



July 14, 2014

Brent L. Green
Chief, Division of Right of Way and Land Surveys
Attention: Affordable Sales Program
California Department of Transportation
1120 N Street, MS 37
Sacramento, CA 95814

Dear Mr. Green:

The Association of Regional Center Agencies (ARCA) represents California's 21 regional centers, which operate under contract with the Department of Developmental Services (DDS) to coordinate services and supports for over 270,000 Californians with developmental disabilities. Those disabilities, within the developmental services system, are clinically defined, and include autism, epilepsy, cerebral palsy, intellectual disabilities, and conditions similar to (or requiring similar supports) as intellectual disabilities.

As you receive enquiries from prospective purchasers of the surplus real property tied to State Route 710, housing-related private affordable housing organizations affiliated with our system may be among those contacting you. It is our hope, shared by DDS, that they will be given favorable consideration. Their work is critical to the development of affordable housing stock for people with developmental disabilities.

In California, only 15% of adults with developmental disabilities are employed, averaging well under 30 hours a week of paid work, and generally earning only slightly above minimum wage (NCI 2012-13 ACS Final Report). On a more local level, Los Angeles County has approximately 40,000 adults with developmental disabilities. Concurrently, as noted in the National Low Income Housing Coalition's 2014 report, fair market rent for a two-bedroom apartment in the Los Angeles-Long Beach HUD Metro Fair Market Rent Area is \$1,398 a month. Self-sufficiency is, therefore a significant challenge – not just in Los Angeles, but statewide.

Given the severe income constraints faced by people with developmental disabilities, it can often be a challenge to afford fair market rent – let alone service a mortgage. Thus, regional centers work with various housing-focused, non-profit organizations (housing NPOs) to develop permanent housing. The common approach is for the NPO to purchase the residential property, and hold it in perpetuity. Such properties range from single-family homes to multi-unit apartment complexes. With a legal mandate to manage the properties for the benefit of people with developmental disabilities, these NPOs act on behalf of low-income tenants. In doing so, they make it possible for people with developmental disabilities to have a permanent, affordable residence that meets their unique needs.

Pursuant to Government Code §§ 54235-54238.7, the disposal of surplus residential property such as that to State Route 710 should be done in a fashion that will meet the intended goal of the Legislature of preserving and expanding the availability of low and moderate income housing. All surplus residential

properties, after being offered to current occupants (where applicable), are then offered to housing-related private and public entities.

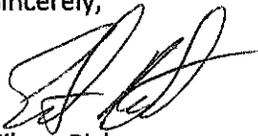
Housing NPOs that work with regional centers are such entities. The development of affordable and accessible homes is critical to DDS and the regional centers. Aside from the aforementioned 40,000 individuals in Los Angeles County, there are also 1,290 individuals living in state-operated developmental centers. During this past year, the Secretary of Health and Human Services, Diana Dooley, established a Task Force to study the concerns regarding individuals still residing in developmental centers. A large part of the recommendations of the final Task Force Report was to build capacity in the community to assist these individuals to transition into integrated living options (copy of the report is attached). Additionally, the governor has asked Secretary Dooley to reconvene the Task Force to continue the work and with focus on strengthening community the community system (copy attached).

All of these individuals have a right to live in the least restrictive environment that includes opportunities for community participation through the availability of housing and supports, which improves their quality of life and their outcomes. Locating housing that is safe, accessible, affordable at their income level, and integrated in the community is extremely difficult.

As offers on the properties are advanced, should you receive any from housing NPOs, please rest assured that their work is towards the development of permanent affordable housing for a population that has an urgent need for such options. Both ARCA and DDS view such work as critical to meeting that need.

Should you have any questions or need any additional information, please do not hesitate to contact Olivia Balcao in our office at obalcao@arcenet.org or (916) 446-7961.

Sincerely,

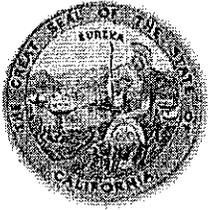


Eileen Richey
Executive Director

CC: Jennifer Lowden, California Department of Transportation

EDMUND G. BROWN JR.
GOVERNOR

State of California HEALTH AND HUMAN SERVICES AGENCY



DIANA S. DOOLEY
SECRETARY

January 13, 2014

The Honorable Darrell Steinberg
President Pro Tempore
California State Senate
State Capitol Building, Room 205
Sacramento, CA 95814

The Honorable John A. Pérez
Speaker of the Assembly
California State Assembly
State Capitol Building, Room 219
Sacramento, CA 95814

Aging

Child Support
Services

Community Services
and Development

Developmental
Services

Emergency Medical
Services Authority

Health Care Services

Managed Health Care

Managed Risk
Medical Insurance Board

Office of Patient Advocate

Office of System
Integration

Public Health

Rehabilitation

Social Services

State Hospitals

Statewide Health
Planning and
Development

Dear Senator Steinberg and Assembly Member Pérez:

Pursuant to the commitment I made last spring to address the declining population in the developmental centers, the resulting fiscal pressures, the challenges of maintaining federal certification in aging facilities and the repeated calls to close these facilities immediately, and to fulfill the requirements of Section 14(a) of Assembly Bill (AB) 89 (Chapter 25, Statutes of 2013), I respectfully submit the enclosed Plan for the Future of Developmental Centers in California.

To begin this effort, I invited a broad cross-section of seasoned leaders committed to meeting the needs of people with developmental disabilities to serve on a Task Force to identify challenges, gather facts, share opinions and seek opportunities for improvement. The Task Force included consumers, family members, regional center directors, consumer rights advocates, labor union members, community service providers, and staff from the Department of Developmental Services. At the outset, there was great division and very little expectation that any consensus could be reached but throughout the six months of intense inquiry and effort, there was a unifying commitment that the well-being of each and every developmental center resident was at the center of our work.

By keeping our focus on the residents and through the open, honest and candid sharing of information and opinions, the full Task Force agreed to present this report and its six recommendations on behalf of us all. Some of the parents and some of the unions have qualified their support to be clear that they do not support any implication that the centers should be closed but the commitment to the need for fundamental transformation of the developmental centers system is shared by all.

I have been humbled and inspired by the understanding I have gained through the work of this Task Force. The Administration is committed to the goals set forth in this report and will continue the active stakeholder engagement that contributed so significantly to this work as we move forward with its implementation.

Respectfully,

A handwritten signature in black ink that reads "Diana S. Dooley".
Diana S. Dooley
Secretary

PLAN FOR THE FUTURE OF DEVELOPMENTAL CENTERS IN CALIFORNIA

*Report to the Legislature
Submitted pursuant to Assembly Bill 89, Section 14(a)
(Chapter 25, Statutes of 2013)*

Submitted by the
California Health and Human Services Agency
On behalf of the Task Force on the Future of Developmental Centers
1600 9th Street, Room 460
Sacramento, California 95814

January 13, 2014

EXECUTIVE SUMMARY

Since the 1960s, with the passage of the Lanterman Developmental Disabilities Services Act (Lanterman Act), the role of the State-operated Developmental Centers (DC) has been changing. The resident population has dropped from a high in 1968 of 13,400, with thousands on a waiting list for admission, to 1,335 residents as of January 1, 2014. The population at each of the four facilities, originally designed to serve between 2,500 and 3,500 individuals, is now below 500, with Fairview DC at 318 residents and Lanterman DC at 101. Additionally, the trailer bill to the 2012-13 budget imposed a moratorium on admissions to DCs except for individuals involved in the criminal justice system and consumers in an acute crisis needing short-term stabilization.

Each year Community Placement Plan (CPP) funding (\$67 million in Fiscal Year {FY} 2013-14) is provided to regional centers to expand and improve services to meet the needs of DC residents transitioning to the community. As new CPP-funded resources become available, on average 175 to 200 consumers move out of a DC into community-based services each year. With the CPP funding provided in FY 2011-12 through 2013-14, over 500 new residential beds will be available for DC movers during the next 18 months.

The moratorium, coupled with CPP placements and prior changes in the service delivery system, has reduced the reliance on State-operated DCs and expedited the decline in resident population in these facilities.

Without intervention, the role of the State in delivering direct services is rapidly diminishing. With the input and assistance of the Task Force, the State now has an opportunity to define and manage the transition from historically large congregate living facilities to more integrated and specialized services using the expertise and resources of the DCs to benefit the consumers.

The DCs will need to transition from large congregate 24-hour nursing and Intermediate Care Facility services to a new model. The recommendations of this Task Force are that the future role of the State is to operate a limited number of smaller, safety-net crisis and residential services coupled with specialized health care resource centers and public/private partnerships, as well as the Porterville DC - Secure Treatment Program (STP) and the Canyon Springs Community Facility.

Following are the six consensus recommendations endorsed by the Task Force with the qualifications and exceptions set forth in the attached letter from the Sonoma DC Parent Hospital Association (PHA), the California Association of Psychiatric Technicians (CAPT), and the California Statewide Law Enforcement Association (CSLEA).

I. INTRODUCTION

The California Health and Human Services Agency (CHHS) submits this plan on behalf of the Task Force on the Future of the Developmental Centers (Task Force) and to fulfill the requirements of Section 14(a) of Assembly Bill (AB) 89 (Chapter 25, Statutes of 2013) which states:

SEC.14. (a) The California Health and Human Services Agency shall, on or before November 15, 2013, submit to the appropriate policy and fiscal committees of the Legislature a master plan for the future of developmental centers. In the preparation of this plan, the agency shall consult with a cross-section of consumers, family members, regional centers, consumer advocates, community service providers, organized labor, the State Department of Developmental Services, and representatives of the Legislature.

This chapter provides pertinent background information and history leading to the creation of the Task Force. Chapter II describes the Task Force approach, the data and information considered by the Task Force, and the Task Force's observations covering: who is currently being served in a DC and their service and support needs; the resources that are or could be available in the community and in the DCs to meet those needs; other service models and their viability for improving services to this population; and funding considerations. Chapter III presents the recommendations of the Task Force for serving DC residents in the future.

HISTORICAL PERSPECTIVE

A need has always existed to provide care and services to individuals with intellectual and developmental disabilities. In 1853, a California system of large, public hospitals for the "mentally disadvantaged" began with the establishment of the Insane Asylum of California at Stockton (which later became Stockton DC) to provide in-patient care and treatment. In 1968 at its highest point, the system of state hospitals for the developmentally disabled served approximately 13,400 individuals in eight facilities, with another 3,000 individuals on waiting lists. For many years the state hospitals, now referred to as DCs, were the only alternative available to families of children with intellectual and developmental disabilities who were unable to be cared for at home.

Changes began in the mid-1960s, both in California and nationally, that would lead to the creation of community alternatives. California initiated a community program in 1965 by establishing two regional centers (now Golden Gate Regional Center and Frank D. Lanterman Regional Center) to test the concept of providing local,

The federal Centers for Medicare and Medicaid Services subsequently noted in a communiqué to states that Olmstead challenges states to prevent and correct inappropriate institutionalization, and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate.

5. *Capitol People First v. Department of Developmental Services* (2001) (CPF). The CPF class action lawsuit alleged unnecessary segregation of Californians with developmental disabilities in large congregate public and private institutions. The lawsuit was settled in 2009, resulting in a greater focus on development of community resources, DC residents and families being provided information on community living options, and regional center resources to work with the DC residents and families.
6. AB 1472 (Chapter 25, Statutes of 2012). With ongoing budget constraints and many challenges facing the DCs, significant new policy limiting DC admissions and the use of institutional care in the community was enacted in the trailer bill to the 2012-13 Budget. Among other provisions, a moratorium was placed on DC admissions, with only limited exceptions for individuals involved with the criminal justice system or in acute crisis; comprehensive assessments were required for all DC residents to determine if community services are available to meet their needs; a new model of care was authorized that would allow for secured perimeters with delayed egress in a community home; and resources were prioritized to reduce state and local institutionalization.

Today, state and federal laws and court decisions clearly favor community integration over institutional care, defined nationally as congregate facilities with a capacity of 16 residents or more. Throughout the United States the population of persons with developmental disabilities receiving services in large settings of 16 or more has dramatically decreased. In 1977, this population represented 83.7 percent of the total number served. In 2007, 30 years later, it represented 14.3 percent. Thirteen states and the District of Columbia have no large state-operated institutions, while many other states have active plans for closure of some, if not all, of their large facilities. In California, the Lanterman Act entitlement to services ensures that an individual will receive appropriate services with any transition out of a large state-operated facility.

In early 2003, the Department, in collaboration with three Bay Area regional centers, consumers, families, and other stakeholders, initiated a planning process for the closure of Agnews DC. In January 2005, the Department submitted the resulting "Plan for the Closure of Agnews Developmental Center" to the Legislature. Unlike prior DC closures that relied in large part on consolidation of populations, Agnews DC was the first closure to incorporate the concept of community integration as the primary objective by

Although there are larger concentrations of people with severe disabilities and complex needs in the DCs, people with similar characteristics are being served successfully in the community. While some residents could successfully be served in the community today, additional specialized resources are required to meet the intense needs of the more difficult to serve DC population.

With significant budget reductions over recent years, various hiring freezes and staff furloughs, the DCs have struggled to meet the intense staffing needs and provide the level of service required in the facilities. Tragically, some incidents of abuse have occurred. Incidents of abuse compounded with staffing problems have resulted in licensing deficiencies at Sonoma DC, including partial federal decertification and loss of federal funding. Other DCs are also facing intense scrutiny from state and federal regulators.

The DCs are large institutions which were each designed to serve from 2,500 to 3,500 residents. As the population decreases, the average cost per resident increases due primarily to the high cost of maintenance and repair of the aging infrastructure designed to support a large facility with a higher resident population. The average cost of DC services is estimated to be over \$400,000 per resident in FY 2013-14, an increase of almost \$60,000 per resident from FY 2012-13. In addition, infrastructure needs are often not addressed due to the significant costs to repair or replace antiquated systems and a hesitancy to invest in these aging facilities with declining populations.

The reduction in population over the years and the associated costs of operation have led to the closure of three large DCs and one state-operated community facility since 1996. Currently, Lanterman DC is in the process of closing. New trailer bill language in AB 89, Section 13 (Chapter 25, Statutes of 2013), requires that the closure of Lanterman DC be completed no later than December 31, 2014. Today, each DC serves fewer than 500 residents, making these large institutions increasingly cost inefficient.

The current DC resident population and aging infrastructure, coupled with recent legislative action that significantly limits admissions to these institutions (most notably AB 1472 [Chapter 25, Statutes of 2012]), generates significant debate surrounding the DCs. Many stakeholders from within the disabilities community speak out against DCs, calling for their immediate closure; while many parents and families of DC residents strongly support the services and benefits provided by these facilities and believe that safety and stability of their loved ones' are dependent on the continued operation of the DCs.

II. TASK FORCE PROCESS AND DELIBERATIONS

PLAN DEVELOPMENT PROCESS

In the June 5, 2013, press release (Attachment 2) Secretary Dooley announced the 21 members of the Task Force on the Future of the Developmental Centers and laid out an ambitious agenda. The basic charge of the Task Force was to “gather facts, share opinions and seek agreement, where possible, on options for the future of developmental centers.” The result was to be “a plan to assure quality, effective and efficient delivery of integrated services to meet the special needs of current residents living in the developmental centers.” The last meeting of the Task Force was December 13, 2013, with the report and recommendations finalized for publication in January 2014.

Secretary Dooley convened and chaired a total of four Task Force meetings, with the first occurring on June 17, 2013. The meetings were open to the public, and public comments were received and recorded. To make best use of the members' time, a Work Group of Task Force members met between Task Force meetings and, based on identified topics, developed information, materials, and agenda items for Task Force consideration. Almost all of the Task Force members made themselves available for the Work Group meetings and additionally performed preparatory work outside of the meetings. Throughout the plan development process, data and historical documents were provided by the Department, and Work Group participants contributed important information from other sources. All materials were provided to the Task Force members electronically and made available on the CHHS website at www.chhs.ca.gov. Additionally, materials were submitted by the public participants. Task Force members were invited to tour DC programs which were coordinated by DDS staff according to individual schedules and preferences.

Packets of materials were prepared and provided before each Task Force meeting. These packets are included as attachments to this plan. They are described generally below, along with observations made by Task Force members.

WORK OF THE TASK FORCE

The work of the Task Force began with presentations and discussions regarding background information, pertinent data, and the important elements of the system of care. The overarching theme for the Task Force was to ensure the health and safety of the individuals being served, regardless of where they live. The Task Force members, although diverse in opinions and perspectives, shared significant common ground

The initial data that was considered by the Task Force (Attachment 3) included: current consumer characteristics taken from the Client Development and Evaluation Report (CDER) for DC residents with comparisons to community consumers; DC population trends from 1969-70 to 2011-12; a breakdown of DC residents by level of care and regional center; community population data by regional center; a map showing DC locations and the areas served by each regional center; and, a June 2002 report titled, "Options to Meet the Future Needs of Consumers in Developmental Centers."

The Task Force carefully considered what additional information it needed throughout its deliberations. The first order of business was to fully understand the DC residents and to identify their needs. Information was requested for those individuals considered "difficult to serve." Task Force members generally shared strong interest in addressing the needs of persons with challenging behaviors and those involved in the criminal justice system. They looked at unmet needs, such as crisis intervention services, and service models from other programs and in other states. The Task Force also focused on the differences between community services versus the DC programs and services, to fully understand what could be replicated in the community. Information was requested both on successful programs as well as challenges from prior DC closure experiences so that both could be examined.

Following are the key subject areas discussed by the Task Force which lead to the recommendations presented in Chapter III.

SERVICE AND SUPPORT NEEDS OF DEVELOPMENTAL CENTER RESIDENTS

Attachments 3 and 4 contain considerable data from the CDER on the characteristics and diagnoses of the DC residents, which were reviewed by the Task Force. While the needs of the individuals are not unique to DCs and individuals with similar needs are already being served in the community, noteworthy is the concentration of individuals in the DCs with complex needs requiring higher levels of care. Following is a list of diagnoses and the percent of individuals in the DC system (1,484 total population as of July 1, 2013, including Canyon Springs Community Facility) with each diagnosis (Attachment 4, Packet 1, Item 1), as an indicator of service needs:

The Task Force focused primarily on the more difficult to serve individuals who would require specialized services to be supported in the community.

For each of the three identified categories, the Task Force used a structured approach to discuss and analyze three areas of interest. First, the Task Force considered the most challenging aspects of providing services and supports to the particular population. Second, the Task Force identified the services and supports that are available in the system to meet those needs. Finally, the Task Force discussed what additional services and supports may be needed.

Following is a high-level synthesis of the Task Force discussion. A particular point or observation may reflect the comment of a single Task Force member.

Individuals with Enduring and Complex Medical Needs. As of October 30, 2013, 445 of the total DC population of 1,385, or approximately 32 percent, were receiving care in a SNF residence, indicating the population of individuals with significant medical needs. When individuals have complex, challenging or multiple medical conditions, certain conditions identified by the Task Force create a generally greater challenge associated with their care, as follows:

- Pica
- Prader-Willi Syndrome
- Seizure Disorders
- Feeding-related
- Respiratory care-related
- Diabetes
- Mobility issues
- Alzheimer's or dementia
- Osteoporosis
- Dual Diagnosis

Various options already exist to serve and support individuals with complex medical needs, ranging from the family home with add-on or wrap-around nursing services; to the residential model authorized under SB 962 and SB 853 (962 homes); to an array of licensed health facilities, including state-operated alternatives. When considering the system needs associated with serving these individuals, the following areas were identified:

- Greater capacity is needed in the community for some services, such as 962 homes, ICF/DD-Nursing and ICF/DD-Continuous Nursing, with consideration for statewide locations.

- Individuals may reside in the family home with identified supports, such as respite services, or reside in their own home using Supported Living Services.
- A limited number of licensed residential facilities serve this population, some with delayed egress and some with psychiatric services.
- Individuals with behavior challenges need various support services, including specialized day programs.
- State-operated facilities serve this population, including crisis services at Fairview DC and transitional services at Canyon Springs Community Facility.
- Individuals may need acute psychiatric facilities.
- There are a limited number of crisis homes and a limited use of crisis teams available to serve this population in the community.
- The individuals with challenging behaviors are also served by emergency rooms and local hospitals, usually as a gateway to other mental health services in the community.
- On occasion, these individuals come in contact with local law enforcement and spend time in jail.

The Task Force considered several areas as common needs for all consumers. These areas were mentioned above for individuals with enduring medical needs and include: coordination and continuity of health and dental care; access to health records; as well as medication management. In addition, the following service needs were identified for individuals with challenging behaviors:

- This population needs greater access to appropriate, qualified and available professionals. Greater psychiatric services are needed generally throughout the system.
- More wrap-around supports for families would help to maintain individuals in the home.
- An increased capacity of crisis homes, crisis response services and step-down or re-entry programs are needed.
- An array of services are needed with the ability of individuals to move between levels as needs change, particularly for crisis services. There was a strong preference expressed for an individual to remain in his or her home with necessary services accessible and available to the provider to address the level of care changes.
- Better coordination is needed with law enforcement, to address vulnerability and risk of victimization issues, and prevent unnecessary involvement with the criminal justice system.
- Resources are needed that provide statewide access and not just access for a particular regional center's catchment area.

The Task Force generally agreed that the services available at Porterville DC-STP are preferable for this population over prison or jail. The STP focuses on restoring competency as a primary function, but also provides rehabilitation programs, vocational education and other services in a secure environment. Secure treatment was viewed as primarily a responsibility of the State. It was recognized that some facilities serving the forensic population are funded using 100 percent General Fund.

Consideration was also given to the statutory cap on the STP population of 170 residents and whether the cap should be lifted; the possibility of expanding the services for other populations of individuals with challenging behaviors; and the need to address individuals with intellectual and developmental disabilities who are in jail (Attachment 5, Packet 5, Item 1).

Other Information Considered. To understand the service needs of the DC residents, the Task Force looked at other related information for additional insights and perspectives. The Task Force analyzed information concerning individuals who had previously transitioned to the community from a DC, and the subsequent moves by those individuals to other residential services (Attachment 4, Packet 1, Items 5 and 6, and Attachment 4, Packet 4, Item 3). The information identified the moves, but did not provide qualitative information about the reasons for the moves. Also considered was the client characteristics of DC residents and persons who had moved to the community from a DC (Attachment 4, Packet 4, Items 6 and 7).

The Task Force considered the assessment data being developed by the regional centers (Attachment 5, Packet 5, Item 2) as a product of the AB 1472 (Chapter 25, Statutes of 2012) requirements. This information is preliminary and was collected through a survey of regional centers based on comprehensive assessments completed in FY 2012-13. The data provided information about the potential service needs of the DC residents.

The work of the Task Force included data from the Statewide Specialized Resource Service (SSRS, Attachment 4, Packet 3, Item 1). The SSRS was developed in response to AB 1472 (Chapter 25, Statutes of 2012) to track the availability of specialty residential beds and services, specialty clinical services, and requests for DC services and supports when community services have not been identified, so that resources can be coordinated and accessed on a statewide basis. Only services developed using CPP funds are included in the SSRS tracking. The Task Force recommends expanding the SSRS to include non-CPP funded resources. The Task Force also considered the DDS report on "Crisis Intervention for Persons with Developmental Disabilities" dated May 2013 (Attachment 4, Packet 4, Item 8) while assessing the availability of services in the community.

Government Code Section 11011(g). Many of the members felt that this valuable resource should not be given up as surplus, but instead should be used for the benefit of the service system. The challenge is to define clearly what the future use should be.

In considering the future use of DC land, the Task Force became familiar with the Harbor Village Project at Fairview DC (Attachment 5, Packet 3, Item 3). The State of California entered into a public-private partnership using a 55-year lease of 60 acres at Fairview DC for the purpose of developing the land for employee and consumer housing. By leveraging state land resources, community integrated housing was successfully developed. This approach to using DC land generated significant interest from the Task Force members as they discussed new models of service delivery.

Additional DC resources identified by the Task Force as gaps in community services are the provision of DME, assistive technology, and specialty services such as the Sonoma DC shoe program, with emphasis on keeping equipment updated and repaired. These supports are available in the DCs and will be a continuing need for the DC residents, wherever they may reside in the future.

COMMUNITY SERVICE MODELS AND OTHER RESOURCES

The Task Force was interested in new service models for addressing the needs of DC residents who may be served in the community in the future. In particular, the members reviewed and discussed the Programs of All-Inclusive Care for the Elderly (PACE, Attachment 5, Packet 4, Item 1). PACE is a federal program that provides community-based health care and services to people age 55 or older who otherwise would need a nursing home level of care. A team of health professionals provide “one-stop” comprehensive health care within a complex of services and functions like a Health Maintenance Organization (HMO). Under the existing PACE model, the care is exclusive, and individuals electing this care give up their other medical coverage. Although serving individuals with intellectual and developmental disabilities would be very different from serving the elderly, the concept of an organized array of needed health services in one “health resource center” was very appealing. Significant interest was demonstrated by the Task Force members in designing a workable model that would address the unmet needs of the DC residents and potentially others at risk in the community.

Examples were provided from other states of Community Resource Centers (Attachment 4, Packet 4, Item 2). These Community Resource Centers are typically developed as medical or dental outpatient clinics serving large-facility residents and/or the community, but may include comprehensive services more like PACE. The service delivery model is flexible and may incorporate other services such as case management

1915(i) State Plan Amendment, and Money Follows the Person. The Task Force received information on federal requirements for funding (Attachment 5, Packet 1, Item 7, and Packet 4, Item 5), including how facilities maintain "home and community character" in order to qualify for federal funding.

Also considered was the CPP funding that is included in the DDS budget (Attachment 5, Packet 4, Items 2, 3 and 4) for developing community housing, day programs, and other services. The CPP was originally established as part of the Coffelt settlement to facilitate the movement of DC residents who could be served in the community. The funding is provided to regional centers for assessments, resource development, start-up and placement costs, for the purposes of developing community resources to meet the needs of their consumers residing in DCs based on individualized planning efforts, and supporting the transition process. The CPP is also used to deflect consumers from DC admission. In 2012, with passage of the moratorium on DC admissions, the regional centers' use of CPP funding was expanded to enhance the capacity of the community service delivery system and address the unique needs of individuals with challenging service needs. Additionally, 10 percent of the fiscal year 2013-14 CPP (excluding funding for assessments) is being used to fund regional projects, where two or more regional centers partner and develop resources for statewide use. The Task Force discussed barriers involved in the CPP process and in the development of community resources as it considered the need for additional homes and services.

With all of the information and data generated by DDS and the Task Force, the public comments and materials, and the in-depth discussions, the Task Force crafted recommendations for addressing the future service needs of the DC residents. The recommendations are presented in Chapter III.

TASK FORCE RECOMMENDATIONS

Recommendation 1: Individuals with Enduring and Complex Medical Needs

Approximately 445 of the total DC population, or 32.1 percent, are individuals with complex medical needs receiving SNF care, many of whom have multiple medical conditions requiring specialty services.

Various community-based models of care exist to serve and support individuals with complex medical needs, ranging from the family home with add-on or wrap-around nursing services; to the residential model authorized under SB 962 and SB 853 (962 homes); to an array of licensed health facilities, including an ICF/DD-Nursing and an ICF/DD-Continuous Nursing. Based on the closure experiences with Agnews DC and Lanterman DC, 70.9 percent of the SNF residents are expected to require the 962 home level of care, or 315 individuals.

To serve DC residents with enduring and complex medical needs, the Task Force recommended regional centers assess and adjust their community capacity. One of five existing licensing categories should be considered for individuals with complex medical needs moving to the community: a 962 home, a small ICF/DD-Nursing, an ICF/DD-Continuous Nursing, a Residential Care Facility for the Elderly (RCFE), or a Community Care Facility with appropriate medical wrap around services. Each regional center should first explore existing resources (vacant beds), both within its catchment area and any available for statewide use, where appropriate and suitable for the consumer based on his or her comprehensive assessment. The regional center should utilize those existing resources to the extent appropriate and propose new community development through the CPP process to address the unmet residential and support needs of the population.

The Task Force further recommended the development of more homes/facilities using the existing models of care. However, they generally agreed that SNFs in the community should only be used for addressing short-term acute needs, and are not an appropriate long-term environment for consumers with enduring medical needs.

With regard to the role of the State, the Task Force recommended:

- The State use CPP funds for regional center development of more 962 homes and other needed residential and support services and day programs to serve DC residents in the community. The development of the additional 962 homes could be supported by annually targeting approximately \$8.5 million in CPP funds over the next three years, or \$25 million over the three-year period.

- Identify community capacity in existing models of care.
- Support regional center efforts to enhance supports to maintain individuals in their own homes.
- Provide or earmark CPP funding for regional centers to:
 - Expand mobile crisis response teams;
 - Expand crisis hotlines;
 - Expand day programs;
 - Create short-term crisis homes; and
 - Develop new “SB 962 like” behavioral homes (see above).
- Provide DC staff to assist with the transition of individuals with challenging behaviors.

Recommendation 3: Individuals Involved in the Criminal Justice System

Roughly 14.4 percent of the DC population has had some involvement with the criminal justice system. Although the number of residents is relatively small, the needs of the population are great. The Task Force considered dual diagnosis of mental illness; individuals charged with a felony, particularly a sex offense; and individuals incompetent to stand trial as significant issues associated with their care.

With regard to the role of the State, the Task Force recommended the State:

- Continue to operate Porterville DC-STP since it is preferable for this population over prison, jail, a locked psychiatric facility, or placement out of state. The Porterville DC-STP focuses on restoring competency as a primary function, but also provides rehabilitation programs, vocational education and other services in a secure environment. Secure treatment was viewed as primarily a responsibility of the State. It was recognized that some facilities serving the forensic population are funded using 100 percent General Fund. Continuing to operate the Porterville DC-STP has an annual cost of \$76 million General Fund.
- Continue to operate Canyon Springs Community Facility as a re-entry program for criminal justice system-involved consumers leaving Porterville DC-STP. Continuing to operate Canyon Springs Community Facility has an annual cost of \$16.1 million, which is eligible for federal financial participation.
- Consider changing the law to allow a continuum of services for competency restoration training rather than all forensic clients being committed to the Porterville DC-STP.

recognized, however, that as community services develop, the need for the health resource center services may change.

Since most DC residents are receiving Medi-Cal and the use of a service model focused on developmental disabilities will likely require prior federal CMS approval (a waiver or a State Plan Amendment), further work needs to be done to determine the most advantageous approach to providing the specialized, coordinated care.

Recommendation 5: Use of DC Land and Resources

The Task Force generally agreed unused (current and prospective) state DC land should be leveraged to benefit consumers rather than being declared surplus. Members understood surplus land disposition is controlled by the State Constitution and sales revenue cannot be diverted to the developmental disabilities system. However, the property should be considered for future State-operated facilities and to develop community services, including the Health Resource Center and mixed use communities similar to Harbor Village in Costa Mesa.

With regard to the role of the State, the Task Force recommended:

- State land should be retained and the State should enter into public/private partnerships to provide community integrated services, where appropriate. (Note: The four large DCs comprise a total of 2,181 acres of land, of which the core campuses use 878 acres, or about 40 percent of the acreage. Canyon Springs Community Facility has a lease agreement through September 2015, including additional acreage that could be developed. The lease agreement has an option to purchase or exercise a 15 year extension.)
- Existing State buildings on DC property should be used, as appropriate, for developing service models identified in the previous recommendations. Repurposing existing buildings requires meeting current building and seismic safety codes.

Recommendation 6: Future of the Community System

Although outside the scope of this Task Force's charge, the Task Force expressed a desire for DDS to form another task force to address ways to make the community system stronger. Among the many issues to be considered are: 1) the sufficiency of community rates and the impact new State and federal laws and regulations may have; 2) whether current regulations can be streamlined, particularly affecting the licensing of facilities; and, 3) whether certain benefits received by DC residents as part of a DC closure process should be broadened to others in the community. These areas have a

State of California

HEALTH AND HUMAN SERVICES AGENCY

FOR IMMEDIATE RELEASE
May 22, 2013

Contact: (916) 654-3304

California Health and Human Services Secretary Diana S. Dooley to Establish Task Force for State Developmental Centers

Sacramento – California Health and Human Services Agency Secretary Diana S. Dooley today announced she will establish a Task Force on the Future of the Developmental Centers. The Task Force will include a cross-section of consumers, family members, regional centers, consumer advocates, community service providers, organized labor, and the Department of Developmental Services.

The Task Force will be charged to develop a Master Plan that addresses the service needs of all developmental center residents, the fiscal and budget implications of the declining population, the aging infrastructure, staffing, and resource constraints, the availability of community resources to meet the specialized needs of residents now living in the developmental centers, a timeline for future closures and the statutory and regulatory changes that may be needed to ensure the delivery of cost-effective, integrated, quality services for this special population.

The challenges facing the residents of the state developmental centers are not new and not easily solved. Until the landmark Lanterman Developmental Disabilities Services Act was adopted in 1969 to establish community-based alternatives, the only care option available to families of children with developmental and intellectual disabilities was state-operated hospitals. Since then, federal and state legal mandates have contributed to the deinstitutionalization of more than 10,000 former developmental center residents and made significant investments in community-based resources. Today, California operates four large, old developmental centers and one small community facility serving a total of 1,510 residents with a budget of \$545 million.

Last year, this Administration sponsored legislation, which placed a moratorium on new admissions to the developmental centers, required all residents to be assessed to determine if community services are available to meet their needs, and prioritized resources to reduce state and local institutionalization. As the combination of this admission moratorium, legal mandates, and investments in community-based services are decreasing the developmental center population by approximately 200 residents per year, continued operation of four large institutions is increasingly inefficient and cost prohibitive.

Secretary Dooley said in announcing the establishment of the Task Force, "The health and safety of citizens served by the developmental disabilities service system is a high priority for California therefore we must provide services to people with developmental and intellectual disabilities in the most integrated setting available to meet their needs and to avoid unnecessary institutionalization."

The Secretary will make appointments to the task force by June 1, 2013 and will convene the first meeting by June 15. The Task Force will complete its work by November 15 and produce a written Master Plan that addresses:

1. The effective and efficient delivery of integrated services to meet the specialty needs of developmental center residents; and
2. The fiscal implications of developmental center operations, including the cost of resident care and services, maintenance of aging infrastructure, and utilization of existing resources.

Developmental Centers. She is the Chair of the Governor's Advisory Board at Lanterman Developmental Center where her brother Patrick lived for many years.

Terri Delgadillo, MSW, is the Director of the California Department of Developmental Services, the lead agency through which the State of California provides services and support to children and adults with developmental disabilities.

David De La Riva, JD, is the Senior Legal Counsel, California Statewide Law Enforcement Association (CSLEA). David joined CSLEA in 2005 as Legal Counsel where he oversees the day to day operations of the CSLEA satellite office in Huntington Beach and represents the Department of Developmental Services' peace officers.

Carlos Flores is the Executive Director (ED) of the San Diego Regional Center. He has 38 years of experience in the field of developmental disabilities. Carlos was the Branch Manager for the Prevention and Children's Services Branch of the Department of Developmental Services. He also has been the ED of the Redwood Coast Regional Center and ED of the Developmental Disabilities Area Board 10 in Los Angeles County.

Dana Hooper, MBA, is the Executive Director of Life Services Alternatives, Inc. (LSA). Dana is a technology industry veteran with extensive sales and marketing experience. He was previously a vice president of U.S. operations for a German software developer and on the leadership team at Speech Machines, Lernout and Hauspie and Centigram.

Connie Lapin is a co-chair of the Government Relations Committee for the Autism Society of Los Angeles. She is a speech pathologist, lecturer and consumer advocate for children and adults with Autism Spectrum Disorders and other developmental disabilities. Her son, Shawn, has autism.

Kevin MacDonald, MBA, has been the CEO of The Arc of Los Angeles and Orange Counties for the past 20 years. The Arc provides work and day services. Kevin established The Arc's Center for Human Rights. He did his Masters Internship at Fairview Developmental Center in Orange County.

Christine Maul, PhD, CCC-SLP, is a speech language pathologist and assistant professor in the Department of Communicative Disorders and Deaf Studies at California State University, Fresno. She is a parent of a resident at Porterville Developmental Center.

Kathleen Miller, LCSW, is President of the Parents Hospital Association for Sonoma Developmental Center (SDC), an organization that represents the families and friends of the SDC residents. Kathleen previously worked as a clinical social worker at SDC. Her son Dan is a resident at SDC.

Marty Omoto is an Advocate and Founder of the California Disability Community Action Network (CDCAN). He publishes a newsletter about the state budget and legislation with a following of over 65,000 people across the state. Marty had an older sister with developmental disabilities.

Ray Rocha is the President of the board of People First of California. He was previously vice president of People First of California and president of People First of Bakersfield. Ray works for Kern Regional Center where he helps other individuals with disabilities to access services.

Robert Riddick, LCSW, is Executive Director of the Fresno-based Central Valley Regional Center covering Tulare, Kings, Fresno, Madera, Mariposa and Merced counties, including the Porterville Developmental Center in Tulare County.

Will Sanford is the Executive Director of Futures Explored, Inc., a community-based organization that provides support to over 500 individuals with developmental and other disabilities each year.

Savaing Sok is a member of People First of California- Region 4 for Sonoma, Solano and Napa Counties. He is a 21-year-old resident of Sonoma Developmental Center and a member of the center's Human Rights Committee.

PACKET OF MATERIALS FOR JUNE 17, 2013

Document

1. Consumer Characteristics at the end of March 2013
2. Developmental Center Population Chart
3. Developmental Center In-Center Population
by Level-of-Care and Regional Center
4. Regional Center Population Residence Types as of June 1, 2013
5. Options to Meet the Future Needs of Consumers
in Developmental Centers (June 2002) *
6. Level of Care and Regional Center Acronym Key
7. Map of Developmental Centers, State-operated Community Facility,
and Regional Centers
8. Services Provided At Each Developmental Center

The above listed attachments can be found at the following address:

<http://www.chhs.ca.gov/Pages/DCsTaskForce.aspx>

* This is a 98-page report that is available on the CHHS website at www.chhs.ca.gov/pages/DCsTaskForce. It is not included here because of its size.

ATTACHMENT 4

(Continued)

PACKETS OF MATERIALS FOR AUGUST 19, 2013

PACKET 2: INFORMATION COLLECTED ON OTHER STATES

Document

1. 2011 Ranking of States by Number of Residents at Large State Facilities
2. List of Completed and In-Progress Closures of State-Operated 16+ Institutions
3. List of 14 States that Have Closed All of their State-Operated Institutions
4. Summaries of Closure Efforts in 5 of the 14 State that Have Closed All Large State Institutions
 - Michigan
 - New Hampshire
 - Maine
 - Vermont
 - Indiana
5. List of 10 States with the Smallest Number of Residents Left in State-Run Institutions
6. List of Links to 18 Different Closure Plans for Various Institutions and States
7. Summary of Agnews Closure Process
8. Summary of Lanterman Closure Process
8. Policy Research Brief: Status of Institutional Closure Efforts in 2005

The above listed attachments can be found at the following address:

<http://www.chhs.ca.gov/DCTFDocs/Other%20States%20Packet%20for%20Workgroup.pdf>

PACKETS OF MATERIALS FOR AUGUST 19, 2013

PACKET 4: FOLLOW-UP DATA REQUESTS

Document

1. Articles Regarding Deinstitutionalization from Christine Maul
2. Examples of Community Resource Center Model from Kathleen Miller
3. Expanded Summary of Moves Made by Individual after Leaving a DC
4. Summary of Monthly Admissions, Transfers and Placements by DC
5. Residence Data on Individuals Who Moved from Stockton and Camarillo
6. Client Characteristics Information—DC Residents
7. Client Characteristics Information—DC Movers
8. DDS Crisis Intervention Report—May 2013
9. Psychiatric Supports for Agnews DC Movers
10. Developmental Center Services and Supports (meeting handout)

The above listed attachments can be found at the following address:

<http://www.chhs.ca.gov/DCTFDocs/August%2019,%202013%20Task%20Force%20Data%20and%20Information.pdf>

PACKETS OF MATERIALS FOR OCTOBER 22, 2013

PACKET 2: DEVELOPMENTAL CENTER STAFF AND RESOURCES

Document

1. Specialty Services at the Developmental Centers
2. California Developmental Centers Services and Supports (Submitted by Terry DeBell)
3. Developmental Centers and Community Facility FY 2013-14 Positions
4. Contracts for Paid Employment at the Developmental Centers and Community Facility

The above listed attachments can be found at the following address:

<http://www.chhs.ca.gov/DCTFDocs/DC%20Task%20Force%20-%20Staff%20and%20Resources.pdf>

PACKETS OF MATERIALS FOR OCTOBER 22, 2013

**PACKET 4: COMMUNITY PLACEMENT PLAN AND
COMMUNITY RESOURCES**

Document

1. Programs of All-Inclusive Care for the Elderly (PACE) Summary
2. Community Placement Plan (CPP) Funding FY 2012-13 and 2013-14
3. Expanded Use of CPP Funding
4. Approved CPP Projects for Development FY 2012-13 and 2013-14
5. Facilities Ineligible for FFP and Out of State Placements
6. Estimate of Potential Need for ARFPSHN Homes
7. Regional Center Community Out-of-Home Living Arrangements
8. Residential Vacancies
9. Statewide Specialized Resource Service Data (Previously Provided)

The above listed attachments can be found at the following address:

<http://www.chhs.ca.gov/DCTFDocs/DC%20Task%20Force%20-%20Community%20Placement%20Plan%20and%20Community%20Resources.pdf>

EDMUND G. BROWN JR.
GOVERNOR

State of California HEALTH AND HUMAN SERVICES AGENCY



DIANA S. DOOLEY
SECRETARY

FOR IMMEDIATE RELEASE
July 3, 2014

Contact: Karin Caves
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Karin.Caves@CHHS.CA.GOV

California Health and Human Services Secretary Diana S. Dooley Reconvenes Task Force

Sacramento – California Health and Human Services Agency Secretary Diana S. Dooley today announced she will reconvene the Task Force that developed the Plan for the Future of Developmental Centers in California. The Task Force includes consumers, consumer advocates, regional centers, community service providers, organized labor, families of developmental center residents, members of the Legislature and Department of Developmental Services staff.

Consistent with a recommendation in the Plan and in response to Governor Brown's message in the recently signed Budget Act, the Task Force will be charged with examining services for the developmentally disabled in the community. The Task Force will develop recommendations to strengthen the community system in the context of a growing and aging population, resource constraints, availability of community resources to meet the specialized needs of clients, and past reductions to the community system. Issues to be examined will include community rates, the impact of new State and federal laws and regulations, and staffing levels at Regional Centers.

When the landmark Lanterman Developmental Disabilities Services Act was adopted in 1969 to establish community-based alternatives, California took the first step to develop a robust community system for those with developmental disabilities to live full, integrated lives in their local communities. Today, California serves approximately 275,000 individuals in the community system with a budget of \$4.7 billion.

Secretary Dooley said in reconvening the Task Force, "This diverse group of stakeholders did a remarkable job coming together, setting aside differences, and producing a set of recommendations to chart a course for the future of the Developmental Centers. I believe this same group can build on that success by examining services in the community. By working together and resisting the inclination toward either/or thinking, we can focus on appropriate services for people with developmental disabilities, regardless of setting."

The first meeting of the Task Force will be July 24, 2014.

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Aging
Child Support
Services
Community Services
and Development
Developmental
Services
Emergency Medical
Services Authority
Health Care Services
Managed Health Care
Managed Risk
Medical Insurance Board
Public Health
Rehabilitation
Social Services
State Hospitals
Statewide Health
Planning and
Development