Priority 1: Build trust in Regional Center systems and other systems, particularly for people of color.

Problem Statement

For many individuals with intellectual and developmental disabilities and their families, trust in the regional center system is broken. Various factors and experiences have contributed to this distrust: the system seems to focus more on the rules than on people's needs; information is not transparent, and clients bear the burden of figuring out how to navigate the system. Some have said it is like searching for the secret code that unlocks a "yes" to meet their needs. Distrust has come from individuals experiencing different rules at different regional centers and staff within the same regional center giving different answers to the same question. Individuals and families do not see regional centers being held accountable for these problems. Distrust has come from individuals not being heard and not being respected as the decision makers of their own lives.

Priority 1 Recommendations

1.1 Redefine the role of service coordinators to ensure the self-determination and neurological acceptance of clients.

Asking for help is one of the most vulnerable things anyone can do. Asking for help is what clients do every time they reach out to a service coordinator. If clients don't trust their service coordinators due to any negative consequences from their advocacy, it will impede their willingness to share information. This trust in the relationship between client and service coordinator is vital for service coordinators to do their job.

Update the role of service coordinator in a way that builds and continues to maintain trust.

<u>The Role of the Service Coordinator</u>

Service coordinators should:

a. Listen to what clients communicate about their needs and goals and ask questions to elicit their thinking.
b. Promote clients' communication to staff at regional centers and service providers rather than promoting their own agenda for clients' "best interest."
c. Communicate to clients all possible options and service providers related to their expressed needs instead of only sharing what they believe clients should get.

d. Refer clients to assessments, when necessary, instead of judging clients' abilities and needs. For example, referral to an agency for having a client's employment skills and interests evaluated.
e. Support clients by asking if they want advice instead of treating clients with nonconsensual advice.
f. Let clients decide where they will be a good fit without imposing their judgment and discouraging what clients want.
g. Value clients' perspectives over others' biases and promote their self-advocacy over social approval. For example, not discouraging clients from communicating their triggers and authentic goals even if the service coordinator judges them to be "too negative."
h. Support clients' feelings including expressing that there is no such thing as being overly sensitive and validating clients' beliefs about flaws in the system.
i. Assume that when clients seek information, they are not necessarily implying an action to be taken and the service coordinator must obtain explicit consent before moving forward.
j. Keep a log of all actions taken for the client and share it with the client.
k. Respect clients' decisions to switch coordinators for any reason.
l. Participate in interviews so clients can choose the coordinator that's right for them, outside of IPP meetings.
m. Fully disclose ahead of time all decisions made about a client without their consent, including decisions to withhold information to prevent clients' anxiety.
n. Learn and respect how clients think and communicate.
o. Assist and encourage clients in making complaints, even against themselves.

1.2 Create more choice for clients in service coordination by giving individuals the option of selecting a service coordinator from outside of their regional center.

The Lanterman Act (Section 4647 (c), (d), and (e)) currently allows for certain individuals from outside of regional centers to serve in the role of service coordinator, with regional center approval.

Amend this section of the Lanterman Act to create an option for any regional center client to obtain service coordination from a qualified external organization or individual. The service coordination role would include all services that meet state and federal requirements for "targeted case management," which is the way service coordination is paid for by Medi-Cal in California. Specifically, service coordination by the external organization or individual would include:

- Assessment
- Person-centered plan development
- Linkage *(to services/resources)* and consultation
- Assistance in accessing services
- Periodic review *(quarterlies, annuals, etc.)*
- Crisis assistance planning

This role would also include assistance to expand the client's and family's circle of support and natural supports.

This position would be compensated.

External service coordination would be a standard option for any Regional Center client and would not require Regional Center approval.

Parameters would be developed that outline the qualifications of the external organization or individual serving in the service coordination role.

1.3 Create a person-centered approach to the development of individual program plans in which service decisions are made promptly and with the client's involvement.

a) Give service coordinators the authority to approve the IPP as part of a collaborative planning process with the individual.

b) Do not have service coordinators play "messenger" whereby they relay information to a manager and/or clinical team or committee that makes decisions without the individual in the room.

c) Make service coordinators' approval authority clear and consistent across all regional centers.

d) Revamp the deficit-oriented "exceptions process" to a "unique needs partnership" in which the regional center staff and client explore creatively how to meet the individual needs of the client. Reduce the need for these circumstances through better training for and empowerment of service coordinators. Make transparent how the "unique needs partnership" process works and which regional center staff are involved in that partnership group. Establish and enforce an expectation that these service decisions will be resolved within five business days.

e) Provide clients verbal and written explanations of all service approvals and denials in a specified and timely manner.

1.4 Information transparency: information needs to be shared in a disability-accessible way.

Disability-accessible information is information that is not dumbed down. It is information that is accessible and available to clients who rely on this information to meet their needs.

Keeping clients informed helps them have choice and control in their lives and know when things are going right, as well as when they are going wrong, so clients can reach out for help. Reliable information will build trust in the regional center. Information that is shared with clients in a timely manner builds trust that nothing is being kept from them and that they are part of any agenda being created to help them. No one likes information being shared behind their back.

Information that should be accessible to all clients at all times - What this information needs to include, at minimum:

a. Policies and Procedures - If I don't know how to do something, I can't do it.
b. Definitions of Services/Support – What does this support do to meet my need, and does it apply to me so I can understand if the service is being implemented the way it is supposed to.
c. Criteria of Services – Am I eligible for this service so I can present my need in a way that meets criteria.
d. Reasons for Denial – Why am I not eligible for service that could help me so I can do what I need to do to meet eligibility or find another service that support my needs.
e. Changes and Updates: Any changes or updates need to be shared before the time of the change occurs to give me time to adapt my needs, as it takes a long time to make any change in supports/services. Help me connect the dots as to how this change will affect me.
f. Roles and Responsibilities: Understanding my roles and responsibility as a client versus support staff roles and responsibilities helps me to do my part and understand what is someone else's' part so I know when they aren't doing their part or when to reach out to someone else. So I know who to contact and not waste someone's time asking for them to do something not in their job description.
g. My Rights: What rights do I have as a client. How do I best protect myself. What do I do when something goes wrong, and I feel unsafe.

All options should be provided: Example: Service Coordinators should give all the options of what could meet a client's need instead of picking one on behalf of the client. Present all the information so the client can make an informed decision.

To be accessible, the information needs to be:

a. More transparent and available.
b. Provided in multiple ways and at multiple times.
c. Shared without judgment when a client asks about the information that has been previously shared.
d. Location is disability accessible: Easier to access as in find or locate. To request or locate information, there needs to be a search or easy way to obtain information that is needed and figure out where to go to get this information. Website function, contact information, easily searchable, clearly organized.

Written information should always include the name and contact information of the person the client can follow up with if they have any questions or want to discuss the information further.

Examples of disability-accessible:

a. Using the bottom-up approach.
b. Taking into account sensory differences, such as sensitivity to color or the number of images.
c. Taking into account processing: taking things literally. When I fill out paperwork that says "Name," I just put my first name, versus paperwork that says "First Name, Last Name."
d. Unable to connect the dots or fill in the blanks: If information is not shared, it is not accounted for. Example: "Use black or blue pen on this form" is not always stated when it is needed.
e. Presenting the information in accessible ways: printable version, video, voice recording, one on one, mailed, with graphics/without graphics.
f. Fonts that are more accessible: fonts that are hard to read include cursive, made to look messy.

1.5 Strengthen the role of the Consumer Advisory Committee at each regional center and at DDS to ensure consumers' formal role in system oversight.

Consumer Advisory Committees (CAC) should play a central role in driving improvements at the regional center level and statewide level of developmental services. This means that:

a. Every regional center should be required to have a CAC (the Lanterman Act currently states that regional centers "may" have one).

b. The regional center CAC should meet monthly.

c. All consumers should be invited to attend CAC meetings.

d. The officers of CAC should be elected by those consumers in attendance at the annual election meeting.

e. The role of the CAC should be primarily to share client experiences and make recommendations to ensure clients' rights to person-centered services and service coordination and eliminate systemic discrimination and ableism; secondarily, the CAC should identify and plan trainings and activities most desired by the clients of the regional center.

f. The CAC should present recommendations for improving developmental services and service coordination at each meeting of the regional center board of directors.

g. The regional center should provide an individual to support the CAC in its preparation and presentation of recommendations. The CAC should choose from options for facilitators.

h. A report of the recommendations should be compiled by each regional center and sent to the DDS Consumer Advisory Committee and posted on each regional center's website under "Transparency."

i. The DDS Consumer Advisory Committee should be comprised of the chairs of each regional center's CAC, or the chair's designee in their absence.

j. The DDS Consumer Advisory Committee should meet quarterly to advise DDS on addressing systemic changes to improve service coordination and delivery, as well as eliminate systemic discrimination and ableism.

k. Each member of the DDS CAC shall be supported by the individual who supports that individual on the regional center CAC.

l. A report of the DDS Consumer Advisory Committee's recommendations should be compiled by DDS and posted on the DDS website under "Transparency."

m. The DDS Consumer Advisory Committee should make recommendations for updates and changes to the Bill of Rights in the Lanterman Act and/or by departmental policy.

n. All of the above requirements should be codified in the Lanterman Act.

1.6 Make sure that regional center governing boards are supported to provide effective and independent oversight of regional center and executive director performance.

1. <u>Recruiting and nominating members of the governing board</u>
   1. Regional center board nominating committees should be selected by DDS and should be representative of the community served in the catchment area.
   2. The board nominating committee should solicit interest and nominations from the broader community through outreach. The committee should interview board member candidates and make recommendations to the governing board for election.
   3. The nominating process should also allow for an individual to be nominated "from the floor" -- meaning that a person could be nominated as a candidate for the board during a board meeting. This would require one board member to nominate the individual at the meeting and have a second board member also express support for this nomination.
   4. The Chair and Vice Chair of the regional center Consumer Advisory Committee (CAC) should automatically have seats on the governing board. (Please see related recommendation on strengthening the CAC.)
   5. Regional center Executive Directors should be prohibited from any involvement in the recruitment or election of board members.

2. <u>Providing effective board training and support</u>
   1. Board member training for all regional center governing boards should be conducted by DDS, in collaboration with the state's designated "protection and advocacy agency" and the State Council on Developmental Disabilities. The training should be developed with community input, including individuals served and family members. This training should be provided annually.
   2. DDS should ensure appropriate and adequate support for consumer and family board members by surveying members about their ability to meaningfully participate and understand the subjects and votes at board meetings and using the survey feedback to make improvements to the training and to ensure additional supports are provided.
   3. Improve facilitation for consumers and family members who sit on regional center boards by using independent supporters, making the board members less reliant on staff.

3. <u>Protecting board members and their families</u>

a. DDS should establish an anti-retaliation policy to protect board members that includes a requirement for DDS to review and decide on a regional center's proposed reduction in services for a consumer board member or the family member of a board member.

b. DDS should establish a grievance procedure and phone number contact for board members who have concerns, complaints, or questions.

c. Governing board members should serve six-year terms and be required to step off the board for five years before being eligible to run for the board again. This would create more opportunity for community members to serve on the board.

4. Other supports and protections
   a. DDS should establish guidelines for governing boards on regional center Executive Director compensation.
   b. Ensure that regional centers are accountable to their contract with DDS and the State of California and not to outside organizations or trade associations.
   c. Require boards to be notified of a provider's involvement in any abuse or negligent injury or death before the board takes up a vote to approve, renew, or deny that provider's contract.

Priority 2: Make sure that anyone who is eligible for services learns about, understands, and gets individualized and timely services – regardless of their age, language access, race, ethnicity, location, or other characteristics.

Problem Statement

Receiving regional center services and supports can be life changing. However, many individuals with intellectual and developmental disabilities (I/DD) do not know they are eligible for regional center services. Many people with I/DD have shared personal stories of the trauma of being without services until their teenage years or until much later. Others do not know how to apply for services or are afraid to apply because they don't trust the system. Many individuals receiving services feel lost and don't know who to go to for help.

Priority 2 Recommendations

2.1 Strengthen community networks that build understanding and connect individuals to services from people they trust.

People look for guidance and information from others they trust in their community: these relationships might be with faith-based organizations, medical providers, schools, senior centers, as well as others. When these communities understand disabilities and the services available to individuals with disabilities, they can serve as essential referral networks and model for others what it means to be a truly integrated community that values all its members.

1. Fund outreach programs in which regional centers partner with trusted leaders and trusted organizations to:
    a. Educate these leaders and organizations about neurodiversity, ableism, and intellectual and developmental disabilities so that they can educate the broader community and model acceptance, respect, and celebration of neurodiversity.
    b. Share accurate and consistent information and materials, in multiple languages, with these trusted community members and organizations about regional center services so they can learn about and connect families and individuals, as early in life as possible, with services.

    These leaders and professionals should include pediatricians and other health providers, school administrators and teachers, religious leaders, senior centers, hospitals, and social workers, among others.

2. Replicate a successful outreach strategy currently used to connect people with health care services like Medi-Cal for outreach about regional center services. Promotores and community health workers educate and refer people to services in communities in California that have been historically marginalized and disconnected from the health system. These individuals speak a variety of languages and serve diverse communities with diverse needs across the state. For immigrant families in particular, who face real and perceived risks of interacting with government-related services, it is critical to partner with organizations who are trusted and trustworthy to connect individuals and families with needed support.

2.2 Foster client support systems through peer mentoring.

Peer mentoring is a process where two people of similar ages and experiences work together to help each other. Peer mentoring offers a level of acceptance, understanding, and validation not found in many other relationships. Turning to peers for advice and support is an important way for clients of regional centers to understand the service system; learn to advocate for themselves; gain leadership, social, and other skills; and discover opportunities and networks in the broader community. It allows clients to connect with others who "get it" and can relate to their specific challenges. There is wide variation across regional centers in the availability of and support for peer mentoring.

DDS should work with regional centers in the following ways to ensure every center is facilitating effective peer mentoring opportunities:

a. Develop an understanding of what "peer mentoring" looks like at each regional center today: have regional centers submit descriptions and share a statewide inventory of the 21 programs or opportunities on DDS' website.
b. Identify regional centers that have strong peer mentoring programs or opportunities and share these best practices across regional centers.
c. Develop a common framework to guide regional centers in the elements of effective peer mentoring to include in program development. For example, peer mentoring group settings should offer logistical and co-facilitation support from professionals, if requested.
d. Have regional centers collaborate with their clients to design a peer mentoring plan that includes elements from the framework and responds to the needs of that client community. For example, clients may want to choose from group and one-on-one mentoring opportunities. They may want to choose from different platforms for communicating with their peer mentor: online, in-person, or through an app.
e. Share the regional center peer mentoring plans with DDS.
f. Develop and implement training for individuals who will serve as peer mentors.
g. Implement peer mentoring programs at regional centers with ongoing client feedback and collaboration to improve peer mentoring programs.
h. Post peer mentoring information and resources on every regional center website where it is easy to find and understand; and have DDS' website serve as a central source of this information.

Priority 3: Ensure individuals have choice and control over their lives by making self-determination the core of the developmental disabilities system.

Problem Statement

Individuals with intellectual and developmental disabilities do not feel heard or respected as decision makers about their own lives. They are confronted with ableism and get told what to do or have decisions made for them that are "in their best interest" instead of being listened to and asked what they want. The traditional service system lacks flexibility to meet the diverse needs of clients. Instead, clients must "fit the service."

Priority 3 Recommendations

3.1 Make the Self-Determination Program (SDP) the core of the developmental services system, while ensuring that individuals remaining in the traditional system have greater opportunities for choice and control over their services and supports.

1. **Break down barriers to participation and make the program more consistent.**
   a. Require DDS to establish streamlined and consistent processes and procedures for the SDP.
   b. Require DDS to hold regional centers accountable for ensuring the five principles of SDP are being met for participants and that regional centers are making measurable improvements toward achieving equity in enrollment by race, ethnicity, geography, and regional center.
   c. Ensure participants have authority over their spending plans by clarifying that:
      i. Regional centers only verify federal funding and generic resource requirements.
      ii. Regional centers still have all responsibilities related to ensuring the health and safety of their clients and that services relate to the goals in individual program plans.
      iii. Services used to develop the individual budget are not tied to services listed in the spending plan.
      iv. Purchase of service (POS) standards from the traditional system are not applied to services in the SDP spending plan.
   d. Standardize and simplify spending plans by requiring participants to assign expenses to only three budget categories, allowing estimation of costs, and not requiring names of providers.
   e. Make the Financial Management Service (FMS) responsible for any penalties or fines resulting from its failure to comply with state and federal labor requirements, such as timely pay.
   f. Require budgets and spending plans to roll over until new authorizations have been completed and sent to the FMS, as an assurance of consumers' continuity in SDP participation.
2. **Reduce delays related to SDP utilization that are within regional center control by setting explicit timelines for:**
   a. Sending a consumer their POS 12-month expenditure report.
   b. Scheduling budget meetings.

   c. Reaching out to a consumer to schedule a renewal budget meeting.
   d. Reviewing the spending plan.
   e. Sending the POS authorization to the FMS.

3. **Ensure every regional center client receives unbiased information about the opportunity to participate in the SDP at each annual IPP meeting.**
   a. Require regional centers to offer SDP as a standard service model option to every client at their first IPP meeting, at each annual IPP meeting, and at any time upon the client's request.
   b. Require DDS to contract with a third-party organization to:
      i. Develop consistent informational materials in plain language and threshold languages.
      ii. Improve the SDP orientation, with multiple shorter online trainings, available when people need them.
      iii. Train all service coordinators on the SDP.

4. **Over time, significantly increase participation in SDP so that it becomes the core of the system by:**
   a. Developing a pilot project in multiple regional centers targeting communities that are underrepresented in the SDP, such as Latinos and African Americans or consumers with low or no purchase of services.
   b. Conducting proactive outreach to individuals from these communities and offering comprehensive training on the SDP, intensive supports from independent facilitators and FMSs, and faster onboarding from the regional centers.
   c. Evaluating the pilot project to assess whether more individuals were able to enroll, their satisfaction and outcomes once people enter the SDP, and whether streamlined processes were used.

3.2 Give clients more choice and flexibility in services and providers.

The developmental services system must be modernized to:

a. Expand the types of services clients can choose from (and pursue necessary steps to authorize these under the state's Medicaid waivers). The more types of services there are, the more a client can customize their individual program plan to support them in leading the life they want to live.
b. Provide more flexibility in service rules and definitions. For example, respite services—which provide temporary relief to family members from the responsibility of providing care to their loved ones with I/DD—can only be used in the home. This means that if the family member takes a break by

using the respite service, their loved one must stay at home during that break. This deprives the client with I/DD of choice or control over where they spend their time during that respite period. To provide more flexibility in the use of services, service definitions must be made less restrictive.

c. Pursue innovations in technology and services. Explore strategic partnerships with technology experts and industry leaders and pursue a formal collaboration to deploy technology in a sustainable and effective way. Invest resources in proactively exploring innovative services in other states and collaborating with consumer stakeholders to pilot new and creative strategies to address unmet needs.
d. Provide full information about service providers so that clients can make informed choices about which providers to use. The anticipated DDS provider directory is a good start; however, details about formal complaints against providers, including whether there was abuse or death, should also be made public and easy to access. This information should also be reported to the relevant regional center board of directors.
e. Prohibit service providers from "cherry picking" clients: this means service providers cannot be allowed to only accept clients that seem "easiest to support." This is unfair and robs individuals of choice in providers.

3.3 Give consumers the choice to leave the school system at age 18.

Young adults with intellectual and developmental disabilities used to be able to leave school at age 18 and pursue other interests. In 2009, in response to State Budget cuts, the Lanterman Act was amended to require consumers who don't formally graduate from high school to remain in public school transition programs until the age of 22. Current law allows an exception to be granted if the consumer participates in the Paid Internship Program or if the IPP team determines, under "extraordinary circumstances," that the generic service is not meeting the consumer's needs.

School isn't for everyone. While many students with disabilities may be happy to stay in their school for a transition program until age 22, some people find school stressful, disrespectful, and infantilizing (meaning they are treated as small children). Young adults without disabilities are given the choice to exit school. Why should adults with disabilities be forced to stay in school against their wishes?

Amend the Lanterman Act to remove these restrictions in the Welfare and Institutions Code - WIC § 4648.55 so that young adults 18 years of age or older may leave the school system, if they so choose, without obtaining a high school diploma.

3.4 Strengthen individuals' decision-making autonomy and minimize conservatorship.

1. **Continue to invest in statewide resources for Supported Decision-Making.**

   A California law passed in 2022 (Assembly Bill 1663, Chapter 894, Statutes of 2022) focused on reforming California's limited conservatorship system and promoting alternatives to conservatorship like supported decision-making (SDM). SDM allows individuals to choose supporters who have a legal right to be part of the individual's decision-making process.

   After the law was passed, the State Council on Developmental Disabilities (SCDD) received $5 million in one-time funding to launch the Supported Decision-Making Technical Assistance Program (SDM-TAP). SDM-TAP is a statewide resource and online hub for people seeking information about SDM. It provides support, education, guidance, assistance and training to educational entities, families, service providers, professionals, people with disabilities, courts, attorneys, mediators, and others in California who wish to use or expand supported decision-making in their professional or personal life. Funding for SDM-TAP will run out in December 2025.

   Invest in greater understanding and use of Supported Decision-Making by:

   a. Securing ongoing funding for the SDM-TAP coordinated through the State Council on Developmental Disabilities.
   b. Ensuring training is provided in the long-term for self-advocates (especially of transition age), parents, regional center staff, educators, health care professionals, lawyers, judges, court investigators, and others.
   c. Making information and training on SDM widely available to ensure individuals and families are aware that SDM is an option and are not automatically directed to look to more restrictive options that unnecessarily restrict a person's rights.
   d. Creating leadership opportunities for people who use supported decision-making to share their experience and best practices.
   e. Developing and making available mentorship programs for experienced users of SDM to provide support to new people and families.
   f. Developing user-friendly apps and platforms that facilitate SDM processes and communication between individuals and their support networks.
   g. Assessing whether SDM has reduced the number of conservatorships in California.

2. **Provide more state guidance and training of regional centers to reduce conservatorships.**

   Regional centers are required by law to play a role in whether an individual with I/DD enters into a conservatorship. The regional center must send a letter to the courts stating that they believe the person should be conserved. But many regional centers use form letters and do not know about the risks of conservatorship, alternatives to conservatorship like SDM, or how to assess an individual's decision-making capacity with use of supports.

   DDS should:

   a. Provide regional centers with clear direction on how to assess whether an individual could have decision-making capacity with supports. Include training for service coordinators.
   b. Assess whether this new directive has reduced the number of regional center clients who are conserved.

3. **Pursue a state plan to remove all conservatorships that DDS is responsible for.**

   DDS is the court-appointed conservator of about 370 consumers. Regional centers are appointed by DDS to serve as the day-to-day conservators for these individuals. In 2022, in response to a multi-media investigation about neglect and conflict of interest related to regional centers as conservators, DDS created an advisory committee that made a set of recommendations for reform. DDS issued a directive in July 2024 that called for regional centers to follow AB 1663 to maximize the person's autonomy and follow their preferences. The directive also said that someone's service coordinator could not also serve as that person's conservator. Regional centers were required to create internal policies and send them to DDS.

   In January 2025, DDS placed a newsletter on its website here regarding visits coordinated by the Office of Ombudsperson to every individual conserved by DDS. These visits resulted in 61 referrals for additional oversight. The update also noted that "the Ombudsperson recommended terminating a number of the conservatorships that she reviewed."

   Many disability rights advocates have questioned the continuation of DDS conservatorships. There remains an inherent conflict of interest in having a regional center in the role of day-to-day conservator. Recent data show that 86% of individuals conserved by DDS live in congregate care homes and none are in the Self-Determination Program. Additionally, many individuals conserved have family members who are prohibited from seeing them and hope to terminate their adult child's conservatorship altogether.

DDS should:

a. Make a plan to remove all DDS conservatorships.
b. Turn down future conservatorship nominations from regional centers and the courts.
c. Use the many options available if an adult is in need of supported decision-making, including having SCDD approve health care decisions on an individual basis or having the regional center physician approve procedures.

Priority 4: Ensure equity of access and options in Regional Center services to support consistency in the experience of families and individuals, while still assuring a person-centered system.

Problem Statement

Individuals with intellectual and developmental disabilities experience different levels of developmental services and supports depending on where they live in California. Across the 21 regional centers there is variation in process, timelines, quality, service types, availability of providers, and more. Individuals who do not speak English as their first language bear an extra burden of navigating this complex service system to get their needs met.

Priority 4 Recommendations

4.1 Enable individuals to access any service they are eligible for no matter where they live.

Offer the same core set of services at every regional center so individuals who are eligible for a service have equal access to necessary support. Make sure those services are available in all areas, including those with fewer resources.

Expand the use of high-quality online services for eligible participants statewide.

Ensure individuals and families can access services within a reasonable driving distance and have reliable and timely transportation options to access those services.

Create ways for vendors to be compensated adequately to send clinicians out to remote areas.

4.2 Ensure language is not a barrier to accessing services.

Create programs and materials in multiple languages to serve diverse cultural communities. Develop a process of sharing these supports across regional centers and hold centers accountable for using them.

Translate plain language service descriptions, forms, and information about resources like In-Home Support Services (IHSS) and employment into multiple languages for clients and families.

Make sure all regional center employees meet linguistic competency and cultural sensitivity requirements.

Make high-quality interpretation services readily available at all regional centers to support client interactions.