Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
A. Client Safety		
1. FDC will report and investigate all incidents and injuries as required by regulation or law.	Immediately and ongoing	FDC
2. FDC will maintain the safety of all clients at FDC during the transition/closure process.	Immediately and ongoing	FDC
3. CDDS will conduct frequent, periodic training for direct support staff and management in the detection and prevention of abuse, neglect and mistreatment and the recognition and elimination of environmental and/or situational factors that may result in such mistreatment.	August, 2016 and then quarterly thereafter	CDDS
4. FDC will ensure that adequate staff are available and assigned during meal times to assist clients as necessary in the consistent implementation of formal/informal feeding programs.	Immediately and ongoing	FDC
B. Client Health Needs		
1. FDC will provide all needed health care services to FDC clients including but not limited to, timely health assessments and timely health interventions, and will comply with physician orders for medication in accordance with 42 C.F.R. § 483.460.	Immediately and ongoing	FDC
2. FDC will ensure that all client injuries are evaluated by health personnel in a timely manner and follow-up interventions are initiated as indicated.	Immediately and ongoing	FDC
3. FDC will ensure that all physician orders received for the care of the clients are followed by the medical staff of the facility.	Immediately and ongoing	FDC
4. FDC will ensure that the nurses in the facility complete quarterly assessments as required by 42 C.F.R. § 483.460(c)(3)(iii) for each client in order to proactively identify health concerns, or on a more frequent basis depending on client needs**.**	Immediately and ongoing	FDC
C. Active Treatment		

Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
1. FDC will provide active treatment to all clients in the units in FDC that are certified to participate in the Medicaid program (the FDC certified units). Particular emphasis will be placed on: a. The protection of clients from abuse, neglect or mistreatment using all reasonable efforts, including without limitation, the development and regular provision of staff training and the consistent implementation of behavior modification plans; b. The incorporation of replacement behaviors into client behavior management plans to facilitate a higher success rate of the plans; c. The identification of each client's most appropriate post-discharge setting and all post-discharge needs; d. The provision of daily programs and interactions as necessary to ensure that clients do not decline in their current skills unless clinically unavoidable due to medical issues; e. The provision of an active program to begin to prepare each client for an alternative post-discharge setting; f. The implementation of client individualized program plans (IPPs) are implemented as written or revised as indicated on a timely basis.	Immediately and ongoing	FDC
2. FDC will ensure that each staff member working with a client receives initial and periodic training on the requirements associated with that client's IPP.	Immediately and ongoing	FDC
3. FDC will ensure that all staff are trained on and implement FDC policies for documentation of client participation in and progress on established goals and programs.	Immediately and ongoing	FDC
4. FDC will ensure that a Qualified Intellectual Disabilities Professional (QIDP) is assigned to every client. FDC will also monitor all client IPPs and initiates program changes as indicated.	Immediately and ongoing	FDC
D. Individual Program Plans (IPP), Transition Plans and Activities		
1. **Individual Program Plan** As required by Sections 4418.3, 4646, and 4646.5 of the California Welfare and Institutions Code an IPP is developed for every individual using a person-centered planning approach by making decisions regarding where a person with developmental disabilities will live and the kinds of services and supports that may be needed. In person-centered planning, everyone who uses regional center services has a planning team that includes the person utilizing the services, family members, regional center staff and anyone else who is asked to be there by the individual. This team is referred to as the Interdisciplinary Team (IDT). The IDT joins together to make sure that the services that people are getting are supporting their choices in where they want to live, how and with whom they choose to spend the day and their plans for the future. **2. Exploration and Identification of Living Options**	IPP completed or amended annually or more frequently, as needed.	FDC staff complete the IPP while the individual resides at FDC and regional center staff complete once the individual moves to the community.

Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
The transition process begins with the already existing IPP as mandated in the Lanterman Act and continues as IDTs meet to identify each person's goals and objectives, and services and supports based upon their assessed needs, preferences and choices. FDC will work with individuals, family, IDT, and where appropriate other participants, to review transition options using the clients' IPPs.	August 1, 2016	FDC
a. FDC will develop and implement a Facility plan to increase opportunities for more individuals to take community tours and experience community living options, in accordance with State policy that each individual is afforded these opportunities.	As potential options are identified	FDC
b. FDC will coordinate "meet & greet" introductions to potential providers where clients, families and providers meet to see if a specific option identified through exploration activities has the potential for success.	As potential options are identified	CDDS FDC
c. The IDT will consider currently available alternative placements for any clients at FDC whose post-discharge needs match the services available and transfers are made as appropriate.	Immediately and ongoing	CDDS FDC
3. **Transition Planning Meetings**		
a. Once a client has had a successful "meet and greet" and identifies a specific living option they want to pursue, a Transition Planning Meeting (TPM) will be held with the IDT to start an Individual Transition and Health Transition Plan for the client.	Within 30 days of IDT identifying a specific living option	CDDS FDC
b. The Individual Transition and Health Transition Plan documents the process of planning and implementing transition activities and specific transition health services.		
4. Familiarization (Cross-training) Activities		
a. The IPP will include specific activities for familiarization of new provider staff with the details of the Comprehensive Assessment, Individual Program Plan, Specialized Support Plans and any informal or personalized knowledge from the FDC staff who know the client best. This may include activities such as:	As transition plans are developed and implemented	CDDS FDC
i. Integrated meetings with IDT and new provider staff for transition of plan information. Includes transition of Residential, Day Services/Vocational, Health Care, Behavioral Health and any other plan to the new provider as identified in the transition plan.		
ii. Cross training of new provider staff and FDC staff is accomplished via visits by FDC staff to the community providers or vice versa, simulated training situations or actual observation of daily activities and programming across support settings.		
5. Individualized Health Transition Plans (IHTPs)		

Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
a. As part of the transition planning process, an IHTP is developed by the ID team to include the client's health history and current health status by the client's medical staff. The client, involved family members, conservator, authorized representative, and/or advocate may participate in the development of the IHTP. The IHTP provides specific information on how the client's health needs will be met and the health transition services that will be provided, such as occupational therapy, respiratory therapy and other specialized health procedures	Upon identification of a specific appropriate living option and ongoing	CDDS FDC
6. **Specialized Behavior Plans and Safety Plans**		
a. As part of the transition planning process, the ID Team will develop Specialized Behavior Plans that include components related to client safety for clients who have significant behavioral support needs, many who currently have rights restrictions or the use of highly restrictive methods such as psychoactive medications. Where indicated by the Comprehensive Assessments, specialized behavior plans will be developed to assist new service providers in understanding the needs of the individual and to adequately provide the needed behavioral supports in the new settings.	Upon identification of a specific appropriate living option and ongoing	CDDS FDC
7. **Transition Review Meeting (TRM)**		
a. A TRM is held to review and finalize a client's Individual Transition and Health Transition Plan and to ensure that all members of the ID Team are satisfied that all arrangements agreed on in the planning process have been implemented and that the client is prepared to move. TRM's are held at the conclusion of the transition process and is when the ID Team sets a move date. An individual's TRM must occur no less than 15 days prior to a planned move date to better inform current quality assurance efforts, meet the expectations of CMS, and provide information to CDDS.	Upon identification of a specific appropriate living option and ongoing	CDDS FDC
8. Fairview Certified Unit Population Projections The projections below establish the maximum permissible client census eligible for federal funding in the FDC certified units as of the first calendar day of the listed month. Federal Financial Participation is only permissible for clients on the Client List as of June 27, 2016. No Federal Financial Participation can be sought for the number of clients that exceed the projections below, even if the clients that exceed the census limits below are on the Client List as of June 27, 2016. Census July 2016 ……..136 July 2017……106 July 2018……57 July 2019……5 October 2019…….0		

Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
E. Post-Move Monitoring		
1. The California Department of Developmental Services' Fairview Developmental Center Closure Plan will detail the process and mechanisms the Department, regional centers and other oversight entities will employ for monitoring the health, safety and well-being of individuals who transition from Fairview Developmental Center to the community. a. Expectations and a clear process will be established for post-move monitoring and required documentation. b. State employees, regional center staff and providers will share responsibility in assuring identified outcomes are met while providing and accessing resources to make community living successful	April 1, 2016	CDDS FDC
2. The Department will maintain an active Quality Management System, in conjunction with the Regional Centers, to monitor consumers' quality outcomes and satisfaction and to identify areas where interventions and improvements may be needed through the use of: a. The National Core Indicators (NCI) b. Onsite visits and interviews. c. Consistent with ongoing CDDS and Regional Center operations, existing systems and databases. d. Review of IPPs.	Continuous and ongoing	CDDS FDC
3. The California Parties will meet the obligations set forth in Attachment B, which relates to the discharge of FDC clients and requires development of a plan for enhanced oversight of client transitions from developmental centers to the community.	Immediately and ongoing	CDDS FDC
4. FDC will perform on-site post-move monitoring at residential settings for up to one year after each individual transitions to the community. The monitoring will occur on the following intervals – 5 days, 30 days, 90 days, 180 days, and 360 days. This post-move monitoring shall include feedback obtained from client family members or responsible parties regarding the transfer process to the new community setting.	At 5, 30, 90, 180 and 360 days from transfer from FDC	CDDS FDC
5. Once the individual transitions to the community, regional center staff performs at least quarterly face-to-face visits for anyone residing in out-of-home placement to ensure health, safety and quality services. a. In addition, anyone moving from a developmental center to the community receives enhanced (1:45) regional center case management services for at least two years. b. Individuals who move from the developmental center to an Adult Residential Facility for Persons with Special Healthcare Needs or to Enhanced Behavioral Supports Home, receive enhanced clinical staffing in the home and oversight by the regional center and CDDS. CDDS shall use the National Core Indicators (NCI) to measure the	At least quarterly following move	CDDS FDC

Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
outcomes for individuals who have transitioned to the community. Annually, CDDS will review the outcome measures with the CDDS Quality Management Advisory Group that consists of parents and families, representation from the State Council on Developmental Disabilities, protection and advocacy organizations, DC clients and Regional Center representatives.	Annually	CDDS
F. Monitoring by Independent Monitor		
1. Subject to CMS's approval, the CDDS will employ at its own expense an independent external organization with proven capabilities in quality assurance systems in the ICF/IID environment ("Independent Monitor") to develop a monitoring plan and implement the quality assurance performance indicators and conduct the following tasks:	Monitor to be submitted to CMS for approval no later than August 1, 2016	CDDS and monitor
a. The Independent Monitor will conduct frequent monitoring of conditions at FDC with an emphasis on provision of Active Treatment, quality Health Care outcomes, Behavioral Health outcomes and Client Protections.	As needed	Independent Monitor
b. Additional specialized monitoring of the transition process and outcomes will be developed by the Independent Monitor based on information gained during the transition process and post move monitoring by FDC and CDDS.	As needed	Independent Monitor
c. The Independent Monitor will provide reports based on the data regarding the status of compliance with the provisions and requirements of this Attachment A, Statement of Tasks, data obtained pursuant to Attachment B and data obtained by F (1)(a) and (b) to CMS, CDPH, and California Parties beginning on September 1, 2016, and every month thereafter, or more frequently if requested by CMS. The reports shall at a minimum include the items identified in paragraph E.3-6 and G.1.a-b, updated data on the client census each month, verification of CDDS activities pursuant to Attachment A as described in F.1.d below, and may include other items that the Independent Monitor deems material.	September 1, 2016 and every month thereafter	Independent Monitor
d. The independent Monitor's reports will also include verification that CDDS has met its obligations pursuant to Attachment A, including, but not limited to: i. Providing trainings in the detection and management of abuse, neglect and mistreatment and the recognition and elimination of environmental and /or situational factors that may result in such mistreatment pursuant to § A.3 of Attachment A ii. Providing familiarization/cross-training activities to facilitate transfer of FDC clients pursuant to pursuant to § D.4 of Attachment A. iii. Participating in Transition Review Meetings pursuant to § D.7 of Attachment A. iv. Ensuring that Quality Assurance activities are undertaken and monitored for effectiveness pursuant to § G.1 of Attachment A.	September 1, 2016 and every month thereafter	Independent Monitor

Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
v. Providing competency evaluations and trainings as necessary for FDC staff and management pursuant to § G. 3 of Attachment A. vi. Ensuring that the monitoring plan is reviewed and revised as necessary pursuant to § G.6 of Attachment A. vii. Ensuring that QMS activities were conducted, including the factors listed in § E.2 of Attachment A. viii. Maintaining a list of clients transitioned to Adult Residential Facility for Persons with Special Healthcare Needs or to Enhanced Behavioral Supports Homes, to which CDDS has an obligation to provide enhanced oversight pursuant to § E.5(b) of Attachment A.		
G. Quality Assurance		
1. CDDS will develop and implement a detailed QA plan and maintain the plan over the life of the FDC closure/transition agreement. The QA system will include: a. A quality oversight and internal monitoring system with tools and a data system for monitoring. This will be applied by both internal and external reviewers to ensure the timely discovery and investigation of all incidents and injuries, the thorough conduct of investigations, the maintenance of quality of investigative reports and the effectiveness of any required corrective actions. b. Monitoring the effectiveness of incident management, investigations, and corrective actions. c. A process to monitor abuse, neglect, and mistreatment of clients, and revise as identified. d. Quality measurement tools for both internal and external reviewers to use to conduct observations and compare various records to ensure that all incidents and injuries are reported and appropriate related actions undertaken. e. Unannounced visits on all shifts, including the continuation of CDPH performing unannounced visits to observe for situations that may indicate safety concerns.	August 1, 2016 and ongoing	CDDS CDPH FDC
2. Review competency of FDC and other staff as required in Person Centered Planning in accordance with the Lanterman Act and relevant CMS requirements FDC will continue the development of its integrated Person Centered and Planning (PCP) and Interdisciplinary team (IDT) process, including: a. Increasing IDT members' understanding of the basic PCP concepts and gaining commitment to the underlying values; b. Improving the assessment process to increase identification of client's personal desires/goals in addition to needs/strengths, while maintaining the rights of the clients; c. Increasing involvement of the individual/family members/direct support staff in the IDT and transition planning process; d. Including goals/desires that will assist for a successful transition in each client's IPP and implement a "discovery log" to identify additional individual interests/desires throughout the year that will	August 1, 2016 and ongoing	

Attachment A to Fairview Developmental Center Settlement Agreement Dated July 1, 2016 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
assist in matching the person to the most appropriate setting. e. A monitoring process to perform ongoing competency evaluation of both individual staff and IDT function will be incorporated in the quality assurance plan. f. When indicated by the monitoring results, competency-based training/retraining will occur. Independent Monitor will perform quality assurance on a representative sample of comprehensive assessments.	September 1, 2016 and ongoing	Independent Monitor
3. Determine competencies and train/re-train FDC/RC staff in transition planning. Provide IDT members with training related to the general identification of barriers to successful transition and the consequent design and implementation of strategies to reduce those barriers. The training will focus specifically on the role and responsibilities of the Interdisciplinary team in identifying family/guardian concerns that may serve as a barrier to placement and in the development of strategies to resolve those concerns. Often these concerns are based on the perceived lack of protections, services, and supports in the community. Obstacles and concerns should be defined with sufficient detail to allow the State to identify and address issues related to the current community system.	August 1, 2016 and ongoing	CDDS FDC
4. IDT members in all disciplines will visit community programs on a regular and ongoing basis. Facilitators/IPCs, in particular, should begin visiting community programs immediately to become familiar with options and services.	August 1, 2016 and ongoing	FDC
5. Identify Outcome and Process measures to be monitored, tracked and trended to assure successful transitions and achievement of closure plan objectives.	As needed	CDDS, FDC
6. The CDDS will review and revise the monitoring plan previously provided during the PIP by developing a two-pronged quality assurance approach. The primary concentration of this approach will be to: 1) assure that clients of FDC achieve the *outcomes* specified in their IPPs; and 2) that the policies, procedures, and practices employed at FDC support the achievement of these outcomes.		CDDS