GUIDELINES FOR COLLABORATIVE SERVICE DELIVERY

FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

Between

Community Living British Columbia

Regional and Provincial Health Authorities

Ministry of Health

and

Ministry of Social Development and Poverty Reduction

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1.0 BACKGROUND

The Government of British Columbia is committed to a comprehensive system of care and support for individuals with developmental disabilities to assist them to live a full life in their family home and/or in the community. This commitment was confirmed with the establishment of a focused Community Living Program, and service delivery system managed by the Ministry of Children and Family Development (MCFD). This commitment also included funding to the Ministry of Health Services (now the Ministry of Health (MoH)) to provide specialized health and mental health services for those individuals with co-existing developmental disabilities.

In 2001, governance of the health service delivery system was changed, creating five regional health authorities and one provincial health authority, responsible for the planning and delivery of health services. In addition, in 2005 the MCFD devolved Community Living Services to a new provincial authority, Community Living British Columbia (CLBC). CLBC undertook a substantial redesign of its service model in 2005, restructuring how services were delivered and redefining staff responsibilities, and adding an increased emphasis on community access for adults with developmental disabilities.

In June 2008, the Ministry of Housing and Social Development (now the Ministry of Social Development and Poverty Reduction (MSDPR)) was created and CLBC moved to this Ministry. Integration of supports including financial, housing, medical and employment supports will create a closer working relationship between the groups when building on existing supports to address the unique needs of all adults with disabilities.

The significant shifts in health care and community living service structures and increasing client populations created a need to clarify working relationships between ministries, health authorities and CLBC to best meet the needs of this population and achieve government's vision for improved quality of life for individuals with developmental disabilities.

In 2021, to meet their commitment to provide collaborative, integrated service planning for adults with developmental disabilities, CLBC now under MSDPR and the health authorities under the MoH jointly clarified language and processes pertaining to Added Care Funding (see Appendix 6).

2.0 PURPOSE

The purpose of these guidelines is to provide direction and support to regional providers in the development of policies and processes to meet the needs of adults with developmental disabilities in an integrated and sustainable manner. These guidelines reaffirm the commitment to provide appropriate specialized services for adults with developmental disabilities. They define the roles and responsibilities of the service partners as outlined in the following appendices:

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3.0 GUIDING PRINCIPLES

The guidelines and supporting appendices in this document are based on the following principles.

Services to adults with developmental disabilities are:

- Person-centered and fit the needs of those receiving them;
- Delivered in a coordinated manner that ensures appropriate access to meet the special needs of this population;
- High quality and safe;
- Driven by positive outcomes;
- Efficient, effective, evidence-based, and cost-effective;
- The right service provided at the right time, and in the right place; and
- Inclusive of and accountable to the community.

The specialized health support services outlined in these guidelines primarily focus on adults with developmental disabilities and those eligible for CLBC community supports. However, Developmental Disabilities Mental Health Services (DDMHS) also provide services to individuals aged 14 and above who have both a mental illness and developmental disability, some of whom may not be eligible for CLBC services. Services provided by MCFD to children and youth previously served by CLBC will also be in alignment with these guidelines.

4.0 SCOPE

These guidelines apply to those individuals who have a developmental disability as defined under the *Community Living Authority Act* as those with significantly impaired intellectual functioning (diagnosis of Intellectual Disability in accordance with DSM-5) with a concurrent impairment in adaptive functioning, having occurred before the age of 18 years.

These guidelines do not apply to individuals that are eligible for CLBC services as a result of the February 2010 expanded eligibility criteria (i.e., diagnosis of fetal alcohol syndrome disorder, pervasive developmental disorder) and therefore are considered to be out of scope for these guidelines.

5.0 RESPONSIBILITIES

Services will be provided in a manner consistent with the above guiding principles and the attached appendices. Any major organizational or service change which may impact other service partners, and/or individuals with a developmental disability, will be coordinated in consultation with all service partners.

All service partners agree that their respective roles and responsibilities, as articulated in the appendices, are in addition to and take place in the context of service plan and performance agreements that are established for each organization. Service partners will establish regional processes to collaboratively plan and deliver services to ensure client needs are addressed. These processes will reflect the principles of person-centered planning and service delivery, community inclusion, and collaboration with individuals and their families and support networks.

Community Living British Columbia:

- Provide individual planning, support, and service coordination for eligible adults;
- Provide relevant care, service, and financial information to health authorities and MoH, as appropriate, to facilitate individual service delivery and to effectively plan for services to this population;
- Provide information to health authorities on services provided and application of funding when the health authorities contribute funds to CLBC to support an individual with complex clinical care needs;
- Provide residential and community inclusion and family support services to individuals with developmental disabilities in accordance with available resources;
- Make available referral and service composition information to health authorities, MoH, service providers, and individuals with developmental disabilities and their families;
- Coordinate support services for individuals with developmental disabilities through CLBC staff and other funded support services, and when required, provide planning supports service coordination, information and referral service, and problem solve with individuals and their families; and
- Work collaboratively with professionals in the community to provide coordinated care, program review and evaluation, problem solving, crisis response, and recommendations for future service development.

Health Authorities:

- Develop and implement services consistent with the needs of persons with developmental disabilities;
- Ensure services for adults with developmental disabilities are funded in an equitable and appropriate manner;
- Plan and provide services in a manner that is consistent with the Planning Guidelines for Mental Health and Addiction Services for Children, Youth, and Adults with Developmental Disabilities;
- Provide services which support individuals with developmental disabilities in accordance with the above principles, MoH and health authority policies and service guidelines, and within available resources;
- Work collaboratively with professionals and support individuals and families in the community to provide coordinated care, participation in program review and evaluation, conflict resolution, crisis response, and recommendations for future service development; and
- Provide information to other service partners included in these guidelines on the type and volume of health services delivered.

Ministry of Social Development and Poverty Reduction:

- Work with the ministries of Education and Child Care, Health, Children and Family Development, Post-Secondary Education and Future Skills, Public Safety and Solicitor General, and CLBC, BC Housing, and the Office of the Public Guardian and Trustee, and the health authorities to ensure the effective transition of services to individuals with special needs, aged 14 to 25 years, in accordance with the Cross-Ministry Provincial Transition Planning Protocol for Youth with Special Needs; and
- Provide information and be a resource for Provincial Working Group members on disability benefits, medical, dental, and other.

Regional Community Living BC/Health Authority Service Committees:
Each region will establish an inter-ministerial committee including service representatives involved in these guidelines and other relevant service providers for the purpose of supporting coordinated service delivery. The committees will:

- Develop regional policies and processes to support collaboration among service partners;
- Develop local understanding and approaches that encourage individual and family involvement in the delivery of services and supports;
- Create processes to ensure issues pertaining to clients with complex care needs are planned collaboratively and funded within the available resources;
- Collaborate to ensure community appropriate service approaches are developed, and that the best interests of individuals with developmental disabilities are served;
- Ensure that complaints resolution processes are available and communicated to those accessing service, including how to communicate concerns to the Advocate for Service Quality for Community Living Services;
- Deliver services and supports to promote inclusion for adults with developmental disabilities; and
- Consider opportunities to explore join educational opportunities.

6.0 FUTURE DEMAND AND SERVICE LEVELS

Community Living BC, Health Authorities, Ministry of Health, and Ministry of Social Development and Poverty Reduction will jointly:

- Establish performance indicators; and
- Conduct joint reviews, as necessary, to consider issues such as the appropriateness of current service levels to ensure compliance with standards and the health and safety of the client population.

APPENDIX 1: Community Living BC Supports

Preamble:

CLBC provides a range of services and funding to adults with developmental disabilities and their families which assist them to live a full life in their family home and/or in the community. CLBC funded supports are coordinated with specialized health support services and are enhanced through collaborative care planning.

CLBC's service delivery model uses two primary staff roles:

CLBC Facilitators who:

- Confirm eligibility and work with people to develop Individual Support Plans;
- Provide information about options, including generic services and informal supports;
- Assist with service coordination and individual crisis response;
- Fulfil mandated adult guardianship responsibilities; and
- Provide goal focused direct support in response to specific issues.

Quality Service Analysts who:

- Make funding allocation decisions for each individual's supports and services provided by CLBC in relation to an individual's disability related support need;
- Develops resources and manages contracts and budgets; and
- Monitor service quality.

Services:

1. Home Living: A range of home living options support adults to live as fully and independently as possible in their community, based on their support needs. Individuals who can live in their own residence or in home sharing arrangements can receive assistance for development of life and home management skills, health, social relationships and working lives. Individuals who require additional supports can reside with live-in caregivers, in semi-independent living or in fully staffed environments[1]. Personal home support, or homemaker services can assist individuals in independent or semi-independent living.

2. Family Supports for families of adults who live in their own family home: Direct Family Support may include counselling, support, networking, and referrals. Respite Services support family members providing full-time care to their adult relative and can be offered in the respite caregiver's home, in a community setting or in a group home. Direct Respite provides a direct payment to families for the purchase of respite support.

3. Community Inclusion Supports: are provided to adults in either an individualized or group service to assist them in achieving greater independence. Supports include:

[1] Staffed Residential Resource (SRR) models are one of the Home Living settings funded by CLBC and are defined as service structures that provide on-site, 24-hour staffing in a residential setting to individuals requiring full and ongoing care as determined by their disability-related needs. Standard supports occur in a shift-based staffing model and could include assistance with eating, drinking, toileting, bathing, dressing, grooming and use of personal assistive devices. SRRs also support access to community through assistance with transportation and completion of tasks such as banking, attending appointments, meal preparation and laundry as well as activities to support community inclusion and social relationships. Staffing ratios and number of residents vary based on disability-related needs.

- Community-based activity life skills such as shopping, banking, and transportation;
- Recreation and leisure activities;
- Development of social and interpersonal relationships and volunteer opportunities;
- Access to generic services such as informal community supports;
- Employment support to assist adults to find paid employment; and
- Professional support for assessment or other interventions.

Provincial Assessment Centre

The Provincial Assessment Centre (PAC) provides multi-disciplinary mental health services for referred individuals ages 14 and up with a developmental disability and concurrent mental illness, or behaviour issue. PAC works with regions to determine appropriate referrals, after all reasonable community-based options have been explored.

PAC provides the following services:

- Community consultation and planning for individuals referred to PAC;
- Community, family, and caregiver education and training for people accepted to the PAC;
- Diagnosis;
- In-patient assessment and treatment;
- Medical and psychiatric assessment;
- Recommendations for planning, follow-up and consultative support to families, professionals, and service providers for individuals returning to their community.

APPENDIX 2: Specialized Nursing and Rehabilitation Supports

Preamble:

A key component of the community-based system of care and support for individuals with a developmental disability is the provision of specialized nursing consultation and rehabilitation supports. These supports are provided by health authorities through the Health Services for Community Living (HSCL) program. The focus of the service is on individuals with current, anticipated, or emergent nursing and rehabilitation support needs.

Services:

1. The HSCL program will develop and implement ongoing specialized nursing consultation and rehabilitation services delivered at the community level.

2. Referral methods to the HSCL program will be determined at the local level, in consultation with CLBC.

3. Specific services will include screening, assessment, training, referral and planning of supports services for ongoing, acute, and complex health issues. Consultation will be based upon the development of individual health care plans and specific training of individuals, caregivers, and families. Referrals will be received from CLBC staff.

4. HSCL will provide consultation to clients, caregivers, families and CLBC staff as well as liaise with other professionals as needed to ensure appropriate coordination of health services. When required, HSCL clinicians will develop individual specific health care plans consistent with the British Columbia College of Nurses and Midwives (BCCNM) standards of practice.

5. HSCL will be responsible for maintaining specialized competencies relevant to the nursing and rehabilitation needs of adults with developmental disabilities.

6. HSCL will coordinate access to specialized support services including seating, nutrition, and dysphagia through the relevant interdisciplinary services.

7. Health authorities will maintain an individual's specific information and monitor service delivery indicators with respect to HSCL services.

8. The MoH will continue to provide program policy and standards direction to the health authorities, as required.

APPENDIX 3: Nutrition and Specialized Dysphagia Services

Preamble:

An integral component of the community-based system of care and support to individuals with a developmental disability is nutrition and specialized dysphagia support services. Adults with a developmental disability whose health and well-being are at high risk because of complex nutrition and swallowing issues will be eligible for services through the regional Health Services for Community Living (HSCL) and Nutrition Programs.

Services:

1. Nutrition and specialized dysphagia services, individual health care plan consultation and crisis management.

2. Services may be provided through the HSCL program or existing community, and regional dysphagia services provided through hospitals, where available.

3. Referrals will be directed through the HSCL professional staff and provided by the health authority. Specialized services will be provided as indicated through clinical assessment by speech and language pathologists, occupational therapists and/or physiotherapists. Nutrition services will be accessed through registered dietician/nutritionists.

APPENDIX 4: Dental Health Services for Persons with a Developmental Disability

Preamble:

This program was developed to facilitate access to community-based dental services. The focus of this service is on individuals with developmental disabilities who are unable to access generic dental health services in their community. The objective of these services is to maintain optimum levels of oral health.

Services:

1. Provide oral assessments, screening, and examinations to identify dental conditions that require attention, and develop personal oral care plans in consultation with the individual and caregivers, and where appropriate with Health Services for Community Living (HSCL) staff.

2. Provide support and act as liaison between adults, their families, care provider staff, local dentist, community health and CLBC staff to ensure that dental needs are understood, and appropriate treatment services are obtained.

3. Provide familiarization to adults with developmental disabilities to generate greater comfort for the individual in accessing community dental services appropriate to their needs. This may include provision of dental hygiene, where appropriate.

4. Provide training for other professionals, care providers, families, and students in health training programs on the management of dental health issues for persons with developmental disabilities.

5. Program direction, policies and standards will be provided by the Senior Dental Health Consultant in the MoH.

6. Provide support and consultation on dental services for this population, including problem solving and coordination on behalf of individuals with a developmental disability, with local dental professional services.

7. Dental services available through this province-wide service are supplementary, but not duplicative of, the dental benefits provided through the Medical Services Plan and the dental plan administered by the MSDPR.

APPENDIX 5: Mental Health and Substance Use Services to Persons with Developmental Disabilities

Preamble:

Developmental Disabilities Mental Health Services (DDMHS) was created to provide services to individuals who have coexisting developmental disabilities and a mental illness, substance use or severe behavioural problems which are associated with an emotional, psychological, or psychiatric condition. In 2007, the MoH developed Planning Guidelines for Mental Health and Addiction Services for Children, Youth and Adults with Developmental Disability to support services for this population. The program's age criteria is 14 years or older (12 years in the Lower Mainland), making it different than the adult-only eligibility for other health support services identified in this guide. While this program performs discrete specialized services for this population, the interface and collaboration with CLBC and MCFD services is an essential component in the overall service response and quality of care.

DDMHS is multidisciplinary where possible and disciplines include, but are not restricted to: Nursing, Psychology, Psychiatry, Behavioural Specialists, Sensory Interventionists, Therapists (Art, Music, etc.). DDMHS practitioners are knowledgeable in both developmental disability and mental health.

Services:

1. Provide an integrated assessment and diagnosis, based on knowledge of the individual's physical health, emotional needs, mental health/psychological symptoms, and behavioural patterns as well as past history. Consultation with family, primary physician and community supports will be part of the holistic assessment process.

2. Referral procedures to DDMHS will be determined at the local level, in collaboration with CLBC.

3. Recommend a plan for treatment of the mental illness, addictions and/or behavioural issues (e.g., medication changes, environmental adaptations). Treatment recommendations are initiated by DDMHS and may be implemented by the person's family physician and primary service providers, with support and consultation from DDMHS. The DDMHS staff may provide some time-limited treatment support to assist the members of the care-giving team and review the treatment plan as appropriate.

4. Collaborate with the individual, the individual's family, and support team (including CLBC, MCFD, heath authorities, physicians, and other relevant service providers) on developing the overall support plan for the person.

5. Provide review and follow up where appropriate.

6. Collaborate with mainstream mental health/substance use services when needed for acute admissions or access to mainstream adult or child/youth mental health services, addictions, and other health care services as appropriate.

APPENDIX 6: High Intensity Health Care Needs in Adults with a Developmental Disability

Introduction:

A collaborative approach between organizations is required to support adults with complex functional and medical needs to successfully live inclusively in their community. In 2001, the MCFD and the Ministry of Health Services (now the MoH) committed to providing consistent and coordinated services for those adults with developmental disabilities (DD) assessed as having a need for complex integrated care planning. In 2005, a crown corporation under MCFD, CLBC was formed to serve this population. In 2008, CLBC moved to the newly formed MSDPR, where it remains today. MSDPR, the health authorities (HA), and the MoH continue to be committed to these approaches and supports, and to provide collaborative, integrated service planning for individuals.

Principles for Planning and Delivery of Supports and Services to Adults with Developmental Disabilities:

1. Adults with DD are considered to have high intensity health care needs (HIHCN) where a clinical assessment by the HA identifies complex clinical care needs which require collaborative, interdisciplinary planning (See Assessment for HIHCN below).

2. CLBC provides personal care services that arise because of the individual's DD. Personal care services that stem from HIHCN are the responsibility of the HA, regardless of where the individual resides. When a CLBC client is assessed by the HA as having HIHCN, CLBC and HA staff will work collaboratively to develop an individual care plan. Planning will identify the client needs, consider appropriate community living options, necessary health care services, and/or Added Care Funding (ACF) to address the identified needs. It will also clarify the responsibilities of each organization involved in the plan.

3. HIHCNs are personal care needs, however they may also include provisions of care to prevent the use of higher intensity resources such as acute care and long-term care (LTC).

4. At least one year prior to an individual turning 19 years of age, the HAs agree to provide consultation on transitional planning in accordance with the Cross-Ministry Provincial Transition Planning Protocol for Youth with Special Needs.

5. CLBC retains the responsibility to coordinate the overall service plan when ACF is provided in conjunction with CLBC supports. CLBC will provide regular reporting back to the HA on the expenditure and outcome of the ACF using a provincially standardized reporting framework.

6. If the individual moves to LTC, CLBC will make existing funding available to provide additional supports within the facility such as community inclusion. CLBC will liaise with facility leadership to determine the most effective supports.

Definitions:

When an adult with a DD is assessed as meeting a threshold of complexity that meets qualifying criteria, CLBC and HA staff will meet to collaboratively develop an individual care plan and identify appropriate community living and health care services to address the goals of care and specific health supports identified. The following definitions are intended to provide a general understanding of the potential needs of individuals, and how these needs may be supported through integrative planning between HA and CLBC. It should be noted however, that in determining the needs of an individual, in reality these needs are not distinct from one another and cannot be divided. HAs and CLBC may use the definitions below as general guiding principles to discuss integrated supports and planning, however a client-centred approach to care and supports should always be the focus.

Added Care Funding (ACF) is a term used exclusively to describe the funding transfer between a HA and CLBC pursuant to which the health authority will provide funding for health care services, to CLBC, to augment the support and services provided by CLBC, where the client has complex health care needs as determined by the health authority. ACF supports the provision of care to an individual with HIHCN who requires a collaborative approach between CLBC and HAs. The following ACF principles guide the planning of health services for clients with HIHCN:

- CLBC and HA services (Home and Community Care Policy Manual, 2.B.) work in partnership with clients, families, caregivers, and other providers to meet the needs of an individual and make decisions about lifestyle and care.
- ACF is based on professionally assessed needs and goals for care.
- All efforts to support the individual's needs through CLBC's and HA's individual program mandates and community-based services and supports (formal and informal) have been explored and maximized prior to review of added resources such as ACF.
- ACF is provided either episodically or on a long-term basis, depending on the unique needs of the individual.
- ACF is provided once the HA confirms a start date for the contracted provider.
- In order to be reviewed for consideration for ACF, a client must meet the Resident Assessment Instrument-Home Care (RAI-HC) threshold.
- For a client who meets the RAI-HC criteria for ACF, a Time Task Analysis (TTA) is a tool utilized to support planning for funding allocation.

Health Related Needs (HRN) and Developmental Disability-Related Needs (DRN):

CLBC eligible individuals may experience a range of health issues and are eligible for many HA services. In these guidelines these are referred to as ***HRN.*** Like the general population, CLBC eligible individuals access HA services, and other non-HA related practitioners. These services and providers successfully address many HRNs.

DRN are often, but not always, clearly distinct from HRN in that they are support needs that arise as a result of a DD. DRN are addressed through the provision of CLBC services (see Appendix 1, CLBC Supports), and these services include home living, family supports and community inclusion. They are designed to enhance an individual's ability to achieve maximum independence, community inclusion, and quality of life in the context of the unique expression of their DD.

High Intensity Health Care Needs (HIHCN):

HIHCN occur when HRNs meet a threshold where support requirements for CLBC eligible individuals are impacted. Individuals whose clinical assessment identifies complex clinical care needs will require augmented personal care supports to further support the individual's medical or functional condition. The clinical assessment criteria for home and community care form the basis of this eligibility. Where an adult with DD is assessed by the HA as having complex clinical and functional care needs, CLBC and the HA staff will meet to collaboratively develop an individual care plan, and identity appropriate community living and health care services, or funding contribution to address the goals of care and specific health supports identified.

Assessment for HIHCN:

An individual has HIHCN when they meet a threshold for supports as determined by two outcomes of the RAI-HC Assessment, Resource Utilization Groups (RUGs) and Activities of Daily Living (ADL) Index.

***Resource Utilization Group*:** Is a RAI-HC algorithm that sorts a client into one of seven RUG groups. Each group describes clients with similar clinical characteristics and homogenous resource use.

ADL Index: Is used to further divide RUGs into 23 subgroups that provide additional granularity on resource use. An ADL Index score of 11 or greater is the HIHCN threshold. This identifies clients with greater dependence (at least hands on help) in bed mobility, transfers, eating (including tube feed) and toilet use.

The combination of RUG group (health conditions and resource use) with ADL Index criteria provides a consistent method to identify clients with HIHCN.

Five RUGs may meet the HIHCN eligibility threshold with the ADL Index as indicated below.

- **Special Rehabilitation:** Client has rehabilitative needs related to speech, occupational, or physical therapy. Must have an ADL Index of 11 or higher.
- **Clinically Complex:** Client has multiple medical co-morbidities. Must have an ADL Index of 11 or higher.
- **Reduced Physical Function:** Client has physical dependence (is receiving hands on assistance) in toileting, transfers, bed mobility, and/or eating. These clients may also have cognitive impairments or behavioural issues. Must have an ADL Index of 11 or higher.
- **Extensive Services:** Clients has respiratory care needs, including a dependency on tracheotomy and/or ventilation. Must have an ADL Index of 12 or higher.
- **Special Care:** Client has special care requirements, for example tube feeding. Must have an ADL Index of 12 or higher.

Two RUGs do not meet the HIHCN eligibility threshold, because their maximum ADL Index score is 10. Clients have the following clinical characteristics with less dependence in bed mobility, transfers, eating and toilet use.

- **Impaired cognition**: Client typically presents with dementia or impaired cognition.

- **Behavioural problem(s):** Client demonstrate behavioural problems arising from dementia, an acquired brain injury, DD, etc.

ADDED CARE FUNDING – SAMPLE SCENARIOS

These examples highlight:

1. Real world situations commonly faced by local CLBC and HA teams.
2. Agency specific roles and responsibilities.
3. Areas for shared responsibility.
4. HAs have assessed the client to meet the RAI-HC criteria for HIHCN, and in order to address the client's care needs, as identified in their care plan, ACF is required.
5. Examine potential opportunities for creative and collaborative solutions.

SCENARIO I: Young Adult Living with Family

A 20-year-old individual lives with their mother and teenaged sibling in the family home, their mother works variable shifts, which creates some stress for caregiving. The individual is a wheelchair user and requires total care for ADLs[2] and instrumental activities of daily living (IADLs)[3], currently managed by their mother and siblings. The individual can navigate an electric wheelchair in home and school settings. They are on medication for seizures and diabetes and their care needs are reviewed by their specialist physicians annually.

Client Key Needs

- Appropriate residential setting to address care needs.
- Respite services for family caregiver.
- Support and teaching to caregivers for ADLs.
- Medical consultation and support for health-related issues.

CLBC Responsibility

- ✓ Provide supports for DRNs as defined above.
- ✓ Arrange respite as appropriate for family caregivers.
- ✓ Provide information on supported residential options.
- ✓ Utilize referral pathway of regional HA for ACF assessment and/or other HA services.

Health Authority Responsibility

- ✓ Upon receiving CLBC referral, re-assess and optimize health careplan, assess using RAI- HC for HIHCN and ACF eligibility, and, where appropriate, advise CLBC to also submit referral to other HA services.

Both

ACF cannot be paid to families directly. CLBC must ensure that an appropriate contracting structure is in place to facilitate ACF. Examples include an Individualized Funding Agreement, a

[2] Activities of daily living for CLBC clients include mobilization, nutrition, lifts and transfers, bathing, cueing, grooming, and toileting.

[3] Instrumental activities of daily living include transportation, housekeeping, shopping, etc.

person-centred society (e.g., microboard), or the provision of services through a contracted service provider who can deliver service in the individual's home. Staff from both agencies can assist families to explain the process, roles and responsibilities, and build a team approach.

SCENARIO II: Youth Living in Home Sharing Arrangement

A young adult will turn 19 in 2 months and has high medical complexity and fragility. The plan is for the youth to move into home sharing. The caregiver works outside the home, and transition planning for adult services is underway. The caregiver has requested access to health authority day programming so that they can continue working outside the home.

Individual's Key Needs

- Respite for caregiver.
- ADL and IADL support.
- Community inclusion support.
- Understanding how the adult system works.

CLBC Responsibility

- ✓ Through the Welcome and Planning process, provide information about government services, local community resources, planning options, and CLBC supports and services.
- ✓ Provide support for DRNs as defined above.
- ✓ Negotiation of appropriate service contract including education and support to home sharing caregiver to understand scope of CLBC role with respect to community inclusion.
- ✓ Utilize referral pathway of regional HA for ACF assessment and/or other HA services.
- ✓ Respite for caregiver.

Health Authority Responsibility

- ✓ Education to home sharing provider/CLBC to understand eligibility for HA services. In this case, the individual is not eligible for HA funded day programming.
- ✓ Upon receiving CLBC referral, re-assess and optimize health careplan, assess using RAI- HC for HIHCN and for ACF eligibility; and, where appropriate, advise CLBC to also submit referral to other HA services.
- ✓ Assess for eligibility to other generic health programs and services and refer as appropriate.

Both

- ✓ HAs and CLBC are responsible to participate in planning for adult services with the individual, their family, Child & Youth Services, and possibly Services to Adults with Developmental Disabilities (STADD).
- ✓ To understand and reach consensus of an individual's needs, and to clarify roles and responsibilities, it is advised that CLBC and HA teams meet prior to engaging the individual, their family, STADD, and Child & Youth Services.
- ✓ HAs and CLBC are both responsible for transparent communication with individuals and their families about their team' respective decisions regarding an individual's supports and services.

SCENARIO III: Older Adult with Dementia

A 54-year-old individual resides in a Staffed Residential Resource (SRR) (see Appendix 1) and has developed dementia. The individual is prone to wandering, is incontinent and requires considerable assistance with dressing, bathing, and cueing for eating and medication. The SRR provider has requested that this person be reviewed for increased funding for higher support.

Individual's Key Needs

- Determination of appropriate services and care planning.

CLBC Responsibility

- ✓ Provide appropriate support for DRNs, as defined above.
- ✓ Request collaborative care planning meeting in partnership with the family.
- ✓ Identify if there is another SRR or package of resources that can successfully support the individual in the community. If this does not exist, make a service request to HA to collaboratively determine appropriate services.
- ✓ Utilize referral pathway of regional HA for ACF assessment and/or other HA services.

Health Authority Responsibility

- ✓ Upon receiving CLBC referral, re-assess and optimize health careplan, assess using RAI-HC for HIHCN and for ACF eligibility; and, where appropriate, advise CLBC to also submit referral to other HA services.
- ✓ Participate in collaborative planning meeting.
- ✓ Provision of specialized education and training to service provider and care staff
- ✓ Assess eligibility to other health programs and services and refer as appropriate.
- ✓ Should care needs exceed what CLBC can provide according to their mandate, provide assessment for LTC.

Both

- ✓ Ensure fulsome support plan is in place to sustain residential placement that includes specialized supports to manage dementia related needs and mechanisms for transition plan to health facility if required.
- ✓ If the individual moves to LTC, CLBC will make existing funding available to provide additional supports within the facility, such as community inclusion. The HA will close the ACF file, but CLBC will liaise with facility leadership.
- ✓ Examine other opportunities where the HA may have a resource better suited to the needs of the individual, with CLBC funding contribution as per their mandate. This may help to facilitate longer term stability for the individual.
- ✓ Where it is not possible to clearly delineate between a DRN and an HRN, collaborate to determine funding responsibilities on a case-by-case basis, using a person-centered approach.

SCENARIO IV: Individual resides in SRR

A 37-year-old individual presents with significant functional challenges, secondary to their DD. They have lived in their current CLBC contracted SRR (see Appendix 1) for 10 years. They have been successfully supported with high personal care needs. Recently, they have developed further health concerns and now require a feeding tube and diabetes management.

Individual's Key Needs

- Ensure adequate level of support for both DRNs and HRNs as defined above.

CLBC Responsibility

- ✓ Continue to provide supports for DRNs, as defined above.
- ✓ Utilize referral pathway of regional HA for ACF assessment and/or other HA services.

Health Authority Responsibility

- ✓ Upon receiving CLBC referral, re-assess and optimize health careplan, assess using RAI- HC for HIHCN and for ACF eligibility; and - where appropriate – advise CLBC to also submit referral to other HA services.

Both

If the individual is eligible for ACF, collaborate to determine what funding responsibilities lie with each organization. Given the wide range of residential arrangements within the community living philosophy, it is highly advised to collaborate on a case-by-case basis.

SCENARIO V: Acute discharge planning to a higher level of care in the community.

An individual who resides in an SRR (See Appendix 1) was recently admitted to hospital. The hospital states this person no longer has needs that require acute care and that they are ready for discharge but must have "awake overnight support". The individual now requires dialysis, and this translates into treatment for 4 hours, three times weekly. Staff must accompany the individual. CLBC states that they do not have the resources that can safely support the individual in the community when they are discharged.

CLBC is concerned that discharge to the current location (location A) is not safe due to insufficient staffing. There is no ACF at location A. The CLBC manager notes there is another CLBC resource (location B) that has a staffing model which allows for both awake overnight support and dialysis support that will require ACF. However, the bed at location B is not available for another month. The contractor at location B wants to know the funding is in place to secure a safe placement, prior to agreeing to house the individual. Clients are not assessed for ACF while hospitalized, so it is not possible to commit to the ACF that would be required to house the client in location B.

Individual's Key Needs

- ✓ Safe home with appropriate level of support for both DRNs and HRNs, as described above.

CLBC Responsibility

- ✓ Consider short-term enhanced supports from within CLBC programming and facilities to facilitate discharge to current placement until future placement is set up.
- ✓ Utilize local referral pathway for ACF assessment and/or other HA services.

Health Authority Responsibility

- ✓ Consider short-term support within HA programming and facilities to facilitate discharge.
- ✓ Upon receiving CLBC referral, assess for ACF eligibility once discharged; and, where appropriate, advise CLBC to also submit referral to other HA services.

Both

Personal care services that stem from HIHCN are the responsibility of the HA, regardless of where the individual resides. To ensure person-centred practice occurs, collaborative planning for both short-term and long-term mitigation planning should be done by CLBC and the HA.

Glossary to Appendix 6

ACF: Added Care Funding

ADL: Activities of Daily Living

CLBC: Community Living British Columbia

DD: Developmental Disability

DRN: Developmental Disability-Related Needs

Guidelines: Guidelines for Collaborative Service Delivery

HA: Health Authority

HIHCNs: High Intensity Health Care Needs

HRN: Health Related Needs

HSCL: Health Services Community Living

IADLs: Instrumental Activities of Daily Living

LTC: Long-Term Care

MCFD: Ministry of Children and Family Development

MoH: Ministry of Health

MSDPR: Ministry of Social Development and Poverty Reduction

RAI-HC: Resident Assessment Instrument - Home Care

RUGs: Resource Utilization Groups

SRR: Staffed Residential Resource

STADD: Services to Adults with Developmental Disabilities

TTA: Time Task Assessment

APPENDIX 7: In-Hospital Services for Persons with Development Disabilities

Preamble:

Some adults with developmental disabilities require one-to-one support during hospital stays, as well as appropriate nursing and medical care. As agreed to in the 2001 agreement between the MCFD and the MoH, health authorities agree to work collaboratively to ensure that individuals who require extra in-hospital support are provided with one-to-one support while in a hospital setting.

Services:

Health authorities will fund additional services required to support an adult with a developmental disability in a hospital setting where necessary, unless such one-to-one support is specifically included within the provisions of the service providers' contract with CLBC. Health authority approval must be given in advance of the one-to-one support for planned hospital visits. In crisis situations, a mechanism for authorization of emergency supports will be developed by the health authority.

An effective plan for identifying the need for one-to-one supports in-hospital for adults with developmental disabilities must consider:

1. Communication: An adult with a developmental disability may have severe compromise of their ability to communicate. Where specialized systems or techniques must be utilized to support the individual to make his/her needs known, a plan must be developed to ensure these are in place to support quality of care and safety for the individual.

2. Feeding: Where the individual is at risk of gastro-esophageal reflux with or without aspiration, or requires major assistance with feeding or specialized positioning, supports may be required to augment hospital services available.

3. Unstable medical conditions/unusual presentations: An adult with a developmental disability may have unusual or idiosyncratic presentation of complex conditions, especially those with seizure disorders. Familiarity with agreements of management for the unique care support of such individuals may be required to provide appropriate physical and emotional support and ensure continuity of care.

4. Behavioural phenotypes: Specific genetic or syndrome linked abnormalities may be accompanied by unique behavioural patterns which require specialized responses, especially when the individual is in a new or unfamiliar environment. Maintaining continuity of care and management is essential to prevent the need for intrusive restraints and ensure quality of care and safety of the individual (see Planning Guidelines for Mental Health and Addiction Services for Children, Youth and Adults with Developmental Disabilities).

APPENDIX 8: End-of-Life Care for Adults with Developmental Disabilities

Preamble:

All individuals, including those with developmental disabilities, have the right to die in their own home, or other home-like environments, and to expect to receive support and coordinated care to enable this wherever possible. Providing good care at the end-of-life requires an effective and integrated approach that includes the individual, family, caregivers, decision-makers, health care professionals, and service providers.

To facilitate a respectful environment and a dignified death, there must be a clear plan in place supported by appropriate documentation (e.g., Advance Directive or no CPR order) and an unambiguous definition of roles and responsibilities of the involved parties, specific to the needs of the individual.

Services:

1. Health authorities will ensure that a person-centred end-of-life health care plan is developed and maintained, supervised, and monitored including the delivery of health care supports as needed, and will assume the lead in facilitating collaboration related to health support and quality of end-of-life care for community living adults.

2. Health authorities will ensure that education is provided to families and caregivers regarding end-of-life issues and will provide liaison with physicians, health care services and community supports as appropriate.

3. When a family member or personal support network member is not available to provide a primary point of contact, CLBC will ensure that a designated CLBC staff member or service provider is identified to act as a single point of coordination for the duration of the individual's palliative care.

4. CLBC will ensure participation in collaborative care and service planning, ensure that contractual arrangements are in place for supports as needed, and that when end-of-life phase services are funded by the health authority but provided by CLBC, information is provided to health authority on the expenditure and outcome of the service.

   Additional Reference: Provincial Communique on Expected Home Deaths (December 2006)

APPENDIX 9: Adult Guardianship – Response to Issues of Abuse, Neglect and Self-Neglect

Preamble:

Both health authorities and CLBC are specifically designated under the *Adult Guardianship Act* (Part 3) as being responsible for responding to allegation of abuse, neglect, or self-neglect of vulnerable individuals. CLBC is responsible for investigating allegations relating to adults with developmental disabilities who would be or are eligible for CLBC services while health authorities investigate allegations made about individuals whose vulnerabilities are associated with physical or mental health concerns or challenges related to aging.

Services:

1. CLBC facilitators and health authority staff respectively respond to reports of abuse or neglect to determine:
    - If the adult is unable to seek support and assistance as per Section 44 of the *Adult Guardianship Act*,
    - If the information provided constitutes a report of abuse or neglect, and
    - Which is the appropriate designated agency to look into the situation.

2. CLBC will act as the designated agency where:
    - The adult is in receipt of CLBC funded or planning supports;
    - Information is available that confirms that the adult meets the eligibility criteria for services from CLBC; or
    - The individual or organization making the referral and the CLBC facilitator mutually agree that the individual, in all probability has a developmental disability, where an assessment of a Registered Psychologist has not been received for the individual.

3. If a CLBC facilitator determines that CLBC is not the appropriate designated agency to respond, they will immediately inform the regional health authority or police (when appropriate), to ensure that a timely and appropriate response is initiated. The designated agency reporting the concern will be informed of who is following through on the report.

4. If a health authority determines that they are not the appropriate designated agency to respond, and that CLBC is the appropriate designated agency as outlined above, they will immediately inform CLBC and the police (when appropriate), to ensure that a timely and appropriate response is initiated. The designated agency reporting the concern will be informed of who is following through on the report.

Shared Resources or Clients:

Allegations of abuse or neglect that may involve more than one "client" or vulnerable adult, e.g., an adult with a developmental disability living with an elderly, frail parent should be responded to collaboratively by CLBC and health authority staff to determine the most appropriate and effective response. (Where the client resides in a licensed care facility and the allegations involve staff or the operator of a facility, Community Care Facilities Licensing must be informed immediately).

Problem Resolution:

- CLBC and health authorities agree that timely responses are essential. If there is uncertainty as to which designated agency is responsible; a collaborative decision will be made as quickly as possible about who should respond. Where the potential for risk to an individual is imminent, either or both agencies may decide to respond immediately with the agreement that ongoing responsibilities may be assumed by either agency and is not dependent on which one was initially contacted or first responded.

- Each health authority and corresponding Community Planning and Development Office will establish mechanisms for determining primary responsibilities and response expectations.

- Additionally, these designated agencies will establish a process for reviewing disagreements involving individual clients, assessments of initial responsibility for response, ongoing allocation of staff and funded resources and other areas of mutual concern.

- Each designated agency commits to working in partnership to provide the most effective network of adult guardianship services in their respective communities.

- In situations of imminent risk, any designated agency will contact the most appropriate first responder (i.e., police, fire, or ambulance).

The MoH, CLBC, and the MSDPR are committed to improving service collaboration for adults with developmental disabilities.

The "Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities" has been jointly developed, and is endorsed by the following to advance this commitment:

March 1, 2023
Stephen Brown
Deputy Minister
Ministry of Health

Friday February 24, 2023
Ross Chilton
Chief Executive Officer
CLBC

Thursday, February 16, 2023
David Galbraith
Deputy Minister
Ministry of Social Development and Poverty Reduction