BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Consolidated Matters of:

CLAIMANT

v.

HARBOR REGIONAL CENTER,

Service Agency

OAH Nos. 2020011161, 2020050525

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter remotely by video and teleconference on April 12 and 28, 2021.

Latrina Fannin, Manager of Rights and Quality Assurance, represented Harbor Regional Center (HRC or Service Agency).

Johnanthony Alaimo, Attorney at Law, Office of Clients' Rights Advocacy, represented claimant, who was not present.[1]

At hearing, the parties stipulated that the ALJ may issue a single decision covering both consolidated cases.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on April 28, 2021.

ISSUE

Is the Service Agency required under the Lanterman Developmental Disabilities Services Act (Lanterman Act) to fund a rehabilitation aide for claimant?

EVIDENCE RELIED UPON

Documents: Service Agency's exhibits 2-14; claimant's exhibits 1, 3, 5-8, 10-18, 22, 24, and 25.

Testimony: Jessica Guzman; Ahoo Sahba, M.D., Seka Metran; Pam Hellman; Katheryn Kassai; Kelli Smith; claimant's mother; claimant's father.

[1] Family and party titles are used to protect claimant's privacy.

FACTUAL FINDINGS

Parties and Jurisdiction

1. Claimant is a 23-year-old conserved woman who lives at home with her parents, who are her conservators. Claimant is nonverbal but utilizes a speech-generating device operated by her eye gaze to communicate. She is unable to walk and uses a wheelchair for mobility. She is eligible for regional center services due to diagnoses of Cerebral Palsy (CP), intellectual disability (ID), and seizure disorder.

2. During a series of several Individualized Program Plan (IPP) meetings in May 2020, without an IPP being finalized, on May 11, 2020, claimant's mother filed a Fair Hearing Request, seeking to require that HRC provide "gap funding" for occupational therapy (OT), physical therapy (PT), and para-educator services, as claimant was scheduled to transition out of her school district in June 2020 and would lose those services.

3. In a decision letter dated May 29, 2020, HRC denied claimant's request, writing that claimant's "Medi-Cal managed health care plan needs to be explored before HRC can consider funding for such therapies." (Ex. 5, p. 2.) HRC cited as authority for its position Welfare and Institutions Code sections 4659, subdivision (c).

4. This hearing ensued.

Claimant's Services and Service Requests

5. Claimant aged out of school in June 2020. Her final school district Individualized Education Plan (IEP) provided for her to OT, PT, and an aide, whom the school district referred to as a "para-educator," to assist in providing OT and PT. Near

the close of the school year, claimant asked HRC to continue funding those three services as an interim measure to prevent any gap until claimant could secure the services through HRC or through generic sources of funding. HRC would not fund the OT and PT until generic sources of funding were exhausted. HRC never agreed to fund someone to fill the role of the para-educator.

6. Ultimately, HRC agreed to fund OT and PT services as soon as the providers become HRC vendors. HRC approved three and one-half hours of OT and four and one-half hours of PT per week. As of the hearing date, the vendorization process is nearly complete.

7. HRC disputes, however, the need for a rehabilitation aide and has refused funding for that service. Claimant argued she is failing to reach her IPP goal of good health due to the lack of funding for a rehabilitation aide over the past 10 months. Her strength, endurance, and range of motion have all suffered. Claimant wants HRC to fund for a rehabilitation aide to provide services 40 hours weekly, and she wants HRC to vendor the aide who has worked with claimant in the past.

8. In addition to HRC funding 40 hours of monthly respite, claimant receives 283 hours of In-Home Support Services and 77 hours per month of a Home and Community Based Alternatives (HCBA) waiver, including a waiver of personal care services (WPCS), funded by Medi-Cal. The waiver allows additional personal care hours for companionship, community outings, and activities of daily living. Daily, claimant receives 16 hours of LVN services through the HCBA waiver. This totals approximately 28 hours of support per day, excluding the additional eight total hours of PT and OT that HRC has approved.

Service Agency's Assessment of Claimant's Service Needs

9. Jessica Guzman, Client Services Manager for HRC's Adult Department, supervises 11 service coordinators, one of whom, Anthony Foner de la Cruz, is claimant's service coordinator. The service coordinator is claimant's primary contact at HRC, and helps the family access and advocate for services and supports, including from generic sources of funding such as school districts, In-Home Supportive Services (IHSS), and Medi-Cal.

10. Ms. Guzman testified that she and Mr. de la Cruz wrote HRC's May 29, 2020 decision letter, after HRC performed a comprehensive assessment of claimant's request for funding. Claimant requested funding for a rehabilitation aide (rehab aide) for 40 hours per week. A rehab aide is not licensed; he or she provides support to a licensed therapist in accordance with the plan of care. The position requires stamina (clients typically have limited mobility) and a good bedside manner.

11. HRC believes the IHSS worker and the LVN could serve the requested function and assist the occupational therapist and physical therapist with claimant's home exercise program.

12. HRC also has concerns about claimant's daily exercise schedule, specifically about the frequency and duration of therapies and the level of support the rehab aide would provide. Concerned the program might be too strenuous for claimant, HRC's consultants asked to speak to claimant's neurologist to understand the prescription for these therapies. The family did not consent. HRC's OT consultant asked to speak to claimant's OT provider of many years, but the family allowed only written questions to be submitted. Ms. Guzman and Mr. de la Cruz have requested records from claimant's family, but the family has provided only partial records,

making it difficult to do an accurate assessment. The family wants to be involved in all phone conferences. Ms. Guzman has tried to call the family many times, but the family is mistrustful and will not take her calls, so she has to communicate by email.

13. Claimant's mother, who is the IHSS worker, can assist claimant in implementing her home exercise program using IHSS non-medical personal services hours. Over 57 hours per week are allocated for non-medical personal services such as ambulation, transferring, rubbing skin, repositioning, and helping with prosthetics. The WPCS worker can also assist.

14. Ms. Guzman believes claimant is meeting her goal of remaining in good general health. But HRC's medical team does not have access to claimant's physician.

15. Ms. Guzman testified that HRC discovered after the fact, from claimant's OT provider, that claimant's therapy services ended in August 2020. By letter dated September 1, 2020, claimant's medical insurer denied coverage for OT, PT, and rehab aide services. With no generic source of funding for OT and PT, HRC agreed to fund those services. HRC did not agree to fund a rehab aide.

16. Ahoo Sahba, M.D., a board-certified pediatrician and physician consultant to HRC since 2017, reviewed claimant's medical records, which he characterized as limited and old. Claimant is medically fragile, quadriplegic, with CP and intractable epilepsy, idiopathic scoliosis, and hip subluxation. She has incontinence of bowel and bladder and other conditions. Dr. Sahba believes claimant is most likely receiving adequate support, but he cannot confirm that without being allowed either to speak to claimant's neurologist or to see claimant's current medical records. Dr. Sahba asked to speak with Dr. Joyce Matsumoto, claimant's neurologist. Dr. Sahba agrees with Dr. Matsumoto that claimant's current rehabilitation program benefits claimant greatly,

but he wants to learn from her whether too much strenuous physical activity may be causing stress and exhaustion, worsening claimant's seizures. The family, however, would not consent to contact. Dr. Sahba does not believe claimant needs two-to-one services, based on a five-year-old nursing assessment. If claimant's condition has changed since that assessment was performed, and the service is necessary, Dr. Sahba believes claimant's current IHSS worker and the LVN can provide the service.

17. Seka Metran, an occupational therapist, provided consultation services to HRC regarding claimant's case. She testified she cannot understand what activities claimant would engage in without the licensed therapist, solely with the rehab aide, for 40 hours per week. A skilled therapist is required for any skilled therapy, and a rehab aide is not qualified. Certain exercises performed by the rehab aide and LVN should have been performed with a licensed therapist instead, depending on goals, because the licensed person can adjust the program based on how claimant is reacting. If claimant requires the exercises in her program daily, then she needs a physical therapist or occupational therapist every day. The rehab aide should implement the exercise program under the direct supervision of a physical therapist. Ms. Metran testified that certain activities in the program do not require two people, e.g., stretching and working on fine motor skills, so there is a need for rehab aide during only part of the 40 requested hours.

18. Pam Hellmann, an occupational therapist, consulted with HRC on this case. She testified that rehab aides usually work in a clinic environment, performing clerical tasks to help management or preparing a session for therapy. Claimant's exercise program requires a certified OT or PT assistant to help the paraprofessional, someone who has completed a licensing program. A rehab aide is not qualified to perform those tasks. Ms. Hellmann testified she is very concerned about sending an

unlicensed person to help a very medically fragile girl without the paraprofessional on site. Only a licensed assistant can provide clinical treatment. Given that claimant has between five and 15 grand mal seizures per day, she requires well-trained individuals helping her with her program. Ms. Hellmann asked to speak directly to claimant's OT and PT providers, but the family would not provide their consent. Ms. Hellmann questions whether it is necessary for more home programming after a full morning of therapy sessions, especially when fatigue brings on seizures. Without the presence of the physical therapist, an unlicensed person, such as the IHSS worker or LVN, could perform some of the low tech, sit to stand, exercises in the program, but not the portions of the program requiring the use of specialized equipment.

Claimant's Providers' Assessments of Claimant's Service Needs

19. Katheryn Kassai, PT, a physical therapist for 43 years, owns an outpatient PT clinic. She worked with claimant from July 2018 to June 2020, and did not see her again until Ms. Kassai conducted a PT evaluation of claimant two weeks before this hearing. Ms. Kassai testified that claimant is the most medically fragile, functionally limited patient she has ever worked with.

20. Without the home exercise program, claimant's life is under threat. Her heart gets weakened without exercise, and claimant relies on movement to clear her lungs. She suffers from painful constipation, leading her to eat less, and leading to worse seizures. Claimant's osteoporosis worsens, because there is no axial loading to stimulate her bones. Mobility is important for anyone, but especially for claimant. Ms. Kassai met with HRC in April 2020 and again in early 2021 to request services to avoid a nine-month lag after school terminated.

21. Ms. Kassai testified she cannot effectively provide PT services to claimant without a rehab aide. "Rehab aide," Ms. Kassai testified, is synonymous with "para-educator," the term claimant's school used for claimant's aide.[2] Ms. Kassai described the type of work a rehab aide would be expected to perform for claimant to help implement her home exercise program. The rehab aide would work with claimant on daily mobility, getting her out of bed and into and out of her wheelchair. The rehab aide would work under the close supervision of the paraprofessionals, i.e., the occupational therapist and the physical therapist. Ms. Kassai believes the rehab aide should have a college degree.

22. Claimant weighs only 70 pounds now, having lost a lot of weight and muscle mass since Ms. Kassai last treated her. There has been what Ms. Kassai described as a "devastating" regression from claimant's condition when Ms. Kassai last provided therapy to her in June 2020. Two weeks ago, claimant could not even keep her head up, lift her legs, or shift her weight.

23. While the physical therapist or occupational therapist is providing therapy, the rehab aide will assist; outside that time, the rehab aide would take the lead, with the assistance of the LVN. This is how claimant's school program was implemented for years. Ms. Kassai will not provide therapy without a rehab aide. The aide has to lift and carry the equipment, assist during sessions, and otherwise carry out

[2] Ms. Kassai claimed to have invented the title and job description of "rehab aide." Other witnesses more credibly testified that the term "rehab aide" is in common use. Ms. Kassai's claim is not credited. This does not affect the credibility of the remainder of her testimony, which was detailed and corroborated in part by documentation and other witnesses' testimony.

the home exercise program. Many exercises require two skilled people to safely perform. Ms. Kassai testified it would be a waste of time for her to visit claimant if the rehab aide is not there. Ms. Kassai testified that claimant's mother is too infirm and lacks the strength to work as the rehab aide, and can only perform very light work while claimant is in bed.

24. If the LVN is available and is capable of lifting and carrying claimant, the LVN could assist Ms. Kassai. But lifting an 83-pound girl, or now a 70-pound girl, is not an LVN job qualification, and Ms. Kassai believes almost no LVN would be interested in the job. The current LVN has not walked with claimant in months. He requires a second person's assistance, especially in case claimant has a seizure. The LVN, who provides 16 hours of service per day, has too many tasks other than exercise to perform with claimant, such as bathing, preparing meals, feeding, diapering, and writing progress notes. The LVN could, according to Ms. Kassai, assist but could not replace the rehab aide.

25. Ms. Kassai alternates with the OT provider, each servicing claimant on two different days each week. After the hours of rehabilitation, claimant stays in bed and recovers. Ms. Kassai testified that the rehab aide will work with both paraprofessionals on tasks that require two people. In addition, the rehab aide must start to prepare claimant one hour before the paraprofessional begins, and remove equipment after the paraprofessional concludes. For an additional five or six hours per week, the rehab aide will help claimant with simple mat stretches, an activity requiring only one person. Without the rehabilitation activity, claimant would be bedridden 16 hours per day during the week and 24 hours per day on weekends.

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26. Kelli Smith, OT, testified concerning claimant's needs with respect to a rehabilitation aide and with respect to the training and experience necessary to provide that service. Ms. Smith has been claimant's occupational therapist, on and off, for the past 12 years, both as a school-based therapist at claimant's high school and as a center-based therapist, and supervising occupational therapists, at Abundance Therapy.

27. Ms. Smith testified that a rehab aide performs the same tasks the para-educator did at school. Ms. Smith worked with the para-educator, training him in motor tasks, feeding, positioning, and equipment for endurance, strength, postural control, mobility, and function. Over the past six years, Ms. Smith has also trained nursing staff in claimant's life. She recommends 40 hours per week of a skilled rehab aide for claimant; during the 40 hours, the rehab aide will help with OT, PT, and all the daily living aspects of her care of claimant.

28. Ms. Smith testified that claimant needs a rehab aide whom the paraprofessionals have trained on the use of braces and splints and on preparatory activities. This will allow claimant to work toward her goals and increase her levels of function, not just maintain her current level. The rehab aide will, alone, get claimant up and fed and ready, with splints on. The therapist will arrive and get claimant out of her splints. The rehab aide will do diapering and address seizures during the session, and then get claimant ready for her next daily living activity, such as her next meal. Most of the rehab aide's activity is getting claimant's splints and braces on, getting claimant ready for home exercise, helping during the exercise activity (e.g., oral motor exercises), and then getting her ready for other activities of daily living such as eating and showering.

29. According to Ms. Smith, only one person is needed to prepare claimant for exercises that require two people. But most of the home OT program cannot be done with only one person. To move toward more volitional control by claimant and increase her endurance and postural control requires exercises that need two people.

30. Ms. Smith is concerned claimant currently has endurance only for smaller amounts of activity throughout the day. She will require more rest breaks to get her back into form so she can tolerate upright positions. Claimant tolerated up to two hours of therapy before needing a 20- to 30-minute rest break, after which she would be prepared for the next activity. But claimant has been without consistent therapies now for almost a year. A home exercise program for claimant is medically necessary. And a rehab aide is necessary for claimant to succeed in her therapy goals.

31. Ms. Smith does not currently provide services to claimant. Funding for OT ended in June 2020, and her vendorization process began in January 2021. She just completed the vendorization process last week and has not yet received HRC authorization to provide services. Ms. Smith trained all claimant's staff and providers, including the LVN. The LVN's duties differ from those of a rehab aide; the LVN is in charge of more medical-related activities, changing claimant's clothes or diapers, and helping with showering. An LVN should not be tasked with implementing the exercise program. A rehab aide here must perform prep exercises to allow claimant to attend and function at her daily activities, including getting claimant's body ready for the day, working on range of motion, getting claimant into splints and braces, and getting her upright for feeding. For OT services, Ms. Smith would want the rehab aide to carry over the oral motor exercises from meal preparation and other exercise routines when skilled providers are not there, as well as to be the second person when the occupational and physical therapists are there.

32. To help her deliver OT services, Ms. Smith testified she would typically hire a certified OT assistant who has undergone schooling for this program. This corroborates Ms. Hellman's testimony about the qualifications required for someone funded to help paraprofessionals. But to carry over claimant's school program, Ms. Smith's agency has been using the paraeducator and the LVN, and has trained them. Ms. Smith would not otherwise hire them for her OT team, considering it less than ideal to do so, but claimant has come to Ms. Smith with her own team of providers, so Ms. Smith has trained them on postural control, passive range of motion exercises, positioning in bed, and other matters. Ms. Smith cannot train the LVN to implement the home exercise program alone, just the passive exercises that are safe for one person to perform. Active exercises require two people, one of whom should be a rehab aide and the other of whom should be a skilled provider. But again, though not ideal, the second person, who helps the skilled provider, could be an LVN, if properly trained.

Claimant's Parents' Assessment of Claimant's Service Needs

33. Claimant's mother testified claimant requires 24 hours of care seven days per week. In typical day, she likes to interact with people; she is mostly content except when in pain or having a seizure. She likes routine, and loves her therapist and nurse. The physical activities are a challenge for her but are essential to prevent further disabling conditions associated with CP. Claimant has nursing care during the day but none at night. Claimant's mother provides coverage for all hours not covered by any other professionals, i.e., night and early morning. She also assists as needed during the day. Claimant takes three seizure medications and has an implanted device to help regulate seizures. Most of claimant's grand mal seizures occur at night, with fewer occurring during the day. Claimant's mother must keep claimant safe during seizures

and must administer oxygen from a generator to help claimant recover. Claimant sweats during seizures and must have her clothes changed. Claimant also has bowel and bladder incontinence.

34. Claimant's health has regressed since June 2020. Lack of exercise has caused muscle wasting, affecting her functioning. Continuous effort is required to keep claimant's muscles active and working. Currently, claimant's LVN works 16 hours per day, starting at 6:00 a.m.; the LVN's hours are being reduced to 13.5 per day.

35. Claimant's mother admitted she and her husband did not sign consent forms for HRC's occupational therapist and medical doctor to speak to claimant's providers. She did not offer a reasonable justification for her failure to sign. She did, however, testify she only learned of Dr. Sahba's request on the first day of this hearing.

36. Nor did claimant's mother offer a reasonable justification for her failure to sign an IPP for claimant since 2018. Her testimony that the process of developing any subsequent IPP was not persuasive. She testified that HRC is not supposed to just meet with her and write an IPP that governs services for the coming year, but is required to hold multiple meetings with providers, after each of which claimant's goals must be reevaluated, before any IPP can be completed. In contrast, HRC's position, which is consistent with the Lanterman Act, is that if further pertinent information becomes available after an IPP is signed, the parties may execute an IPP addendum. Signing the IPP should not be delayed throughout the year, and current services and goals should be established and documented at the IPP meeting.

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37. Claimant's father testified he is 71 years old, takes insulin for diabetes, received four arterial stents in 2005, and takes muscle relaxants so he can have a limited range of motion. His ability to help claimant with her activities is limited.

DISCUSSION

1. The Lanterman Act governs this case. (Welf. & Inst. Code, § 4500 et seq.)[3] An administrative "fair hearing" to determine the respective rights and obligations of the consumer and the regional center is available under the Lanterman Act. (§§ 4700-4716.) Claimant requested a fair hearing to appeal the Service Agency's denial of her request for funding a rehabilitation aide. Jurisdiction in this case was thus established. (Factual Findings 1-4.)

2. Because claimant seeks benefits or services, she bears the burden of proving she is entitled to the services requested. (See, e.g., *Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 789, fn. 9; *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161.) Claimant must prove her case by a preponderance of the evidence. (Evid. Code, § 115.)

3. The Lanterman Act acknowledges the state's responsibility to provide services and supports for developmentally disabled individuals and their families. (§ 4501.) The state agency charged with implementing the Lanterman Act, the Department of Developmental Services (DDS), is authorized to contract with regional

[3] Statutory references are to the Welfare and Institutions Code.

centers to provide developmentally disabled individuals with access to the services and supports best suited to them throughout their lifetime. (§ 4520.)

4. Regional centers are responsible for conducting a planning process that results in an IPP. Among other things, the IPP must set forth goals and objectives for the client, contain provisions for the acquisition of services based upon the client's developmental needs and the effectiveness of the services selected to assist the consumer in achieving the agreed-upon goals, contain a statement of time-limited objectives for improving the client's situation, and reflect the client's particular desires and preferences. (§§ 4646, subd. (a)(1), (2), and (4), 4646.5, subd. (a), 4512, subd. (b), 4648, subd. (a)(6)(E).)

5. Although regional centers are mandated to provide a wide range of services to facilitate implementation of the IPP, they must do so in a cost-effective manner. (§§ 4640.7, subd. (b), 4646, subd. (a).) A regional center is not required to provide all of the services that a client may require but is required to "find innovative and economical methods of achieving the objectives" of the IPP. (§ 4651.) Regional centers are specifically directed not to fund duplicate services that are available through another publicly funded agency or other "generic resource." Regional centers are required to "identify and pursue all possible sources of funding. . . ." (§ 4659, subd. (a).) The IPP process "shall ensure . . . [u]tilization of generic services and supports when appropriate." (§ 4646.4, subd. (a)(2).) But if no generic agency will fund a service specified in a client's IPP, the regional center must itself fund the service in order to meet the goals set forth in the IPP; thus, regional centers are considered payers of last resort. (§ 4648, subd. (a)(1); see also, e.g., § 4659.)

6. The Lanterman Act defines "services and supports" to include personal care and physical and occupational therapy. (§ 4512, subd. (b).)

7. Claimant established that HRC must fund a rehabilitation aide. Claimant's physical and occupational therapists demonstrated a need for a trained aide to assist them in delivering paraprofessional services to claimant. Though both claimant's occupational therapist and a consultant for HRC testified as to the preference for a licensed or certified rehabilitation assistant, the evidence was persuasive that claimant's educational aide has been trained sufficiently well to warrant vendorization to continue to provide service as a rehabilitation aide under the supervision of claimant's occupational therapist and physical therapist. Claimant established that her requested service is required under the Lanterman act to achieve agreed-upon goals in the IPP, however outdated it may be, and to improve her physical condition, and that the service is best suited to meet her unique needs, notably due to her significant regression over the past 12 months due a lack of services.

8. Claimant's position in this matter has not been helped by parents' refusal to sign an IPP each year and to sign consent forms allowing HRC's professional team to contact claimant's service providers. To the extent claimant's IPP does not reflect her current service needs due to claimant's parents' decision not to agree to finalize an IPP since 2018, claimant's parent may provide supplemental information to HRC and, if they believe it necessary, claimant's parents may request another IPP meeting.

LEGAL CONCLUSION

The evidence established that the Service Agency is required under the Lanterman Act to fund a rehabilitation aide for claimant.

ORDER

Claimant's appeal of the Service Agency's decision to deny the request to fund a rehabilitation aide is granted.

DATE:

HOWARD W. COHEN
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.