Program Design Tool - Enhanced Behavior Support Homes

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Enhanced Behavior Support Homes

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Introduction

This Program Plan tool is designed to assist you with developing a successful program plan. A program design template is available for your convenience. These documents are not a substitute for familiarizing yourself with the relevant laws and regulations including: California Code of Regulations Titles 17 and 24 and Regional Center Policies and Procedures presented at Vendor Orientation.

The specific regulations for Enhanced Behavior Supports Homes (EBSH) can be found in the California Code of Regulations: Title 17. Public Health. Division 2. Health and Welfare Agency-Department of Developmental Services Regulations. Chapter 3. Community Services. Subchapter 24. Articles referenced in this document refer to this subchapter unless otherwise stated. You can find these laws and regulations at: http://www.dds.ca.gov/Statutes/LawsRegs_Home.cfm [3].

What is an Enhanced Behavior Supports Home?

An EBSH is an adult residential facility or a group home certified by the California Department of Developmental Services and licensed by the Department of Social Services. It provides 24-hour, nonmedical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike setting. An EBSH has a maximum capacity of four residents. [1] Enhanced Behavioral Services and Supports are additional staffing, supervision, and other services and supports to address a client?s challenging behaviors, which are beyond what is typically available in other community living arrangements. [2]

Qualifications of Administrator

The Administrator of an EBSH must have a minimum of two years of prior experience providing direct care or supervision to individuals with developmental disabilities, and be a registered behavioral technician, a licensed psychiatric technician, or a qualified behavioral modification professional. [3] A qualified behavior modification professional is someone who has a minimum of two years of experience designing, supervising, and implementing behavior modification services as a behavior analyst, certified assistant behavior analyst, licensed clinical social worker, licensed marriage and family therapist, psychologist, or other professional with California licensure which permits the design of behavior modification intervention services. [4]

Enhanced Behavior Supports Homes Program Philosophy: Overview

Background

Under the Lanterman Act, Californians with developmental disabilities are entitled to the services and supports they need to maximize their potential, regardless of their support need. The services and supports provided through the entitlement are determined individually through a person-centered planning process. [5] Person-centered teams are led by the client and their authorized representative(s) in collaboration with representatives from their local regional center agency and other experts. Teams develop an Individual Program Plan (IPP), which is reviewed at regular intervals, and revised as needed. [6]

Home and Community Based Settings

For those with the most complex medical, developmental and behavioral support needs, successful community living requires considerable flexibility and expertise. EBSHs were established to reduce reliance on institutional living arrangements or out-of-state placement for people with developmental disabilities who have intensive or unique support needs. California has committed to closing its remaining large, residential institutions and replacing them with small?scale services, which enable people with developmental disabilities to live in their own homes in the community.

Rather than define home and community in terms of location or number of people with disabilities living in the same location, the Centers for Medicaid and Medicare Services defines community in terms of people?s ability to be integrated into and have full access to the greater community. To receive Federal funding, Enhanced Behavior Supports Homes must optimize client?s individual initiative, autonomy, and independence in making life choices. This includes but is not limited to, daily activities, their physical environment, and with whom to interact. The services must also facilitate choice of services and supports and who provides them. [7,8,9]

Flexible, Individualized, Program Design

EBSHs introduce housing security for those clients with complex needs who are at risk of housing loss due to mental, behavioral or physical health crises. This is the client?s home. The service design should support their individual preferences, autonomy and goals. Enhanced Behavior Supports Home program plans create a process which allows client growth and self-determination, which in turn reduces behaviors and improves health and quality of life.

Rather than emphasizing the development of a comprehensive menu of specific services, Program Plans for EBSHs emphasize:

1. A stable infrastructure upon which person-centered planning teams can build individualized support plans. This includes:
    a. compliance with all regulations set forth by the California Department of Developmental Services;
    b. a safe facility which affords individuals privacy;
    c. highly qualified and experienced core staff;
    d. a comprehensive network of highly experienced medical, dental, developmental, vocational, therapeutic, communication, recreational, and behavioral consultants who planning teams can access promptly;
    e. emergency and crisis plans
    f. continuous quality assurance and improvement, and staff development
2. Eliciting client input and supporting communication and decisions however they are expressed.
3. Efficient processes for identifying when modifications of the plan, or methods are needed, and making adjustments.
4. Client participation in interviewing and selecting staff who provide their direct support and consultation.

Quality Measurement Emphasizing Outcomes rather than Process Measures

The success of an EBSH is based on the:

1. Level to which services are provided in a manner consistent with a person?s needs, goals, and preferences that help the person to achieve desired outcomes.
2. Level to which individuals in EBSHs, make life choices, choose their services and supports, and control how those services and supports are delivered.
3. Level to which people in EBSHs are integrated into their communities, and are socially connected, in accordance with personal preferences.
4. Level of support (e.g., financial, emotional, technical) available to and received by family caregivers or natural supports of individuals who reside in EBSHs.
5. Adequacy, availability, and appropriateness of the paid workforce available to clients of EBSHs.
6. Level to which the human and legal rights of individuals residing in EBSHs are promoted and protected.
7. Level to which services and supports are equitably available to all individuals residing in EBSHs.
8. Extent to which all dimensions of holistic health are assessed and supported.
9. Extent to which the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

10. Level to which individuals in EBSHs are well supported to actively participate in the design, implementation, and evaluation of the system at all levels. [10]

Care for adults with developmental disabilities is interdisciplinary team-based care with clients and their supporters at the center of the team. You, the licensee applicant, are responsible for all content of your facility program plan, but you are encouraged to consult with other professionals in the development of your plan on sections that are not your expertise. Resources are available on the Office of Developmental Primary Care website http://odpc.ucsf.edu [1] including documentation forms, training materials, and explanations of terms and concepts.

Developing your Program Plan

Submitting your Program Plan

You can submit your proposed plan to the vendoring regional center. The regional center is responsible for developing a contract. [11,12] Before applying for your program, you must complete the regional center?s residential services orientation. [13,14] The regional center will submit your plan and their recommendation to the California Department of Developmental Services, who will issue a certificate of approval within 10 days of our plan being approved. This certificate should be included in the plan of operation submitted to the California Department of Social Services. If you want to make any changes to your operations which change your Program Plan including changing the administrator, you must submit your proposed changes to the Department and to your contracting regional center. You need approval from both before you can change your operations. [15]

Contract

After you have your certificate of approval and before any client moves into their home, you must have a contract executed with your vendoring regional center. If the contract is terminated, your vendorization will also be terminated and your Program Plan will be decertified. [16]

Rates

The procedures for establishing rates for your services are outlined in Article 11. You should complete Form DS 6023 Rate Development- Facility Costs and DS 6024 Rate Development ? Individual Costs Associated with Residency and include them in your appendix.

Formatting your Facility Program Plan

- The Program Plan is to be type written.
- The Program Plan must be in Microsoft Word format.
- Pages of the program design are to be numbered in sequential order.
- All pages are required to have a footer of the home/program name and address.
- Use present tense when writing the Program Plan (as if facility is in operation)

Cover Page

Include program name, contact information, and date (month/year) that your Program Plan was submitted and approved.

Deadlines

The initial Program Plan shall be submitted within 3 months of completing the Program Plan workshop. All revisions to the program design are to be received by the regional center within 1 month of the latest plan review.

General Requirements: Your Program Plan must include the following:[17]

1. The number of clients you will serve, up to four. [18]

In your procedures include the contact information of the administrator. Every client in your program will have their own, private bedroom. [19] However, you may not use seclusion or restraint to manage behavior. [20] You must install and maintain an operable, automatic fire sprinkler system. [21] You must follow all the laws and

ensure the health and safety of clients; otherwise the Department of Developmental Services can decertify your home. [22] To assist you, the regional center will assign your home a liaison. [23]

2. The criteria and procedures for admitting a client. [24]

Before a referral is made for a potential resident, the regional center will assess the client?s need for enhanced behavioral services and supports and arrange a medical assessment. They will give you a copy of these assessments.

Within seven days of a resident moving into their home, you are responsible for getting input from the client and their individual behavior supports team to write an individual behavior supports plan. Within 30 days, you should complete a written functional behavioral assessment and update the individual behavior supports plan. It is your job, as administrator, to coordinate the development and updating of the plans with the client, their supporter(s), and their individual behavioral supports team. [25]

A successful admission may require other procedures. For example, it is important to set a positive tone for your client and staff. The client is moving to their own home where you and your staff will provide support. The client is not moving into your home or work place. The emphasis should be on designing the services and supports in the home to meet your client?s needs as opposed to fitting the client into a pre-determined program and staffing model. You should be prepared to adjust staffing and procedures to the needs and preferences of your clients. The goal is not to force compliance in the face of an unacceptable lifestyle. It is to improve quality of life by creating a supportive social and physical environment, and respecting client?s self-determination. Admission procedures which engage and support clients in planning for their future and which emphasize consent will help set the right tone and expectations.

Your plan should outline how you will ease the transition of a new client. Transitions involve changes in people, places and activities. For people with complex disabilities, it is helpful to stagger changes in these areas, rather than changing them all at one time. For example, a transition plan might start with new staff doing a familiar activity with a prospective client in a familiar place. A second step might be to have familiar people accompany the prospective client to their new home to do a familiar activity. A third step might be to practice a new activity or routine with familiar people in a familiar place in preparation for the new routines.

Other procedures to consider in your plan for admitting new clients include obtaining any missing medical or developmental history. Since illness presents as a change in behavior or function, it is important to document your client?s baseline traits and characteristics in the areas of communication, cognition, neuromotor function and mobility, seizure threshold and behavior and mental health. This will be helpful in assessing any changes. [26] In addition, this will help you assess if your client will need home modifications. Obtaining input and consent from existing residents in the home will also smooth transitions.

3. A description of how your EBSH program will ensure that the appropriate services and supports are provided at the time of admission to meet the client?s immediate needs pending development of the individual behavior supports plan. [27]

Staffing during transitions may need to be enhanced. Consultants or lead staff may need additional hours in the home. Matching staff to client preferences is one of the most important elements of success. Client input is essential in matching transition and permanent staff and consultants to their needs, personality, and preferences. In some cases, it may make sense to temporarily or permanently continue to use service providers and supporters from before a move. Note that direct care staff who have not completed the required on-site orientation and training must be under the direct supervision and observation of a direct care lead staff person who has completed all requirements. [28] Also, note that direct care staff may not implement emergency interventions prior to successful completion of training. [29]

4. An organizational chart for the staff of your EBSH program, and, if applicable, for your organization. [30]

Note that your home must have at least one direct care lead staff person and one direct care staff person on duty at all times when a client is under your supervision. Additional staffing is determined by the client?s individual support needs. [31,32] Note that each client must work with a qualified behavior modification professional for at least six hours per month of consultation per client to review, implement, and train direct care staff. [33] In addition, a minimum of 6 consultant hours per month per client must be provided to meet individual needs. [34] A consultant is an individual or group eligible for vendorization, or other individual qualified by

training, education, and/or experience who provides a service integral to a consumer?s Individual Behavior Supports Plan, as identified by the Individual Behavior Supports Team. [35] The regional center in consultation with the individual behavior supports team may require additional staffing. [36]

Please attach to your program plan the curriculum vitae of your administrator, lea direct care staff, and consultants which includes information demonstrating that they meet the minimum requirements which are described in appendix A and B. The administrator?s curriculum vitae should include the date they completed the residential services orientation. [37] The administrator must be on duty a minimum of 20 hours per week per home. [38]

5. A description of client services to be provided, including the instructional methods and techniques to be utilized.

5. A description of client services to be provided, including the instructional methods and techniques to be utilized.

Provide a description of services designed to promote behavioral health and wellness for individuals who require a high level of support and intervention. Target behaviors that impact health, safety, access to the community, participation, and quality-of-life. Behaviors that are developmentally appropriate, beyond the client?s control, or merely atypical rather than harmful should be accepted or accommodated.

It is extremely rare that the behavior of any person can be explained by a single reason. A combination of issues may be involved including: developmental (the type and impact of their disability); biological (including health, sensory or physical issues); psychological (mental health, trauma, thinking and problem solving abilities, etc.); and social issues (communication difficulties, lack of meaningful opportunities, unmet needs). Individuals are usually doing the best they can to cope.

Most behaviors serve a purpose or function and may be occurring to have a need met. The need may be to avoid, get, or express something. It may be occurring because the person does not know other ways to get their needs met. Often the behavior has worked for the person in the past, or previous attempts to have their needs met have been ignored. [39,40]

You, the facility administrator, will take the lead in the development of a home culture that promotes behavioral wellness. The culture is one that promotes person-centered, self-directed, whole-person thinking in the development of an individualized behavior supports plan. Your plan should emphasize the range of methods and techniques which your staff and consultants have training and experience to implement. Selecting specific methods and techniques to address specific goals or objectives in specific individuals will be negotiated in Individual Program Planning or individualized behavior supports team meetings.

Describe the proactive and preventative strategies you will use to reduce the chance of the individual needing to use the behavior. Describe how you will involve the individual in the plan development and implantation.

a. Environmental ? describe the ways in which you will create an environment that will reduce the need to use behaviors. What information will you need? Who will be involved? When will it happen? How will consistency be maintained?
b. Skill Development ? describe the ways in which you will support the individual in learning skills that promote behavioral wellness. Describing how communication skill development will be a crucial part of the planning. What information will you need? Who will be involved? When will it happen? How will consistency be maintained?
c. Direct Services ? describe the ways in which you will use service providers such as behaviorists, mental health therapists, psychologists, speech therapists, occupational therapists, orientation and mobility consultants, etc. to help achieve specialized skill development.
d. Describe the way you will intervene when behaviors occur. What information will you need? Who will be involved? When will it happen? How will consistency be maintained?

Illness often presents as a change in behavior or function. People with developmental disabilities often have medical conditions in addition to their disability or their disability can contribute to secondary medical or behavioral problems. Treatment or therapies can cause side effects or distress. Communication challenges can create challenges with accurate and timely diagnosis. Therefore, processes for managing medical care are critical. [41]

Describe how you will ensure that all individuals involved understand the process and are implementing the plan in a consistent and appropriate way. Communication is the foundation of self-determination and of care. Please specifically include information on the communication specialists, methods and techniques available.

6. A description of how you will ensure all direct care staff and consultants are competent to perform their assigned duties, including, but not limited to:

a. a. A description of the consultant disciplines, qualifications, and hours to be utilized.

Please describe the consultant disciplines, qualifications and hours to be utilized for your administrator, direct care lead staff, direct care staff, behavioral consultants, consultants and licensures. Qualified behavior modification professionals and consultants vary significantly in their training, philosophy, methods, and attitudes. Please describe how you will offer clients a range of choices for who provides consultation, and allow changes based on changes in client needs and preferences.

Please describe staff qualifications and a duty statement for each staff position. Your plan should reflect the requirement that direct care lead staff must have at least one year of prior experience providing direct care to individuals with developmental disabilities with a focus on behavioral services and become a registered behavior technician within 60 days of initial employment, or be either a licensed psychiatric technician or a qualified behavior modification professional. [42] Your plan should also reflect the requirement that direct care staff must have at least six months prior experience providing direct care to individuals with developmental disabilities with a focus on behavioral services and become a licensed psychiatric technician within 12 months or be either a licensed psychiatric technician or a qualified behavior modification professional. [43]

b. A sample staff schedule

Note that an administrator of the home must be on duty a minimum of 20 hours per week per home to ensure effective operations. [44] Identify staff available for shifts during work/school/day program hours. Match staffing hours to your cost sheet. Staffing plans should enable clients to leave the facility whenever they desire, especially in delayed egress/secure perimeter homes.

c. A staff training plan

Note that within the first 40 hours of employment, direct care staff must complete a minimum of 32 hours of on-site orientation including training as required pursuant to title 22, California code of Regulations Sections 80065(f) and 84065(i). It should also address the specialized needs of each resident, the facility?s program plan, the implementation of the client?s individual program plan, health and safety procedures including fire safety, client?s rights and protections, disaster and mass casualty plans, identification and reporting of special incidents, identification and reporting of suspected abuse or neglect, and assistance to clients with prescribed medications. [45]

Also note that direct care staff must receive a minimum of 16 hours of emergency intervention training including techniques used to prevent injury and maintain safety regarding clients who pose a danger to themselves or others. This must emphasize de-escalation, environmental and positive behavior supports and techniques as opposed to restraint. This training must be renewed annually. [46]

All staff providing direct care must receive hands on training in first aid and cardiopulmonary resuscitation prior to providing direct care, and maintain records of certification in facility personnel records and update their certification annually. [47]

Direct care staff must all complete competency-based training and pass their competency test or challenge test required by Section 4695.2(a) and (d) of the Welfare and Institutions Code within one year of employment in the home. [48]

Direct care staff must complete a minimum of 20 hours of continuing education on an annual basis. [49] Training in supporting decision making and communicating with non-traditional communicators is key to successful behavioral support.

7. A description of your EBSH program?s emergency procedures:

A serious episode of behavior is one that requires rapid implementation of an emergency procedure to mitigate

the likelihood of harm to the individual, other residents, and staff. A combination of issues may be involved including: developmental (the type and impact of their disability); biological (including health, sensory or physical issues); psychological (mental health, trauma, thinking and problem solving abilities, etc.); and social issues (communication difficulties, lack of meaningful opportunities, unmet needs).

Emergency procedures should be designed to manage, prevent and minimize the impact of crises. They should also minimize the chance of secondary complications such as social exclusion, injury, or home or staff loss for the client. The plan should include a plan for urgent response by expert consultants to assist with managing behavioral or medical crises that exceeds the comfort and expertise of the home?s direct care staff, or which may require judgement about whether to transfer a client to a hospital.

Your plan should describe the home?s emergency procedures, including procedures for evacuation when delayed egress and secured perimeters are in use pursuant to sections 56068 through 56074. [50] A client wishing to go to into the community?even from a delayed egress or secure perimeter home-- is not a behavioral emergency. It should be supported, not prevented. Unless their individual behavior supports plan has a formal denial of rights restricting their ability to do so, staffing should be in place to support clients who wish to go out whenever they choose.

Describe the emergency intervention plan. [51] Calling 911 may be necessary especially if there are injuries, unstable vital signs, weapons, or if chemical restraint is needed. However, that is not a sufficient emergency plan for psychiatric or behavioral emergencies. Alternatives to using 911 should be maximized. Emergency responders should not be used in place of adequate staffing, expertise, or transportation.

Include in your program plan, the type, location, and response time of emergency medical services. [52]

Describe how regularly scheduled fire and earthquake drills will be conducted on a schedule of no less than every three months, with the drills conducted on alternating work shifts so that the drills are conducted during the day and evening hours. [53] Include a plan to support clients when they are in the emergency room, hospital or other location. Describe of how you will support clients to complete an Advanced Directive and POLST form for their chart: http://coalitionccc.org/what-we-do/physician-orders-for-life-sustaining-treatment-polst/; The Thinking Ahead Matters tool can be used: http://coalitionccc.org/tools-resources/people-with-developmental-disabilities/. Also include a plan to support transition of clients back to their home once stable.

Emergency prevention and preparedness is also important. Plans may include an earthquake kit for each client; off-site meeting places and contacts in case the home becomes inaccessible; securing furniture and items which could fall or become weaponized; home modifications such as safety glass, built in appliances, alarms or automatic shut offs, delayed egress or secure perimeters, rugged furniture, multiple egress routes in each room; limiting access to hazards; no open flames in the home; adaptive equipment to prevent appliances from running; and low water heater temperatures .

8. An explanation of how your EBSH program will ensure the protection of client?s personal rights, including those specified in Title 17. Division 2. Chapter 1. Subchapter 5. Clients? Rights Sections 50500-50550. [54]

The most effective way to ensure the protection of client?s personal rights is to adopt person-centered planning and supported decision making processes. To do this, clients may need support to maximize their communication and support to make decisions. Providing this support as part of your service plan and policies and procedures will promote client?s rights and self-direction.
Please outline your plan to educate your clients about their rights and options. Specific requirements for notification of rights are found in Title 17. Division 2. Chapter 1. Subchapter 5. Clients? Rights Sections 50520. They are included in the Program Plan template. The rights are listed in Appendix C. The regional center may provide you with copies of these rights in formats to post and reference.

Competing interests among individual program planning and individual behavior supports team members, staff, housemates and clients are inevitable. For example, staff may need time to do paperwork, and clients may need their attention. One client may need quiet, while another needs more activity. Sometimes competing access needs can be addressed with solutions that meet everybody?s needs. Sometimes compromises can be negotiated. And sometimes, needs are incompatible and changes are required. Changes to the staffing, methods, techniques, or procedures should always take precedence over a client losing housing. However, sometimes competing access needs can?t be resolved. One way to manage competing interests is to have each stakeholder independently identify what is important to them and what is important for them. This exercise

allows each person to state their goals and needs without consideration of the goals and needs of others. From there, solutions can be negotiated to meet everybody?s goals and needs as much as feasible. When negotiating solutions, team members should be aware of the power dynamics among team members, and ensure that the client and direct care staff is supported and heard.

Describe your plan to facilitate your client choosing their own supporters and engage them when decisions that impact them are made. Outline your plan to prepare clients to take the lead in their individual program planning meetings, as much as possible including structuring the meeting to ensure the client and their will and preferences remain the focus. Without specific procedures and facilitation, it is easy for the focus of a meeting to shift to staff preferences and convenience or to what others feel is in the client?s best interest. Please outline your plan to assess and support your client?s communication.

Clients referred to EBSH homes are typically at particular risk of having their rights violated by restraint and seclusion. ?Restraint? means control of the client's behavior or activities through the use of physical or pharmaceutical means other than postural supports. Legally, restraint is distinguished from the temporary constraint of a client by direct physical contact only, where there is clear evidence for believing the existence of an imminent danger to either the client or others if such constraint is not accomplished. However, direct physical contact to constrain a client puts the client and supporter at risk for injury and can be traumatic. In general, this technique should only be used with the active consent of the client (e.g. client asks a supporter to hold their arm while having a blood draw or immunization.). It should not be used to prevent property damage or behaviors which cause pain, but not injury. If there is significant risk of serious injury, consultants or licensed medical and/or law enforcement professionals should be engaged. ?Seclusion? is the involuntary isolation of a client in a locked room. [55] If clients are unable to freely exit a room without fear, even if there is not hardware on the door, they are effectively secluded. [56]

9. The methodology used to measure client progress which includes:

Measurable objectives and data regarding person-centered goals, health and behavior are important. Data is important to determining quality and effectiveness. However, data collection should not be complex, time consuming, excessive, or obtrusive. More data or more detail is not always better. The objectives should be meaningful to the person. The types of data to be collected includes target behaviors and the use of emergency interventions. It should also include tracking health and medical data relevant to the client. Forms for tracking behavior and health and medical data are available at http://odpc.ucsf.edu/odpc/html/for_clinicians/charts_forms_c.htm [4]. These samples can be incorporated into your program plan.

Data collection and monitoring can become intrusive in client?s lives. Care should be taken to ensure that methods for collecting data are not overbearing, shaming, disruptive or triggering. Reward systems that control access to activities and items a person prefers can violate the rights of an adult, and should not be used without the client?s consent.

Note that the qualified behavior modification professional?s hours must be documented in the client?s file. [57]

10. Client exit criteria

There may be rare situations where a client chooses to move, where a residents? needs change such that the physical environment is no longer appropriate and can?t be modified, or where competing access needs with other clients compel a resident to move. However, the emphasis should be on adapting the services, supports and staffing to meet the evolving needs and preferences of clients in their own home. The people who you live with and who provide support are some of the most important choices a person can make. Engaging clients and their authorized representatives in the interview process for selecting, evaluating, and promoting direct care staff and consultants will enhance self-determination and minimize conflicts and bad outcomes. Your Program Plan should detail the procedures for minimizing home loss by maximizing flexibility, adaptability and client choice.

11. A description of the proposed home, including size, layout, and location

For many people with complex behavior features of the physical environment of the home and community are key to success. Provide information to help prospective clients choose wisely.

Please describe access to indoor and outdoor space including rooms, dimensions and approximate square

footage. Briefly describe the location, neighborhood, and demographics of the community. Describe neighborhood businesses, transportation, and features. Provide details about sensory issues such as loud trains, nearby airports, or highways. Provide details if the home or neighborhood gets excessively hot or cold or is in flood, earthquake, landslide, or is prone to extreme weather. Describe the lighting. Some people are sensitive to fluorescent lights or high or low contrast lighting and need more natural light. Describe hazards such as roads, ponds, schools, attractive nuisances) or attractions (e.g. parks, restaurants, stores, gyms, amenities).

Describe any special modifications or features of the home. Please describe sight lines in the home, furniture and room layout that allows multiple egress options. Please describe how the home has been modified or ruggedized if at all (e.g. walls reinforced, plastic windows, reduced water heater temperatures, bolted or built in furniture or wall hangings, any locked doors, special window dressings, cabinets or spaces.).

Also describe the physical accessibility of the home.

12. A description of the EBSH program?s continuous quality improvement system, including but not limited to how:

a. Clients will be supported to make choices, including community integration;
b. Clients will be supported to exercise rights;
c. Changing needs of consumers will be addressed;
d. Clients receive prompt and appropriate routine and specialized medical; services;
e. Individual risk is managed and mitigated;
f. Medication is safely managed; and
g. Staff turnover is mitigated.

Quality documentation and record keeping facilitates quality care, reduces errors, enhances communication, and assists with risk management and risk mitigation. The minimum requirements for maintaining documentation are detailed in Article 10 and are listed in Appendix D.

Good documentation is essential for quality assurance and identifying and correcting problems before they cause harm. Everybody makes mistakes and some bad outcomes are inevitable even when everybody performs to the best of their ability. Striving for perfection doesn?t mean that we can achieve it. What we can do is listen carefully to our clients, supporters, and staff, and respond to their needs and concerns; adopt best practices to set ourselves up for success; and learn from mistakes by analyzing how they happened and work to prevent recurrences. Quality services and supports thrive in an atmosphere of trust and respect where clients, staff and administrators communicate freely and are committed to identifying and solving problems rather than focusing on assigning blame or punishment for honest mistakes. Best practice is also to have a no tolerance policy for any type of intentional abuse, neglect, or unauthorized denial of rights.

Your regional center will monitor and evaluate the services in your client?s home with a face-to-face visit with each resident at least quarterly or more often if it is specified in a client?s Individual Program Plan. [58] They will also conduct a quarterly quality assurance visit. [59] A qualified behavior modification professional will make announced and unannounced visits at least monthly. [60]The California Department of Developmental Services will also visit your client?s home at least every six months. [61] These quality assurance visits can lead to urgent action to protect clients including obtaining alternative or additional services and supports or relocating a client from their home. If this happens, an Individual Program Planning meeting will be convened within two working days to review and update the plans as needed. [62]

Unless your client objects, the regional center will tell the client?s rights advocate about all team meetings so they can attend. [63]

Regional centers will investigate situations that may pose immediate danger or that constitute a substantial inadequacy and may institute corrective action plans or sanctions. [64]

Appendix A: Definitions [65]

?Administrator? means the licensee, or the adult designated by the licensee to act in his/her behalf in the overall management of the facility. 66

?Assistant Behavior Analyst" means an individual who is recognized by the National Behavior Analyst Certification Board as a Board Certified Assistant Behavior Analyst

?Authorized Consumer Representative? means the parent or guardian of a minor, conservator of an adult, or person who is legally entitled to act on behalf of the consumer (client).

?Behavior Analyst" means an individual who is recognized by the national Behavior Analyst Certification Board as a Board Certified Behavior Analyst.

?Clients' Rights Advocate? means the representative of the nonprofit agency with which the Department contracts for clients' rights advocacy services pursuant to Section 4433 (b) of the Welfare and Institutions Code who is responsible for clients' rights assurances for persons with developmental disabilities.

?Consultant? means an individual or group eligible for vendorization in accordance with Sections 54319 and 54342,or other individual qualified by training, education, and/or experience who provides a service integral to a consumer?s Individual Behavior Supports Plan, as identified by the Individual Behavior Supports Team

?Consumer? means an individual who has been determined by a regional center to meet the eligibility criteria of Section 4512 (a) of the Welfare and Institutions Code, and Sections 54000, 54001 and 54010, and for whom the regional center has accepted responsibility. A consumer residing in an Enhanced Behavioral Supports Home is a **?client.?**

?Continuous Quality Improvement System? means a process to ensure systematic improvement of services to increase positive outcomes for the consumers being served

?Direct Care Staff? **means facility staff who personally provide direct supervision and special services to consumers. The term includes the licensee, the administrator, management, supervisory, and lead staff during that time when they are providing direct supervision and special services to consumers. Direct supervision and special services shall include ?care and supervision.?**

?Emergency Intervention(s)? means the interventions used with a consumers during the time they present an imminent danger of serious injury to self or others, which cannot be prevented by the use of a less restrictive technique

?Emergency Intervention Plan? means a written plan which addresses the implementation of emergency interventions and the prevention of injury.

"Immediate Danger" means conditions which constitute an impending threat to the health and safety of a consumer and which require immediate action by the regional center to safeguard the health and safety of the consumers in the facility.

?Individual Behavior Supports Plan? means the plan that identifies and documents the behavior and intensive support and service needs of a consumer, details the strategies to be employed and services to be provided to address those needs, and includes the entity responsible for providing those services and timelines for when each identified individual behavior support will commence.

?Individual Behavior Supports Team? means those individuals who contribute to the development, revision and monitoring of the individual behaviors Supports Plan for consumers residing in an Enhanced Behavioral Supports Home. The team shall at a minimum, be composed of the following individuals: (1) Consumer and, where applicable, authorized consumer representative; (2) Regional center service coordinator and other regional center representatives, as necessary; (3) Licensee?s qualified behavior modification professional; (4) Enhanced Behavioral Supports Home administrator; (5) Regional center clients? rights advocate, unless the consumer objects on his or her own behalf to participation by the clients' rights advocate. (6) Any other individuals deemed necessary by the

consumer, or, where applicable, his or her authorized consumer representative, if any, for developing a comprehensive an effective individual behavior supports plan.

"Individual Program Plan" (IPP) means a written plan that is developed by a regional center planning team.

?Planning Team" refers to the planning team which develops and reviews a consumer's IPP through the planning process.

"Qualified Behavior Modification Professional" means an individual with a minimum two years of experience in designing, supervising, and implementing behavior modification services who is one of the following (1) An Assistant Behavior Analyst certified by the National Behavior Analyst Certification Board as a Certified Assistant Behavior Analyst. (2) A Behavior Analyst certified by the National Behavior Analyst Certification Board as a Certified Behavior Analyst; (3) A Licensed Clinical Social Worker (4) A Licensed Marriage and Family Therapist, (5) A psychologist, licensed by the Medical Board of California or Psychology Examining Board; or (6) A licensed professional with California licensure, which permits the design of behavior modification intervention services.

?Registered Behavior Technician? means an individual who is recognized by the National Behavior Analyst Certification Board as a Registered Behavior Technician.

?Substantial Inadequacy? means conditions posing a threat to the health and safety of any consumer, that are not considered an immediate danger.

Appendix B: Direct Care Staff Qualifications [67]

1. A direct care lead staff person must:
    a. Have at least one year prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and
    b. Become a registered behavior technician within 60 days of initial employment; or, be either:
        i. A licensed psychiatric technician; or
        ii. A qualified behavior modification professional.
2. A direct care staff person must:
    a. Have at least six months prior experience providing direct care to individuals with developmental disabilities, with a focus on behavioral services; and
    b. Become a registered behavior technician within twelve months of initial employment; or be either:
        i. A licensed psychiatric technician; or
        ii. A qualified behavior modification professional.

Appendix C: Client?s Rights [68]

Each person with a developmental disability, is entitled to the same rights, protections, and responsibilities as all other persons under the laws and Constitution of the State of California, and under the laws and the Constitution of the United States. Unless otherwise restricted by law, these rights may be exercised at will by any person with a developmental disability. These rights include, but are not limited to, the following:

a. **Access Rights**
    1. A right to treatment and habilitation services. Treatment and habilitation services shall foster the developmental potential of the person. Such services shall protect the personal liberty of the individual and shall be provided under conditions which are the least restrictive necessary to achieve the purposes of treatment.
    2. A right to dignity, privacy, and humane care.
    3. A right to participate in an appropriate program of publicly-supported education, regardless of the degree of handicap.
    4. A right to religious freedom and practice, including the right to attend services or to refuse attendance, to participate in worship or not to participate in worship.
    5. A right to prompt and appropriate medical care and treatment.
    6. A right to social interaction and participation in community activities.
    7. A right to physical exercise and recreational opportunities.
    8. A right to be free from harm, including unnecessary physical restraint, or isolation, excessive

medication, abuse or neglect. Medication shall not be used as punishment, for convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program.

9. A right to be free from hazardous procedures.
10. A right to advocacy services, as provided by law, to protect and assert the civil, legal, and service rights to which any person with a developmental disability is entitled.
11. A right to be free from discrimination by exclusion from participation in, or denial of the benefits of, any program or activity which receives public funds solely by reason of being a person with a developmental disability.
12. A right of access to the courts for purposes including, but not limited to the following:
    A. To protect or assert any right to which any person with a developmental disability is entitled;
    B. To question a treatment decision affecting such rights, once the administrative remedies provided by law, if any, have been exhausted;
    C. To inquire into the terms and conditions of placement in any community care or health facility, or state hospital, by way of a writ of habeas corpus, and
    D. To contest a guardianship or conservatorship, its terms, and/or the individual or entity appointed as guardian or conservator.

b. **(b) Personal Rights. Each person with a developmental disability who has been admitted or committed to a state hospital, community care facility, or health facility shall have rights which include, but are not limited to, the following:**
    1. To keep and be allowed to spend one's own money for personal and incidental needs.
    2. To keep and wear one's own clothing.
    3. To keep and use one's own personal possessions, including toilet articles.
    4. To have access to individual storage space for one's private use.
    5. To see visitors each day.
    6. To have reasonable access to telephones, both to make and receive confidential calls, and to have calls made for one upon request.
    7. To mail and receive unopened correspondence and to have ready access to letter-writing materials, including sufficient postage in the form of United States postal stamps.
    8. To refuse electroconvulsive therapy (?ECT?).
    9. To refuse behavior modification techniques which cause pain or trauma.
    10. To refuse psychosurgery. Psychosurgery means those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for any of the following purposes:
        A. Modification or control of thoughts, feelings, actions, or behavior rather than treatment of a known and diagnosed physical disease of the brain.
        B. Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior.
        C. Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thought, feelings, actions, or behavior.
    11. Other rights as specified by administrative regulations of any federal, state, or local agency.

Appendix D: Records Maintenance: Facility Files and Consumer Files[69]

Facility Files. [70]

Facilities shall maintain a facility file available on site, which may include electronic records, that includes at least the following:

a. Facility program plan;
b. Weekly staff schedules;
c. Personnel records including:
    1. Administrator current credentials, degrees, certificates
    2. Direct care and direct care lead staff current credentials, degrees, certificates
    3. Qualified behavior modification professional current credentials, degrees, certificates
    4. Documentation of completed staff training
    5. Hire and separation dates;
d. Emergency intervention plan as required by the Department of Social Services;
e. Certificate of program approval as issued by the Department;

f. Regional center facility liaison monitoring;
g. Regional center qualified behavior modification professional monitoring;
h. Behavior and emergency intervention data collection and reporting;
i. Findings of immediate danger;
j. Substantial inadequacies;
k. Corrective action plans;
l. Sanctions; and
m. Facility appeals.

Consumer Files [71]

Facilities shall maintain a consumer file available on site, which may include electronic records, for each consumer that includes at least the following:

a. Medical assessment required in Section 59056(a);
b. Individual behavior supports plan;
c. Updated individual behavior supports plan(s);
d. Emergency contact information;
e. Current IPP;
f. Special incident reports, pursuant to Section 54327;
g. Data collection, including progress notes,

professional/consultant visits, and interventions/outcomes; and

h. Record of medications administered, including initials of staff providing assistance.

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