Little Hoover Commission
Written Testimony Regarding Mandatory Overtime
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Thank you for inviting the Department of Developmental Services (DDS) to have the opportunity to offer information regarding mandatory overtime as it relates to services provided by the Department at Developmental Centers. I have worked for Developmental Services for more than 35 years and have held assignments at its Centers/Facilities up until last year. This has afforded me a direct understanding of the operations of the centers, and the use of overtime at DDS facilities.

Program Background

The Department of Developmental Services is part of the California Health and Human Services Agency. The Department has been given authority under the Lanterman Developmental Disabilities Service Act to provide services and supports for individuals who are intellectually/developmentally disabled, and through those services, help each individual live the most independent and productive life possible.

Currently the Department of Developmental Services operates three Developmental Centers—or DCs—in Sonoma, Porterville, and Costa Mesa, as well as one community based facility (CF) in Cathedral City. The DCs are licensed under three categories: General Acute Care (GAC), Nursing Facility (NF) residential units, and Intermediate Care Facility (ICF) residential areas. The state-operated community-based facility is smaller and is licensed only as an Intermediate Care Facility (ICF). A brief description of client characteristics and the current population for each facility is provided below:

Sonoma Developmental Center (in Sonoma, CA)

- 392—current population (as of August 10, 2015)
- 23% have autism
- 28% have an additional mental health diagnosis with severe or extreme impact
- 51% have cerebral palsy
- 57% have epilepsy
- Average age is 57

Fairview Developmental Center (in Costa Mesa, CA)

- 265—current population (as of August 10, 2015)
- 20% have autism
- 37% have an additional mental health diagnosis with severe or extreme impact
- 30% have cerebral palsy
- 51% have epilepsy
- Average age is 52

Porterville Developmental Center (in Porterville, CA)
[Porterville is the only Center that also provides secure treatment for individuals who have been accused of a violent felony, but have been found incompetent to stand trial. Under this commitment, PDC is responsible for providing treatment in a secure area, and also provides competency training and frequent reporting to the courts for those individuals involved in the criminal justice system.]

- 367 (193, general treatment; 175, secure treatment)—current population (as of August 10, 2015)
- 6% have autism
- 48% have an additional mental health diagnosis with severe or extreme impact
- 15% have cerebral palsy
- 40% have epilepsy
- Average age is 52 in general treatment, and 36 in secure treatment

Canyon Springs Community Facility (in Cathedral City, CA)

- 53—current population (as of August 10, 2015)
- 13% have autism
- 27% have an additional mental health diagnosis with severe or extreme impact
- 2% have cerebral palsy
- 19% have epilepsy
- Average age is 38

All of the DDS facilities provide complete 24-hour long-term care, habilitation and treatment services. Individuals residing in a DC must be intellectually/developmentally disabled, have a court commitment, and typically have significant behavioral support needs or are very medically involved. Also, a substantial number of individuals have been dually diagnosed with mental health issues and/or have been involved in the criminal justice system. Consequently, direct care staff must be on duty 24 hours per day, and be constantly alert to ensure that individuals served are not under the threat of harm from any person (including self), physical condition, or environmental condition.

The Department's highest priority is the health and safety of all DC residents and the protection and quality of care. In order to ensure these individuals are protected, the Department has a number of systems in place as safeguards and standards. Minimum staffing guidelines are set to assure that staffing standards established by Title 22 of the California Administrative Code, and Federal Staffing Guidelines are met. Additionally, these expectations extend beyond those required by regulation and legislation; it is expected that DCs provide appropriate levels of supervision and support at all times to meet the varying intensive service needs of the DC population. Facility programs adhere to the established standards by assigning staff in accordance.

Since resident/patient safety is such a high priority, a critical component of retaining the license and certification at each DC/CF is assuring that a staffing acuity or staffing

needs assessment is provided as necessary, to ensure all services and supports are provided. Staffing acuity is adjusted by assessing changing resident need and can vary from shift-to-shift and day-to-day, with many residents requiring one-to-one staffing on any given day to prevent harm to themselves or others.

The DCs/CF currently use the classifications of Registered Nurses, Licensed Vocational Nurses, Psychiatric Technicians, and Psychiatric Technician Assistants (PTA) for direct resident care services, also known as Level of Care-Nursing staff. As state employees, each of these classes is represented by a collective bargaining unit and has a memorandum of understanding in place.

Voluntary and Mandatory Overtime

Based on assessed resident needs, DCs/CF are allocated sufficient staff to cover, or "deliver", the numbers required to meet staffing guidelines. Overtime is incurred when identified staff are "undelivered," e.g., the staff are absent, the position is vacant, or there is an acuity need to staff above the guidelines. In the DC system, undelivered staff—for the most part—consists of absent workers in filled positions. Reported data indicate the main factors related to undelivered staff at DCs include absences related to workers compensation, Family and Medical Leave Act absences, other sick leave, and resident acuity and safety issues requiring 1-to-1 staff. The DCs/CF make every effort to minimize overtime and only authorize overtime when absolutely necessary. DCs schedule staff to ensure minimum staffing guidelines are routinely covered and overtime rarely used; in the DC system, undelivered staff is the driving force in overtime use.

A procedure for scheduling and distributing overtime has already been agreed upon in all the relevant Bargaining Unit Agreements. Each center/facility has systems in place to assure adherence to those agreements. Both the Bargaining Unit 17 and 18 Agreements (which cover RN's, PT's, and PTA's) essentially require the state to utilize qualified volunteers to perform overtime work to reduce the amount of mandatory overtime, and distribute overtime fairly as much as health and safety permit. Mandatory overtime is only assigned when other staffing measures have been exhausted.

The attached document is a summary of data provided by the Department to staff of the fiscal and policy committees of the Legislature, and includes both overtime and filled-but-undelivered staff hours. The document covers 12 months of data from June 2014, through May 2015 regarding overtime use by Level of Care-Nursing staff.

A review of the data indicates:

- the total number undelivered hours from filled positions versus the total number of overtime hours closely parallel each other and, on average, accounts for more than 90% of overtime
- voluntary overtime in the DCs is used at a ratio of about 4:1 and accounts for an average of 80% of the overtime used
- the full time equivalent of about 270 positions system wide (of time use from about 1200 employees per month) are filled but not providing needed coverage

Impacts of Overtime Prohibitions

Any prohibition of overtime for direct care staff under the current system would prevent the appropriate staff of the Centers and would adversely impact resident health and safety absent other solutions, and is an ethical issue.

- DC residents are substantially-to-completely dependent upon direct care providers to meet their personal care needs and provide safety awareness. Without continual supervision, there would likely be an increase in injuries, accidents, and deaths as a direct result.
- Inability to appropriately mitigate risk for an individual who is dependent on staff would lead to additional licensing violations, penalties, and fines.
- Current overtime use is needed to meet established staffing guidelines. Given the fact that DC overtime use is closely tied to the amount of undelivered staff, limits could mean no service would be provided. In some cases, this could mean individuals could be left alone for extended periods.
- Not meeting minimum staffing requirements places the facility's license and certification at risk for providing sub-standard care, and results in increased costs in addition to overtime.
- Not meeting minimum staffing requirements places the facility at risk for providing sub-standard care, and increases liability for rights violation complaints and possible litigation by individuals and their advocates.
- Not meeting minimum staffing requirements places the facility at risk for providing sub-standard care, increasing the risk of imposed solutions such as receivership or court sanctions.

Limiting voluntary overtime would have a greater potential impact on patient safety.

- A previous state audit asserted that, in order to make certain that residents receive an adequate level of care and are protected from harm, the department should encourage Human Resources—which is responsible for negotiating labor agreements with employee bargaining units—to include provisions in future collective agreements to cap the number of voluntary overtime hours an employee can work and/or allow departments to distribute overtime hours more evenly among staff.
- Given the total continuous staffing need, limiting voluntary overtime would likely result in an increase in mandatory overtime, but would reduce the highest numbers of individual overtime hours.

Prohibition of mandatory overtime would likely require new staffing standards and will have fiscal impact.

- There currently is no process for establishing new or additional positions to fill behind or cover for client health and safety/acuity needs, or for staff illness and injury—one of the main reasons for overtime in the DC system.
- In regard to a question posed by the Commission on whether there are other opportunities to re-train staff into positions that could reduce overtime (as DCs

close or downsize), it is possible that such opportunities could occur, but would be subject to budget discussions and closure needs.

- In the DC system, use of local registry or community-based staffing resources can still pose health and safety risks, since continuity of care and familiarity with residents and their programs is necessary to mitigate risk.
- Some overtime costs might be saved if new positions were established, provided undelivered staff totals don't rise with increased staffing numbers, but would more likely be an offset.
- To my knowledge, no study has been done to determine whether the resources exist to cover possible staffing deficits statewide or whether our training system has the capacity to produce qualified staff that could fill possible staffing gaps—especially in rural areas of the state.
- As I far as I am aware, there has been no study or analysis reviewing recruitment issues in rural and underserved areas, or what the recruitment and retention costs in those areas would be.
- Use of private staffing registries would also be cost prohibitive.
- No studies have been done to determine the cost of a registry or additional staffing pools required to provide necessary coverage.
- The recent announcements regarding developmental center closures will have an impact on the ability recruit and retain employees.
- Currently each center and community facility has a rotational staffing cycle to ensure staffing coverage. These existing cycles, agreed upon by the collective bargaining agreements, would need to be reviewed and analyzed which has not been done.

<u>Other Considerations</u>

Limiting mandatory overtime may have no effect on patient safety.

- If the intent is to reduce prolonged work hours and greater fatigue, then limits on all overtime would need to be reviewed. Staff are by far working more hours voluntarily, and would experience the same fatigue factors.

Limiting all overtime may have no effect on patient safety.

- Analysis of previously proposed bills regarding mandatory overtime did not appear to include provisions to improve enforcement of incompatible activities outside the staff person's primary job that could contribute to error-producing fatigue.
- Experience in past local bargaining at one DC revealed that a requirement for no mandatory overtime allows for the ability to commit to and maintain a second job with another employer. Excess hours worked anywhere impacts the same fatigue factors.
- It is likely that a number of DC/CF employees hold seconds jobs in other non-state facilities at this time, and the DC/CF currently has no way of monitoring those community hours worked per day. This would be the same as overtime work.
- If the intent is to reduce prolonged work hours and greater fatigue, then limits on total hours per day and number of days per week by any number of employers

would need to be set for nursing staff. Staff working multiple shifts with multiple employers would experience the same fatigue factors.
- Analysis of previously proposed bills regarding mandatory overtime did not appear to include provisions to provide management with the ability to have more control over the schedule and assure that all overtime is more evenly distributed among staff. While this may increase overtime for some, it could reduce higher levels of error-producing fatigue.

Safeguards would need to be put in place to assure that severely ill and/or dependent individuals are not left alone or abandoned.
- If the intent is to improve patient safety, then an uncovered shift or inadequate nursing ratios cannot be an option.
- Analysis of previously proposed bills regarding mandatory overtime did not appear to offer any safeguards to assure individuals are provided minimal care; staffing levels in the DCs change on a daily and, sometimes, hourly basis, leaving little room to provide coverage if no volunteers step forward.

Summary

In the Developmental Centers system, there is a continuous effort to reduce overtime. It is a recognized risk factor that is monitored and reviewed at both the Department and Center/Facility levels. The facilities have differing ratios in the various root causes of undelivered staff, and all have plans to address them, with a return-to-work program as a main focus.

Other recent efforts have included:
- DDS/ DCD has engaged in conversation with the Department of State Hospitals as they have recently piloted and now adopted a new staff scheduling system called Assist. The Developmental Centers Division will continue to review this as progress is made.
- In July 2015, training in Attendance Management and Family Medical Leave Act has been provided to all supervisor and managers in our system, as these issues were identified notable sources of overtime. This training was completed with the expectation that all supervisors and managers will implement the updated techniques and information to administer these programs more efficiently.
- Each facility has a Governing Body that reviews and takes action on information received from their quality management systems on a number of issues related to undelivered staff.
- The Department is currently looking at starting (or modifying) the online application process for expediting qualifications appraisal of direct care staff to be able to move potential candidates into the background process as soon as possible.

While staff vacancies comprise one factor in the need to utilize overtime, the more significant factors include absences related to workers compensation, medical leave; and resident acuity.

With the health and safety of our residents as the highest concern, the solitary approach of prohibiting mandatory overtime would appear to have a number of gaps and no assurances that it would address the root cause of the identified issue.

LEVEL OF CARE-NURSING OVERTIME
DC SYSTEMWIDE JUNE 2014 - MAY 2015

TOTAL LOC FILLED/ UNDELIVERED	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Total EEs Using Time	1,145	1,156	1,250	1,240	1,209	1,183	1,221	1,140	1,193	1,199	1,146	1,171
Total Undelivered Hours	43,791	47,918	52,693	51,903	49,619	47,310	48,432	44,362	45,605	45,459	41,886	42,173

TOTAL LOC Overtime*	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Mandatory OT Hours	12,323	11,127	12,322	7,745	10,433	11,289	11,726	10,239	10,598	11,656	9,186	9,378
Voluntary OT Hours	38,232	39,819	43,275	42,794	40,206	45,003	39,074	35,796	37,810	41,963	36,678	38,663
Total OT Hours	50,556	50,946	55,597	50,539	50,639	56,292	50,800	46,035	48,408	53,619	45,865	48,041
TOTAL LOC Overtime %	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Mandatory OT Hours	24%	22%	22%	15%	21%	20%	23%	22%	22%	22%	20%	20%
Voluntary OT Hours	76%	78%	78%	85%	79%	80%	77%	78%	78%	78%	80%	80%
Total OT Hours	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Full Time Equivalent	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Undelivered	249	272	300	295	280	269	275	252	259	258	238	239
Overtime	287	289	316	287	288	320	289	262	275	305	261	273

* Overtime is driven by a number of factors including, but not limited to: daily sick time; Workers Compensation, Family Medical, and other long-term leaves, and; acuity staffing to meet changing consumer needs/safety issues.