

**County of Sonoma and Sonoma Developmental Center Coalition**  
**Statement of 2016 Priorities:**  
**“Building a Health Disability Resource Center that Supports and Serves**  
**Individuals with Intellectual and Developmental Disabilities”**

**Introduction**

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On June 25, 2015, the FY 2015-16 State budget was adopted requiring the California Department of Developmental Services (DDS) to submit a plan to close the Sonoma Development Center (SDC) to the California Legislature by October 1, 2015, with an intended closure of 2018. On October 1, 2015, DDS submitted to the Legislature a *Plan for Closure of Sonoma Developmental Center* (SDC Closure Plan). The SDC Closure Plan established as its highest priority the health and safety of SDC residents, with a promise to the people of the State of California, the SDC residents and their families that no residents will be moved “...from SDC until appropriate services and supports identified in their Individual Program Plan (IPP) are available in the community.” DDS has set a target for closure of SDC for 2018 – which would make it the quickest closure of a developmental center in California history. While DDS’s statement provides some surety that residents will have consistent care throughout the closure process and beyond, there is little detail in the Draft Closure Plan or provided by DDS regarding the development of the needed services and supports within the community.

Long before the release of the SDC Closure Plan, the health and well-being of the SDC residents has been a priority of the County of Sonoma (County); SDC Coalition (Coalition); and the Parent Hospital Association (PHA). Since 2013, the County has been working closely with the SDC Coalition, a diverse partnership comprised of the County of Sonoma (County), the Sonoma County Agricultural Preservation and Open Space, the Sonoma County Water Agency, the PHA, the Sonoma County Land Trust, and the Sonoma Ecology Center. Committed to the health and well-being of the SDC residents and exploration of options for the future of the SDC site, in 2014, the SDC Coalition launched a broad-based community driven-effort – **Transform SDC** – to transform the site’s unique health service programs and preserve its natural resources.

In the letter dated September 23, 2015, the Sonoma County Board of Supervisors provided information to DDS regarding the future use of the SDC. The County’s input not only expressed its support for the SDC Coalition’s guiding principles for the future use of the SDC, but focused on the transformation of the SDC from a state-run facility to a service model that is community-based; developed through public-private partnerships; and is able to serve as a regional-hub providing high quality health care services to individuals with intellectual and developmental disabilities (I/DD).

The purpose of this brief is to set forth the core structural elements that will guide the development of a new innovative service delivery model called a **Health Disability Resource Center** (HDRC). The following provides a summary of HDRC services; operations; and key next steps for implementation.

## Health Disability Resource Center Services

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This section provides a summary of the Health Disability Resource Center's (HDRC) three core service areas:

The County's letter expressed support for the continuation of three core health services:

- (1) A *Federally Qualified Health Center (FQHC)* focused on the specialized health care needs of individuals with developmental disabilities;
- (2) A *Equipment, Resource, and Information Center* focused on building life skills, education, training, and other specialized services; and
- (3) An *Acute Crisis Center/Place of Last Resort* to provide emergency and other necessary health/behavioral services for I/DD individuals in the community in need of short- and long-term crisis services.

Critical to the success of the HDRC service model will be the development of close partnerships with the California Department of Developmental Disabilities, North Bay Regional Center (NBRC) and all intellectual and developmental disabilities (I/DD) providers. HDRC services will be available to thousands of individuals currently residing in Sonoma County and the North Bay, and SDC residents with the most severe health and behavioral needs as they are transitioned into the County. For all individuals with I/DD and their families, the HDRC will act as a *circle of support*, working to address the many challenges individuals with I/DD and their families face.

### 1. *Federal Qualified Health Center*

It is understood that individuals with developmental disabilities suffer from high rates of poor health and chronic illness. Despite their numerous health complexities and chronic health problems, individuals with I/DD are less likely to have access to quality health care. Reasons for their disparities in health care include 1) shortage of physicians, specialists and other health care providers trained to treat individuals with I/DD; 2) the reluctance of many providers to care for I/DD patients because they require lengthy consultations for which they are not adequately compensated; and 3) the low rates of reimbursement for public insurance programs such as Medi-Cal and Medicare that provides health coverage for most individuals with I/DD.

To address these disparities in health, a key function of the HDRC will be development of a Federally Qualified Health Center (FQHC) focused on the specialized needs of I/DD individuals.

*FQHC Services.* The FQHC will focus on and develop expertise caring for the individuals with I/DD. The FQHC, will provide the full array of services, including primary care and specialty care. Dental services will include preventative services such as cleaning and sealants, and general and sedation/anesthesia dentistry through contracts with hospitals and other dental providers. Behavioral health and medical services will be integrated with Sonoma County Behavioral Health Division staff placed into the clinic setting. The FQHC will provide access to preventative care such as well visits, immunizations, and vaccines, durable medical equipment, orthotics, and other services.

As a primary care medical home, the FQHC will be responsible for coordinating and managing the primary, specialty, acute, and behavioral care of their I/DD patients. All I/DD individuals assigned to the

FQHC will be assigned a personal primary care physician who will understand their patient's health care needs and manage their care accordingly. With the support of the HDRC and working closely with the NBRC, the FQHC will integrate health care services with the long-term services and supports from traditional I/DD providers.

The geographic catchment area for the FQHC will depend on service being provided. For primary care services the patient catchment area will likely be Sonoma County and portions of contiguous counties. However, for specialty services the catchment area will expand especially for difficult to access services such dental care and repair of durable medical equipment.

*FQHC Governance.* The FQHC will likely be operated by an existing Sonoma County non-profit FQHC either as a satellite or a stand-alone clinic. Sonoma County has a very strong network of FQHCs from which to establish a clinic focused on serving people with I/DD. The development of such a clinic will require the support of the State and North Bay Regional Center (NBRC). The County Department of Health Services (County DHS) has retained the consulting firm, Pacific Health Consulting Group, to prepare a feasibility plan and has already had preliminary meetings with Sonoma County based FQHCs who have expressed significant interest in the developing such a clinic. The Achievable Clinic, an I/DD focused FQHC in Southern California that works closely with the Westside Regional Center, recently met with Sonoma County based clinics to provide them information on establishing a clinic in Sonoma County.

*FQHC Funding.* Most community-based I/DD individuals receive their health care coverage through Medi-Cal and Medicare with a significant percentage having coverage under both. A small percentage of I/DD individuals have private health coverage. Individuals with Medi-Cal will be enrolled in Partnership HealthPlan of California (PHC). For Medi-Cal enrollees the FQHC will contract with PHC and bill PHC for services. For individuals with Medicare coverage or with dual eligibility, the FQHC will bill the Center for Medicare and Medicaid Services (CMS) for services as the primary payer, and PHC for Medi-Cal services not covered by Medicare.

In addition to negotiating a rate with the area health plans, FQHCs negotiate a rate with the State either based on comparable rates of FQHCs serving a similar population, or based on the FQHCs projected costs. If the FQHC is established as a satellite of an existing clinic, the clinic is required to utilize the rates of the parent clinic.

One challenge to the financial sustainability of an I/DD focused FQHC is the reduced number of encounters the FQHC can bill the state resulting from the complex needs of the I/DD population. An I/DD focused FQHC provides services to a high risk, high need population, with a time per encounter rate three to four times the average. According to the Achievable Clinic, the average patient encounter for an I/DD patient is approximately 45 minutes to an hour. In order to avoid reduced reimbursement from the state, an FQHC operating under the umbrella of the HDRC must attain an exemption from the productivity standards which are based on the average population. Such an exemption was approved by the State for the Achievable Clinic, located in Culver City, California.

In addition to receiving a waiver of the productivity standards, the FQHC must be allowed to bill for services using an enhanced Medi-Cal Prospective Payment System (PPS) rate established by the State.

Also, individuals with I/DD are less mobile and less care-compliant than the average patient. Therefore, the Department of Health Care Services (DHCS) may be interested in working with CMS on revised rules for the specific payment codes for FQHCs PPS that would allow for stand-alone billing for home visits to home-bound patients; transitional care management services; chronic care management; and behavioral health services. If FQHC are forced to bill encounters on separate days, as they are currently, I/DD patients would have to undertake multiple trips to the clinic and be discouraged from complying with medical procedures. Structuring an enhanced reimbursement rates will encourage providers to serve more people with I/DD and spend adequate time to ensure access to the appropriate amount, duration, and scope of services.

*FQHC Staffing.* For the patients that will transition from the SDC to the community, the physician – patient relationship plays a critical role in well-being of the patient. While trust is an important component of every patient’s relationship with their doctor, for patients with I/DD it is even more critical and takes longer, sometimes years to establish. For this reason, it is important that the FQHC include staff from the SDC. In discussions with FQHCs they have expressed interest in retaining SDC staff in their clinics. (For more information related to staffing of the HDRC services, please see next section).

***FQHC Cost Summary and State Requests.***

The construction and operational costs of the specialized FQHC will depend on various factors including, but not limited to: 1) the results of the FQHC assessment and proposal; 2) the location of the FQHC clinic; 3) new construction vs. lease of an existing building; 4) the cost to renovate existing SDC building as determined by State SDC Site Assessment; 5) the services provided by the clinic (i.e., anesthesia dentistry); and 6) the number of clients served by the clinic.

The following is a summary of identified costs and list of State requests related to the FQHC:

- **Construction Costs:** (\$5,000,000) The cost to construct a new stand-alone building off the SDC site would be cost prohibitive - \$8,000,000 to \$15,000,000. Therefore, the Parties request the State provide funding for improvements to the current SDC that will allow the FQHC to operate as a regional hub serving transitioned SDC residents, current NBRC clients; and I/DD individuals from other regional centers. The costs of required improvements to the existing center will be approximately \$5 million depending on the extent of required improvements.
- **SDC Site Assessment:** Request the State conduct a site assessment of the current SDC Health Clinic and work with Parties, including identified FQHC, to assess the costs of improvements to the current clinic site.
- **Expedited Enhanced State Rate Setting Process and Relief from Productivity Requirements:** The FQHC will request enhanced rate from State DHCS based on costs of the specialized clinic. Until the enhanced rate is set by the state, the FQHC will be paid at 70% of its closest clinics rate (“Temporary FQHC Rate”). It takes generally 1-3 years for the State DHCS to set a final rate (“Final FQHC Rate”). The parties request the State expedite the rate setting process so as to minimize the time the clinic is operating at a loss. The Parties also request relief from the FQHC productivity requirements.
- **Operational Hold Harmless:** The FQHC ongoing operations will be funded by Medi-Cal, Medicare, private payors, grants, and donations. Pending the establishment of the Final FQHC Rate, the Parties request the State agree to hold harmless the FQHC for the difference between the Temporary FQHC Rate and the FQHC actual costs. Upon establishment of the

Final FQHC Rate and retroactive State payment to the FQHC, the FQHC will repay the State an amount equal to the State's operational hold harmless payments minus \$2 million which will be held in sustainability reserve to support the ongoing operations of the FQHC.

- **FQHC State Staff Funding:** In order to preserve continuity of care and retain staff expertise, the FQHC will employ current SDC physicians and other health care providers. Parties request through the State's Community State Staff Program (CSSP) the State agree to provide funding to the FQHC to cover the cost of SDC staff transitioned into the FQHC setting.

## 2. *Equipment, Resource, and Information Center*

One of the main challenges facing an I/DD patient is the fragmented nature of health care system. This fragmentation exists at multiple levels including their health care coverage – navigating the Medi-Cal system and/or Medicare FFS system; the lack of integration of medical and behavioral services; and the silo between traditional medical providers and those who provide I/DD services and supports.

A second key function of the HDRC will be development of an Equipment, Resource and Information Center (ERIC). ERIC will include an 1) information hub that will allow for coordination of services across the full continuum of the I/DD patient's care; 2) a health resource center that will provide life skills training and education and a navigator function that will support I/DD patients, families, guardians and health care providers; and 3) a unit specializing in repair of durable medical equipment. The SDC currently employs a number of technicians who excel in adapting and repairing specialized equipment; it is rare to find skilled individuals offering these services to the Regional Center clients. For this reason, it is critical to retain these skills at ERIC.

*Information Center.* A key to the HDRC's success will be the development of an information hub. Similar to the portal established by the San Diego Aging and Disability Resource Center accept focused on the developmentally disabled population, the HDRC's information hub will provide I/DD patients, families, guardians, and providers with information, assistance, education and access to available community services and supports. The information hub will also serve as a focal point for the collection of client specific data (i.e., client demographic information; medical home; primary care physician; residence; regional center case manager; conservator/family contact information; etc.) All providers, clients, families, and other parties such as North Bay Regional Center will have access to a common set of data regarding I/DD patients and a common understanding regarding the I/DD client's needs and condition. The information hub will be a case management system located at NBRC.

*Resource Center.* Working closely with the FQHC and NBRC, the ERIC will also include health resource center that will provide a core set of services that will foster community involvement, consumer empowerment and connectivity for I/DD individuals and their families. Health Resource Center services will include:

- *Life Skills Training and Education.* Similar to the services currently provided by the Health Resource Center on the SDC site, the health resource center will provide health education and training services, life skills and care management, wellness, exercise and nutrition classes, job training, and other services that support the capacity of the I/DD individual to successfully reside in an appropriate community-based setting.

- *Navigator Services.* The ERIC Resource Center will be staffed by designated navigators that will work closely with the NBRC to assist I/DD individuals, their families and guardians in planning their care management, educate and link I/DD individuals to appropriate services both within and outside the HDRC; and utilize the information hub to provide critical information to I/DD providers that will improve their capacity to care for their patients and ensure their needs are met. The navigators could link up with navigators in the Sonoma Human Services Department to provide information regarding other public assistance program, as well as train and educate navigators within existing FQHCs on I/DD services.
- *Primary Care Medical Home.* The ERIC Resource Center through the Navigator function will track I/DD individuals in Sonoma County, ensuring that they have a designated primary medical home and personal physician. The primary care medical home may be the FQHC operating under the HDRC, another Sonoma County based FQHC, a private practice primary care medical group/physician, hospital-based medical group, or possibly Kaiser Permanente Health Plan. Ensuring I/DD clients are linked to a primary care home will improve patient health and coordination of services.
- *Hotline.* The Resource Center could include a hotline that could be a vital resource for not only I/DD patients and their families, but I/DD providers including residential providers. The hotline could be staffed by the navigators and would provide basic education or in the case of a crisis, link the client, family member, or provider to a case manager, primary care physician, behavioral health provider, or other provider etc.

*Durable Medical Equipment Services.* Individuals with I/DD have a greater reliance on durable medical equipment (DME). While Medi-Cal managed care health plans and Medicare may provide limited coverage to purchase DME, coverage for repair and replacement is more limited. Working closely with NBRC and the specialized FQHC, the HDRC will continue to provide education on DME coverage and benefits as well retain existing capacity to provide durable medical equipment repair services for IDD individuals.

***ERIC Cost Summary and State Requests.***

Because many of ERIC services would be the continuation of services currently provided on the SDC site, the cost would be consistent with cost of the existing SDC programs.

The following is a summary of identified costs and list of State requests related to the ERIC:

- ***Construction Costs:*** (\$1,500,000) The cost to construct a new stand-alone building off the SDC site would be cost prohibitive (\$2,500,000 to \$3,000,000). Therefore, the Parties request the State provide funding for the required tenant improvements of the current SDC site as determined by SDC Site Assessment (requested below) that will allow the ERIC to operate as a regional hub providing durable medical equipment adaption and repair services and health resource center services to transitioned SDC residents, current NBRC clients; and I/DD individuals from other regional centers. The Parties request ERIC services be co-located near the current SDC outpatient health clinic.
- ***Information Hub:*** (\$750,000) Request funding for the NBRC to conduct assessment of current systems; identification of system requirements; release a Request for Proposal, and implementation and maintenance of a case management system that will integrate health

and regional center services and supports information allowing for enhanced coordination of services and supports. The initial costs for the system will depend on system capabilities. Ongoing maintenance costs would be approximately 25% of the initial system cost.

- **Health Resource Center:** (\$700,000+) Because this would be the continuation of a service currently provided on the SDC site, the cost would mirror the cost of the existing program. The salary and benefits cost of the navigators will be approximately \$255,000 per year (3 navigators at \$85,000 per year). The cost of a hotline including telecommunications costs, training, etc., will be approximately \$100,000. The Parties request the State identify the costs of the current HRC program and fund NBRC or a private entity to operate the Health Resource Center on the SDC site.
- **Durable Medical Equipment Services:** (\$750,000) Because this would be the continuation of a service currently provided on the SDC site, the cost would mirror the cost of the existing program. SDC currently employs six individuals who provide wheelchair repair, fabrication and maintenance; shoe repair and fabrication; and adaptive technology development and repair. The total annual salary with benefits for the current SDC employees is \$500,000. An estimated cost for services and supplies for the DME Services is \$250,000 for a total cost of approximately \$750,000. The Parties request the State identify the actual costs of the program and fund NBRC or a private entity to operate the program on the SDC site.
- **SDC Site Assessment:** Request the State conduct a site assessment of buildings located near the health clinic that could house ERIC services to assess required tenant improvements and other costs.
- **ERIC State Staff Funding:** In order to preserve continuity of care and retain staff expertise, the operators of the ERIC services desire to retain the services of current SDC providers. Parties request through the State's Community State Staff Program (CSSP) the State agree to allow the SDC staff to work for ERIC services while retaining their status as State employees including all salary and benefits. .
- **Data Request:** Request DDS provide additional data regarding SDC's current Health Resource Center and Biomedical Engineering Equipment program. Data to include budget including salary and benefits, services and supplies, etc., facilities, and identification of current program staffing.

### *3. Continuum of Care for Individuals in Crisis – Acute Crisis Center & Place of Last Resort/Intermediate Care Facility*

A third key function will be the continued provision of Acute Crisis Center (ACC) and Place of Last Resort/Intermediate Care Facility (ICF) services that will provide a *continuum of care* for I/DD individuals that fail in the community setting and are in need of short- and long-term crisis services.

- **Acute Crisis Center.** The first component of continuum of care for individuals in crisis includes the expansion of the existing ACC from the current 5 beds to 15-20 beds. The ACC will provide emergency and other necessary services for I/DD individuals in the community who are in need of short term transitional crisis services and are experiencing extra-ordinary health episodes with acting-out behavior, aggression, self-injury, running away or being at risk of losing housing. The ACC could include a crisis response team that could support NBRC and deflection of individuals from existing developmental centers or more costly institutional services.

Currently there are only two acute crisis centers operating in California, both linked to developmental centers – one located at the SDC and a second at the Fairview Developmental

Center in Costa Mesa California. Both centers, one located in Northern California and one located in Southern California, not only play an important role in deflecting individuals from more expensive care facilities, they assist clients in returning to and succeeding in the community setting. Existing utilization and waiting lists demonstrate the need for these services especially as the most complex residents in the DC system are transitioned to the community. Legislative action is required to expand the facility beyond its current 5-bed capacity.

- *Place of Last Resort.* The second component of continuum of care for individuals in crisis includes a 30-bed place of last resort/ICF that together with the ACC will provide a continuum of care that will ensure residents receive appropriate services that support their successful transition back to the community.

Only individuals with the most complex medical and behavioral need, or those who have failed in a community setting are currently residing at the SDC and the other developmental centers. Because the residents transferring out of SDC are the systems most complex, it is likely that some community placements will fail. As such, it is imperative that these individuals have a place to return to – a continuum of care – that will provide them with access to required services that will support their return to a community setting. Delayed egress/secured perimeter facilities are being developed by DDS and regional centers throughout the state; however, these types of facilities are not appropriate for SDC residents transitioning into the community and/or other regional center clients who experience a short-term crisis or require longer term services and supports.

***ACC/Place of Last Resort Cost Summary and State Requests.***

The following is a list of State requests related to the ACC and Place of Last Resort:

- ***ACC Construction Costs:*** (\$4,000,000) The cost to construct a new stand-alone building off the SDC site would be cost prohibitive. Therefore, the Parties request the State provide funding for the required tenant improvements of the current SDC site as determined by SDC Site Assessment (requested below) that will allow the ACC to operate as a regional hub providing short term crisis services to SDC residents I/DD individuals who fail in the community setting. Funding would include costs to expand the ACC from 5 to 15-20 beds and the costs to co-locate the ACC near the health clinic.
- ***ACC Operating Costs:*** (\$2,500,000 to \$6,000,000) According to DDS the annual base budget for the ACC is \$2,000,000 not including certain costs such as ancillary services, general administrative support, facility support (building and grounds, plant operations), or protective services. Including excluded costs and the proposed expansion the projected annual operating costs may increase up to \$6 million. The Parties request the State identify the actual costs of the program and fund NBRC or a private entity to operate the program on the SDC site.
- ***Change in Law:*** Welfare and Institutions Code § 4418.7(h) provides that the ACC must be distinct from other residential units and limits the number of individuals served by an ACC to 5. Expansion to 15-20 beds will require legislative action.
- ***Place of Last Resort Construction Costs:*** (\$3,600,000+) The cost to construct a new stand-alone building off the SDC site would be cost prohibitive. Therefore, the Parties request the State provide funding for required tenant improvements as determined by SDC Site



Assessment (requested below) that will allow the Place of Last Resort to be located near the health clinic.

- **Place of Last Resort Operations:** (\$4,000,000) The Parties request the State identify the actual costs of the program and fund NBRC or a private entity to operate the program on the SDC site.
- **ACC/Place of Last Resort State Staff Funding:** In order to preserve continuity of care and retain staff expertise, the operators of the ACC and Place of Last Resort desire to retain the services of current SDC providers. Parties request through the State's Community State Staff Program (CSSP) the State agree to allow the SDC staff to work for ERIC services while retaining their status as State employees including all salary and benefits.
- **Data Request:** Request DDS provide additional data regarding SDC's current ACC program. Data to include budget including salary and benefits, services and supplies, etc., use of facilities, and identification of current program staffing.

## Health Disability Resource Center Operations

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This section provides an overview of the proposed HDRC's operations including its funding, governance, and staffing.

### *HDRC Funding*

While the SDC closure process is under way, HDRC partnering agencies need to ramp up services with enough time and funding for capacity building that ensures a seamless transition from SDC-based to community-based services. Achieving sustainability is an important activity for the HDRC and will require close and timely collaboration with the state. As noted above, for the operation of an FQHC, this may include hold harmless agreements, rule changes to FQHC encounters, and a close monitoring to determine whether enhanced PPS rates are sufficient for an optimal throughput that still maintains quality of care.

To meet these challenges the HDRC, DDS and DHCS need to join forces to focus on identifying potential resources, to pursue funding opportunities in both the public and private sectors. For example, while the FQHC would primarily be funded through contracts with the state and federal governments, health plans and hospitals who will experience reduced costs as a result of coordinated care of I/DD patients, may be willing to contribute funding to HDRC operations described above.

### *HDRC Governance*

The form of Governance has two options: centralized or decentralized. Under the centralized model, partnering agencies could form a consortium with a board comprised of members from partnering counties and agencies. In the decentralized model, the Sonoma County Board of Supervisors would facilitate a process for the partnering agencies to forge agreements that ensure seamless delivery of HDRC services along critical pathways within the continuum of care. Each model will be vetted in detail at the Coordinated Care Forum planning sessions discussed below.

Under either a centralized or decentralized model, the HDRC Governing Board will involve consumers and their guardians in the planning and implementation of the HDRC through focus groups to review marketing messages, materials, and branding of the HDRC. Inviting consumers to review and comment on materials and tools can provide HDRC operators with valuable feedback on how they could be improved to better meet the needs of the target audience.

### *HDRC Staffing*

SDC residents currently benefit from a broad community of professional staff including doctors, nurses, psychiatric technicians, and nurse assistants. These professionals have vast experience with the I/DD population and the majority of them have been at the SDC for years. They have developed relationships with residents that are the basis of the positive and therapeutic system of care they deliver.

A principle tenet of the planning process is ensuring continuity of the patient-provider relationship and retention of SDC staff expertise in the community. This means that DDS will need to work with the California Legislature guarantee employment placements in the community for SDC healthcare and care management providers whenever feasible. The core functions of the HDRC - the FQHC, ERIC, and ACC - will all provide opportunities for current SDC workers to continue their employment upon closure of the SDC. Through the transition process and for some time beyond, it is imperative that the state provide incentives to professional staff to continue their care for residents to ensure more successful placements and adequacy of care.

In addition, the State's Community State Staff Program (CSSP) allows a community entity (typically a service provider or a regional center) to contract with a DC to obtain the services of a DC employee to support former DC residents during transition and/or in their new home. The Department received authorization to expand the use of the CSSP to support any consumer who has transitioned out of any DC as part of SB 856, the Developmental Services 2014-15 Budget trailer bill that was signed into law in June 2014. The CSSP enables experienced staff, familiar with the needs of the DC residents, to continue supporting them in the community. This continuity of care benefits the consumer being cared for, the family members of the consumer who have trust in this level of support, the DC employees who are seeking new employment options, and the FQHCs by building capacity to better serve their I/DD patients. It also retains the staff expertise in the community and gives the service providers and regional centers greater access to qualified staff. Employing DD staff in FQHCs will build a foundation for a sustained network of providers in the community with expertise caring for I/DD patients – with the opportunity to maintain capacity through training and educational efforts.

However, the opportunity to build this capacity in the community is threatened by a severe lack of State funding for the Community State Staff Program. Without funding the CSSP will fail and the State's promise that appropriate services will be in place before a resident is transferred from the SDC to the community, will not be realized. An appropriately funded CSSP is integral to the success of this plan.

### **Implementation: Next Steps**

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This section identifies a few key next steps in the development of the HDRC. As described below, the formation of strategic partnerships, concurrent planning, and the coming together of all stakeholders to discuss ways to better serve I/DD individuals are all critical first steps in the successful implementation and ongoing operations of the HDRC.

*Strategic Partnerships.* While building strategic partnerships is one of the most critical components of HDRC success, it also is one of the most challenging aspects of program development. Therefore, particular effort must be spent on establishing relationships of trust among local and State agencies before the start of the transition. Standing meetings will ensure continuing engagement at critical junctures of the project roll out.

*Concurrent Planning.* The Sonoma County Department of Health Services (DHS) along with the NBRC will convene agency representatives who contribute to the “critical pathways” of care with a focus to create integrated points of entry into the HDRC service delivery system. The system will provide timely access to services, information, equipment and repairs. This design addresses many of the frustrations consumers and their families experience when trying to access needed information and timely services. Integrated points of entry reduce consumer confusion and build consumer trust fostering individual choice and informed decision-making. Giving consumers timely information about the complete spectrum of care options will break down barriers to community-based living.

*Coordinated Care Forum.* County DHS in partnership with the DDS and NBRC will convene a Coordinated Care Forum. Agencies that are connected to the critical pathways in the continuum of care will convene to forge understandings based on their existing responsibilities with the goal of creating a seamless service delivery-system under the umbrella of the HDRC. Consumers will be represented at the Coordinated Care Forum to ensure consumer empowerment in the planning process and leverage the remarkable level of expertise among consumers for the good of the service delivery design.

*SDC Closure Plan Amendment.* The California Legislature is required to approve the SDC Closure Plan before it can be finalized and implemented. To ensure the successful and safe transition of SDC residents to the community, the County of Sonoma, SDC Coalition, and PHA respectfully request the Legislature direct DDS to amend the draft SDC Closure Plan to include services and supports addressed above.

## **Conclusion**

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The overriding priority of the State, the County, the SDC Coalition, and the guardians and families of those who live at SDC is the health and well-being the SDC residents. Ensuring a system of care is in place to care for SDC residents as they are transitioned into the community is a commitment that is articulated throughout the State’s Closure Plan, unanimously voiced at every public meeting, steadfastly supported by the County and SDC Coalition, and most importantly, is a commitment we all share. The development of a Health Disability Resource Center does not run counter to this commitment, but supports it – designed to ensure that before those who have been cared for most of their lives in a state-run facility, will be cared for when they move into the community. By following this strategic plan, together we can build a Health Disability Resource Center that will support and serve individuals with intellectual and developmental disabilities.