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A. GENERAL INFORMATION

1. Date

February 24, 2020

2. Department

Department of Developmental Services

3. Organizational Placement (Division/Branch/Office Name)

Office of Statewide Clinical Services, Clinical Monitoring Branch

4. CEA Position Title

Assistant Deputy Director

5. Summary of proposed position description and how it relates to the program's mission or purpose. (2-3 sentences)

The Career Executive Assignment (CEA), Level A, Assistant Deputy Director (ADD), Office of Statewide Clinical Services (OSCS) is being retitled with a change in concept from Branch Chief, Programs and Policy, Community Services Division. In a department reorganization approved in the Budget Act of 2019, the Community Living Program and related Program and Policy Section were consolidated with other clinical services in a newly established OSCS. This CEA formulates, develops and implements policies associated with the DDS's oversight and clinical monitoring of Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHN), Enhanced Behavioral Supports Homes (EBSH), and Community Crisis Homes (CCH). There are currently 86 ARFPSHNs, 26 EBSHs, and 6 CCHs for adults with significant developmental disabilities in operation. An additional 7 ARFPSHNs, 46 EBSHs and 16 CCHs are in the development phase, with more homes being continually developed. These homes provide community living options for individuals with significant developmental disabilities who are transitioning from the closing developmental centers (DCs) or living in the community and require enhanced medical and/or behavioral supports or are in need of crisis intervention services in a homelike setting.

6. Reports to: (Class Title/Level)

Deputy Director, Office of Statewide Clinical Services

7. Relationship with Department Director (Select one)

- Member of department's Executive Management Team, and has frequent contact with director on a wide range of department-wide issues.
- Not a member of department's Executive Management Team but has frequent contact with the Executive Management Team on policy issues.

(Explain):

8. Organizational Level (Select one)

- 1st
- 2nd
- 3rd
- 4th
- 5th (mega departments only - 17,001+ allocated positions)

B. SUMMARY OF REQUEST

9. What are the duties and responsibilities of the CEA position? Be specific and provide examples.

The CEA, Level A, ADD, OSCS will formulate, develop, implement, and promulgate policies associated with the DDS's oversight, certification and monitoring of ARFPSHNs, EBSHs, CCHs to ensure compliance with statute, regulations and licensing requirements. Also, this CEA will formulate, develop, implement and promulgate policies associated with the DDS's oversight of regional centers (RCs) to ensure RCs comply with statute and regulations in developing the homes, finding and contracting with appropriate community providers to operate the homes, and ensuring consistent standards of care in clinical services provided in the homes. In addition, the CEA, Level A will oversee the mandated monitoring of ARFPSHNs, EBSHs and CCHs as outlined in W&I sections 4684.70 (e), 4684.84 (c) and 4698 (e). The onsite monitoring, by the DDS is required by statute at least every six months.

ARFPSHNs are adult residential facilities that provide 24-hour health care and intensive support services in a homelike setting for individuals transitioning from a closing DC. An EBSH provides non-medical care for individuals who require enhanced behavioral supports, staffing and supervision in a homelike setting. CCHs are adult residential facilities that provide 24-hour non-medical care to individuals in need of crisis intervention services, who would otherwise be at risk of admission to a more restrictive setting. ARFPSHN, EBSH and CCH are certified by the Department of Developmental Services (DDS) and licensed by the Department of Social Services (DSS). This CEA position will have primary responsibility for developing and implementing policies and procedures for the DDS's certification standards, appropriate clinical and staffing standards, and oversight methods and tools over these homes. Also, this CEA will have responsibility for policies to ensure licensed clinical staff working in the homes (nurses, behavioral specialists, etc.) meet the professional standards for their clinical license. In addition, as new residential service models are developed such as the recently approved CCH for children (SB 81, Budget Trailer Bill for 2019), this CEA will have lead policy role in developing new regulations governing these homes, and policies and procedures over the certification and monitoring of these homes.

The CEA, Level A, will also lead and manage the most difficult, complex, or sensitive nursing consultation for DDS staff, residential service providers, RC staff, and/or physicians related to consumer health care in the community. The CEA, Level A, will provide direction and guidance to staff reviewing all program plans for residential facilities serving individuals with a developmental disability, ensuring compliance with state laws and regulations, and will provide quality assurance and standards of clinical practice related to health care services for individuals with a developmental disability, including, but not limited to, approving specialized procedures for residential facilities. By promoting workforce management, the CEA, Level A, will effectively communicate with staff and administrators on policy, procedures and regulatory interpretations in order to achieve established goals and objectives of the DDS.

This CEA will lead and manage a Senior Psychologist (Supervisor), and Behavioral Specialist positions for the oversight and monitoring of EBSHs and CCHs, and Nurse Consultants to for the oversight and monitoring of ARFPSHNs. This includes policy and procedures in the development, implementation and maintenance of systems, processes and protocols that streamline and coordinate the DDS certification, monitoring, reporting and tracking activities as they relate to ARFPSHN, EBSH, CCH and other residential programs, including the written protocol for monitoring ARFPSHN, EBSH and CCH compliance with current requirements for the provision of health care and licensure. This also includes Overseeing and monitoring RC and service provider compliance with ARFPSHN, EBSH and CCH requirements, including, but not limited to, ensuring that appropriate health care is provided as prescribed in each consumer's Individual Health Care Plan and in accordance with the provider's written policies and procedures. In addition, provides or arranges for appropriate technical assistance for RCs, ARFPSHN, EBSH and CCH staff regarding licensing and certification requirements.

This CEA A will communicate extensively with DDS staff, other state departments, RCs, and residential service providers on residential programing, and nursing and behavioral care issues related to the unique characteristics, behaviors, and health care needs of RC consumers. Also, will meet regularly with and update the DDS executive management on the clinical monitoring activities and issues concerning consumer health care in the community.

B. SUMMARY OF REQUEST (continued)

10. How critical is the program's mission or purpose to the department's mission as a whole? Include a description of the degree to which the program is critical to the department's mission.

- Program is directly related to department's primary mission and is critical to achieving the department's goals.
- Program is indirectly related to department's primary mission.
- Program plays a supporting role in achieving department's mission (i.e., budget, personnel, other admin functions).

Description: The DDS is responsible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) for ensuring that more than 330,000 persons with intellectual and developmental disabilities receive the services and supports they need in order to lead more independent and productive lives and to make choices and decisions about their lives. The DDS provides services and supports to individuals with intellectual and developmental disabilities in several ways, that include; community settings for the majority of consumers, institutional settings at the state-operated facilities for a small portion of the population and newer models of care including, Stabilization, Training, Assistance and Reintegration (STAR) Homes. The DDS contracts with 21 non-profit RCs to provide services to consumers in community settings. The DDS also operates two DCs, one community facility to care for residents on a 24/7 basis and the STAR Homes. Pursuant to Senate Bill 82, Chapter 23, Statutes of 2015, the DDS submitted plans to close Sonoma DC, Fairview DC, and the Porterville DC General Treatment Area, that requires the transition of residents to community living arrangements.

Assembly Bill 89, Chapter 25, Statutes of 2013, required that a master plan be submitted to the Legislature for the future of the DCs and a report to the Legislature regarding, among other things, the ability of community resources to meet the specialized needs of consumers now living in the DCs. The California Health and Human Services Agency (Agency) created a Task Force to review DC issues to meet this mandate. The Task Force compiled a report titled, "Plan for the Future of Developmental Centers in California". "The report focused on individuals with challenging behaviors and support needs and recommended the development of community residential models that provide a higher level of behavioral services than existing community models. From this recommendation, the DDS developed two new models of residential care, EBSH and CCH.

Existing law requires the DDS and RCs to establish policies and procedures for the development of an annual CPP and CRDP. Through the CPP and CRDP, the DDS and RCs are working with service providers to develop the two models of care that resulted from Agency's recommendations and investing in existing models of care such as ARFPSHN for individuals transitioning out of the DCs.

Welfare and Institutions Code (WIC) requires the DDS to certify ARFPSHN, EBSH and CCH, and monitor RC oversight of the services provided by these homes. In general, DDS on-site monitoring is required by statute at least every six months. The DDS currently has eight Nurse Consultant III positions assigned to monitoring ARFPSHN; and three Behavior Specialist I, three Behavior Specialist II and a Senior Psychologist (Supervisor) assigned to monitoring EBSH and CCH.

B. SUMMARY OF REQUEST (continued)

11. Describe what has changed that makes this request necessary. Explain how the change justifies the current request. Be specific and provide examples.

Part of the DDS reorganization was due to the philosophical and statutory shift to integrated community living as dependence on the DCs and other institutional settings has declined. As part of the reorganization, the OSCS was established to centralize community living and clinical services, program and policy, along with monitoring functions to address statewide issues and needs that arise regarding medical, dental, autism spectrum disorders, and new models of residential living. This leadership role is imperative to address needs, including those identified in Special Incident Reports (SIRs) and related RC and community service provider monitoring data, as well as to ensure standards of consistent care. The reorganization moved the Community Living Program, Clinical Monitoring and related Program and Policy Sections under an existing CEA A, Program and Policy, to the Clinical Monitoring Branch in the OSCS. The CEA A is being retitled to Assistant Deputy Director, Office of Statewide Clinical Services, to have a similar responsibility over the Clinical Monitoring Branch. The Program and Policy Section will report directly to the Deputy Director but the CEA A, ADD, will continue to work closely with this Section on policy and procedures for clinical monitoring. Specific functions of the new Clinical Monitoring Branch as approved in the 2019-20 Budget Act include the following:

- Provide a clinical perspective for community-based services and specialists to influence and guide what services should be statewide;
- Provide plans of operation and policy and procedure reviews for ARFPSHNs, and monitor the homes;
- Provide nursing consultation for ARFPSHN, ICF/DD-N and ICF/DD-CN facilities, and consults with community providers;
- Provide behavioral services program reviews and consultations for EBSH and CCH and state-operated facilities;
- Monitor EBSH and CCH and state operated facilities to promote and track development of crisis services statewide; and
- Develop, revise and provide technical assistance to regional centers on residential regulations.

The DDS must monitor RC compliance with statutes and regulations, thus extending the DDS oversight role of DC residents after they transition to community living arrangements. Statutes and regulations require RCs to perform regular, ongoing monitoring of ARFPSHN, EBSH and CCH to evaluate the care provided, as follows:

- ARFPSHN: WIC Section 4684.70 (d) requires “a regional center licensed nurse to visit, with or without prior notice, the consumer, in person, at least monthly in the ARFPHSN, or more frequently if specified in the consumer’s individual health plan.”
- EBSH: WIC Section 4684.84 (b) requires “a regional center qualified behavior modification professional shall visit, with or without notice, the consumer, in person, at least monthly in the enhanced behavioral supports home, or more frequently if specified in the consumer’s individual behavior supports plan. At least four of these visits, annually, shall be unannounced”. Title 17, California Code of Regulations (CCR) Section 59055 (a) through (c) state, (a) The consumer’s regional center is responsible for monitoring and evaluating services provided in the Enhanced Behavioral Supports Home by conducting or coordinating at least quarterly face-to-face case management visits with each consumer, or more frequently if specified in the consumer’s IPP. (b) In addition, the vendoring regional center is responsible for monitoring and evaluating services provided in the Enhanced Behavioral Supports Home by conducting a quarterly quality assurance visit using a format prescribed by the Department. (c) A vendoring regional center Qualified Behavior Modification Professional shall visit the consumers, announced or unannounced, in person, at least monthly in the Enhanced Behavior Supports Home to monitor the Individual Behavior Supports Plan objectives, and prepare written documentation on the status of the objectives. At least four of these visits per year must be unannounced.”
- CCH: WIC Section 4698 (e) states “The local regional center and each consumer’s regional center shall have joint responsibility for monitoring and evaluating the provision of services in the community crisis home. Monitoring shall include at least monthly face-to-face, onsite case management visits with each consumer by his or her regional center and at least quarterly quality assurance visits by the vendoring regional center.

CCR Section 59013 (a) through (c) state, “(a) The consumer’s regional center is responsible for monitoring and evaluating services provided in the community crisis home by conducting or coordinating with the vendoring regional center at least monthly face-to-face case management visits with each consumer, or more frequently, if specified in the consumer’s IPP. (b) In addition, the vendoring regional center is responsible for monitoring and evaluating services provided in the community crisis home by conducting a quarterly quality assurance visit. (c) The vendoring RC Qualified Behavior Modification Professional shall visit the consumer(s), in person, at least monthly in the community crisis home to monitor the Individual Behavior Supports Plan objectives and prepare written documentation on the status of the objectives. At least four of these visits per year must be unannounced.”

Through the CPP and CRDP, a total of 93 ARFPSHN, 72 EBSH, and 22 CCH are currently operational or in development, with new homes proposed for development. Without appropriate leadership and management and the needed policy role of this CEA A, DDS will be unable to comply with statutory requirements to complete semi-annual visits to these new community homes, and by extension, evaluate RC compliance. In turn, DDS will be unable to determine whether consumers’ health and behavioral needs are being met in the community.

C. ROLE IN POLICY INFLUENCE

12. Provide 3-5 specific examples of policy areas over which the CEA position will be the principle policy maker. Each example should cite a policy that would have an identifiable impact. Include a description of the statewide impact of the assigned program.

The CEA A, ADD, OPCS, will have the primary policy role for the clinical oversight and monitoring of ARFPSHNs, EBSHs, and CCHs. The policy role extends from developing regulations for staffing and clinical care standards in each type of home, to policies for monitoring protocols including addressing clinical care and staff issues, to policies to ensure that appropriate health care is provided as prescribed in each consumer's Individual Health Care Plan and in accordance with the provider's written policies and procedures. Specific examples of these policy areas are below.

The 2019 Budget Trailer Bill, Senate Bill 81, amended WIC Section 4698 to require the DDS to use CPP funds to establish CCH to serve children, whereas previously this model of care was only available for adults. As a new model of care, there is a need for policy development and regulations/guidelines on the provision of and level of clinical and related services in the homes. Expanding this model to children adds another layer of complexity to program development and oversight. The CCHs for children are expected to be developed on a statewide basis. The policies for these CCHs are critical to the success of this new model of care. Currently, there are few options for placement of children with significant developmental disabilities that are in a behavioral crisis and as a result many of these children end up in large institutions of mental disease or skilled nursing facilities, sometimes for an extended period of time.

The CEA, Level A position will be responsible for developing, implementing, maintaining, and promulgating policies that impact 93 ARFPSHN's that are currently operational or in development statewide, and additional ARFPSHN proposed for development in the future. These homes are critical to RCs' ability to meet the needs of individuals who are transitioning from the closing DCs and have very complex medical needs. These policies will need to align with Section 1567.50 of the Health and Safety Code (HSC), which dictates that DDS implement the pilot project to test the effectiveness of the licensing program to provide special health care and intensive support services to adults in homelike community settings. The CEA, Level A, position will also oversee the Office's activities related to certification for ARFPSHN and will work with California Department of Social Services (DSS) to ensure the license approval process for these facilities are completed in accordance with Section 4684.50 of the WIC. The impact of the policies to the success of the ARFPSHNs cannot be overstated. Individuals placed in ARFPSHNs have the most significant medical challenges (ventilator dependent, etc.). When living in a DC these medically vulnerable individuals had immediate access to medical care staff and a general acute care hospital at the DC to respond to medical emergencies. The policies and procedures developed for the ARFPSHNs are critical to ensure that medical emergencies are responded to appropriately. Also critical are the policies and procedures developed for placement of the individuals when they are evacuated from their ARFPSHN during an emergency such as fire, flood, earthquake, etc.

The 2019 Budget Trailer Bill, Senate Bill 81, amended HSC Section 1180.4 to include CCHs as a facility that cannot use physical restraint or containment for more than 15 consecutive minutes. The DDS may, by regulation, authorize an exception to the 15-minute maximum duration if necessary to protect the immediate health and safety of residents or others from risk of imminent serious physical harm and the use of physical restraint or containment conforms to the facility program plan approved by the DDS pursuant to WIC Section 4698(d). Section 4698(d)(1) requires the DDS, no later than March 1, 2020, to develop guidelines regarding the use of restraint or containment in community crisis homes, which must be maintained in the facility program plan and plan of operation. This CEA A will have a policy role in developing the required guidelines regarding use of physical restraint and containment in CCHs and for the reporting and tracking of the use of physical restraints and containment in CCHs. These policies have an impact on both the individuals living in the CCHs as well as compliance will be monitored closely by the legislature and advocacy organizations.

The CEA A, ADD, will also be responsible for developing policies for the new centralized and expanded role of the Clinical Monitoring Branch to provide statewide clinical expertise, best practices, and overall a clinical perspective for RC community programs including residential settings such as ARFPSHNs, EBSHs and CCHs. With the additional CEA leadership capability and additional clinical positions received in the 2019 Budget Act, a plan needs to be developed for enhanced monitoring of ARFPSHNs, EBSHs, and CCHs. While the Department currently monitors for compliance with law and regulations on clinical standards of care, there is an expectation that we monitor to a higher standard of clinical care and to ensure consistency among RCs and providers. The CEA A will develop a plan and protocol for the monitoring branch to complete an assessment of each ARFPSHN, EBSH, and CCH home for consistency, appropriate standards of care, and best practices. In addition, the CEA A will implement regular collaborative meetings, North and South, to include RC, ARFPSHN, EBSH and CCH staff, and Clinical Services staff. These efforts to provide for the highest quality of clinical care and standards in these homes will have a direct impact on the health, safety, and well-being of the individuals with developmental disabilities living in these homes.

C. ROLE IN POLICY INFLUENCE (continued)

13. What is the CEA position's scope and nature of decision-making authority?

The CEA, Level A, position is responsible for keeping the Deputy Director (DD), Office of Statewide Clinical Services apprised of issues and policy decisions, given the size and scope of the Community Services Division's responsibility and the size of California's system of services and supports, and for making daily decisions regarding the areas under their purview. These decisions can have limited, local impact or have statewide consequences and impact the quality of life for multiple individuals.

14. Will the CEA position be developing and implementing new policy, or interpreting and implementing existing policy? How?

The CEA, Level A, position will be developing, interpreting and implementing both new and existing policy. There are many large and small policy decisions that arise, and the CEA, Level A, must be able to make these calls and know when an issue should be elevated to others for decision making. The CEA, Level A, must ensure policies must align with Section 1567.50 of the HSC which dictates that DDS implement a pilot project to test the effectiveness of a DSS licensed program to provide special health care and intensive support services to adults in homelike community settings. Another example of new policy is the CCH model for children, which was approved for funding in the 2019-20 Budget Act. As a new model of care there will be the need for policy development and regulations on the provision of and level of clinical related services in the homes.