Evaluation of Senate Bill 962 Pilot Project—Final Report

Prepared for

The California Department of Developmental Services

Prepared by

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EXECUTIVE SUMMARY

INTRODUCTION

The Lanterman Developmental Disabilities Services Act (AB 3800-3809), a California law enacted in 1976 gives people with developmental disabilities the right to receive services and supports that allow them to make decisions and choices about how and with whom, they want to live their lives; achieve the highest self-sufficiency possible; and lead productive, independent and satisfying lives as part of the communities in which they live.

Many strides have been made to complete the goals outlined in the Lanterman Act. However, a gap remained in the continuum of community-based care available to persons with developmental disabilities that also have special health care and intensive support needs. This specific population requires a higher level of professional staffing than other persons with developmental disabilities living in community based facilities. To meet the needs of this population, the California legislature passed Senate Bill 962 (SB 962), which established the Adult Residential Facility for Persons with Special Health Care Needs Pilot Project. The California Departments of Developmental Services (DDS) and Social Services (DSS) are jointly responsible for the SB 962 pilot project.

As a requirement of the statute, DDS contracted with the Center for Human Services at the University of California, Davis, Extension, to conduct an independent evaluation of this SB 962 pilot project. Site visits were conducted between January 18, 2008 and May 25, 2009. All consumers were transitioned to these homes by the end of March 2009, but, as a result of the rolling timetable in which evaluation site visits were conducted, not all homes were at full capacity at the time of the evaluation team's final site visit. Thus, not all of the homes were operating at capacity during the evaluation period. This document is the final report from the evaluation.

METHODOLOGY

Evaluation Questions

This evaluation examines the following areas as outlined in SB 962:

1) The number, business status, and location of all SB 962 homes.
2) The number and characteristics of the consumers served.
3) The effectiveness of the Pilot Project in addressing consumers' health care and intensive support needs.
4) The extent of consumers' community integration and satisfaction.
5) Consumers' access to, and quality of, community-based health care and dental services.
6) The types, amounts, qualifications, and sufficiency of staffing.
7) The overall impressions, problems encountered, and satisfaction with the SB 962 service model by SB 962 home employees, regional center participants, state licensing and monitoring personnel, and consumers and families.

8) The cost of all direct, indirect, and ancillary services.
9) An analysis and summary of findings of all SB 962 consumer special incident reports and other events reported during the evaluation period.
10) [1]The recommendations for improving the SB 962 service model.
11) The cost-effectiveness of the SB 962 model of care compared with other existing public and private models of care serving similar consumers.

Participants

Participants in the present evaluation include 75 of the 88 consumers[2] residing in 23 SB 962 homes. Two hundred and seventy-two[3] (79%) of the 346 staff[4] members from these 23 homes participated, as did 30 (40%) family members of the 75 consumers participating in the evaluation.

Data Collection Period

Data collection took place from January 1, 2008 through June 15, 2009. Data were collected through site visits to the SB 962 homes and through surveys from January 18, 2008 through May 25, 2009 (see Section 2.4 Procedures). Focus groups and key informant interviews were primarily held between April and June 2009. Throughout the evaluation period new homes were opening and consumers were being placed. As a result of the rolling timetable in which site visits were conducted, not all SB 962 homes were operating at full capacity at the time of the evaluation team's final site visit.

Procedures

The evaluation team conducted initial site visits to each of the 23 SB 962 homes and follow-up site visits to 10 of the SB 962 homes. The evaluation team's medical consultants reviewed consumers' files to document the consumers' characteristics, their health care and intensive support needs as well as to assess the quality of the health care and support services they receive in the homes. Staff members were given survey packets to complete and to mail back to the evaluation team. Staff members reported on their employment positions, qualifications, satisfaction, consumer quality of life, and consumer satisfaction. These staff members also helped consumers report on their own satisfaction with similar aspects of the SB 962 homes, when possible. Administrators provided information about staffing, staff training, and staff qualifications.

Survey packets were also mailed to the family member(s) identified on each consumer's Community Living Options document around the time of each site visit to the home.

[1] The results related to recommendations are integrated throughout the results sections for items 1-9 and 11 rather than being presented in their own section.
[2] The conservators for 13 consumers declined to have the consumer participate in the study. The term "declined" is used to describe conservators who, verbally declined participation or who the evaluation team was unable to reach after multiple attempts by phone and mail correspondence.
[3] This is an unduplicated number of staff that participated in the evaluation.
[4] Throughout this report the term "staff" refers to direct care personnel. Individuals that do not interact directly with consumers are not included in this use of the term.

Family members reported on their satisfaction and general impressions with the SB 962 homes. They also provided information regarding their contact with consumers.

A series of focus groups and interviews with key informants was also conducted. Key Informants included representatives from DSS, DDS, the three Regional Centers participating in the SB 962 pilot project, administrators, staff, family members and Hallmark, the master developer of the homes.

RESULTS

1) The number, business status, and location of all SB 962 homes.

Key Findings

- This evaluation includes 23 SB 962 homes with a total capacity of 110 consumers.
- Two thirds of the SB 962 homes are operated by non-profit organizations.
- The largest number of homes (six) is in the city of San Jose. The remaining homes are located in surrounding cities throughout the Bay Area of California.

2) The number and characteristics of the consumers served.

Key Findings

- Consumers have multiple developmental disabilities; the most common combination of disability diagnoses was profound mental retardation coupled with seizure disorder and cerebral palsy.
- Consumers also have a broad range of medical conditions and have high levels of health care needs; almost all require cardio-respiratory monitoring and oxygen support, and 100% require manual fecal impaction removal, enemas, or suppositories.
- Most consumers require total assistance with bathing, dressing, hygiene and grooming, toileting, and transferring.
- All require some level of nutritional support.
- Few consumers have a need for behavioral plans and few have been diagnosed with mental illness.
- The vast majority of consumers are non-verbal, non-ambulatory, and many have vision problems.
- Consumers meet the eligibility requirements to reside in the SB 962 homes.

Recommendations: None

3) The effectiveness of the Pilot Project in addressing consumers' health care and intensive support needs.

AND

5) The Consumers' access to, and quality of, community-based health care and dental services.

Key Findings

- Individual Health Care Plans (IHCP) are effective and are a key strength of the SB 962 model.
- Consumers have access to licensed nursing care 24 hours per day, seven days per week.
- The quality of health care is good and meets standards.
- At the time of the evaluation team's final site visits dental sedation resources, although limited, were continuing to be developed in the community.
- Primary care physicians in the community provide accessible, quality care.
- Some consumers have experienced improvements in health conditions and/or level of functioning.
- The few consumers with behavioral concerns have experienced improvements.

Recommendations: None

4) The extent of consumers' community integration and satisfaction.

Key Findings

- Many consumers go on a variety of outings in the community. Other consumers have not yet experienced outings. Considerations affecting outings include staff concerns about consumers' medical fragility, insufficient availability of extra licensed staff to accompany consumers, and the length of time consumers have resided in the homes.
- Several of the SB 962 homes have successfully brought community members into the home to visit with consumers.
- Consumers appear to be satisfied with their lives in the SB 962 homes.
- Some consumers show improvements in happiness and mood.

Recommendations: None

6) The types, amounts, qualifications, and sufficiency of staffing.

Key Findings

- The types, qualifications, and sufficiency of staffing meet and/or exceed the requirements of SB 962.
- The role of the RCs is crucial to ensuring sufficient staffing (numbers of licensed and total staff per shift; administrator hours on-duty per week) for SB 962 consumers who often require staffing above the minimums.
- Some administrators and staff members who meet the SB 962 staffing requirements would benefit from additional and/or earlier training to succeed in caring for SB 962 consumers in the community.

Recommendations

The evaluation team recommends that the parties responsible for the interagency coordination of the project, including RC nurses, reconvene to consider making a few key changes to training requirements for administrators and staff. Potential revisions may include these provisions:

- Require training specific to the unique roles, responsibilities and expectations of administrators of community-based facilities, or equivalent prior experience. This training should include a hands-on mentoring component.
- Mandate administrators complete the 35 hour administrator certification program, without exception (no challenge test).
- Require that staff receive training on the unique roles, responsibilities and expectations of working in a community-based facility prior to, or directly upon beginning work in the home.
- Mandate that staff receive hands-on training related to the specific care and support needs of the individual consumers with which they are working directly upon beginning work.
- All staff must complete training that covers IHCP and teaches how to translate the plans into direct care. Direct care personnel must demonstrate competency with hands-on care shortly after employment.

7) The overall impressions, problems encountered, and satisfaction with the SB 962 service model by SB 962 home employees, regional center participants, state licensing and monitoring personnel, and consumers and families.

Key Findings

- A high degree of satisfaction with the impact of the SB 962 homes for consumers.
- Staff are mostly satisfied with their working conditions and feel well-supported.
- Most administrators feel overwhelmed and would benefit from additional training and supports from RCs and/or provider organizations.
- Most family members are satisfied with the SB 962 homes.
- Some family members are concerned about access to medical care in the community.
- Families are pleased with the quality of care their loved ones receive and many report visiting consumers more often now that they live in the SB 962 homes.
- Some family members would like more regular communication with the homes and regional centers.

Recommendations

The evaluation team does not recommend any changes to SB 962 based on these findings. However, please refer to the recommendations for Staffing (question 6) as they are also relevant to the findings on satisfaction of key personnel.

8) The cost of all direct, indirect, and ancillary services.

Key Findings

- Average costs per SB 962 home range from approximately $90,000 to $100,000 per month.[2]
- Average monthly property costs per SB 962 consumer is approximately $4,000.
- Average monthly residential services and supports cost per SB 962 consumer is approximately $15,000.
- Ancillary costs are very minor with two RCs having no Ancillary costs while the third had only $291.00 in costs.

Recommendations: None

9) An analysis and summary of findings of all SB 962 consumer special incident reports and other events reported during the evaluation period.

Key Findings

- Consumers had a variety of Special Incidents and other events.
- The most common types of Special Incidents were admissions to the hospital for respiratory illness or internal infection.
- Special Incidents were generally handled very well.
- A minority of Special Incidents and other events appeared to have been preventable.

Recommendations

Based on these findings and those outlined in the section on Staffing, the evaluation team recommends that the parties responsible for the interagency coordination of the project, including RC nurses, reconvene to consider making a few key changes to the required training for staff of SB 962 homes. Please refer to the list at the end of the section on Staffing.

11) The cost-effectiveness of the SB 962 model of care compared with other existing public and private models of care serving similar consumers.

Key Findings

- The SB 962 homes are cost-effective.
- The SB 962 homes cost per consumer is less than private and public modalities of care serving similar consumers.

Recommendations: None

[2] Figure based on five-bed facilities.

CONCLUSIONS

In conclusion, the results from this evaluation highlight the overall success of the SB 962 pilot project. Although the project faced some challenges during implementation, key personnel involved in the project have worked hard to ensure that these challenges did not compromise consumers' health or well-being. Findings show that consumers are receiving high quality care and have good access to health care in their homes and in the community. Moreover, the SB 962 model appears to be cost-effective and to have contributed in meaningful ways to consumers' health, quality of life, level of functioning, and overall happiness.

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1. INTRODUCTION

The Lanterman Developmental Disabilities Services Act (AB 3800-3809), a California law enacted in 1976 gives people with developmental disabilities the right to receive services and supports that allow them to make decisions and choices about how and with whom, they want to live their lives; achieve the highest self-sufficiency possible; and lead productive, independent and satisfying lives as part of the communities in which they live.

Many strides have been made to complete the goals outlined in the Lanterman Act. However, a gap remained in the continuum of community-based care available to persons with developmental disabilities that also have special health care and intensive support needs. This specific population requires a higher level of professional staffing than other persons with developmental disabilities living in community based facilities. To meet the needs of this population, the California legislature passed Senate Bill 962 (SB 962), which established the Adult Residential Facility for Persons with Special Health Care Needs Pilot Project. The California Departments of Developmental Services (DDS) and Social Services (DSS) are jointly responsible for the SB 962 pilot project.

As a requirement of the statute, DDS contracted with the Center for Human Services at the University of California, Davis, Extension, to conduct an independent evaluation of this SB 962 pilot project. Site visits were conducted between January 18, 2008 and May 25, 2009. All consumers were transitioned to these homes by the end of March 2009, but, as a result of the rolling timetable in which evaluation site visits were conducted, not all homes were at full capacity at the time of the evaluation team's final site visit. Thus, not all of the homes were operating at capacity during the evaluation period. This document is the final report from the evaluation.

2. METHODOLOGY

2.1 RESEARCH QUESTIONS

This evaluation examines the following areas as outlined in SB 962:

1) The number, business status, and location of all SB 962 homes
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8) The cost of all direct, indirect, and ancillary services
9) An analysis and summary of findings of all SB 962 consumer special incident reports and other events reported during the evaluation period
10) The recommendations for improving the SB 962 service model
11) The cost-effectiveness of the SB 962 model of care compared with other existing public and private models of care serving similar consumers

2.2 DATA COLLECTION PERIOD

Data collection took place from January 1, 2008 through June 15, 2009. Data were collected through site visits to the SB 962 homes and through surveys from January 18, 2008 through May 25, 2009 (see Section 2.4 Procedures). Focus groups and key informant interviews were primarily held between April and June 2009. Throughout the evaluation period new homes were opening and consumers were being placed. As a result of the rolling timetable in which site visits were conducted, not all SB 962 homes were operating at full capacity at the time of the evaluation team's final site visit.

2.3 PARTICIPANTS

Participants in the present evaluation include 75 of the 88 consumers[5] residing in 23 SB 962 homes. Two hundred and seventy-two (79%) of the 346 staff members from these 23 homes participated, as did 30 (40%) family members of the 75 consumers participating in the evaluation.

2.4 PROCEDURES

The evaluation team conducted initial site visits to each of the 23 SB 962 homes and follow-up site visits to 10 of the SB 962 homes. Initial site visits took place an average of 3.39 months (with a range of one to nine months) after the first consumer was placed in

[5] The conservators for 13 consumers declined to have the consumer participate in the study. The term "declined" is used to describe conservators who, verbally declined participation or who the evaluation team was unable to reach after multiple attempts by phone and mail correspondence.

each home. During both the initial and follow-up site visits, the evaluation team's medical consultants reviewed consumers' files to document the consumers' characteristics, their health care and intensive support needs as well as assess the quality of the health care and support services they receive in the homes. Files that were reviewed include the Individual Consumer files, Special Incident Report files, the Medication Administration Records, and the Flow charts or Daily Information files that contain data about vital signs, weights, and notes on medical visits.

During the site visits, staff members were given survey packets to complete and to mail back to the evaluation team. Staff members reported on their employment positions and qualifications, and rated their satisfaction with working conditions. Administrators identified staff members who knew each consumer best, and the evaluation team asked those staff members to complete a survey regarding consumer quality of life and consumer satisfaction with their lives in the SB 962 homes (home, other consumers, staff, outings, activities, and overall life). When possible, these staff members also helped consumers report on their own satisfaction with similar aspects of the SB 962 homes. Administrators provided information about staffing, staff training, and staff qualifications.

Survey packets were also mailed to the family member(s) identified on each consumer's Community Living Options document around the time of each site visit to the home. Family members reported on their satisfaction and general impressions with the SB 962 homes. They also provided information regarding their contact with consumers.

During the last few months of the evaluation period, a series of focus groups and interviews with key informants was also conducted. Key informants consisted of experts in their respective areas related to the SB 962 project (representatives from DSS, DDS, the three RCs participating in the SB 962 pilot project, and Hallmark Community Solutions, the master developer of the homes) and key individuals involved in the implementation and day to day experience of the SB 962 consumers and homes (administrators, staff, family members).

2.5 MEASURES

This section of the report outlines the measures utilized during the site visits and in the surveys. Copies of the measures are included in Appendix B.

Consumer Demographics and Characteristics

The evaluation team developed the *Consumer Common Data Template* to gather information regarding consumer demographics, characteristics, and other data needed to respond to the evaluation requirements set forth in SB 962. The Template was developed to provide basic descriptive information about consumers, their medical conditions and needs, and the effectiveness of the SB 962 homes in addressing consumers' medical and support needs. The template was designed to provide a single form that would capture data from various sources in consumer records (e.g., data from care home staff, RC and DDS assessments and plans, medical and allied health

consultants, information from consumers' previous placements, and outpatient medical, emergency, and hospital data as appropriate).

This measure was adapted from a similar assessment instrument used in an earlier evaluation conducted by this contractor. This instrument was developed in consultation with medical professionals on the evaluation team that were familiar with consumer files and the types of data needed to assess quality of care. Specific item contents and formats were adapted to meet the needs of the current project and were reviewed by members of the evaluation team and DDS prior to its use to ensure that the information collected met the needs of the Department and the intent of the legislation.

The section of the *Consumer Common Data Template* measuring consumer demographics and characteristics provided information regarding consumer's age, gender, ethnicity, legal decision makers and conservators, mental illnesses, medical conditions, and sensory functioning such as vision, hearing, and communication.

Consumer Health Care and Intensive Support Needs

The *Consumer Common Data Template* (described above) was used to assess the specific aspects of consumer health care and intensive support needs outlined in SB 962.

Quality of Medical and Health Services

The *Consumer Common Data Template* (described above) was used to collect information in order to assess the quality of medical and health services provided to consumers of the SB 962 homes as outlined in SB 962. The medical consultants from the evaluation team developed a set of standards from which to judge the appropriateness of medical and health services provided to consumers. These standards were based on detailed health guidelines for adults with developmental disabilities (Massachusetts Department of Mental Retardation, University of Massachusetts Medical School's Center for Developmental Disabilities Evaluation and Research, 2003) and other current health and medical guidelines for preventive care (Centers for Disease Control and Prevention, 2007; U.S. Department of Health and Human Services, 2007) as well as the standards outlined in SB 962, and were approved by the DDS prior to the first site visit.

Special Incident Reports and Other Event Reports

This evaluation assessed special incidents and other events in two ways. First, the evaluation team's medical consultants completed the *Consumer Common Data Template* that includes a section on special incidents and other events and how these incidents and events were handled by staff members of the SB 962 homes. The evaluation team's medical consultants used this form to track all special incidents that are reportable under the California Code of Regulations, Title 17, as well as those events outlined in SB 962 and Health and Safety Code 1538.55 that are not reportable under Title 17. A second source of information for special incidents that are reportable

under Title 17 was the database of special incidents housed by DDS. SB 962 homes are required to report special incidents to the RC within 48 hours. The RC then reports the incident to DDS.

Consumer Satisfaction

Consumer satisfaction was assessed in three ways. First, the *Personal Well Being Index* (Cummins, Eckersley, Lo, Okerstrom, Hunter & Davern, 2004; Cummins, Eckersley, Pallant, Van Vugt & Misajon, 2002) was used to collect information regarding consumer satisfaction from individual consumers who were able to respond to interview questions. The staff member who was identified as knowing each of the consumers best asked the consumers a series of nine questions regarding their happiness with their health, safety, home, doing things, learning or making things, money or things they have, people they live with, life in general, and how things will be later in life. Each item was rated on a three point pictorial scale with 1 = "unhappy" (sad face), 2 = "neither happy nor unhappy" (neutral face) and 3 = "happy" (smiley face). Consumers responded by pointing to the appropriate face or otherwise indicating their response.

Consumer satisfaction was also reported by staff and by consumers' family members using a survey designed for use in the present evaluation. This survey is equivalent for family and staff members and was developed, in part, based on similar items from the *Adult Family Survey* and the *Adult Consumer Survey of the National Core Indicators* (National Association of State Directors of Developmental Disabilities and the Human Services Research Institute, 2003). Staff and family members were asked to rate how happy they thought the consumer was with six items including the place that he/she lived, the people that he/she lived with, the staff, the day program, opportunities and activities, and his/her life overall. Items were rated on a six point scale from 1 = "unhappy" to 5 = "happy."

Family Satisfaction

Consumers' family members reported on their own satisfaction with the SB 962 homes through a family survey. This survey was modeled after the one utilized in the *Pennhurst Longitudinal Study* (Conroy & Bradely, 1985) that assesses family satisfaction and the frequency of family contact with consumers in both institutional and community settings. Only those items related to satisfaction with community settings were used for the purposes of this evaluation. The modified survey utilized in the present study included three questions about overall satisfaction with services after placement in community-based homes, each rated on a five point scale from 1 = "very dissatisfied" to 5 = "very satisfied." The survey also included nine items regarding satisfaction with the residence and 14 items about the community-based services, all of which were rated on a five point scale from 1 = "very poor" to 5 = "excellent." Finally, family members were asked the extent to which they believe that all of the services their relative needed were available in the community, rated on a 5 point scale from 1 = "strongly disagree" to 5 = "strongly agree."

Community Integration

The level of community integration experienced by consumers residing in the SB 962 homes was assessed by the *Life Circumstances Questionnaire (LCQ)* (Young, Ashman, Sigafoos, & Suttie, 1996). The *LCQ* was originally designed as a semi-structured interview in a study of older people with mental retardation living in the community (Ashman, Hulme, and Suttie, 1991). The *LCQ* can also be used as a questionnaire with proxy respondents; this is how it was used in the present evaluation. The *LCQ* has been used with proxy respondents in research studies with participants who have severe and profound intellectual disability, limited behavioral repertoire, and/or no communication skills. It is completed by a staff member or caregiver that knows the consumer well. The *LCQ* assesses a variety of aspects of consumers' lives including material well-being, well-being, community integration, daily routines, self-determination, contact with family and friends, and residential well-being.

The community integration subscale of the *LCQ* contains 13 items regarding the frequency of consumer's access to and use of community activities and resources (e.g., shopping, bank, park, church, etc.). Items were rated on a six point scale from 0 = "never" to 5 = "weekly." Information regarding the other person(s) with whom the consumer participated in these activities (e.g., group, staff, friends, family, alone) was also obtained. The community integration scale also included two items regarding trips or vacations. Additionally, the *LCQ* includes a seven item scale regarding consumers' participation in formal structures and activities such as training and employment programs that was omitted from the present study.

Additionally, the evaluation team developed a set of questions to assess the extent to which consumers experience aspects of the community within the SB 962 homes. Staff were asked to report whether consumers ever experience visits from community members or organizations (such as volunteers from schools or community groups, holiday carolers, neighbors, etc.) in the home and if so, how often these visits occur (rated from 1 = "yearly" to 6 = "weekly").

Staffing

The evaluation team developed the *Facility Survey* to address the research objectives regarding staffing patterns outlined in SB 962. Administrators of the homes listed the positions, licenses or certifications, work schedules, and trainings related to the SB 962 homes for each of their staff members including themselves. Administrators also completed two more specific questions about their own qualifications. Staff members of the SB 962 homes also reported on their own work experience, positions, and qualifications in the *Staff Survey* developed by the evaluation team to assist in addressing staff-related research questions. The evaluation team also consulted the SB 962 homes' Facility Program Plans as an additional data source related to staffing patterns and qualifications, as needed.

Staff Satisfaction

The evaluation team developed the *Staff Survey* to collect information regarding staff members' opinions on a variety of topics including the SB 962 homes, the services provided to consumers, staffing allocations, working conditions, training, work schedules, salaries and benefits. For the purposes of the present report, the items were grouped into two rating scales: "the community-based home model and implementation," and "working conditions." Staff members rated the extent to which they agreed with each statement from 1 = "disagree" to 4 = "agree."

Overall Impressions

In addition to the measures described above, the evaluation team's medical consultants charted notes during and after the site visits to the SB 962 homes to capture any observations and experiences from the site visits that may have helped to address the research questions in SB 962. Findings from these notes are incorporated as general comments and impressions throughout the results section of this report.

Cost and Cost Effectiveness

Financial data has been obtained from DDS, Bay Area Housing Corporation, Hallmark, each of the RCs, online sources for housing information and other institutions of care for similar consumers (e.g., Laguna Honda Hospital), and the Center for Human Services. Additionally, information from the contracts/agreements for each SB 962 facilities was collected from each of the individual Facility Program Plans. Various financial issues have been discussed with the appropriate personnel (e.g., HCBS waiver with DDS personnel).

The *Consumer Common Data Template* was used to ensure the validity of the cost comparisons. The demographics and characteristics of the consumers of SB 962 homes as derived from the *Consumer Common Data Template* was the basis used to match consumers in comparable care modalities. In addition, the Special Incidence Reports section of the *Consumer Common Data Template* ensured that the number of special incidences reported and not reported corresponded.

Costs are divided into direct, indirect, and ancillary costs. However, direct and indirect costs are accounting terms equivalent to an economist's fixed and variable costs. Also, several additional monetary issues were discussed including future housing cost differences, as a result of the Bay Area Housing Plan (BAHP).

Costs are categorized by the RC. There should be no value judgment placed upon cost differences by the RC. The variation in costs by the RC is most likely derived from numerous external influences such as physical location or governmental barriers to development, such as zoning issues, or number of consumers per SB 962 home. By categorizing costs according to the RC, information for an individual consumer is avoided and consumers are intrinsically grouped within a SB 962 home that, in turn, is grouped within a Service Provider and then by the RC. Classifying costs by the RC

provided the level of fiscal detail deemed necessary for this study without extraneous and unnecessary details.

The basic standard for a cost effectiveness assessment is to select among competing wants whenever resources are limited. These techniques were first developed by the military and subsequently applied to health care in the mid-1960s. If an intervention or health care modality is determined to be "cost-effective," and it has the same intrinsic meaning, then the new intervention is a good value. An oft over-looked conundrum is that a strategy that saves money may not be cost-effective while one that is cost-effective may not save money. Cost-effectiveness requires a value assessment on what is a good price for an additional or superior outcome. It is also necessary to note that cost-effectiveness presupposes a comparison to another care modality but is only useful if the new strategy is both more effective and more costly (or similarly, less effective and less costly). Hence, strictly speaking, cost-effectiveness is not applicable when the outcome is 'better" and is cheaper to implement. In this cost-effectiveness analysis it is therefore assumed that care in the SB 962 homes is at least as good as it is in the other care modalities. Hence, if the cost of the SB 962 homes is lower than the comparable care modalities, then cost-effectiveness, in an economic sense, is not relevant. Thus, cost differences was the metric used to determine cost-effectiveness.

The SB 962 evaluation study complies with the Centers of Medicare and Medicaid Services (CMS) requirements for calculating and reporting cost-effectiveness.

CMS' Technique for Evaluating Cost-Effectiveness

Essentially, the cost-effectiveness assessment consists of the following:

1. The projected costs for the relevant time period were determined by agreements between the RCs, DDS staff, and home operations entities.
2. Actual expenditures for the relevant time period were collected for the available time period.
3. Actual costs were determined for comparable modalities of care and projected for the relevant time period.
4. The difference between the sum of the SB 962 projected expenditures and comparable modalities' expenditures was determined.
5. Cost effectiveness was demonstrated when the projected expenditures for SB 962 homes were less than or equal to the projected expenditures for comparable modalities of care.

The time period used to assess actual program costs of SB 962 facilities was 12 months. For homes which had been in operation less than 12 months, a compilation of actual and projected costs, equaling 12 months, was used.

2.6 DATA ANALYSIS

Evaluation questions were examined with the data from the most recent site visits and surveys, impressions of the evaluation team's medical experts, the results of the focus groups, and interviews with key informants. Evidence was triangulated across these sources, whenever it was available, through multiple methods.

Data from Site Visits and Surveys

Analysis of the data from site visits to the SB 962 homes and surveys from staff, administrators, and family members was examined quantitatively. The focus of these analyses was to reveal findings that represented the majority, or average, of respondents. Whenever possible, these data were analyzed for changes over time from the first to the last site visit/survey was conducted using all available data. Analyses of change employed paired-sample t-tests and Analysis of Variance to test whether changes that were observed between two or more points in time were statistically significant. Following convention, findings that were significant at the $p < .05$ level were reported as statistically significant.

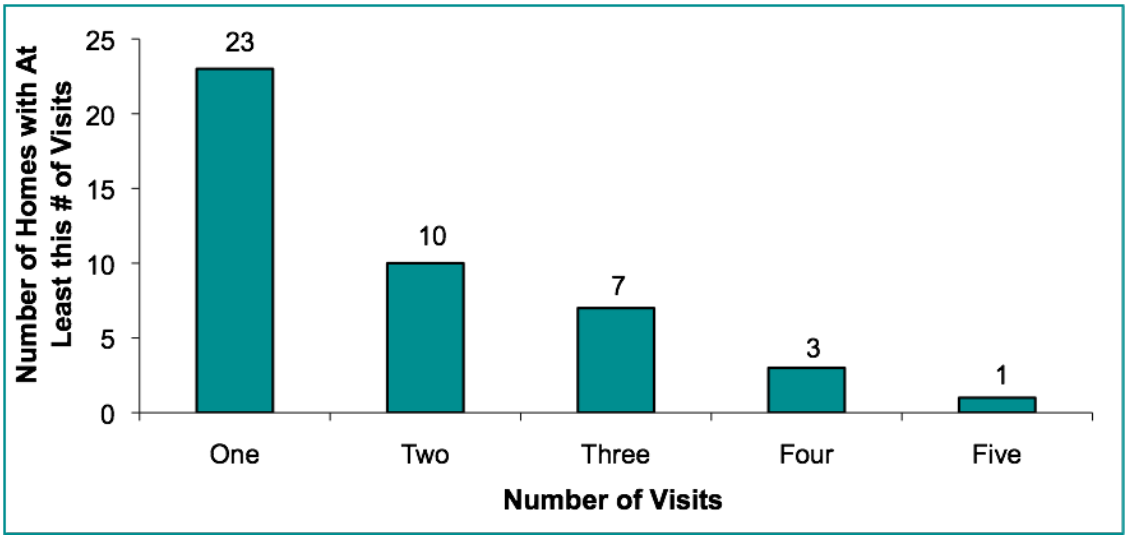
Data from Focus Groups and Interviews

Focus groups and interviews with key informants were audio taped and transcribed. Transcripts were then analyzed through standard qualitative data analysis procedures. Using grounded theory principles (Glaser, 2004), transcripts were first examined using open coding to identify common themes without pre-conceived notions about coding categories to ensure the grounding of the theory in the data. Once core themes had been identified, the transcripts were re-coded using systematic coding procedures.

2.7 METHODOLOGICAL CHALLENGES

The evaluation faced a few methodological challenges during implementation that affected the number of visits to each SB 962 home. Figure 1 illustrates the number of visits conducted at each SB 962 home prior to the end of the evaluation's data collection period (May 31, 2009). As shown in the figure, 23 homes had *at least* one visit, 10 homes had *at least* 2 visits, and 7 homes had *at least* 3 visits.

Figure 1. Numbers of Site Visits to SB 962 Homes



3. RESULTS

3.1 STATUTE: 4684.74 #1: THE NUMBER, BUSINESS STATUS, AND LOCATION OF ALL SB 962 HOMES

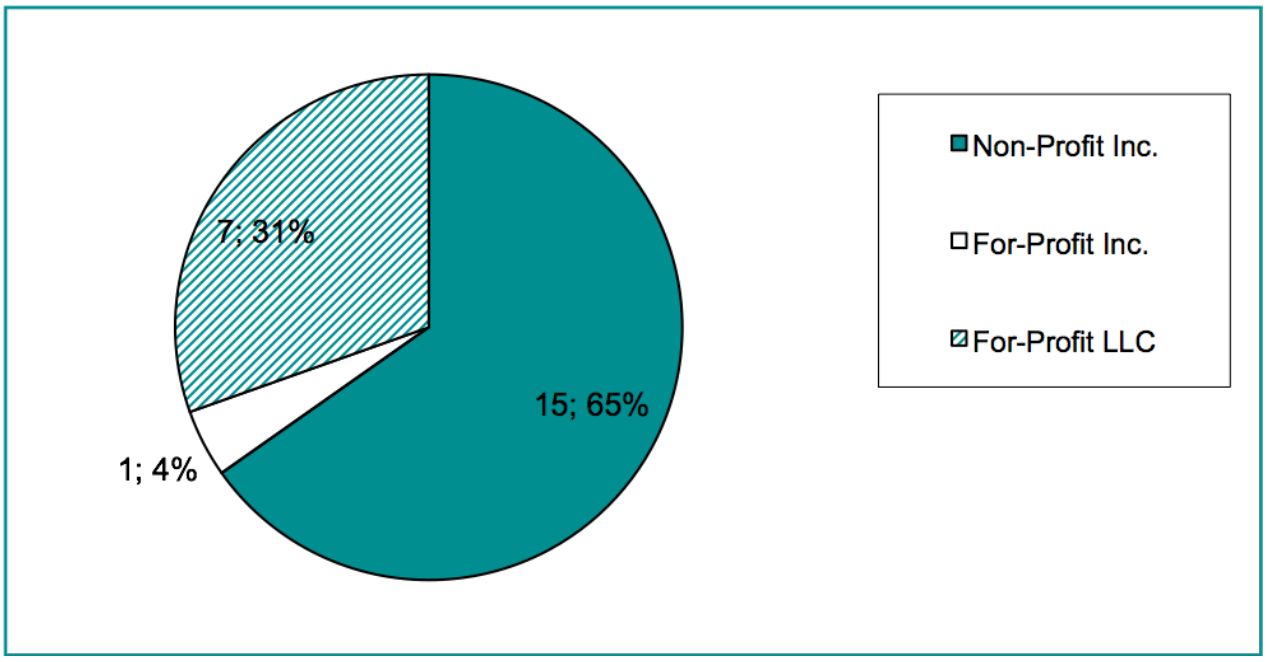
3.1.1 Number

This evaluation includes 23 SB 962 homes with a total capacity of 110 consumers

3.1.2 Business Status

Figure 2 shows the business status for the 23 SB 962 homes that are included in this final evaluation report. Fifteen (65%) of the homes are operated by a non-profit corporation. Seven (31%) homes are operated by a for-profit limited liability corporation and one home (4%) is run by a for-profit corporation.

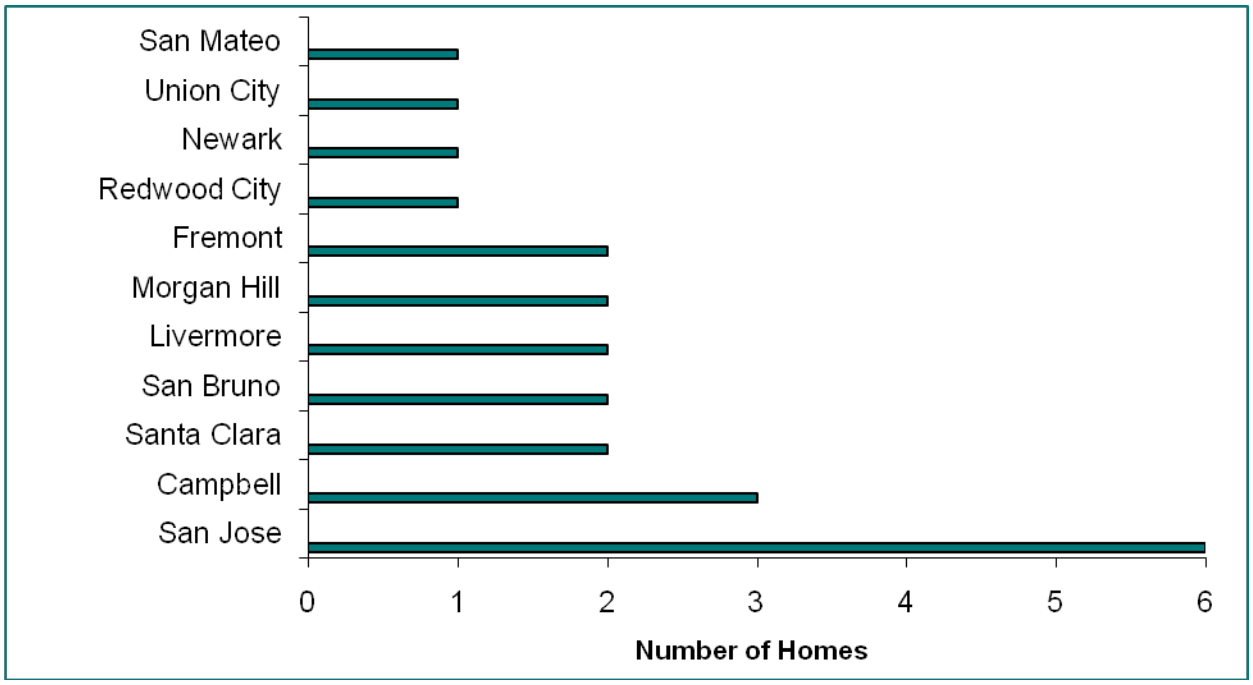
Figure 2. Business status of SB 962 homes



3.1.3 Location

Figure 3 depicts the locations of the SB 962 homes. The largest number of homes (N=6) is in San Jose. The remaining homes are located in surrounding cities throughout the Bay Area of California.

Figure 3. California cities in which SB 962 homes are located



3.1.4 Summary and Recommendations

Findings presented in this section show the following:

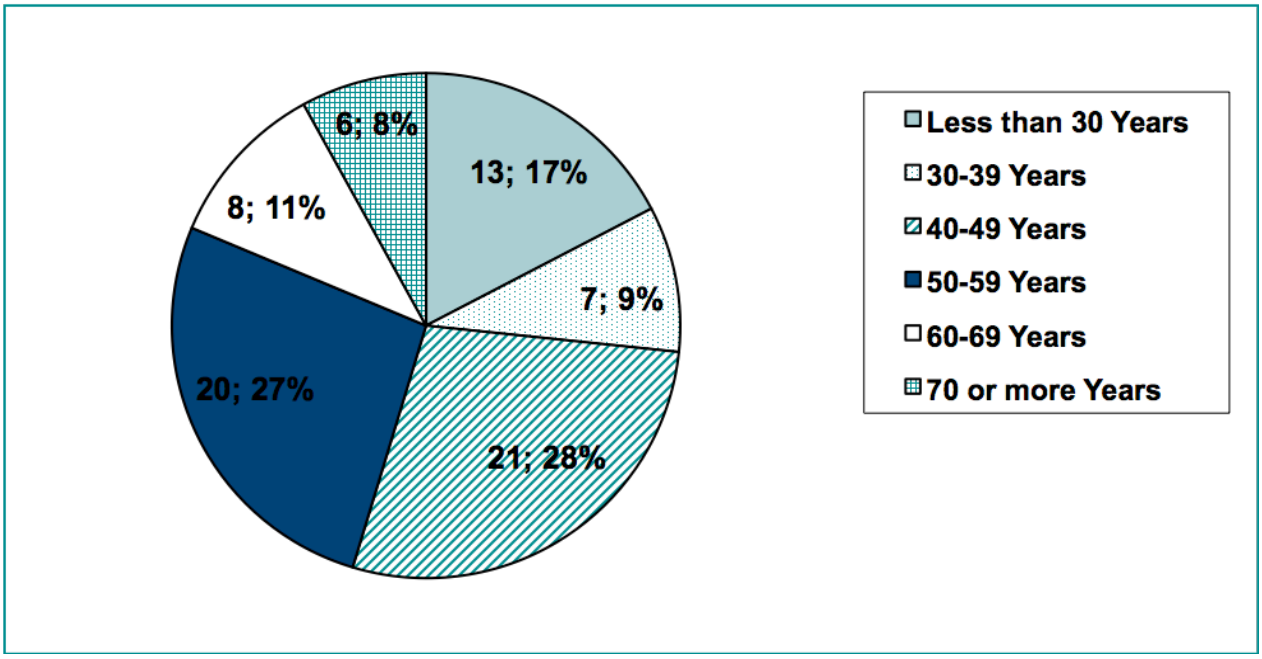
- This evaluation includes 23 SB 962 homes with a total capacity of 110 consumers.
- Two thirds of the homes are operated by non-profit corporations.
- The largest number of homes (six) is in the city of San Jose. The remaining homes are located in surrounding cities throughout the Bay Area of California.

3.2 STATUTE: 4684.74 #2: NUMBER AND CHARACTERISTICS OF CONSUMERS SERVED

3.2.1 Demographic Characteristics

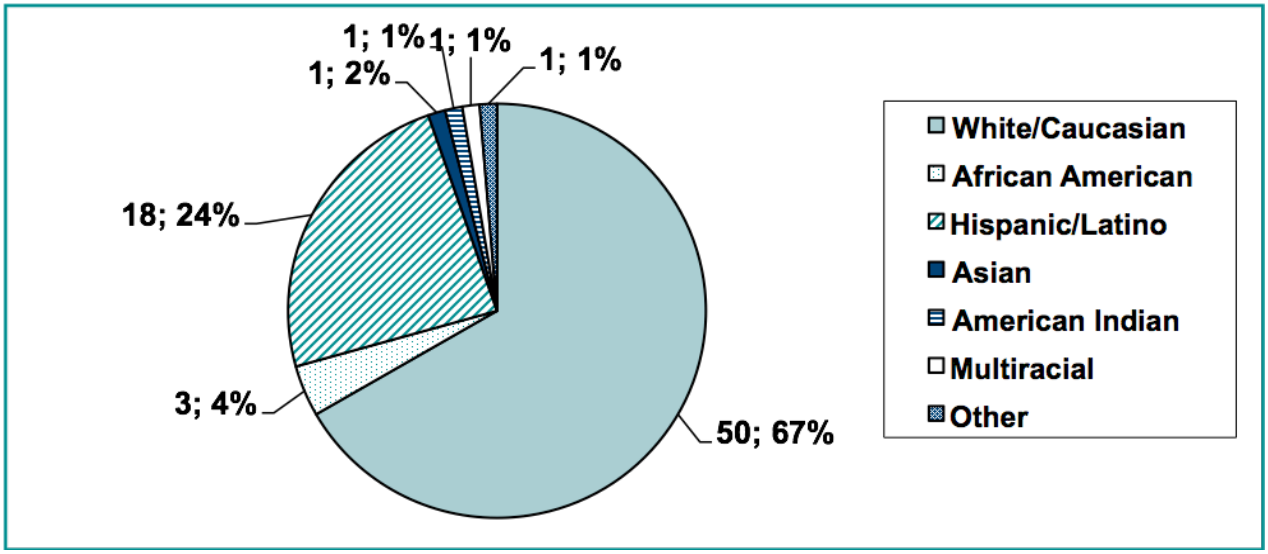
At the time of the final site visits, the 23 SB 962 homes served 88 consumers, 75 of whom participated in the evaluation study. Forty-three (57%) of the 75 consumers are male and the other 32 are female. The average age of the 75 consumers is 47.35 years with a range of 19 to 88 years. The majority (55%) of consumers are between 40 and 59 years of age although consumers vary widely in their ages. A substantial proportion (17%) is younger than 30 years of age and 8% are 70 years or older (Figure 4).

Figure 4. Ages of SB 962 Consumers



The majority (69%) of the consumers are White/Caucasian (Figure 5). Other ethnicities represented by consumers of these 23 SB 962 homes are African American, Hispanic/Latino, multiracial, and other (not specified).

Figure 5. Ethnicities of SB 962 Consumers

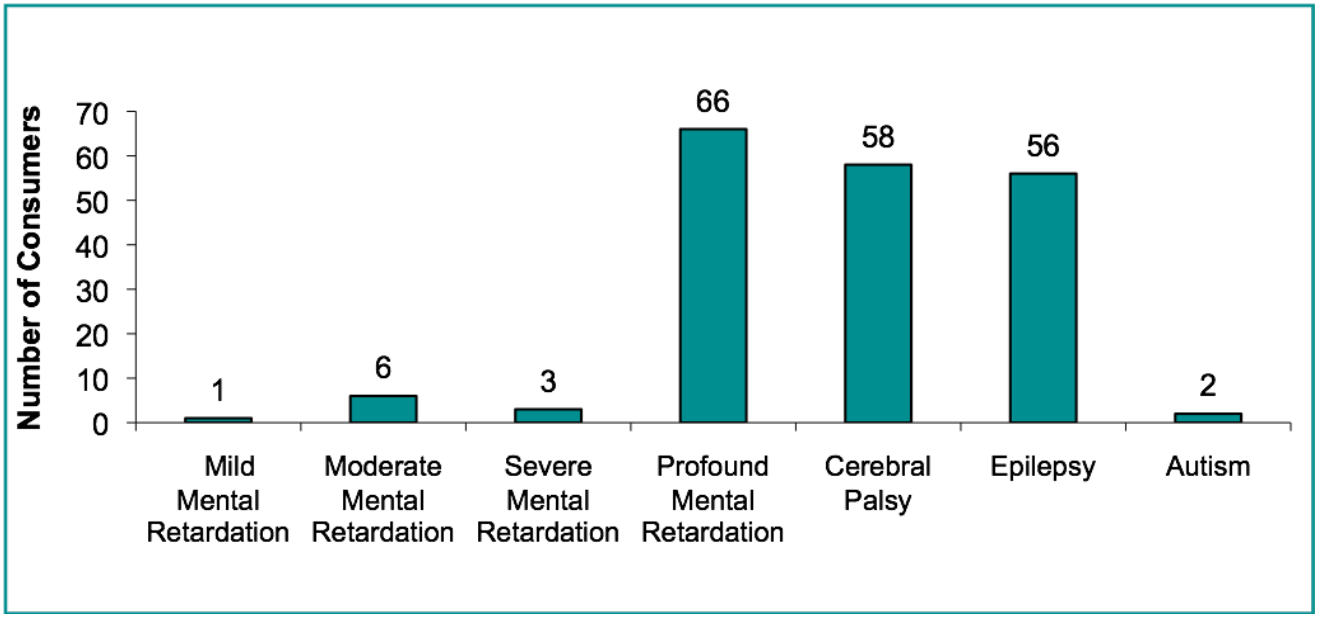


Eighteen (24%) of the 75 consumers are conserved. Of those who are not conserved, 29 have been appointed a decision maker. Eight of the appointed decision makers are family members, 16 are RC personnel, four are area board members or advocates, and one consumer has both a family member and a RC employee as appointed decision makers. As previously discussed, the transition of consumers from their previous residence to their new one at an SB 962 home was still underway at the time of the evaluation team's final site visits. As a result, consumers had been living in the homes for an average of 6.5 months with a range of less than one month to 22 months.

3.2.2 Disability Diagnoses

The disability diagnoses for the SB 962 consumers are shown in Figure 6. All 75 consumers have some degree of mental retardation; 66 (88%) have profound mental retardation. Most consumers (66, 88%) also exhibit more than one disability diagnosis. The most frequently occurring combination of disabilities was profound mental retardation coupled with both cerebral palsy and epilepsy, a pattern exhibited by 47 (63%) of the 75 consumers.

Figure 6. Disability Diagnoses of SB 962 Consumers



3.2.3 Medical Conditions

Together, the 75 consumers of the SB 962 homes have been diagnosed with 118 different types of medical conditions (see Appendix C). Individual consumers have an average of 9.7 of these conditions with a range of five to 19 conditions. Most consumers (83%) suffer from constipation, and the majority (59%) also has dysphagia. Other common conditions include gastrostomy (49%), gastroesophageal reflux disease (44%), seborrhea or seborrheic dermatitis (39%), osteoporosis (32%), acne (24%), hypothyroidism (24%), scoliosis (23%), anemia (21%), and tracheostomy (21%).

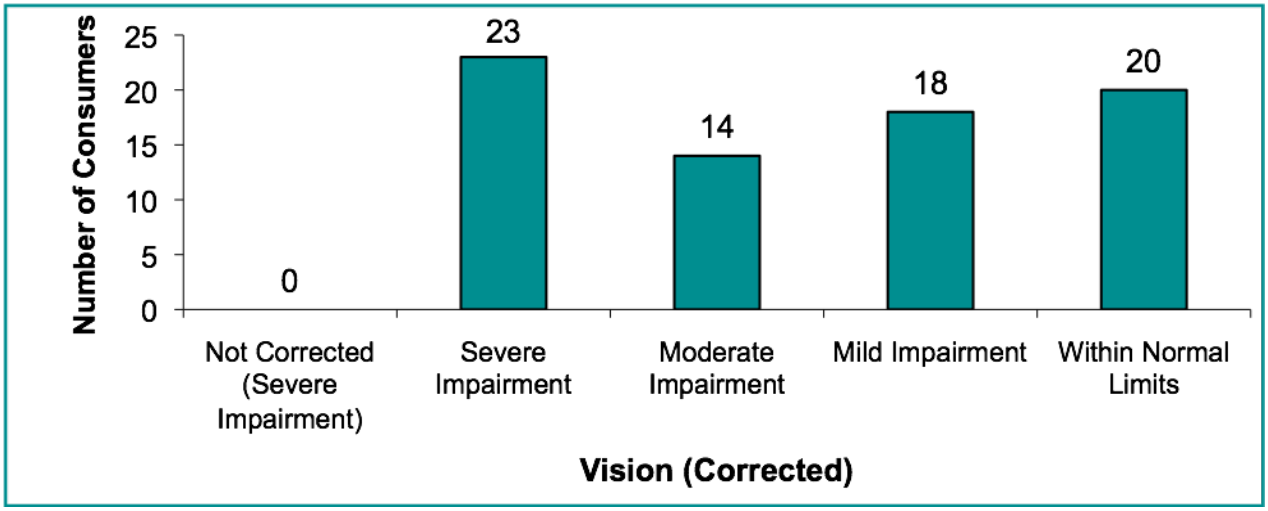
3.2.4 Mental Illness

Three (4%) of the 75 consumers have one or more diagnosable mental illness apart from the disability diagnoses. One consumer has senile dementia coupled with chronic undifferentiated schizophrenia. Another has been diagnosed with bipolar I disease and the third has pre-senile depression.

3.2.5 Sensory Functioning

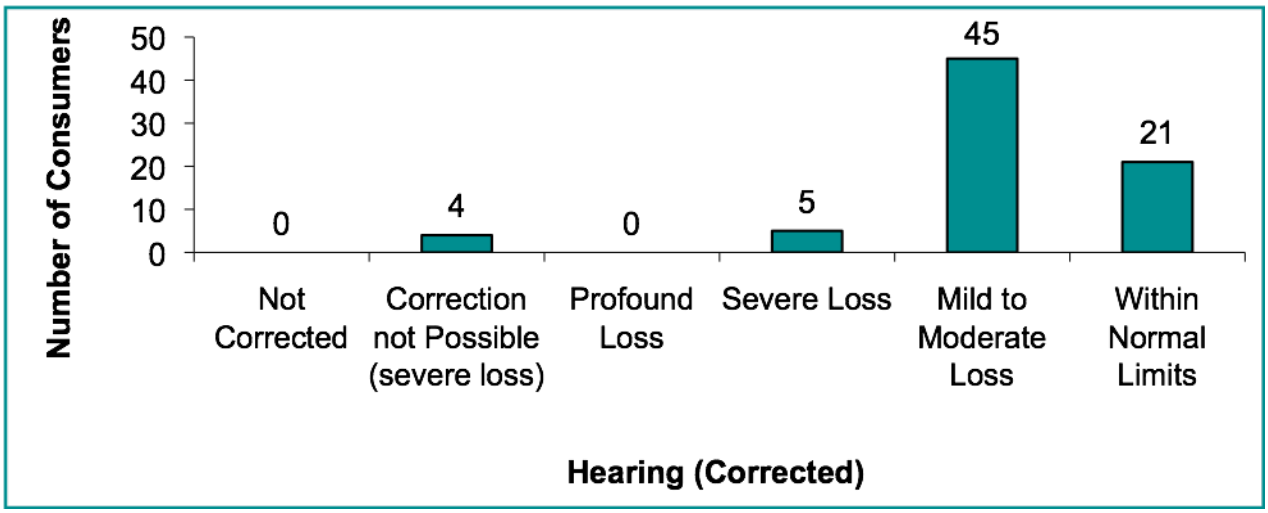
Consumers residing in the SB 962 homes vary in their (corrected) vision abilities (Figure 7). Thirty-eight (51%) of the 75 consumers have (corrected) vision that is either within normal limits or represents only mild impairment. The other 37 (49%) have either moderate or severe impairment. Correction of visual abilities for 23 (62%) of these 37 consumers with moderate or severe impairment was not possible.

Figure 7. Vision of SB 962 Consumers



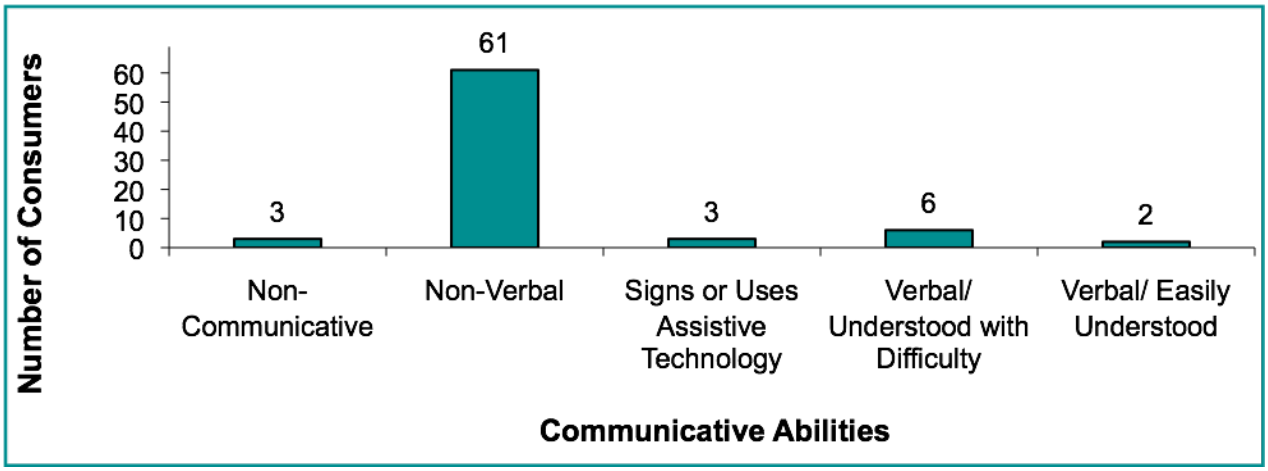
On the other hand, consumers have fairly good (corrected) hearing ability (Figure 8). Sixty-six (88%) of the 75 consumers have (corrected) hearing that is either within normal limits or represents mild to moderate loss.

Figure 8. Hearing of SB 962 Consumers



Consumers have difficulty with communication (Figure 9). Sixty-one (81%) can only communicate non-verbally. Three are completely non-communicative. Eight consumers (11%) have some verbal communication abilities but only two are understood easily.

Figure 9. Communicative Abilities of SB 962 Consumers



3.2.6 Special Health Care Needs

Consistent with the variety and intensity of their medical conditions, consumers living in the SB 962 homes have a number of special health care needs. Table 1 illustrates the number of consumers with each of the special health care needs outlined in section 4684.5g of Article 3.5 from Chapter 558 of SB 962.

Each of the 75 consumers exhibited the need for manual fecal impaction removal, enemas, or suppositories. Seventy-three (97%) also require cardiorespiratory monitoring and sixty nine (92%) need oxygen support. Other common special health care needs included nursing interventions for colostomy, ileostomy, or other medical or surgical procedures (65%), special medication regimes (45%), and tracheostomy care and suctioning (23%). Consumers had an average of 4.57 of these special health care needs, with a range of two to eight.

Table 1. Special Health Care Needs of SB 962 Consumers

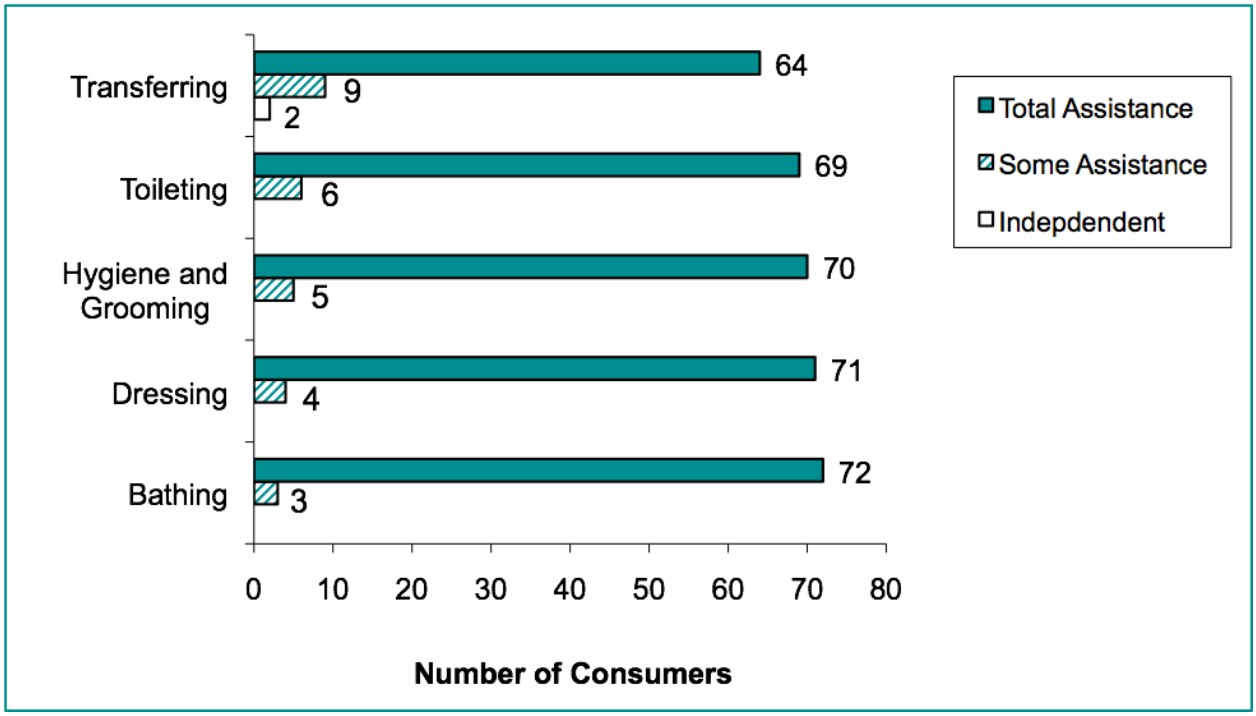
Special Health Care Needs	Number (Percentage) of Consumers
Cardiorespiratory monitoring	73 (97%)
Oxygen support	69 (92%)
Ventilator dependent (for any length of time during 24 hour period)	0 (0%)
Tracheostomy care and suctioning	17 (23%)
Nursing interventions for colostomy, ileostomy, or other medical or surgical procedures	49 (65%)

Special Health Care Needs	Number (Percentage) of Consumers
Special medication regimes	34 (45%)
Management of insulin-dependent diabetes	1 (1%)
Manual fecal impaction, removal, enemas, or suppositories	75 (100%)
Indwelling urinary catheter/ catheter procedure	4 (5%)
Treatment for staphylococcus infection	1 (1%)
Treatment for wounds or pressure ulcers (stages 1 and 2)	10 (13%)
Postoperative care and rehabilitation	3 (4%)
Pain management and palliative care	1 (1%)
Renal dialysis	0 (0%)

3.2.7 Intensive Support Needs and Activities of Daily Living

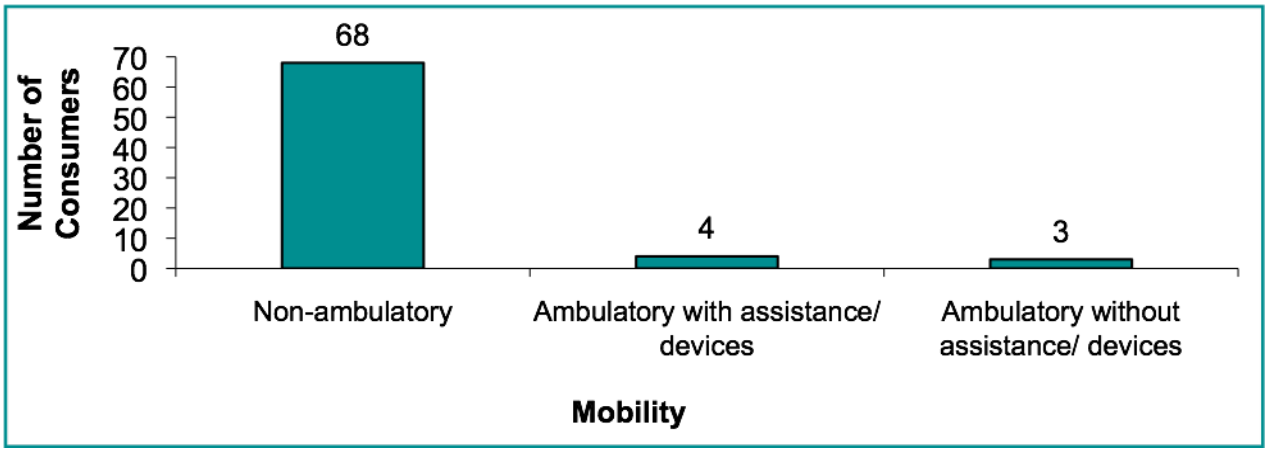
Figure 10 illustrates the number of consumers with each of the special health care needs outlined in section 4684.5f of Article 3.5 from Chapter 558 of SB 962. Most consumers require total assistance with bathing, dressing, hygiene and grooming, toileting, and transferring. A few consumers only need some assistance with these tasks, and two consumers are independent in regard to transferring. SB 962 also outlines continence as an additional intensive support need that is not included in Figure 10. The evaluation team's medical consultants consider continence to be part of toileting. Consumers who were incontinent were rated as needing total assistance with toileting.

Figure 10. Intensive Support Needs of SB 962 Consumers



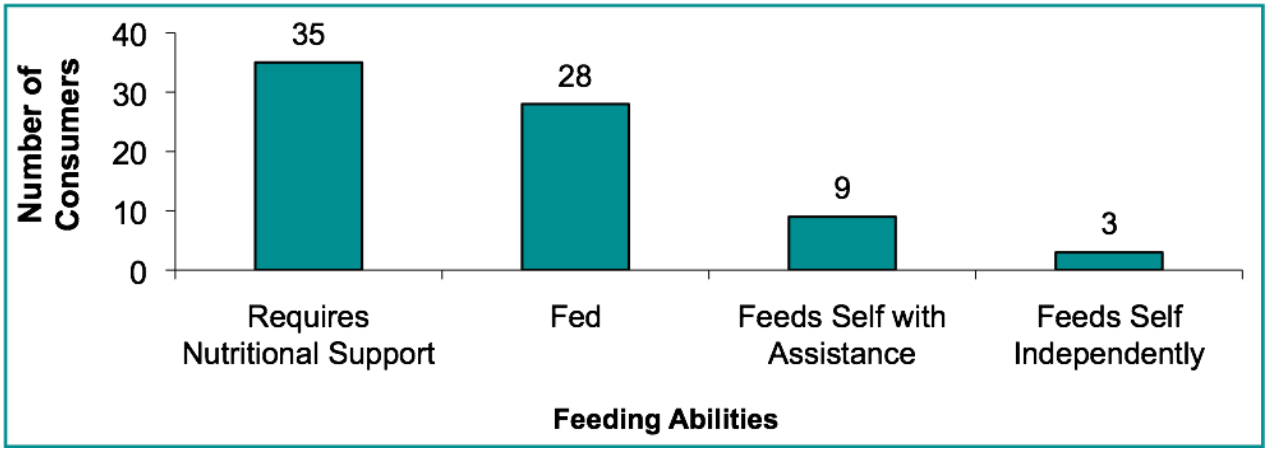
Consistent with their need for assistance in transferring, consumers face challenges with mobility (Figure 11). Sixty-eight (91%) of the 75 consumers are non-ambulatory, four (5%) are only ambulatory with assistance and/or assistive devices, and three (4%) are ambulatory without assistance.

Figure 11. Mobility of SB 962 Consumers



The consumers of the SB 962 homes also require substantial supports related to food intake (Figure 12). Sixty-three consumers (84%) either have to be fed or require nutritional support such as parenteral feeding, gastrostomy feeding, and a hydration or feeding tube. Nine consumers (12%) are able to feed themselves with assistance and three consumers (4%) are able to feed themselves independently.

Figure 12. Eating Abilities of SB 962 Consumers



Only four out of the 75 consumers (5%) have a behavioral plan. One of these consumers has erratic sleep behaviors. The medical consultant from the evaluation team that visits this consumer's home noted that the care home staff has been very flexible in accommodating these erratic sleep patterns.

The behavioral plan for the other consumer indicates that he/she requires additional supervision to help in eating a low protein, low calorie diet. Another consumer entered the SB 962 home with a behavioral plan because of yelling or screaming when the environment became noisy or crowded. One additional consumer does not have an official behavioral plan but has steps outlined in his/her Individual Service Plan (ISP) to help calm the consumer in order to prevent self-biting.

Two of these consumers with behavioral plans reside in the same SB 962 home. The evaluation team's medical consultants noted that the staff working at this home is gathering data and trying different strategies to deal with the consumers' behaviors. Staff will then consult the psychologist again to see if modifications to the behavioral plans would be appropriate.

3.2.8 Summary and Recommendations

Findings presented in this section show the following:

- Consumers have multiple developmental disabilities; the most common combination of disability diagnoses was profound mental retardation coupled with seizure disorder and cerebral palsy.
- Consumers also have a broad range of medical conditions and have high levels of health care needs; almost all require cardio-respiratory monitoring and oxygen support, and 100% require manual fecal impaction removal, enemas, or suppositories.
- Most consumers require total assistance with bathing, dressing, hygiene and grooming, toileting, and transferring.
- All require some level of nutritional support.
- Few consumers have a need for behavioral plans and few have been diagnosed with mental illness.

- The vast majority of consumers are non-verbal, non-ambulatory, and many have vision problems.
- Consumers meet the eligibility requirements to reside in the SB 962 homes.

The evaluation team did not make any recommendations related to this section.

3.3 STATUTE: 4684.74 #3: THE EFFECTIVENESS OF THE SB 962 PILOT PROJECT IN ADDRESSING CONSUMER HEALTH CARE AND INTENSIVE SUPPORT NEEDS

AND

STATUTE: 4684.74 #5: THE EXTENT OF SB 962 CONSUMERS' ACCESS TO, AND QUALITY OF, COMMUNITY-BASED HEALTH CARE AND DENTAL SERVICES

3.3.1 Care Plans

The SB 962 model utilizes the Individual Health Care Plan (IHCP) to outline consumers' health care and intensive support needs and to specify the means for addressing these needs. SB 962 requires that the IHCP is developed before the consumer is placed in the SB 962 home and should be present in the SB 962 home on the first day of placement.

Evidence from this evaluation showed that the IHCP was crucial to adequately addressing consumer health care and intensive support needs. Although a few challenges with the implementation of the IHCPs were also identified, the final outcome of the IHCP was a process for ensuring that each consumer's health and intensive support needs would be met. The medical consultants from the evaluation team judged that all of the IHCPs that were in place at the time of the site visits were current and appropriate to consumers' needs. In addition, one of the common themes that emerged from the analysis of interviews with key informants was the strength of the IHCP documents. Results showed that the meetings that were held to develop each consumer's IHCP were effective in bringing everyone to the table including physicians, staff, specialists, family members, the administrator of the SB 962 home, and others, to collaborate in addressing consumers' needs.

From this IHCP, the SB 962 homes also develop a more specific Nursing Care Plan (NCP) that is updated regularly. The NCP lays out specific nursing plans for each health concern the consumer has, emergency procedures, etc. It is an expanded version of the IHCP.

Another important indicator of the extent to which the SB 962 Pilot Project effectively addresses consumers' health care and intensive support needs is consumers' access to the necessary services outlined in the IHCPs and the quality of those services. SB 962 specifies that the RCs are responsible for, "*monitoring and evaluating the quality of care and intensive support services*" (SB 962). Findings from this evaluation show that the SB 962 model provides consumers with appropriate access to quality health care and dental services (see Section 3.3.3).

3.3.2 Consumers' Health Outcomes

Evaluation evidence, including analysis of key informant interviews and data collected during the evaluation team's site visits to the homes, suggests that

***"Now he's actually able to not have the oxygen as much, he's doing much better. He's able to breathe on his own and only needs the oxygen at night."* (Key Informant)**

most consumers are responding very positively to their lives in the SB 962 homes. Most consumers' health status is relatively stable, and some have experienced remarkable improvements in health and functioning. These included decreased constipation, reductions in skin conditions, fewer interventions and less reliance on supports like oxygen. Documentation of these types of improved health outcomes for individuals with special health care needs following community placement is a unique strength of the current evaluation, as this area has not been well studied in the research literature.

> ***"Particularly someone like [consumer], who I never heard speak at all, and now hearing him speak a word or two, and smiling ... so I think that's made a huge difference."*** **(Family Member)**

Moreover, a number of success stories were also reported in the area of consumers' level of functioning. Informants, including staff and family members, described consumers who were previously non-verbal who have begun to say a few words since moving into the SB 962 homes as well as those who were immobile and have since experienced increased mobility. In addition, several consumers have gained increased awareness and cognition. Some have learned new skills such as self-feeding or using tools to communicate nonverbally with staff members.

Findings also show that the vast majority of consumers who previously had behavioral concerns have experienced reductions in those behaviors since living in the SB 962 homes with staff who are attuned to their needs.

3.3.3 Access and Quality of Services

Findings from this evaluation show that the SB 962 model provides consumers with appropriate access to quality health care and dental services. The SB 962 legislation requires 24 hour nursing care, examination by primary care physician at least once every 60 days, and a network of health and medical resources in the community for meeting the needs identified in consumers' IHCPs. SB 962 also states that the RCs have responsibility for monitoring and evaluating the implementation of the consumer's IHCPs.

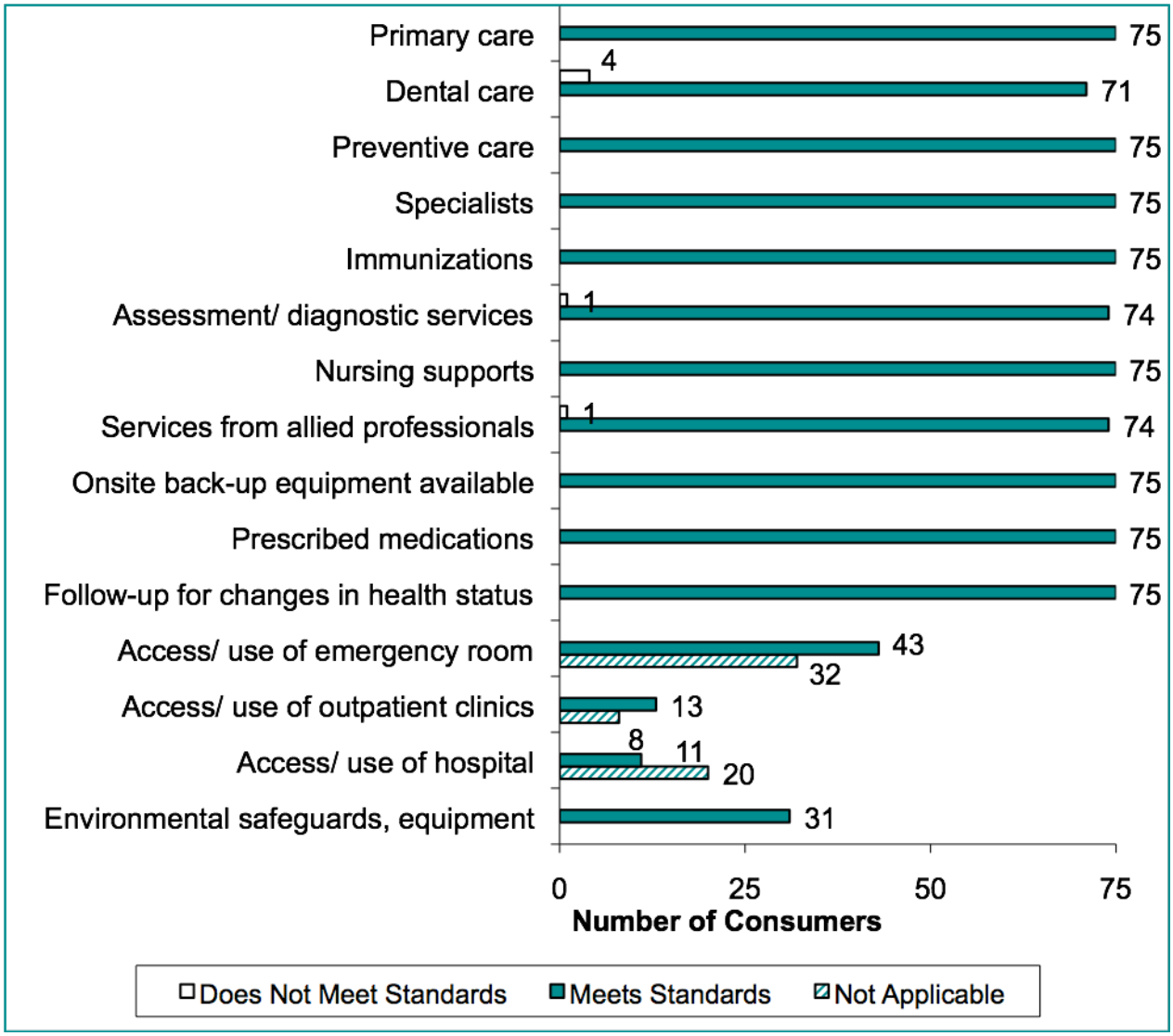
Results from the analysis of the evaluation team's medical consultants' observations, as well as focus groups and interviews with key informants, showed that this SB 962 service model was successful in achieving appropriate access to quality health and dental services for consumers. The evaluation team's medical consultants examined consumers' health care services during their site visits to the SB 962 homes. They found that provisions in the SB 962 model were key to ensuring quality services for consumers. For example, SB 962 requires that "*the consumer remains under the care of a physician at all times and is examined by the primary care physician at least once every 60 days, or more often if required by the consumer's individual health care plan (SB 962)*." The medical consultants found that this was carried out for 100% of the SB 962 consumers (see Figure 13) and that it was key to meeting consumers' health care needs.

Moreover, SB 962 mandates that the facility program plan include a *"plan for accessing and retaining consultant and health care services, including assessments, in the areas of physical therapy, occupational therapy, respiratory therapy, speech pathology, audiology, pharmacy, dietary/nutrition, dental, and other areas required for meeting the needs identified in consumers' individual health care plans (SB 962)*." The evaluation team's medical consultants found that these services met the standards necessary to promote consumer health (see Section 2.3 Measures for a description of these standards). Medical consultants noted only a few minor concerns in three out of the 15 areas of health care services: assessment or diagnostic services, services from Allied Professionals, and dental services (Figure 13). Each case of standards not being met resulted from routine health care appointments that were either not completed according to the necessary schedule or were not documented in consumers' files. At the time of the final site visit to these homes, none of these minor concerns had resulted in any adverse health outcomes for the consumers.

Findings further documented the importance of the RCs' role in "*monitoring and evaluating the implementation of the consumer's individual plan objectives"* (SB 962). For example, accessing community-based dental care for consumers requiring sedation during routine dental exams and other procedures was a challenge for the administrators due to an insufficient number of available providers in the community. Consumers requiring sedation during dental procedures are able to access care through the Agnews outpatient clinic. However, only one dentist is on staff and waitlists for appointments are generally months longer than the recommended schedule for routine exams. At the time of the evaluation, there were few dental providers apart from the Agnews clinic who were able to provide sedation dentistry to consumers residing in SB 962 homes. Each of these providers also had very limited availability for serving SB 962 consumers. UCD Medical Consultants noted that regular preventive dental exams are crucial elements of medical care for SB 962 consumers who have complicating medical issues such as: those consumers who take Dilantin for epilepsy which makes them at increased risk of acquiring gingival hyperplasia that can lead to trauma and infection; consumers who have craniofacial anomalies which is often accompanied by hypodontia, hypoplasia and malocclusion, making it more difficult to maintain good dental health; finally bruxism (tooth grinding) is very common among people with developmental disabilities, and may lead to enamel and dentin abrasion, fracture, abnormal mobility of the teeth, or temporomandibular joint disorder. The RCs and the SB 962 home administrators have made important strides in improving access to community-based dental services requiring sedation and were continuing to work toward this goal at the end of the evaluation period.

Analysis of focus groups and interviews with key informants further supported the conclusion that the SB 962 model includes sufficient provisions to ensure access to appropriate health and dental services for consumers. Key informants also discussed additional strengths of the SB 962 homes, such as their proximity to medical facilities, including emergency services, and the ability to administer IV antibiotics in the home, which limits hospital stays and can eliminate the need for temporary placement in other facilities.

Figure 13. Quality of Health Care Services for SB 962 Consumers



3.3.4 Summary and Recommendations

In sum, results show that the SB 962 homes are effective in meeting consumers' health and intensive support needs, and that consumers' have access to quality services. More specifically, findings indicated that.

- IHCPs are effective and are a key strength of the SB 962 model.
- Consumers have access to licensed nursing care 24 hours per day, seven days per week.
- The quality of health care is good and meets standards.
- At the time of the evaluation team's final site visits dental sedation resources, although limited, were continuing to be developed in the community.
- Primary care physicians in the community provide accessible, quality care.
- Some consumers have experienced improvements in health conditions and/or level of functioning.

- The few consumers with behavioral concerns have experienced improvements.

The evaluation team does not recommend any changes to SB 962 based on these findings.

3.4 STATUTE: 4684.74 #4: THE EXTENT OF CONSUMERS' COMMUNITY INTEGRATION AND SATISFACTION

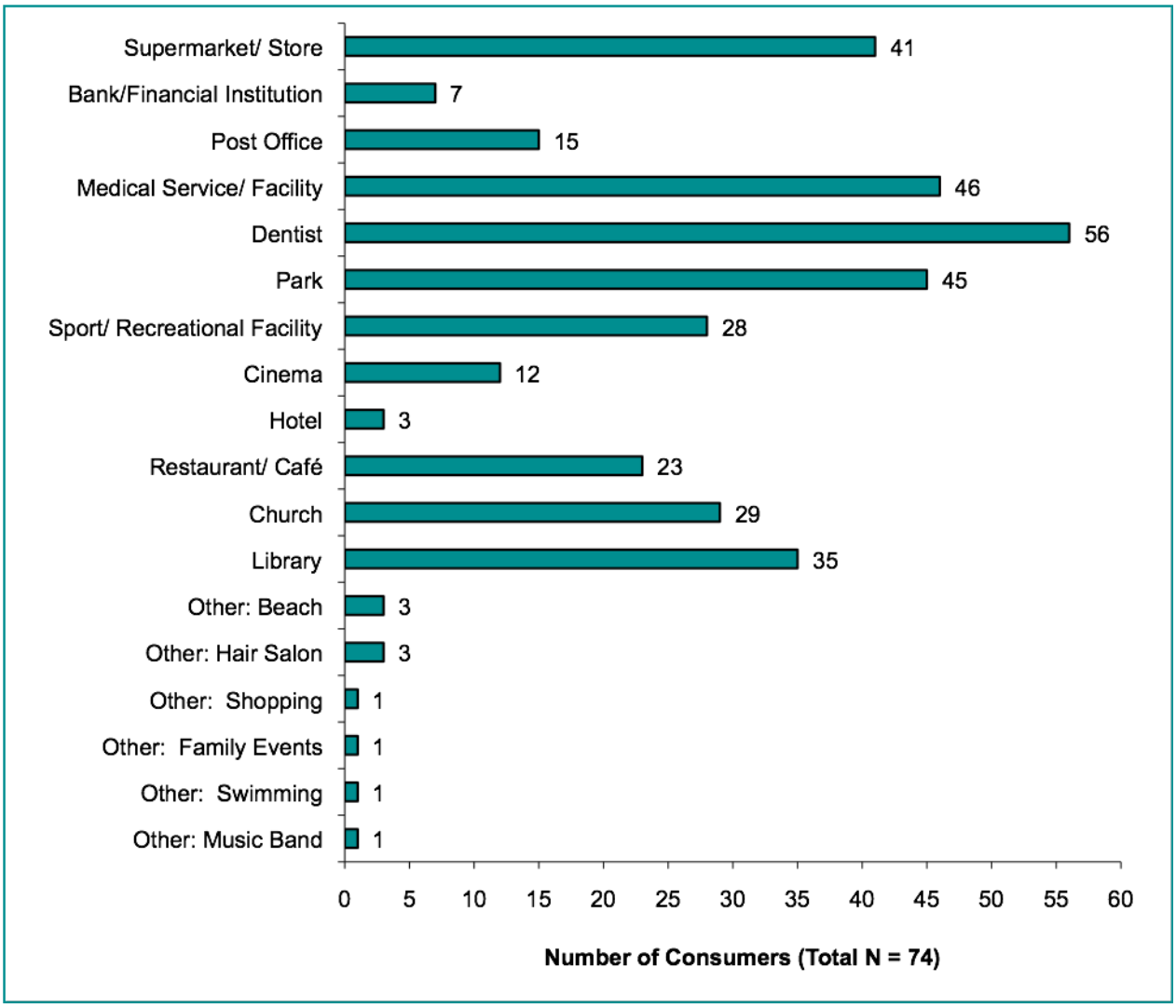
Data from evaluation surveys regarding community integration and satisfaction are available for 74 of the 75 consumers who are participating in this evaluation. Survey data for the other consumer was not successfully obtained from the staff at the SB 962 home. In addition, information regarding community integration and satisfaction of consumers of the SB 962 homes was provided through analysis of the interviews and focus groups with key informants.

3.4.1 Type and Frequency of Community Outings

In their responses to the consumer survey, staff reported that consumers went on various community outings. Staff members were asked to rate how frequently consumers visited 12 different types of community locations, ranging from never to weekly. Community outings included the supermarket/store, park, church, medical and dental appointments, among others. Staff also reported that consumers had access to "other" community experiences including the hair salon, the beach, family events, music, and swimming. Figure 14 illustrates the number of consumers who had experienced each type of community outing at least once since moving into the SB 962 homes, at the time of the most recent site visits to the homes. The majority of consumers accessed medical (62%) and dental (76%) services in the community (see Section 3.3 for a discussion of considerations related to community-based care). Other common outings included going to parks, the supermarket or store, library, sport or recreation facilities, and church.

Consumers go out almost exclusively with staff and sometimes with other consumers from the home. One consumer went to a hotel with his/her family and another went to a restaurant/café with family. One consumer was reported to having gone on overnight trips or vacations. Staff explained that this consumer spent the night at his/her parents' house twice since moving into the SB 962 home. Overnight trips or vacations have been discussed for two other consumers but have not yet been planned. These three consumers reside in three different SB 962 homes.

Figure 14. Number of Consumers Going on Community Outings



Survey results showed that the amount of community integration which consumers of the SB 962 homes experience varies widely across individual consumers. Results from the most recent survey for each consumer indicated that consumers experienced a minimum of zero (11 consumers) and a maximum of 11 different types of community outings with an average of 4.7 types of outings. In order to better understand the reasons for these variations in community outings, the evaluation team examined three key factors: the length of time that consumers have resided in the SB 962 homes, the availability of licensed staff members for outings, and consumer's level of disability. These factors are described in the following sections.

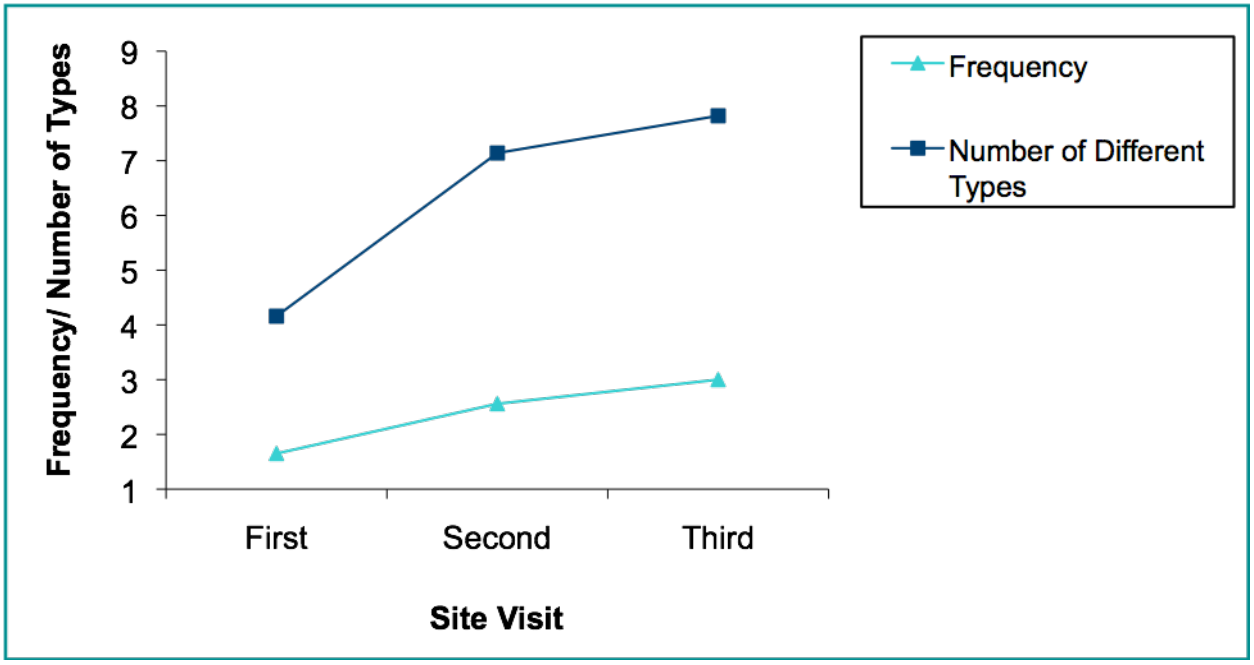
Responses from key informants interviewed and focus group questions are consistent with these findings. They noted that the degree to which consumers go out of the homes and into the community appears to vary quite dramatically across homes and across consumers. Some consumers go on community outings several times per week

while others have not yet left the homes other than for medical appointments. One of the key reasons for this is that staff and administrators at some of the homes are concerned about consumer health and safety. Several administrators explained that consumer safety comes first and that they are simply not comfortable taking certain consumers out into the community. Other administrators are more comfortable with community outings and described successfully taking consumers with them on a regular basis when they run errands as well as taking consumers for walks around the neighborhood.

3.4.2 Community Outings and Length of Time in Residence

Findings suggest that community integration for the consumers of the SB 962 homes increases over time. Several lines of evidence support this assertion. For example, ten out of the 11 consumers who have not yet experienced any community outings resided in newer homes that the evaluation team had only visited once since they had opened. Moreover, the length of time (months) that consumers had resided in the SB 962 homes was significantly associated with both the number of different types of community outings consumers had experienced ($r = .54$, $p < .01$) and the frequency with which consumers went on those outings ($r = .36$, $p < .01$). Figure 15 shows that number of different types of community outings consumers experienced increased from an average of 4.16 to 7.82 from the first to the third site visit. Similarly, the frequency with which consumers went on these outings increased from 1.65 (in between “yearly” and “every 6 months”) to 3.00 (“every three months”). Results from paired sample t-tests for the consumers with follow-up surveys from repeat site visits show that this increase in the frequency of community outings was statistically significant ($t (25) = 2.03$, $p < .05$) though the increase in the number of different types of outings they experienced did not quite reach statistical significance ($t (25) = 1.96$, $p = .06$).

Figure 15. Increase in Community Outings Over Time



3.4.3 Availability of Licensed Staff

Findings from the evaluation also indicated that another factor limiting community outings at some of the SB 962 homes was insufficient availability of licensed staff to take consumers out into the community.

3.4.4 Community Outings and Medical Fragility

Concerns by administrators, staff, and family members about consumers' health and safety also help to explain why some consumers experience little or no community integration.

3.4.5 Role of the Regional Centers

In sum, findings presented in this section document the wide variety in consumers' extent of community integration. Results suggest that some of the SB 962 homes may need additional staffing supports or a reconfiguration on staff schedules, to successfully integrate their consumers into the community. SB 962 states that the RCs are responsible for "*monitoring and evaluating the implementation of the consumer's individual plan objectives, including . . . the consumer's integration and participation in community life"* (SB 962). Thus, the evaluation team does not recommend any changes to the language of SB 962 with respect to community integration but highlights the crucial role of the RCs in facilitating community integration of SB 962 consumers.

3.4.6 Community in the Home and Contact with Neighbors

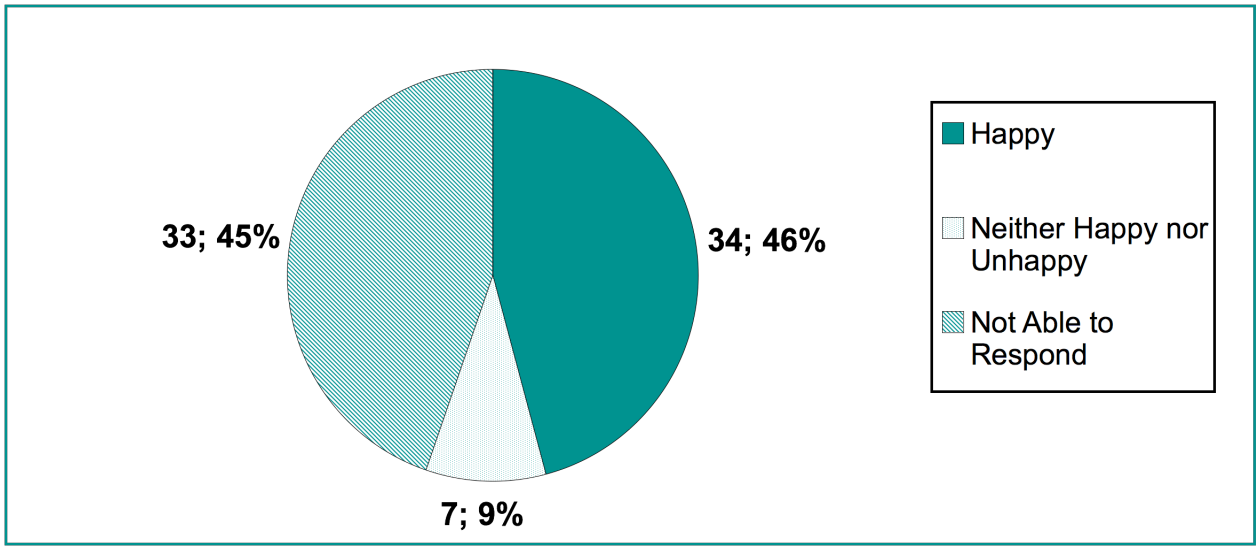
Staff reported that ten (13%) of the 74 consumers with data on the consumer survey experienced visits from community members or organizations in the home. Examples of

community members that visit the consumers include high school students, church pastors, a children's choir, Christmas carolers, and a jazz band. While these were only reported by the caregivers for 10 consumers, it is likely that the other consumers in the six homes in which these 10 consumers live (total N = 21 consumers) also experienced these visits in one form or another. In addition, staff members reported in the consumer survey that 19 (26%) out of the 74 consumers who had survey responses had some form of contact with their neighbors.

3.4.7 Consumer Satisfaction, Reported by Consumers

Staff recorded satisfaction scores for 41 out of the 74 consumers with consumer surveys. Responses from these 41 surveys indicated a fairly high degree of satisfaction with consumers' lives in the SB 962 homes. Figure 16 shows the overall scores for all 41 consumers' responses to the nine items. For consumers who had responses to the consumer satisfaction survey from more than one site visit, the responses from the most recent survey were used in these analyses. Thirty-four out of the 41 (83% of those with responses; 46% of all 74) consumers indicated that they were "happy" with their lives in the SB 962 homes. Seven out of the 74 consumers (9%) responded with an average score of "neither happy nor unhappy."

Figure 16. Consumer Satisfaction: "How happy are you with . . .?"
(overall score rated by self, with assistance from staff)



Four of these seven consumers responded "neither happy nor unhappy" to all nine of the survey items. It is unclear from the available data whether or not these responses indicate true neutrality of opinion on behalf of these consumers or whether or not staff members recorded "neither happy nor unhappy" when consumers were not responding

to the questions[6]. The other three consumers that had average scores of "neither happy nor unhappy," showed a pattern of responses that varied across the nine items suggesting that the average of "neither happy nor unhappy" is a valid representation of their level of satisfaction.

As a check of the validity for utilizing this self-report survey of consumer satisfaction for the consumers of the SB 962 homes, most of the people whom are severely disabled, the evaluation team examined differences in survey responses across different groups of consumers with varying levels of mental retardation. Ten (91%) out of the 11 consumers with either mild, moderate, or severe mental retardation were able to successfully respond to the survey questions, whereas only 31 (49%) out of the 63 consumers with profound mental retardation were able to respond. This pattern indicates that the staff members of the SB 962 homes were correctly noting which consumers were capable of responding to the survey questions. Some may also question the accuracy of the responses for the 31 consumers with profound mental retardation. However, results from a one-way Analysis of Variance show that consumers with the most profound mental retardation reported similar levels of satisfaction as the consumers with mild or moderate mental retardation (F (3) = 0.18, p = .91).

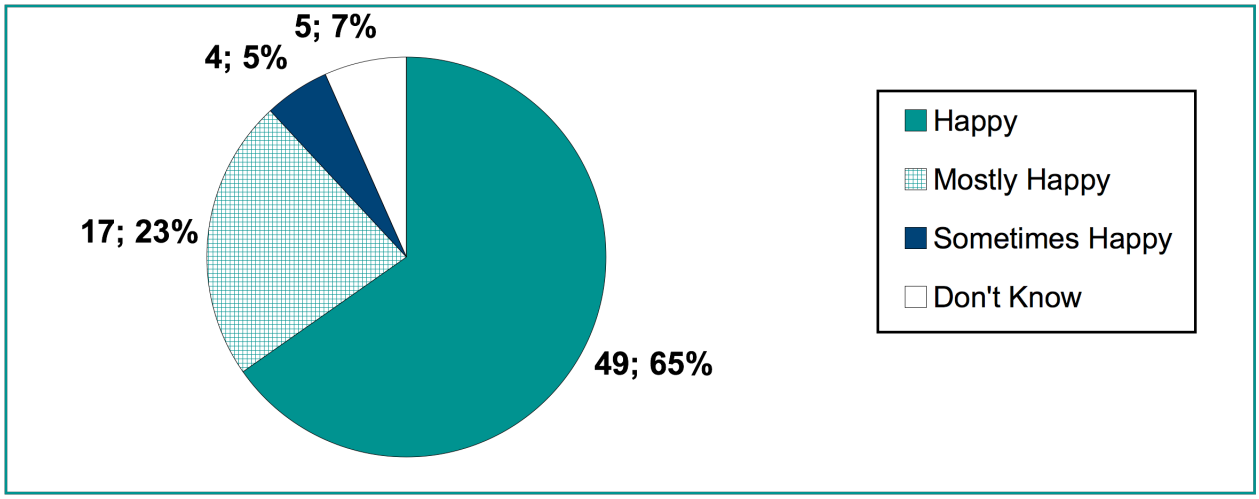
3.4.8 Consumer Satisfaction, Reported by Staff

Staff members who cared for the consumers in the SB 962 homes reported that they believed that the consumers were quite happy (Figure 17). They reported an average score of 4.6 out of 5, with a range of 3.00 to 5.00. Response options ranged from 1 = "unhappy" and 5 = "happy". Several caregivers commented that they used consumers' facial expressions such as smiles and eye contact to judge consumers' happiness. The caregivers for five consumers responded "don't know" for all six items on this satisfaction scale and explained that the consumers are non-responsive, and it is not possible to gauge the consumers' levels of happiness.

> ***"one [consumer] also who was sleeping, you know, most of the time. Now, you know, she smiles, she laughs, you can see her teeth and she makes choices"*** **(Key Informant)**

[6] Although the survey was modified to include a separate response option titled "not responding" to avoid confusion between neutrality of opinion and non-response prior to the site visit at the second home, one of these three surveys with this pattern of responses was also received from the third home.

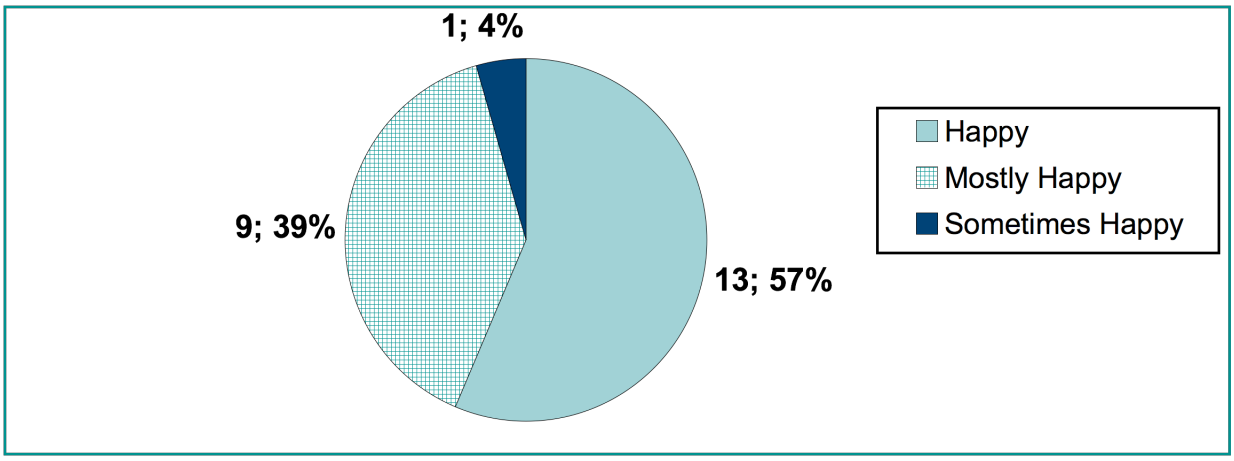
Figure 17. Consumer Satisfaction: "How happy do you think this consumer is with . . .?"
(overall score rated by staff)



3.4.9 Consumer Satisfaction, Reported by Families

Family members also reported positive impressions of overall consumer satisfaction with life in the SB 962 homes (Figure 18). Twenty-six of thirty family members provided ratings of consumer satisfaction on their most recently completed Family Surveys. They rated the six items with an average score of 4.57 out of 5, with a range of 3.00 to 5.00. Response options ranged from 1 = "unhappy" and 5 = "happy."

Figure 18. Consumer Satisfaction: "How happy do you think your relative is with . . . ?"
(overall score rated by family)



No statistically significant differences were noted for family members' ratings of consumer satisfaction over time.

3.4.10 Consumer Happiness and Mood

Findings from the analysis of interviews and focus groups with key informants suggest that at least some of the SB 962 consumers have experienced improvements in the SB 962 homes. For example, several informants explained that consumers have begun to smile and to appear comfortable and calm.

3.4.11 Summary and Recommendations

Findings indicated that staff in the SB 962 homes is working on community integration in several ways.

- Many consumers go on a variety of outings in the community. Other consumers have not yet experienced outings. Considerations affecting outings include staff concerns about consumers' medical fragility, insufficient availability of extra licensed staff to accompany consumers, and the length of time consumers have resided in the homes.
- Several of the SB 962 homes have successfully brought community members into the home to visit with consumers.
- Consumers appear to be satisfied with their lives in the SB 962 homes.
- Some consumers show improvements in happiness and mood.

The evaluation team does not recommend any changes to SB 962 based on these findings.

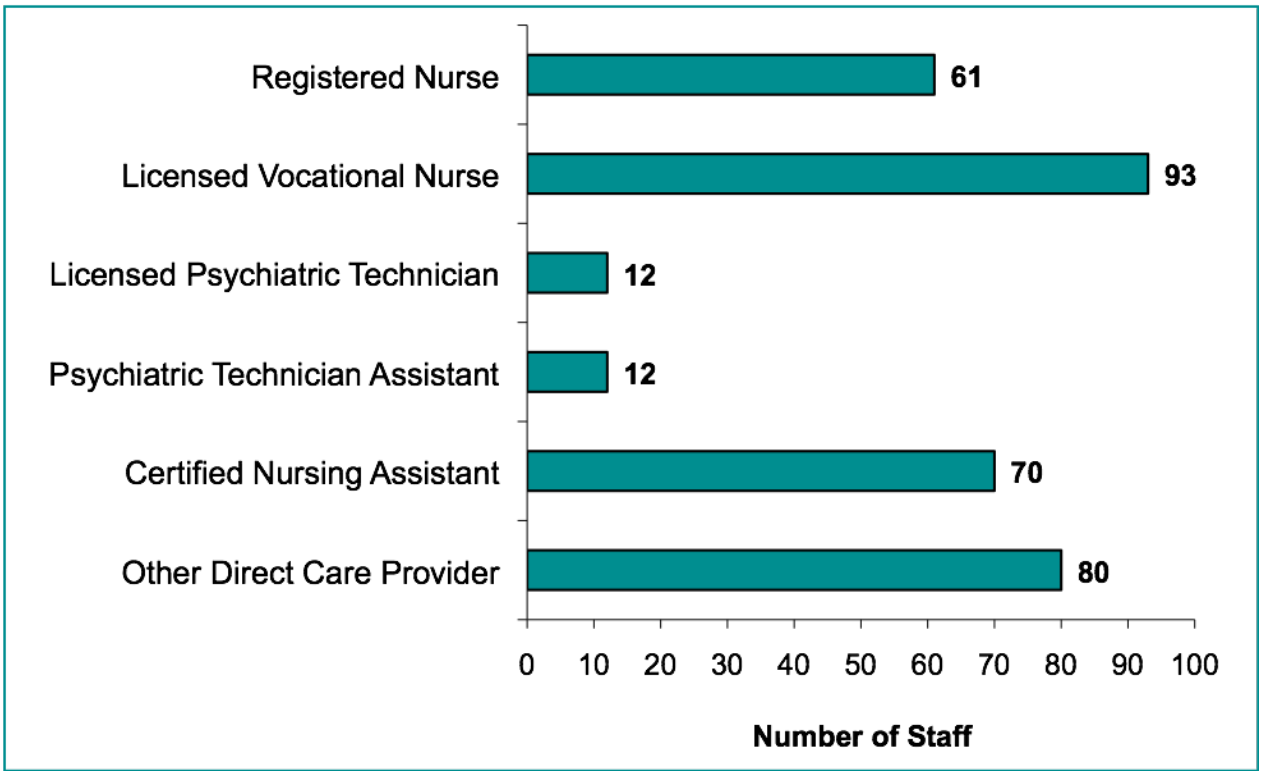
3.5 STATUTE: 4684.74 #6: THE TYPES, AMOUNTS, QUALIFICATIONS, AND SUFFICIENCY OF STAFFING IN SB 962 HOMES

3.5.1 Types and Amounts

Analysis of administrators' responses to the *Facility Survey* showed that a total of 346 staff members worked in the 23 SB 962 homes at some point between the first site visit and the most recent site visit to each home. This number includes 18 administrators: six Licensed Psychiatric Technicians (PT or LPT) and 12 Registered Nurses (RN). Fifteen of the 18 administrators were currently working at the time of the final site visits to the home. Three had moved on to other employment or retirement.

The positions of the remaining 328 staff members are presented in Figure 19. Slightly more than one half (166; 51%) of the staff were licensed care providers (RN, LVN, LPT). The most frequent type of licensed staff was LVN (93; 56%), followed by RN (61; 37%), and LPT (12; 7%).

Figure 19. Types of Direct Care Providers in the SB 962 homes



3.5.2 Qualifications and Training

Administrator Qualifications

Of the 18 individuals who have served as administrator to one or more of the 23 SB 962 homes, 12 are RNs and six are LPTs with more than five years of experience. Administrators of SB 962 homes reported an average of more than 11 years (range from 1 to 22 years) of experience serving as an administrator or supervisor in a licensed residential program for persons with developmental disabilities. It was a challenge for homes to locate and hire administrators who met the SB 962 qualification standards. Nonetheless, all 18 of the administrators met the administrator qualifications as outlined in SB 962.

The UCD evaluation team medical consultants noted concerns about the minimum standard of the qualifications for administrators and lack of community experience of the administrators from several of the SB 962 homes. They noted that, even when they met the SB 962 standards for administrator qualifications, a subset of administrators did not have an adequate knowledge base to ensure an optimal health environment for all consumers under all conditions. In addition, results showed that this subset of administrators experienced difficulties foreseeing the need for certain specialty medical follow-up in particular situations, and/or anticipating consumers' health issues and taking steps to prevent them. These concerns were evidenced by the medical consultants' observations and interactions with the home administrators in regard to Special Incidents and other events that appear to have been preventable by care home administrators and staff (see Section 3.8, delays in scheduling medical appointments, and IHCPs missing from consumers' files). These concerns regarding minimum qualifications of SB 962 home administrators, all of whom met the SB 962 standards, were echoed by key informants that were intimately involved in the SB 962 pilot project, including several of the administrators themselves.

The UCD evaluation team's medical consultants, along with key informants, pointed to the critical role of the home administrators to ensuring the health and safety of SB 962 consumers. Thus, the evaluation team recommends expanded training for administrators (see below).

Administrator Training

SB 962 requires that all administrators complete an "administrator certification program" with "a minimum of 35 hours of classroom instruction that provides training on a uniform core of knowledge." The legislation then goes on to outline nine key areas of knowledge that must be included in the classroom instruction. SB 962 mandates that the administrator certificate program be complete prior to employment. However, SB 962 allows exemptions to completion of the certification program. For example it states that, "the requirement for 35 hours of classroom instruction pursuant to this subdivision shall not apply to persons who were employed as administrators prior to July 1, 1996." SB 962 further requires administrators to complete, "40 hours of continuing education in the

general laws, regulations and policies and procedural standards applicable to adult residential facilities," every two years.

Findings from the current evaluation show that all 18 (100%) of the SB 962 home administrators had either completed the 35-hour administrator certification program or had been exempt from the course. As described earlier, in the section on Administrator Qualifications, the evaluation team's medical experts were of the opinion that some administrators, who met all of the SB 962 standards with respect to minimum qualifications and training, needed additional knowledge in order to protect consumers' health and safety. Other research evidence gathered during this evaluation also points to the need for more specific training related to being an administrator in a community-based setting.

Results also suggest two key revisions to training requirements regarding administrator training to better meet consumers' needs. First, the UCD evaluation team's medical experts recommend requiring all administrators to complete the 35 hour administrator certification program, without exception. The UCD medical experts further suggest requiring administrators to complete hands on training that teaches the unique roles, responsibilities and expectations of an administrator in a community-based setting. In particular this training should cover Individual Health Care Plans (IHCP) and teach how to translate the plans into direct care.

Staff Training

Employment in the SB 962 homes has special training requirements. All direct care personnel (RNs, LVNs, LPTs, CNAs, and other direct care staff) must complete the Direct Care Support Professional Training (DSP). The first half (35 hours) of this training must be completed within the first 12 months of hire at the SB 962 homes. Administrators reported in the *Facility Survey* that all 45 (100%) direct care personnel that had worked in the SB 962 homes for 12 months or longer by the time of the last site visit had completed Part I of the DSP training. Sixteen (36%) of these staff members had exceeded the requirement by also completing Part II of the training prior to the final site visit by the evaluation team.

In addition, 161 (57%) of the 283 direct care personnel who had not yet worked in the SB 962 homes for 12 months had also completed Part I of the required DSP Training at the time of the most recent site visits. Another 22 (8%) were scheduled for the first part of the training. The final 100 (35%) direct care personnel had not yet received any DSP Training. Since these individuals had not been employed for 12 months, the homes were not out of compliance.

Findings from this evaluation support revision to training requirements for non-administrative staff. In their expert opinion, the UCD evaluation team's medical consultants recommend requiring training to prepare staff for working in a community-based facility, which varies significantly from a hospital setting, prior to or directly upon beginning work in the homes. Upon beginning work in the homes all staff should also receive hands-on training related to the specific care and support needs of the individual

consumers with which they are working, many of who's needs differ substantially from those staff have worked with in the past. Finally, the medical experts strongly suggest that in order to reduce the number of preventable Special Incidents (see Section 3.8), all staff complete training that covers Individual Health Care Plans (IHCP) and teaches how to translate the plans into direct care. Medical experts also recommend that Direct care personnel demonstrate competency with hands-on care shortly after employment.

3.5.3 Sufficiency

All 23 homes met or exceeded the minimum requirement of having a RN awake and on duty for at least eight hours per consumer, per week during all initial and follow-up site visits the evaluation team made to the SB 962 homes. At the time of the final site visits, the home administrators reported that an RN was awake and on duty an average of 21.84 hours per consumer per week, with a range of 8 to 56 hrs. Twenty-one (91%) of these 23 homes exceeded the minimum requirement by having staffed an RN for more than 8 hours per consumer per week.

Each of the 23 homes was also staffed with at least one licensed staff member (RN, LVN, or LPT) at all times when consumers were in the home. As described just above, many of the homes utilize RNs for a substantial number of hours. While SB 962 calls for a licensed registered nurse, licensed vocational nurse, or licensed psychiatric technician to be awake and on duty 24 hours per day seven days a week, three homes have all consumers attending a day program outside the home. Thus, these homes do not consistently have staff members on duty during these day program hours although they always have licensed staff on-call in case a consumer needs to come home prior to the end of the day program or in the event that a consumer has a medical appointment scheduled during the day. In addition, administrators are always available either in the home or by telephone, and all administrators are licensed RN or LPTs.

Twelve (52%) of the 23 homes explained that they exceeded this minimum requirement by having more than one licensed staff member at some times during each week. The extra number of hours ranged from a few hours per week to 120 hours per week. Five of these 12 homes explained that they bring in extra licensed staff to accompany consumers to their medical appointments and community outings. Seven others have scheduled overlaps and double coverage by licensed staff.

All 23 homes also met or exceeded the minimum standard of staffing an administrator on duty at least 20 hours per week and having at least two staff awake and on duty when caring for four or more consumers.

In sum, many SB 962 homes often exceeded the minimum staffing requirements that are described in the legislation. Findings showed that this was necessary to meet the needs of particular groups of consumers in several SB 962 homes. This highlights the critical importance of the RCs in monitoring staffing. SB 962 states that, "*the regional center may require an ARFPSHN to provide additional professional, administrative, or supportive personnel whenever the regional center determines, in consultation with the*

individual health care plan team, that additional personnel are needed to provide for the health and safety of consumers."

Results showed that when service providers and RCs worked together to match staffing to consumers' needs, the SB 962 homes successfully provided for the health and safety of consumers. When homes remained staffed at the minimums laid out in SB 962 (regarding numbers of licensed and total staff per shift; administrator hours on-duty per week) the administrators and staff were typically able to meet consumers' needs but often experienced difficulties while striving to do so. They struggled with organization and planning, community integration, stress and morale, and coordination of staffing. Thus, the evaluation team does not recommend any changes to the language of SB 962 with respect to sufficiency of staffing but highlights the crucial role of the RCs in ensuring that the SB 962 homes are staffed sufficiently.

3.5.4 SUMMARY AND RECOMMENDATIONS

In summary, evidence related to the types, qualifications, and sufficiency of staffing revealed the following:

- The types, qualifications, and sufficiency of staffing meet and/or exceed the requirements of SB 962.
- The role of the RCs is crucial to ensuring sufficient staffing (numbers of licensed and total staff per shift; administrator hours on-duty per week) for SB 962 consumers who often require staffing above the minimums.
- Some administrators and staff members who meet the SB 962 staffing requirements would benefit from additional and/or earlier training to succeed in caring for SB 962 consumers in the community.

Based on these findings, the evaluation team recommends that the parties responsible for the interagency coordination of the project, including RC nurses, reconvene to consider making a few key changes to training requirements for administrators and staff. Potential revisions may include these provisions:

- Require training specific to the unique roles, responsibilities and expectations of administrators of community-based facilities, or equivalent prior experience. This training should include a hands-on mentoring component.
- Mandate administrators complete the 35 hour administrator certification program, without exception (no challenge test).
- Require that staff receive training on the unique roles, responsibilities and expectations of working in a community-based facility prior to, or directly upon beginning work in the home.
- Mandate that staff receive hands-on training related to the specific care and support needs of the individual consumers with which they are working directly upon beginning work.
- All staff must complete training that covers Individual Health Care Plans (IHCP) and teaches how to translate the plans into direct care. Direct care Personnel must demonstrate competency with hands-on care shortly after employment.

3.6 STATUTE: 4684.74 #7: THE OVERALL IMPRESSIONS, PROBLEMS ENCOUNTERED, AND SATISFACTION WITH THE SB 962 SERVICE MODEL BY SB 962 HOME EMPLOYEES, REGIONAL CENTER PARTICIPANTS, STATE LICENSING AND MONITORING PERSONNEL, AND CONSUMERS AND FAMILIES.

In their responses to interviews and focus groups, key informants (home administrators and staff, RC coordinators, RC nurses, family members, representatives from RCs, DDS, and DSS) commented on strengths and challenges of the SB 962 project in several key areas. The evaluation team analyzed these comments systematically to identify common themes. Results are organized according to satisfaction of key informants in four outcome areas: consumers, staff, administrators, and families.

3.6.1 Consumers

Table 2 presents an overview of the strengths and challenges of the SB 962 project for consumers as identified by interviews and focus groups with key informants. Following the table is a brief description of each of the key areas. Most of these areas have already been discussed in earlier sections of this report and are therefore not described in detail here.

Table 2. Strengths and Challenges of SB 962 Homes for Consumers

	Strengths	Challenges	Examples
Quality of Life	▪ Personalized homes ▪ Private rooms ▪ Outdoor spaces ▪ Normalization ▪ Calm, peaceful	None noted	*"They're in their own homes, with their own rooms, with their own things, and people are there to address their specific needs."* (Key Informant)
Level of Functioning	▪ Increased mobility ▪ More verbalization ▪ Higher awareness ▪ New skills ▪ Choices	None noted	*"We have one client that cannot verbalize before but now he can, he can talk, could verbalize before. Yeah, he can say yes and no, he can verbalize."* (Staff)
Happiness	▪ More smiling ▪ Calm and relaxed ▪ Fewer behavior concerns ▪ Positive mood ▪ More joy and comfort	None noted	*"We are seeing miracles happen in these homes... [previously] she kept her eyes closed all the time, possibly blind and she would keep her head down all the time...now [in the*

	Strengths	Challenges	Examples
Happiness (continued)			*home]...she's smiling. And she has no trouble keeping her head up, she is not blind."* (Key Informant)
Health & Safety	▪ Relatively stable ▪ More bathing, & grooming ▪ Eating better ▪ Improved health ▪ Need fewer interventions	▪ Some concerns about how the most medically fragile consumers will fare in the future remain.	*"Every other day he needed suppositories, and in the home, after one month, he doesn't require any suppository for the rest of the whole year. That's really improvement."* (Staff)
Access and Quality of Services	▪ 24 hour nursing care ▪ Low ratios ▪ Proximity to services ▪ Good primary care physicians visit in-home ▪ In-home services	▪ Access to dental care under sedation ▪ Practitioners unfamiliar with SB 962 population	*"They [practitioners] need to really understand that there's a huge difference between talking to a normal person and talking to a developmentally disabled person, and especially even medically fragile people."* (Staff)
Community Integration	▪ Community outings ▪ Neighbors visit some	▪ Few outings for some ▪ Little contact with neighbors	*"Depending on the home and the provider, the amount of access to the community is limited."* (Key Informant) *"We have to cancel outings because we cannot find staff."* (Staff)
Quality of Care in Home	▪ Individualized ▪ Relationships with Staff	▪ None noted	*"Because you see them every day… any significant change in their condition – you're able to notice it right away."* (Key Informant)

Quality of Life

Informants universally praised the SB 962 model for improving the quality of life for consumers. They pointed to the advantage of living in a home environment, such as private rooms, a calm atmosphere, social opportunities, and other aspects of more normalized lives.

Moreover, key informants were also very positive about the physical aspects of the SB 962 homes and their contributions to consumers' quality of life. They explained that the SB 962 homes were constructed with many advantages for the SB 962 consumers. For example, green products were used to minimize exposure to toxic substances, bedrooms were individually temperature controlled, and a tracking system was used in many of the houses to transport immobile consumers from room to room. Not only were the SB 962 homes designed for medically fragile people, but they were also specifically modified to meet the needs of each individual consumer.

Level of Functioning

Another theme that emerged from the focus groups and interviews was improvement in consumers' level of functioning in the SB 962 homes (See Section 3.3).

> ***"The homes were designed with their unique health needs in mind … we installed electronic air filtration systems to help minimize the allergens … we created comfortable outdoor environments … we created sun protection in those outdoor environments so individuals who were taking specific drugs were protected … I felt like we really helped to improve the potential quality of life for people served."*** **(Key Informant)**

Happiness

Positive changes in consumers' happiness, mood, and behavior were also frequently mentioned by key informants (See Section 3.4).

Health and Safety

Most of the comments related to consumers' health and safety were positive including several improvements in health conditions, nutrition, and hygiene (see Section 3.3).

Access to Services

Analysis of interviews and focus groups highlighted several strengths and challenges of consumer's access to medical, dental, and health care services in the community (see Section 3.3). Nearly all informants pointed to the advantage of 24 hour nursing care. A few also explained that the locations of the homes were selected for their proximity to medical facilities, including emergency services. Many positive remarks were also made about the primary care physicians who see consumers in their homes and are consistently

> ***"We focused on creating home-like settings that provided normalization, so the focus was on the individual and not just on their health needs."*** **(Key Informant)**

available for consultation by phone. Another advantage that was noted was the ability to administer IV antibiotics in the home, which limits hospital stays and often eliminates the need for temporary placement in other facilities.

Another theme that emerged from the analysis of focus groups and interviews with key informants was that certain community practitioners, such as hospital staff and outpatient specialists, (but not community-based primary care physicians) are unfamiliar with the SB 962 consumers. Informants explained that community practitioners are not always in-tune with how the interactions between consumers' developmental disabilities and ongoing medical conditions affect their responses to medical issues and that they also have difficulty communicating with the consumers.

Finally, results suggested that Agnews outpatient clinic remains crucial to providing dental care for consumers of the SB 962 homes that require dental sedation (see Section 3.3).

Community Integration

Findings revealed wide variation in consumers' level of community integration with some consumers being highly integrated and others experiencing very little integration into the community (see Section 3.4).

Quality of Care in Home

One of the key strengths noted by the key informants was the quality of consumers' care in the SB 962 homes (see Section 3.3). Key informants were overwhelmingly positive regarding the quality of care that consumers receive in the SB 962 homes. They felt that the small group settings facilitated individualized care from staff members who know consumers' needs, cues, and who have the time to attend to them right away.

3.6.2 Staff

The key findings regarding the strengths and challenges of the SB 962 with respect to staff are outlined in Table 3. Several of these areas relate to the qualifications, training, and sufficiency of staffing in the homes, which has already been discussed in Section 3.5. Other areas include staff satisfaction, work load and roles, and support. Each of these areas is presented briefly in this section. Analysis included responses from focus groups and interviews as well as data related to staff satisfaction that were collected from a larger pool of staff members as part of the *Staff Survey.*

Table 3. Strengths and Challenges of SB 962 Homes for Staff

	Strengths	Challenges	Examples
Qualifications	▪ Some staff had prior experience with consumers ▪ Others were experienced in community care	▪ Staff new to community care had restricted skill sets ▪ Other were unfamiliar with consumers	*"There isn't this delineation of, I only do these jobs - it doesn't translate well to the community."* (Key Informant)
Training	▪ DSP training required ▪ Extra training to broaden skills	▪ No hands-on ▪ Doesn't include daily challenges ▪ DSP training not required until end of 1st year.	*"Adjusting to new work environment with other staff in the community who have no experience working with developmentally disabled consumers [is challenging]."* (Staff)
Staffing	▪ 24 hour nursing care ▪ Several homes exceed requirements	▪ Minimum required RN hours may be insufficient when homes are at capacity ▪ 1 licensed staff per shift may be insufficient when homes are at capacity	"*It is unsafe for some of these homes just thinking about having 8 [RN] hours… Pretty minimal, minimal staffing. "* (Key Informant)
Working Conditions	▪ Calm and Peaceful ▪ Relationships with Consumers, Families, and Staff ▪ Low ratios	▪ Not enough licensed staff	*"Its more calm … less people."* (Staff) *"You'll not be able to leave [for a break, when you are the only licensed staff on duty] because there should [always] be a licensed staff."* (SB 962 Staff)
Work Load & Roles	None noted	▪ Broad roles and responsibilities ▪ House Managers always on-call	*"You're doing paperwork, your meds, changing, wiping, cooking, so it's really hard for the household to do everything."* (Staff)

	Strengths	Challenges	Examples
Support	▪ Relationships with supervisors ▪ Peer-support	▪ Administrator not always on-site ▪ No manuals or document supports	*"Supervisors in the community are more like family"* (Staff)

Qualifications

Findings document a mix of strengths and challenges with respect to staff qualifications. The prior experience of staff who had previously worked with the consumers of the SB 962 homes was identified as a clear advantage. Staff who had not previously worked with this population faced some challenges in getting to know consumers and their needs. However, these staff had a different advantage in that most of them had experience working in small community homes and were therefore familiar with their roles and responsibilities. Several of the staff that were new to community-based care reported having difficulties adjusting to their new responsibilities such as coordinating care, community outings, cooking, housekeeping, etc. A common theme from the focus groups and interviews was that licensed staff that were new to community-based care settings had more narrow skill sets than more experienced community staff. For example, many RNs had not received updated training in I.V. therapy, which initially created delays for some consumers returning home from the hospital until all RNs had received updated training in I.V. therapy.

> ***"And so as [staff] move to a community setting, they might find that they're the sole RN out there, or the sole LVN and then they have the two CNAs working with them. ... it's a different kind of nursing."*** **(Key Informant)**

Training

Results show that staff members are completing the required training on schedule but that more training is needed and that staff should receive some specific training prior to or directly following their commencement of work in the homes (See Section 3.5). This was a common theme identified through analysis of the key informant interviews and focus groups showing that experts as well as staff members themselves strongly suggested more training. Even RNs asked for more training.

> ***"It would be better if they would, even [for] us the RNs . . . put us in the home with more training . . . it's important to have the DSP training before having the staff come work in the homes."*** **(SB 962 Staff)**

Staffing

Findings document that all of the SB 962 homes meet minimum standards for number of hours worked per week by licensed staff. However, based on the needs of the

consumers in the home, many SB 962 homes need additional hours of licensed staff beyond the minimum. Many homes already exceed the minimum standards but others do not (See Section 3.5).

Staff Satisfaction

Data regarding staff satisfaction comes from the *Staff* Survey. Satisfaction is broken down into two subscales: satisfaction with the implementation of the community based model and satisfaction with working conditions.

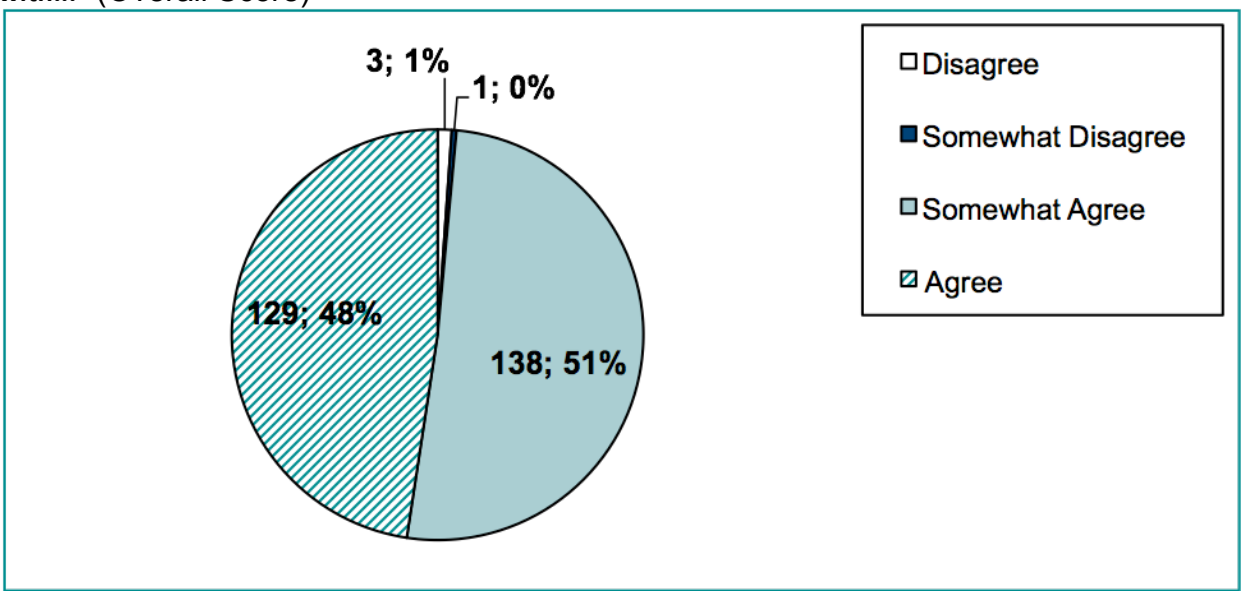
Satisfaction with the Community-based SB 962 Model

For the subscale assessing satisfaction with the implementation of the community-based model, 271 staff members reported an average total score of 3.85 (with a range of 1.50 to 4.00) where 1 = "disagree" that they were satisfied and 4 = "agree" that they were satisfied. Overall, most staff members (98.5%) either "agreed" or "somewhat agreed" that they were satisfied with the community-based model of the SB 962 homes though one "somewhat disagreed" and three "disagreed" (see Figure 20). Staff were slightly less satisfied, however, with a few specific items including the sufficiency of staffing and time allocated for helping consumers with non-medical/support needs such as involvement in household activities and routines, community activities, decision making (average score = 3.77) as well as for the homes' relationships with neighbors and the surrounding communities (average score = 3.67). Although staff indicated a lower satisfaction with these items, these two indicators of satisfaction with the implementation of the community based homes still fell into the "somewhat agreed" category.

> ***"Working the SB 962 homes is a less stressful work environment. I'm more sensitive and observant of consumer's needs."*** **(SB 962 Staff)**

Previous work experience played a significant role in staff satisfaction with the implementation of the community-based model of care. Findings show that staff who did not have prior experience working in community-based settings reported slightly lower (but statistically significant) satisfaction with the community-based SB 962 model and implementation than staff that did have similar experience in the community (t (235) = 2.26, p = .03). In addition, individuals with less prior experience working with people with developmental disabilities reported slightly less satisfaction with the community-based SB 962 model of care than those with higher levels of experience (r = -.11, p = .08). This association was not statistically significant.

Figure 20. Staff Satisfaction with Community Based SB 962 Model and Implementation: "I am satisfied with…" (Overall Score)



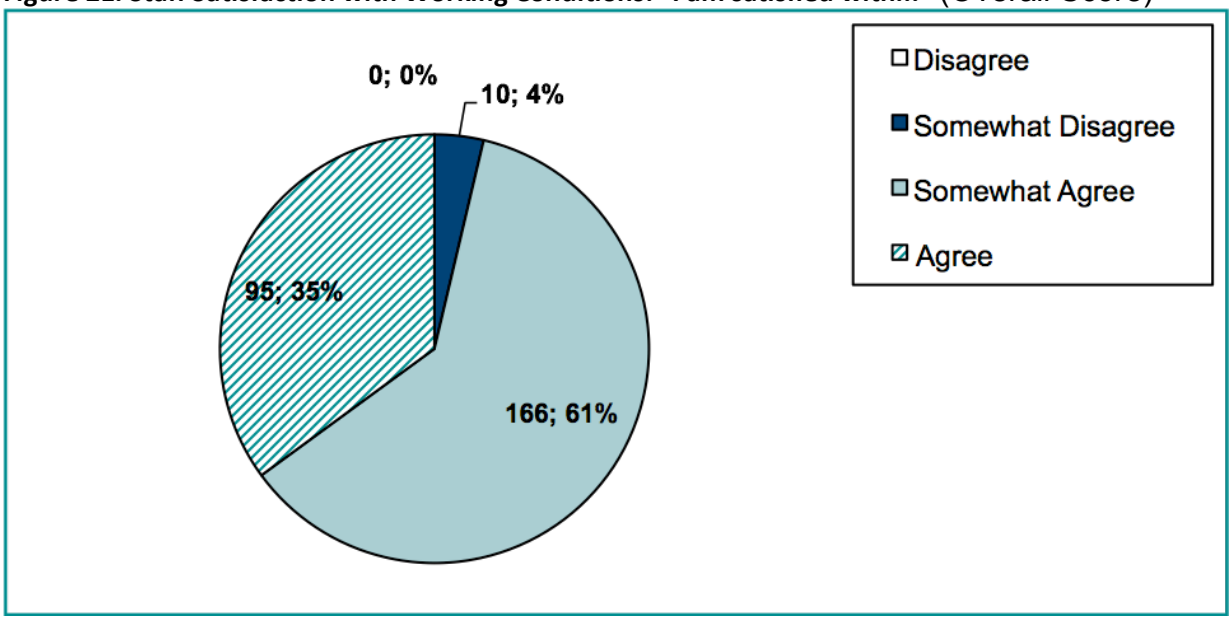
Satisfaction with Working Conditions

Staff also reported on their satisfaction with their working conditions in the SB 962 homes. For this set of items, the 271 staff members reported an average total score of 3.85 (with a range of 1.50 to 4.00) where 1 = "disagree" and 4 = "agree." Overall, most staff members (96%) either "somewhat agreed" or "agreed" that they were satisfied with their working conditions though ten "somewhat disagreed" (see Figure 21).

While staff reported a moderate level of satisfaction with their working conditions overall, they were less satisfied with their salaries and benefits. The average score for the item "I am satisfied with my rate of pay" was 3.26 where 1 = "disagree" and 4 = "agree." Fifty one (19%) out of the 262 staff members who responded to this item reported that they either "disagreed" or "somewhat disagreed" that their pay was satisfactory. Similarly, the average score for the item "I am satisfied with my benefits (e.g., medical, dental, retirement)" was 3.21. Forty eight (21%) of the 228 staff members who responded to this item reported that they either "disagreed" or "somewhat disagreed" that their benefits were sufficient.

There were no significant differences in satisfaction with working conditions for staff who were new to community-based care and those with experience in the community (t (235) = 1.28, p = .20) nor was there a significant association between amount of previous experience working with individuals with developmental disabilities and satisfaction with working conditions (r = .01, p = .86).

Figure 21. Staff Satisfaction with Working Conditions: "I am satisfied with..." (Overall Score)



On the other hand, working as an employee of the State of California had a statistically significant positive effect on staff satisfaction with working conditions (t (211) = 2.70, p = .01). State employees were slightly more satisfied with their working conditions than were the employees of the owners of the community-based homes, though both groups of employees reported average levels of satisfaction in the range between "somewhat agree" and "agree" about being satisfied with working conditions.

Changes in Satisfaction Over Time

Levels of staff satisfaction were very stable over time. For the 58 staff members who completed surveys during at least two site visits to the SB 962 homes, no differences in satisfaction between the first and second site visits for either staff satisfaction with the community-based model (t (57) = .18, p = .86) or for staff satisfaction with working conditions (t (57) = .002, p = .99).

Work Load and Roles

One of the key themes identified through analysis of responses to the *Staff Survey* as well as the focus groups and interviews was that staff members faced challenges getting accustomed to their roles in the SB 962 homes. Staff that were new to community-based care, in particular, experienced difficulties adjusting to the wide variety of tasks they were responsible for in the homes including cooking, cleaning, paperwork, coordinating outings, dealing with neighbors, etc., on top of their caretaking responsibilities. House managers also reported frustrations with always being on-call to answer questions and handle issues that arise during their time off.

Support

One of the key strengths of the SB 962 homes is that the direct care staff feels well-supported. Most direct care staff members explained that they feel supported by families, by each other, and by the administrators. Staff noted that the home setting allowed families and staff to get to know one another better and that they are developing mutual trust and support. However, a couple of exceptions were noted by staff members who experienced negative interactions with consumers' family members.

Several direct care staff members commented that their close relationships with one another and also with their supervisors helps them to feel good about their work and ultimately contributes to better care for the consumers.

3.6.3 Administrators

The results from the analysis of focus groups and interviews with key informants regarding the strengths and challenges of the SB 962 with respect to administrators are outlined in Table 4. Several of these areas relate to the qualifications, training, and sufficiency of staffing in the homes, which have already been discussed in Section 3.5. Other areas include work load, roles, and support.

Table 4. Strengths and Challenge for Administrators

	Strengths	Challenges	Examples
Qualifications	▪ Some highly qualified	▪ Difficulty locating qualified administrators	*"Just being a high level staff or nurse . . . did not qualify a person to be a good administrator in a community setting [it's] a much broader, generalized knowledge."* (Key Informant)
Training	▪ All completed required training	▪ Not hands-on ▪ Only covers small amount of actual duties	*"Nobody fully understood how to do the job. You don't get - you don't get like several weeks of training to really comprehend what you're going to be doing."* (Home Administrator)
Work Load & Roles	None noted	▪ Paperwork ▪ Staffing ▪ Amount of work ▪ Broad responsibilities	*"Having to run two homes, for 20 hours a week is unrealistic...The quality's not there."* (Home Administrator)

	Strengths	Challenges	Examples
Support	▪ A few administrators feel well supported and network with one another	▪ Insufficient support ▪ Communications with provider organizations	"*Most people who did this job were near insanity because you have to work enormous hours and nobody-there's no one to talk to.*" (Home Administrator)

Qualifications

Findings revealed challenges in finding qualified administrators for the SB 962 homes (See Section 3.5).

Training

Results showed that all administrators have completed the required trainings but that additional training is needed (See Section 3.5).

Work Load and Roles

Participants from the focus group with home administrators argued that 20 hours per week is not sufficient to run a quality SB 962 home, especially since a 20 hour minimum opens the opportunity for one administrator to be in charge of two SB 962 homes, which several were. As discussed earlier in this report, many of the administrators of the homes are experiencing high levels of stress and are overwhelmed by the demands of their roles. As a group, they explained that increasing the administrative hours to 40 hours per week would mean that each administrator only runs one home (several currently run two homes). This would provide the opportunity to be more successful and to ultimately provide better support to both consumers and staff.

> ***"Not to mention stress on them [administrators] … the learning curve was very steep . . . to be an administrator of a home is very tough."*** **(Key Informant)**

It should be noted that DSS does not normally specify a minimum number of hours an administrator is to work at a particular facility. The 20 hour minimum was specifically inserted into the SB 962 legislation as a safe guard that there be a strong administrator presence in the home.

In addition to concerns about not having enough time, findings showed that many administrators also struggle with their work load and roles. For example, several administrators discussed having too much paperwork to handle successfully. During their site visits to the SB 962 homes, the evaluation team's medical consultants noted this as well. While some administrators kept orderly and complete files, others' paperwork was disorganized and often incomplete. House managers also appear to be

very involved in handling paperwork responsibilities and expressed similar frustrations regarding paperwork. In addition, licensing personnel noted some difficulties with paperwork in the homes that led to citations for not having appropriate paperwork. Findings also suggest that coordinating staff was also a daunting task for many administrators. Some administrators had a hard time retaining good staff members. Other administrators, as well as house managers, experienced difficulties coordinating sufficient staff for community outings and medical appointments and particularly had difficulties bringing in extra licensed staff to cover when consumers became ill.

Support

> ***"I really think that we need more support . . . we're kind of a really key pivotal person for these homes because of all the staff and all the clients and we are, you know, ultimately responsible; I don't think people have a clue yet as to what our daily life is."*** **(Home Administrator)**

One of the key messages from the interviews and focus groups was the critical importance of the SB 962 administrators to the overall success of the project. Results also revealed, however, that many administrators lack the support they need to accomplish all that is expected of them. While a handful of administrators do seem to be well-supported by both the RC and one another, these administrators seem to be the exception. Their homes are coordinated under one RC that only has a few SB 962 homes, and they are all owner-operators who have a substantial degree of control and autonomy. The other administrators experience challenges communicating with their provider organizations and obtaining necessary resources as well as difficulties getting the information and support that they need from the RCs. Administrators expressed these sentiments not only during the focus group but also throughout the length of the project during their conversations with the evaluation team.

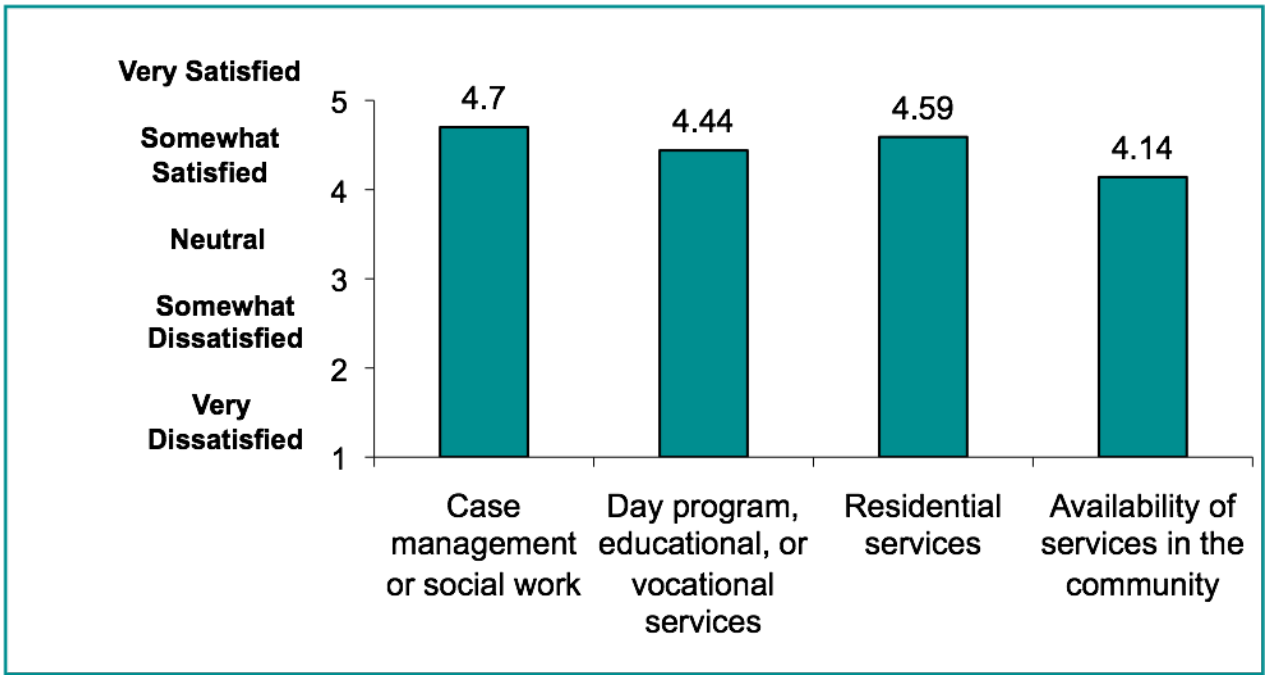
3.6.4 Families

The 30 family members who have participated in this evaluation study reported a relatively high level of overall satisfaction with the SB 962 homes and the services they provide for their family members. When asked to rate a series of four items regarding their overall satisfaction from 1 = "Very Dissatisfied" to 5 = "Very Satisfied," they reported an average total score of 4.49 (with a range of 3.00 to 5.00), which is equivalent to a rating between "Somewhat Satisfied" and "Very Satisfied."

> ***"I feel my son is finally and truly living in safety with dignity and respect and is a member of the community."*** **(Family Member)**

As shown in Figure 22, family members are slightly more satisfied with case management and residential services than they are with the day programs or the availability of services in the community.

Figure 22. "Overall, how satisfied are you with the ... that your family member is now receiving in the community?"



Overall Satisfaction--Strengths and Challenges

Table 5 outlines the specific areas of strength and challenges that were noted as key themes in the analysis of family surveys and focus group interviews. Each of these areas is discussed in the following sections along with more detailed family ratings of satisfaction with the SB 962 residences, services, and transition process.

Table 5. Strengths and Challenges of SB 962 Project Identified by Family Members

	Strengths	Challenges	Examples
Residence	▪ Indoor and out ▪ Food ▪ Family Atmosphere ▪ Calm and quiet ▪ In communities	▪ Some staff don't cook well.	*"My daughter can look out the window and see the world outside."* (Family Member)
Services	▪ Individualized care ▪ 24 hour nursing care ▪ Good staff-consumer ratio	▪ Access to Medical Care ▪ Experience of practitioners	*"They do get a lot of attention. It is wonderful and a real advantage."* (Family Member) *"I am concerned because his [doctor's] office is far away. He comes when called, but what if we need him quickly and he cannot be here in time?"* (Family Member)
Consumer Health and Quality of Life	▪ Eating better ▪ More alert ▪ Higher functioning ▪ Happier	None noted	*"She has blossomed out. She is very alert and happy."* (Family Member)
Communication with Home	▪ Good relationships with staff ▪ Staff very caring	▪ Need more communication with provider	*"I would like to hear more from the provider. We don't hear from them unless we go to them [SB 962 homes]."* (Family Member)
Contact with Consumer	▪ Closer to consumers ▪ Visit more often	None noted	*"We visit more often now and spend all day with her."* (Family Member)

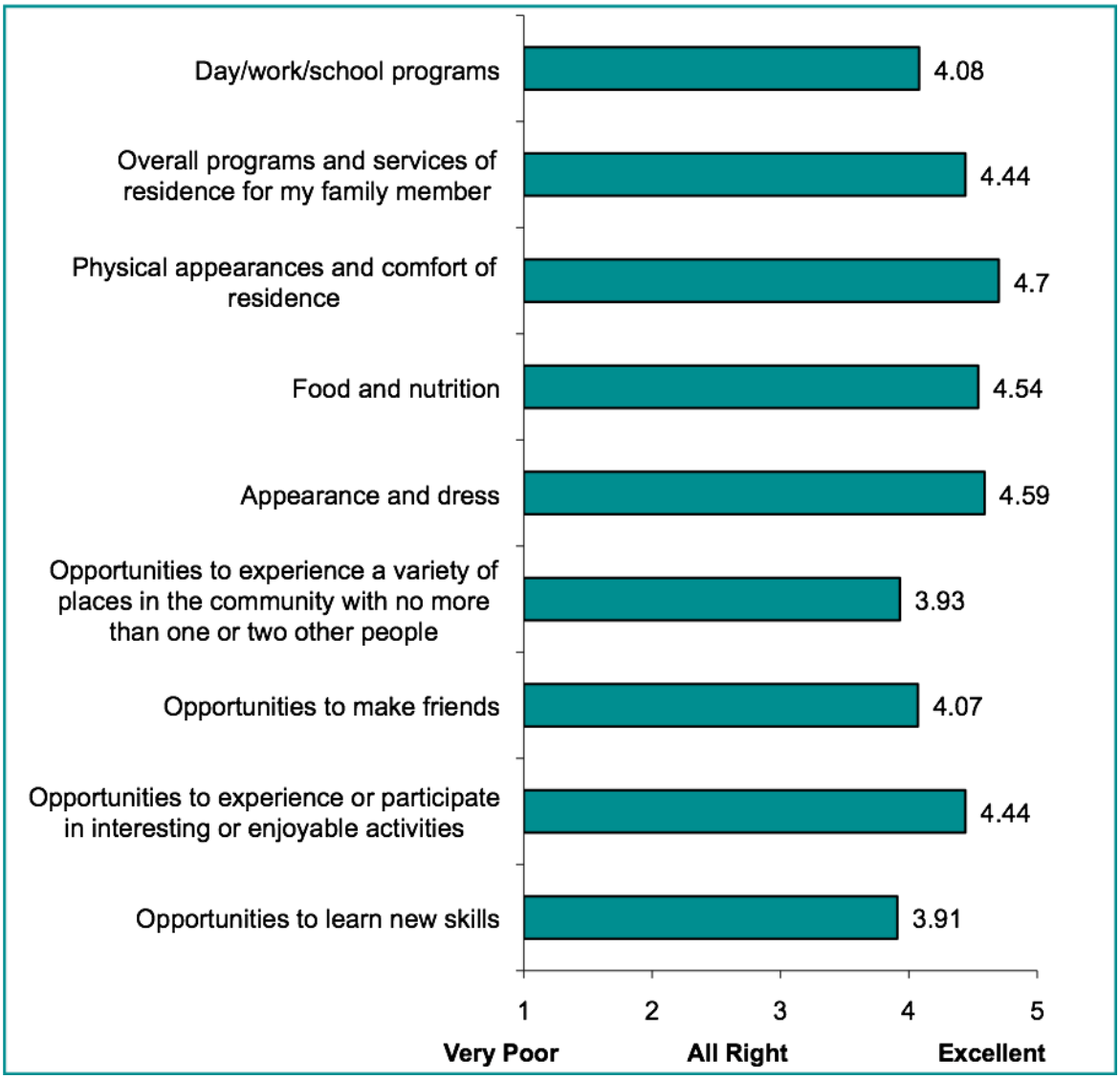
Residence

The *Family Survey* asked family members to rate a series of nine items regarding the SB 962 residences from 1 = "very poor" to 5 = "excellent." They reported an average total score of 4.32 (with a range of 2.75 to 5.00), which is equivalent to a rating of "good." Items receiving the highest scores were physical appearance and comfort of the

residence, appearance and dress, overall programs and services, and opportunities to experience or participate in interesting or enjoyable activities (Figure 20). Aspects of the residences that received the lowest scores from family members were opportunities to learn new skills and opportunities to experience a variety of places in the community. This high level of satisfaction with the residences was echoed in the family focus group interview. Most participants noted that they were pleased with the family-type setting and that the homes were very nice, clean, and peaceful. (Table 5).

"The homes are wonderful. They are cozy and nice." **(Family Member)**

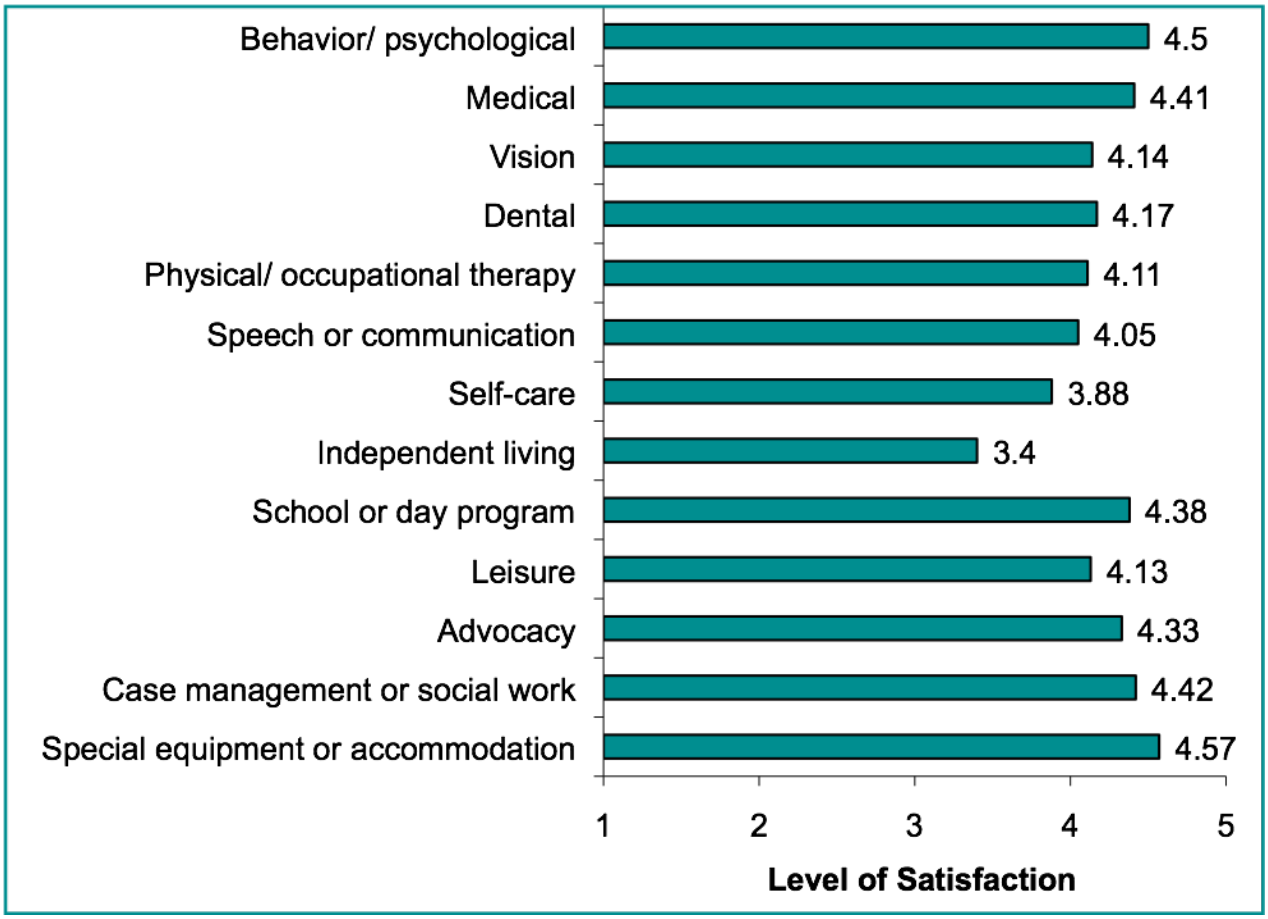
Figure 23. Family Satisfaction with SB 962 Residences



Services

Results from the *Family Survey* showed that family members were also satisfied with the services their family members received through the SB 962 homes (Figure 23).

Figure 24. Family Satisfaction with SB 962 Services



Family members rated a series of thirteen items related to services on a scale from 1 = "very poor" to 5 = "excellent." They reported an average total score of 4.23 (with a range from 2.63 to 5.00), which is equivalent to a rating of "good." Individual services received scores ranging from 3.4 (independent living) to 4.57 (special equipment or accommodation) (Figure 24).

Nursing and Other Direct Care in the Home

Family members were very pleased with the amount of attention and individualized care their loved ones received and they reported being satisfied with the 24 hour nursing care. Several family members also noted that the staff treat consumers like family and do little extras for them, like setting up for birthday parties.

***"The staff seems truly devoted to providing the best possible care to clients."* (Family Member)**

***"We are so thankful that she looks well and her physical self is so nice. We are thankful for such nice care-takers."* (Family Member)**

Medical and Dental Care

On the other hand, a common theme that was identified through analysis of the transcripts from the family focus groups was an ongoing concern about access to medical care. Family members worried about not having doctors and specialists available on-site. They were concerned that consumers had to wait for doctors to come to the home to see them, and that at other times they had to go to the hospital for care.

***"You have a lot of challenges with being sent off to a hospital on a heartbeat. I can't say that the medical out there are really OK ... He still has to wait in an ER for up to 11 hours. He could have had a doctor sent to the house instead."* (Family Member)**

Several of the concerns were related to questions about whether levels of funding for the SB 962 homes and consumers would be reduced in the future and how these potential changes would affect consumers' access and quality of medical care. A few family members, however, did make positive comments about their loved ones' experiences with medical or dental services in the community. It should be noted that at the time focus groups were held some of the consumers had transitioned into their new residence at the SB 962 homes fairly recently. This may at least partially explain the hesitations that some of the family members expressed about medical and dental care.

Consumer Health and Quality of Life

Families expressed very positive impressions of consumers' health and quality of life in the SB 962 homes. They commented that their loved ones appear happy and more alert. A few even discussed substantial changes in consumers' level of functioning such as beginning to speak a few words, eating normal food, or increased bonding with family members.

***"She (my daughter) is finally realizing that the two of us are together."* (Family Member)**

Communication

Almost all family members described very positive relationships with the staff from the SB 962 homes. They talked about the warmth and generosity of the staff who genuinely seemed to care about them and their family members. Administrators and RC employees ask for families input through surveys and also welcome comments at anytime. A couple of exceptions were noted in comments to the *Family Survey* in which respondents described frustrations in dealing with staff members and that

***"The staff is fantastic. They hug us and always have a smile. It is wonderful."* (Family Member)**

their concerns are not always taken seriously. Some family members also called for more communication. They indicated that they don't hear much from the providers unless they actually visit the home or specifically request information..

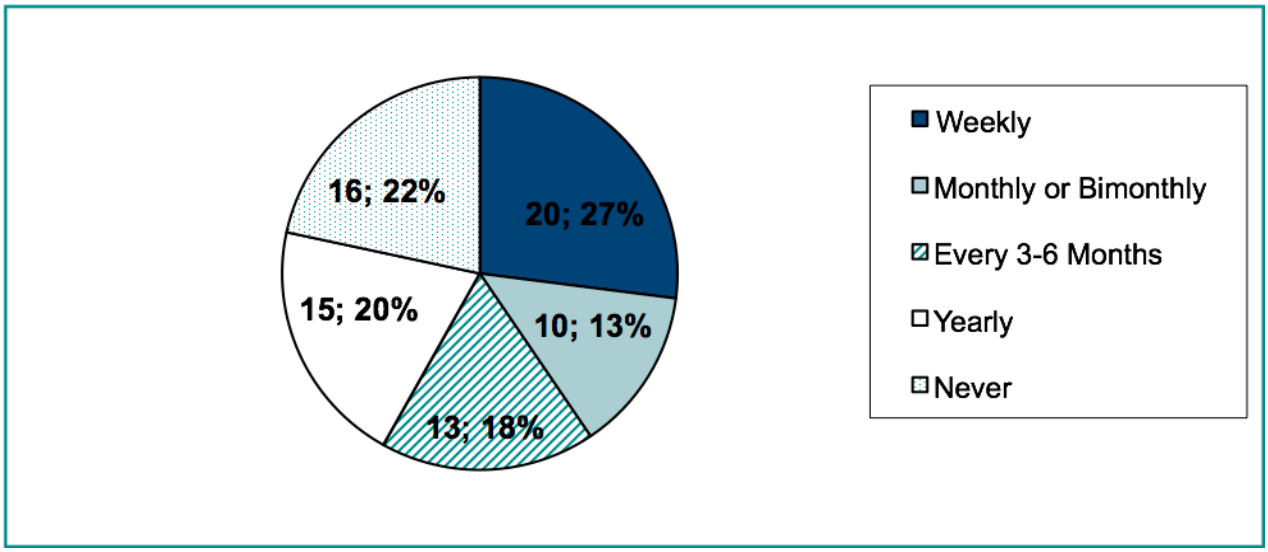
Contact with Consumers

A common theme that emerged from the analysis of family focus groups and surveys was that the SB 962 homes have made it possible for many consumers to live closer to their family members and those families are now able to visit consumers more often. In fact, the locations of the SB 962 homes were selected, in part, for their proximity to consumers' families. Families also noted that the SB 962 homes are enjoyable to visit. They are comfortable and have a family-like environment. Family members report being encouraged to get involved and to visit as often as they like.

> ***"...and the mother loves it. She's there like three times a week and it's like a home. And we have heard her, you know, saying, Hey, this is like my family. She loves the staff, she loves the home."*** **(SB 962 Staff)**

Results from the consumer survey offer a description of the frequency with which consumers and their family members have contact with one another. Findings showed that while many consumers enjoyed frequent contact with their family members, others had little or no contact with family (Figure 25). Twenty (26%) of the 74 consumers who had responses for this item had personal contact with one or more family member on at least a weekly basis. Others had less frequent contact with their families and 16 (22%) have not had any contact with family since moving into the SB 962 home.

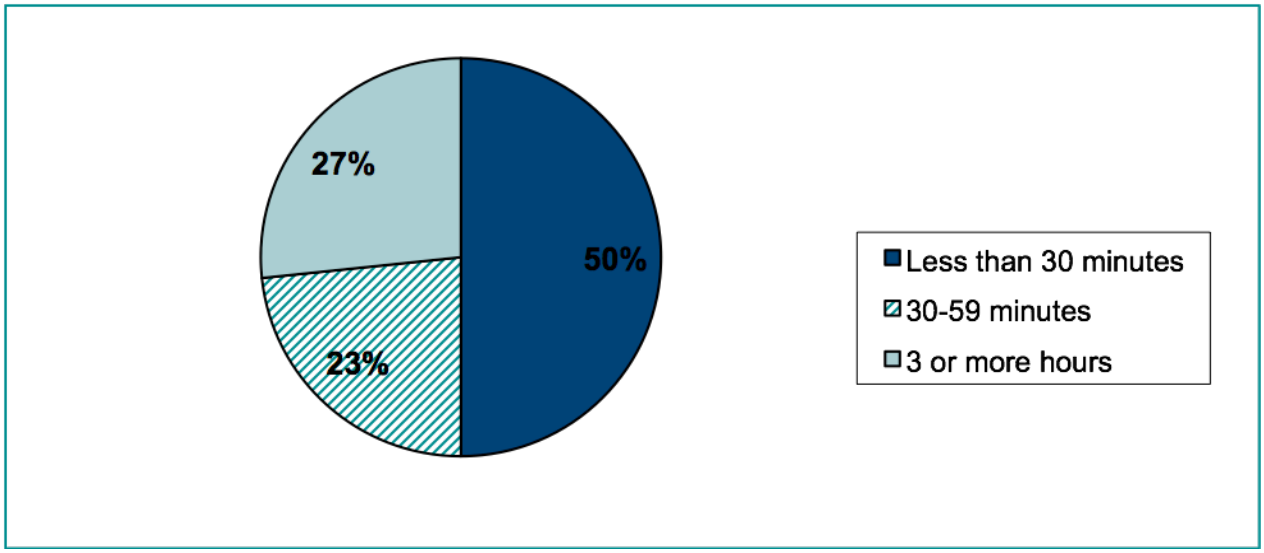
Figure 25. Personal Contact with Family: Overview



The frequency of family contact may be related to the time or distances that family members have to travel to visit consumers in the homes. Thirty family members completed questions related to travel time and/or distance on their most recently

available family surveys. They reported traveling an average of 283.8 miles (ranging from 0.8 to 2,500 miles) to visit their family members in the SB 962 homes, with the majority (53.6%) traveling less than 20 miles. Figure 26 shows that 50% of family members traveled 30 minutes or less to visit consumers in the SB 962 homes. Twenty three percent had to travel between 30 minutes and one hour. Eight family members (27%) reported having to travel 3 or more hours or having to fly to make visits. DDS has worked to make SB 962 homes available in communities near consumers' family members.

Figure 26. Distance (in hours) from Family Members



3.6.5 Summary and Recommendations

Overall, analysis of the impressions of SB 962 home employees/staff; RC, state licensing, and monitoring personnel; families and DDS indicates the following;

- A high degree of satisfaction with the impact of the SB 962 homes for consumers.
- Staff are mostly satisfied with their working conditions and feel well-supported.
- Most administrators feel overwhelmed and would benefit from additional training and supports from RCs and/or provider organizations.
- Most family members are satisfied with the SB 962 homes.
- Some family members are concerned about access to medical care in the community.
- Families are pleased with the quality of care their loved ones receive and many report visiting consumers more often now that they live in the SB 962 homes.
- Some family members would like more regular communication with the homes and regional centers.

The evaluation team does not recommend any changes to SB 962 based on these findings. However, please refer to the recommendations for Section 3.5 as they are also relevant to the findings from the current section.

3.7 STATUTE: 4684.74 #8: THE COSTS FOR ALL DIRECT, INDIRECT AND ANCILLARY SERVICES

3.7.1 Overview

The costs to be determined by the SB 962 legislation are direct, indirect, and ancillary service costs. Costs are categorized into the direct costs of monies spent on the direct care of SB 962 consumers, indirect costs for the housing of the SB 962 consumers, and ancillary costs. The time period used as the evaluation period for assessing program costs in this assessment is the actual time of operation of the SB 962 homes or in some cases, the sum of the projected costs over a future time period.

3.7.2 Direct and Indirect Operating Services Costs

The SB 962 facilities receive payments based upon rate structures determined by DDS staff, RCs, and Service Providers. DDS staff and the RCs classify costs into one of three categories. The first category is Residential Support, the second is Home Costs, and the third is Ancillary Costs. The two categories of costs determined by Schedule B of the contracts/agreements vary by SB 962 home and by RC. Ancillary costs are listed later and include costs not contained in either the Residential Support or Home Cost categories. Table 6 lists the total average monthly rate for each SB 962 home, negotiated by Service Provider organizations and the Regional Centers.

Table 6. Total Monthly Cost per SB 962 Home by RC

Regional Center	Monthly Residential Support	Monthly Home Costs	Total Monthly Costs
Golden Gate Regional Center, Inc. (GGRC)	$70,200.00	$20,914.87	$91,114.87
Regional Center of the East Bay, Inc. (RCEB)	$77,795.15	$18,929.00	$96,724.15
San Andreas Regional Center (SARC)	$79,303.14	$20,634.63	$99,937.77

Column 2 consists of costs that correspond to providing direct care for the SB 962 consumer. These costs were determined by summing all line items as listed in Schedule B in each of the agreements/contracts between Service Provider Organizations and the individual RCs.

Column 3 corresponds to indirect costs for the SB 962 consumer and was determined in the same manner as the direct cost. It includes the base rent which is not expected to vary over time and will eventually become zero. Other costs which make up the figure listed in column 3 are necessary maintenance, upkeep, taxes and insurance on the SB 962 homes. It should be noted that because the SB 962 homes are in different neighborhoods, housing costs are expected to vary by RC.

It should also be noted that the major difference in dollar amounts for Monthly Residential Support Costs (column 2) and Monthly Average Costs (column 4) for GGRC in comparison to the two other RCs is due to the difference in facility capacity. All of the SB 962 homes in the GGRC catchment area are four-bed facilities. In contrast, all of the remaining SB 962 homes are five-bed facilities with the exception of one four-bed facility in RCEBs catchment area. All the SARC SB 962 homes have five consumers.

3.7.3 Ancillary Service Costs

According to language in the various "Agreement for providing residential services under the Bay Area Housing Plan," between a Service Provider and one of the three RCs, Ancillary services are explained as ". . .provided by Service Providers to Consumers (that is, additional services not expressly included within the Maximum Monthly Rate (MMR) [and] must be identified by the Interdisciplinary team. . .in accordance with each Consumer's Individual Program Plan."

Each of the three RCs has tracked those costs outside of the MMR costs since any reimbursement for these costs must be submitted in advance and in writing to the RC. The ancillary service costs for each of the three RCs varies widely with only one RC having spent any money on Ancillary Service Costs as determined by the intent of the legislation and in clarifying discussions with DDS staff. In terms of dollar amounts, a total of $291.00 under Service Code, 117 – Specialized Therapeutic Services - was spent as an Ancillary Service Cost.

3.7.4 Summary and Recommendations

The SB 962 legislation required direct, indirect, and ancillary costs to be identified. The data provided was insufficient to directly distinguish between direct and indirect cost ratios so cost estimates were made based upon the relationship between average direct costs and actual total costs. Residential and Housing costs are detailed and negotiated by Service Provider organizations and the Regional Centers.

- Average costs per SB 962 home range from approximately $90,000 to $100,000 per month.[7]
- Average monthly property costs per SB 962 consumer is approximately $4,000.
- Average monthly residential services and supports cost per SB 962 consumer is approximately $15,000.
- Ancillary costs are very minor with two RCs having no Ancillary costs while the third had only $291.00 in costs.

The evaluation team did not make any recommendations related to this section.

[7] Figure based on five-bed facilities.

3.8 STATUTE: 4684.74 #9: ANALYSIS AND SUMMARY OF FINDINGS OF ALL CONSUMER SPECIAL INCIDENT REPORTS AND OTHER EVENTS REPORTED DURING THE EVALUATION PERIOD.

3.8.1 Number and Type of Incidents and Events

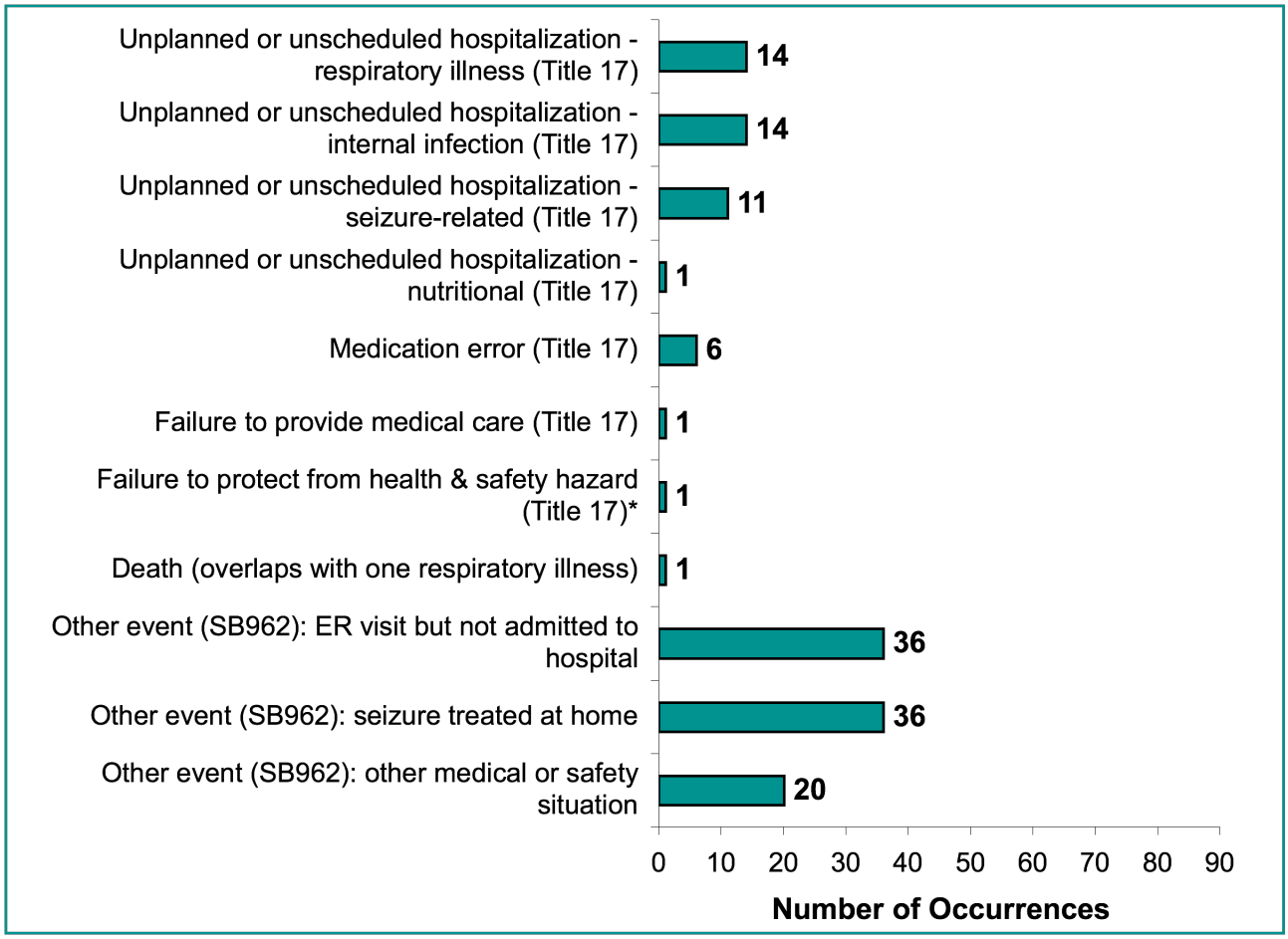
Based on information gathered from consumers' files during site visits to the facilities, 35 (47%) out of the 75 consumers participating in this evaluation study had at least one special incident report (SIR) or other event between the time that they were placed in the SB 962 homes and the time of the most recent site visit. Of those consumers who had at least one SIR/other event, the number of incidents or events ranged from one to 22 with an average of 4.06 SIRs/events per consumer and a total of 141 SIRs and other events. Figure 27 shows the types of SIRs and other events and the number of incidents for each type.

Forty-nine incidents were reportable under Title 17. Of these 49 incidents 40 were related to an unplanned or unscheduled hospitalization that included an overnight stay. The length of stay for 37 incidents ranged from one to twenty nine nights with an average of 7.52 nights. The length of stay for the remaining three incidents were unknown, at the time of the final site visit to the home(s).

Eleven of these incidents involving hospital stays were related to seizures. Fourteen of the hospitalizations were for respiratory illnesses, another 14 were for internal infections, and one was for nutritional deficiency. The unplanned hospitalization that involved a 29-night hospital stay was connected with the special incident involving a consumer's death, which resulted from a respiratory infection (pneumonia) that did not respond to treatment.

Six SIRs involved medication errors. In one of these cases, a consumer with diabetes was not administered insulin as it was ordered. Although the staff member who was on duty at the time stated to the evaluation team's medical consultant that he/she gave the insulin, there is no record of it and the consumers blood sugar levels were not in the normal range. At the next regularly scheduled testing, the consumer was administered insulin and blood sugar levels were back in the normal range the following day. The incident was not noted until the RC nurse discovered it in her audit. The other six medication errors involved missed doses of medication and/or errors in recording medication administration.

Figure 27. Number and Types of Special Incidents and Other Events (Data Gathered From Facility Files)



*Note. The "failure to protect" incident involved a power outage at one of the homes. Five SIRs were filed, one for each consumer, but they are collapsed into one incident for the purposes of this report. No harm was caused to any of the consumers. Since the home administrator safely moved the consumers to a motel.

The remaining 92 incidents were not considered reportable under Title 17 but fell into the category of other events that threaten the physical or emotional health or safety of any client as outlined in SB 962, Health and Safety Code Section 1538.53. The UCD evaluation team organized these incidents into three categories. Thirty-six of these 92 other events involved a visit to the Emergency Room (ER) but not hospital admission. Another 36 were related to seizures that required treatment in the home but not a trip to the ER. The final 20 involved a variety of other medical or safety situations that did not require ER services.

3.8.2 Handling of Incidents and Events

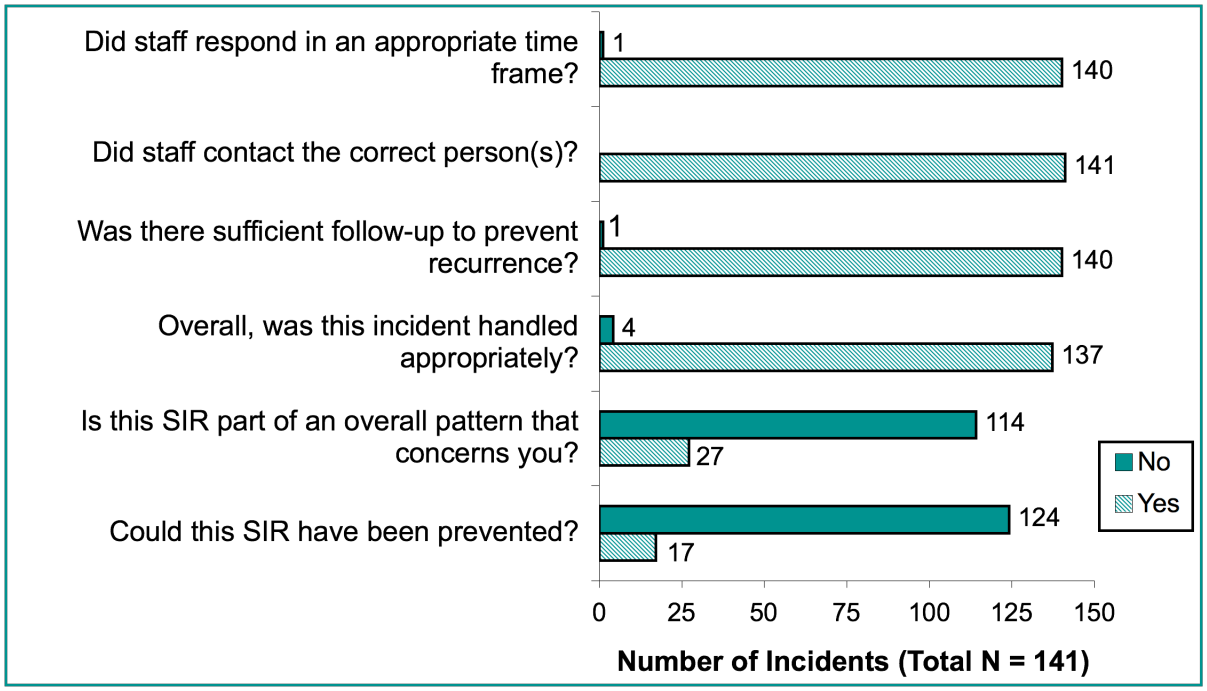
The SIRs were generally handled very well (see Figure 28). Only four of the 141 incidents were handled inappropriately according to at least one of the criteria displayed in Figure 28. In one of these four incidents, staff was judged not to have responded

within an appropriate time frame. In this incident a consumer had elevated blood sugar but no insulin was administered. Due to problems with the recording of the elevated blood sugar and the failure to administer the insulin, it was not possible to confirm that the staff responded in an appropriate time frame. The second out of the four incidents that was not handled appropriately was a situation in which a consumer's gastrostomy tube fell out. The evaluation team's medical consultants explained that the home should have had a backup tube available at the facility. However, it did not have one, and the consumer had to be transported to the ER. Fortunately, the staff did follow-up to prevent recurrence by obtaining an extra tube for the facility.

The third incident that the evaluation team's medical consultants did not judge to be handled appropriately involved insufficient follow-up by ER staff contributing to repeated hospitalizations within a two day period. The evaluation team's medical consultant noted that ER staff might have been more cautious the first time the consumer was in the ER and kept the consumer under observation longer to ensure that he/she had no further symptoms before discharge; the consumer was not admitted to the hospital. This consumer had to return to the ER the following day, was diagnosed with a urinary tract infection and was admitted to the hospital for three nights.

In addition to the three aforementioned SIRs, one additional SIR was not considered to have been handled appropriately. During this incident the staff of the SB 962 home followed the physician's orders by transporting the consumer to the ER but did not have a licensed person accompany the consumer to the ER. Rather, two unlicensed staff were sent. The attending physician felt it was not safe for unlicensed staff to bring the consumer to the ER and that this put the consumer at additional risk. After review of the incident and given the consumers' medical fragility the UC Davis medical consultants agree with the concern expressed by the doctor.

Figure 28. Special Incidents: Handling, Concerning Patterns, and Prevention



3.8.3 Patterns of Concern

The evaluation team's medical consultants also noted any concerns that related to multiple SIRs. For example, patterns of concern could refer to several incidents regarding insufficient staff training at one of the homes or to multiple SIRs resulting from an unresolved health issue of a particular consumer. As shown in Figure 28, 27 incidents or other events were part of overall patterns that concerned the medical consultants. It should be noted that there is a system of oversight in which the RCs and DDS requires corrective action following preventable SIRs to prevent recurrence. None of these incidents resulted in serious problems for the consumers.

Two of these patterns involved concerns related to the staff/administrators at the SB 962 homes. In one pattern of concern, two of the SIRs that were not handled appropriately (discussed above in *Handling of Incidents*) occurred in the same SB 962 home and were considered to be part of an overall pattern that was concerning to the medical consultants on the evaluation team. The medical consultants noted that there did not seem to be a strong enough administrative presence at this facility to prevent these types of incidents from occurring. A similar pattern of concern was noted at another home that had six preventable SIRs within a four-month period of time, including four medication-related errors that occurred within two months. The four medication-related events involved either skipping a dose of medication or not charting it. Follow up notes for the first couple of medication errors stated that staff involved were given more training and were required to work with another staff member for a period of time before being on their own again. However, medication-related errors continued to occur. The other SIR that was part of the concerning pattern in this home involved a

consumer who developed aspiration pneumonia within days of being admitted to the home. The administrator was new to this home. The medical consultant believed that if there had been better staff training and supervision, these errors would not have occurred.

Three other patterns of concern involved repeated medical problems that were unresolved. One involved a consumer with repeated urinary tract infections requiring hospitalization due to prostate issues and because the consumer is not considered a candidate for surgery the issue is persistent and requires a high level of monitoring by staff. The other medically-related concern involved a consumer who repeatedly had low Dilantin levels that resulted in increased seizure activity and hospitalizations. The third pattern of repeated medical problems involved a consumer with declining oral skills and repeated aspirations resulting in hospitalization for respiratory illness. At the time of the final site visit to this consumer's home, the consumer was in the hospital being evaluated for a possible gastrostomy tube.

Another pattern of concern involved four SIRs for two different consumers who had repeated hospitalizations within very short periods of time. The evaluation team's medical consultant noted that ER staff may have released the consumers prematurely as a consequence of being unfamiliar with the interaction between developmental disabilities and serious medical conditions treated with numerous medications. The evaluation team is hopeful that these types of repeated hospitalizations that may occur from premature hospital discharge will be reduced as community hospitals and ERs become more familiar with the consumers of the SB 962 homes who now reside in their communities.

Finally, two SIRs involved concerns about medical care related to changes in medical insurance coverage. In one instance staff of the SB 962 home was left without a primary care physician (PCP) to contact for a consumer with conjunctivitis. Due to the change in residence, it was necessary to change the health care plan of this consumer which required a change in the PCP. The SB 962 home staff was not informed of this change in PCP and was not given a phone number where they could reach the newly assigned physician. The consumers' prior physicians were no longer able to treat the consumer due to the change in insurance. Since they could not get medical advice from a physician in another way, the staff had to transport the consumer to the ER. It should be noted that nearly all consumers required a change in their health insurance plan at the time of placement and that the majority of changes occurred without incident.

Contrary to the issues that were noted in the homes above, the evaluation team's medical consultants felt very comfortable with the administrator and licensed staff at other homes. For example, In their notes from the initial site visit to one home, the evaluation team's medical consultants reported that, "*subtle changes [in consumers' health] have been noticed by staff and brought to medical attention before a major crisis happened*." In one instance, the administrator noted abdominal distention and crying in one consumer and sought ER care immediately despite no clear indication of a problem. It turned out that the consumer had severe bowel impaction and the bowel

was obstructed. The evaluation team's medical consultant believed that this incident could have been much worse if the care provider had not noticed early warning signs and acted quickly. In addition, the evaluation team's medical consultants noted that staff at this home frequently conducts oxygen monitoring of fragile consumers when they are ill or are having seizures so that less intrusive methods of treatment can be used when necessary and thus prevent the need for ER visits.

3.8.4 Prevention of Incidents and Events

As shown in Figure 28, the evaluation team's medical consultants believed that 16 (12%) out of the 141 incidents and other events could have been prevented. Several of these incidents that appeared to be preventable have already been described (e.g., 6 medication errors, medication recording error, no replacement for a gastrostomy tube that fell out). Another was an event in which two consumers were accidentally locked in a van while a group of staff and consumers were exiting the vehicle. While this incident could have been prevented by having a spare key available it should be noted that staff stayed outside of the vehicle while roadside assistance were called and unlocked the vehicle. At no time were the consumers left unattended. The medical consultants also noted a preventable incident in which a consumer's prescription had not been renewed in a timely fashion and a dose was missed. While this was an error by the physician and/or pharmacy, the SB 962 home now has a system in place so that it does not happen again. In another preventable incident, a consumer experienced severe respiratory distress when his/her tracheostomy was dislodged requiring re-positioning by the SB 962 home staff. Examples of other preventable events include a consumer who had a red knee from his/her wheelchair being pushed under the table at the day program. This could have been prevented by better attention to positioning by day program staff. Finally, another consumer had a bleeding toenail that was cut too short. This could have been prevented by more careful toenail trimming. All 16 preventable events received sufficient follow-up so that they should not recur.

3.8.5 Summary and Recommendations

- Consumers had a variety of Special Incidents and other events.
- The most common types of Special Incidents were admissions to the hospital for respiratory illness or internal infection.
- Special Incidents were generally handled very well.
- A minority of Special Incidents and other events appeared to have been preventable.

Based on these findings, and those outlined in Section 3.5 (Staffing), the evaluation team recommends that the parties responsible for the interagency coordination of the project, including RC nurses, reconvene to consider making a few key changes to Senate Bill 962 related to staffing. Please refer to the list at the end of Section 3.5.

3.9 STATUTE: 4684.74 #11: THE COST-EFFECTIVENESS OF THE SB 962 MODEL WHEN COMPARED WITH OTHER EXISTING PUBLIC AND PRIVATE MODELS OF CARE SERVING CONSUMERS WITH SIMILAR TYPES OF SUPPORT NEEDS

3.9.1 Overview

This section of the report examines the cost-effectiveness of the SB 962 homes compared to other models of care. In order to accomplish this, a clear definition of cost-effectiveness was necessary. In the absence of an operationally explicit methodological standard for cost-effectiveness, this evaluation considered the cost differences between the SB 962 homes and other modalities that serve comparable consumers. A cost comparison is made using the cost data of 24 similar consumers in other modalities of care extrapolated to a total of 50 consumers with 10 consumers in each modality of care.

3.9.2 Public and Private Modalities

As discussed in Methodology (Section 2), cost comparisons with other public and private modalities serving similar consumers are required by SB 962 to be included in the cost-effectiveness analysis. The comparable modalities in this report consist of Acute Care Facilities (private), Developmental Centers (public), Sub-Acute Care Facilities (private), State Operated Facilities (public), and Skilled Nursing Facilities (private). The cost-effectiveness of the SB 962 homes consists of cost comparisons (dollar differences) adjusted to the standard of 2007-2008 dollars, if needed, for the same number of consumers in the aforementioned modalities.

3.9.3 Comparison Consumers

The comparison consumers are considered “medically fragile” and are similar to the SB 962 consumers. These consumers exhibit the following characteristics: have profound mental retardation (51.3%), have seizure disorders (56.4%) and/or Cerebral Palsy (41.0%), are non-ambulatory (92.3%), require a G-tube for feeding (61.5%), and are non-verbal (53.8%). The comparison consumers came from a variety of care facilities. The majority came from acute or sub-acute facilities or from DCs.[8]

Table 7 presents results from the cost comparisons of the SB 962 consumers with 50 comparison consumers. Column 1 lists the type of facility, column 2 lists the number of consumers within that facility (normalized to 10), column 3 lists the prior or current total cost adjusted for inflation, if necessary, column 4 lists the average SB 962 cost for the number of consumers in column 2, column 5 lists the cost difference between columns 3 and column 4 (Column 4 minus Column 3). Column 4 is calculated by taking the average cost per consumer in a SB 962 home and multiplying by the number of consumers in the other model of care. The final column (cost difference) indicates the cost-effectiveness of the SB 962 homes by modality. If the column total is positive, then the SB 962 homes are considered not to be cost effective; if the column cell is negative, then the SB 962 homes are cost effective. A variety of data sources were used to

[8] Developmental centers consist of Agnews, Fairview, Lanterman, Porterville, and Sonoma Developmental Centers.

determine the costs represented in column 3 below. The DDS provided actual average costs from DCs and State Operated Facilities for the fiscal year 2007-2008 so no adjustment was needed. Other costs were collected and are for the time period of October 1, 2004, through September 30, 2006, but were adjusted to 2007-2008 dollars using year-to-year changes in DHCS certified daily rates from Laguna-Honda Hospital.

Table 7. Cost Comparisons for Similar Consumers in Comparable Modalities of Care[9]

Prior or Current Facility	Number of Consumers	Adjusted to Current Costs	SB 962 Cost for same number of consumers	Cost Difference
Acute Care	10	$11,157,992.86	$2,343,930.00	$-8,814,062.86
Developmental Centers	10	$2,756,269.50	$2,343,930.00	$-412,339.50
State Operated Facilities	10	$3,947,881.00	$2,343,930.00	$-1,603,951.00
Sub Acute Care	10	$4,354,443.33	$2,343,930.00	$-2,010,513.33
Skilled Nursing	10	$2,813,749.50	$2,343,930.00	$-469,819.50
Total	**50**	**$25,030,336.19**	**$11,719,650.00**	**$-13,310,686.19**

The cost of care for consumers by type of facility indicates a net savings of $13,310,686.19 per year for 50 consumers if they were taken in equal numbers from a variety of facilities. However, since the consumers were mostly from Agnews DC, each SB 962 home of five consumers would have a cost savings of approximately $206,169.75 per year or an individual consumer savings of approximately $41,233.95 per year. If the SB 962 homes are filled to a capacity of 110 consumers who came from a DC, savings will be $4,535,734.50 per year.

3.9.4 Summary and Recommendations

The conclusion can be drawn for the following:

- The SB 962 homes are cost-effective.
- The SB 962 homes cost per consumer is less than private and public modalities of care serving similar consumers.

The evaluation team did not make any recommendations related to this section.

[9] Data Source for Columns 1, 2, and 3: UC Davis Extension, Center for Human Services, 2007 with the exception of figures for Developmental Centers and State Operated Facilities which was provided by DDS

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5. Appendices

APPENDIX A: UC DAVIS EVALUATION TEAM

Medical Consultant: *Diana Koin, MD,* is Board Certified in Internal Medicine and Geriatric Medicine. She is a former Director of Elder and Adult Abuse Education at the University of California, Davis and has chaired the committee that developed the forensic form for documenting abuse of elders and dependent adults. Dr. Koin is an associate clinical professor of medicine at UC San Francisco, and also served on the faculties of Stanford and the University of Colorado. Dr. Koin's areas of expertise include health care ethics, decision making by frail older people, post-traumatic stress disorder, substance abuse, and direct care of older patients.

Medical Consultant: *Mary Sheehan RN, MSN,* holds certification in Public Health Nursing and is a certified Pediatric Nurse Practitioner. She has over 30 years experience working with developmentally disabled individuals and their care.

Medical Consultant: *Paula Nahhas RN, MSN,* holds certification in both school nursing and Public Health Nursing. She has worked twenty-six years with all age groups, birth to death, including those individuals with developmental disabilities, mental illness, and genetic disorders. During this time she has functioned as direct care provider for all age groups, and case manager for children with and at-risk for developmental disabilities. She spent eight years as a Discharge Coordinator/Utilization Manager for children and infants being discharged from hospital/long term care facility, whose health care needs require coordination of services within their communities.

Economic Consultant: *Garland L. Brinkley MPH, PhD.* received his PhD. from the University of California, Davis, Department of Economics with concentrations in Health Economics, Economic Development and International Trade. He received an MPH from University of California, Berkeley in Biostatistics and Epidemiology. He spent three years as a postdoctoral fellow with the Prevention Research Center addressing the economic costs and benefits of alcohol consumption and mental illness. Prior to his graduate work, he spent 20 years as a manager with the State of California and taught at UC Berkeley for eight years and another eight years at UC Davis. Dr. Brinkley is currently the Research Director of the College of Health Sciences at Touro University California.

Evaluation Consultant: *Shannon Williams, PhD*, is a professional researcher providing a wide range of research, evaluation, and consulting services to public and private organizations. Dr. Williams is skilled in all aspects of the research endeavor, from initial design considerations to final statistical analysis, interpretation and report writing. She has expertise in both qualitative and quantitative methods, secondary data analysis of large archival datasets, research design and implementation, literature reviews, report writing and presentation of findings. She received her PhD in Human Development and Family Studies from the University of California, Davis.

Evaluation Consultant: *Holly Hatton, MS,* is a Social and Behavioral Researcher at the University of California Davis. Her interests focus on developing, implementing, and

evaluating intervention and prevention programs with expertise in both qualitative and quantitative methods and analysis of large longitudinal datasets. She is completing her PhD in Human Development and Family Studies from the University of California, Davis.

Evaluation Consultant: *Cindy Parry, PhD*, specializes in research design; instrument development; data collection, analysis and interpretation; and proposal and report development for program evaluation in the human services. She is a former Director of Program Analysis and Research at American Humane Association where she managed a variety of evaluation and research projects. In addition to her time at American Humane Association Dr. Parry has had over 20 years experience in program evaluation as private consultant, and as a researcher with the New York State Division for Youth and at Crescent Counties Foundation for Medical Care in Illinois. She received her PhD in Educational Psychology from the State University of New York at Albany.

Principal Investigator: *Susan Brooks, MSW,* is a Program Director at the Center for Human Services, UC Davis Extension. Susan has 20 years of experience in social services, with expertise in program development, planning, implementation and administration of state, federal and foundation grants. Susan has experience in qualitative and quantitative research and evaluation.

Project Manager: *Melanie Schindell,* is a Program Coordinator at the Center for Human Services, UC Davis Extension. Melanie has experience in program planning, implementation, management and evaluation.

APPENDIX B. MEASURES

Consumer Common Data Collection Template

***This survey will be filled out with existing data obtained from the consumer's files.**

UCI number: _____ Date: _ _/_ _/_ _ _ _
mm/dd/yyyy

Section 1 Consumer Profile

Consumer DOB: _ _/_ _/_ _ _ _

Current Facility Name: _____

Regional Center: _____

Admission Date: _ _/_ _/_ _ _ _

Discharge Date: _ _/_ _/_ _ _ _

1. Current Day Program
   - ☐ 1) Attends school or day program in community
   - ☐ 2) Programming provided in the home independent of residential services provided

2. If consumer does not attend a community day program, what is the reason?
   - ☐ 1) Consumer health does not permit attending community day program
   - ☐ 2) No community day program available

3. Gender ☐ 1) Male ☐ 2) Female

4. Ethnicity/Race
   - ☐ 1) African American
   - ☐ 2) American Indian/Alaska Native
   - ☐ 3) Asian/Pacific Islander
   - ☐ 4) Hispanic/Latino
   - ☐ 5) White/Caucasian
   - ☐ 6) Multi-racial (specify): _____
   - ☐ 7) Other (specify): _____

5. Is resident conserved? ☐ 1) Yes ☐ 2) No

   If yes, is the conservator

1) A family member
☐ 2) Friend
3) Other (please specify)

If consumer is not conserved, is there a legally authorized decision maker identified for them?
☐ 1) Yes ☐ 2) No

If consumer has a legally authorized decision maker, is the decision maker
☐ 1) A family member
☐ 2) A Regional Center Employee
☐ 3) Other (please specify) _____

Is resident ventilator dependent? ☐ 1) Yes ☐ 2) No

Disability Diagnosis:
1) Mild MR
2) Moderate MR
3) Severe MR
4) Profound MR
5) Cerebral Palsy
6) Autism
7) Seizure disorder
8) Other (specify) _____

Medical Conditions

Condition	ICD-9 code
a.	
b.	
c.	
d	
e.	
f.	
g.	

Nursing supports required

- ☐ a. Cardio-respiratory monitoring
- ☐ b. Oxygen support (including continuous positive airway pressure and bi-level positive airway pressure, and use of other inhalation-assistive devices)
- ☐ c. Ventilator dependent (for any length of time during a 24 hr. period)
- ☐ d. Tracheotomy care and suctioning
- ☐ e. Nursing interventions for colostomy, ileostomy, or other medical or surgical procedures.
- ☐ f. Special medication regimes including injection and intravenous medications
- ☐ g. Management of insulin-dependent diabetes

- ☐ h. Manual fecal impaction, removal, enemas, or suppositories
- ☐ i. Indwelling urinary catheter/catheter procedure
- ☐ j. Treatment for staphylococcus infection
- ☐ k. Treatment for wounds or pressure ulcers (stages 1 and 2)
- ☐ l. Postoperative care and rehabilitation
- ☐ m. Pain management and palliative care
- ☐ n. Renal dialysis
- ☐ o. Other (specify) _____

6. Mental Health Diagnoses

Condition	DSM-IV code
a.	
b.	
c.	
d.	
e.	
f.	

7. Vision (corrected)
   - ☐ 1) Within normal limits
   - ☐ 2) Mild impairment
   - ☐ 3) Moderate impairment
   - ☐ 4) Severe impairment
   - ☐ 5) Correction not possible
   - ☐ 6) Not corrected

8. Hearing (corrected)
   - ☐ 1) Within normal limits
   - ☐ 2) Mild to moderate loss
   - ☐ 3) Severe loss
   - ☐ 4) Profound loss
   - ☐ 5) Correction not possible
   - ☐ 6) Not corrected

9. Communications
   - ☐ 1) Verbal/easily understood
   - ☐ 2) Verbal/understood with difficulty
   - ☐ 3) Signs or uses assistive technology
   - ☐ 4) Non-verbal
   - ☐ 5) Non-communicative

10. Mobility
    - ☐ 1) Ambulatory without assistance/assistive devices
    - ☐ 2) Ambulatory with assistance/assistive devices
    - ☐ 3) Non-ambulatory

11. Eating
    - ☐ 1) Feed self independently
    - ☐ 2) Feeds self with assistance
    - ☐ 3) Fed
    - ☐ 4) Requires nutrition support (including total parenteral feeding and gastrostomy feeding, and hydration. feeding tube)

12. Bathing
    - ☐ 1) Bathes independently
    - ☐ 2) Requires some assistance
    - ☐ 3) Requires total assistance

13. Dressing
    - ☐ 1) Dresses independently
    - ☐ 2) Requires some assistance
    - ☐ 3) Requires total assistance

14. Hygiene and grooming (oral care, brushing hair, nail care)
    - ☐ 1) Independent
    - ☐ 2) Requires some assistance
    - ☐ 3) Requires total assistance

15. Toileting
    - ☐ 1) Toilets self independently
    - ☐ 2) Requires some assistance
    - ☐ 3) Requires total assistance/incontinent

16. Transferring
    - ☐ 1) Transfers independently
    - ☐ 2) Requires some assistance
    - ☐ 3) Requires total assistance

17. Behavior
    - ☐ 1) No behavioral concerns
    - ☐ 2) Has behavioral plan

18. If consumer has behavioral issues, do these issues require (check all that apply)
    - ☐ a) Additional supervision
    - ☐ b) Physically restrictive procedures
    - ☐ c) Medication

☐ d) Other intervention (describe)
_____

Section 2 Quality of Health Care Services

Required plans are in place and current (check all that apply)

a. Individual Health Care Plan	☐ 1) Yes	☐ 2) No	Date of most recent: _ _/_ _/_ _ _ _
b. Nursing Care Plan	☐ 1) Yes	☐ 2) No	Date of most recent: _ _/_ _/_ _ _ _
c. IPP	☐ 1) Yes	☐ 2) No	Date of most recent: _ _/_ _/_ _ _ _
d. ISP	☐ 1) Yes	☐ 2) No	Date of most recent: _ _/_ _/_ _ _ _
e. Other (specify) _____	☐ 1) Yes	☐ 2) No	Date of most recent: _ _/_ _/_ _ _ _

19. Required plans meet the consumers needs (check all that apply)
    a. Individual Health Care Plan ☐ 1) Yes ☐ 2) No
    b. Nursing Care Plan ☐ 1) Yes ☐ 2) No
    c. IPP ☐ 1) Yes ☐ 2) No
    d. ISP ☐ 1) Yes ☐ 2) No
    e. Other (specify) _____ ☐ 1) Yes ☐ 2) No

If "No", explain the nature of the concern(s) and the data used to reach this decision.

_____

_____

_____

_____

_____

_____

_____

20. The consumer has a primary care physician ☐ 1) Yes ☐ 2) No

21. The consumer sees the primary care physician every 60 days, or as required by IHCP or other health care plan.
    ☐ 1) Yes ☐ 2) No Most recent date seen: _ _/_ _/_ _ _ _

22. The consumer sees specialists as required by ICHP or other health care plan, or as appropriate to medical needs. ☐ 1) Yes ☐ 2) No

If "No", explain the nature of the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

23. The consumer has a dental care provider ☐ 1) Yes ☐ 2) No

24. The consumer receives dental care as required by the Oral Health Care Plan, IPP, or other plan, or as appropriate to needs.
☐ 1) Yes ☐ 2) No Most recent date seen: _ _/_ _/_ _ _ _

If "No", explain the concern and the data used to reach this decision.

25. The consumer receives preventive care appropriate to age, gender, and diagnosis.
☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

26. The consumer has received immunizations as required by ICHP or other health care plan, or as recommended by Centers for Disease Control guidelines.
☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

27. The consumer receives needed assessment/diagnostic services (including lab work, nursing assessments, planned hospitalizations, and annual physicals). ☐ 1) Yes
☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

28. The consumer receives appropriate nursing supports (e.g. feeding tube care, pain management, wound care/prevention, breathing treatments, etc.) as outlined in the IHCP, nursing care, or other plan(s). ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

29. The consumer receives appropriate services from allied professionals (OT, PT, speech, nutrition, behavioral/psychological, other) as outlined in the IHCP, nursing care, or other plan(s). ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

30. Onsite back-up medical equipment is available for this consumer.
☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

31. Prescribed medications are consistent with the consumer's diagnoses.

☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

32. Changes in consumer health status (including weight loss or gain) receive prompt and appropriate follow-up. ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

33. Has this consumer had any special incidents reported (if this is a follow-up visit, has the consumer had any SIRs since the last visit)? ☐ 1) Yes ☐ 2) No
If yes, please describe:

1st incident: _____

_____

How was this incident handled? _____

_____

Was a hospital stay involved? ☐ 1) Yes ☐ 2) No If yes, # days/nights: _____

Did staff respond in appropriate time frames? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

Did staff contact the correct person(s)? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

Was there sufficient follow up to prevent recurrence? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Overall, was this incident handled appropriately? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.
Could something have been done to prevent this incident from happening?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

Is this incident part of a pattern of SIRs at this home that you are concerned about?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

2snd incident:

How was this incident handled?

Was a hospital stay involved? ☐ 1) Yes ☐ 2) No If yes, # days/nights:

Did staff respond in appropriate time frames? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Did staff contact the correct person(s)? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Was there sufficient follow up to prevent recurrence? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Overall, was this incident handled appropriately? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.
Could something have been done to prevent this incident from happening?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

Is this incident part of a pattern of SIRs at this home that you are concerned about?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

3rd incident:

How was this incident handled?

Was a hospital stay involved? ☐ 1) Yes ☐ 2) No If yes, # days/nights:

Did staff respond in appropriate time frames? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Did staff contact the correct person(s)? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Was there sufficient follow up to prevent recurrence? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Overall, was this incident handled appropriately? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.
Could something have been done to prevent this incident from happening?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

Is this incident part of a pattern of SIRs at this home that you are concerned about?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

4th incident:

How was this incident handled?

Was a hospital stay involved? ☐ 1) Yes ☐ 2) No If yes, # days/nights:

Did staff respond in appropriate time frames? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Did staff contact the correct person(s)? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Was there sufficient follow up to prevent recurrence? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Overall, was this incident handled appropriately? ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

Could something have been done to prevent this incident from happening?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

_____

_____

Is this incident part of a pattern of SIRs at this home that you are concerned about?

☐ 1) Yes ☐ 2) No If "Yes", please describe:

_____

_____

34. Consumer access to/use of emergency room services is appropriate.
☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

35. Consumer access to/use of outpatient clinics (urgent care, Agnews Outpatient Clinic) is appropriate. ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

36. Consumer access to/use of hospital services is appropriate. ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

37. Environmental safeguards, medical and adaptive equipment identified in the consumers' IPP or IHCP are in use and in good working order. ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

38. Any restrictive procedures used to manage the consumer's behavior are appropriate to the situation and have been reviewed and approved per Regional Center policy.
☐ N/A ☐ 1) Yes ☐ 2) No

If "No", explain the concern and the data used to reach this decision.

_____

_____

_____

_____

_____

SURVEY B

Consumer Satisfaction

UCI number: _____ Date: _ _/_ _/_ _ _
mm/dd/yyyy

Introduction: *This survey will help us find out how to best meet the needs of consumers who transitioned from Agnews Developmental Center to homes like this one.*

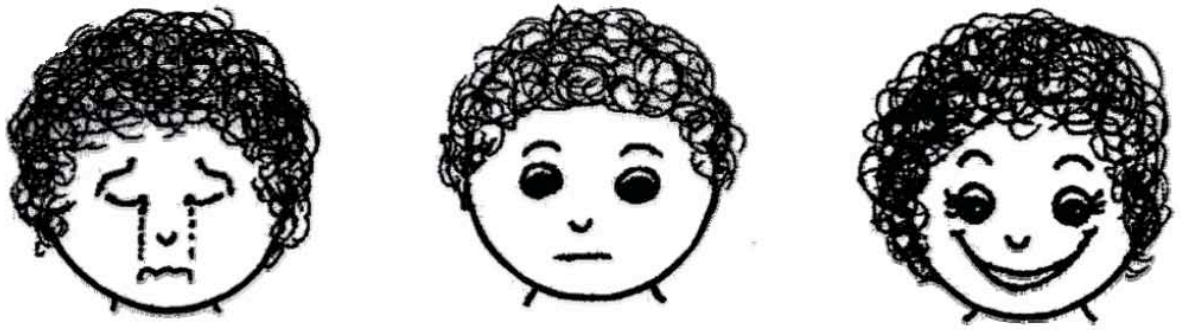
Complete this survey in an interview with the consumer. Please read the instructions. Then read each question for the consumer and ask him/her to point to the face [see attached sheet with 3 faces] that tells how happy he/she feels. Record the answer on this survey. If it is not possible for the consumer to actively participate in this survey please do not complete the survey for him or her. Leave it blank instead. The answers will be kept confidential, which means that individual responses will not be seen by anyone except the evaluation staff. ***Please return the survey in the envelope provided within one week. Thank you!***

Instructions: Say to the consumer: "I am going to ask you a few questions about how happy you feel, using these [point to faces] faces. This face means you feel happy [point]. This one means you feel sad. The one in the middle means you feel neither happy nor sad [point]. When I ask you the questions afterwards point to the face which tells me how you feel."

"Using these faces, how happy do you feel about . . . "

	Sad	**Neither Happy nor Sad**	**Happy**
1. your life as a whole?			
2. the things you have? Like the money you have and the things you own?			
3. how healthy you are?			
4. the things you make or the things you learn?			
5. how safe you feel?			
6. doing things outside your home?			
7. the home you live in?			
8. the people you live with?			
9. how things will be later on in your life?			

Faces



SURVEY C
Quality of Life Survey

UCI number: _____ Date: _ _/_ _/_ _ __
mm/dd/yyyy

Introduction: *This survey will help us find out how to best meet the needs of consumers who transitioned from Agnews Developmental Center to homes like this one. It asks questions about the consumers' life in this home and in the community. Your answers will be kept confidential, which means that no one except the evaluation team will see your responses.*

This survey should be completed by a caregiver who knows the consumer and his/her daily activities well. This survey will be repeated every 3 months, so it is best to choose a caregiver who will be able to complete the survey for this consumer in the future as well, if possible. Please write the initials and date of birth of the caregiver completing this survey so we can ask this same person to complete the survey in the future:

*Caregiver Initials*_____ *DOB:* _____

Please return the survey in the envelope provided within one week. Thank you!

Part A: COMMUNITY ACCESS

1. First, we'd like to know about the activities *this consumer does* in the community, like shopping and going to see the doctor. For each activity we would like to know how often *this consumer* does that activity. Then we would like to know who *this consumer* usually does the activity with.

Please check one box for "how often" and one box for "with whom" for each item in the grid on the next page.

How often, and with whom does *this consumer* go to a . . .

	How Often?							With Whom?					
	Weekly	Every 2 Weeks	Monthly	Every 3 months	Every 6 months	Yearly	Never	Alone	Friend from home	Friend from outside home	Staff	Group: specify	Family
Supermarket/Store													
Bank/Financial Institution													
Post Office													
Medical Service/Facility													
Dentist													
Park													
Sport/Recreational Facilities													
Cinema													
Hotel													
Restaurant/Cafe													
Church													
Library													
Other: _____													

Please feel free to comment about the above grid (e.g. to provide further explanation, such as why some of these things never or only rarely happen):

Part B: COMMUNITY IN THE HOME

2. Does *this consumer* ever experience visits from community members or organizations (e.g. volunteers from schools or community groups; Christmas carolers, etc.) in this home (without having to leave the residence)? Please check the box below for either “Yes” or “No”. Note: Please do not count visits from family and/or friends.

☐ Yes
☐ No

If yes, please list these organizations/activities below, and check the box to indicate how often *this consumer* experiences them in this residence:

	How often?					
Name of the community activity or organization below:	Weekly	Every 2 weeks	Monthly	Every 3 Months	Every 6 months	Yearly
a.						
b.						
c.						
d.						
e.						

Please feel free to comment about the above grid (e.g. to provide further explanation, such as why some of these things never or only rarely happen):

Part C: COMMUNITY ACCESS: VACATIONS AND TRIPS

Now we are going to ask you a couple of questions about *this consumer's* vacations or overnight trips.

3. How often *does this consumer* go on vacation or overnight trips? (Please check one)
   - ☐ More than yearly
   - ☐ Yearly
   - ☐ Rarely
   - ☐ Discussed but not yet planned
   - ☐ Never

Please feel free to comment (e.g. to provide further explanation, such as why this never or only rarely happen):

4. When *this consumer* goes on vacation or an overnight trip who does he/she usually go with? (Please check all that apply)

- ☐ Parent
- ☐ Sibling
- ☐ Friend/s with disability
- ☐ Friend/s without disability
- ☐ Volunteer
- ☐ Staff
- ☐ Group with support

Part D: DAILY ROUTINES

The next questions ask about the things *this consumer* does at home.

5. How often is *this consumer* given the opportunity to , , , ?

	Every day	Several times a week	Weekly	Every 2 weeks	Monthly	Rarely or Never
Prepare meals						
Wash laundry						
Shop for food						
Clean the house						
Wash dishes						
Garden						
Other:						

Please feel free to comment about the above grid (e.g. to provide further explanation, such as why some of these things never or only rarely happen):

6. How often does this consumer actually do each of these things . . .?

Score	Every day	Several times a week	Weekly	Every 2 weeks	Monthly	Rarely or Never
Prepare meals						
Wash laundry						
Shop for food						
Clean the house						
Wash dishes						
Garden						
Other:						

Please feel free to comment about the above grid (e.g. to provide further explanation, such as why some of these things never or only rarely happen):

Part E: CHOICE-MAKING

Now we would like to know how involved this consumer is in making choices concerning the following aspects of his/her daily life.

7. Who makes decisions about:

	4 Client, guardian, or trusted friend/family member makes all decisions	3 Client, guardian, or trusted friend/family member make most decisions; paid staff make a few	2 Client, guardian, or trusted friend/family member makes about half of decisions; paid staff make about half	1 Paid staff make most decisions; Client, guardian, or trusted friend/family member make a few decisions	0 Paid staff make all decisions
Meals/food					
Clothing					
Furnishings					
Bath/shower times					
Bedtime					

	4 Client, guardian, or trusted friend/family member makes all decisions	3 Client, guardian, or trusted friend/family member make most decisions; paid staff make a few	2 Client, guardian, or trusted friend/family member makes about half of decisions; paid staff make about half	1 Paid staff make most decisions; Client, guardian, or trusted friend/family member make a few decisions	0 Paid staff make all decisions
Get-up times					
Meal times					
Television					
Purchases (clothes, possessions)					
Participation in outings					
Participation in work type activities					
Going to visit					
Accepting visitors					
Participation in staff/employee selection					
Choosing goals in Individual Plans (IP)					
Choosing with whom one will live					
Choosing bedroom décor (e.g. colors, personal affects, etc.)					

Please feel free to comment about the above grid (e.g. to provide further explanation):

8. How much of the time does *this consumer* make decisions about major events, like what clothes to buy, or about going on vacation? (please check a box)

- ☐ 100%
- ☐ 75%
- ☐ 50%
- ☐ 25%
- ☐ 0% of time

Please feel free to comment (e.g. to provide further explanation for the consumer making only a small percentage of decisions):

9. How much of the time does *this consumer* make decisions about minor choices, like what shirt to wear today, or whether he/she wants jam or honey on his/her toast?

- ☐ 100%
- ☐ 75%
- ☐ 50%
- ☐ 25%
- ☐ 0% of time

Please feel free to comment (e.g. to provide further explanation for the consumer making only a small percentage of decisions):

Part F: FAMILY CONTACT

Now we have a few questions about *this consumer's* family.

10. How often does *this consumer* have contact (visits, phone calls, letters, etc) with the following family members?

	Regularly (Monthly)	Occasionally (every 6 months)	Rarely (once a year)	Never	Not Applicable (please explain why)
Mother					
Father					
Brother(s)					
Sister(s)					
Other relative					
Friend (with an equivalent relationship to consumer that a family member would have – not just a typical friend)					

Please feel free to comment about the above grid (e.g. to provide further explanation, such as why some of these things never or only rarely happen):

11. Overall, how often does *this consumer* have personal contact with his/her family (any family member)? (please check one box)

☐ Daily ☐Weekly ☐ Every 2 weeks ☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐Yearly ☐Rarely ☐ Never

Please feel free to comment (e.g. to provide further explanation, such as this never or only rarely happen):

12. How often does *this consumer* go out of this home with family? (please check one box)

☐ Daily ☐Weekly ☐ Every 2 weeks ☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐Yearly ☐Rarely ☐ Never

Please feel free to comment (e.g. to provide further explanation, such as this never or only rarely happen):

13. How often does family visit *this consumer* in this home? (please check one box)

☐ Daily ☐Weekly ☐ Every 2 weeks ☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐Yearly ☐Rarely ☐ Never

Please feel free to comment (e.g. to provide further explanation, such as this never or only rarely happen):

14. How often does *this consumer* get personal mail e.g. cards from family? (please check one box)

☐ Daily ☐Weekly ☐ Every 2 weeks ☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐Yearly ☐Rarely ☐ Never

Please feel free to comment (e.g. to provide further explanation, such as this never or only rarely happen):

15. How often does *this consumer* get personal phone calls from family? (please check one box)

☐ Daily ☐Weekly ☐ Every 2 weeks ☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐Yearly ☐Rarely ☐ Never

Please feel free to comment (e.g. to provide further explanation, such as this never or only rarely happen):

16. *Does this consumer* have personal contact with the neighbors? (please check a box)

☐Yes
☐ No

If yes, is this contact positive, negative, or mixed?

☐ Positive ☐ Mixed (Positive/Negative) ☐ Negative

Please feel free to comment (e.g. to provide further explanation):

Part G: SATISFACTION

Next we would like you to tell us how happy you think *this consumer* is with different things in his/her life.

17. How happy do you think *this consumer* is with:

(check one box for each question)

	Unhappy	**Mostly Unhappy**	**Sometimes Happy**	**Mostly Happy**	**Happy**	**Don't Know**
a. The place that he/she lives?						
b. The people that he/she lives with?						
c. The staff working in this residence?						
d. His/her day program/ school/ or work?						
e. The opportunities and activities available to him/her?						
f. His/her life overall?						

Please feel free to comment (e.g. to provide further explanation):

Part H: FRIENDSHIPS

The last questions we have ask about *this consumer's* friends.

18. How many friends does *this consumer* have that are: ?

	None	1	2-3	4-7	8
Persons with disabilities					
Persons without disabilities (not family or staff)					
Paid staff					
Volunteers					

Please feel free to comment (e.g. to provide further explanation for none or a small number of friends):

19. How often does *this consumer have contact with* these friends?

	Never	Yearly	Monthly	Weekly	Daily
Persons with disabilities					
Persons without disabilities (not family or staff)					
Paid staff					
Volunteers					

Please feel free to comment (e.g. to provide further explanation):

20. Does *this consumer* socialize in the following ways?

	YES	NO
Outings with friends		
Outings with family		
Inviting family/friends to residence		
Having friends stay overnight		
Seeing friends in private room		
Having friends over for meals, snacks, drinks, etc.		

Please feel free to comment (e.g. to provide further explanation):

21. Is *this consumer* now or has *this consumer* previously been involved in any of the following relationships in the last six months? (check one box for each relationship)

	Yes, currently	Not now, but yes in the past 6 months	No (by own choice)	No (no opportunity)	Don't Know
Boyfriend/girlfriend					
Marriage					
Is a parent					
Other					

Please feel free to comment (e.g. to provide further explanation):

Those are all of the questions we have for you today. Thank you!

Family Survey

UCI number: _____ Date: _ _/_ _/_ _ _
mm/dd/yyyy

Introduction: *This survey will help us find out how to best meet the needs of consumers who transitioned from Agnews Developmental Center to community based homes. Feedback from consumers' families is very important to us! Your answers will be kept confidential, which means that individual responses will not be seen by anyone except the evaluation staff.*

For any questions regarding this survey please contact Melanie Schindell at (530) 757-8643.

Please complete this survey within one week and return it in the envelope provided.

(PLEASE PRINT) ***Thank you*!**

1. What is your relationship to your family member living in the residence?

_____

2. About how many miles is your home from the residence at which your family member now resides? _____ miles

About how long does it take to drive this distance to his/her current residence?_____

PLEASE RATE YOUR LEVEL OF SATISFACTION WITH SERVICES YOUR FAMILY MEMBER IS CURRENTLY RECEIVING (circle answer):

3. Overall how satisfied are you with the residential services your relative is now receiving in the community?	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
4. Overall, how satisfied are you with the day program, educational, or vocational services your relative is now receiving?	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
5. Overall, how satisfied are you with the case management or social work services your relative is now receiving in the community?	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied

6. PLEASE INDICATE HOW STRONGLY YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS (circle answer):

I believe that all services needed by my relative are available to him/her in the community.	Agree Strongly	Agree Somewhat	Neutral	Disagree Somewhat	Disagree Strongly

7. PLEASE RATE THE FOLLOWING ASPECTS OF YOUR RELATIVE'S CURRENT RESIDENCE (circle one answer for each item):

a. Opportunities to learn new skills.	Excellent	Good	Alright	Not Very Good	Very Poor
b. Opportunities to experience or participate in interesting or enjoyable activities.	Excellent	Good	Alright	Not Very Good	Very Poor
c. Opportunities to make friends, acquaintances.	Excellent	Good	Alright	Not Very Good	Very Poor
d. Opportunities to experience a variety of places in the community with no more than one or two other people.	Excellent	Good	Alright	Not Very Good	Very Poor
e. Appearance, dress are:	Excellent	Good	Alright	Not Very Good	Very Poor
f. Food, nutrition are:	Excellent	Good	Alright	Not Very Good	Very Poor
g. Physical appearance and comfort of residence are:	Excellent	Good	Alright	Not Very Good	Very Poor
h. Overall for my family member the programs and services are:	Excellent	Good	Alright	Not Very Good	Very Poor
i. Day/work/school program are:	Excellent	Good	Alright	Not Very Good	Very Poor

7. PLEASE RATE THE FOLLOWING SERVICES FOR YOUR RELATIVE (circle one answer for each item):

a. Behavior/psychological (assessment, behavior modification, eliminating problem behavior)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
b. Medical (check-ups, exams, treatment, nursing)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
c. Vision (check-ups, glasses)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
d. Dental (check-ups, treatment, dentures)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed

e. Physical/occupational therapy (evaluation, therapy, training)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
f. Speech or communication	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
g. Self-care (grooming, hygiene, dressing)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
h. Independent living (cooking, budgeting public transportation)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
i. School or day program	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
j. Leisure (hobbies, sports, trips)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
k. Advocacy (citizen, volunteer, or legal)	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
l. Case management or social work	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
m. Special equipment or accommodation	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed
n. OTHER, please indicate	Excellent	Good	Alright	Not Very Good	Very Poor	Not needed

THINKING BACK TO WHEN YOUR FAMILY MEMBER WAS PLACED IN THE COMMUNITY HOME:

9. Please describe how you felt about your relative's proposed move to the current home before it happened.	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
10. Please describe how you now feel about your relative's community placement.	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied

11. How often have you visited your relative at the current residence? AT LEAST:

_____ weekly _____ 3-4 times a year _____ less than once a year

_____ monthly _____ once a year _____ never

12. How often has your relative visited you at your home from his/her current residence? AT LEAST:

_____ weekly _____ 3-4 times a year _____ less than once a year

_____ monthly _____ once a year _____ never

13. How happy do you think your family member is with the following:
(Please circle one box for each question)

a. The place that he/she lives or lived?	Unhappy	Mostly Unhappy	Sometimes Happy	Mostly Happy	Happy	Don't Know
b. The people that he/she lives or lived with?	Unhappy	Mostly Unhappy	Sometimes Happy	Mostly Happy	Happy	Don't Know
c. The staff working in this residence?	Unhappy	Mostly Unhappy	Sometimes Happy	Mostly Happy	Happy	Don't Know
d. His/her day program/ school/ or work?	Unhappy	Mostly Unhappy	Sometimes Happy	Mostly Happy	Happy	Don't Know
e. The opportunities and activities available to him/her?	Unhappy	Mostly Unhappy	Sometimes Happy	Mostly Happy	Happy	Don't Know
f. His/her life overall?	Unhappy	Mostly Unhappy	Sometimes Happy	Mostly Happy	Happy	Don't Know

14. Please make any comments regarding your feelings about your relative's transition from the State Regional Center (Agnews) to the current residence.

Facility Survey

Home/ Facility Name: _____ Date: _____

Introduction: *This survey will help us find out how to best meet the needs of consumers who transitioned from Agnews Developmental Center to homes like this one. This survey will be kept confidential, which means that individual responses will not be seen by anyone except the evaluation staff.* ***Please return the survey in the envelope provided within one week. Thank you!***

1. Total number of consumers in the home/facility: _____

2. Please complete the following grid. ***Only include hours worked in the residence and not those worked as part of a day program, if applicable.***

Staff Initials	Position (RN, LVN, LPT, LPTA, Admin, DCP)	Degree/ certification/ license	Total hours per week	Schedule (Specific days of the week and hours)	On-call schedule, if applicable	List required trainings completed[•]
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

[•] Please only provide information regarding the trainings that are specifically required for working in this SB 962 home. Please list the trainings that each staff members has completed to date, and comment on his/her progress toward meeting the requirements. For example, administrators are required to complete the DSS Admin Certificate Training (40 hours) before licensing; Direct care staff must complete the "Direct Support Care Professional Training" (roughly 35 hours within the first 12 months and another 35 hours within the next 12 months). *Please do not include* information about other trainings such as those that are specific to this facility or regional center.

11						
12						
13						
14						

If individual work schedules vary please complete the following grid (*instead* of the "schedule" column above).

	Total hours per week	**Schedule (Specific days of the week and hours)**	**On-call schedule, if applicable**
RN:			
1			
2			
3			
LVP/LPT:			
1			
2			
3			
4			
5			
6			
Other (Unlicensed) DSP, Caregiver, LPTA)			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
Administrator			
1			

2			

2b. Please check the response that best describes the qualifications of the administrator of this home:

☐ Licensed Registered Nurse
☐ Licensed Nursing Home Administrator
☐ Bachelor's degree in the health or human services field + 2 years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.
☐ Other (please describe); _____

_____

2c. How many years of experience does this administrator have serving as an administrator or supervisor in a licensed residential program for persons with developmental disabilities?

_____ years

3. Please describe how you meet (or exceed) the minimum requirement of having an RN, LVN, or LPT awake and on duty 24 hours per day, seven days per week.

How many of these hours are fulfilled by RNs, and during what shifts?
_____# Hours _____Shifts
How many of these hours are fulfilled by LVNs, and during what shifts?
_____# Hours _____Shifts
How many of these hours are fulfilled by LPTs, and during what shifts?
_____# Hours _____Shifts

Do you have any other comments to help us better understand how you meet this requirement?

_____

_____

Do you exceed this requirement? Yes or No (circle)
If yes, how? (e.g. how many hours per day or per week do you have additional RNs, LVNs, or LPTs awake and on duty? Which hours/shifts are these?)

_____

_____

4. Please describe how you meet (or exceed) the minimum requirement of having a RN awake and on duty at least 8 hours per consumer, per week.

How many hours do you have an RN awake and on duty per week? _____

_____

Which days, and hours/shifts do these tend to be? _____

_____

Do you have any other comments to help us better understand how you meet (or exceed) this requirement?

5. Please describe how you meet (or exceed) the minimum requirement that at least 2 staff on the premises are awake and on duty when providing care to four or more consumers.

Please list the days and hours/shifts that you are providing care to four or more consumers:

	Days of the Week (e.g. M-F, or MWF, or Sat & Sun)	**Hours/Shifts (e.g. 1-9am or 10pm-6am)**	**Number of Staff awake and on duty**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Do you have any other comments to help us better understand how you meet (or exceed) this requirement?

6. Do you have any additional comments to help us better understand the staffing at this facility/home (e.g. hours, schedules, qualifications, etc)?

Staff Satisfaction Survey

Staff ID Number (evaluation team completes this): _____

Home/Facility Name: _____ Date: _ _/_ _/_ _ _
mm/dd/yyyy

Introduction: *This survey will help us find out how to best meet the needs of caregiving staff working in homes like this one, and consumers who transitioned from Agnews Developmental Center to homes like this one. Your feedback about your experiences and satisfaction are very important to us! The answers will be kept confidential, which means that individual responses will not be seen by anyone except the evaluation staff.*

Please return the survey in the envelope provided within one week. Thank you!

I. Please tell us about your current job duties and experience.

1. How long have you worked with people with developmental disabilities? ____ years ___months

2. How long have you been in your current job? ____ years ___months

3. Which best describes your current position and qualifications?
   - ☐ Administrator
   - ☐ Direct care--RN
   - ☐ Direct care—LVN/LPT
   - ☐ Psych. Tech.
   - ☐ Other direct care provider
   - ☐ Other (please specify)

     _____

3a. What are your current degree(s) and/or certificate(s) for this position, and how long have you held each of them?

	Degree/ certificate	**Length of time**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

3b. What classification do you currently hold in California state service? _____

4. What hours do you work? _____

5. If you had a job working with people with disabilities prior to your current job, was it at:
   - ☐ Agnews Developmental Center
   - ☐ Another Developmental Center
   - ☐ A Skilled Nursing Facility
   - ☐ Another community care facility/home
   - ☐ Other (please specify)

   _____

6. If you previously worked at Agnews Developmental Center did you provide care for any of the same consumers at Agnews that you now provide care for in this community home?
   ☐ Yes ☐ No

7. If yes, how many? _____

8. Who is your employer? (check one)
   - ☐ The State of California
   - ☐ The owner of this community home
   - ☐ Other (please specify)

   _____

II. Please Rate the following areas.

Circle the option that best describes your overall opinion on each item. Please feel free to explain your ratings in the comment space provided below the item.

	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Don't Know
The Community-Based Home Model/Implementation					
9. The transition from Agnews developmental center to this community-based home was a smooth one for my consumers. Comments:	1	2	3	4	9

	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Don't Know
10. During my consumers' transition to this home I had all the information about them (e.g. their disabilities, service needs, preferences, habits, daily routines, relationships, etc.) to provide them with the best possible care in this home. Comments:	1	2	3	4	9
11. The health care provided for my consumers in the home is of high quality. Comments:	1	2	3	4	9
12. My consumers have adequate access to a primary care physician. Comments:	1	2	3	4	9
13. My consumers have adequate access to community health care services (e.g. urgent care, emergency room, acute care hospital) Comments:	1	2	3	4	9

	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Don't Know
14. My consumers have adequate access to community dental services. Comments:	1	2	3	4	9
15. My consumers' have adequate access to specialty care Comments:	1	2	3	4	9
16. Special incidents are handled appropriately by the home's staff. Comments:	1	2	3	4	9
17. Consumer records are complete, up-to-date, and accessible. Comments:	1	2	3	4	9
18. There is sufficient staffing and time allocated for helping consumers with non-medical/support needs (e.g. involvement in household activities and routines, community activities, decision-making). Comments:	1	2	3	4	9

	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Don't Know
19. The move to a community-based 962 home has had a positive effect on my consumers' quality of life. Comments:	1	2	3	4	9
20. My consumers have adequate access to community activities, resources, and day programs. Comments:	1	2	3	4	9
21. The move to a community-based 962 home has increased my consumers' participation in community activities/outings, resources, and/or day programs. Comments:	1	2	3	4	9
22. The home has positive relationships with its neighbors and surrounding community. Comments:	1	2	3	4	9

Working Conditions					
	Disagree	**Disagree Somewhat**	**Agree Somewhat**	**Agree**	**DK**
23. The expectations for this job were clearly communicated to me before I started working here. Comments:	1	2	3	4	9
24. I received a complete and timely orientation to the job and community-based care home environment. Comments:	1	2	3	4	9
25. I have sufficient training and experience to successfully complete all of my current job responsibilities Comments (what additional training would be helpful?):	1	2	3	4	9
26. I have sufficient training and professional development opportunities available to me through this job. Comments:	1	2	3	4	9

	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Don't Know
27. I have a positive relationship with my supervisor. Comments:	1	2	3	4	9
28. My supervisor is available to answer questions or provide assistance Comments:	1	2	3	4	9
29. My supervisor provides me with fair and helpful feedback and evaluation. Comments:	1	2	3	4	9
30. I am satisfied with my rate of pay Comments:	1	2	3	4	9
31. I am satisfied with my benefits (e.g. medical, dental, retirement). Comments:	1	2	3	4	9

	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Don't Know
32. I am satisfied with my work schedule. Comments:	1	2	3	4	9
33. I am satisfied with the availability of paid time off Comments:	1	2	3	4	9
34. I am satisfied with the degree to which my professional skills are used on the job. Comments:	1	2	3	4	9
35. I am satisfied with attitude of consumers and families toward our organization. Comments:	1	2	3	4	9
36. I am satisfied with communications with other professionals who are involved with my consumers. Comments:	1	2	3	4	9

37. What are the most positive aspects of the community-based 962 home:
    a) For your consumers?

    _____
    _____
    _____
    _____
    _____
    _____

    b) For you?

    _____
    _____
    _____
    _____
    _____
    _____

38. What have been the most challenging or difficult aspects of the move?
    a) For your consumers?

    _____
    _____
    _____
    _____
    _____
    _____

    b) For you (even if you didn't previously work at Agnews Developmental Center)?

    _____
    _____
    _____
    _____

APPENDIX C. MEDICAL CONDITIONS OF SB 962 CONSUMERS

Medical Condition	ICD-9 Code	Number (Percentage) of Consumers
Bifid uvula	750.26	1 (1%)
Otitis externa	381.5	1 (1%)
Bursitis of hip with peritendinous calcification	727.3	1 (1%)
Ventriculoperitoneal shunt	2.3	1 (1%)
Hyponatremia	276.1	1 (1%)
Hypomagnesia	275	1 (1%)
L hydronephrosis	591	1 (1%)
Undecided testes	608.3	1 (1%)
Chronic cough	786.2	1 (1%)
Hepatitis C+	V02.62	1 (1%)
Status post aspiration pneumonia	507	1 (1%)
Leukopenia	288.5	1 (1%)
Arrhythmia	427.9	1 (1%)
Optic nerve hypoplasia	377.43	1 (1%)
Bilateral retinopathy	362.1	1 (1%)
Recurrent urinary tract infection	465	1 (1%)
Aspiration pneumonia	486	1 (1%)
Legally blind	369.1	1 (1%)
OT Lymphoma mult	202.88	1 (1%)
Panuveitis	360.12	1 (1%)
S/P tracheal laryngeal diversion	748.3	1 (1%)
S/P surgical removal of Lt Testicle	None	1 (1%)
Carnitine deficiency	277.84	1 (1%)
Herpes zoster t4 dermatome	53.9	1 (1%)
Small inguinal testes	752.89	1 (1%)

Chronic venous hypertension	459.3	1 (1%)
Gingival hypertrophy	523	1 (1%)
Prostatic hypertrophy	600	1 (1%)
Parkinsonism	332	1 (1%)
Mild aortic insufficiency	396.1	1 (1%)
Suprapubic catheter	57.17	1 (1%)
Urethral stricture	598.9	1 (1%)
Laryngotracheal separation	519	1 (1%)
Nocturnal low oxygen stats	V47.2	1 (1%)
Gastric atony	536.3	1 (1%)
R kidney stone	592	1 (1%)
Bladder stones	592.9	1 (1%)
Subluxation of R hip joint	706.3	1 (1%)
Down's syndrome	758	1 (1%)
Atrial septal defect	743.5	1 (1%)
Umbilical hernia	553.1	1 (1%)
Liver cirrhosis	571.5	1 (1%)
Hepatitis B positive	70.42	1 (1%)
Chronic hip dysplasia	736.3	1 (1%)
Congenital hiatus hernia	750.6	1 (1%)
Ceruminosis	380.4	1 (1%)
End state renal disease	403.11	1 (1%)
Fibromas on fingers and toes	213.9	1 (1%)
Lipomas on liver, kidney	214.9	1 (1%)
Diverticulitis	562	1 (1%)
Hyperparathyroidism	252	1 (1%)
Abdominal hernia	553	1 (1%)
Right renal calculi	V13.01	1 (1%)

History of ileus	560.1	1 (1%)
Folliculitis	704.8	1 (1%)
Mild aortic regurge	424.1	1 (1%)
Central respiratory depression	786	1 (1%)
Nephrostomy tube	53.03	1 (1%)
Renal failure	586	1 (1%)
Coagulopathy	286.9	1 (1%)
Myopia	367.1	1 (1%)
Moebius syndrome	352.6	1 (1%)
Dandruff	704.8	1 (1%)
Inclusion cyst	706.1	1 (1%)
Multiple nevi	448.1	1 (1%)
Dry lips	528.5	1 (1%)
Uterine bleeding	626.8	1 (1%)
Dystrophic toenails	757.5	1 (1%)
Chronic intertigo	111	1 (1%)
Bilateral labial hypertrophy	624.3	1 (1%)
Cholelithiasis	574	1 (1%)
Dependent stasis edema	459.3	1 (1%)
Small cervical polyps	219	1 (1%)
Pancreatic insufficiency	577.8	1 (1%)
Chronic dacryoblepharitis	373	1 (1%)
Chronic malrotation with intermittent gastric outlet obstruction	751.4	1 (1%)
Hypophosphatemia	273.3	1 (1%)
Esophageal occlusion	530.3	1 (1%)
Asymptomatic cholethiasis	573.1	1 (1%)
Underweight	783.22	1 (1%)

Pierre Robin Syndrome	756	1 (1%)
Eczema	692.9	1 (1%)
Dyslipidemia	272.4	1 (1%)
Bruises easily	924.9	1 (1%)
Old abrasions on arms due to self biting	959.2	1 (1%)
Chronic sinusitis	473.9	1 (1%)
Phthisis	360.41	1 (1%)
Congenital absence R kidney	753	1 (1%)
Cataract removed	13.19	1 (1%)
Klinefelter syndrome	758.7	1 (1%)
Peripheral vascular disease	443.9	1 (1%)
Bilateral deep vein thrombosis	453.4	1 (1%)
Conjunctivitis	372.3	1 (1%)
Cholelithiasis	574.8	1 (1%)
Hypoalbuminemia	273.8	1 (1%)
Severe myopia	367.1	1 (1%)
COPD	492.8	1 (1%)
History of Lacunar infection	434.91	1 (1%)
Stage III Chronic Kidney Ds	583.3	1 (1%)
Anxiety Attacks	300	1 (1%)
Onchyomycosis	681.11	1 (1%)
Liver Cysts	753.19	1 (1%)
Keratosis	701.1	1 (1%)
Acrocyanosis of feet	443.9	1 (1%)
Tinea Corporis	110.5	1 (1%)
Dilated Esophagus	530.89	1 (1%)
Esophageal Stricture	530.87	1 (1%)
Mega colon	564.7	1 (1%)

Episodic emesis	536.2	1 (1%)
Bilateral Hydroceles	603.9	1 (1%)
Vagal Nerve Stimulator	343.41	1 (1%)
Recurrent deep vein thrombosis	451.1	1 (1%)
Astrocytoma Rt optic nerve	224.8	1 (1%)
Angiofibromas	210.7	1 (1%)
Sub epidermal hematomas	432	1 (1%)
Angiomyolipomas of kidneys	223	1 (1%)
Hypo menorrhea	623.3	1 (1%)
Chronic respiratory failure	518.84	1 (1%)
Laryngeo-tracheal Diversion with Trach	748.3	1 (1%)
Keratitis	370.9	1 (1%)
Sarcoma of right foot	239.2	1 (1%)
Bullous Dermatoses	694.9	1 (1%)
Onychomycosis, bilateral feet	681.11	1 (1%)
Reactive airway disease	493	10 (13%)
Dermatitis/Contact dermatitis	691/692	11 (15%)
Hyperlipidemia	272	12 (16%)
Cataracts	366	12 (16%)
Hypercholesteremia	272	13 (17%)
Anemia	281.9	16 (21%)
Tracheostomy	31.2	16 (21%)
Scoliosis	737	17 (23%)
Hypothyroidism	243	18 (24%)
Acne	706.1	18 (24%)
Oligomenorrhea	626.1	2 (3%)
Hyperammonemia	270.6	2 (3%)
Vegetative state	780.03	2 (3%)

Temperature instability	780.99	2 (3%)
Chronic lung disease	496	2 (3%)
Gallstone	573.1	2 (3%)
Gallstone ileus	560.31	2 (3%)
Calcification of Lt Breast	793.89	2 (3%)
Fibrocystic Mass/ Rt buttock	214.9	2 (3%)
Onychia of toe	681.11	2 (3%)
Neurogenic bladder	596.54	2 (3%)
Decubitis	707.09	2 (3%)
R Gynecomastia	611.1	2 (3%)
Barrett's esophagus	530.85	2 (3%)
Chronic bronchitis	491.9	2 (3%)
Diaper rash	691	2 (3%)
Weight maintenance	783.1	2 (3%)
Hypersalivation	527.7	2 (3%)
Intestinal obstruction	560.9	2 (3%)
Tinea pedis	110.4	2 (3%)
Tinea blanca	111.1	2 (3%)
Flexion contractures	754.89	2 (3%)
Bradycardia	427.8	2 (3%)
Urinary tract infection/disease	599.9	2 (3%)
Restricted lung disease	496/493	2 (3%)
Dyskinesia	n/a	2 (3%)
Equinovarus	754.51	2 (3%)
Arthritis	716.66/716.9	2 (3%)
Osteoporosis	733	24 (32%)
Seborrhea/ Seborrheic dermatitis	706.3	29 (39%)
Tuberous sclerosis	793.5	3 (4%)

Undescended testicles	752	3 (4%)
Osteoarthritis	715	3 (4%)
MRSA carrier	V02.54	3 (4%)
Seizure disorder	343.3	3 (4%)
Allergic rhinitis	477	3 (4%)
Status post L hip dislocation	835	3 (4%)
Diabetes mellitus type II	250	3 (4%)
Hypokalemia	276.8	3 (4%)
Esophagitis	530.1	3 (4%)
Seborrhea capitis	690.11	3 (5%)
Dystonia	333.7	3 (5%)
Gastroesophageal reflux disease	530.80	33 (44%)
Gastrostomy	43.1	37 (49%)
Hydrocephalus	742.3	4 (5%)
Asthma	492/493	4 (5%)
Amenorrhea	626	4 (5%)
Hypothermia	99.81	4 (5%)
Optic nerve atrophy	272.4:	4 (5%)
VRE colonized	V09.8	4 (5%)
Xerosis	706	4 (5%)
Microcephaly	742.1	4 (5%)
Dysphagia	787	44 (59%)
Bronchospasm	591.11	5 (7%)
Hip dislocation/ subluxation	754	6 (8%)
Edema of lower extremities	782.3	6 (8%)
Dysmenorrhea	623.3	6 (8%)
Glaucoma	365	6 (8%)
Dry cornea	371.9	6 (8%)

Hypertension	401.1	6 (8%)
Constipation	564	62 (83%)
Hiatal Hernia	553.3	7 (9%)
Optic atrophy	377.1	7 (9%)
Osteopenia	733.9	7 (9%)
Mycotic nails or toenails	110.1	8 (11%)
History of MRSA colonization	V090	8 (11%)
Fibrocystic breast disease	610.1	9 (12%)
Sleep apnea	327.2	9 (12%)
Overweight/Obesity	278	9 (12%)