ONTARIO PARTNERSHIP
ON AGING AND DEVELOPMENTAL DISABILITIES

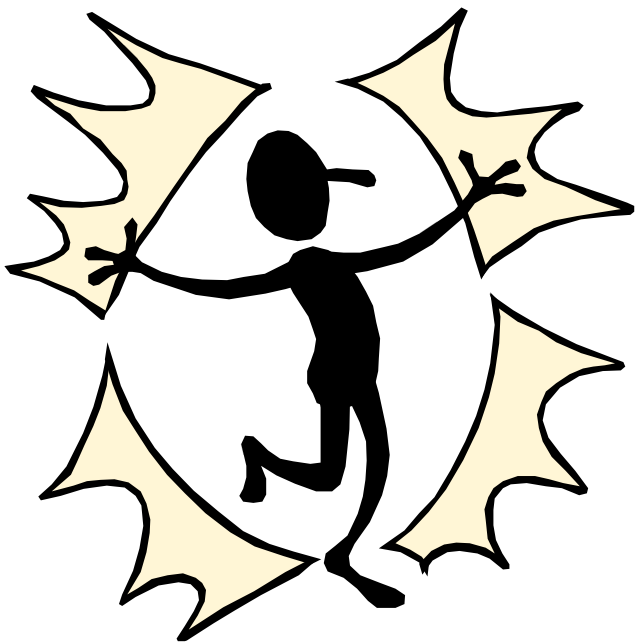
Best Practices in Transition Planning

OPADD STUDY 2005

OPADD developed a model of transition practices in the long term care and developmental services sectors with data from:

- 250 service providers
- Literature
- Case studies

OPADD Model of Transition Planning



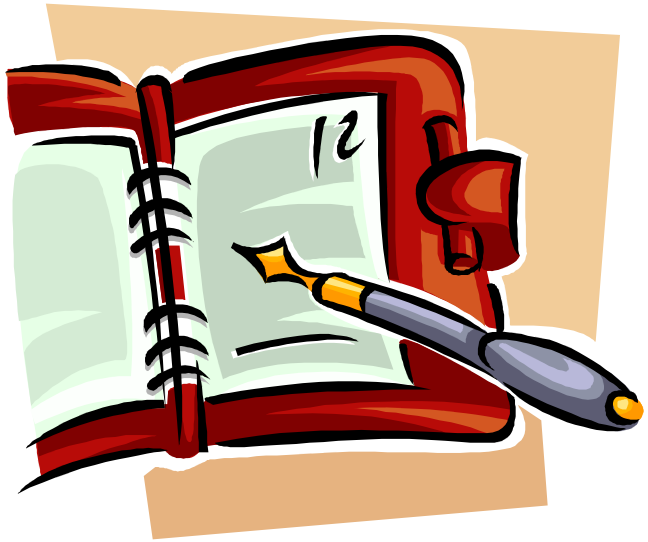
SIX KEY PHASES:

- Preparation
- Training
- Cooperation
- Quality of Life
- Funding
- Maintenance

PREPARATION

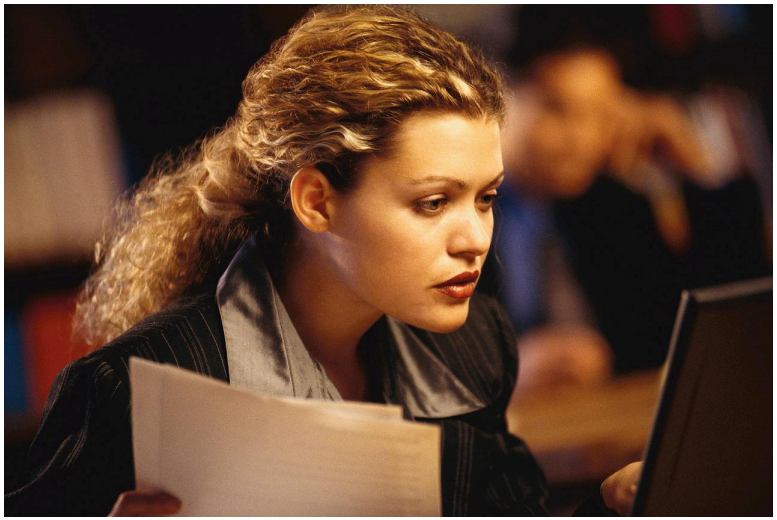
Begin the transition planning process early – in the person's forties

PREPARATION



Gather and maintain a history and background information on each person

PREPARATION



Create baseline data on each person prior to the onset of the aging process

The baseline data will provide a point of comparison as age-related changes take effect

TRAINING

Ensure staff acquire new skill sets related to support during the aging process

TRAINING

Quality of Life → The whole person:

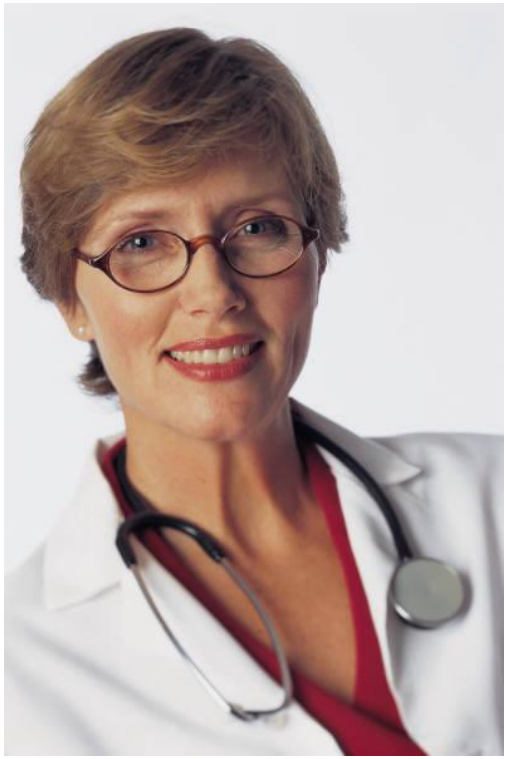
1. Physical – Health
2. Psychological – Emotional
3. Spiritual - Beliefs
4. Social – Relational
5. Daily Living – Practical
6. Leisure – Relaxation
7. Community - Belonging
8. Growth – Learning

TRAINING

Develop capacity to engage in:

- medical
- psychological and
- psychiatric

consultation, assessment and intervention



TRAINING

Become aware of the full range of services available to older adults and how to access them

TRAINING

Get to know the contact people at:

- The Community Care Access Centre (CCAC)
- All Seniors programs and services

Visit senior centres and other community programs

Become familiar with what they offer

TRAINING

Develop and maintain cross sector training processes to support your staff training plan:

- Workshops
- Exchange visits
- Guest speakers

COOPERATION - caregivers

Promote open and continuous cross sector cooperation between caregivers in the developmental services and seniors sectors

COOPERATION - family

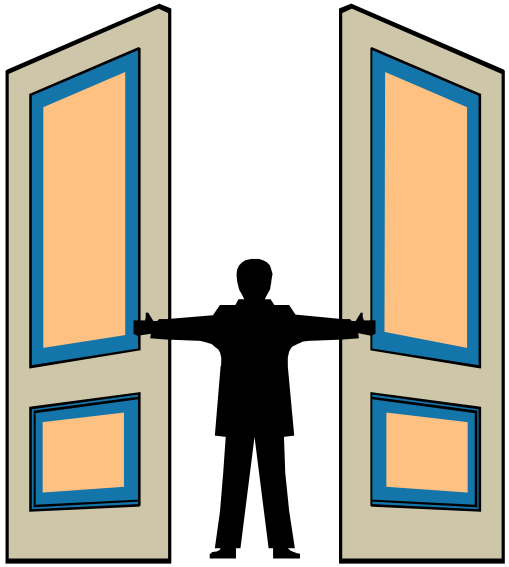
Support family involvement in the transition planning process

COOPERATION - planners

Work with the
Community Care Access Centre (CCAC)

CCACs:

- Are the gate to LTC
- Have assessment tools
- Can provide information



COOPERATION - LHINs

Make sure the health care needs of older adults with a developmental disability are known to your LHIN

COOPERATION – full circle

Ensure all the relevant actors are involved:

- The individual
- Family
- Guardians
- Friends
- Support circle
- Staff
- Community Care Access Centre
- MCSS Coordinated Access Programs

QUALITY OF LIFE

Develop a transition planning process and plan that supports Quality of Life

QUALITY OF LIFE

Consider the impact that aging has on all other people in the client's life (staff, roommates, friends, family) and how this may influence planning decisions

QUALITY OF LIFE

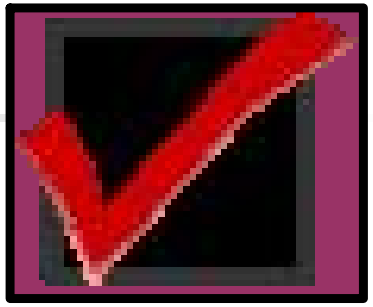
Ensure the individual's plan includes clearly identified risk factors:

- Family history
- A syndrome
- Living situation
- Lifestyle

QUALITY OF LIFE

Identify and be guided by the important philosophical themes of the developmental services system and the long term care system

QUALITY OF LIFE



- Ensuring support in making choices
- Developing strategies that promote inclusion and overcome barriers to using seniors services
- Individualizing a mix of programs and systems of support to the individual's needs

QUALITY OF LIFE

- Aging in place with support from mainstream seniors services
- Moving to a seniors residential program when this is the best available option to maintain quality of life

FUNDING

Find funding:

- **Additional funds** or
- **Flexibility in the allocation of existing funds**

to cover costs related to the transition process.

FUNDING

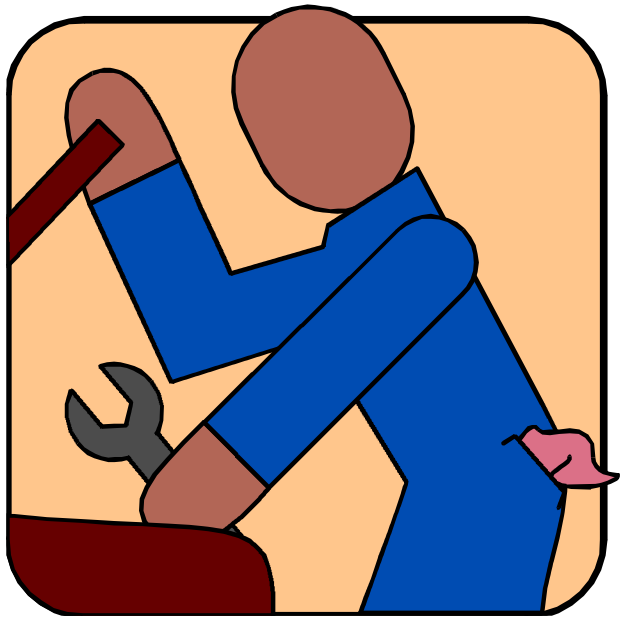
Transition costs may include:

- Orientation visits to a new program
- Support to ensure successful inclusion in the new program
- Follow-up visits from staff
- Consultation to solve problems

MAINTENANCE

Transition planning is an ongoing process

It requires a maintenance plan



MAINTENANCE

- *Begins*

  prior to the aging process

- *Continues*

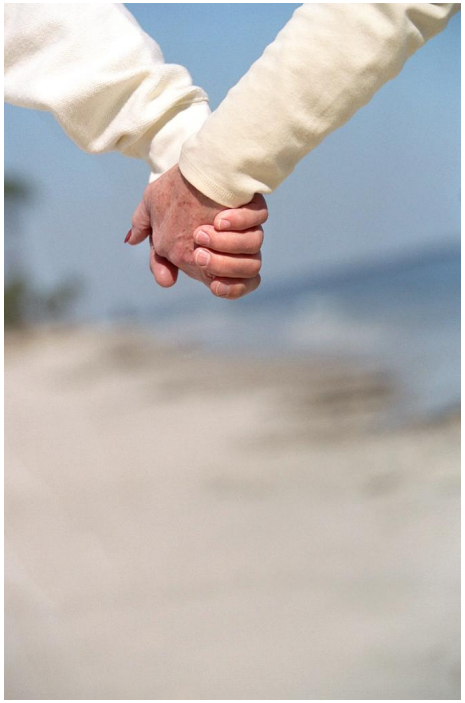
  as the individual takes advantage of mainstream seniors services

- *Does not end*

  even if the individual leaves all of the programs provided by the developmental services sector

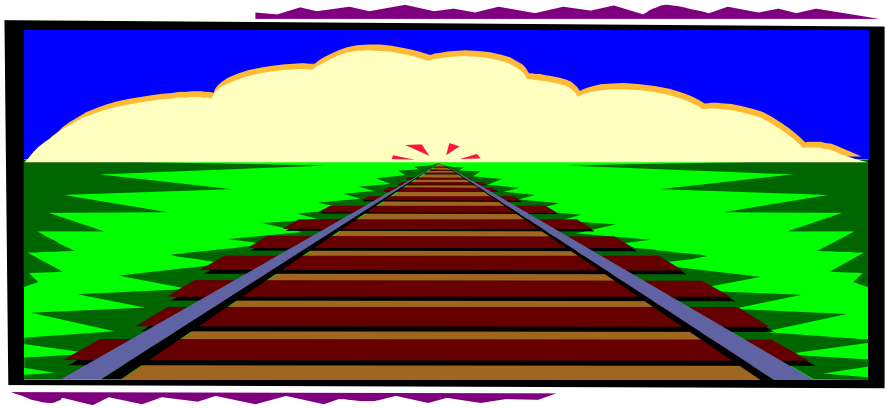
MAINTENANCE

The commitment is to the individual not to the service sector



TRANSITION PLANNING CHALLENGES

Transition planning is a commitment to support that continues throughout the aging process – how do you ensure continuity?



TRANSITION PLANNING CHALLENGES

May stem from inexperience with cross sector partnering:

- A lack of information on who or how to contact a provider in the other sector
- The lack of connection between the sectors in a local area

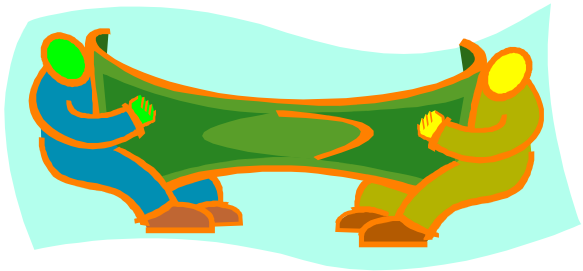
TRANSITION PLANNING CHALLENGES

The regional committee on aging and developmental disabilities may not have established a presence with all service providers in both sectors

TRANSITION PLANNING CHALLENGES

Funding issues:

- Service pressures may constrain a provider's capacity to reallocate funds
- Funding bodies may not have been educated about transition planning costs



TRANSITION PLANNING CHALLENGES

There may be a gap between the level of help given by developmental service providers and the level of help required by long term care agencies during the transition process

TRANSITION PLANNING CHALLENGES

The level of involvement by coordinating bodies (CCAC and MCSS Coordinated Access) may vary from one jurisdiction to another

It may be necessary to orient them to the idea of transition planning and the need for their expertise

OPADD TRANSITION PLANNING - BEST PRACTICES

Six Key Phases:

- Preparation
- Training
- Cooperation
- Quality of Life
- Funding
- Maintenance