



Consumer Services Committee Meeting

4:00 P.M.

Monday, June 1, 2020

VMRC Stockton Office Cohen Board Room

702 N. Aurora Street

Stockton, CA, 95202

Call in number: 669-900-6833 - Meeting ID: 950 7752 3583- Password: 228038

If you need accommodation during the meeting (i.e. translation), please notify us at least 3 days in advance of the scheduled meeting.



Meeting Book - Consumer Services Committee Meeting June 1, 2020

Consumer Services Committee

Public Comment - 3 minutes

Review of Minutes of May 4, 2020

CSB Draft Minutes 5.4.2020.pdf - Page 4

SAC6 Update - Crystal Enyeart

CLASP Update - Daime Hoornaert

Consumer Services Projects or Presentations

Clinical Update

Claire Lazaro

Thinking-Ahead-Booklet_web.pdf - Page 10

SP_Thinking-Ahead_Web.pdf - Page 32

IPP Is Coming Up-How to be ready (SAC6).docx - Page 54

Advance Care Planning - IPP Objective.docx - Page 55

CDPH Visitor Limitation Guideline All Facilities 2020_05_02.pdf -
Page 57

Tara Sisemore Hester

Resource Development

Brian Bennett

Robert Fernandez, Jr.

Quality Assurance

Alerts

QA Alerts 4.16-5.14 2020.pdf - Page 59

Case Management

Case Management Reports

Transfer status.pdf - Page 61

POS Exception Tracking April 2020.pdf - Page 62

Special Incident Reports Apr 16 2019 to May 15 2020.pdf - Page
63

Case Management Update

Transportation - Wilma Murray

Consumer Services will not meet again until September 2020

VALLEY MOUNTAIN REGIONAL CENTER
MINUTES OF CONSUMER SERVICES COMMITTEE MEETING
Monday, May 4, 2020

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PRESENT: **Committee Members:** Dena Pfeifer, & Lori Smith her facilitator; Daime Hoornaert; Liz Herrera Knapp; Margaret Heinz; Mohamad Rashid
 VMRC: Brian Bennett; Christine Couch; Cindy Mix; Claire Lazaro; Colia Howell; Danielle Wells; Douglas Bonnet; Erin Goudreau; Nicole Weiss; Cindy Strawderman; Robert Fernandez; Tara Sisemore-Hester; Tony Anderson
 Guests: 209-XXX-5904; 209-XXX-5673; Carlos Hernandez, Interpreter; Dena Hernandez, SCDD; Elio's iPhone; Gricelda Estrada; iPad; Lisa Culley, Family Resource Network; Margarita Torres; Mary; Rachelle Munoz; Rgome; Sandra Graham; Stella Hernandez, Casa de Stella

ABSENT: Robert Balderama; Linda Collins; Nadia Robinson; Wilma Murray;

=====

Dina Pfeifer, Chairperson, called the meeting to order at 4:00 PM.

1.0 PUBLIC COMMENT

Dena Hernandez, Regional Manager- SCDD North Valley Hills Office, was late to the call, however wanted to share her update:

- Thank you to VMRC for signing onto the Personal Protection Equipment (PPE) Letter – letter attached.
- Next SCDD North Valley Hills Regional Advisory Committee (RAC) meeting will be held on Tuesday, May 26, 2020 and will be a zoom meeting. Details to follow. All are welcome to participate.
- State Council on Developmental Disabilities Cycle 43 Program Development Grant requests for proposals is due May 20, 2020. The proposals must relate to either SCDD State Plan Goals= Employment or Housing. Info can be found at www.scdd.ca.gov/NorthValleyHills page.
- Self Advocacy Council 6 will be hosting SAC6 Zoom Chats- info is posted on the SAC6 and SCDD, and VMRC Facebook page. The SAC6 leadership has worked hard to connect with their peers during this pandemic.

2.0 REVIEW OF MINUTES

M/S/C (Rashid/Enyeart): Approve the minutes of April 6, 2020 with the update of: the CLASP report did not include SCDD was also a collaborator in obtaining PPE's for RSP's anyone in need PPE supplies.

3.0 SAC6 UPDATE

Crystal Enyeart shared the following:

- We are encouraging self-advocates to be safe and stay healthy. We hosted a zoom call for about 70 self-advocates with Tony Anderson. It went really well and self-advocates are asking for another call. We will work with Tony to schedule another one.
- We are excited to announce that Rachelle Munoz is our new coordinator. She will support us with managing our business.
- We held our goals meeting via zoom and worked on our goals for the 2020-2021 year.
- Our next board meeting is scheduled for June.

4.0 **CLASP UPDATE**

Daime Hoornaert shared the following:

- CLASP members approved to use \$2000.00 out of our fund to purchase PPE (Gloves, eye protection, gowns and masks) for CLASP member in need of this equipment.
- Membership: CLASP currently has 83 members. This is the highest member count CLASP has had.
- CLASP members voted to keep the current officers and committee members for the next year:
 - **Officers:**
 - President: Corinne Seaton
 - Vice President: Diana Bonnet
 - Secretary: Chris Martin
 - Treasurer: Marisol Moreno
 - Membership: Karyn Gregorius
 - **CLASP Representatives:**
 - VMRC Board: Elizabeth Knapp
 - Finance and Personnel: Connie Uychutin
 - Consumer Services: Daime Hoornaert
 - Legislation: Candice Bright
 - By laws: Rita Redondo
 - VMRC nominating: Daime Hoornaert
 - Provider Conference Chair: Candice Bright
- Residential Service Provider Group: They have begun meeting again monthly. During this COVID-19 period, RSP's are having several concerns:
- RSP's are working around the clock to provide coverage, searching and standing lines to make supply purchases. Staff are leaving and some are having difficulty finding staff. Hourly rate too low, Unemployment rate is good, why work when you can stay at home and get the Unemployment rate. They are doing their own Day Programming and want to know they can't be paid more.
- RSP aren't medical providers, they should be getting hazard pay

- RSP's are providing Day Program services for those Day Programs who are not reaching out. Someday programs are sending packets, standing outside of a car for 5 minutes a week, or not coordinating with RSP times for Zoom classes. Some packets are not appropriate for some individuals, not person centered.
- Increase Utilities increase cost of supplies (copying, laminating, PPE) and food, increase behaviors and Property destruction across the board, not just behavior homes or negotiated rate homes. **DDS has promised PPE equipment, but RSP's would have to drive to Sacramento.
- RSP's are afraid if they complain, there will be retaliation. Some RSP's reported that this has happened in the past
- Day Program Network: will begin meeting to discuss what all are doing to reach out to individuals, share resources, etc. Most are waiting for a directive for DDS.
- DDS is expected to develop a Day Program directive giving expectations of what day programs should be doing during this "Shelter in Place".

5.0 **CONSUMER SERVICE PRESENTATIONS**

There were no presentations

6.0 **CLINICAL**

6.1 Claire Lazaro shared information

- Went over the attachments to the meeting packet: CDC Sick with 2019 nCoV Fact Sheet; DDS Expectation on Hospital Discharges & other Placement 4/9/2020; Discharge Algorithm during COVID-19 4/7/2020; Discharge algorithm during COVID-19 from Other Placement 4/8/2020; FAQs on Discharge Isolation during COVID-19 4/8/2020
- This week we worked with the local hospitals the advocacy regarding hospital visitations, Claire will share in our next consumer services meeting. We are aware that there are hospitals that have a no visitation policy. If you go to a hospital or emergency room, you need your support person. Now the department of health has advised them that persons with disabilities need the support person and the hospital should allow at least one person with them. And when they are in the hospital, the patient may have 2 individuals with them.

6.2 Tara Sisemore Hester shared the following:

- Tara went over the caseload ratios that were included in the packet.
- The expansion positions have not started yet.
- Early Start Service Coordinators have reached out to all consumers/families to make sure they have the support they need.

- Tara went over the Intake status provided in the packet.
- We are anticipating intake will start to skyrocket. We have just posted two new intake coordinator positions.
- We just posted a Sr. Intake position that will serve all 3 offices where needed.
- Remote services have been going well. The parent-coaching model has blossomed, as the parent needs to facilitate the services. The provider have found it very useful and will include this in their intervention in the future.
- Working with Resource Development to develop new services for Early Start.
- One of the hands on providers is providing hands on service remotely.

7.0 **RESOURCE DEVELOPMENT**

Brian Bennet shared the following that they are continuing to work with DDS to create Surge homes.

Robert Fernandez shared the following

- We have HCBS vendor training two weeks ago.
- Last week we had Day Program Orientation via Zoom & SLS/ILS orientation the following day.
- Our next scheduled orientation is August for Residential Services. I hope that we will be back in the office.
- Doing interviews with service providers and administrators thru Zoom.

8.0 **QUALITY ASSURANCE**

8.1 **Alerts**: Nicole Weiss shared that we only had 12 alerts for the period of March 18 thru April 15. Most of those were untimely SIRs.

9.0 **CASE MANAGEMENT**

9.1 Cindy Mix reviewed the Case Management Reports.

- Caseloads ratios have increased 1:92, which is extremely high. Up from 1:88 last month. Due to loss of staff, several promoted and no longer carrying case loads. We had a few resignations. Even though we continue to hire not everyone is able to start right now.
- Transfer in/out report thus far this year 128 came in and 92 that went out. That leaves 36 additional cases. If this keeps going this will mirror the other years prior. Every year it seems we need 1-2 caseloads additional.
- We received the SIR report – the top number of SIR's were unplanned hospital & death. We are not receiving as many SIR's as we were receiving, as day programs, schools, etc. are closed.

Christine Couch shared the following information regarding Fair Hearings as of April 20, 2020:

- The OAH, Office of Administrative Hearings, has rescheduled all mediation and state level hearings for June. We continue to hold informal meetings via zoom conference calls.
- We have 2 open Lanterman eligibility cases. One adult and one child. Both are scheduled for state level hearings in June.
- We have 3 open service request cases. One is for ABA compensatory funding and is pending a state level hearing in June. Another is for HCBS waiver eligibility and has an informal meeting in April, a mediation in June and a state level hearing in July. The third is for SPED attorney fees and has a state level hearing scheduled in June.
- Since April 20th, we have received 3 additional fair hearing requests and those are being scheduled for June, July & August.

9.2 Cindy Mix shared the following update for Case Management:

- We are continuing to meet with families since March, and most of our meetings have been remote as families and consumers are good with this. 2-3% want to meet face to face. We are extending the IPP's. Some families do not want service in their homes. We are assisting with many resources.
- We are assisting with Cal Fresh, PPE's requests, food bank access, even meal deliveries in some cases.
- We have contacted all consumers either directly or by letter. We did a wellness check last week by Everbridge our mass notification system. We had a few parents call to advise to stop contacting us, and some wanting more contact.
- We have generated Title 19 reports from Sandis showing our contacts and outcomes. These are interdisciplinary notes. In our last report, we had a 99.4% contact rate.
- We are now processing Participant directed services. This was a directive from DDS. Many of those we have approached already had services in place and did not opt for that service. We have only had 10-12 requests.
- We have had very positive feedback from consumers and families with the remote access meetings via Zoom. We have noticed the meetings have been a bit shorter, but they have been jproducti8ogv.
- We are planning a virtual Transition Fair for our consumers who will be exiting school programs. We are very excited about this and have a lot of ideas. It is planned for May 27th. Dena Hernandez has been working on the fliers that will be going out soon. Thank you Dena!
- Had a recent statewide ARCA meeting regarding Employment. Supported employment is being provided remotely & the state will be coming out with a frequently asked questions sheet so people will know about what is going on with employment. We had some consumers that had jobs and are now unemployed and collecting unemployment, as well as we have some consumers in essential jobs that

are still working. There is a trend in adding number of participants in group employment. Not the number of vendors, but the number of people in the group.

- At the ARCA meeting the also talked about the budget. Tony will talk more of that in an upcoming meeting. They are expecting us to have some tough times ahead. Some of this is due to the delayed tax deadline to July. There will be a May revise as well as an August revise. They are expecting some decreased revenues.
- There was a meeting today at the capital targeting budget issues. There will be some tough decisions ahead. Some of the bills on the table, one being the reduced caseloads for the 3, 4 & 5 year olds has been taken off the table, as well as few others.
- Everything is continuing with transfers between Regional Centers.

10.0 **TRANSPORTATION**

Wilma Murray was not in attendance

11.0 **NEXT MEETING**

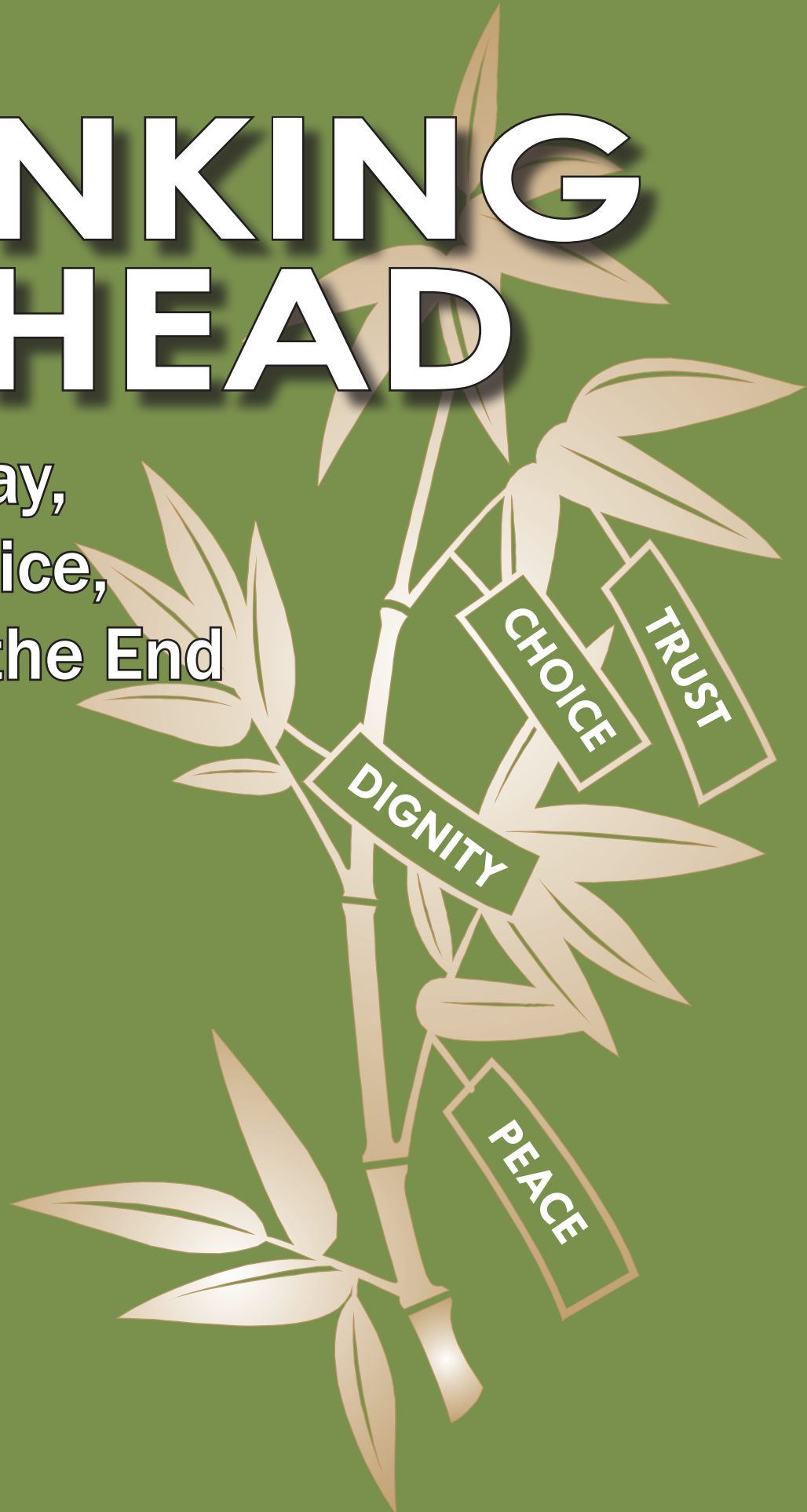
Monday June 1, 2020, 4:00 p.m., **Via Zoom. Meeting ID: 950 7752 3583; Password 228038. Call in number 669-900-6833**

The meeting was adjourned at 4:40 p.m.

Recorder: Cindy Strawderman

THINKING AHEAD

My Way,
My Choice,
My Life at the End



"There is life, and there is death. You don't know what's going to happen today or tomorrow so you have to be prepared."

Connie Martinez, 2008



Introduction

Today more than ever, you are making important decisions. Living your life your way also means making choices about the end of your life. You probably know someone, a family member, support person or friend, who has died. Talking about death and dying is hard, but being prepared for that time makes sure your choices are respected. Making your own decisions shows you are in control, now and up through the very end.

This **Thinking Ahead** workbook provides a way to advocate for what you want in life support treatment and other end-of-life choices. Complete these pages and you will be prepared. You will have a plan to share with important people in your life.

1

Review the whole workbook before making your decisions or writing down your choices.



2

**Take your time to complete the workbook.
Take 2 or more sessions.
Use support from a Trusted Helper.**

3

Complete the Personal Requests and Advance Directive forms on the back pages. Give copies to important people.

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Making Your Decisions

Making important decisions means taking time to think carefully, deciding on your choices, then taking action with support.



THINK

What is important to you.



PLAN

Choose what you want.



DO

Complete the forms and let people know.



Connie and Betty Think Ahead



Connie Martinez

Connie knows that being an advocate means making choices all through life. When a friend of hers died, she wanted to pay her respects but could not. His body was gone and no one knew what happened.

Connie's friend had been a strong advocate but he had not made his own plans. After he died, other people took over his belongings and his burial. Connie decided this was not going to happen to her. She thought about what was important and made her plan. She took action to make sure she was in control of her life — now and at the very end.



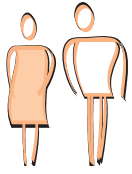
Betty Pomeroy

Betty knows how important it is to make your own choices and have your own plans.

Her brother was in the hospital and very sick. He never told anyone about what he wanted for medical treatment at the end of his life. Because she was the closest person to her brother, the doctor called Betty about making medical treatment choices for him. She alone had to make the decision to let him go.

Because of this, Betty wanted to be prepared herself and make her own decisions ahead of time. She took steps to be in control — now and at the very end.

■ Choosing the Right Person to Help



Everyone needs help when thinking ahead and carrying out plans at the end of his or her life. Choosing a **Trusted Helper** to help you complete this workbook is the first step. This person should be comfortable talking with you about end-of-life choices. Think about who can help you.



THINK – Who Can Help Me

Someone who:

- Knows me well and cares about what is important to me.
- Helps without telling me what they think I should do.
- Listens to me and is respectful.
- Will advocate for me.
- Will help me complete this workbook.



PLAN – My Trusted Helper



I want _____ to help me.
Name

As a **Trusted Helper**, I agree to listen, explain and write down what is important without taking over or saying what to do.

Signature _____
Trusted Helper



Making Personal Requests



Everyone has the right to die with dignity, respect and feeling at peace. When people close to you know what comforts you, they can give the caring support you need. At the end of life, there are important decisions to make about your final wishes. This is the time to think about what you want during your final days.



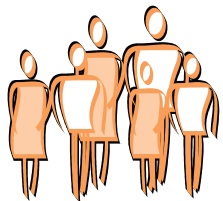
THINK – My Final Days and After Death

With your Trusted Helper, share your thoughts about how you want your final days of life to be. Ideas to think about:



Where you want to be.
How you want to be cared for.

This is also the time to think about what you want to have happen after your death. Ideas to think about:



Where you want your personal belongings to go.
Your funeral, burial.
How you want to be remembered.



PLAN – Make Personal Arrangements

Connie and Betty knew that end-of-life planning included choices about their final days, where their belongings would go, and how they wanted to be remembered. They made decisions about their final wishes and put together their personal plans.

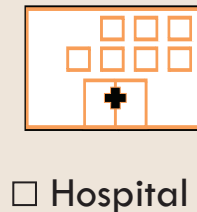
■ ■ Making Personal Requests

Make a plan about your final days and how you want to be remembered by completing pages 5–7.

(1) Where I want to be

Near the end of their lives people have choices about the place where they want to spend their final days. Here are some ideas to think about.

Mark your choice.



☐ Other Place

(2) How I want to be cared for

Near the end of their lives, people sometimes make special requests. It is important to let others know what you want.

Mark your choices or write in other ideas.



- ☐ Have my family and friends near.
- ☐ Have personal care that helps me feel comfortable.
- ☐ Have my favorite things around me.
- ☐ Have my favorite music playing.
- ☐ Have my religion respected.
- ☐ Other ways I want to be cared for:





Making Personal Requests

(3) Where I want my things to go

Everyone has important things that belong to them. Sometimes people donate personal items to organizations or give them to friends and family members.

Think about where you want your things to go and write it down.

Money _____

Clothing _____



Furniture _____



Equipment _____

Pet _____



Other _____

(4) Gifts I want to give



Sometimes people give special gifts to friends and family members who have been important to them.

Write what you want to give and to whom.

Item: _____ To: _____

Item: _____ To: _____

■ ■ Making Personal Requests

(5) My body

Sometimes people have religious or family ideas that help them decide what happens to their bodies after death.

Think about what you want and write it down.



☐ I want to be buried. Where: _____



☐ I want to be cremated. Where I want my ashes to go:

(6) Being remembered

Having a time to remember is a way people pay their respects and celebrate the life of someone who has died.

Think about what you want and write it down.

I want a funeral service. ☐ Yes ☐ No

☐ At my place of worship _____

☐ At a funeral home _____

☐ Other place _____

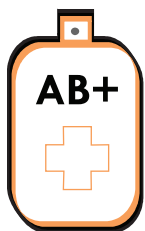
☐ I want people to remember me by doing this: _____



DO – Next Steps

1. Put your choices on the tear-out **Personal Requests Form**.
2. Take your completed **Form** and make copies for important people.
3. Save your workbook and the original **Form** you completed.

Making Medical Treatment Choices



You have the right to make decisions about your health care during your life. There are also medical treatment choices to make at the end. When you are very sick, you need help to make sure doctors know what you want.

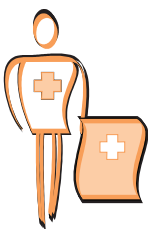
This section helps you decide what medical treatment you want or don't want in your final days. It will help you think about your **Quality of Life** and make choices about **Life Support Treatment**.

THINK – My Quality of Life and Life Support



Quality of Life is different for each person. When death is near, there are decisions to make about what life will be like during those final days. It is important that people decide how they want to feel at the end and what Life Support Treatment is right for them.

Thinking about what makes your life worth living will guide you in making your end-of-life choices.



Life Support Treatment is used to help keep people alive when they are very sick and close to death. Treatments can be medicines, breathing machines, tube feeding and drinking, CPR, dialysis and surgeries.

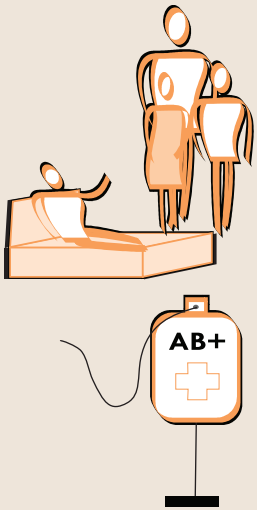
No matter what end-of-life treatment a person wants or doesn't want, doctors must make everyone as comfortable as possible through the very end.

■■■ Making Medical Treatment Choices

With your Trusted Person, share your thoughts and feelings about what would make up your quality of life at the end.

A person's life quality is different for everyone. Think about what is important to you.

Mark your choices or write in other ideas.



- ☐ Being awake and thinking for myself.
- ☐ Communicating with family or friends.
- ☐ Being free from constant and severe pain.
- ☐ Not being connected to a machine all the time.

More thoughts I have about my quality of life at the end:

1
2
3

PLAN – Make Life Support Treatment Decisions

Connie and Betty knew that end-of-life planning included thoughts about quality of life in their final days. They made decisions about life support treatment and put together their personal plans.



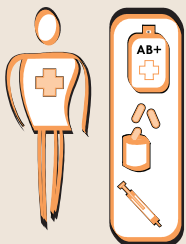
Making Medical Treatment Choices



Make your plan about life support treatment choices.

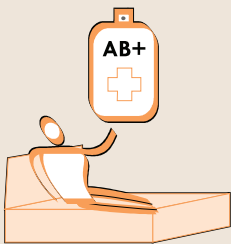
If my doctors say I am likely to die in a short time and life support treatment would only postpone my death:

Mark your choice:



☐ I **want** life support treatment as long as possible.

☐ I **do not** want any life support treatment.



☐ I **want** life support treatment **only** if my doctor thinks it could help.

☐ I **want** someone I know and trust to decide for me.

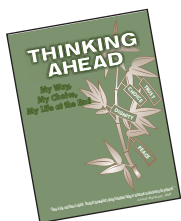


DO – Next Steps



1. Put your medical treatment choices on the tear-out **Advance Directive Form** at the back of the workbook.

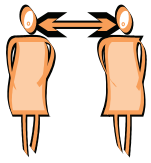
2. Take your completed **Form** and make copies for your Doctor and other important people.



3. Save your workbook and the original **Form** you completed.



Choosing an End-of-Life Advocate



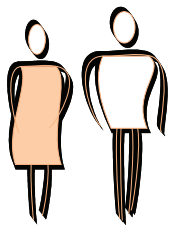
It is important to choose a person who can be your **End-of-Life Advocate**, also called a **Health Care Agent**.

Decisions in your **Advance Directive** are carried out by your End-of-Life Advocate.



THINK – Who Will Speak For Me?

End-of-Life Advocate (Health Care Agent)



- Is nearby to help me when I need him or her.
- Will speak to doctors, nurses and social workers for me.
- Follows my Advance Directive.
- Is my legal spokesperson when I cannot speak for myself.

End-of-Life Advocate cannot be:



- Your doctor.
- Staff of a clinic/hospital where you get health care.
- Your group home or nursing home operator.
- Staff of a group home or nursing home where you live.

Advance Directive is a document that:



- Has your choices about life support treatment.
- Says who will speak with your doctor when you cannot.
- Guides your doctor about what you want.



Choosing an End-of-Life Advocate

PLAN – My End-of-Life Advocate

Connie and Betty knew that end-of-life planning included deciding who would speak up for them to their doctors. They made decisions about who would be their End-of-Life Advocates and put together their personal plans.

Good to remember!

Some people have **conservators**. If you have a conservator, check to see if they may already be your End-of-Life Advocate.

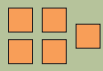
Meet with him or her to complete the workbook.

My Decision:

I want _____ to be
Name
my End-of-Life Advocate and he or she agrees.

DO - Next Steps

1. Complete the **Advance Directive Form**.
2. Sign the **Advance Directive** with two witnesses.
3. Complete the **Personal Requests Form**.
4. Make sure your End-of-Life Advocate has a copy of both forms.



Staying in Control



When you finish your **Thinking Ahead** workbook and complete the forms at the end, you have exercised your right to live your life, your way – now and at the very end. You will be prepared.

You will have a plan to share with loved ones, your doctor and other important people in your life.

Here are some tips:



1

Get information in ways YOU can understand.



2

Share your plan with important people.



3

Make changes to your plan, if you need to.



4

Make your own decisions.



Advocates Lead Project

The **Thinking Ahead** workbook project was led by California advocates with developmental disabilities from three regional centers. They wanted to share their experiences and ideas because they know how important it is to make their own decisions now and through the very end. The advocates came together in three focus groups to guide the project and ensure the workbook reflected their voices.



Alta California Regional Center
Sacramento, CA
Focus Group Participants



Golden Gate Regional Center
San Francisco, CA
Focus Group Participants



Eastern Los Angeles Regional Center
Alhambra, CA
Focus Group Participants



Resources

CoalitionCCC.org

The Coalition for Compassionate Care of California is a statewide partnership of organizations and individuals dedicated to the advancement of palliative medicine and end-of-life care. It provides helpful information about end-of-life decision making, legislation and forms. You can download copies of the Thinking Ahead Workbook and facilitator guideline on this site.

CaringInfo.org

Caring Connections is a program of the National Hospice and Palliative Care Organization, a national consumer and community organization committed to improving care at the end of life.

iha4health.org/our-services/advance-directive

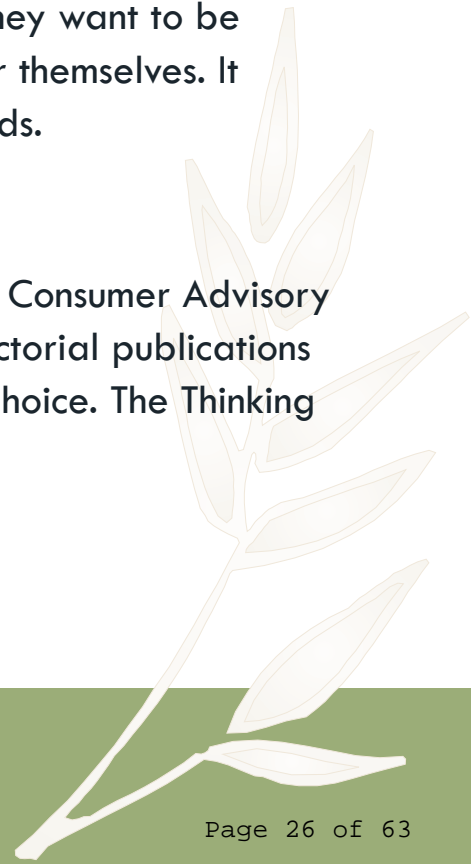
This easy-to-read California Advance Health Care Directive form was created to help people better understand these legal documents.

fivewishes.org

The Five Wishes document helps people express how they want to be treated if they are seriously ill and unable to speak for themselves. It includes medical, personal, emotional and spiritual needs.

dds.ca.gov/ConsumerCorner/Publications.cfm

The California Department of Developmental Services, Consumer Advisory Committee has developed numerous plain language pictorial publications and DVDs that encourage self-direction and personal choice. The Thinking Ahead Workbook is also available for download.





Acknowledgments



Alta California Regional Center

David Lopez, Consumer Advocate

Terry Wardinsky, MD, Medical Director



Eastern Los Angeles Regional Center

Jesse Padilla, Consumer Advocate

Felipe Hernandez, Chief of Consumer Services



Golden Gate Regional Center

Elizabeth Grigsby, Consumer Rights Advocate

Felice Weber Parisi, MD, Director, Clinical Services

Gabriel Rogin, Strategic Development Coordinator



Connie Martinez – Advocate

Alta California Regional Center



Betty Pomeroy – Advocate

Redwood Coast Regional Center



Board Resource Center

Making Complex Ideas Simple

Mark Starford, Executive Director

www.brcenter.org



To order copies or for more information, contact:

Coalition for Compassionate Care of California

Judy Thomas, JD, Executive Director

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www.CoalitionCCC.org



Personal Requests

These are my personal requests, but not a Will.

Name: _____

(1) Where I want to be

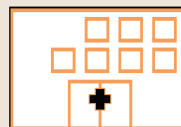
This is my choice about where I want to spend my final days.



☐ My Home



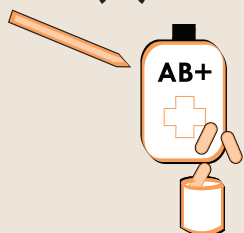
☐ With My Family



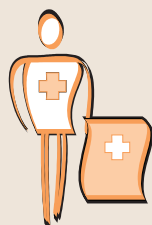
☐ Hospital

☐ Other Place

(2) How I want to be cared for



- ☐ Have my family and friends near.
- ☐ Have personal care that helps me feel comfortable.
- ☐ Have my favorite things around me.
- ☐ Have my favorite music playing.
- ☐ Have my religion respected.
- ☐ Other ways I want to be cared for:



(3) Where I want my things to go



Money

Clothing

Furniture



Equipment



Pet

Other



Personal Requests



(4) Gifts I want to give

Item: _____

To: _____

Item: _____

To: _____



(5) My body

☐ I want to be buried. Where: _____

☐ I want to be cremated. Where I want my ashes to go: _____



(6) Being remembered

I want a funeral service ☐ Yes ☐ No

☐ At my place of worship _____

☐ At a funeral home _____

☐ Other place _____

☐ I want people to remember me by doing this: _____



Sign Your Name

Date

Street Address

City

State

Zip Code

Home Phone

Work Phone

Email



Advance Directive

(Name) _____ is my
End-of-Life Advocate (Health Care Agent).

Street Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Email _____

My End-of-Life Advocate will make decisions for me only if I cannot make my own decisions.



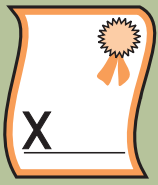
My End-of-Life Choices

During my final days, my quality of life means:

- ☐ Being awake and thinking for myself.
- ☐ Communicating with family or friends.
- ☐ Being free from constant and severe pain.
- ☐ Not being connected to a machine all the time.
- ☐ _____

During my final days, my life support treatment decision is:

- ☐ I want life support treatment as long as possible.
- ☐ I do not want any life support treatment.
- ☐ I want life support treatment **only** if my doctor thinks it could help.
- ☐ I want my End-of-Life Advocate to decide for me.



Advance Directive



Sign Your Name

Date



Print Your Name

Date

Address

City

State

Zip Code

For Witnesses:

As a witness, I promise that (person) _____,
signed this form while I watched. He/she was not forced to sign it.

I also promise that:

- I know this person and he/she can confirm their identity.
- I am 18 years or older.
- I am **not** this person's End-of-Life Advocate (Health Care Agent).
- I am **not** this person's health care provider or work for this person's health care provider.
- I do **not** work where this person lives.



Witness Signature

Date



Witness Signature

Date

One witness must not be related by blood, marriage or adoption and not receive any money or property from this person after he/she dies.

MIS PLANES

A mi manera,
Mis decisiones,
El final de mi vida



"La muerte es parte de la vida. Uno nunca sabe lo que pasará hoy o mañana, entonces hay que estar preparado."

Connie Martinez, 2008



Presentación

Hoy más que nunca, usted está tomando decisiones importantes. Vivir la vida a su manera también quiere decir elegir cómo pasar sus últimos días. Usted probablemente conoce a alguien, un familiar, una persona que lo apoyaba o un amigo, que ha muerto. Hablar sobre la muerte y el morir es difícil, pero estar preparado para ese momento asegura que se respeten sus elecciones. Tomar sus propias decisiones muestra que usted tiene el control, ahora y hasta el mismísimo final.

Esta guía **Mis Planes** le ofrece una manera de defender lo que usted quiere sobre el tratamiento de soporte vital y otras elecciones relacionadas con el fin de la vida. Cuando complete estas páginas, estará preparado. Tendrá un plan para compartir con las personas que son importantes en su vida.

1

Revise toda la guía antes de tomar decisiones o escribir sus elecciones.



2

**Tómese su tiempo para completar la guía.
Hágalo en 2 o más veces.
Aproveche el apoyo de un Ayudante de confianza.**

3

**Complete los formularios de Pedidos Personales e Instrucciones por adelantado de las páginas de atrás.
Reparta copias entre las personas que son importantes para usted.**

Índice

	Connie y Betty: Sus Planes	Página 2
■	Cómo elegir a la persona correcta para ayudar	Página 3
■■	Cómo hacer pedidos personales	Páginas 4-7
■■■	Cómo elegir los tratamientos médicos	Páginas 8 - 10
■■■	Cómo elegir un Defensor del final de la vida	Páginas 11-12
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■■■	Defensores lideran el proyecto	Página 14
■■■	Recursos	Página 15
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<hr/>		
	Formulario de Pedidos Personales	Contratapa A
	Formulario de Instrucciones por Adelantado	Contratapa B

Cómo tomar sus decisiones

Para las decisiones importantes, hay que tomarse tiempo para pensar con cuidado, decidir qué quiere y después actuar con apoyo.



PENSAR Qué es importante para usted.



PLANIFICAR Elija lo que quiere.



HACER Complete los formularios y avise a las personas.

Connie y Betty: Sus Planes



Connie Martinez

Connie sabe que ser un defensor de derechos significa que tendrá que elegir durante toda la vida. Cuando un amigo suyo murió, ella quiso darle el pésame a alguien, pero no pudo. Su cuerpo ya no estaba y nadie sabía lo que había pasado.

El amigo de Connie había sido un gran defensor de sus derechos, pero no había hecho sus propios planes. Después de su muerte, otras personas se adueñaron de sus pertenencias y de su entierro. Connie decidió que esto no le iba a pasar a ella. Pensó qué era importante para ella y armó su plan. Se aseguró de que su vida estuviera bajo su control: ahora y al mismísimo final.



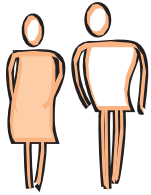
Betty Pomeroy

Betty sabe lo importante que es tomar decisiones propias y tener planes propios.

Su hermano estuvo muy enfermo en un hospital. Él nunca le había dicho a nadie qué clase de tratamiento médico quería al final de su vida. Como ella era la persona más cercana a su hermano, el médico llamó a Betty para que tomara las decisiones sobre el tratamiento médico. Ella tuvo que tomar sola la decisión de dejarlo ir.

Por esta razón, Betty quería estar preparada y tomar sus propias decisiones con anticipación. Tomó medidas para tener el control: ahora y al mismísimo final.

■ Cómo Elegir a la Persona Correcta Para Ayudar



Todos necesitan ayuda para hacer planes y cumplirlos al final de la vida. Elegir un **Ayudante de confianza** para que le ayude a completar esta guía es el primer paso. Esta persona debe sentirse cómoda al hablar con usted sobre sus decisiones relacionadas con el fin de la vida. Piense quién puede ayudarle.



PENSAR: ¿Quién puede ayudarme?

Alguien que:

- Me conozca bien y se preocupe por lo que es importante para mí.
- Ayude **sin** decirme lo que cree que **yo** debería hacer.
- Me escuche y sea respetuoso.
- Defienda mis derechos.
- Me ayude a completar esta guía.



PLANIFICAR: Mi Ayudante de confianza



Deseo que _____ me ayude.
Nombre

Como **Ayudante de confianza**, acepto escuchar, explicar y anotar lo que es importante sin tomar el control ni decir qué se debe hacer.

Firma _____
Ayudante de confianza

California Coalition for Compassionate Care provides suggestions for Trusted Helpers to assist a person with completing this workbook and forms. Go to: www.CoalitionCCC.org.

■ ■ Cómo Hacer Pedidos Personales

QUIERO

- 1 sí
- 2 sí
- 3 no

Todos tienen derecho a morir con dignidad, respeto y sintiéndose en paz. Si las personas que lo rodean saben qué le hace sentirse más a gusto, le pueden dar el apoyo que usted necesita. Al final de la vida, tendrá que tomar decisiones importantes sobre sus últimos deseos. Este es el momento de pensar lo que usted quiere para sus últimos días.



PENSAR: Mis últimos días y después de la muerte

Comparta con su Ayudante de confianza sus pensamientos sobre cómo quiere que sean los últimos días de su vida. Ideas en que pensar:



Dónde quiere estar.
Cómo quiere que le atiendan

También es el momento de pensar sobre lo que quiere que pase después de su muerte. Ideas en que pensar:



A dónde quiere que vayan sus pertenencias.
Su funeral, entierro.
Cómo desea que lo recuerden.



PLANIFICAR: Haga preparativos personales

Connie y Betty sabían que planificar el final de la vida incluía tomar decisiones sobre sus últimos días, a dónde irían sus pertenencias y cómo querían que las recordaran. Tomaron decisiones sobre sus últimos deseos y armaron sus planes personales.

■ ■ Cómo Hacer Pedidos Personales

Haga un plan sobre sus últimos días y sobre cómo quiere que lo recuerden completando las páginas 5 a 7.

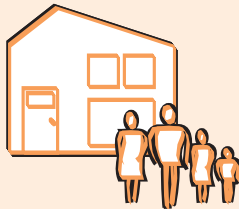
(1) En dónde quiero estar

Cuando se acerca el final de sus vidas, las personas pueden elegir el lugar donde quieren pasar sus últimos días. Estas son algunas ideas en que pensar.

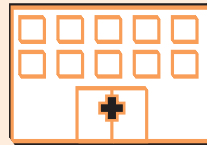
Marque su elección.



☒ Mi casa



☐ Con mi familia



☐ Hospital

☐ Otro lugar

(2) Cómo quiero que me atiendan

Cuando se acerca el final de la vida, a veces las personas hacen pedidos especiales. Es importante avisar lo que usted quiere.

Marque sus elecciones o escriba otras ideas.



☐ Tener cerca a mis familiares y amigos.

☐ Tener una atención personal que me ayude a sentirme cómodo.

☐ Tener mis objetos preferidos cerca.

☐ Escuchar la música que más me gusta.

☐ Hacer que se respete mi religión.

☐ Otras formas en las que quiero que me cuiden:



■ ■ Cómo Hacer Pedidos Personales

(3) Adónde quiero que vayan mis cosas

Todos tienen cosas importantes que les pertenecen. A veces, las personas donan sus cosas a organizaciones o se las dan a amigos y familiares.

Piense adónde quiere que vayan sus cosas y escríbalo.



Dinero _____

Ropa _____



Muebles _____

Equipos _____



Mascota _____

Otros _____

(4) Regalos que quiero hacer



A veces las personas hacen regalos especiales a amigos y familiares que han sido importantes para ellos.

Escriba lo que quiere regalar y a qué persona.

Artículo: _____ Para: _____

Artículo: _____ Para: _____

■ ■ Cómo Hacer Pedidos Personales

(5) Mi cuerpo

A veces las personas tienen ideas familiares o religiosas que les ayudan a decidir qué hacer con sus cuerpos después de la muerte.

Piense lo que quiere y anótelo.



☐ Quiero que me entierren. Lugar: _____



☐ Quiero que me cremen. Mis cenizas irán a:

(6) Cómo me recordarán

Dedicar un momento al recuerdo es la manera en que las personas presentan sus respetos y celebran la vida de alguien que murió.

Piense lo que quiere y anótelo.

Quiero un funeral. ☐ Sí ☐ No

☐ En mi lugar de culto _____

☐ En una funeraria _____

☐ Otro lugar _____

☐ Quiero que me recuerden haciendo esto:



HACER: Próximos pasos

1. Escriba sus decisiones en el **Formulario de Pedidos Personales** para separar.
2. Tome su **Formulario** completo y haga copias para las personas importantes.
3. Guarde su guía y el **Formulario** original que usted completó.

■■■ Cómo Elegir los Tratamientos Médicos



Usted tiene derecho de tomar decisiones sobre la atención médica durante su vida. También al final hay que elegir entre opciones de tratamiento. Cuando uno está muy enfermo, necesita ayuda para asegurarse de que los médicos sepan lo que usted quiere.

Esta sección le ayuda a decidir qué tratamiento médico quiere o no quiere para sus últimos días. Le ayudará a pensar sobre su **Calidad de vida** y a elegir sobre el **Tratamiento de soporte vital**.

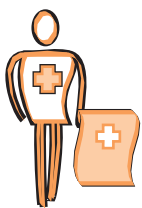


PENSAR: Mi calidad de vida y el Soporte vital



La **Calidad de vida** es distinta para cada persona. Cuando se acerca la muerte, hay que tomar decisiones sobre cómo será la vida en esos días finales. Es importante que las personas decidan cómo quieren sentirse al final y qué Tratamiento de soporte vital es correcto para ellos.

Pensar en lo que hace que valga la pena vivir su vida lo guiará para elegir lo que quiere para el final de la vida.



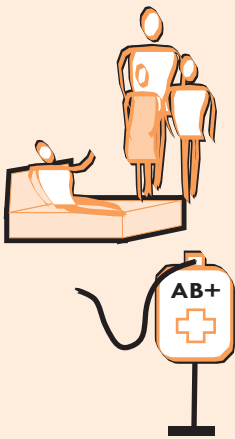
El **Tratamiento de soporte vital** se usa para ayudar a mantener vivas a las personas cuando están muy enfermas y cerca de la muerte. Los tratamientos pueden ser medicamentos, ventilación mecánica, tubos para recibir alimentos y bebidas, reanimación cardiopulmonar, diálisis y cirugías. Sin importar qué tratamiento quiera o no quiera una persona al final de la vida, los médicos tienen que hacer que todos se sientan lo más cómodos posible hasta el mismísimo final.

■■■ Cómo Elegir los Tratamientos Médicos

Comparta con su Persona de confianza sus ideas y sentimientos sobre qué sería para usted calidad de vida al final.

La calidad de vida es diferente para cada persona. Piense qué es importante para usted.

Marque sus elecciones o escriba otras ideas.



- ☐ Estar despierto y pensar por mí mismo.
- ☐ Comunicarme con la familia o los amigos.
- ☐ Estar libre del dolor constante y fuerte.
- ☐ No estar conectado a una máquina todo el tiempo.

Más ideas sobre mi calidad de vida al final:

1
2
3

PLANIFICAR: Tome decisiones sobre el Tratamiento de soporte vital

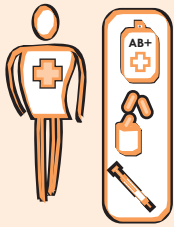
Connie y Betty sabían que la planificación para el final de la vida incluía ideas sobre la calidad de vida en sus últimos días. Tomaron decisiones sobre el tratamiento de soporte vital y armaron sus planes personales.

■■■ Cómo Elegir los Tratamientos Médicos



Haga su plan sobre las elecciones de tratamiento de soporte vital. Si mis médicos dicen que probablemente voy a morir en poco tiempo y el tratamiento de soporte vital solamente postergaría mi muerte:

Marque su elección:



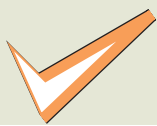
☐ **Quiero** tratamiento de soporte vital por todo el tiempo que sea posible.

☐ **No quiero** ningún tratamiento de soporte vital.

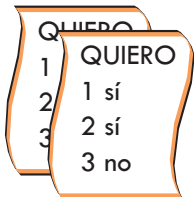


☐ **Quiero** tratamiento de soporte vital **solamente** si mi médico cree que podría ayudar.

☐ **Quiero** que alguien que conozco y en quien confío decida por mí.

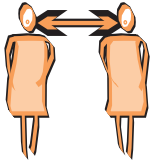


HACER: Próximos pasos



1. Anote sus elecciones sobre tratamiento médico en el **Formulario de Instrucciones por Adelantado** al final del cuaderno. Se puede despegar dicho formulario por la línea perforada.
2. Tome su **Formulario** completo y haga copias para su Médico y otras personas importantes.
3. Guarde su guía y el **Formulario** original que usted completó.

❏❏ **Cómo Elegir un Defensor de Final de la Vida**

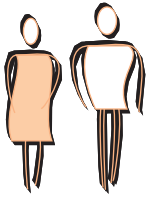


Es importante elegir a una persona que pueda ser su **Defensor de final de la vida**, también llamado **Agente de atención médica**. Decisiones en su **Formulario de Instrucciones por Adelantado** son llevadas por su Defensor de final de la vida.



PENSAR: ¿Quién hablará por mí?

Defensor del final de la vida (Agente de atención médica)



- Estará cerca para ayudarme cuando lo necesite.
- Hablará con los médicos, las enfermeras y los trabajadores sociales por mí.
- Seguirá mis Instrucciones por adelantado.
- Será mi vocero legal cuando no pueda hablar por mí mismo.

El Defensor del final de la vida no puede ser:



- Su médico.
- Personal de una clínica/un hospital en donde usted recibe atención médica.
- El operador de su hogar de grupo o de convalecencia.
- Personal del hogar de grupo o de convalecencia en donde usted vive.

Las Instrucciones por Adelantado son un documento que:



- Contiene sus decisiones sobre el tratamiento de soporte vital.
- Dice quién hablará con su médico cuando usted no pueda.
- Le explica a su médico lo que usted quiere.

❏❏ Cómo Elegir un Defensor de Final de la Vida



PLANIFICAR: Mi Defensor del final de la vida

Connie y Betty sabían que la planificación para el final de la vida incluía decidir quién hablaría por ellas con sus médicos. Tomaron decisiones sobre quiénes serían sus Defensores del final de la vida e hicieron sus planes personales.

¡Bueno para recordar!

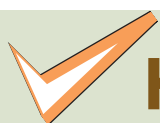
Algunas personas tienen **custodios**. Si usted tiene un custodio, verifique si esta persona ya es su Defensor del final de la vida.

Reúnase con esta persona para completar la guía.

Mi decisión:

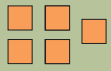
Quiero que _____ sea mi
Nombre

Defensor del final de la vida y él/ella está de acuerdo.



HACER: Próximos pasos

1. Complete el **Formulario de Instrucciones por Adelantado**.
2. Firme las **Instrucciones por Adelantado** ante dos testigos.
3. Complete el **Formulario de Pedidos Personales**.
4. Asegúrese de que su Defensor del final de la vida tenga una copia de los dos formularios.



Cómo Mantener la Situación Bajo Control



Cuando termine su guía **Mis Planes** y complete los formularios que encontrará al final, habrá ejercido su derecho de vivir su vida a su manera: ahora y al mismísimo final. Estará preparado.

Tendrá un plan para compartir con sus seres queridos, su médico y otras personas que son importantes en su vida.



1

A continuación, le damos unos consejos:

Obtenga información de maneras que **USTED** pueda entender.



2

Comparta su plan con las personas importantes.



3

Modifique su plan si lo necesita.



4

Tome sus propias decisiones.



Defensores Lideran el Proyecto

El proyecto de la guía y el DVD **Mis planes** fue dirigido por defensores con discapacidades del desarrollo de tres centros regionales de California. Querían compartir sus experiencias e ideas porque sabían qué importante es tomar decisiones propias ahora y hasta el mismísimo final. Los defensores se reunieron en tres grupos temáticos para guiar el proyecto y asegurar que la guía y el DVD reflejaran sus voces.



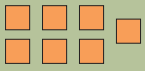
Alta California Regional Center
Sacramento, CA
Participantes del grupo temático



Golden Gate Regional Center
San Francisco, CA
Participantes del grupo temático



Eastern Los Angeles Regional Center
Alhambra, CA
Participantes del grupo temático



Recursos

www.CoalitionCCC.org

(California Coalition for Compassionate Care) Coalición de California para el Cuidado Compasivo es una asociación presente en todo el estado formada por más de 60 organizaciones dedicadas a dar a conocer la medicina paliativa y la atención al final de la vida. Brinda información útil sobre cómo tomar decisiones relacionadas con el final de la vida y sobre leyes y formularios. En este sitio está disponible para su descarga una copia de la Guía Mis Planes y pautas para facilitadores.

www.caringinfo.org

(Caring Connections) es un programa de la (National Hospice and Palliative Care Organization) Organización Nacional de Hospicios y Cuidados Paliativos, una organización nacional comunitaria y de consumidores comprometida con la mejora de la atención al final de la vida.

www.ih4health.org/index.cfm/MenulItemID/266.htm

(California Advance Health Care Directive) Este formulario de fácil lectura de Instrucciones de salud por adelantado de California fue creado para ayudar a entender mejor estos documentos legales.

www.agingwithdignity.org/5wishes.html

(Five Wishes) El documento Cinco deseos ayuda a las personas a expresar cómo quieren que los traten si sufren una enfermedad seria y no pueden hablar por sí mismos. Incluye necesidades médicas, personales, emocionales y espirituales.

www.dds.ca.gov/ConsumerCorner/Publications.cfm

(California Department of Developmental Disabilities, Consumer Advisory Committee) El Comité Asesor del Consumidor del Departamento de Servicios de Desarrollo de California preparó numerosas publicaciones con ilustraciones y lenguaje simple y DVD que alientan la autodirección y la toma de decisiones propias. La Guía Mis Planes también está disponible para descargar.





Agradecimientos

ALTA CALIFORNIA
REGIONAL CENTER



Alta California Regional Center

David Lopez, Consumer Advocate

Terry Wardinsky, MD, Medical Director



Eastern Los Angeles Regional Center

Jesse Padilla, Consumer Advocate

Felipe Hernandez, Chief of Consumer Services



Golden Gate Regional Center

Elizabeth Grigsby, Consumer Advocate

Felice Weber Parisi, MD, Director, Clinical Services

Gabriel Rogin, Strategic Development Coordinator



Connie Martinez - Defensora

Alta California Regional Center



Betty Pomeroy - Defensora

Redwood Coast Regional Center



COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Coalition for Compassionate Care of California

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Board Resource Center

Making Complex Ideas Simple

Mark Starford, Executive Director

Charlene Jones, Editor; Donna Aikins, Layout

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916.574.1023 www.brcenter.org



Pedidos Personales

Estos son mis pedidos personales, pero **no es un Testamento**.

Nombre: _____

(1) En dónde quiero estar

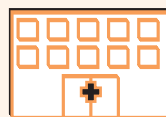
Esta es mi elección del lugar donde quiero pasar mis últimos días.



☐ Mi casa



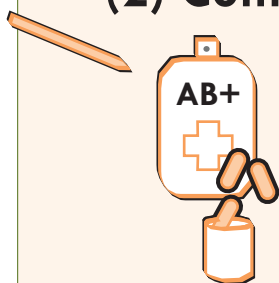
☐ Con mi familia



☐ Hospital

☐ Otro lugar

(2) Cómo quiero que me atiendan



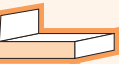
- ☐ Tener cerca a mis familiares y amigos.
- ☐ Tener una atención personal que me ayude a sentirme cómodo.
- ☐ Tener mis cosas preferidas cerca.
- ☐ Escuchar la música que más me gusta.
- ☐ Hacer que se respete mi religión.

Otras formas en las que quiero que me cuiden:

(3) Adónde quiero que vayan mis cosas



Dinero



Ropa



Muebles

Equipos

Mascota

Otros



Pedidos Personales



(4) Regalos que quiero hacer

Artículo: _____ Para: _____

Artículo: _____ Para: _____



(5) Mi cuerpo

☐ Quiero que me entierren. Lugar: _____

☐ Quiero que me cremen. Mis cenizas irán a:



(6) Cómo me recordarán

Quiero un funeral ☐ Sí ☐ No

☐ En mi lugar de culto _____

☐ En una funeraria _____

☐ Otro lugar _____

☐ Quiero que me recuerden haciendo esto: _____



Firme con su Nombre

Fecha

Calle

Ciudad Estado

Código Postal

Teléfono particular

Teléfono del trabajo Correo electrónico



Instrucciones por Adelantado

(Nombre) _____ es mi

Defensor del final de la vida (Agente de atención médica).

Calle _____ Ciudad _____ Estado _____ Código Postal _____

Teléfono particular _____ Teléfono del trabajo _____ Correo electrónico _____

Mi Defensor del final de la vida tomará decisiones por mí sólo cuando yo no pueda tomar las decisiones por mí mismo.



Mis elecciones del final de la vida

En mis últimos días, calidad de vida para mí significa:

- ☐ Estar despierto y pensar por mí mismo.
- ☐ Comunicarme con la familia o los amigos.
- ☐ Estar libre del dolor constante y fuerte.
- ☐ No estar conectado a una máquina todo el tiempo.
- ☐ _____

Para mis últimos días, mi decisión sobre tratamiento de soporte vital es:

- ☐ Quiero tratamiento de soporte vital por todo el tiempo que sea posible.
- ☐ No quiero ningún tratamiento de soporte vital.
- ☐ Quiero tratamiento de soporte vital **solamente** si mi médico cree que podría ayudar.
- ☐ Quiero que mi Defensor del final de la vida decida por mí.



Instrucciones por Adelantado



Firme con su nombre

Fecha



Su nombre en letras de molde

Fecha

Dirección

Ciudad

Estado

Código Postal

Para los testigos:

Como testigo, doy fe de que (persona) _____
firmó este formulario ante mi vista. Él/ella **no** fue forzado(a) a
firmarlo.

También doy fe de que:

- Conozco a esta persona y él/ella puede comprobar su identidad.
- Soy mayor de 18 años.
- **No** soy el Defensor del final de la vida de esta persona (Agente de atención médica).
- **No** soy el proveedor de atención médica de esta persona ni trabajo para su proveedor de atención médica.
- **No** trabajo en el lugar donde vive esta persona.



Firma del testigo

Fecha



Firma del testigo

Fecha

Uno de los testigos no debe tener lazos de sangre, matrimonio ni adopción y no debe recibir dinero ni propiedades de parte de esta persona luego de su muerte.



(DRAFT) From the VMRC Consumer Advocates- SAC6

Your VMRC Individual Program Plan (IPP**) Is coming up!**

This is **YOUR** life and **YOU** make the decisions and choices about how to live it! If **YOU** want or need help to get ready for **YOUR** meeting just ask people that **YOU** want and who support **YOU**! Having a plan will help **YOU** and those that love and care about **YOU** know **YOUR** wants and needs and wishes.

How can **YOU** be ready for **YOUR** meeting?

- 1.
- 2.
- 3.

Instruction to SC:

Mail out the 'Thinking Ahead Booklet' to the Individual prior to the IPP meeting. Individual will complete the booklet with support from family, care provider, SLS, ILS or day program staff, as needed. Planning Team will discuss the responses at the IPP meeting, which will be incorporated in the IPP objective.

This objective will be reviewed and updated as needed at least annually; and a copy of the source document 'Thinking Ahead Document' and/or completed and signed Form A (Personal Requests) & Form B (Advance Directive) that were discussed in the IPP meeting are retained in the legal section of the individual's file.

Advance Care Planning / Supported Decision-Making

- Describe individual's baseline abilities – ability to feed self, type of diet (regular / puree / mechanical soft / no restrictions / g-tube) ambulation skills, use of hands, does the individual use any DME, continent / incontinent.
- Communication – Describe how the individual communicates - verbal, non-verbal, receptive skills, ability to demonstrate understanding of medical procedure.
- Unique traits – Nickname, preferred activities, any special accommodations (i.e. special pillow, music, and toy), likes / dislikes.
- Reasonable Accommodation – Will the individual need a known support person / caregiver to stay in the hospital with them?
- Legal / Authorized Representative – Is the individual conserved? Does Conservatorship include power over medical decisions? Does the individual have Power of Attorney for medical decisions? Does the individual have an Advanced Health Care Directive? Is there a POLST in place?
- Next of Kin / Circle of Support – Who are the people this individual relies on to make health care decisions and their contact information?
- End of Life Planning –
Has there been an 'End of Life Planning' conversation with the individual? ☐ Yes ☐ No
What is the individual's choice? Understanding of DNR? Is there a POLST in place?
- If Individual is unwilling to discuss 'End of Life Planning' – note that it will be reviewed at the next meeting.

Organ / Tissue Donor - ☐ Yes ☐ No

As a non-conserved adult, _____ is presumed to have the capacity to make informed decisions regarding *his / her* health care, residence, psychiatric care and other objectives implemented in her IPP. If a physician is concerned about _____'s capacity to consent for medical treatment, Planning Team will assist _____ with making an informed decision, including, but not limited to, the risks and benefits of said decision. If there remain concerns about _____'s capacity, the family and/or VMRC Medical Director will be contacted. In the event of a medical emergency, if no family member or next of kin can be contacted, the Planning Team will follow Section 4655 of the California Welfare and Institutions

OUTCOME # : **Provided with support, will be able to make decisions that require informed consent.**

PLANS:

's Role -

- a. Individual will consent to all services and supports as stated in her IPP, as he / she so chooses.
- b. will provide his / her Planning Team contact information of family members to contact in case of emergency.
- c.

What supports will help achieve his / her outcome.

- d. Planning Team will provide support in weighing risks and benefits with to assist with making informed decision.
- e. Service Coordinator / Service Providers will ensure that 's record has the current contact information of 's next of kin or family members.
- f.

Regulatory Standards (if applicable) -

- g. In the event of a medical emergency, if no family member can be contacted, the Planning Team will follow Section 4655 of the California Welfare and Institutions Code.
- h. This objective will stay in place until a court rules that Individual is no longer able to give informed consent.
- i.

Funding Source: _____ **Start Date:** _____ **Target Date:** _____



SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

State of California—Health and Human Services Agency **California Department of Public Health**



GAVIN NEWSOM
Governor

May 2, 2020

AFL 20-38.1

TO: All Facilities

SUBJECT: Visitor Limitations Guidance
(This AFL supersedes AFL 20-38)

All Facilities Letter (AFL) Summary.

- This AFL notifies all facilities of new visitor limitation guidelines for pediatric patients, patients in labor and delivery, and patients at end-of-life.
- This AFL clarifies that health facilities may permit a support person to accompany a patient for whom a support person has been determined to be essential to the care of the patient (medically necessary), including patients with physical, intellectual, and/or developmental disabilities and patients with cognitive impairments.

Due to the community spread of Coronavirus Disease 2019 (COVID-19), considerations must be made for the safety of health facility staff and patients, resulting in many health care facilities suspending visitation, except when medically necessary or essential to the care of the patient. The California Department of Public Health (CDPH) recognizes the importance that visitors play in the mental well-being of patients, including pediatric patients, patients in labor and delivery, and patients at end-of-life. CDPH also recognizes the importance of ensuring people with disabilities receive the support they need while hospitalized. CDPH considers visitors an essential part of patient care and recovery.

CDPH has developed recommended visitor guidelines for certain patients to ensure support for their mental health and well-being, while striving to limit the spread of the virus.

Pediatric Patients

- Visitors are essential for the mental health of pediatric patients. CDPH recommends that pediatric patients be allowed one support person.
- In the case of prolonged hospitalization, CDPH recommends two designated support persons for pediatric patients, provided that only one visitor is present at a time.

Labor and Delivery Patients

- The presence of a partner or support person is essential to the mental health of patients who are in labor and delivery. CDPH recommends that one support person be allowed to be present with the patient.

Patients at End-of-Life

- Visitors are essential to the mental health of patients who are at end-of-life. For their continued mental health, and well-being, the department recommends that one visitor be allowed to be present with the patient.

Patients with Physical, Intellectual, and/or Developmental Disabilities and Patients Cognitive Impairments

The presence of a support person is essential to patients with physical, intellectual, and/or developmental disabilities and patients with cognitive impairments. CDPH recommends that one support person be allowed to be present with the patient when medically necessary.

For hospitalized patients, especially with prolonged hospitalization, the patient or family/patient representative may designate two support people, but only one support person may be present at a time.

All support persons must stay in the room and be asymptomatic for COVID-19 and not be a suspected or recently confirmed case. Support persons may be screened prior to entering the clinical areas. Support persons must comply with any health facility instructions on personal protective equipment.

Additionally, CDPH strongly encourages facilities, including but not limited to skilled nursing facilities, to create ways for residents and patients to have frequent video and phone call visits. If shared devices are used for video calls facilities should ensure appropriate infection control measures are in place.

Sincerely,

Original signed by Heidi W.Steinecker

Heidi W. Steinecker

Deputy Director

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA
95899-7377
(916) 324-6630 . (916) 324-4820 FAX
Department Website (cdph.ca.gov)



Page Last Updated : May 2, 2020

VALLEY MOUNTAIN REGIONAL CENTER



Detailed Alert Data

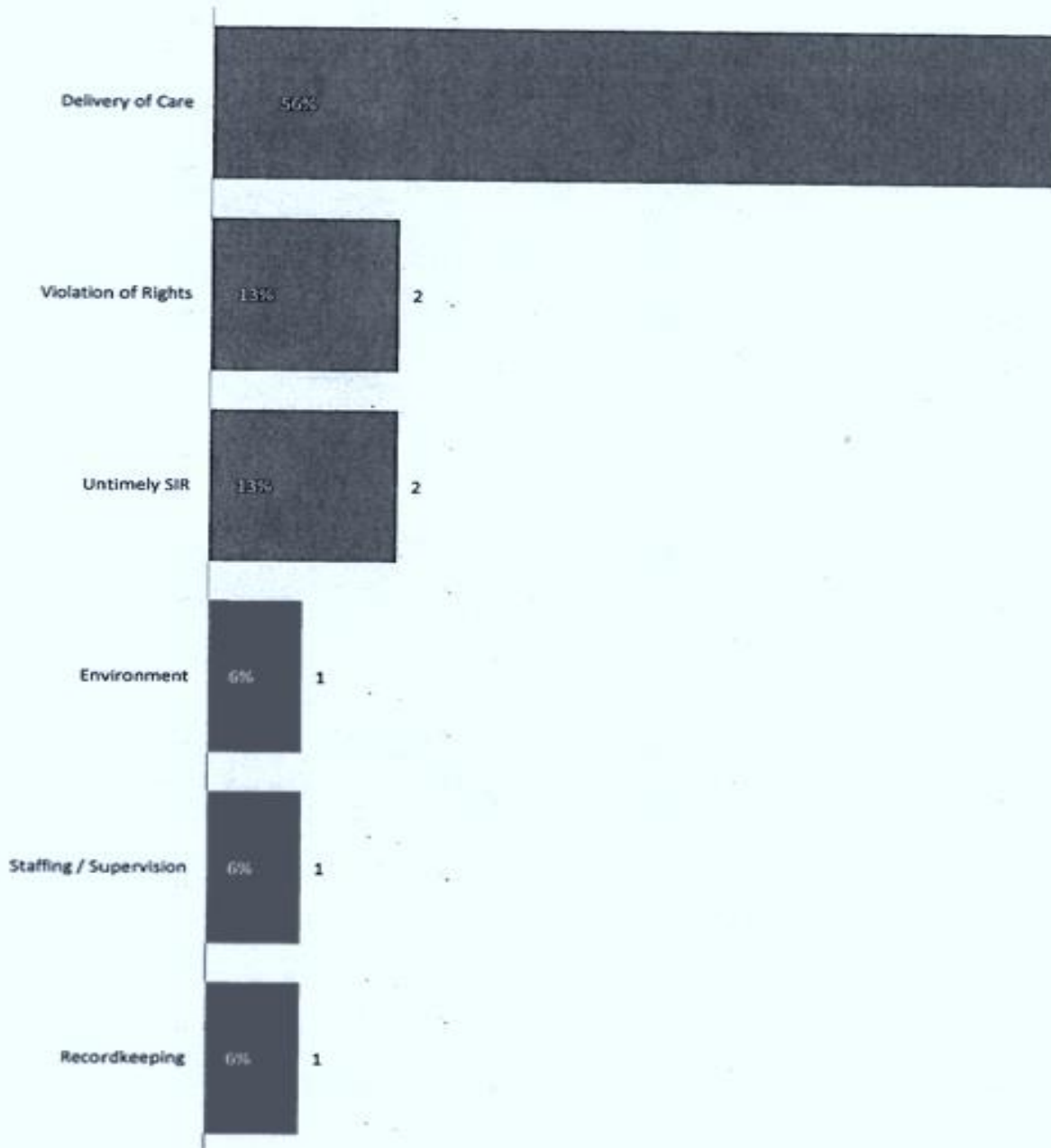
Date Opened	Presenting Issue	Action	Finding	Date Closed	Control #
4/16/2020	Staffing / Supervision				2020-04-08.0
4/17/2020	Untimely SIR				2020-04-09.0
4/20/2020	Delivery of Care				2020-04-10.0
4/20/2020	Violation of Rights				2020-04-10.1
4/23/2020	Untimely SIR				2020-04-11.0
4/30/2020	Violation of Rights				2020-04-13.0
5/4/2020	Delivery of Care				2020-05-01.0
5/6/2020	Delivery of Care				2020-05-02.0
5/11/2020	Recordkeeping				2020-05-03.0
5/12/2020	Delivery of Care				2020-05-04.0
5/13/2020	Delivery of Care				2020-05-05.0
5/13/2020	Delivery of Care				2020-05-06.0
5/14/2020	Delivery of Care				2020-05-07.0
5/14/2020	Environment				2020-05-08.0
5/14/2020	Delivery of Care				2020-05-09.0
5/14/2020	Delivery of Care				2020-05-10.0
Total					16



QA Alert Report

4/16/2020 - 5/15/2020

Alert Presenting Issues Received



Consumer File Transfer Status - To and From VMRC

2017			
Files Received		Files sent out	
January	23	January	31
February	41	February	19
March	38	March	25
April	33	April	14
May	53	May	31
June	21	June	21
July	41	July	12
August	41	August	28
September	40	September	29
October	53	October	30
November	52	November	57
December	41	December	19
total for 2017	477	Total for 2017	316

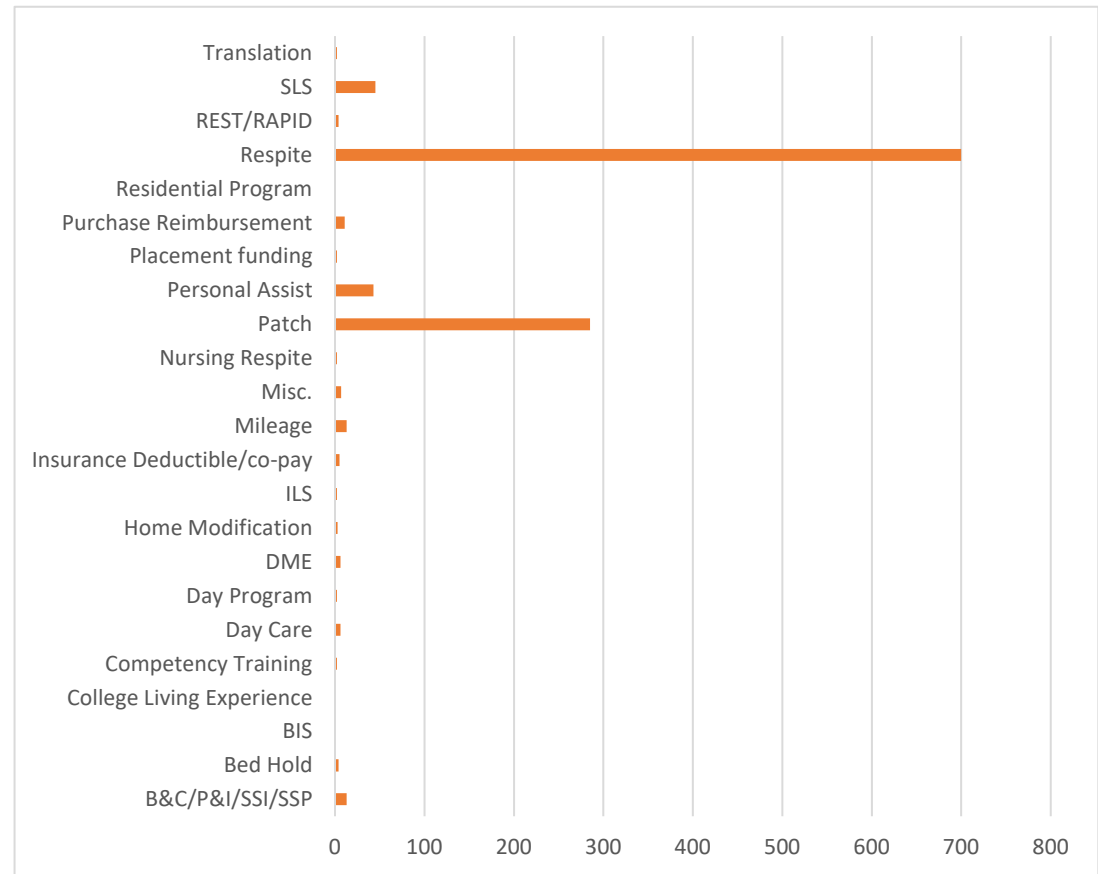
2018			
Files Received		Files sent out	
January	53	January	37
February	33	February	20
March	28	March	24
April	36	April	31
May	32	May	32
June	39	June	28
July	39	July	23
August	51	August	35
September	41	September	22
October	43	October	23
November	37	November	30
December	33	December	18
total for 2018	465	Total for 2018	323

2019			
Files Received		Files sent out	
January	33	January	32
February	31	February	37
March	36	March	33
April	49	April	21
May	33	May	26
June	25	June	26
July	33	July	38
August	42	August	25
September	39	September	38
October	41	October	32
November	28	November	15
December	26	December	23
total for 2019	416	Total for 2019	346

2020			
Files Received		Files sent out	
January	36	January	28
February	43	February	29
March	32	March	25
April	30	April	23
May	8	May	7
June		June	
July		July	
August		August	
September		September	
October		October	
November		November	
December		December	
total for 2019	149	Total for 2019	112

POS Exceptions 2019-2020	
2019/2020	Apr
B&C/P&I/SSI/SSP	13
Bed Hold	4
BIS	1
College Living Experience	1
Competency Training	2
Day Care	6
Day Program	2
DME	6
Home Modification	3
ILS	2
Insurance Deductible/co-pay	5
Mileage	13
Misc.	7
Nursing Respite	2
Patch	285
Personal Assist	43
Placement funding	2
Purchase Reimbursement	11
Residential Program	1
Respite	700
REST/RAPID	4
SLS	45
Translation	2
TOTAL POS	1160
Approved	1156
Deferred	1
Denied	3

POS Exceptions April 1 - 15, 2020



16 Apr 2020 to 15 May 2020 Incident Report Consumer Count: 34

Special Incident Types	Count	Percent
HOSPITAL/INTRNL INFECT-VND CARE	8	17.0%
COVID 19 VIRUS	6	12.8%
LACERATIONS-SUTURES/STAPLES-VND CR	5	10.6%
DEATH	5	10.6%
FRACTURES-VND CARE	5	10.6%
MEDICATION ERROR-VND CARE	4	8.5%
EMERGENCY ROOM VISIT	4	8.5%
HOSPITAL/RESP ILLNESS-VND CARE	3	6.4%
HOSPITAL/OTHER	2	4.3%
HOSPITAL/CARDIAC-VND CARE	2	4.3%
MISSING PERSON-LAW NOTIF-VND CARE	1	2.1%
ALLEGED PHYSICAL ABUSE-VND CARE	1	2.1%
HOSPITAL/DUE TO SEIZURE-VND CARE	1	2.1%
Grand Total	47	100.0%

