Attachment A to Settlement Agreement Dated June 30, 2015 Statement of Tasks to be fulfilled by the California Parties	Completion Date	Responsible Party
A. Client Safety		
1. **SDC will report and investigate all incidents and injuries as required by law.**	Immediately and ongoing	SDC
2. **SDC will maintain the safety of all clients at SDC during the transition/closure process.**	Immediately and ongoing	SDC
3. **CDDS will conduct frequent, periodic training for Direct Support Staff and Management in the Detection and Prevention of Abuse, Neglect and Mistreatment, as well as the recognition and elimination of environments and situations that may foster such mistreatment.** Annual refresher training as required under the Performance Improvement Plan dated March 13, 2013 ("PIP"), as well as more frequent training will be held for all staff. The content will be updated and refreshed, based on the findings of the internal and external monitoring tools, to assure that the training objectives focus on positive and improvement outcomes for the clients and staff.	Immediately and ongoing	CDDS
B. Client Health Needs		
1. **SDC will provide all needed health care services to SDC clients in the Stoneman, Brent, Roadruck, Bentley, Malone, Cohen, and Poppe units (the "SDC Units"), 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	SDC
C. Active Treatment		
1. **SDC will provide active treatment to all SDC clients in the SDC Units** Particular emphasis will be placed on: a. The protection of clients from abuse, neglect or mistreatment, including the development and consistent implementation of behavior modification plans; b. The on-going medical assessment and the provision of timely and appropriate health services, as indicated; 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 avoidably decline in their current skills; e. The provision of an active program to begin to prepare each client for an alternative post-discharge setting.	10/01/2015 and ongoing	SDC
D. Comprehensive Assessments and Needs Identification		
1. **Comprehensive Assessments** Consistent with California Welfare and Institutions Code § 4418.25(c), CDDS will ensure complete, initial comprehensive assessments for all SDC residents to identify consumer choice and preferences, and identification of current	08/31/2015 (with annual update through	CDDS

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support needs and future supports needed to ensure a successful transition from SDC to the community.	placement)	
2. Define and utilize categories of services/support similar to Lanterman Closure Process a. Utilize categories as appropriate to SDC clients based on definitions used in the Lanterman closure: Protection and Safety: Individuals who need a highly structured setting because of a lack of safety awareness, a pattern of self-abuse or other behavior requiring constant supervision and ongoing intervention to prevent self-injury. Significant Health Care Services: For individuals with significant health or nursing needs, such as intermittent pressure breathing, inhalation assistive devices, tracheotomy care, or treatment for recurrent pneumonias or apnea. Significant nursing intervention and monitoring are required to effectively treat these individuals. Significant Behavioral Support: Individuals who have challenging behaviors that may require structured positive behavioral supports and interventions for the safety of themselves or others. Extensive Personal Care: Some individuals do not walk or ambulate, require total assistance and care, and/or receive enteral (tube) feeding and will need more extensive hands on support and services Low Structured Setting: Some individuals do not require significant behavioral support or intervention, but do require careful supervision. This category would address their needs.	Ongoing	SDC
b. Revise category determination on periodic basis to account for changes in comprehensive assessments and transition plans, changing support requirements or changes to individual client's status or needs.	Ongoing	SDC
3. Identify community resources that are currently available that may meet clients' needs as identified in their comprehensive assessments	09/30/2015 and ongoing	SDC, CDDS
4. Develop a plan to create additional community resources needed to meet clients' needs as identified in their comprehensive assessments and transition plans.	10/01/2015 and ongoing	SDC, CDDS
5. Prioritize development of community resources to support individuals who have significant and intense support needs, to ensure careful and timely development and transition planning.	01/01/2016 and ongoing	SDC, CDDS
6. Create additional community resources needed to meet clients' needs as identified in their comprehensive assessments and transition plans, such as residential services, outpatient clinics, medical providers, supportive living arrangements, employment opportunities, and other supportive services.	04/01/2016 and ongoing	CDDS

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E. Individual Program Plans (IPP), Transition Plans and Activities		
The IPP, Individual Transition Plan and related transition activities are all part of a coordinated and fluid planning and execution process that is flexible to meet each individual consumer's unique needs. Team members exchange information; perform and participate in assessments; document findings, recommendations and outcomes; and carefully coordinate the transition from the developmental center to the community.		
1. **Individual Program Plan** As required by Sections 4418.3, 4646, and 4646.5 of the 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.	IPP completed or amended annually or more frequently, as needed.	DC staff complete the IPP while the individual resides at the DC and regional center staff complete once the individual moves to the community.
2. **Exploration and Identification of Living Options** 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. SDC will work with individuals, family, IDT, and where appropriate other participants, to review transition options using the clients' IPPs.	No later than 30 days of a client's IPP	SDC
a. SDC 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.	11/20/15	SDC
b. SDC will coordinate "meet & greet" introductions to potential providers where residents, 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 SDC
c. The IDT will consider currently available alternative placements for any clients at SDC whose post-discharge needs match the services available and transfers are made as appropriate.	Immediately and ongoing	CDDS SDC
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	Within 30 days of IDT identifying a specific living	CDDS SDC

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the client. The Individual Transition and Health Transition Plan documents the process of planning and implementing transition activities and specific transition health services.	option	
4. Familiarization (Cross-training) Activities		
a. The IPP will include specific activities for familiarization of new staff with the details of the Comprehensive Assessment, Individual Program Plan, Specialized Support Plans and any informal or personalized knowledge from the SDC staff who know the individual best. This may include activities such as: i. Integrated meetings with IDT, provider(s) for transition of plan information. Includes Residential, Day Services/Vocational, Health Care, Behavioral Health and any other provider needs as identified in the transition plan. ii. Cross training of provider and SDC staff is accomplished via visits by SDC staff to the community providers or vice versa, simulated training situations, or actual observation of daily activities and programming across support settings.	As transition plans are developed and implemented	CDDS SDC
5. Individualized Health Transition Plans (IHTPs)		
a. As part of the transition planning process, an IHTP is developed by the ID team to include the resident's health history and current health status by the resident's medical staff. The resident, 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 resident'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 SDC
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 SDC
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 IDT are satisfied that all arrangements agreed on in the planning process have been implemented and that the client is prepared to	Upon identification of a specific appropriate	CDDS SDC

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move. TRM's are held at the conclusion of the transition process and is when the IDT 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.	living option and ongoing	
F. Post-Move Monitoring		
The monitoring and oversight will be consistent with provisions of Title 17 and Title 22, California Code of Regulations.		
1. The Department of Developmental Services' Sonoma 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 Sonoma 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	10/1/15	CDDS SDC
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 SDC
3. CDDS will develop a plan for enhanced oversight of resident transitions from developmental centers to the community.	10/1/15	CDDS SDC
4. SDC will perform 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.	One year after each transition	CDDS SDC
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.	At least quarterly following move	CDDS SDC

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6. CDDS shall use the National Core Indicators (NCI) to measure the 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 residents and Regional Center representatives.	Annually	CDDS SDC
G. 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: a. The Independent Monitor will conduct frequent monitoring of conditions at SDC with an emphasis on provision of Active Treatment, quality Health Care outcomes, Behavioral Health outcomes and Client Protections. 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. 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, to CMS, CDPH, and California Parties on November 1, 2015, and every two months thereafter, or more frequently if requested by CMS. The reports shall at a minimum include the items identified above in paragraph G.1.a-b and may include other items that the Independent Monitor deems material.	Monitor to be submitted to CMS for approval no later than October 1, 2015 As needed November 1 and every two months thereafter	CDDS and monitor Independent Monitor Independent Monitor
H. Quality Assurance		
1. **CDDS will develop and implement a detailed QA plan and maintain the plan over the life of the SDC closure/transition.** 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	10/01/2015 and ongoing	CDDS

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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.		CDPH
2. **Review competency of SDC and other staff as required in Person Centered Planning in accordance with the Lanterman Act and relevant CMS requirements** SDC 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; 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 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.	10/01/2015 and ongoing	SDC
External quality reviewer will perform quality assurance on a representative sample of comprehensive assessments.	12/01/15 and ongoing	Independent Monitor
3. **Determine competencies and train/re-train SDC/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.	10/01/2015 and ongoing	CDDS SDC
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.	10/01/2015 and ongoing	SDC
5. Identify Outcome and Process measures to be monitored, tracked and trended to assure successful transitions and achievement of closure plan objectives.	10/01/2015 and ongoing	CDDS, SDC

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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 SDC achieve the *outcomes* specified in their IPPs; and 2) that the policies, procedures, and practices employed at SDC support the achievement of these outcomes.	As needed	CDDS