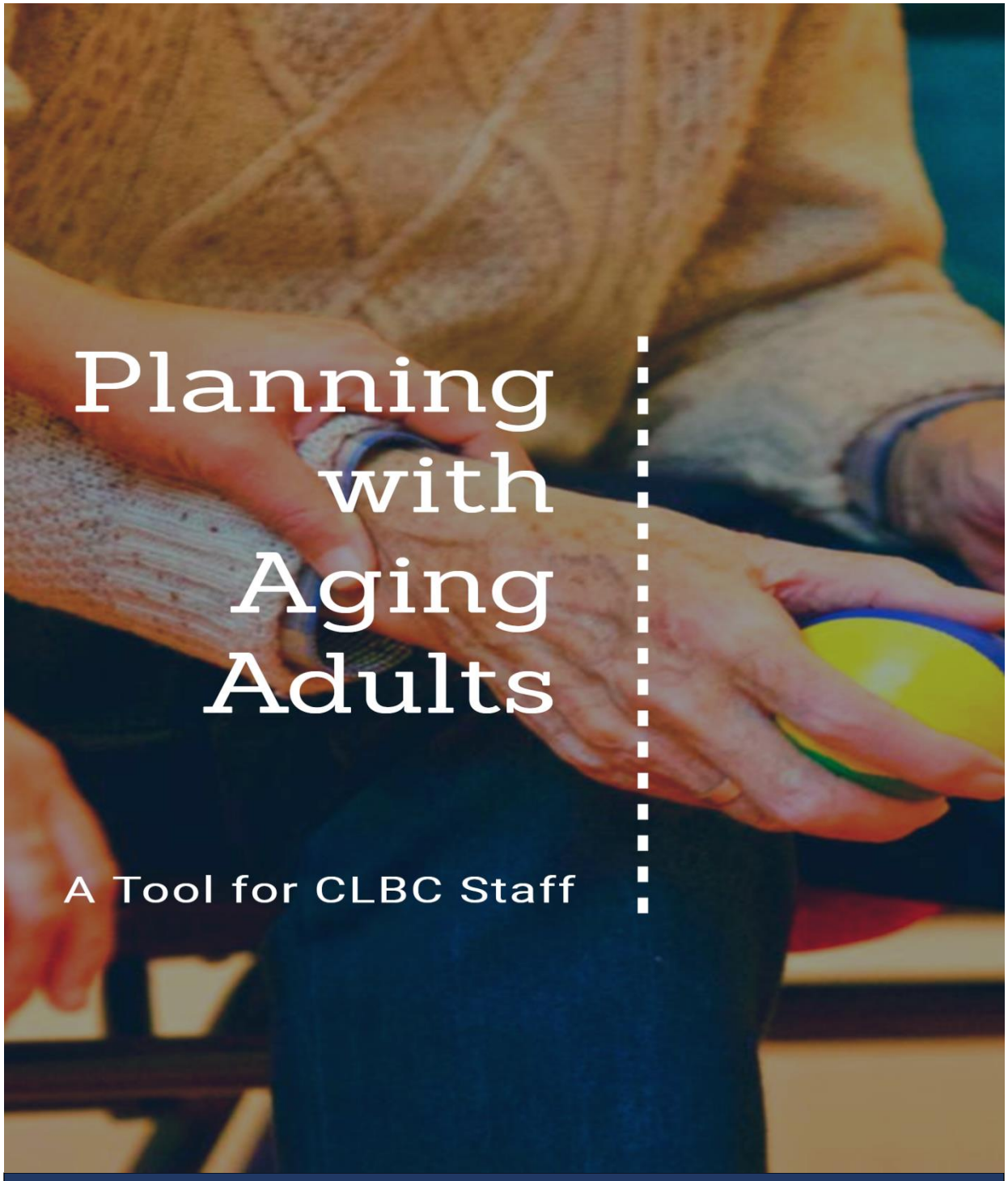

Planning with Aging Adults

A Tool for CLBC Staff

A growing number of people with developmental disabilities are living well into their senior years in community. This is a new trend with both challenges and opportunities.

Individuals have a chance to participate in and contribute to their communities and also experience new care and support needs and increased vulnerabilities as they age - just like all seniors.

The realities and concerns individuals and their families face are changing, and the services they need shift over time, as they grow older.

Planning with Aging Adults - Shifting Practice

These changes require a deeper involvement in planning and coordination with aging individuals and other services than at other times in people's lifespan. In many ways, it is a similar set of transition planning skills and practices as when we are planning with families for the transition of their children into CLBC services. And just as with that transition, working collaboratively with partners is key to success.

There are also **requirements** to consider at different age junctures:

When	Required
At age 55	☐ Check-in with the person and service provider to gather planning information and complete or update the GSA, RFS and find out care team members or important people in the person's life.
Ongoing after age 55	☐ Participate in, develop and/or coordinate with person's care team ☐ Facilitate community connections with person to aging adult resources ☐ Respond to requests for aging-related support changes
At age 63	☐ Check-in with the person and service provider to gather planning information and complete/update GSA, RFS and associated people ☐ Support the person's financial transition to OAS benefits (for example: ensuring two years of tax filing prior to age 65)
A change in service provider or services	☐ Develop/update aging transition plan in concert with care team ☐ Implement changes in services check-in with the person and service provider
Annually	☐ Forecast aging transition numbers/needs

You can expect there to be more players involved in an individual's life, requiring more communication and collaboration.

Getting Ready

Learning about the generic supports and services for seniors in your community is a great point to start. This is all about community awareness and capacity building. There is a lot of established research and awareness about the needs of aging adults, and many initiatives and organizations that support them. With your lens and understanding of developmental disability, you need to find those resources and start thinking about how they may be relevant to the aging adults you work with.

- As a CLBC local or regional team, what are the trends emerging of both interest and need for your region's aging adults?
    - At a team meeting, create a wish list of community services and supports for seniors

- As a team, how would you like to maintain communication and information-sharing about the supports for aging adults in your community/region?
    - Consider the dedicated time of an interested staff to support creating connections within community

- What clinics, support groups and other services does the local health authority offer in your community?
    - Who are the good contacts for care team development in your region?

- We are deliberately using the term **care team** to align with our health partners. Care team members should include the individual and everyone who has a role in caring for or supporting them. In a way, it is like an enhanced support network – with each member having a specific role the individual's life.

Having Planning Conversations with Aging Adults

You will find yourself having more and different planning conversations with individuals as they age. The Age 55 and Age 63 check-ins are required points for this, along with whenever there is a change in service or service provider.

However, you will find that needs, concerns and circumstances may shift unexpectedly and you should be prepared to have planning conversations whenever they do. A phone call from a concerned neighbour could be enough to trigger one. ***Any contact with the individual, their family, support network, care team or service provider, is an opportunity to have a future-oriented conversation, and to document it.***

Possible Guiding Questions for Planning with Aging Adults

○ **How are you feeling these days?** ○ **What do you like best about your life right now?** ○ **Are there any big problems in your life you would like to solve?** **What are you interested in?** ○ **Are your interests changing?** ○ **Do you feel any different or the same as you used to?** **What's different?** ○ **Is there something you would like to change?** ○ **What could help you find more enjoyment in life?** ○ **What's most important to you in your life right now?**	*Each conversation focuses on who they are as a person first, aging adult second.* *To open a conversation on aging related issues, you can explore the Quality of Life domains such as social inclusion, emotional, material and physical well-being, meaningful relationships and personal choices.* *Start taking notes on how things are going, to explore how an individual might want or need further connection, referral, or support.*
○ **Tell me about your social networks of friends and family.** ○ **Do you participate in any community or social activities?** ○ **Does someone help you do that?**	*Think about what might be a welcoming community place to support the person to expand or develop new social connections. Is there a recreation centre, seniors centre, church, temple, sports or hobby club, service group, college, or other place where the individual might connect with their interests?* *What can be supported for connection to occur?* *Is there another participant, friend, family member, or like-minded support staff who could facilitate participation?* *What safeguards might be needed?*
○ **How is your daily living going? Have you had any changes happen?** (Examples: cooking, eating, cleaning, dressing, bathing, walking, lifting items, pushing or pulling items, picking up small things like coins, making a telephone call, taking medications, etc.)	*Individuals may need support to relay changes to their family doctor or care team members.* *Changes may need to be taken into consideration regarding community, supports, or services.*
○ **How are you doing getting around your house?** ○ **How is it getting up from a chair or sofa?** ○ **Getting into and out of the shower?** ○ **Getting in and out of bed**	***Depending on answers or actions,*** *this may indicate follow up with a Health Services for Community Living (HSCL) referral for an Occupational Therapist.* *Communication with Care Team Members may be indicated.*
○ **Do you get in some physical activity or exercise in your daily or weekly routine?** ○ **If so, what do you do?** ○ **Is there some information you'd like, about some activity you are interested in?** ○ **Is there something you'd like to do for physical activity at home, in your community, at the recreation or seniors centre?**	*Like all aging adults, CLBC-eligible individuals gain many benefits from increased physical activity and decrease potential for heart disease and other health-related issues.* *Transportation support may be needed (application for bus pass, HandiDart card, local seniors volunteer supports i.e. Better at Home).*
○ **Have you recently experienced a fall?** ○ **When?** ○ **What happened?** ○ **Who knows about your fall?**	*Information to share with Care Team.* *May also indicate follow up with a Health Services for Community Living (HSCL) referral for an Occupational Therapist.* *Or fall prevention clinic referral through the local health authority*

Potential Medical Issues Associated with Aging Adults
Some Questions

○ **Have you recently been to see a doctor?**	*Follow up regarding medications, requests for screenings, specialists, etc. and share with Care Team.*
○ **Have you recently had your eyes tested?**	*Screening for cataracts, glaucoma, cancers, and the need for support may be needed. Would include both the optometrist and ophthalmologist.*
○ **Have you recently had your hearing tested?**	*Screening for hearing loss, other auditory conditions, and support for follow-up may be needed.*
○ **Have you recently had any lab bloodwork or screening tests done? (mammogram, prostate exam diabetes)**	*Screening for diabetes, cancers, osteoporosis, cholesterol, incontinence, Parkinson's disease, etc.*
○ **Have you been to see the dentist in the last while?**	*Screening for dental work, cancers, and the need for support. May also indicate need for a referral to Health Services for Community Living (HSCL) dental hygienist.*
○ **Do you feel more forgetful?** ○ **Have you forgotten how to do something you've done your entire life?** ○ **Are you forgetting words?** ○ **Have you gotten lost in familiar places?** ○ **Are you misplacing things?** ○ **Have you been losing interest in some things you've always liked?**	*Consider support through the Alzheimer Society.* *For memory related issues, consider suggesting to the individual's care team the National Task Group Early Detection Screening as baseline and follow up: http://aadmd.org/sites/default/files/NTG-EDSD-ElectronicForm-9%271%2716-pdf%20%281%29.pdf* *Once a diagnosis is received of any form of dementia, consider participating in supports through the Alzheimer Society for the individual and caregiver.* *Possible referral to Developmental Disability Mental Health (DDMH) may be required.*
○ **Do you live with pain in any part of your body?** ○ **What kinds of changes have you felt in your body recently?** ○ **Can you tell me about it?**	*Communicate with Care Team partners.*
○ **Have you been hospitalized recently? When?** ○ **What happened?** ○ **Were you supported in any follow up activities?**	*Support for follow up may be required due to age-related health issues.* *Request information from the doctor or care team, who should have received a discharge plan.*
○ **Do you have any long-term illnesses that need support?**	*May indicate increased need for supports and services that are specifically aging-related.*
○ **How is sleep going?** ○ **Do you fall asleep easily?** ○ **Do you feel well rested when you wake up?**	*May indicate follow up with doctor regarding quality of sleep and in some instances screening for sleep apnea.* *Communicate with Care Team may be indicated.*
○ **Have you done some planning for your future?** ○ **Where would you like to live?** ○ **Who would you like to live with?**	*Reference Housing Considerations for Aging Adults in this document.*
○ **Have you done some planning for your future?** ○ **Where would you like to live?** ○ **Who would you like to live with?** ○ **Do you have end of life wishes?** ○ **Do you have a will?** ○ **Do you have a representation agreement or other supports?** ○ **Does your family or care network know how to set up a trust so it doesn't affect your PWD funds?** ○ **Has anyone talked to you about the changes that happen with your finances at age 65?**	*Will development through Legal Aid BC* http://www.mylawbc.com/ Representation agreement help through NIDUS BC http://www.nidus.ca/ Contact PLAN for a list of developmental disability confident lawyers http://plan.ca/ *Refer to the Appendix 1 Tip Sheet on Financial Transition at Age 65 appended here*

Housing Considerations for Aging Adults – See Appendix 1

Financial Transition at Age 65 – See Appendix 2

Caregiver Considerations Associated with Aging Adults – See Appendix 3

Appendix 1 - Housing Considerations for Aging Adults

Where someone lives, and what kind of physical and other supports they have, is usually the primary consideration when people get older. They may have lived somewhere for a long time that has worked well. They have friends and routines and know their service provider or caregiver very well. Then either suddenly or gradually, it is not working so well anymore.

Ideally, people will want to stay in the same place and have additional supports put in place. If that is not possible, then people often prefer to stay in the same neighbourhood and be able to access some of the same services close by – such as their doctor, for example. Aging in place is not always possible or even preferable. Aging in the right place is what we should aim for. Knowing that can change over time is important.

Below you will see some of the possible housing scenarios that people may need, and some suggestions for things or options to consider and resources to access.

Independent living or supported living

Here are some considerations when working with individuals living on their own or in some kind of supported living arrangement:

- HSCL involvement for occupational therapy and accessibility, nursing support for unmanaged medical concerns (i.e. diabetes or wound care)
- Consider a fall prevention clinic referral http://www.fraserhealth.ca/media/Revised_Fall_Prevention_Mobile_Clinic_Feb2014.pdf
- Stay on your feet booklet http://fallprevention.vch.ca/stay-on-your-feet-booklet/stay-on-your-feet-booklet
- Home Adaptations for Independence to increase one's ability to stay in their own home longer: http://www.bchousing.org/Options/Home_Renovations

Staffed residential homes

Group homes are licensed by Health and often have a BC Housing component. Group home residents often are already involved with HSCL as well, sometimes with a delegation of task in place. This creates a more complex environment when making changes in response to aging-related needs. For example, BC Housing needs to be in the conversation for physical accessibility changes, and Licensing needs to have updated health care plans. Whoever is coordinating the care team – whether the service provider or CLBC – needs to be aware of all the players and ensure those connections are happening. Collaborative problem-solving is needed.

Planning conversations need to include discussions about staff knowledge, health care needs, aging resources and physical accessibility Some group homes have medical consultants who can be involved in this. Some service providers will approach you directly with requests or suggestions for accessibility improvements such as an elevator or an accessible bathroom.

Because CLBC funds fewer group homes that we used to, and because many group home residents have been there for many years, these sorts of planning conversations in this multi-player environment may be new for both CLBC staff and service provider staff. Don't hesitate to ask for help from your colleagues or manager.

Assisted living

This is a housing type that is new to most individuals with developmental disabilities, and to CLBC staff. Assisted living complexes are usually apartment style residences that may be publicly or privately funded. They generally offer meals, housekeeping, and some type of personal alarm system. Some offer medical appointment transportation, recreational activities or medication support. Some are attached to extended care facilities. They vary widely in size, funding arrangements and types of services included. In many cases, the monthly costs may be similar to home share.

- This may be an option for someone living at home whose family cannot manage anymore. The family may be willing to cover all or part of the cost or help the individual apply for a publicly funded space.
- It could be an option for CLBC to fund a space for an individual who would otherwise be eligible for residential support.

Living in the family home

Many individuals are living in their family home, or with a sibling. Planning conversations need to address not only their aging-related changes, but those of aging family members who may be having difficulty continuing to provide care and support. A small amount of respite may have been sufficient for many years and then, either slowly, or suddenly, it is not. Be prepared to talk about wishes and practicalities of aging in place with a family caregiver, including accessibility; live-in support; decision making; and wills and trusts. You may need to arrange health-related referrals such as HSCL.

New supports such as homemaker services may be required. It is also important to provide help to develop support networks to help support aging parents and/or ease a transition to another living arrangement. http://www.communitylivingbc.ca/learn-more/safeguards-publications/

Living in Shared Living

Facilitators need to be involved when home share or live-in support is a new service– such as someone moving into home share from the family home - or when a change in service provider is occurring. Planning conversations need to consider caregiver knowledge, aging resources, physical accessibility and health care needs.

Extended Care

Extended Care services provide 24-hour professional supervision and care in an environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence.

Extended care services include:

- standard accommodation;
- development and maintenance of a care plan;
- clinical support services (e.g., rehabilitation) as identified in the care plan;
- ongoing, planned physical, social and recreational activities (e.g., exercise, music programs, crafts, games);
- meals, including therapeutic diets prescribed by a physician, and tube feeding;
- meal replacements and nutrition supplements as specified in the care plan or by a physician;
- routine laundry service;
- general hygiene supplies;
- routine medical supplies;
- incontinence management;
- basic wheelchairs for personal exclusive use and basic cleaning and maintenance of wheelchairs; and
- any other specialized service (e.g., specialized dementia or palliative care) as needed by the individual that the service provider has been contracted to provide.

Housing Innovation

CLBC does not have a mandate to fund the cost of housing. Rather, its mandate is to:

- Provide supports to address disability-related needs, including in an individual's home
- Assist individuals and their families to find and use generic and community supports such as transit, recreation, social clubs etc.
- Coordinate amongst various agencies where an individual has complex support needs

More and more, individuals and their families, service providers, and other groups are seeking and creating innovative housing options in their communities. CLBC supports innovative projects that fit into its mandate and works with government and organizational partners to strengthen supports for people with developmental disabilities so that they can be meaningfully included in community life. People who are aging and people with developmental disabilities are exploring innovative housing models and options that do not fit neatly into the current boxes. Check out the resources on the CLBC website.

Appendix 2: Tip Sheet on Financial Transition at Age 65

All individuals must transition from provincial to federal financial benefits at age 65. Here's how it works:

1. Overview

The main agency in charge of federal income benefits for seniors is called Service Canada (SC). Their phone # is 1.800.277.9914. It can sometimes take several tries to get through to them on the phone. There are 4 different financial benefits you may receive at 65:

a) Old Age Security (OAS): this one is always a set amount for everyone who is eligible. Right now it's around $564. Eligibility is age based. You also have to have lived in Canada as an adult for 10 years to receive OAS.

b) Guaranteed Income Supplement (GIS): You have to apply for this separately from OAS. You have to do your taxes every year in order to qualify for it as eligibility is income based. Even CPP is considered income when determining the GIS amount. So if you're getting less GIS than your friend, it may be because you have CPP.

c) Seniors Supplement: Once you are determined eligible for GIS, you will automatically be assessed for the seniors supplement. It'll be about $30 or $40 per month.

d) Canada Pension Plan (CPP): CPP eligibility is based on your financial contributions through employment, or your spouse's contributions if you are receiving survivor benefits. Some people receive CPP Disability before they turn 65. Once you turn 65 your CPP Disability will stop and you'll only receive regular CPP. This will mean the amount of CPP will likely go down a lot. You'll have to request for SC to reassess your GIS eligibility amount after your CPP goes down. They will send you a form and it actually takes them about 7 months to process this reassessment, even though they are just reviewing their own info (i.e. their reduction of your CPP).

If you have no other source of income and you are a single person, you should end up with somewhere around $1300 in federal benefits once all the different applications are completed. Complicated, I know!

2. Apply for OAS and GIS one year before you turn 65. It takes them about 4 months to process your application. Make sure you do your taxes in preparation for applying. If your OAS and/or your GIS are not approved by the time you turn 65 and you were on provincial disability assistance benefits, you can apply for a monthly top-up until your OAS and GIS come in. You have to apply for this monthly, they won't automatically send it to you after you apply once. The ministry office will also want a confirmation that you've done everything you can to move your OAS/GIS application along.
Find the application form here: Service Canada forms: http://www.servicecanada.gc.ca/cgi-bin/search/eforms/index.cgi?app=lst&grp=oas&ln=eng

3. It's good to have someone help you. The Consent to Communicate form is an important step if someone is going to help you with Service Canada. It can take up to 2 months for Service Canada to add the consent onto your file, so best to do it way in advance. If you're in a pinch, you can bring the consent in, in person to the Service Canada office. If you're on call with Service Canada, many people working for SC will not share info with you based only on the individual's verbal consent, so don't count on that.
Find the Consent to Communicate form here: Service Canada forms: http://www.servicecanada.gc.ca/cgi-bin/search/eforms/index.cgi?app=lst&grp=oas&ln=eng

4. Medical and dental coverage: If you were on PWD Benefits through the BC Provincial Government, you must request to stay on Medical Services Only Assistance in order to remain eligible for health supplements and medical coverage past the age of 65. If you were not on BC Government Benefits before 65 then you can apply for premium assistance if your monthly income is less than $22,000.00: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/premiums. There's no longer a gold card for extra health benefits after 65. This is a really important step as Pharmacare coverage is essential to many seniors and they may not know that they have to make this request to keep it

5. Bus Pass: If you are eligible for GIS you will be eligible for the provincial bus pass program. But you do have to apply for it separately: http://www.sd.gov.bc.ca/programs/bus-pass.html

6. Third Party Administration: If you have trouble managing your own money, you can request 3rd party administration to help with paying your bills and budgeting your funds. Service Canada has forms for allowing a third party to receive your money in order to administer your funds. Agencies like the Bloom Group in Vancouver offer voluntary adult guardianship services:

http://www.thebloomgroup.org/our-work/adult-guardianship/. The Public Guardian and Trustee may also be involved in adult guardianship and financial administration.

Appendix 3: Caregiver or Service Provider Considerations for Aging Adults

Key transition points in individual's lives

- ☐ Age 55 planning check-in with CLBC
- ☐ Age 63 planning check-in with CLBC
- ☐ Age 65 transition from PWD to OAS financial benefits (tip sheet)
- ☐ Health emergency with discharge planning leading to service changes
- ☐ 'Retiring' from day programming
- ☐ Accessing generic community seniors' resources

Housing

- ☐ Training for staff and caregivers on aging-related needs e.g. fall prevention
- ☐ Recruiting staff/caregivers with health care or aging-related experience
- ☐ Group home or home share physical accessibility
- ☐ Transitioning for individuals moving from home share to group home

Health and personal care needs

- ☐ Health Services for Community Living (HSCL) relationships
- ☐ Developmental Disabilities Mental Health Services (DDMHS) relationships
- ☐ Accessing generic community health supports such as fall clinics
- ☐ Emergency and hospitalization protocols
- ☐ Orientation of health care staff to individual
- ☐ Homemaker supports (help with cleaning, personal hygiene)
- ☐ Added care funding

Other supports/safeguards

- ☐ Respite for caregivers (consider pooling respite resources)
- ☐ Life skills supports for activities of daily living
- ☐ Support network development/support

Aging-related planning needs and responsibilities

- ☐ Aging transition plan
- ☐ Care team coordination
- ☐ Hospital discharge planning
- ☐ Representation agreements, wills and estate planning
- ☐ End of life wishes and dying at home