BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

SAN DIEGO REGIONAL CENTER

Service Agency

OAH No. 2019091087

DECISION

Adam L. Berg, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on January 13, 2020, in San Diego, California.

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

Claimant's mother represented claimant.

Oral and documentary evidence was received. The record was closed and the matter submitted for decision on January 13, 2020.

ISSUE

Should SDRC change claimant's in-home respite care from its current level of Licensed Vocational Nurse (LVN) to non-medical respite care and increase the respite care hours to 100 per month?

FACTUAL FINDINGS

Background

1. Claimant is an 11-year-old boy who qualifies for regional center services based on diagnoses of intellectual disability, cerebral palsy, and epilepsy. Claimant lives at home with his parents and sister. Claimant is medically fragile and requires care 24 hours per day. SDRC provides four hours per month of LVN in-home respite. Claimant also receives 283 hours per month of In-Home Supportive Services (IHSS). Claimant's mother is the IHSS provider. Claimant is insured through Medi-Cal through the Medicaid Waiver Institutional Deeming program.

2. On September 17, 2019, SDRC served claimant with a Notice of Proposed Action denying claimant's request to change his LVN-level respite to non-medical respite, which is also known as "sitter-service" respite. As the basis for its action, SDRC stated that a nursing health assessment completed on August 29, 2019, recommended LVN level of care.

3. On September 27, 2019, claimant filed a fair hearing request appealing SDRC's decision not to change the level of respite care. In support of her request, claimant's mother stated that LVN-level of care is not needed and there are no appropriate caregivers who can meet the family's needs.

4. On November 4, 2019, SDRC held an informal meeting with claimant's mother. Following the meeting, SDRC adhered to its determination not to change the level of respite care from LVN to non-medical level. At the meeting, claimant's mother requested an increase in respite hours from four hours per month to 100 hours per month. In response to this request, SDRC approved an increase to 60 hours per month for six months.

5. At the hearing, SDRC agreed that claimant's request to increase his respite hours to 100 per month could be adjudicated, despite the fact that the request was made at the informal meeting. Thus, the issue to be determined is whether IRC must fund non-medical respite and increase the hours to 100 per month.

Evidence Presented by SDRC

6. Neil Kramer, SDRC Fair Hearings Manager, testified at the hearing. As the Fair Hearings Manager, he is SDRC's Executive Director's designee for decisions involving fair hearings. Mr. Kramer testified that SDRC denied claimant's request because a nursing assessment recommended LVN-level respite care. Because of the level of care claimant requires, SDRC is prohibited under Welfare and Institutions Code section 4686 from funding non-medical respite care. Under that statute, an in-home respite worker who is not a licensed health care professional may perform "incidental medical services" for regional center consumers with stable conditions, but only after successful completion of a Department of Developmental Services (DDS) training program performed by a respite agency. In this case, claimant asks that the respite hours be performed by his uncle, who has not undergone the required training. Even if the uncle were trained in incidental medical services, Mr. Kramer testified that SDRC's nursing assessment determined that LVN level of care is required. However, he agreed to increase the funded LVN hours to 60 hours per month based on the understanding

that claimant could apply for nursing services through a Medi-Cal program, which would provide up to 40 hours per month of nursing services.

7. Janet Friehofer, RN, BSN, is SDRC's registered nurse clinician. She has held that position for the past 27 years. She has been licensed as a registered nurse since 1986. In response to claimant's request that SDRC change the level of respite care, a nursing assessment was completed on August 29, 2019. Ms. Friehofer reviewed the assessment, which was conducted by SDRC contractor Maria Vella, RN, BSN. After reviewing the assessment, Ms. Friehofer performed her own assessment at claimant's home on September 11, 2019. The following summarizes her assessment:

Claimant is non-verbal and non-ambulatory. He receives all of his nutrition/fluids via a J-tube port and medications through a G-tube port. His feedings are given 24 hours per day by a pump. Claimant wears a pulse oximeter 24 hours per day and uses supplemental oxygen by mask as needed. According to claimant's mother, he requires oxygen two or three times per week and 24 hours per day when he is ill. He also requires shallow oral suctioning about five to six times per hour and deep suctioning every three to four hours when he is ill. Claimant also receives nebulizer treatments, that are given every four hours when he ill. He wears a chest therapy vest to assist with coughing that is used twice daily. Because claimant is non-verbal, claimant's mother relies on claimant's pulse rate and oxygen saturation to determine if he is ill. Claimant has intractable epilepsy. He has up to 25 seizures per day. He has had previous hospitalizations due to seizures and has been on life support as a result. If a seizure lasts longer than five minutes, claimant's mother administers Diastat rectal gel, which is usually effective. This occurs approximately once per week. If the Diastat is ineffective, claimant's mother administers Lorazepam. Claimant requires total care for all of his daily life activities. He requires diligent skin care and

repositioning. Based on claimant's medical condition, Ms. Freihofer recommended LVN-level respite care.

8. Shelia Minick is claimant's Service Coordinator. Prior to taking a position as a service coordinator, Ms. Minick worked in SDRC's federal programs unit, so she is very familiar with the requirements of various Medi-Cal programs. Ms. Minick testified there are two generic resources that could possibly provide nursing services if claimant to were apply. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program through Medi-Cal provides benefit for children under the age of 21 who receive full-scope Medi-Cal benefits, as does claimant. EPSDT is a generic resource that provides up to 40 hours per month of nursing care. In addition, the Home and Community-Based Alternatives (HCBA) waiver program allows Medi-Cal beneficiaries to receive services that will allow them to live outside an institution. This program may also fund nursing services and allows flexibility for claimant to select providers.

9. Ms. Minick informed claimant's mother about nursing services that can be offered through EPSDT and HCBA that could provide significantly more hours and expanded options for locating nursing services. However, both programs require applications and approvals. Claimant's mother indicated she is not interested in either program. She told Ms. Minick that she did not believe a nurse could meet claimant's needs, and has also had problems with finding nurses able to come at the time she needs and working consistently. She also expressed concern about having a stranger providing care that could expose claimant to germs. One of the reasons SDRC denied claimant's request is because he has not pursued generic resources.

10. Up until this point, SDRC has funded four hours per month of LVN-level respite. However, the primary purpose of the funding is to maintain Medi-Cal eligibility under a waiver program that provides Medi-Cal for families exceeding the income

level. Claimant does not utilize the full four hours per month. Currently, no individual is providing respite care for claimant. After SDRC increased the respite hours to 60 per month, Ms. Minick reviewed an updated vendor list for LVN services with the hope of finding a resource that could fill the 60 hours. She identified several possibilities of vendors. However, claimant's mother indicated her desire to wait until the fair hearing is resolved.

Claimant's Evidence

11. Claimant's mother testified that she has been unable to find LVNs who are able to work the times she needs and who are consistent. The requirement that claimant receive LVN-level care is onerous and preventing her from obtaining the help she needs. Funding sitter-level respite would allow her flexibility to have a family member care for claimant. In addition, claimant is heavy and requires lifting. Claimant's mother doubts a woman is able to handle the task, and because of cultural reasons, it would be inappropriate to have a male in the house alone. Claimant's mother is willing to sign anything to release SDRC from liability for not electing LVN-level care. In support of this, she submitted a waiver and release from Inland Regional Center, which authorizes a consumer to waive LVN or higher level of care. She believes that SDRC should be consistent with other regional centers in allowing a consumer to waive the higher level of care requirement.

12. Claimant submitted three letters from his physicians, each noting that claimant's family has been unable to secure a vendor for LVN-level respite services. Each physician wrote that claimant would benefit from increased respite hours that could be performed by another family member who could be appropriately trained to provide care to claimant.

LEGAL CONCLUSIONS

Burden of Proof

1. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard is a preponderance of the evidence. (Evid. Code, § 115.)

Relevant Law and Regulations

2. The Legislature enacted a comprehensive statutory scheme known as the Lanterman Act (Welf. & Inst. Code, § 4500 et seq.) to provide 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. (*Assn. for Retarded Citizens v. Dept. of Developmental Services* (1985) 38 Cal.3d 384, 388.) Welfare and Institutions Code section 4501 outlines the state's responsibility for persons with developmental disabilities and the state's duty to establish services for those individuals.

3. 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, DDS contracts with private non-profit community agencies, known as "regional centers," to provide the developmentally disabled with "access to

the services and supports best suited to them throughout their lifetime." (Welf. & Inst. Code, § 4620.)

4. Welfare and Institutions Code section 4512, subdivision (b) defines "services and supports" as:

[S]pecialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option . . . Nothing in this subdivision is intended to expand or authorize a new or different service or support for any consumer unless that service or support is contained in his or her individual program plan.

5. A regional center's responsibilities to its consumers are set forth in Welfare and Institutions Code sections 4640-4659.

6. Welfare and Institutions Code section 4646 requires that the Individual Program Plan and the provision of the services and supports be centered on the individual with developmental disabilities and take into account the needs and preferences of the individual and the family. Further, the provisions of services must be

effective in meeting the IPP goals, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources.

7. Welfare and Institutions Code section 4646.4, subdivision (a), requires regional centers to establish an internal process that ensures adherence with federal and state law and regulation, and when purchasing services and supports, ensures conformance with the regional center's purchase of service policies.

8. Welfare and Institutions Code section 4648 requires regional centers to ensure that services and supports assist individuals with developmental disabilities in achieving the greatest self-sufficiency possible and to secure services and supports that meet the needs of the consumer, as determined by the IPP. This section also requires regional centers to be fiscally responsible.

9. A regional center may, pursuant to vendorization or a contract, purchase services or supports for a consumer in order to best accomplish all or any part of the IPP. (Welf. & Inst. Code, § 4648, subd. (a)(3).)

10. The regional center is also required to consider generic resources and the family's responsibility for providing services and supports when considering the purchase of regional center supports and services for its consumers. (Welf. & Inst. Code, § 4646.4.)

11. The regional center is required to identify and pursue all possible sources of funding for consumers receiving regional center services, including governmental entities such as Medi-Cal. (Welf. and Inst. Code, § 4659, subd. (a).) A regional center is prohibited from purchasing services available from generic resources, including Medi-Cal, "when a consumer or family meets the criteria of this coverage but chooses not to pursue this coverage." (*Id.* at subd. (c).)

12. Welfare and Institutions Code section 4686 provides:

> (a) Notwithstanding any other provision of law or regulation to the contrary, an in-home respite worker who is not a licensed health care professional but who is trained by a licensed health care professional may perform incidental medical services for consumers of regional centers with stable conditions, after successful completion of training as provided in this section. Incidental medical services provided by trained in-home respite workers shall be limited to the following:
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> (1) Colostomy and ileostomy: changing bags and cleaning stoma.
>
> (2) Urinary catheter: emptying and changing bags and care of catheter site.
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> (3) Gastrostomy: feeding, hydration, cleaning stoma, and adding medication per physician's or nurse practitioner's orders for the routine medication of patients with stable conditions.
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> [¶] . . . [¶]
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> (c) The training in incidental medical services required under this section shall be provided by physicians or registered nurses. . . .
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> [¶] . . . [¶]

(d) The in-home respite agency providing the training shall develop a training protocol which shall be submitted for approval to the State Department of Developmental Services.

[¶] . . . [¶]

(f) The treating physician or surgeon shall give assurances to the regional center that the patient's condition is stable prior to the regional center's purchasing incidental medical services for the consumer through an appropriately trained respite worker.

(g) Prior to the purchase of incidental medical services through a trained respite worker, the regional center shall do all of the following:

(1) Ensure that a nursing assessment of the consumer, performed by a registered nurse, is conducted to determine whether an in-home respite worker, licensed vocational nurse, or registered nurse may perform the services.

(2) Ensure that a nursing assessment of the home has been conducted to determine whether incidental medical services can appropriately be provided in that setting.

Evaluation

13. Claimant had the burden to show by a preponderance of the evidence that SDRC should fund non-medical level respite and increase the hours to 100 per

month. Claimant failed to meet his burden. After performing two nursing assessments, SDRC determined that LVN-level of care is required for respite workers. Given the evidence regarding claimant's medical needs, this determination was reasonable and appropriate.

Welfare and Institutions Code section 4626 permits a respite-worker who is not a licensed medical professional to perform incidental medical services if the person receives proper training through a respite agency. Assuming that claimant's preferred respite provider (his uncle) was able to obtain this training from a respite agency, SDRC would still not be able to fund sitter-level service. First, subdivision (g), requires a regional center to conduct a nursing assessment to determine whether incidental medical services can appropriately be provided. As noted, SDRC's assessment concluded that it cannot. Next, subdivision (a), limits incidental medical services to certain tasks. Not included in this list of tasks are: administering oxygen, administering nebulizer treatments, administering medication during seizures, and suctioning – tasks that claimant's mother currently, and regularly, performs. As such, claimant requires care that exceeds the level of incidental medical services. Finally, the treating physician must give assurances to the regional center that claimant's condition is stable prior to the regional center's purchasing incidental medical services for the consumer through an appropriately trained respite worker. (*Id.* at subd. (e).) Here, none of the physician letters addressed the level of care that is required for claimant, only that claimant should be able to choose a trained respite provider. A physician has no authority to permit unlicensed individuals to perform skills that fall within the practice of vocational nursing.

Although claimant's mother argued that other regional centers permit consumers to sign a release and waive liability in order to select a lower level of respite

care when a higher level of care has been assessed, SDRC does not permit such waivers. There are multiple regional centers, each of which has its own policies and procedures. So long as the regional center complies with the Lanterman Act and regulations, a regional center is free to enact policies as it chooses. SDRC's decision not to permit a consumer to waive a higher level of respite is squarely in accordance with the Lanterman Act.

With regard to claimant's request to increase respite hours to 100 per month, SDRC is prohibited from purchasing services available from generic resources, including Medi-Cal, "when a consumer or family meets the criteria of this coverage but chooses not to pursue this coverage." (Welf. & Inst. Code, § 4659, subd. (c).) There are two generic resources that could potentially provide nursing services (and expand the scope of available providers). However, claimant's mother does not wish to apply. Although she cites several reasons why she has found nursing services to be lacking, this does not obviate the requirement that claimant first utilize all available generic resources. Finally, it appears that claimant's request to increase the hours is based only on the condition that a sitter-level worker will be funded. As claimant has not regularly used the four hours of respite that has already been approved, there is no justification in further increasing the hours beyond the 60 that SDRC has agreed to fund.

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ORDER

Claimant's appeal from San Diego Regional Center's determination that it will not fund non-medical respite care and increase the hours to 100 per month is denied.

DATE: January 24, 2020

ADAM L. BERG
Administrative Law Judge
Office of Administrative Hearings

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 90 days.