DDS's most recent caseload ratio survey shows that two-thirds of the regional centers are not complying with at least one or more of their statutorily required (Wel. & Insti. Code 4640.6) caseload ratios, and over one-half of the regional centers cannot meet the specific caseload ratio requirement for consumers enrolled in the Waiver.[xvi] This requirement is not only specified in statute, but it is included in the state's approved application for the Waiver. Thus, the state is not fully complying with an assurance to the federal government upon which the receipt of federal funding was predicated.

The seriousness of this situation becomes all the more evident when one considers that state law requires that service coordination be the ". . . *highest priority*,"[xvii] with respect to regional center staffing patterns. Many regional centers' inability to meet even this statutorily prioritized service delivery requirement, despite their best efforts, suggests something about the severe resource issues that exist in other important regional center operational areas.

IV. CONCLUSION

The Lanterman Developmental Disabilities Services Act sets forth the state's commitment to people with developmental disabilities, as follows: *"The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge . . ."*[xviii] The state has elected to discharge this responsibility through a network of 21 regional centers. This statewide network of regional centers manages over $4.1 billion in federal and state funds and serves as the primary safety net for Californians with developmental disabilities. However, the viability of this network is now threatened by the cumulative impact of decisions that have led to

severe underfunding of the regional center OPS budget. Absent intervention, the state is again exposed to the potential loss of hundreds of millions of dollars in federal funds and, more importantly, the health and well-being of consumers and their families for whom the state has “accepted a responsibility” is directly threatened.

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4. "Regional Center and CCSB Differential Caseload Staffing," State of California, Department of Finance, Program Evaluation Unit, April 1980.

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14. "Controlling Regional Center Costs, Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007.

15. "2008-09 Governor's Budget November Estimate - Local Assistance for Regional Centers," California Department of Developmental Services, Estimates Section, January 10, 2008.

16. "Community Services Program – Expenditure and Caseload History," Department of Developmental Services, Budget Section, April 17, 2008.

17. "Regional Centers' Budget History," Department of Developmental Services, Budget Section, April 8, 2008.

ENDNOTES

[i] Wel. & Insti. Code §4621.5

[ii] Wel. & Insti. Code §4501.

[iii] "Regional Center Operations: Unique Value-Added Services," Frank D. Lanterman Regional Center, October 13, 2008.

[iv] Based on the FY 2012-13 budget data prepared by the Department of Developmental Services, Estimates Section, May 14, 2013.

[v] These data reflect (a) budgeted amounts per the Budget Act for FY 1988-89 through 1991-92, (b) actual expenditures for OPS and POS for FY 1992-93 through 1999-00 per the Department of Developmental Services' budget charts entitled *"Regional Centers Budget History (dated May 4, 2004*)", (c) actual budget allocations of OPS and POS to the regional centers for FY 2000-01 through 2011-12, and (d) OPS and POS budgets for FY 2012-13 per the 2013 May Revision of the 2013-14 Budget.

[vi] Wel. & Insti. Code Sec. 4642 and 4643, and Government Code Sec. 95016.

[vii] "Regional Center Core Staffing Study – Final Report," prepared by Citygate Associates for the California Department of Developmental Services, September 1999, p. III-8.

[viii] Assembly Bill 21, the Budget Act of 1982, Item 4300-101-001, Provision 8.

[ix] Department of Developmental Services, Regional Centers 2013-14 May Revision, May 14, 2013.

[x] Department of Developmental Services, Developmental Centers 2013 May Revise.

[xi] Dennis Amundson, *Testimony for the Oversight Hearing of the Senate Budget Subcommittee #3 on Health, Human Services and Labor, Department of Developmental Services*, November 5, 1992, p. 18 and 22.

[xii] "Estimate of Lost Federal Financial Participation Due to CMS Freeze on Enrollments," Department of Developmental Services, Community Operations Division, Federal Programs Section, October 23, 2007.

[xiii] "Controlling Regional Center Costs," Report to the Legislature Submitted to Fulfill the Requirements of Section 102.5, Chapter 188, Statutes of 2007, Department of Developmental Services, December 2007, p. 29.

[xiv] Based on the FY 2008-09 May Revision Core Staffing. Included in the 60% figure is all funding budgeted for service coordinators, service coordinator supervisory and support staff, and proportional funding for office rent and other operating expenses and equipment.

[xv] "Compliance Review of California's Home and Community Based Services Waiver Program for the Developmentally Disabled – Control Number 0129.91," Health Care Financing Administration, Regional IX, January 12, 1998, p. 27.

[xvi] Regional center caseload ratio surveys of March 2013.

[xvii] Wel. & Insti. Code §4640.6 (a).

[xviii] Wel. & Insti. Code §4501.

ATTACHMENT A

CORE STAFFING FORMULA

ATTACHMENT A

Attachment A
CORE STAFFING - BY 2013-14
Comparison of the 2013-14 Governor's Budget to the 2013 May Revision

	Governor's Budget	May Revision Budgeted Positions	May Revision Budgeted Salary	May Revision Budgeted Cost	Difference
I. CORE STAFFING FORMULA					
A. PERSONAL SERVICES					
1. DIRECT SERVICES					
a. Clinical					
(1) Intake and Assessment					
(a) Physician	$10,598,533	**133.22**	**$79,271**	**$10,560,483**	-$38,050
(b) Psychologist	11,165,020	**266.43**	**41,754**	**11,124,518**	-40,502
(c) Nurse	4,969,763	**133.22**	**37,171**	**4,951,921**	-17,842
(d) Nutritionist	3,760,981	**133.22**	**28,130**	**3,747,479**	-13,502
(2) Clinical Support Teams					
(a) Physician/Psychiatrist	6,350,346	**69.00**	**92,034**	**6,350,346**	0
(b) Consulting Pharmacist	4,171,050	**69.00**	**60,450**	**4,171,050**	0
(c) Behavioral Psychologist	3,793,068	**69.00**	**54,972**	**3,793,068**	0
(d) Nurse	3,482,982	**69.00**	**50,478**	**3,482,982**	0
(3) SB 1038 Health Reviews					
(a) Physician	2,195,011	**22.12**	**92,034**	**2,035,792**	-159,219
(b) Nurse	5,618,201	**103.23**	**50,478**	**5,210,844**	-407,357
b. Intake / Case Management					
(1) Supervising Counselor (Intake) (1:10 Intake Workers in Item (2) below)	3,176,767	**82.74**	**38,036**	**3,147,099**	-29,668
(2) Intake Worker	26,333,950	**827.42**	**31,532**	**26,090,207**	-243,743
(3) Supervising Counselor (Case Management) (1:10 CPCs in Items (6) and (7) below)	22,073,797	**419.61**	**52,392**	**21,984,207**	-89,590
(4) Supervising Counselor (Capitol People First) (DC Case Management 1:10 CPCs)	242,592	**3.61**	**67,200**	**242,592**	0
(5) Client Program Coordinator (CPC), 1:66 DC Consumers Capitol People First	1,698,326	**36.12**	**47,019**	**1,698,326**	0
(6) CPC, 1:66 Consumers(Total Pop w/o DCs,CPP,ES)	66,394,390	**1,950.79**	**34,032**	**66,389,285**	-5,105
(7) CPC (Waiver, Early Start only), 1:62 Consumers	75,322,005	**2,197.06**	**34,032**	**74,770,346**	-551,659
(8) CPC, Quality Assurance for ARM	1,666,547	**48.25**	**34,032**	**1,642,044**	-24,503
(9) Supervising Counselor, DSS Incidental Medical Care Regulations (1:10 CPCs)	71,253	**1.36**	**52,392**	**71,253**	0
(10) CPC, DSS Incidental Medical Care Regs	515,541	**13.62**	**37,824**	**515,163**	-378
c. Quality Assurance / Quarterly Monitoring					
(1) Supervising Counselor	2,061,101	**40.08**	**52,392**	**2,099,871**	38,770
(2) CPC	13,387,168	**400.82**	**34,032**	**13,640,706**	253,538
d. Early Intervention					
(1) General					
(a) Prevention Coordinator	876,792	**21.00**	**41,752**	**876,792**	0
(b) High-Risk Infant Case Manager	856,905	**21.00**	**40,805**	**856,905**	0
(c) Genetics Associate	798,714	**21.00**	**38,034**	**798,714**	0
(2) Early Start / Part C					
(a) Supervising Counselor	1,142,670	**20.93**	**52,392**	**1,096,565**	-46,105
(b) CPC	7,423,740	**209.32**	**34,032**	**7,123,578**	-300,162
(c) Administrative and Clinical Support (see next page)					
e. Community Services					
(1) Special Incident Coordinator	1,100,232	**21.00**	**52,392**	**1,100,232**	0
(2) Vendor Fiscal Monitor	1,309,741	**21.88**	**50,844**	**1,112,467**	-197,274
(3) Program Evaluator	898,653	**21.00**	**42,793**	**898,653**	0
(4) Resource Developer	898,653	**21.00**	**42,793**	**898,653**	0
(5) Transportation Coordinator	898,653	**21.00**	**42,793**	**898,653**	0
(6) Administrative Services Analyst (SB 1039 Consumer Complaints)	449,327	**10.50**	**42,793**	**449,327**	0
(7) Developmental Center Liaison	226,695	**3.33**	**38,036**	**126,660**	-100,035
(8) Diversion	126,584	**4.00**	**31,646**	**126,584**	0
(9) Placement Continuation:					
(a) Supervising Counselor	6,287	**0.13**	**52,392**	**6,811**	524
(b) CPC (Supplement at 1:45 Consumers)	40,838	**1.34**	**34,032**	**45,603**	4,765
f. Special Incident Reporting (SIR)					
(1) Supervising Counselor	388,749	**7.40**	**52,392**	**387,701**	-1,048
(2) QA/CPC	2,525,855	**74.02**	**34,032**	**2,519,049**	-6,806
(3) Nurses	1,873,239	**37.01**	**50,478**	**1,868,191**	-5,048
g. Mediation					
(1) Clinical Staff	7,093	**0.11**	**64,484**	**7,093**	0
(2) Supervising Counselor	52,916	**1.01**	**52,392**	**52,916**	0
(3) CPC	17,356	**0.51**	**34,032**	**17,356**	0
h. Expansion of Autism Spectrum Disorders (ASD) Initiative					
(1) ASD Clinical Specialist	1,371,888	**21.00**	**65,328**	**1,371,888**	0
(2) ASD Program Coordinator	1,318,464	**21.00**	**62,784**	**1,318,464**	0
i. SUBTOTAL DIRECT SERVICES	**$293,658,436**	**7,669.41**		**$291,678,437**	-$1,979,999

Attachment A

CORE STAFFING, BY (continued)

	Governor's Budget	May Revision Positions	Budgeted Salary	Cost	Difference
2. ADMINISTRATION					
a. Executive Staff					
(1) Director	$1,279,698	**21.00**	**$60,938**	**$1,279,698**	$0
(2) Administrator	1,009,449	**21.00**	**48,069**	**1,009,449**	0
(3) Chief Counselor	986,643	**21.00**	**46,983**	**986,643**	0
b. Fiscal					
(1) Federal Program Coordinator (Enh. FFP, Phase I)	1,206,177	**21.00**	**57,437**	**1,206,177**	0
(2) Federal Compliance Specialist (Enh. FFP, Phase II)	4,221,241	**105.82**	**39,887**	**4,220,842**	-399
(3) Fiscal Manager	963,480	**21.00**	**45,880**	**963,480**	0
(4) Program Tech II (FCPP)	882,890	**24.21**	**36,468**	**882,890**	0
(5) Revenue Clerk	1,234,546	**60.82**	**20,617**	**1,253,926**	19,380
(6) Account Clerk (Enh. FFP, Phase II)	584,640	**21.00**	**27,840**	**584,640**	0
(7) Account Clerk	8,198,991	**444.05**	**18,397**	**8,169,188**	-29,803
c. Information Systems and Human Resources					
(1) Information Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(2) Information Systems Assistant	1,000,692	**21.00**	**47,652**	**1,000,692**	0
(3) Information Systems Assistant (SIR)	500,346	**10.50**	**47,652**	**500,346**	0
(4) Privacy Officer (HIPAA)	898,653	**21.00**	**42,793**	**898,653**	0
(5) Personal Computer Systems Manager	1,397,844	**21.00**	**66,564**	**1,397,844**	0
(6) Training Officer	1,099,728	**21.00**	**52,368**	**1,099,728**	0
(7) Training Officer (SIR)	549,864	**10.50**	**52,368**	**549,864**	0
(8) Human Resources Manager	1,067,724	**21.00**	**50,844**	**1,067,724**	0
d. Clerical Support					
(1) Office Supervisor	489,867	**21.00**	**23,327**	**489,867**	0
(2) PBX/Mail/File Clerk	1,378,188	**63.00**	**21,876**	**1,378,188**	0
(3) Executive Secretary	1,148,490	**52.50**	**21,876**	**1,148,490**	0
(4) MD/Psychologist Secretary II	279,019	**11.06**	**23,388**	**258,671**	-20,348
(5) MD/Psychologist Secretary I	4,387,232	**199.83**	**21,876**	**4,371,481**	-15,751
(6) Secretary II	3,913,748	**166.77**	**23,388**	**3,900,417**	-13,331
(7) Secretary I	19,328,526	**1,023.64**	**18,757**	**19,200,415**	-128,111
(8) Secretary I (DC Case Management - Capitol People First)	210,834	**6.62**	**31,848**	**210,834**	0
e. SUBTOTAL ADMINISTRATION	**$59,616,354**	**2,452.32**		**$59,427,991**	**-$188,363**
3. TOTAL POSITIONS AND SALARIES (Item A.1.i. + Item A.2.e.)	$353,274,790	**10,121.73**		$351,106,428	-$2,168,362
a. CPCs	*168,476,225*			*167,846,293*	*-629,932*
b. All Other Staff	*184,798,565*			*183,260,135*	*-1,538,430*
4. Fringe Benefits					
a. CPCs 23.7%	**$39,928,865**			**$39,779,571**	-$149,294
b. All Other Staff 23.7%	**43,797,260**			**43,432,652**	-364,608
c. Total Fringe Benefits	**$83,726,125**			**$83,212,223**	-$513,902
5. Salary Savings					
a. CPCs 1.0%	**-$2,084,051**			**-$2,076,259**	$7,792
b. All Other Staff 5.5%	**-12,572,770**			**-12,468,103**	104,667
c. Total Salary Savings	**-$14,656,821**			**-$14,544,362**	$112,459
6. Early Start / Part C Administrative and Clinical Support (salaries, fringe benefits and salary savings)	$694,000			**$694,000**	$0
7. TOTAL PERSONAL SERVICES (Items A.3. + A.4. + A.5. + A.6.)	**$423,038,094**			**$420,468,289**	-$2,569,805
ROUNDED	**$423,038,000**	**10,122.00**		**$420,468,000**	-$2,570,000
B. OPERATING EXPENSES AND RENT					
1. Operating Expenses	**$39,785,000**			**$39,600,000**	-$185,000
2. Rent	**$52,022,000**			**$52,020,000**	-$2,000
a. Rent	*55,022,000*			*55,020,000*	
b. Elimination of Office Relocation and Modifications	*-3,000,000*			*-3,000,000*	
3. Subtotal Operating Expenses and Rent	**$91,807,000**			**$91,620,000**	-$187,000
C. TOTAL CORE STAFFING (Items A.7. + B.3.)	**$514,845,000**			**$512,088,000**	-$2,757,000

Attachment B

CORE STAFFING FORMULAS

CORE STAFFING CLASSIFICATION	STAFFING FORMULA		
A. PERSONAL SERVICES			
1. DIRECT SERVICES			
a. Clinical			
(1) Intake and Assessment			
(a) Physician (minimum of 1)	1.0 position	:	2,000 total consumers
(b) Psychologist	1.0 position	:	1,000 total consumers
(c) Nurse (minimum of 1)	1.0 position	:	2,000 total consumers
(d) Nutritionist (minimum of 1)	1.0 position	:	2,000 total consumers
(2) Clinical Support Teams			
(a) Physician/Psychiatrist	1.0 position	:	1,700 consumers in community care facilities (CCF) and supported living and those with severe behavior and/or medical problems
(b) Consulting Pharmacist	1.0 position	:	1,700 " "
(c) Behavioral Psychologist	1.0 position	:	1,700 " "
(d) Nurse	1.0 position	:	1,700 " "
(3) SB 1038 Health Reviews			
(a) Physician	1.5 hours	:	Referral/1,778 hrs./ full-time equivalent (FTE) position
(b) Nurse	1.75 hours	:	Individual program plan (IPP) review/1,778 hrs./FTE position
b. Intake/Case Management			
(1) Supervising Counselor: Intake	1.0 position	:	10 Intake Workers
(2) Intake Worker	1.0 position	:	14 monthly intake cases (assume average intake case lasts 2 mos.)
(3) Supervising Counselor: Case Management	1.0 position	:	10 CPCs in Items b.(4 and 5) below
(4) Client Program Coordinator (CPC)	1.0 position	:	62 Waiver and Early Start consumers (excluding CPP placements)
(5) CPC	1.0 position	:	66 consumers (all other consumers, excluding CPP placements)
(6) Supervising Counselor: Capitol People First	1.0 position	:	10 CPCs in Items b.(7) below
(7) CPC Capitol People First	1.0 position	:	66 consumers (Developmental Center residents)
(8) CPC, Quality Assurance for Alternative Residential Model	1.0 position	:	527 CCF consumers
(9) Supervising Counselor: DSS Incidental Medical Care Regulations	1.0 position	:	10 CPCs in item b.(10) below
(10) CPC, DSS Incidental Medical Care Regulations	1.0 position	:	2.5 hrs x 8 visits per year to CCF consumers who rely on others to perform activities of daily living

CORE STAFFING CLASSIFICATION	STAFFING FORMULA		
A. PERSONAL SERVICES (continued)			
1. DIRECT SERVICES (continued)			
c. Quality Assurance/Quarterly Monitoring			
(1) Supervising Counselor	1.0 position		10 CPCs in Item c.(2) below
(2) CPC	10 hrs/yr.	:	CCF consumer/1,778 hrs./FTE
	14 hrs./yr.	:	Supported/Independent Living consumer/1,778 hrs./FTE
	10 hrs/yr.	:	Skilled Nursing Facility and Intermediate Care Facility consumer/1,778 hrs./FTE
	10 hrs/yr.	:	Family Home Agency consumer/1,778 hrs./FTE
d. Early Intervention			
(1) General			
(a) Prevention Coordinator	1.0 position	:	RC
(b) High-Risk Infant Case Mgr.	1.0 position	:	RC
(c) Genetics Associate	1.0 position	:	RC
(2) Early Start/Part C			
(a) Supervising Counselor	1.0 position	:	10 CPCs in Item d.(2)(b) below
(b) CPC:			
Marginal positions from:	1.0 position	:	62 children<age 3yrs.
to:	1.0 position	:	45 children<age 3yrs.*
e. Community Services			
(1) Special Incident Coordinator	1.0 position	:	RC
(2) Vendor Fiscal Monitor	0.5 position	:	RC plus 1: every 3,140 vendors
(3) Program Evaluator	1.0 position	:	RC
(4) Resource Developer	1.0 position	:	RC
(5) Transportation Coordinator	1.0 position	:	RC
(6) Administrative Services Analyst (SB 1039, Chapter 414, Statutes of 1997) Consumer Complaints	0.5 position	:	RC
(7) Developmental Center Liaison	1.0 position	:	400 DC consumers
(8) Diversion	4.0 positions	:	21 RCs
(9) Placement Continuation			
(a) Supervising Counselor	1.0 position	:	10 CPCs in Item e.(9)(b) below
(b) CPC:			
1. Marginal positions from:	1.0 position	:	62 CPP Placements
2. to:	1.0 position	:	45 CPP Placements

* Note: This 1:45 staffing ratio is a funding methodology, not a required caseload ratio.

CORE STAFFING CLASSIFICATION	STAFFING FORMULA		
A. PERSONAL SERVICES (continued)			
1. DIRECT SERVICES (continued)			
f. Special Incident Reporting (SIR)			
(1) Supervising Counselor	1.0 position		10 CPCs in Item f. (2) below
(2) QA/CPC	1.0 position	:	RC plus 1:every 5,000 consumers
(3) Nurse	0.5 position	:	RC plus 0.5: every 5,000 consumers
g. Mediation			
(1) Clinical Staff	2.0 hours	:	25% of annual mediations/ 1,778 hrs /FTE position
(2) Supervising Counselor	4.5 hours	:	mediation/1,778 hrs./FTE position
(3) CPC	4.5 hours	:	50% of annual mediations/ 1,778 hrs./FTE position
h. Expansion of Autism Spectrum Disorders (ASD) Initiative			
(1) ASD Clinical Specialist (effective January 1, 2007)	1.0 position	:	RC
(2) ASD Program Coordinator (effective January 1, 2007)	1.0 position	:	RC
2. ADMINISTRATION			
a. Executive Staff			
(1) Director	1.0 position	:	RC
(2) Administrator	1.0 position	:	RC
(3) Chief Counselor	1.0 position	:	RC
b. Fiscal			
(1) Federal Program Coordinator (Enhancing FFP, Phase I)	1.0 position	:	RC
(2) Federal Compliance Specialist (Enhancing FFP, Phase II)	1.0 position	:	1,000 HCBS Waiver consumers
(3) Fiscal Manager	1.0 position	:	RC
(4) Program Technician II, FCPP	0.5 position	:	RC
	1.0 position	:	1,778 hours of FCPP determinations
(5) Revenue Clerk	1.0 position	:	400 consumers for whom RCs are representative payee
(6) Account Clerk (Enhancing FFP, Phase II)	1.0 position	:	RC
(7) Account Clerk	1.0 position	:	800 total consumers
c. Information Systems and Human Resources			
(1) Information Systems Manager	1.0 position	:	RC
(2) Information Systems Assistant	1.0 position	:	RC
(3) Information Systems Assistant, SIR	0.5 position	:	RC
(4) Privacy Officer, HIPAA	1.0 position	:	RC
(5) Personal Computer Systems Manager	1.0 position	:	RC
(6) Training Officer	1.0 position	:	RC
(7) Training Officer, SIR	0.5 position	:	RC
(8) Human Resources Manager	1.0 position	:	RC

CORE STAFFING CLASSIFICATION		STAFFING FORMULA
A. PERSONAL SERVICES (continued)		
2. ADMINISTRATION (continued)		
d. Clerical Support		
(1) Office Supervisor	1.0 position :	RC
(2) PBX/Mail/File Clerk	3.0 positions :	RC
(3) Executive Secretary	2.5 positions :	RC
(4) MD/Psychologist Secretary II	1.0 position :	2 Physicians in Item 1.a.(3)(a), SB 1038 Health Reviews
(5) MD/Psychologist Secretary I	1.0 position :	2 Physicians/Psychologists in Items 1.a.(1)(a) and (b), Clinical Intake and Assessment
(6) Secretary II	1.0 position :	6 professionals in Items: 1.a.(3)(b), SB 1038 Health Reviews 1.b.(9) and (10), DDS Incidental Medical Care Regulations 1.c., Quality Assurance/ Quarterly Monitoring 1.e.(1), (2) and (9)(a) and (b) Community Services 1.e.(9)2., Community Services (see Secty I, line 1.e.(9)1., below) 1.f.(1) thru (3), Special Incident Reporting 2.b.(1), Federal Program Coordinators (FFP Phase I) 2.b.(2), Federal Compliance Coordinators (FFP Phase II) 2.c., Information Systems and Human Resources
(7) Secretary I	1.0 position :	6 professionals in Items: 1.a.(1)(c) and (d), Clinical Intake and Assessment 1.b.(1) to (5) and (8), Intake/Case Mgt. 1.b.(6) and(7) Capitol People First 1.d., Early Intervention 1.e.(3), (4), (6) to (8), Community Services 1.e.(9)1., Community Services (see Secty II, line 1.e.(9)2., above)

ATTACHMENT B

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE ADDED SERVICES

PUBLISHED BY

FRANK D. LANTERMAN REGIONAL CENTER

REGIONAL CENTER OPERATIONS:

UNIQUE VALUE-ADDED SERVICES

Over the years, as the state legislature has sought acceptable strategies to resolve repeated budget shortfalls, stakeholders in the developmental service system have offered a variety of remedies to reduce costs. Proposed solutions have included changing or reducing the entitlement defined by the Lanterman Act, implementing parental cost-sharing or co-payment requirements, cutting reimbursement to service providers, and reducing funding to regional centers and developmental centers.

One proposal to achieve savings in regional centers has been to cut regional center "operations". Those who recommend this as a solution argue that this would do no more than reduce "red tape," and that taking money away from what some perceive to be strictly administrative functions would leave more money for purchasing services for clients.

This argument fails to recognize that the vast majority of activities classified as operations in the regional center budget are actually direct services to clients and their families. As stated in the Lanterman Act, it was the intent of the Legislature that "the design and activities of regional centers reflect a strong commitment to the delivery of direct service coordination and that all other operational expenditures of regional centers are necessary to support and enhance the delivery of direct service coordination and services and supports identified in individual program plans (Section 4620)."

Most "operations" activities are direct services to clients and families.

In conceptualizing the model for the regional center system, the legislature found that "the service provided to individuals and their families by regional centers is of such a special and unique nature that it cannot be satisfactorily provided by state agencies." They reasoned that the array of services and supports required by people with developmental disabilities and their families was so complex that the necessary coordination could not be successfully managed by any existing agency. For this reason, the legislature made the decision to contract with private non-profit community-based agencies to be the organizing hub and center for coordinating services. The mission of these organizations – called regional centers – was two-fold: to ensure that people with developmental disabilities would be afforded the opportunity to live independent, productive and normal lives alongside their non-disabled peers in the community; and to minimize the risk of developmental disabilities and ameliorate developmental delays in infants and young children who are at risk.

In this paper, we attempt to show why the term "operations" when applied to the vast majority of activities of the regional center is a misnomer. We clarify what is included in this category and how many of these activities are more accurately described as direct services to clients and families. While regional centers do have an administrative role, it is small in comparison to the range of direct services provided by regional center staff to clients and families.

We begin by looking at the overall regional center budget and how funding is allocated within centers between purchase of service and operations. While most of this information is derived from Lanterman Regional Center, the general findings can be applied to the other regional centers in California.

How Regional Center Funds are Allocated

The regional center receives funding for two purposes:

- purchasing services for clients and families from community service providers (POS); and
- operating the center, including, for example, paying staff salaries and office rent and purchasing supplies and telephone service (Operations).

Figure 1, below, provides a graphical representation of the relative amounts of the regional center budget that are apportioned to POS and Operations. As can be seen from this chart, POS accounts for approximately 87% of the total regional center budget. The remaining 13% is allocated between what is often called *general administration* (2%) and activities that are *direct services* (11%) to clients and families.

Figure 1

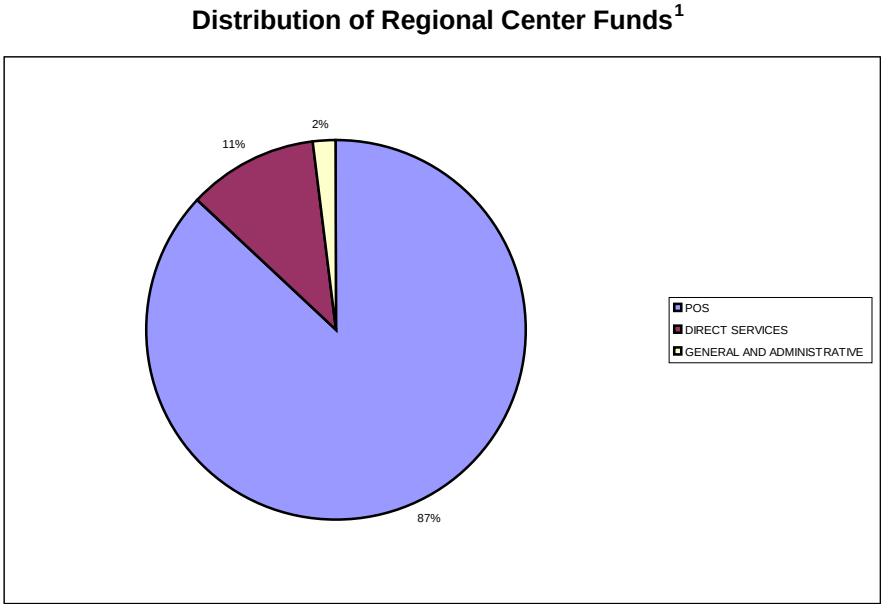
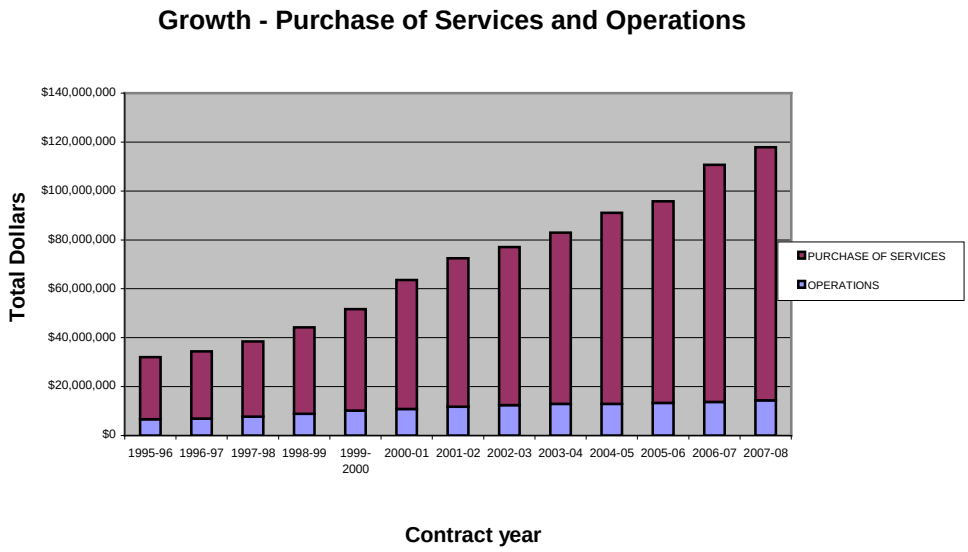


Figure 2, below, illustrates the comparative increases in purchase of service and total operations expenditures between 1995-96 and 2007-08.

[1] Figures are taken from Lanterman Regional Center independent audit report for 2007.

Figure 2



The figure shows that, during that 12-year period, POS expenditures grew at almost twice the growth rate for operations. In 1995-96, "operations" equaled 21% of the regional center budget, whereas currently this category accounts for slightly less than 13% of spending.

Regional centers have not received cost-of-living adjustments since 1991-92.

What is not shown in *Figure 2* is the significant disparity between regional center staff salaries as reflected in the "core staffing formula" used by DDS to fund centers and the actual salaries of regional center staff as demanded by the marketplace. The core staffing formula originally keyed regional center salaries to the mid-range salary of the equivalent state positions at the time each regional center position was added to the formula. Until 1991-92, regional center positions received annual cost-of-living adjustments equivalent to the adjustment received by state employees but the state ceased making these adjustments in 1991-92. From that year until the present, with one exception, the state has not authorized cost-of-living adjustments for regional center staff. The exception occurred in 1998-99 when the state authorized a one-time increase in the core staffing salary for service coordinators. This was in response to controversy surrounding a report[2] concluding that the risk of death increased for people moving from the developmental center into the community.

To highlight the disparities resulting from the failure to adjust regional center salaries, *Table 1* below compares salaries as reflected in the core staffing formula with actual salaries for two regional center positions.

[2] Strauss, D. J. and Kastner, T. A. (1996). Comparative mortality of people with mental retardation in institutions and the community. *American Journal of Mental Retardation* **101**, 26-40.

Table 1

Position	Core Staffing Salary	Regional Center[3] Average Salary
Service Coordinator	$34,032	$42,500
Accounting Associate	$18,397	$36,162

Currently, the actual salaries for LRC staff exceed the total in the core staffing formula by slightly more than 20%. Regional centers adjust for these disparities by employing fewer people than are allocated in the core staffing formula.

OPERATIONS: WHAT DOES IT INCLUDE?

In this section, we take a closer look at what is included in the operations category. We begin by looking at the direct services provided by regional center staff.

Service Coordination for Clients over Age 3

Service coordination consists of a unique set of responsibilities assigned to regional centers by the Lanterman Act. It is the cornerstone service provided by the regional center. This service is universally received by every client and is central to ensuring that the service system meets every client's needs.

Lanterman Regional Center employs approximately 110 professionals who help plan and coordinate services for 7,400 children and adults living at home, in the community, and in the developmental center. These service coordination activities occur in face-to-face meetings as well as via mail, telephone, and e-mail communications. Service coordinators (SCs) work with clients and families on the development of person-centered plans, called Individual Program Plans, or IPPs, and they conduct annual reviews of these plans.

For clients living in licensed residential homes and supported living, SCs also conduct quarterly face-to-face reviews at the home. LRC has approximately 1,000 clients living in these two settings and, for many of them who have no family or others to advocate for them, the SC plays a major role in ensuring that they receive the services, supports, and other opportunities that they need to be active members of their community. In 2007, SCs conducted more than 1,800 IPPs and 3,700 annual reviews, and nearly 4,000 additional quarterly face-to-face visits to clients' homes.

Service coordinators provide IPP development and periodic review, authorization of services, review of client progress, residential monitoring, assistance with IEPs and ITPs, linkage with generic services, advocacy, and crisis intervention.

[3] The regional center data reflects findings of a July, 2007 Hewitt Associates survey of compensation at 9 Southern California regional centers.

As part of each annual review, the SC also completes a health status review, intended to ensure that the client is receiving the recommended medical, mental health, and dental care, and an annual assessment of client adaptive behavior (the Client Development and Evaluation Record, or CDER). SCs whose clients live in a licensed home also participate with staff of the center's Community Services Department in monitoring the quality of services provided in those settings.

Prior to receiving most types of purchased services, a client is formally assessed to determine the necessity and appropriateness of the proposed service. SCs receive and review these reports and, if services are determined to be necessary, identify programs or professionals to provide the services and issue authorizations to purchase services. In many cases the search for a provider requires multiple phone calls to find a provider who is both appropriate and has the capacity to take on a new client. This is a particular problem with regard to speech therapy. Service coordinators typically contact three or four providers before identifying one who will accept a client. In some cases, service coordinators have been required to contact up to ten therapists.

For those clients who receive services, providers are required to submit periodic reports reflecting their progress toward achieving the goals identified in the service plan. Service coordinators have a quality control responsibility - reviewing such reports for all of their clients to ensure that appropriate services are accessed and that the client is making progress toward the stated goals. All reviews and authorizations – for new services, for continuations, and in situations where families or clients request changes in vendors, dates of service, etc. – must be completed in a timely manner so that there is no delay or interruption in services. An SC typically completes between 100 and 200 individual authorizations in a month.

SCs are responsible for receiving and reviewing medical records and, for children in school, Individual Educational Programs (IEPs) and Individual Transition Plans (ITPs). They also help parents prepare for IEP meetings and, at parents' request, attend the IEP and ITP meetings to help the parents advocate for needed services.

Family Cost Participation Program. Service coordinators play a role in implementing the Family Cost Participation Program, begun in 2005 and applying to families of children ages 3 to 17, inclusive, who are not covered by Medi-Cal. This program requires parents to share in the cost of certain services purchased by the regional center for their children. SCs review circumstances of families that meet the criteria for participation in this means-tested program, explain the program to the parents, obtain the required financial information for eligible families, and submit it to the center's fiscal monitor. During 2007, 257 additional families were evaluated for participation and 101 were assessed a share of cost. The number of families evaluated is expected to increase since, in 2008, the program was expanded to included children age birth to 3 receiving early intervention services.

Service Coordination for Children under Age 3 (Early Start)

Early Start is California's name for its early intervention program for children age 0 – 3. Lanterman Regional Center currently serves 1,330 children in this program. For these children, SCs coordinate development of an Individualized Family Service Plan (IFSP) every year and

review that plan every six months. In 2007, SCs completed 1,225 IFSPs and 407 six-month reviews.

Early Start SCs provide outreach and case finding through activities such as maintaining liaison relationships with six neonatal intensive care units serving the Lanterman area. They also have been very successful in helping toddlers gain entry to typical (integrated) preschools. In 2007, 480 children (more than 90% of the center's preschool age clients) were enrolled in community-based preschools.

In 2007, Early Start service coordinators helped more than 90% of the center's preschool age clients enroll in typical preschools in the community.

Children receiving early intervention services are evaluated a second time, when they reach 2 ½ years of age, to determine whether they will be eligible for continued regional center services after age 3. As a result of the services provided through the Early Start program, approximately two-thirds (68%) of these children have caught up with their typical peers and they "graduate out" of the program. These children are no longer eligible for regional center services, although some of them – for example, children with specific learning disabilities – may receive specialized services through the school district. For these children as well as for children who will remain regional center clients, Early Start service coordinators work with families to ease their transition into the public school program.

Coordination of Services

SCs are the *primary contact linking clients and families with services and supports* needed to implement IPPs and IFSPs. They must ensure cooperation and collaboration across agencies and service providers in the interest of clients. This linkage may be to public and community agencies serving the general public, such as the schools, the Department of Rehabilitation, and Social Security, or it may be to regional center authorized service providers. SCs monitor the service relationships to ensure that they are effective in helping clients achieve their desired outcomes, and they intervene when problems or questions arise. These responsibilities require SCs to maintain intensive communications, both verbal and written, with community agencies, direct service providers, and clients and families.

Social work responsibilities. In addition to their service coordination responsibilities, SCs do a significant amount of case management in the social work tradition. (Early in the history of regional centers, SCs were social workers.) For example, they routinely deal with a range of crises experienced by their clients and families, including parents attempting to come to terms with a new diagnosis. They also cope with issues related to domestic violence, divorce, eviction and homelessness, food insecurity, and death or illness of a primary caregiver. Particularly with younger adult clients, they may be called upon to become involved with law enforcement or the courts when a client is thought to have committed a crime.

Information. The SC is the primary keeper of information about the client, the services he or she receives, and significant events in his or her life. This responsibility involves a significant amount of clerical work that arguably would be more appropriately handled by clerical or

secretarial staff if they were available. In the early 1990s, budget pressures caused regional centers to reduce operations costs by eliminating selected support staff. As a result, for example, service coordination units at Lanterman Regional Center were left with one secretary to support 10-12 service coordinators and a regional manager. As a consequence, SCs responsibilities include word processing, handling their own mail, copying, and filing.

Community Placement Plan.

As the primary mechanism for implementing the state's commitment to moving people out of state developmental centers (DCs), Community Placement Plans are created by all regional centers and submitted to DDS for approval. These plans include the identification of DC residents whose needs, as judged by their ID teams, can be met in a community residential setting. For each of these individuals, the ID team assesses their support needs and preferences, and, in partnership with the regional center's Community Services Department, identifies or develops residential and other resources to support these clients in the community.

Lanterman's Community Living Options (CLO) team of four Community Living Specialists (CLS) currently provides specialized service coordination to 62 clients who have moved to the community from a developmental center under the Community Placement Plan. At this time, 101 individuals continue to reside in the DC and the appropriateness of community placement for these residents is discussed at every IPP meeting. An enhanced caseload ratio required for the CLO team (1:45) allows for monthly visits for the first six months after community placement, quarterly progress reviews, annual IPP development and semi-annual review, court reports, and special resource development and re-direction efforts to assist and maintain community placement. CLO staff are also responsible for "deflecting" clients in the Lanterman community who are at risk of being committed to a DC.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move.

Transitioning a person out of a DC into the community can take a year or more of planning and another six to twelve months of client visits to the new home – ranging from a brief introduction, to a few hours, to a few days – before the final move. Since some DC residents are in that placement as the result of a judicial order, the transition process includes a series of court hearings and formal reports to keep the court informed about the status of the transition.

Federal and state laws, reinforced by judicial decisions, support the right of people with disabilities to live in the least restrictive setting. Parents or other family members, however, may be comfortable with the services their relative is receiving in the DC and reluctant to engage in what they view as "change for change sake." Staff of developmental centers are also sometimes resistant to residents leaving their protective environment. A major role for CLO service coordinators, therefore, is to develop a trusting relationship with the family that can serve as the basis for a mutual partnership focused on obtaining an appropriate home for the client in the community. Once such a relationship is developed, SCs work with the family and DC staff in identifying an appropriate community resource, orienting them to what will be necessary to support the client in this less

restrictive living arrangement, and working closely with them in an ongoing way as the transition progresses.

Coordination of appeals. The responsibility for appeals coordination, including both informal appeals at the regional center level and formal hearings with the Office of Administrative Hearings, rests with the division of Client and Family Services. In 2007, a total of 30 requests for fair hearing were filed in the following categories:

- Eligibility – 14 (47%)
- Intensive services for autism – 5 (17%)
- Legal services – 3 (10%)
- Other services – 8 (27%)

Emergency response. Regional center staff respond to urgent situations and emergencies after hours and on weekends. Clients, families, and service providers can contact an on-call staff person 24 hours a day, 7 days a week through the center's emergency line. The most frequently encountered emergency situations include clients who go missing, instances of potential abuse, emergency hospitalizations requiring consent from the regional center, and emergency placements (e.g., for clients whose family has an urgent need for respite). Calls from police departments are also common. When a person with no identification and an inability to communicate is brought to the attention of police, they frequently call the regional center seeking help in identifying the individual. The person may not be a client of the regional center called or may not even be a regional center client, but rather a person with a serious mental illness. In any case, the regional center is expected to provide assistance to the police in their attempt to identify the individual.

Managing risk. Service coordinators, in collaboration with staff of the center's departments of Community Services and Clinical Services, have the primary responsibility for investigating Special Incidents. Special Incidents are occurrences that potentially threaten the health or welfare of clients. Because of their potential serious consequences for the client, they must be handled expeditiously. The service coordinator and other involved staff members must immediately turn their full attention to the investigation of the incident. A service coordinator whose caseload consists of clients living in licensed homes typically has 1 – 2 special incidents to investigate per week, each of which requires a minimum of 3 to 4 hours. The most time consuming type of Special Incident investigation, potential abuse, requires an average of 8-10 hours to complete.

Special incidents include events such as unexpected hospitalizations, physical injury, lost or missing clients, and suspected abuse. The aim of a Special Incident investigation is to intervene quickly to resolve a problem, to determine whether the occurrence was preventable and, if it was, to develop strategies or interventions to prevent a recurrence.

In 2007, Lanterman staff members investigated and resolved 1903 Special Incidents. Many of these investigations required the service coordinator to intervene on behalf of the client with a community agency such as a hospital, the Department of Children and Family Services, the Department of Mental Health, a law enforcement agency or court, Adult Protective Services, or the county's Public Guardian Office. The center's Risk Management Committee monitors

Special Incidents at the aggregate level to determine if there are any systemic issues warranting action by the regional center – for example, implementation of training initiatives, changes to policies or procedures, or the development of new services and supports.

Targeted Case Management (TCM) Program. As a condition of the state obtaining federal financial participation in the funding of regional centers, service coordinators are required to document all of their direct service activities in the interdisciplinary (ID) notes section of their clients' records. The federal government has imposed strict requirements on this documentation – for example, services must be described precisely and in a specific format, and time must be recorded in 15-minute increments. This information is submitted by the regional center to the Department of Developmental Services on a monthly basis. DDS, in turn, bills the federal government for these services. The TCM program brings approximately $140 million in federal funding into the state each year.

Advocacy

The Lanterman Act assigned to regional center service coordinators the role of front line advocate, assisting clients and families in exercising their civil, legal, and service rights. In 1997 funding for advocacy was removed from regional center budgets and transferred to the Office of Client Rights Advocacy, but the primary responsibility for advocacy remains with regional centers and is an important function of service coordinators. SCs represent clients' interests with service providers in the community as well as with generic services such as the school system and the Department of Rehabilitation. In 2007, service coordinators attended Individual Education Program (IEP) meetings for more than 460 clients, and they helped more than 937 families gain inclusion for their sons and daughters in regular classrooms with their typical peers.

Service coordinators helped 937 families gain inclusion for their sons and daughters in regular classrooms with typical peers.

SCs also serve a critical advocacy function helping clients and families achieve and maintain eligibility for entitlements such as Medi-Cal and SSI, and they assist families dealing with criminal justice and immigration matters. For a majority of clients who become involved with the criminal justice system, regional center service coordinators are asked by the court to write a diversion plan to be implemented in lieu of incarceration. In this activity, they work with the public defender or probation department to create a plan of education, restitution, or correction with a goal of preventing the client's future involvement with the justice system. In these cases, service coordinators are required to monitor the client's progress on the plan and submit periodic reports to the court on the client's status.

Through the Koch-Young Resource Center, described below, the center offers an 8-hour course for Lanterman families to help them become more effective advocates for their family member with a disability. This course, called Service Coordinator and Advocacy Training (**SCAT**), is conducted four times a year, three times in English and once in Spanish. The center also offers more specialized educational and training opportunities to help families further sharpen their advocacy skills and learn about services and benefits available for their sons and daughters. These classes focus on transition into school, the individual educational program (IEP) process, transition from school to work, and SSI and employment benefits.

Clients are able to develop and practice their own self-advocacy skills though involvement with the regional center's governance board and committees and the Client Advisory Committee . They are also currently attempting to organize a local chapter of People First.

Three formal self-advocacy experiences, are available to adult clients through the center's Training and Development Department. These programs, which are the responsibility of the center's Peer Advocate, include:

- Women's Reproductive Health Self-Advocacy Training: A peer-advocacy-based training program for women with developmental disabilities; topics include basic anatomy, menstruation, menopause, pregnancy, sexually transmitted diseases, contraception, the importance of women's health exams, and using self-advocacy to communicate with your doctor.
- Abilities: A sexual abuse and exploitation risk-reduction program for adults with developmental disabilities, including topics such as what is sexual abuse, assertiveness training, self-esteem and communication, personal safety training, and what to do if a person is ever sexually abused or assaulted.
- Project Prepare: Disaster preparedness training for clients.

Resource Center staff also recruit students, arrange sites for, and coordinate delivery of two additional programs which are offered by outside organizations. These programs are:

- Get Safe: A personal safety program for adults, teens, and children, including topics such as assertiveness training, community safety awareness, setting limits, defining boundaries and creating healthy relationships.
- SHASTA: A sexual health and safety program for teens and adults.

Intake and Assessment

Intake staff members oversee the process through which prospective clients are assessed to determine whether they are eligible for regional center services – i.e., are at risk for a developmental disability or have such a diagnosis and are substantially handicapped. The Intake Unit completed 1,617 intake and assessments during 2007, completing the process within legally mandated time frames. Approximately 70% of these intakes were for infants and toddlers under age 3.

Regional center are allowed 45 days from the time of the first phone call from a family to complete the development of an Individual Family Serivce Plan for children under age 3.

Intake timelines for the Early Start program are particularly stringent. While 120 days is allowed for completing intake and assessment for applicants over age 3, for children under 3 regional centers are allowed only 45 days from the time of an initial phone call from a family to complete the development of the Individualized Family Service Plan (IFSP). During this time period regional center staff must meet with the family; ensure that formal assessments are completed; review assessment reports and consult with clinical staff to determine eligibility; decide, in cooperation with the family, what services and supports will be provided; complete the writing of the IFSP; and initiate the purchase of services.

For prospective clients who are determined not eligible for regional center services, intake and assessment staff serve as a source of information and referral to other public and private resources that might meet their needs and the needs of their families. These staff members also engage in outreach activities with agencies such as the Department of Children and Family Services, the Department of Mental Health, homeless shelters, and the Los Angeles City jail, to enhance case finding and ensure that referrals made by these agencies are appropriate.

Clinical Services

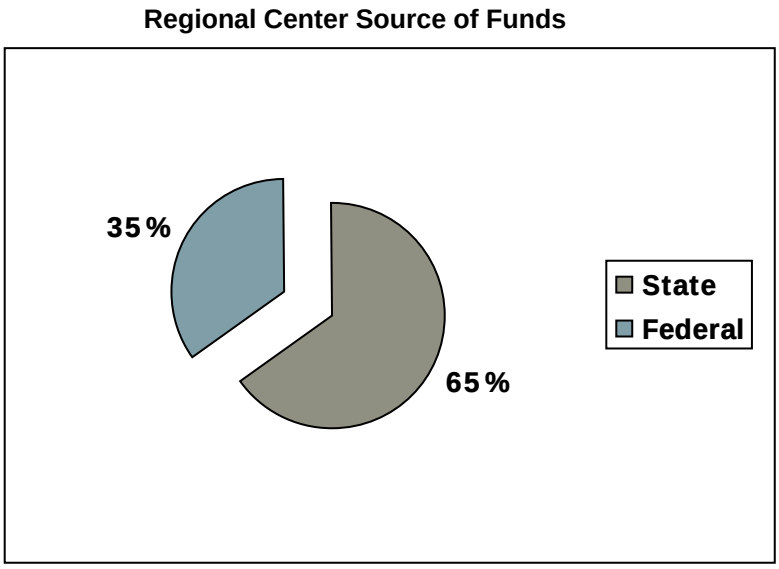
Using an interdisciplinary team approach, Clinical Services specialists conduct a variety of activities aimed at ensuring and improving the health and well-being of clients. Nurses, physicians, psychologists, a dental hygienist, and a dentist are involved in:

- individual clinical assessments of clients;
- review of services being provided to clients by community professionals, and direct consultation with these professionals;
- consultations with service coordination staff on specific clients' health issues;
- consultation with and technical assistance to service providers;
- participation in annual review meetings for clients who have significant health related issues or concerns;
- review of requests for the use of psychoactive medications with clients;
- consultation with service coordination staff on Medicare Part D issues;
- oversight of the review process required under the federal Nursing Home Reform program;
- review of requests for surgical and other interventions from medical professionals, consultation with those professionals about the requests, and providing consent, as appropriate, when no other party is authorized to assume this responsibility;
- mortality review in all cases of client death.

The center's Bio-ethics Committee reviews requests from physicians or families to impose a "Do Not Resuscitate Order" or order hospice or palliative care for a client. The committee develops a report with recommendations for the Executive Director who makes the final decision and forwards it to the institution's Bio-ethics Committee.

Medicaid Waiver. A major activity of Clinical Services is certification and annual re-certification of clients for eligibility under the Home and Community Based Waiver (HCBW) program. This is a collaborative effort of Clinical Services staff and service coordinators, and is part of a program that brings a very substantial amount of federal funding into the developmental services system. Approximately 1,900 of Lanterman's 7,400 clients are currently certified for the waiver. This number represents a 20% increase from the 2006 waiver enrollment. Statewide, the HCBW program brings more than $750 million into the Developmental Services system. *Figure 3* on the following page gives a graphical representation of the portion of the regional center system budget that is covered by federal financial participation, including Medicaid Waiver and Targeted Case Management. As can be seen, these federal funds constitute slightly more than one-third of the total budget for regional centers.

Figure 3



The Clinical Services Department also develops and manages special projects targeted at objectives such as improved dental health, prevention of unnecessary hospitalization, ensuring appropriate use of medications in group homes, enhanced access to psychiatric services, and improved support for aging clients to enable them to "age in place" in the community. For these projects, the regional center has partnered with organizations such as USC Schools of Medicine and Dentistry; UCLA Schools of Medicine, Dentistry, and Nursing; University of the Pacific Special Needs Dentistry; the Semel Institute at UCLA, Childrens Hospital Los Angeles, and LA Care and Health Net Health Plans.

Family Support

The Koch-Young Resource Center (KYRC) is dedicated to the provision of information and support to clients and families and to the professionals who support them. The Center maintains a Help Desk and associated telephone Help Line that responded to approximately 3,000 information and referral requests in 2007. It contains a multimedia lending library housing thousands of educational materials available to clients, families, service providers, and members of the larger community. Nearly 1,200 individuals are registered users of the library.

Nearly 1,200 individuals are registered users of the Koch-Young Resource Center Library.

During 2007, KYRC staff distributed over 1,000 Welcome Kits to new regional center families. These kits contain materials of general interest to new families as well as information that is specific to their children's disabilities. They also publish the ***Viewpoint*** newsletter and support the Lanterman web site, both critical tools for communicating with the Lanterman community. In 2007, the web site had approximately 30,000 unique visitors who viewed more than 70,000 unique pages. During the summer of 2007, the center launched the Network of Care through the center's website. This is a searchable database of more than 975 community resources that

integrate children and adults with developmental disabilities into regular programming and activities with their non-disabled peers. The network listing is continually updated and expanded.

The Resource Center currently coordinates 19 family support groups providing mutual support, education, information sharing, and advocacy. A service coordinator is involved in each of these groups in partnership with and as a mentor for the parent who acts as co-facilitator. The Resource Center also coordinates 3 client support groups and two intensive Sibling Support Groups for children and adolescents whose siblings are regional center clients. It also maintains the Peer Support Program where approximately 40 experienced parents are actively involved in offering one-to-one emotional support and information to families who are new to the center or families who request a partner for a specific purpose.

The KYRC coordinates the regional center's volunteer program. In 2007, approximately 20 volunteers, most of whom are clients, completed over 1,200 hours of volunteer effort on tasks such as mass mailings. Through the KYRC, the regional center has also developed internship opportunities intended to bring young people with non-traditional backgrounds, such as business and the sciences, into the regional center to apply their knowledge and skills while learning about developmental services. The capstone of that effort is the Roberta Happe Memorial Internship, established in 2001.

The Resource Center has been instrumental in developing and maintaining partnerships with community-based organizations with a goal of expanding educational, skill-building, and other opportunities for people with disabilities. In partnership with the Los Angeles Unified School District, Lanterman hosts two computer training classes each semester for clients, family members, and caregivers. As of the end of 2007, 120 students had graduated from these classes with beginner and intermediate computer skills. Up to 60 students are served in each class series and each series is offered four times per year.

The KYRC also maintains partnerships that offer more inclusive opportunities for people with disabilities in programs serving the general public. Such partnerships have been created with Community Technology Centers, offering clients who complete computer classes at LRC an opportunity to transition to advanced training in the community, and local public libraries to provide clients with a variety of opportunities generally available to the wider community.

Assistive Technology Project. Another valued component of the KYRC is the Assistive Technology Project (ATP) that provides consultations, information, and advice to clients and families of clients who might benefit from the use of technology to learn, communicate, or complete activities of daily living. This project is the result of a partnership between Lanterman Regional Center and the Assistive Technology Exchange Center (ATEC), a division of Goodwill of Orange County. The project has provided more than 40 AT "labs" where parents can explore assistive technology options, more than 500 consultations and 200 individualized assessment of need, and 4 AT workshops for service providers. The regional center also partnered with the USC Occupational Therapy program to offer an OT internship focused on assistive technology.

Quality Assurance and Improvement Activities

Residential services. The Community Services Department is responsible for a range of activities mandated by Title 17 and aimed at ensuring the health, safety, and well being of clients living in licensed homes and improving the quality of services provided there. Regular monitoring visits to group homes and other residential settings are also intended to ensure that the residents' rights are protected, that residents' personal funds are being appropriately managed, and that residential staff are helping residents maximize opportunities to participate in the life of the local community. Regional center staff also provide technical assistance and training to service providers to increase their skills and enhance the quality of services they provide. Four Community Services staff members currently monitor 120 homes, 13 of which are Community Placement Plan (CPP) homes.

The monitoring function requires regional center staff to conduct two unannounced visits to each licensed home each year. The regional center is also required to conduct an announced in-depth, day long, comprehensive team evaluation of each home every three years. Given the broad scope of the team evaluation, the Service Coordinator who acts as liaison to the home participates as a member of the team. The Quality Assurance staff conduct the mandated exit interview with the residential provider and write the evaluation report within the mandated timelines.

CPP homes are specialized homes for people moving out of the state developmental center. Given the complex and often intense needs of these clients, the Quality Assurance staff conduct quarterly monitoring of CPP homes to ensure that the client's needs are being met and their health and safety are being ensured.

Homes that do not meet regulatory standards are required to implement Corrective Action Plans. Quality Assurance staff provide technical assistance in development of these plans and they conduct additional unannounced visits to ensure that they are implemented appropriately. They also conduct two subsequent unannounced visits to ensure that the home continues to meet expectations of the CAP.

For all newly vendored residential providers, Quality Assurance staff conduct an orientation and two technical assistance visits in addition to the other required visits. The orientation and technical assistance visits aim to ensure that new providers understand and satisfy regulatory requirements and regional center expectations.

Work-related services. The four Community Services staff members who monitor licensed homes have additional mandated responsibilities with regard to work programs. These activities are aimed at ensuring that work programs are providing paid work opportunities to clients in a safe environment, and that work programs are in substantial compliance with national accreditation standards. Community Services staff provide technical assistance and training to these providers as needed or requested. Lanterman staff currently monitor 10 work programs. These responsibilities were transferred to the regional center from the Department of Rehabilitation in 2004, but no funding accompanied the transfer.

Other services. Community Services Quality Assurance staff members annually monitor day programs, independent living services (ILS), and supported living services (SLS) programs to ensure that they meet regulatory requirements and regional center expectations. These staff members provide technical assistance and training to these providers as needed or requested. They currently monitor 23 day programs, 10 ILS programs and 13 SLS programs. The center's budget does not include staffing to perform monitoring for these three types of services.

Complaint investigations. Community services staff investigate all complaints against vendored service providers. Depending on the nature of the complaint and the number of people who must be interviewed, a complaint investigation requires between one and five days. Community Services staff provide technical assistance and training to these providers as needed. A meeting is held with the provider to discuss the complaint and the findings of the investigation team. Following the meeting, a letter is sent to the provider summarizing the complaint, the results of the investigation, and any further actions needed. Community Services staff participated in 91 of these investigations in 2007.

Resource Development

The Community Services Department is responsible for ensuring that the service system includes the types and numbers of services necessary to meet the service needs of the more than 7,400 children and adults with developmental disabilities in the Lanterman service area. This responsibility includes the entire range of services – e.g., living options, day programs, work programs, autism services, and therapeutic services.

Resource Specialists provide technical assistance to all potential service providers, reviewing regulatory requirements and regional center procedures and expectations, and reviewing the vendor application packet to ensure that those who request vendorization are qualified to meet the needs of people they intend to serve. Site visits are conducted for all potential center-based services and transportation companies to ensure that a safe environment exists. Licenses and credentials, where applicable, are verified. Therapists who seek to conduct in-home services are required to submit three professional references, and these are verified. While not mandated by Title 17, these precautions are taken to ensure the health, safety and well being of all regional center clients who will potentially receive services from the provider.

Because the Centers for Medicare and Medicaid Services promote choice, residential and community based non-residential programs are required to prepare a program design that describes the services to be provided, curriculum, staff qualifications and training, and more. Community Services staff read each program design and provide written feedback to the potential provider. The average program design is 50 pages in length and is typically revised several times before it meets Title 17 standards and satisfies regional center expectations.

The Resource Developer also ensures that appropriate services are developed for clients moving into the community from developmental centers via the Community Placement Plan. These resources are specialized and require community services staff to do increased monitoring, technical assistance and training to ensure the client's needs are met.

Vendorization

The regional center's vendor list includes thousands of providers in the Lanterman area, each of which has a record that must be maintained and updated when changes are made to the provider's name, address, telephone number or rate, or when the provider begins providing a new service. This information must also be made available to other regional centers that use the service provider.

Families wishing to purchase their own diapers, respite, pre-school programs, or transportation are also required to be vendored and must work with community services staff to complete an application and obtain a vendor number. Clients and families seeking to be reimbursed for purchases they made for authorized services or products also must be vendored. The regional center newly vendored 128 providers and made changes to 386 vendor files in 2007.

The regional center requires that providers maintain appropriate insurance coverage as a condition of doing business with the center. A separate database is maintained by the regional center to ensure that providers purchase insurance and renew it annually. Reminder notices are sent to providers who fail to provide proof of annual renewal of coverage.

Client Benefits Coordination

Three staff members in the center's Administrative Services Department spend 100% of their time coordinating client benefits. They are responsible for managing the SSI funds and other public benefits for approximately 1125 clients for whom the regional center is the representative payee. These are clients who are unable to manage their own finances and have no family or other appropriate representatives able or willing to help them with this responsibility. These three staff members currently manage more than $9 million in clients' funds. They also manage the processing of applications for Supplemental Security income, Medi-Cal, and other programs for these 1125 clients as well the annual re-determination of eligibility for these programs. Finally, these employees process an additional 2,000 forms that are required by Social Security Administration for a variety of purposes.

Fiscal Monitoring

One staff member coordinates the development of and monitors more than 84 contracts related to the center's operations and purchase of service activities. Nearly 90% of these contracts pertain to direct services provided to clients. This task is essential to ensuring careful stewardship of funds entrusted to the regional center. The fiscal monitor completed 45 vendor audits in 2007, 11 of which were required, and coordinated recovery of overpayments. She also shares responsibility with service coordination staff for implementation of the Family Cost Participation Program. She receives income information on eligible families and assesses an appropriate share of cost for families who are determined to be participants. In the three years since the inception of this program, 459 families have been reviewed and 252 have been assessed a share of cost for services, as prescribed by law. With the expansion of this program to Early Start clients, the number of families involved in this program each year is expected to increase.

Training

The regional center creates, conducts, and coordinates a wide range of educational and skill development activities for clients, families, service providers, and regional center staff. A director and 1¼ members staff develop, coordinate, and conduct training programs tailored to the needs of clients, parents, services providers, and regional center staff. In 2007, they oversaw the delivery of or conducted 112 programs, including sexuality and socialization skills, personal safety, disaster preparedness, transition to work training, and leadership development. The center also supported the participation of 359 clients, parents, staff members, and providers in 111 local, state, and national conferences.

GOVERNANCE AND ADMINISTRATION

In terms of the entire budget, governance and administration costs – everything other than purchase of services and regional center direct services to clients and families – account for slightly more than 2% of total expenditures. We now take a closer look at what is included in that portion of the budget.

Board and executive activities. The regional center is a community-based, non-profit organization governed by a volunteer board of directors that includes parents, clients, and other interested citizens. The Board along with its executive staff has primary accountability to ensure that the center meets the requirements of all applicable federal and state laws and regulations, including those required for federal financial participation, and of its contract and performance plan with the state Department of Developmental Services, The Board has also committed the center to four strategic initiatives that are critical for our clients and their families: inclusion, information and technology, affordable housing, and employment.

The executive director and senior staff work together to create a climate of accountability and an environment that promotes quality, innovation, and cost-effectiveness within both the center and the center's network of community service providers. The Board and executive group also provide vision and leadership for the creation of special projects intended to enhance the service system and the quality of services provided. A particularly successful example of such projects is the UCLA/NPI/Lanterman Special Psychiatric Clinic.

Accounting and payment functions. The accounting department is charged with ensuring fiscal accountability within the center and among community service providers. In a typical month this department:

- inputs approximately 4,300 initiations, changes, or terminations to POS authorizations;
- adds about 166 new vendor records to the system;
- prints an average of 4,600 invoice forms for POS;
- prints an average of 2,400 checks, about 95% of which are to community providers and families for services delivered to clients;
- makes payments for more than 350 family voucher users.

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Information technology support. One manager and three staff members support all mainframe and personal computer activities of the center. The center's mid-range mainframe computer handles client and financial data on most regional center activities and generates thousands of checks each month. Staff write and revise programs (250 in 2007) to analyze data and generate reports.

IT staff also support the personal computer use of 200 regional center employees. Their activities include training, technical support, help desk response, and maintenance and replacement of computer equipment and peripherals. In addition, these four individuals manage internal networks such as e-mail, shared files, and internet access; they coordinate disaster preparation efforts related to technology; and they assist staff with proprietary software systems that have been installed for specific projects and to automate center functions.

Human resources (HR) functions. The HR Department manages activities necessary to attract and retain knowledgeable, committed, competent staff able to carry out the complex mission of the regional center. In order to ensure that the center can continue to attract and retain such staff, HR personnel are constantly reviewing benefit programs (health, disability insurance, etc.) to provide maximum value to the center and its employees. In 2007, the HR staff worked with the appropriate units in recruiting 39 new hires, 19 of whom were service coordinators. This required the screening and interviewing of hundreds of applicants. HR staff also administer all aspects of personnel including payroll and performance evaluation.

Coordinating annual giving. The HR Department oversees a range of giving programs that, in 2007, brought the center more than $97,000 in cash and gift donations for clients and families.

Operations management. One manager and 2.5 staff members support the center's reception and mail functions. These include 15,000 pieces of mail sent out each month and hundreds of phone calls per day through the switchboard in addition to the calls routed through the automated call distribution system. This unit has the responsibility for coordinating the cleaning and maintenance of the physical plant including more than 40,000 square feet of floor space; they coordinate the ordering of office supplies and are responsible for maintenance, repair and replacement of office equipment; and they manage more than 3,000 boxes of records stored off-site. Finally, they coordinate overall disaster preparations, including the replenishment of supplies.

Insurance. Additional costs to the center's operating budget are incurred by items such as liability insurance and workers' compensation insurance. With no additional funds coming from the state, costs of such coverage have affected the regional center in the same way they have affected service providers. At the same time, interest earnings, used by centers to fund part of their operating budgets, are down dramatically. In 2006-2007, Lanterman had about $710,000 in interest earnings. For 2207-2008, that figure will be about $600,000, a loss of $110,000 in real dollars. This amount would support the hiring of two service coordinators.

Whether referred to as operations or regional center direct services, the activities described in this document are of direct and obvious benefit to clients and families and are value added to the service delivery system as a whole.