# Community Service Information

This information was developed to assist the families of individuals who are living at Lanterman Developmental Center (LDC) prepare for transition into the community. The regional centers involved in the transition process are committed to providing information so that families can make decisions based on knowledge, rather than apprehension. As Francis Bacon (English Philosopher) once said, *Knowledge is Power.* We want to empower you to be a part of the very important team process, for the ultimate goal of the team is to find, develop, and to provide the very best, safest, and individualized community-based services for each and every Lanterman resident.

The regional center is here to help and support you in any way that we can. The information presented here is an overview of available community services. Please feel free to contact the regional center service coordinator (liaison, social worker, or case manager) connected to the regional center that serves your family member if you want more information as you begin the transition process.

## Regional Center

**What is a Regional Center?**
The 21 regional centers in the state of California serve more than over 240,000 individuals with, or at risk for, developmental disabilities, and their families. They are non-profit corporations under contract with the California Department of Developmental Disabilities (DDS).

Regional centers are overseen by a volunteer board of directors, which includes individuals with developmental disabilities, family members, and community leaders. They provide guidance and leadership to each individual regional center.

Regional centers work in partnership with consumers, families, service providers, and communities to plan and coordinate quality services and supports for infants, toddlers, children, adolescents, and adults with developmental disabilities.

**Services**

Regional centers provide or coordinate the following services and supports as they relate to a person's developmental disability:

- Information and referral
- Assessment and diagnosis
- Behavior modification and behavior training
- Individualized planning and service coordination
- Purchase of services included in the individual program plan (IPP)
- Planning, placement, and monitoring of 24-hour out-of-home care
- Advocacy
- Family support
- Transportation services
- Community education about developmental disabilities.

# Community Service Information

## Regional Center Guiding Principles

- Getting to know consumers and families individually and personally is a priority
- Information is complete, up to date, understandable, available in the primary language whenever possible, and accessible through a variety of mediums.
- Regional center staff is knowledgeable about developmental disabilities, the service delivery system, the Individual and Family Centered Planning process, and available supports and services.
- Consumers and families are provided with culturally sensitive information, support, counseling and guidance to advocate on their own behalf.
- Consumers and families are supported in trying a number of options before making a life decision.
- Adult consumers participate in all decisions,
- Families are respected and supported, and recognized as major sources of support for their children.
- Supports and services are individualized and community based.
- Consumers and families have a leadership role in the service delivery system.
- The community is educated to value the participation and inclusion of persons with developmental disabilities.
- Consumers are recognized as the primary focus of the service delivery system.

Once you and your family member begin planning the transition process into a community living arrangement, your current regional center service coordinator or case manager will be your primary contact and partner at the regional center.

A Service Coordinator is a trained professional, often a social worker, in the area of developmental disabilities and is knowledgeable about resources, supports and services that your family member might want or need. Your assigned Service Coordinator has access to a team of staff who will offer expertise in the areas of health, psychology, occupational therapy, and behavioral services.

*What are the Service Coordinator's responsibilities in our partnership?*
In partnering with you, your Service Coordinator is responsible for assisting you and your family member with accessing information, making decisions and choices, developing plans for working toward your desired outcomes, and identifying, locating and accessing the supports and services that may be needed to achieve those outcomes. We believe that when you feel that you have the support and information you need, we can maximize the benefit and enjoyment your family member will experience from community living.

*What's the difference between a Service Coordinator, Case Manager, Social Worker, or Liaison?*
Nothing. These terms are interchangeable. Each regional center determines which term is used to describe the same job category.

*What is meant by the "monitoring" done by service coordinators?*
Service coordinators are responsible for assuring that quality services are being delivered, assessing the health status of an individual, determining if any additional supports are needed and reviewing progress toward meeting Individual Program Plan (IPP) objectives. They do this

by visiting your family member as frequently as is needed, consulting with service providers, reviewing records kept by the staff, reporting any special incidents and following up on what may be necessary to correct a problem. They have access to clinical specialists on staff at the Regional Center for consultation, including joint visits with nurses, occupational therapists, behavior analysts, and supervisors as needed.

All regional centers carry out Quality Assurance activities with a regular schedule of monitoring for health and safety, consumer rights, and other Title 17 regulations.

## Transition Process

The key to a successful move to a community living arrangement is teamwork, comprehensive assessment of needs, thoughtful planning, some creativity and trust. To assist in developing this process, the Resident Transition Advisory Group (RTAG) was charged with evaluating the current transition process in place for residents at Lanterman and developing recommendations. Membership included representatives from the Lanterman Resident Council, parents and family members of Lanterman residents, the involved regional centers, advocacy groups, and employees of Lanterman and DDS.

**Individual Planning/Interdisciplinary Team**
The process developed for Lanterman residents begins with the current Individual Program Plans (IPP) and continues as the Interdisciplinary Team (ID) teams meet to identify each person's goals and objectives, services and supports based upon the assessed needs, preferences and choices. The ID team includes the individual, involved family members, conservator and/or authorized representatives, advocates, identified LDC employees, and regional center service coordinator. Additional team members may include staff that provides direct services including physicians, nursing staff, psychology staff and ancillary staff, based on their involvement with the individual. To help prepare each individual for participation in this team discussion, small-group informational sessions will be held for residents at LDC to learn about the variety of living options available. These sessions will also assist residents in identifying what issues are most important to the individual and to help ensure they are raised for discussion at their IPP meeting.

**Assessments**
Comprehensive assessments are essential to the transition planning process. They are a tool for communicating specific information about a person that may be valuable in identifying services and support needs when developing the IPP. Regional centers will facilitate an assessment that includes input from resident, involved family members, conservator, authorized representatives, LDC employees, and others who know the resident well.

**Individualized Health Transition Plan**
An Individualized Health Transition Plan (IHTP) will be developed by the ID team to include the resident's health history and current health status by the resident's medical staff. The resident, involved family members, conservator, authorized representative, and/or advocate may participate in the development of the IHTP. The IHTP will provide

specific information on how the resident's health needs will be met and the health transition services that will be provided. For residents transitioning to an Adult Residential Facility for Persons with Health Care Needs (ARFPSHN), an Individual Health Care Plan (IHCP) will be developed to identify and document the health care and intensive support needs of the resident.

**Exploring Options**

The transition process continues with an opportunity to explore living options that match the individual's identified service and support needs. Regional centers and Regional Resource Development Projects (RRDPs) will work together to gather and provide relevant materials written in plain language (such as newsletters, flyers, handbooks, etc) to facilitate discussions. Information sessions, presentations and consultations will be provided to introduce individuals and their families to resources and promote discussion about options.

**Identifying Living Options**

When a potential living option that best meets the resident's needs is introduced, a number of activities are coordinated to assist the resident and the service provider to become familiar with one another and determine viability of the proposed option.

Provider visits are scheduled at LDC to assist the potential service provider to learn more about the resident, meet the current LDC service providers and observe the resident interacting in day programs and the services at the Lanterman site. Visits to the potential homes are scheduled for the resident, involved family members, conservators, authorized representatives, advocates and LDC employees to tour and spend time in the home, meet other individuals living in the home, meet the staff, explore the environment, speak directly with service providers to understand what services and supports options are available and to ensure the needs of the resident can be met.

**Transition Planning**

When the ID team has agreed on a potential community living arrangement, a Transition Planning Meeting (TPM) is held by the ID team to begin the development of a Transition Plan which compiles information/observations from the resident's visit with a selected provider.

Upon the implementation of the Transition Plan and the IHTP has been developed, a Transition Review will be held. The purpose of this meeting is to review the results of the Transition Plan implementation, the response of the resident to the transition activities and to ensure all areas of concern have been addressed. Residents of LDC, involved family members, conservators, authorized representatives, advocates, LDC employees who know the resident well, regional centers, regional projects and potential service providers, all share the responsibility for ensuring that the mutual goal of a safe, secure, and appropriate placement is achieved. Only after successful visits and determination that the consumer's needs can be met in the new setting will the consumer move into their new home.

# Community Service Information

## Community Living Options

There are definitely many choices for any individual who are transitioning to the community.

## Residential Models

Today, there exists a wide range of residential models, and more which are being developed specifically for individuals moving from LDC. Ask your regional center case manager to see examples of different types of community living arrangements. Your case manager will be happy to work together with you to help you and your family member understand your choices. Being aware of all of the options available to you and your loved one will help you make the best decision. Asking to see the options do not obligate you to make a decision before you are comfortable doing so.

### Community Care Facilities (CCF's)

A Community Care Facility (CCF) is a home licensed by the Community Care Licensing Division of the State Department of Social Services to provide 24-hour non-medical, supervision and other specialized services to persons with developmental disabilities. Persons who live in CCFs are provided with support and training to assure that basic personal care needs and other essential activities of daily living are met. All CCFs are guided by principles of choice and preferences and stress the importance of community integration and age appropriate activities provided in natural environments. Some newer CCF's are funded at a negotiated rate commensurate with the level of care required by the few with a developmental disability. There are many CCFs being developed for those persons leaving LDC that utilize a negotiated rate structure of reimbursement to provide for the greater service needs of this unique group of individuals. Most of these homes are three to four bed facilities with a focus on a home-like atmosphere. This enhanced rate structure allows for additional specialized staffing which can be organized according to individual consumer needs. CCFs are monitored by the Department of Social Services, Community Care Licensing Division, and by the Regional Center. The person's Supplemental Security Income (SSI) and the Regional Center provide funding for residential services in the CCF.

### Intermediate Care Facilities (ICFs)

An Intermediate Care Facility (ICF) is a community based health facility licensed by the California Department of Health Services to provide 24-hour per day personal care, habilitation, and developmental and supportive health services to persons with developmental disabilities with health care needs.

### Types of ICFs include:

- ICF-DD-H (Habilitative): serves persons with a developmental disability who have intermittent recurring needs for nursing services, but have been certified by a physician or surgeon as not requiring continuous skilled nursing care.

# Community Service Information

- ICF-DD-N (Nursing): serves persons who have intermittent recurring needs for skilled nursing care, but have been certified by a physician or surgeon as not requiring continuous skilled nursing care.
- ICF-FF-Ns serve medically fragile persons with a developmental disability.

  ICFs are monitored by the Licensing and Certification Division of the California Department of Health Services and by the Regional Center. Funding is through MediCal.

**Supported Living Services (SLS)**

SLS assist persons with developmental disabilities who choose to live in homes or apartments they themselves own or lease in the community. A wide range of services are offered, up to 24 hours per day, and are designed to help individuals exercise meaningful choice and control in their daily lives, including where and with whom they reside.

SLS is designed to foster an individual's nurturing relationships, full membership in the community, and to work toward their long-range personal goals. Because these may be life-long concerns, SLS is offered for as long and as often as needed, with the flexibility required to meet a person's changing needs and without regard solely to the level of disability. Because SLS are individualized and very flexible, SLS is available for consumers with very diverse needs. SLS are not licensed because these services are offered in the consumer's own home. SLS are, however, closely monitored by the regional center.

**Family Home Agency (FHA)**

FHA recruit, train, certify, monitor and provide services and supports through a family home provider to serve no more than two adults with developmental disabilities. The FHA matches individual consumers to a preferred home setting in the residence of the Family Home Provider. The Family Home Providers receive intensive training by the FHA. DDS performs criminal record clearances on all FHA staff and adults living in or associated with both the agency and the family home provider employed by the agency.

**Facilities for Adults with Special Health Care Needs**

Legislation has been introduced to create a new residential category called Adult Residential Facility for Persons with Special Health Care Needs (ARFPSHN). Initially introduced into the legislative process as Senate Bill (SB) 962 for individuals transitioning from Agnews Developmental Center, and extended for Lanterman consumers through SB 853, this bill provides for a pilot program for adults with special health care needs.

Facility staffing requirements include licensed nursing staff on duty 24 hours per day, seven days per week. Facilities based on this model will be licensed and monitored by the State Department of Social Services, certified by the State Department of Developmental Services, and closely monitored by the regional centers.

# Community Service Information

## Day Services

A range of day programming options are available to consumers, including site-based programs offering specialized medical and behavioral consultation. For those consumers unable to travel to a site-based day program, day program services within the residential setting are an available option. Options are also available to meet the needs of those individuals who cannot tolerate full days of program activities.

1. Many day programs offer paid work opportunities to individuals who are interested in working.
2. The opportunity to engage in meaningful work and earn wages is a boost to an individuals self esteem.

Day programs that provide services in site-based facilities are licensed and regulated by Community Care Licensing Division and all are monitored by their regional center. Funded by regional centers, these programs provide services designed to meet a variety of consumer needs.

**TYPES OF DAY PROGRAMS**

**Adult Development Center:**

Adult Development Centers provide training in the areas of community integration, self-advocacy, self-care, employment training, education and recreation. The staff to consumer ratio is 1:3 or 4. Transportation to and from the individual's residence to the program is provided. Some programs are located in buildings in the community, while a few providers provide program services 100 percent in the community for individuals who do not tolerate larger groups well. Adult Development Programs are able to serve people who use wheelchairs and are licensed through Community Care Licensing to provide assistance with self-care and dispensing oral medications.

**Adult Developmental Center for Persons with Enduring Medical Needs**

Adult Developmental Centers for Persons with Enduring Medical Needs are being developed for individuals needing a more specialized day program. These centers differ from typical Adult Development Centers in that the staff to consumer ratio is 1:2. These programs will also be required to have a nurse present for a predetermined number of hours and have regular consultation from a physical therapist or an occupational therapist.

**Day Training Activity Center:**

Day Training Activity Center activities are similar to the Adult Development Centers but they serve consumers that have a higher level of independence. These programs are usually based at a physical site in the community and serve consumers who are ambulatory or who use wheelchairs. Participants learn to maximize their independence through the use of individualized goals and skills training. They are licensed through the Department of Social

# Community Service Information

Services Community Care Licensing. Assistance is provided with self-care and dispensing oral medications.

**Behavior Services Day Program:**

Behavior Services Day Program activities are again similar to the Adult Development Centers, but this type of program can serve consumers with challenging behavioral needs. For this reason, the staff to consumer ratio is 1:3. Transportation to and from the program is, of course, provided. Behavior Services Day Programs are usually site based and provide access to the community to teach skills training and integration. Consumers attending this type of program can be ambulatory or non-ambulatory. Behavior Services Day Programs work with their behavioral consultant to develop and implement a behavior plan to assist the consumer.

**Work Activity Center:**

For consumers with more skills and fewer health or behavioral needs, Work Activity Centers provide paid work opportunities, mobility training, and personal and social adjustment training. The staff to consumer ratio is 1:12-15 and most consumers take public transportation to this type of program.

**Supported Employment:**

Consumers who are ready for competitive employment can be referred to a Supported Employment Agency for placement in a community based job. Job coaching service and training is provided on a 1:1 basis for the first several months and is faded to periodic visits from staff over a period of time.

**Adult Day Health Center:**

Adult Day Health Centers are daytime community based programs designed to meet the needs of frail elders or other adults with physical or mental disabilities. They provide activities, social and health services, meals and care in a safe and friendly setting. An individual's MediCal benefits cover the costs of Adult Day Health Center services.