Coordinated Future Planning

Presented by the Alta California Regional Center

Coordinated Future Planning Task Force

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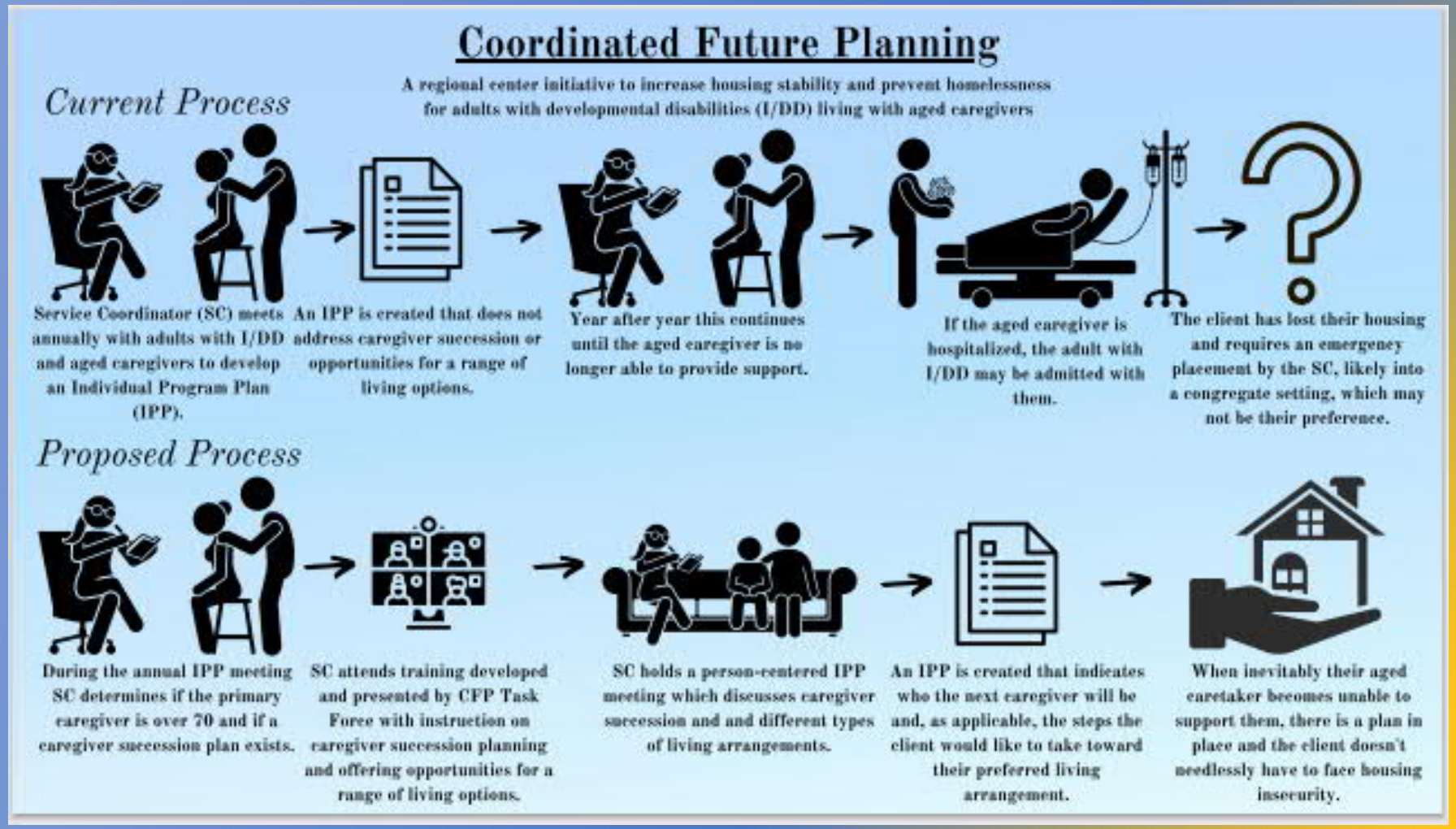
Coordinated Future Planning - Alta California Regional Center (altaregional.org)



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Your takeaways

Document Caregiver Succession Plan in the IPP – for every client with a primary caregiver age 70 or older

Document a range of living options were provided during the IPP

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Learning Objectives

1. Recognize the benefit of reflecting on your own beliefs about dying and end of life care and the impact that may have on your ability to help others with future life planning. (Facilitator – Herman Kothe)
   - dialogue with clients and families, in a culturally respectful, sensitive and humble way, regarding caregiver succession planning using appropriate language.
2. Articulate the benefit to clients and families of early planning for caregiver succession. (Facilitator – Jennifer Bloom)
3. Describe a range of living options, including independent living, supported living, family home agencies, and residential care, to clients and their families. (Facilitator – Johnny Xiong)
   - create a person-centered IPP narrative that captures the wishes of the client and planning team in relation to future living options.
4. Share future planning tools that can assist clients and families related to accessing affordable housing, power-of-attorney, special needs trust, CalABLE, conservatorship, and end-of-life care decisions. (Facilitator – Tracy Brown)

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Learning Objective #1

- Recognize the benefit of reflecting on your own beliefs about dying and end of life care and the impact that may have on your ability to help others with future life planning.
  - dialogue with clients and families, in a culturally respectful, sensitive and humble way, regarding caregiver succession planning using appropriate language.

Facilitator – Herman Kothe

Presenters – Betsy Katz and Daphne Chakurian

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Introduction to our Presenters

- Daphne Chakurian
- Betsy Katz

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Example CFP Interview

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The Importance of Self-Care Now and Always

- Be mindful of your needs throughout this training as well as your ongoing work with clients and families
  - Take time if needed
- Be present and professional with others during their times of need
- Be comfortable “Holding the Space”

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Break Out Session

- Groups of 3 participants
  - Interviewer
    - Practice asking the questions:
      - What in life is important to and for you?
      - Are there early memories from your childhood that have influenced your values and beliefs about the death of a loved one?
      - How did your family respond and what kinds of rituals were observed to process the loss?
  - Respondent
  - Observer/timekeeper
    - Allow 10 minutes of exchange between Interviewer and Respondent
    - Offer constructive feedback
- Rotate roles

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Welcome Back

- How was that?
- Did you encounter any barriers with this exercise (in either role interviewer or respondent)?
- Or were you comfortable asking and answering the questions on the subject?

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My Future Plans – Self Reflection/Insight

- Have I thought about my own end of life wishes?
- Have I shared my end of life wishes with anyone?
- Do I have a documented plan for my end of life wishes?
- Have I experienced end of life decision planning with someone?

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From self reflection to working with Clients

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Group Discussion

- How did watching this video make you feel?
  - What emotions did you experience?
- What would you identify as the clients' needs?
- If you were the Service Coordinator for one of these clients:
  - What would you do during the meeting?
  - What plans would you make for next steps?
- What are Service Coordinator responsibilities?
  - Case Management with empathy/compassion
    - Develop, implement and monitor person centered plans
    - Organizing complex situations like a puzzle
    - Create a linear path with needs prioritized – mutually agreed goals

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Supporting others in their plans

- Be considerate and respectful
- Start where the person is at
- Recognize different members of the team may be at different places
- Value and respect the cultural beliefs of the planning team members

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Considerations for Succession Planning

- Talking to other family members about the future and asking for their opinion, concerns, and hopes
- Conservatorship
- Special needs trust
- Power of attorney
- Advance care directive for health care
- CalABLE account
- Final arrangements
- Completion of a planning tool which addresses employment, education, housing, recreation, transportation, etc.
- Identification of other individuals (relatives, friends, or others) who can serve as a continuing support to the person with IDD

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What are the benefits of early planning when thinking about caregiver succession?

What are we asking families and caregivers to do?

- Participate in a conversation.
- Identify theirs and their loved ones needs.
- Develop partnerships and relationships with others.
- Include the Regional Center and community partners who are engaged with their loved one.

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What are the benefits of early planning when thinking about caregiver succession?

When should these conversations take place?

- Earlier is better.
- Starting early ***helps normalize the conversation***.
- Early conversations provide the opportunity for a “someday” discussion if the caregiver is not ready right away.

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How should we approach this topic?

- Approach with the mindset that we care about what happens to our clients when their caregiver is gone.
- A “handle with care” mindset.
- Approach as emergency planning, this is relatable because we all need to plan for an emergency. Things happen, we must be prepared.
- Reiterate to the family/caregiver that there are many options and choices and tools. We don’t want them to feel like the Regional Center is pushing the conversation.
- Try an open ended question: “Have you thought about who may care for your child if you were not able to?”

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How should we approach this topic?

- Consider including a question/prompt in the individual program plan (IPP) – “Do you have plans for your loved one in an emergency, or if something should happen to you?”
- The IPP will show patterns that this topic has been an ongoing discussion.
- Use support available to you: consult with your Manager, and remember that ACRC Client Advocates can assist and provide perspective and resources.
- Some may feel that the Regional Center is trying to “take over.”
- We have to respect choice.

- This approach may take time become readily accepted.

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Benefits of Early Planning

- When a good plan is in place, there are fewer surprises.
- Reduces intensity of a crisis situation.
- There is value in planning early and giving caregivers a place to start.
- Provides a sense of security.

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Sibling Considerations

- Ask siblings if they are prepared to be a part of the client's future plan?
- In what capacity?
- Assumptions are made – be sure to have a conversation.
- Question for caregivers – "Do siblings have the information they need to access doctors, schools, the Regional Center?"
- Many have not been involved in planning.
- Consider co-conservator with parent and sibling for continuity.

Bailey's Story:

Q:\Training\Coordinated Future Planning (CFP)\Bailey's Story .mp4

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Special Considerations for Younger Caregivers and Parents

- Start by thinking about what your child may need if you're not home, even for a few hours.
- How do you communicate your child's needs to others caring for them?
- Do you have rituals, routines written down for your loved one in case you're not here?

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Person-Centered Thinking Planning Tools

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Routines and Schedules

Daily Hygiene Chart

For Teens

http://www.chartjungle.com

What To Do	S	M	T	W	T	F	S
Morning							
Bath/Shower or Wash Face							
Shave if needed							
Put on Deodorant							
Put on Clean Clothes							
Brush Hair							
Eat Breakfast							
Brush Teeth							
Make Bed							
Evening							
Bath/Shower or Wash Face							
Put on Pajamas							
Brush Teeth							
Sometime each day							
Exercise							
Sometime each week							
Cut Nails							

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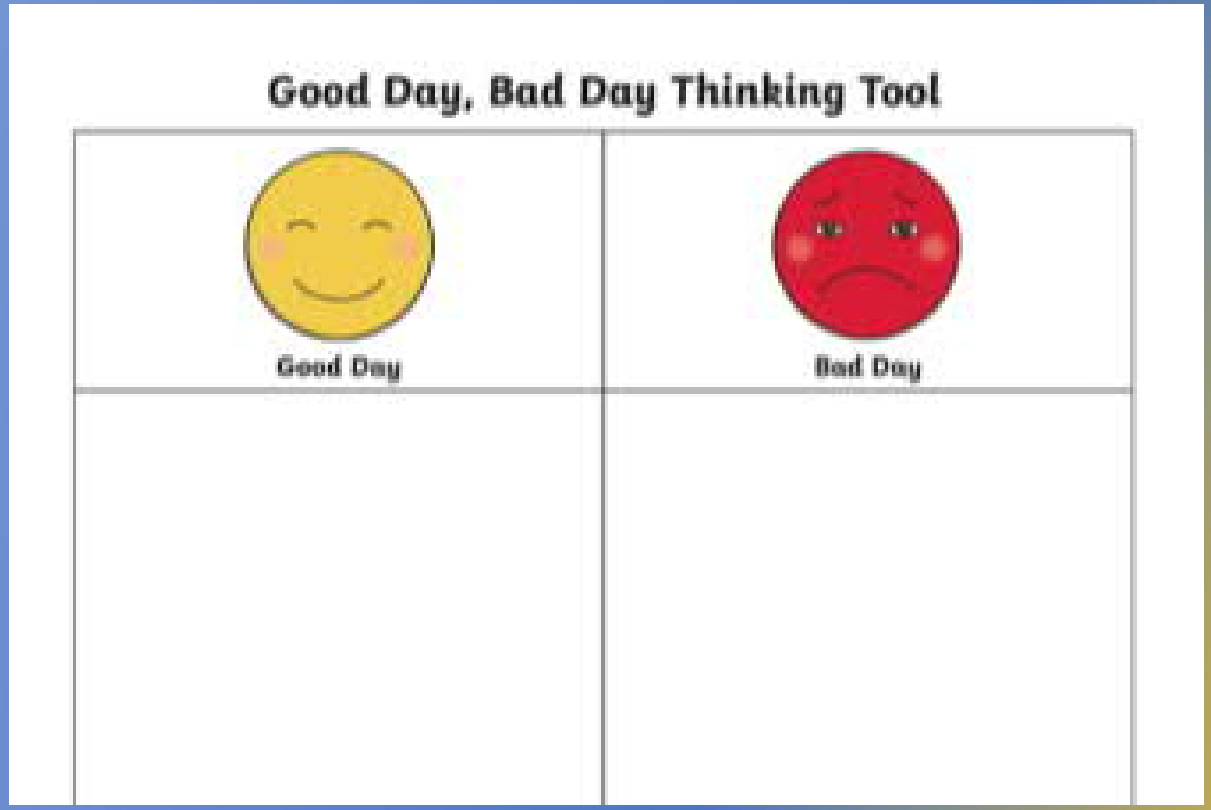
Person-Centered Thinking Planning Tools

- Good day/bad day



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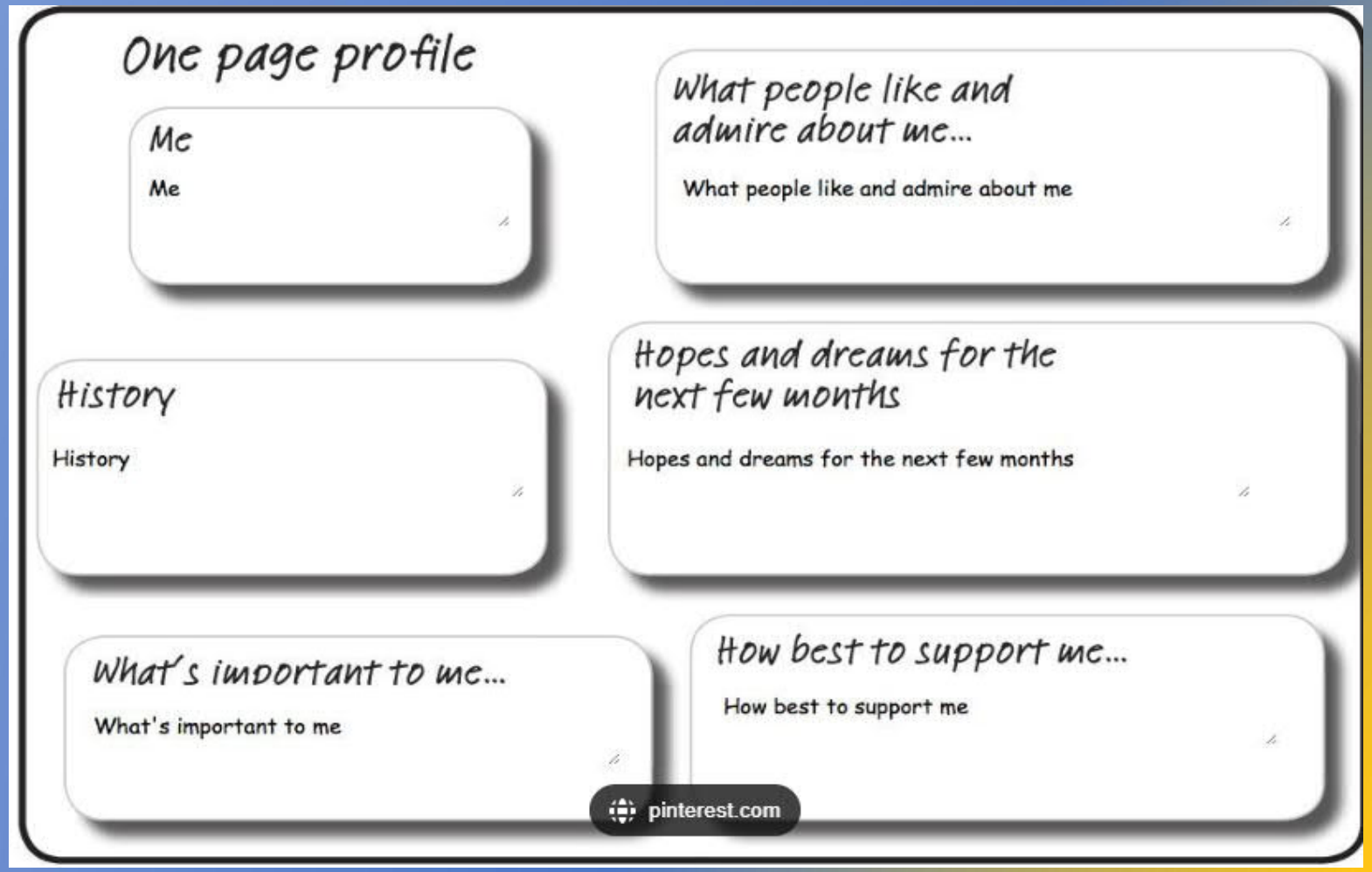
Person-Centered Thinking Planning Tools



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Take-aways

- Family dynamics play a large part in these discussions, including cultural beliefs and norms.
- Be perceptive as to how people are responding to the topic.
- Lack of awareness and planning can create denial, confusion, and fear.
- Planning ahead reduces the intensity of a crisis situation.
- These concepts are important considerations to be highlighted.

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Living Options

- What are the different living options?
- Who is each living option available to?
- What does each setting look like?
- What kind of support is available in each setting?

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Living in the Community with Services, Supports & Resources

- Some adult individuals choose to continue living at home with their parents/family members.
- Others may live in their own home or apartment with supports.
  - Natural Supports
  - Generic Resources
  - Regional Center Services

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Living in the Community with Services, Supports & Resources (cont.)

Generic Resources

- Supplemental Security Income (SSI)
- In-Home Supportive Services (IHSS)
- Medi-Cal
- Cash Assistance Program for Immigrants (CAPI)
- Supplemental Nutrition Assistance Program (SNAP/CalFresh)
- Home and Community Based Alternatives Waiver (HCBA)
- Housing Choice Voucher (HCV)

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Living in the Community with Services, Supports & Resources (cont.)

Regional Center Services

- In Home Respite Services
- Day Care
- Personal Attendant/Homemaker Services
- Environmental Accessibility
- Representative Payee Services
- Independent Living Skills
- Supported Living Services

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Living in the Community with Services, Supports & Resources (cont.)

Supported Living Services (SLS)

- A Home of One's Own
- Choice and Self-Directed
- Relationships
- Community Membership
- Flexible, Tailored Services and Supports

Overview

- At least 18 years of age
- May have behavioral support needs
- May have medical support needs requiring a health care plan
- Typically shared housing with 2 to 3 other individuals receiving SLS
- Receive up to 24 hour support that typically include IHSS

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Family Home Agency (FHA)

- The FHA certifies Family Home Providers and their family home to support 1-2 adults, each with a private bedroom.
- The family home setting of an FHA home may be one of the more comfortable and familiar living options to transition to in cases where an Individual had been living with their natural family.
- Flexible living option designed according to the specific needs and preferences of each Individual including Options for Couples, Parent and Child, Transitioning Youth
- The Individual participates in family life with the Family Home Provider and their family.
- The Family Home Provider assists with medication administration, support with daily living tasks, money management, scheduling and support to appointments, etc.
- Meals, toiletries, furnished bedrooms with all linens

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Family Home Agency (FHA) (cont.)

- An FHA Program Coordinator visits the family home at least monthly
- Direct Support Professional (DSP) staff support additional community integration
- Consultation such as behavior intervention, nursing, counseling, speech and other therapies
- The FHA monitors the certification including quarterly home evaluations and annual recertification.
- Family Home Providers accrue respite nights each month, provided by the FHA
- Referral, intake and matching process
- Funding is similar to residential care homes with a combination of SSI for Board and Care and Regional Center contracted rate depending on level of supports needed

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Family Home Agency (FHA) (cont.)

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Community Care Facility (CCF)

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

- Adult Residential Facility (ARF) – 18 to 59 years old
- Residential Care Facility for Elderly (RCFE) – 60 years and older
- Group Homes – Under 18 years old
- Adult Residential Facility for Persons with Special Health Care Needs (ARFPHSN)
- Enhance Behavioral Supports Home (EBSH)
- Community Crisis Homes (CCH)

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Community Care Facility (cont.)

Individuals residing in CCF's may need personal services, protection or supervision, and assistance, guidance or training to adequately attend to self-care and activities of daily living.

- Home setting with housemates/roommates
- 3 meals, 3 between meal snacks, and prescribed modified diets
- Laundry/household cleaning
- A comfortable bed and fresh linens at least weekly
- Communication with family or other planning team members regarding resident needs
- Bedside care for minor, temporary illness
- Provision of essential personal hygiene items, including but not limited to toilet paper, toothbrush, toothpaste or denture cleanser, comb, soap, shampoo, and sanitary napkins
- Access to local telephone service
- Provision of, or arrangement for, transportation for emergency services and to fulfill the facility Plan Of Operation

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Intermediate Care Facility (ICF)

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) are health facilities licensed by the Licensing and Certification Division of the California Department of Public Health and vendored by regional center to provide 24-hour/7 days per week of residential staffing and services to eligible Individuals. Below are the two different types of ICFs:

Intermediate Care Facility/Developmentally Disabled-Habilitative (ICF/DD-H)
Intermediate Care Facility/Developmentally Disabled-Nursing (ICF/DD-N)

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Intermediate Care Facility (ICF) (cont.)

ICF/DDs provide a wide variety of services based on client needs, which vary according to age and level of intellectual and developmental disabilities. A broad range of services are offered in ICFs/DDs to meet the complex needs of clients while enhancing their quality of life.

- The homes are typically a single residence in a residential neighborhood
- Homes are for children or adults who require institutional level of care and support
- Homes can consist of up to 15 residents, and typically 4-6 residents
- Residents may share a bedroom
- Homes may be gender specific or include multiple genders
- Skills training is provided to the residents and the staff to meet the goals and objectives of the Individual Program Plan and Individual Health Care Plan
- Community outing opportunities are provided by the facility
- Placement at this type of facility is funded by Medi-Cal

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Room and Board

- Rent usually includes utilities and food
- Open to any community member
- Age restriction is typically set by the landlord
- Homes can consist of multiple individuals
- Residents may share a bedroom or have a single bedroom
- Homes may be gender specific or include multiple genders
- Homes are usually furnished and may include cable and Wi-Fi internet
- Rent is covered by the individual's SSI, employment, or other financial means
- May offer occasional transportation
- Can be a temporary residential option during times of transition

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Self-Determination Program (SDP)

- In July 2021, the Self-Determination Program (SDP) became available statewide to most Regional Center clients as an optional alternative to traditional vendored Regional Center services.
- Unlike traditional services SDP participants are able to select and use non-vendored providers to meet IPP goals.
- Participants have more flexibility to determine how available funding is spent.

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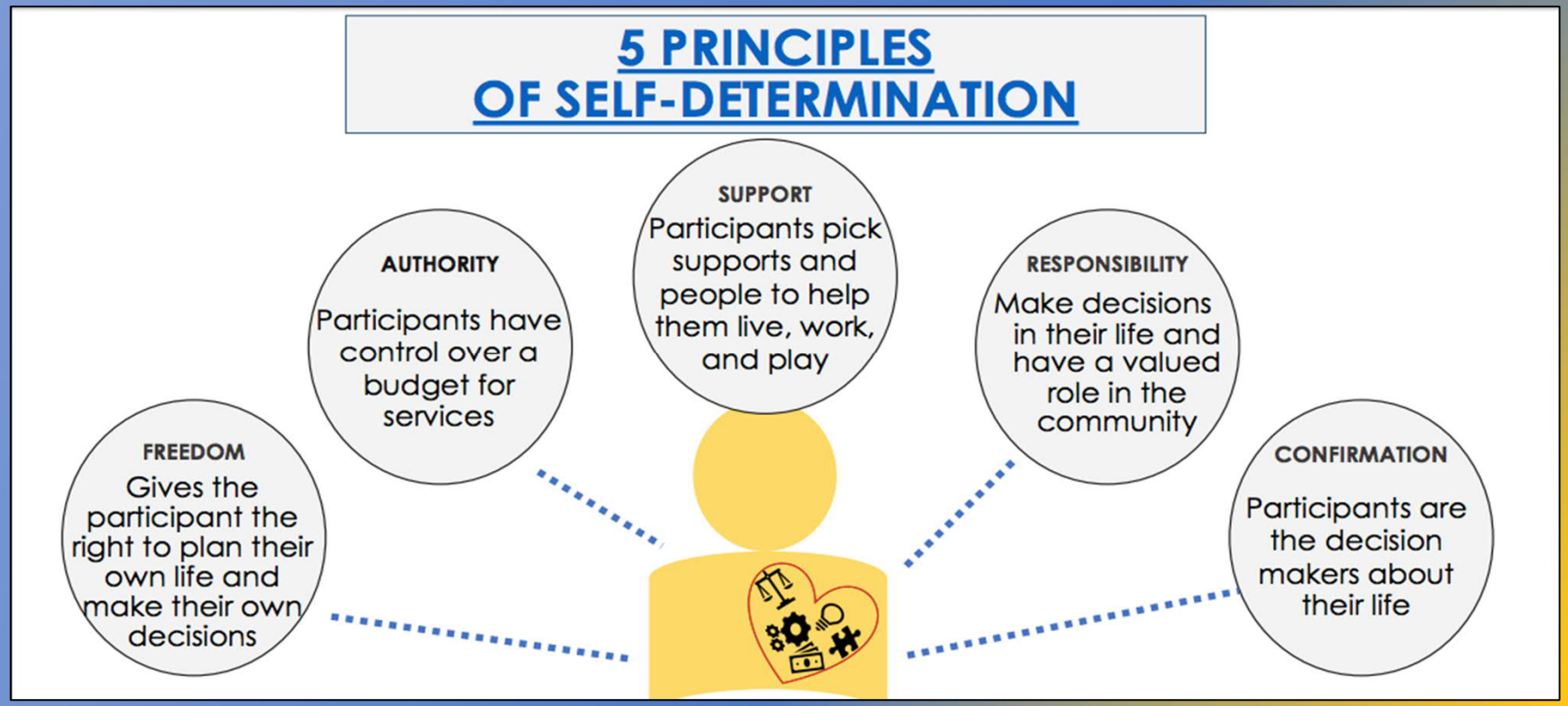
Self-Determination Program (cont.)



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Self-Determination Program (cont.)

- Person Centered Planners and the Independent Facilitator
- Budget and Spending Plan
- Financial Management Service (FMS)
- Self Determination Lanterman Act Statute: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=4685.8
- See DDS Self Determination Program website: https://www.dds.ca.gov/wp-content/uploads/2019/05/SDP_Service_Codes_02142019.pdf

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Future Planning Tools

- Future planning tools are tools which assist Service Coordinators in talking with clients and families about information related to accessing affordable housing, looking at financial planning options, as well as a review of conservatorship and alternatives to conservatorship, and looking at having discussions about end-of-life care decisions and end of life planning.
  - Discuss with clients and families, in a culturally sensitive and respectful manner, their wishes, hopes, dreams, plans for their future.
  - Look at individual situations and needs. Share information and resources about housing options, financial planning, and end of life care planning based on the planning team discussion.
  - Revisit this discussion year to year, from childhood through adulthood, while tailoring the discussion to the ages and stages for each client.

Presenters: Patti Uplinger, Jacob Miller, Kelsey Handcock and David Lopez

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Affordable Housing

- Attaining affordable housing for individuals with a developmental disability is an intentional process.
- There are agencies who have programs to support our clients who are seeking affordable housing.
- Affordable housing vs Low Income housing
- Discuss some of the affordable housing developments in our catchment area

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Things to think about when accessing affordable housing

- Understanding affordable housing resources
- Limited income (SSI)
- Stringent financial requirements (ex. 3 times rent, etc.)
- Credit history/Job history
- Reasonable accommodations and modifications
- Lack of transportation access
- Staff support (IHSS, SLS, ILS)
- Building natural supports
- Safety concerns for clients

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What to discuss at the planning team?

- Children: Discuss ideas about housing and ask questions about the parent's ideas, choices, wishes, outlook for their child's future? Where do they envision their son/daughter living? Share Person Centered Planning tools. Know that this may evolve and change so discussing each year is imperative. Document in discussion in the IPP.
- Transition Age: Discuss the various types of housing options, what type of housing is the client/family seeking into adulthood? Outline the skills and strengths of the client, while also addressing areas the client can continue to build on in order to transition into their choice of housing (cooking, cleaning, etc.) What is their level of independence and what supports will they need in place if they choose to move? Begin to identify specific needs/wants/dreams. Look at referral options, may need to get on a housing wait list. Document in IPP
- Adult: Discuss specific housing options and include coordinated future planning information. Provide specific resources for various housing options, such as care home, supported living, independent living, etc. Discuss the current level of skills and abilities, then outline what services and supports the client will need in order to be supported in the housing arrangement of their choice. Possible referral to housing specialist. Document in IPP

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Financial Planning

Engage the client and family in a discussion about financial planning and navigating the range of services available for a family member who has a disability. Individual situations will vary. Service Coordinators are not educated in the law or how to assess financial plans, so those would require a client and family to consult with a professional in that field.

- What does your client and family need?
- Who can the client/family talk to about their plans? (i.e. legal support, financial planner, estate planner, etc.)
- Special Needs Trust- legal process and consultation with an attorney could be warranted
- Cal Able- possible consultation with an investment advisor

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Future Financial Planning

Representative Payee:

- A person or agency who has been designated to manage the benefit payments for someone who needs the additional support. Our clients can be referred to a representative payee agency if the client/family chooses that option.

Special Needs Trust:

- Definition from The ARC: A Special Needs Trust is a special trust that holds title to property for the benefit of a child or adult who has a disability without interfering with eligibility for public benefits. The Special Needs Trust can be used to provide for the needs of a person with a disability and supplement benefits received from various governmental assistance programs, including SSI and Medi-Cal. A trust can hold cash, real property, personal property and can be the beneficiary of life insurance policies.

CalAble:

- Definition from Cal Able: CalABLE is a savings and investment plan offered by the state of California to individuals with disabilities. Eligible individuals, family, friends and employers can contribute up to $16,000 a year without affecting the account beneficiary's public disability benefits. CalABLE account owners who work can contribute even more to their accounts. Best of all, earnings on qualified withdrawals from a CalABLE account are federal and California state tax-free.

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Supported Decision Making

- Think about a time when you had to make a decision about something you were not familiar with….what did you do?
  - Reach out to family or friends for advice, feedback, guidance
  - Talk it through with people you trust
  - Gather information from specialists/professionals

  This is Supported Decision Making!
- Our clients may need extra support and additional people to support them with making their own decisions. If our clients CAN make some or all, of their own decisions in their lives, then Supported Decision Making can be an alternative to conservatorship.

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Discuss and Assess Supported Decision Making

- Talk with your client, listen to their interests, strengths, needs and goals for their future. How are they making decisions now? What decisions do they want to make but are a little challenging for them?
- What are the challenges and opportunities for your client? What is stopping them from being able to make certain decisions? Who might be able to help them?
- Find the support team. What people, agencies, organizations are available to support the client to overcome the challenges and be able to make decisions?
- Support the client in identifying the people who can support them, and outline the type of support each person can provide and how they will provide the support.
- Write this into the IPP. Document they types of support, when they will need the support, and who will provide that support. This will help the team stay organized and outline who is responsible for what portion of support.

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What is a Conservatorship?

A legal process, one where a client/family may need to access outside legal support, as a Service Coordinator is unable to provide legal advice or guidance.

A court order that appoints a person to manage the personal and/or financial affairs of an adult individual who is incompetent or has limited capacity.

- An individual or agency is appointed by the court to be legally responsible for a person and/or estate.
- Takes fundamental rights away from an individual.
- Applies to people over the age of 18.
- Lasts until terminated by a court or statutory occurrence.
- Limited vs General
- Conservatorship handbook (DRC) can be shared with clients and families

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Alternatives to Conservatorship

- Circle of support/Supported Decision Making
- Durable Power of Attorney
- Right to make educational decisions
- Right to make medical decisions
- Right to manage finances

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Caregiver Succession Planning

- Caregiver Succession Plan (CSP) – Caregiver succession planning is intended for clients residing not under vendored care, but rather, with a caregiver (family or non-family) that is their primary support. The caregiver succession plan can be discussed with all clients and families, although it is imperative that SCs assess this plan with clients age 52 or older who reside with family. Service Coordinators are encouraged to conduct this assessment with every client with a primary caregiver age 70 and older.
    - If no caregiver succession plan exists SC will facilitate a discussion about caregiver succession planning and document the discussion in the IPP.
    - If a caregiver succession plan exists SC will hold a discussion to determine if the caregiver succession plan needs to be updated and document the discussion in the IPP.
    - SC provides their CSM the updated information for clients age 52 and older, and the CSM is responsible to update the CFP Tracking Workbook on the Q Drive.

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End of Life Planning Discussion

Children

- Begin to identify who is the decision maker for the child at this time
- Who are natural supports
- Share information on person centered planning tools
- Discuss the “what if” scenario
- Provide resources for families to begin looking at future planning

Transition Age

- Gather information about the client’s circle of supports, including who is supporting them with decision making (housing, medical, education, etc.)
- Discuss access to public benefits for adults (IHSS, SSI, Medi Cal, etc.)
- Assess where the comfort level is with the conversation about end of life plans
- Share, discuss and provide information about future planning options, including Healthcare Decision Making and End of Life Planning resources
- https://futureplanning.thearc.org/pages/see-how-others-have-planned

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Adult

- Continue to discuss end of life planning options and provide resources.
- Who will be providing the support the client needs? Caregiver Succession Plan?
- Talk with client and family about full range of choices, where do they want to be, living, how do they want to be cared for, who do they want caring for them, etc.?
- Person Centered Plan, important to and important for
- Plan for funeral, burial, celebration of life?

Things to think about when having these delicate discussions:

- Cultural norms/beliefs
- Religious beliefs
- Family system supports, not looking at any outside help/services
- Hard to discuss in a short amount of time/at IPP meeting, it should be a “planting of the seed” discussion, not a meeting for the client/family to make a decision, SC can provide resources for reading on their own time.

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Advance Care Planning

- Advance Care Planning- this is a process that supports a person at any age or any stage of their health. It allows us to understand and gather information from clients about their personal values, life goals and preferences. We can also continue to gather information about their medical care and choices for medical care. The goal in having advance care planning is to help ensure that our clients receive the care that is consistent with their values, goals and preferences, and to plan ahead so that there is documented record of this if they were to encounter a time when they could not make these decisions (serious illness, accident, chronic illness, etc.)
- Advanced Health Care Planning is a process and may not be a, “one and done” conversation, meaning having the conversation and completing the Thinking Ahead booklet may not occur in one setting. If the client is not ready to discuss the topic, document the attempt in the IPP and revisit in a future meeting.

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Advance Health Care Directive VS Physician Orders for Life Sustaining Treatment (POLST)

- Advance Health Care Directive (AHCD)- Thinking Ahead
  - A tool clients/family use to make healthcare wishes known when a patient is unable to communicate
  - Gives directions for *future* care
  - Must include the individual's signature, date of execution, 2 witnesses OR a Notary (witness criteria in Tab 5)
  - Does not expire unless the document says otherwise
  - Should be reviewed periodically for any needed updates/changes
  - Service Coordinators will add this information into the Legal Section of the IPP for clients 18 years or over.
  - Advanced Health Care Directive document will be filed in the client's chart.
  - Service Coordinators can sign and date as a witness, if requested by the client.

- Physician Orders for Life-Sustaining Treatment (POLST)
  - Specific order for *current* medical care
  - All POLSTs go to clinical team, SCs/CSMs DO NOT sign. (see ACRC Medical Consent Procedure on Policy Manager)

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