CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES

LDC Closure News

SPRING 2013

Understanding ICFs

This issue focuses on different types of living arrangements available in the community and the role of the LRP.

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Follow-up questions, comments, suggestions?

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Adult Residential Facilities for Persons with Special Healthcare Needs (ARFPSHNs or 853 Homes) are not the only type of home that can serve individuals with medical needs moving from LDC. Intermediate Care Facilities (ICFs) are another option for people that have the need for nursing services, but don't need continuous skilled nursing care.

ICFs are health facilities licensed by the Licensing and Certification Division of the California Department of Public Health (CDPH) to provide 24-hour-a-day services.

In fact, most of the living units at LDC are also licensed as ICFs. Held to the same regulatory requirements as the ICF units at LDC, community ICFs are just smaller, more home-like environments.

Additionally, there are specialized ICF's that focus on individuals that need skilled nursing care that could be viable options for people living in LDC's nursing facility (NF) units.

An ICF may not be appropriate for every individual, you should talk with your RC service coordinator/case manager and LDC Interdisciplinary Team to determine the residential option that best meets your loved one's unique service needs.

Following are descriptions of the four types of ICFs that provide services to Californians with developmental disabilities:

ICF/DD (Developmentally Disabled) - a licensed health facility that provides 24-hour care and support services to clients with developmental disabilities whose primary need is for developmental services and who have a recurring, but intermittent need for skilled nursing services.

ICF/DD-H (Habilitative) - a licensed health facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to people with developmental disabilities with intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

ICF/DD-N (Nursing) - a licensed health facility that provides 24-hour personal care, developmental services, and nursing supervision to medically fragile people with developmental disabilities who have intermittent recurring needs for skilled nursing care, but have been certified by a physician and surgeon as not requiring continuous skilled nursing care.

ICF/DD-CNC (Continuous Nursing Care) - provides services similar to ICF/DD-N services with the addition of 24-hour skilled nursing services (licensed vocational nurse & registered nurse) for individuals with medical conditions that require continuous nursing and observation. DD/CNC development is limited by a DHCS cap on the number of beds statewide.

Supported Living Services (SLS)

Supported Living Services (SLS) consist of a broad range of services to adults with developmental disabilities who, through the Individual Program Plan (IPP) process, choose to live in homes they themselves own or lease in the community. Many adults that have lived in developmental centers have chosen SLS because it fits their personal needs.

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Family Home Options

The Family Home Agency (FHA) residential program model was adopted in 1996, giving Californians with intellectual and developmental disabilities a new way to receive the supports they need.

In an FHA program, up to two individuals live in private family homes where they can receive services, participate in everyday family activities and be active members of their community.

The FHA is a private, non-profit organization under contract to, and vendored by a regional center. FHAs are certified by DDS and responsible for recruiting, training, approving and monitoring family homes, as well as providing ongoing support to family homes.

Social service staff employed by the FHA make regular visits to the family home to ensure that necessary services and supports are in place, and that the match between the family and the new family member is working, and continues to work.

A Family Teaching Home (FTH) is another kind of living arrangement for adults with developmental disabilities. It is different from an FHA in two ways:

1. The family and the person (s) with a disability do not share the same private home. The teaching family lives in a home adjoining the home of the individual(s), usually a duplex that is owned, leased, or rented by the FHA.

2. The FTH is designed to support up to three adults with any kind of developmental disability who do not need continuous skilled nursing care.

Responsibilities of the teaching family are:

- They must be certified and trained by the FHA, get additional training throughout the year, and renew their certification annually.
- They provide support and supervision for the people with disabilities.
- They manage the adjoining home, provide direct support, and directly supervise any staff that work for them when they are not available.

The FHA must provide or arrange the services and supports that the people with disabilities need, including work and other program supports.

Just like FHAs, Family Teaching Homes are certified, monitored, and evaluated by the regional center and DDS.

Make sure to visit: http://www.dds.ca.gov/lantermannews for the latest news, public notices, updates, reports, press releases and other information and resources related to the LDC closure process.

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CCFs - Another Residential Option

Community Care Facilities (CCFs) are licensed by the Community Care Licensing Division of the State Department of Social Services. CCFs provide 24-hour, non-medical, residential care to children and adults with developmental disabilities who need personal services, supervision, and/or assistance essential for self-protection or sustaining the activities of daily living.

CCFs include Adult Residential Facilities (ARFs) and some specialized homes including Residential Care Facilities for the Elderly (RCFEs) and Adult Residential Facilities for Persons with Special Healthcare Needs (ARFPSHNs). Regional centers may refer to CCFs as negotiated-rate homes, Specialized Residential Facilities (SRFs) or Specialized Residential Homes (SRHs).

Some CCFs vendored by a regional center (RC) may be designated as a "service level" from 1 through 4 based upon the types of services provided and the persons served. A lower service level number reflects less intensive care and supervision needs for the individuals living there. Service Level 4 is further subdivided into Levels 4A through 4I, in which staffing levels are increased to correspond to the escalating severity of disability levels.

The majority of residents who have transitioned into the community from LDC have moved into a CCF. Of the 177 residents of LDC that moved as of April 1, 2013, 146 have moved into a CCF-L4i, RCFE, or ARF. Fifteen of the 177 moved into an ARFPSHN.

There are a variety of CCFs available to meet everyone's individual needs. To learn more about CCFs and what may be appropriate for your loved one, contact your RC representative.

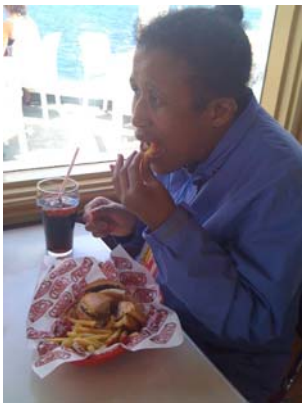
A Story of Transition

A "meet and greet" at LDC with a potential provider and two of their staff in the Spring of 2011 was the "formal" start of Kimberly's transition to a home in the community. After visiting with Kimberly, the provider was confident they would be able to provide services for her. And so a Transition Planning Meeting (TPM) was held to start outlining Kimberly's transition process to her new home.

Kimberly's transition process included provider visits at LDC where staff from her new home got to know Kimberly and build rapport with her, then proceeded to training on her activities of daily living and other cross-training.

Kimberly's parents visited the home, and observed that it appeared to be in a very nice, quiet neighborhood very near their home. As the transition progressed and Kimberly became more familiar with the providers and her new housemates, she began eagerly anticipating her visits to the home.

Kimberly's parents were kept informed of every visit and were sent reports of her progress



Kimberly enjoying a special birthday lunch out on the town.

throughout the transition process.

Initially very cautious about the transition and unsure if Kimberly would do well at a home other than LDC, Kimberly's parents were grateful for the information and opportunities to weigh in with concerns. When Kimberly came back to Lanterman from her visits she would tell the LDC staff all about the home, what she liked and that she wanted to move.

In Fall of 2011, Kimberly moved into her new home. Post Placement Conferences were held for Kimberly at her home to make sure the transition was going well. The conferences were attended by her parents, a representative from LDC and representatives from Kimberly's regional center (RC).

Kimberly and her housemates go on weekend outings, take trips to the park, go grocery shopping and enjoy walks around their neighborhood. Kimberly likes meeting new people and interacting with her peers and staff.

Kimberly enjoys her day program and the daily activities that come with living in her own home. She assists with her laundry, folding and putting away her own clothes, loading the dishwasher and making her bed.

More than a year after moving, Kimberly continues to thrive in her new home. Her parents are pleased and ensure quality care for Kimberly by communicating with their RC service coordinator and the provider.

Her father stated, "I never would have believed she could do this well."

FACTS & FIGURES

- **As of April 1, 85 homes in development for LDC closure have site control.**
- **9 homes were licensed from January 1, 2013 to April 1, 2013.**
- **14 new day programs for LDC closure have been licensed.**
- **As of April 1, 72 residents are in active transition**

As of April 1 187 residents live at LDC

Supported Living Services (SLS), *cont.*

From Pg. 1: SLS may include, but is not limited to :

- Assistance with selecting and moving into a home/ apartment/condominium
- Choosing staff support and roommates, if desired
- Engagement in common daily living activities and life experiences
- Managing personal financial affairs
- Other supports as identified

SLS is designed to further develop individuals' relationships, inclusion in the community, and work toward their short- and long-range personal goals.

Because there may be life-long concerns, SLS are offered for as long and as often as needed, with the flexibility required to meet a persons' changing needs over time, and without regard solely to the level of disability.

Typically, a SLS agency works with the individual to establish and maintain a safe, stable, and independent life in his or her own home.

The guiding principles of SLS are found in Section 4689(a) of the Lanterman Act. DDS's regulations for SLS are found in Title 17, Division 2, Chapter 3, Subchapter 19 (Sections 58600 et seq) of the California Code of Regulations (CCR).

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Role of the Lanterman Regional Project (LRP)

The LRP is one of 5 remaining Regional Resource Development Projects (RRDPs) that were authorized by the Lanterman Act and assigned to California's developmental centers to assist in activities related to admissions, transition planning, deflection and resource development.

The RRDPs are designed to:

- Assist residents and their interdisciplinary planning teams with planning and transition from developmental centers to community living alternatives and provide post placement follow up.
- Assess residents experiencing difficulty in their community environment and identify possible supports to preserve their community living arrangements.
- Assist in the transition to, or preservation of, community living arrangements by providing focused training on specific needs to residents, families, service providers and regional center (RC) staff.

This means that once you have identified a specific community living option for your loved one, the LRP will be working closely with your loved one, LDC staff, your RC, you and the provider to facilitate transition activities and your loved one's placement in the community.

Once your loved one has moved, the LRP continues to be a resource to them, the provider and your RC to help address any issues that may come up as a result of the transition. Follow up services include, but are not limited to:

- Regularly scheduled and as-needed contacts and visits with residents, involved family members, conservators, authorized representatives, advocates and LDC employees during the 12 months following the move date
- Participation in the development of an individual program plan
- Assistance with issues that need resolution
- Arrangement for the provisions of developmental center services including, but not limited to medication review, crisis services, and behavioral consultation.

The RRDP and RC coordinate their follow-up reviews and share information obtained during follow up visits.

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