DEPARTMENT OF DEVELOPMENTAL SERVICES
1600 NINTH STREET, Room 340, MS 3-17
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1963

January 31, 2013

Dear Resident Transition Advisory Group Member:

The *Transition Guidelines* have been finalized and are ready for dissemination amongst the Lanterman Developmental Center community. As you know from your participation as a member of the Resident Transition Advisory Group (RTAG), the membership of the workgroup included, but was not limited to, family members of Lanterman residents, regional centers, advocates, and Lanterman employees. These guidelines include the valuable insight and input of the members, drawing upon a variety of areas of expertise and experiences.

This document is the final remaining item for the transition process developed by the workgroup. It joins the completed *Transition Plan and Individual Health Transition Plan* and the *Transition Activities* tools that were finalized and implemented with the new process in July 2011.

Thank you once again for your contribution to the RTAG in establishing a comprehensive transition process that benefits all residents at Lanterman.

Sincerely,

ORIGINAL SIGNED BY

JULIA LOWE
Assistant Deputy Director, Program Operations
Developmental Centers Division

LANTERMAN DEVELOPMENTAL CENTER
TRANSITION GUIDELINES

VALUES AND GUIDING PRINCIPLES

Consistent with the Lanterman Act and the Department of Developmental Services' (DDS) vision statement of *Building Partnerships, Supporting Choices,* these guidelines are based on the values of collaboration and person-centered planning. The shared goal of facilitating seamless and personalized transitions will promote collaboration among the participants and shall drive the planning process for each of the residents of Lanterman Developmental Center (LDC). These guidelines are intended to include, but not be limited to, a process for residents to safely and successfully transition from LDC into a living option that provides the necessary services and supports. Each resident's transition plan will be based upon the resident's needs, will be developed by the interdisciplinary team (ID team), and will ensure that needed services and supports are in place at the time the resident moves.

Each element of the guidelines to follow must comply with the agreement that:

- Communication with LDC residents, involved family members, conservators, authorized representatives, advocates, and LDC employees who know the resident well, about potential living options is essential
- The pace of transition activities will be determined by the resident's needs for preparation, understanding, and response to each phase of the process
- Participants will conduct a thorough review of the potential living option and the resident's assessment-based service needs prior to moving to the new living option, which will be documented in detail to ensure continued communication before, during, and after transition.

PROCESS

The process begins with the already existing Individual Program Plan (IPP) as mandated in the Lanterman Act and continues as ID teams meet to identify each person's goals and objectives, and services and supports based upon the assessed needs, preferences and choices.

To help prepare each resident for maximum participation in this team discussion, peer informational sessions will be held for residents at LDC to learn about the variety of living options available and the services and supports they provide. These sessions will also assist residents in identifying what issues are most important to them to help ensure they are raised for discussion at their IPP meeting. Information will be made available in an appropriate form for residents to assist in their understanding of the process. This information will also be made available for involved family members, conservators, authorized representatives, and advocates to support the resident in comprehension and participation.

Assessments

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

Assessments should include, but not be limited to:

- Observations and interaction with the resident
- Information gathered from people who know the resident the best
- Information gathered from people who work with the resident on the different shifts and in various environments
- Review of the clinical record and relevant reports
- Historical information that may be valuable in understanding the resident's past experiences

Comprehensive assessments should be detailed and focus on personal interaction between the resident and the assessor whenever possible, reflecting the resident's capabilities, strengths, and unique characteristics. Assessments should also include, but not be limited to recommendations to address challenges and personal needs in areas such as health/medical, dental, psychological, rehabilitation, social, leisure, religious, vocational, educational, behavioral, environmental, safety, family involvement, dietary, personal preferences, staffing support needs, etc. The compilation of assessments should address considerations for all aspects of the resident's life in a variety of environments including non-standard areas such as hereditary medical conditions, rhythm of the day, end of life needs, durable medical equipment needs.

Exploring Living Options

The transition process continues with an opportunity to explore living options that match identified service and support needs. To educate residents, involved family members, conservators, authorized representatives, advocates and LDC employees about the variety and types of living options, housing, and program services that are available or currently being developed, RCs and Regional Resource Development Projects (RRDPs) 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 to resources and promote discussion about options. Preferences for geographical locations (close to family, friends, or other people important to the resident) design of homes, (supported living, smaller group homes, family home agency), day programs, environmental factors (such as air quality and temperature) and availability of needed medical services should be part of these discussions and considerations. The ID team documents service and support preferences in the IPP to be discussed in conjunction with RRDP staff and RC service coordinator.

For the Adult Residential Facility for Persons with Special Health Care Needs (ARFPSHN) as defined in Section 4684.50 of the Welfare and Institutions Code, the need for the ARFPSHN must be specified in the resident's IPP.

Transition Activities for a Potential Living Option

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 of the DC.

Visits to the identified living option 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.

- Visits can be supported by involved family members, conservator, authorized representatives, advocates, LDC employees, RC and RRDP staff.
- Visits provide an opportunity to review the physical structure of the living option to ensure the resident's safety, mobility, and access, e.g. hallways that provide access for a person in a wheelchair, bathrooms/doorways that the space needed to move about in the home, etc.
- ID team members may assist in the exploration of living option and the introduction to the service provider. They may also provide information and insight that will encourage a social and interpersonal connection between the resident and the service provider.
- Cross training opportunities for the potential service provider may be coordinated to promote the exchange of effective approaches and strategies.
- Visits also allow the service provider to get to know the resident and determine if their services are a good match.
- Overnight and weekend visits are encouraged for a more thorough experience.
- Observations of the resident's response to the living option and service provider, input and feedback from those involved in the visits, and items in need of further discussion should be documented in the clinical record and/or meeting minutes.

Meetings are coordinated to promote communication among all involved in the ID team process. Meeting participants who cannot attend in person are supported through alternatives methods of participation.

A Transition Planning Meeting (TPM) is held by the ID team and others to begin the development of the **Transition Plan**. Drawing from the resident's IPP, observations

from the resident's involvement in the exploration stages and the visits with the service provider, the ID team prepares and documents a Transition Plan that addresses:

- A review of the resident's response to events that have occurred thus far
- Identification of additional activities needed to assist the resident to specific environmental changes such as access to the kitchen appliances, public transportation, equipment, etc.
- Consideration of social support needs throughout the transition experience
- Opportunities for additional cross-training of the service provider
- Preliminary identification of specific resources and services that will be in available upon placement with the living option
- Resources and services still needed to be in place prior to transition
- Administrative supports needed.

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. The IHCP must be prepared and full and immediately implemented upon the resident's placement.

Once the Transition Plan has been implemented 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.

The Transition Review will occur no less than 15 days prior to the planned move. If the team identifies significant unresolved issues, a plan for resolving the situation will be developed and if necessary, the move will be postponed pending the resolution of the issues. The review will affirm:

- Consensus of the ID team that the Transition Plan implementation has been effective thus far
- The resident and potential service provider have been oriented to one another
- All services and supports essential to the resident's quality of life are addressed and arranged
- Reports and/or checklists for service needs are developed, utilized, and made available for references
- Upcoming medical appointments are scheduled
- Follow up services are scheduled.

When all issues have been resolved and questions have been answered, the consensus of the ID team will be documented in the IPP. If the team is not in consensus, a description of the discrepancy will be documented in the IPP. The RRDP will ensure the objecting team member(s) are advised of the appeal processes, and provided the materials to either file a Richard S. (for ID team members other than conservators) or a Fair Hearing request (for conservators).

Fair Hearings
Authority for the fair hearing process can be found at Welfare & Institutions Code sections 4700 through 4730. For the purposes of these guidelines, the relevant regional center shall be considered the "service agency" for matters on community placement.

- The RRDP will ensure the resident and/or conservator receive a copy of the regional center Fair Hearing brochure that explains who may file for a Fair Hearing and the steps of filing for Fair Hearing with the regional center.
- The appellant should file the fair hearing request with the regional center within thirty (30) days after being notified of the decision or action that is the basis of the complaint.
- Exploratory activities related to community placement may continue during the fair hearing process but the community placement decision will not be finalized until the fair hearing process is completed.

Richard S. v. Department of Developmental Services Settlement Agreement
The Department entered into a Settlement Agreement that establishes procedures to be followed when a "member" of the ID team (other than conservators) makes an objection to the placement of a consumer from a developmental center into the community.

- The RRDP will provide a "Request for Hearing" form to the objecting team member.
- LDC will provide written notification to the applicable regional center and the California superior court having jurisdiction over the consumer of the intent to transfer the consumer and of the proposed transfer date. LDC shall include in the written notification to the court a statement than an ID team member has objected to the recommendation to transfer the consumer to the community placement, along with the name and position of the objecting ID team member. LDC shall also attach to the notification of the court:
    - A "Request for Hearing," dated and signed by the objecting ID team member notifying the court that the objector requests that the court hold a hearing to review the ID team recommendation. In the event that the objector declines, refuses, or otherwise fails to sign and date the request form, the form will not be attached to the notice.
    - A copy of the complete IPP setting forth the highlighted objections of the appellant.
    - LDC will send to the applicable court the notification by overnight mail, at least fifteen (15) days prior to the proposed transfer date of the consumer into the identified community placement.

- If the court takes no action on the request for hearing, the transfer of the consumer shall take place as scheduled. If the court notifies LDC that a hearing shall be held, no transfer shall be made until after a ruling by the court after the hearing.
- If the court notifies LDC that a hearing shall be held, LDC shall promptly notify the members of the ID team of the date and time of the hearing.

Follow Up Services

In cooperation with the DC, the RRDP and RC shall provide follow up services to help ensure a smooth transition. Follow up services shall 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
- Identification of 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 shall coordinate their follow up reviews and share with each other information obtained during the course of the follow up visits.

ROLES AND RESPONSIBILITIES

All members of the ID team share the responsibility for ensuring that the mutual goal of a safe, secure, and appropriate placement is achieved. More specifically, shared responsibilities of the parties include, but are not limited to, the following:

- Identifying and including a circle of support (in addition to the above) for the resident as appropriate and necessary to ensure a smooth transition from the developmental center to the community. .
- Maintaining a commitment to work collaboratively
- Identifying and conveying the unique characteristics and observations of the resident as they relate to participation in transition activities
- Contributing to the development and review of the plan, preparation for the move, and support for the individual throughout all transition activities
- Visiting the potential living option and programs and becoming familiar with potential service providers and services
- Attending transition activities and events (if desired and suitable to the resident's needs)
- Contributing to the review of health and medical planning
- Supporting the resident in moving and adjusting to the new living environment
- Voicing issues in need of clarification/attention, participating in the resolution process if/when there are disputes, and identifying the need for and pursuing input from others with related expertise when additional team discussion is warranted.

- Maintaining the confidentiality of the resident's information and records pursuant to Welfare and Institutions Code section 4514.

Residents

Residents of LDC are empowered with the right to personal choices and preferences before, during, and after transitioning to a new living environment. The transition process will ensure this right is afforded including:

- Expressing personal needs and preferences
- Attending meetings
- Making choices
- Participating in all aspects and set the pace of the transition process
- Having family and/or friends present when desired
- Having the support of and access to advocacy services when there is no conservator or authorized representative, or when requested.

Family and Representatives

While the participation of family members and representatives may vary for each resident, the transition process will afford opportunities to:

- Participate in informational opportunities to become familiar with alternate living options
- Participate in the coordination of dates/times for transition activities
- Participate in pre/during/post placement trouble shooting
- Actively participate in discussions and activities about services, supports, and goals
- Represent the best interests of the individual

Family Members and Friends

Family members and friends may include any involved relatives and associates of the resident who know him/her well.

Conservators

Conservators are individuals with legal standing as appointed by the court. This may include family members or friends of the resident who have obtained conservatorship, or a representative from the public guardian’s office.

Authorized Representative

Authorized Representatives are individuals appointed by the Area Board to represent the resident if a need has been identified by either the resident or the Area Board, and there is no court appointed conservator. Family members or friends of the resident may be appointed.

Advocacy Services

Advocacy services are available to residents when there is no conservator or authorized representative, or when requested. The advocate may:

- Help the individual understand his or her rights
- Participate in informational opportunities to become familiar with alternate living options
- Participate in the coordination of dates/times for transition activities
- Participate in pre/during/post placement trouble shooting
- Support the resident's participation in decisions and activities about services, supports, and goals
- Represent the best interests of the individual
- Respond to the resident's pace for ensuring a smooth transition
- Assist in dispute resolution.
- Initiate action on behalf of residents who are unable to register a complaint on their own behalf

Volunteer Advocates

Volunteer Advocates are individuals assigned by the State Council on Developmental Disabilities via the Volunteer Advocacy Services Coordinator to provide advocacy resources to residents who have no legally appointed representative to assist in making choices and decisions.

Clients Rights Advocates (CRA)

Clients Rights Advocates are individuals contracted by the State Council on Developmental Disabilities to act as a resource to residents, families, and professionals to understand and assert the resident's rights.

Regional Centers

The regional centers serve as the case manager for LDC residents and have a unique role in the transition planning process to establish appropriate community living options, identify supports such as day program services, community groups, consultants, etc. The regional center staff will:

- Participate as members of the ID team
- Understand and support resident preferences
- Develop (when needed) and ensure provision of community placement options to the resident
- Provide information about community placement options to the ID team
- Ensure all services to meet the needs of residents are accessible including health/medical services
- Facilitate the referral packet and transfer of information to the potential provider
- Communicate with the potential service provider regarding training and support needs
- Ensure the availability and recommending appropriate timing for the transition

- Evaluate the transition planning and provide recommendations for adjustments as needed
- Ensure the successful transition into a new living option
- Schedule follow-up visits, communicate findings, and facilitate resolution to issues found.

Service Providers

The identified service provider is responsible to prepare for the provision of all of the supports identified for the resident. In accepting this responsibility, it is imperative that critical information is made available to the service provider. The ID team will identify opportunities for the resident and the service provider to mutually determine the viability of any option. Throughout the transition process, the service provider will:

- Participate in the development of the IHTP
- Secure the resources necessary to meet the needs of resident
- Identify and participate in training opportunities to acclimate to the resident's specific needs and preferences
- Promote opportunities to engage the resident in orienting to the living option's surrounding community
- Prepare for implementation of the transition plans as indicated by the planning team upon the resident's placement
- Provide information about the resident's adjustment to the living option throughout the transition, including the post-placement follow-up activities.

Lanterman Employees

LDC employees know many critical details of LDC residents' needs and desires through day to day support and service. LDC employees who know the resident well and who are involved in the provision of services:

- Seek training to understand all aspects and phases of the transition process
- Are responsible for continuously evaluating the efficacy of the resident's program plans, making recommendations for improvement of the plans as needed
- Support residents by assisting with transition phases in a positive manner so as to alleviate anxiety/fears, promote a smooth process, and minimize disruption to daily routines
- Listen to and observe the residents reactions to transition, then documenting and communicating to those who need to know.

Regional Project

The regional project serves as the coordinator of activities during a transition. Working closely with the residents, involved family members, conservators, authorized representatives, advocates, LDC employees who know the resident well, regional centers, and potential service providers, the regional project will:

- Ensure communication to assist in developing and implementing the resident's transition plan

- Facilitate team discussions and ensure the exchange of information and documentation
- Trouble-shoot for potential challenges and seeking resources for resolution
- Provide education and materials to ID team members regarding the appeal process
- Evaluate the transition planning and recommending adjustments as needed
- Ensure accountability and completion (who does what by when)
- Facilitate the logistical aspects of transition (personal property, supplies, transportation, etc.)