

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

Claimant,

and

THE SAN DIEGO REGIONAL CENTER,

Service Agency.

OAH No. 2014070594

DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings (OAH), heard this matter in San Diego, California, on September 2, 2014.

Claimant's mother, who is also his guardian, represented claimant, who was present at the fair hearing and was assisted by a licensed vocational nurse (LVN).

Ronald House, Attorney at Law, represented the San Diego Regional Center (SDRC).

On September 2, 2014, the matter was submitted.

ISSUES

1. Should SDRC fund 24 hours of 1:1 skilled LVN services for claimant?
2. Should SDRC fund eight hours of 2:1 skilled LVN services on Saturdays so claimant can go into the community and "attend[the] library" for recreation/leisure?
3. Should SDRC be required to have a registered nurse (RN) write a comprehensive plan of care?

FACTUAL FINDINGS

Jurisdictional Matters and Procedural History

1. On September 3, 2009, following an administrative hearing, SDRC was ordered to fund 310 hours per month of nursing respite services. The total number of monthly hours was divided between 95 hours of LVN respite services and 215 hours of certified nursing assistant (CNA) respite services. (OAH No. 2009040141, ALJ James Ahler.)

2. On November 2, 2010, SDRC and claimant participated in mediation. In the Final Mediation Agreement SDRC agreed to fund nursing respite services “up to the total amount of \$148,564 for 12 months.” As written, the agreement expired on November 2, 2011. (OAH No. 2010060987, ALJ Valleria Johnson.)

3. On May 2, 2013, SDRC and claimant again participated in mediation. In that Final Mediation Agreement SDRC agreed to annually fund \$219,564 of LVN respite services. Claimant’s mother agreed to terminate her vendorization as a parent vendor. The mediation agreement became effective on June 1, 2013. (OAH No. 2013031101, ALJ Roy Hewitt.)

4. On November 14, 2013, following two days of hearing, claimant’s appeal that the mediation agreement was being violated and that his request for 24 hour, 2:1 respite services, were both denied. The evidence established that claimant required 2:1 nursing care, but this was not a service SDRC funded. (OAH No. 2013070454, ALJ Mary Agnes Matyszewski.)

5. On June 26, 2014, claimant requested that SDRC fund “1:1, 24 hours of skilled, not respite, LVN care” (emphasis in original), “2:1 LVN skilled care on Saturday for only 8 hours, so he can safely go into [the] community and attend [the] library for recreation/leisure” (emphasis in original), and “an RN to write a comprehensive plan of care for home care SDRC vendored LVNs to follow.” On July 2, 2014, SDRC issued a Notice of Proposed Action denying claimant’s requests.

Motion to Quash

6. Claimant subpoenaed SDRC to produce records at this hearing. SDRC moved to quash the subpoenas on the grounds that they did not contain the required declarations attesting to good cause for production. Claimant objected on the grounds that the requested records were relevant. SDRC’s motion to quash was granted. The subpoenas did not comport with the laws governing subpoenas.

Evidence Presented at Hearing

7. Claimant is a 25-year-old male diagnosed with epilepsy, autism and severe mental retardation. He resides at home with his family. Claimant participates in the Home and Community-Based Waiver for Individuals with Developmental Disabilities Program (HCBS Waiver Program). In the summer of 2013, claimant was hospitalized for several

weeks after his mother became overwhelmed with caring for him in the home. As a result of that hospitalization, claimant's family was able to procure 24 hour LVN care for claimant by using the funds the family did not spend while claimant was hospitalized. By using those funds after claimant was discharged, the family has been able to purchase 24 hours of 1:1 LVN care per day and an additional eight hours on Saturdays for 2:1 LVN care for community outings to the library. To continue at this current level of care, the family is requesting that SDRC increase claimant's funding from \$219,564 to \$269,160.32.

Claimant's mother testified that the currently-provided level of care has greatly benefited claimant and reduced his maladaptive behaviors; nonetheless, SDRC rejected claimant's request for increased funding. SDRC asserted that there had not been a change in claimant's circumstances to warrant an increase in his respite funding. Claimant responded that he was not seeking an increase in respite, he was requesting nursing care, to which SDRC asserted that it did not fund 24 hour nursing care. Although the issue of SDRC providing nursing care was previously decided in OAH No. 2013070454, SDRC agreed to proceed with this hearing because claimant asserted that OAH No. 2013070454 involved the issue of respite nursing care, and claimant was not seeking respite nursing care in this appeal.

8. Daniel Clark, SDRC Director of Community Services, testified about the SDRC Purchase of Services Standards (POS). He explained that the POS dictates the services SDRC may purchase and fund, as set by the law and approved by SDRC's board of directors. Mr. Clark testified that the nursing care request would fall under the Medical/Dental Services section of the POS. That section lists the generic resources that generally meet the consumer's needs. The POS does not authorize SDRC to fund nursing care to its clients. Mr. Clark acknowledged that claimant does receive LVN respite care, but that service is vendored as respite care. Claimant is requesting 24 hour nursing care, a service that SDRC does not fund.

Mr. Clark also testified that the cost of residential treatment for claimant would be approximately \$8,000 per month, making placement a much more cost-effective option for SDRC. Mr. Clark acknowledged that he was not familiar with the generic resources available to claimant but again explained that 24 hour nursing services were not a service SDRC is authorized to fund. Additionally, Mr. Clark explained that there has been no change in claimant's circumstances that would necessitate an increase in his services.

9. Darrin Trammel, SDRC Program Manager, who was claimant's Program Manager until just recently, testified about his interactions with claimant and his mother. Mr. Trammel found no justification for the requested increase in funding of services. He testified that SDRC is providing sufficient funding, at \$219,564 of LVN respite services, to meet claimant's needs. Mr. Trammel testified that SDRC vendors nurses to perform assessments, not plans of care. Mr. Trammel pointed out that although there are physician notes referencing a need for 2:1 services, none of them mention requiring that service on a continuous basis, nor do they mention that it be two LVNs who provide the assistance. Mr. Trammel refuted claimant's contention that he was a unique SDRC client, as there are many other SDRC clients with similar needs. Mr. Trammel acknowledged that \$219,564 was an insufficient amount to maintain the current level of services being offered to claimant; 1:1

LVN care 24 hours per day and 2:1 LVN care on Saturdays for community outings. At his current rate of services, claimant will run out of funding in approximately April of next year. However, Mr. Trammel testified about Deflection Homes, a provider that could meet claimant's needs and would be much more cost-effective for SDRC.

10. Lori Sorenson, SDRC Regional Manager for North County, testified that the HCBS Waiver Program contains an Appendix outlining the services for which states may bill the federal government. Ms. Sorenson testified that the list contained several services SDRC does not fund and that nothing requires SDRC to provide the services contained on the list; it merely identifies services for which SDRC can seek federal reimbursement.

11. Kathy Karins, R.N., SDRC Nursing Supervisor, testified that SDRC does not vendor nurses to write comprehensive plans of care or to go into the clients' homes and perform periodic reviews. Instead, SDRC utilizes nurses to perform one-time assessments of clients to assist in developing IPPs. The HCBS Waiver Primer and Policy Manual, prepared by the Department of Developmental Services, outlines the roles and responsibilities of the various governmental participants, including regional centers. The manual provides that the terms "plan of care" and "Individual Program Plan (IPP)" are synonymous. Ms. Karins testified that SDRC's IPP for claimant satisfies the HCBS requirement that he have a plan of care; therefore, there is no need to have a nursing plan of care prepared.

12. Claimant submitted a letter from his Kaiser physician that he "would benefit from a written plan of care from an RN." However, there was no showing that claimant's IPP was insufficient to address his medical needs. Other documents stating he required two people to catheterize him did not indicate that the two persons must be LVNs and the catheterization was not continuous, as it was performed every few hours.

13. Group home assessments contained conclusions that "claimant would likely require a 2:1 staffing ratio." However, the conclusions are questionable because, only one LVN assisted claimant during the several hours of hearing, lending credence to SDRC's position that 1:1 staffing was sufficient to meet claimant's needs. Moreover, SDRC may properly consider the extent to which claimant's parents are natural supports when determining the necessity that an LVN be present 24 hours.

14. Claimant's mother testified about her son's unique needs and asked that SDRC "think outside the box" and come up with creative ways to fund 24 hour, 1:1 care. She asserted that she was asking for the "bare minimum" for her son and that he has improved greatly with his current level of 24 hour, 1:1 care. Claimant also has greatly enjoyed his community outings on Saturdays, and it would be very detrimental to him to take those outings away from him. Claimant's mother explained how placing her son in a facility concerns her, given the injuries he sustained during a prior placement attempt. She described the array of amenities available to claimant at their home and worried he would not have those in a group home. However, she was amenable to discussing placement in the future. She requested a nursing plan of care because she feared that too many LVNs caring for her son could cause confusion in the continuity of his care. However, she offered no evidence to demonstrate that her fears had ever come to fruition.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. “Burden of proof” means the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court; except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evid. Code, § 115.) In this matter, claimant had the burden of establishing that he was entitled to the services being sought.

The Lanterman Act and Regional Centers

2. The Legislature enacted a comprehensive statutory scheme known as the Lanterman Developmental Disabilities Services Act (the Lanterman Act), which is found at Welfare and Institutions Code section 4500 et seq.

3. The Lanterman Act provides a pattern of facilities and services sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life. The purpose of the statutory scheme is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community; and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (*Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388.)

4. The Department of Developmental Services (DDS) is the public agency in California responsible for carrying out the laws related to the care, custody and treatment of individuals with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code, § 4416.) In order to comply with its statutory mandate, the DDS contracts with private non-profit community agencies, known as “regional centers,” to provide developmentally disabled consumers with “access to the services and supports best suited to them throughout their lifetime.” (Welf. & Inst. Code, § 4620.)

5. A regional center’s responsibilities to its consumers are set forth in Welfare and Institutions Code sections 4640-4659. Regional centers must meet consumer’s needs and be cost-effective.

Evaluation

6. Following his hospital discharge, claimant’s LVN respite services “morphed” into 24 hour, 1:1 LVN care, with eight hours of 2:1 LVN care on Saturdays. Maintaining that level of service will cost \$269,160.32 per year, an amount that exceeds the previously agreed upon yearly sum of \$219,564. While maintaining claimant in his home is admirable, appropriate group homes will cost approximately \$96,000 annually. Although claimant may require additional services while in the group home, it is doubtful that those services will surpass the currently agreed upon sum of \$219,564. As the Legislature has required regional

centers to be cost-effective in their use of public funds, funding claimant's current request would violate that mandate, absent a showing of a change in needs.

Respite is intended to be a temporary break for caregivers. It is not intended to be 24 hour care. Parents are natural supports and there should be times when they do not receive payment for providing care. Claimant's request for 24-hour care seeks funding to which he is not entitled. His request for 24-hour nursing care seeks a service SDRC does not fund.

Furthermore, Welfare and Institutions Code section 4648.5 suspended regional centers' authority to purchase social recreation services absent an exemption. Claimant attends a day program, and there was no showing that the requested Saturday library outings are the "primary or critical means for ameliorating" his disability, or that they are necessary to enable him to remain in his home and that no alternative services are available to meet his needs. Claimant's mother's testimony about those outings was insufficient to qualify for an exemption. Thus, the request for funding for those outings is denied.

A preponderance of the evidence did not establish that SDRC should have an RN write a comprehensive plan of care. SDRC does not vendor nurses to provide comprehensive plans of care or to go into clients' homes and perform periodic reviews. Claimant has a plan of care, his IPP. The evidence did not establish that it did not adequately address his medical needs or that his LVNs needed RN supervision in order to perform their tasks. Claimant's argument that too many LVNs could cause confusion in the continuity of claimant's care was speculative. No evidence demonstrated that claimant had not received quality care from his LVNs. In fact, claimant's mother was quite complimentary of the current team of LVNs assisting her son.

ORDERS

Claimant's appeal is denied. SDRC shall not fund 24 hours of 1:1 LVN services for claimant. SDRC shall not fund eight hours of 2:1 LVN services on Saturdays so claimant can go into the community and attend the library for recreation/leisure. SDRC shall not have a registered nurse write a comprehensive plan of care.

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within ninety days.

DATED: September 15, 2014

_____/s/_____
MARY AGNES MATYSZEWSKI
Administrative Law Judge
Office of Administrative Hearings