



**GUIDELINES FOR COLLABORATIVE SERVICE DELIVERY  
FOR ADULTS WITH DEVELOPMENTAL DISABILITIES**

*Between*

**Community living British Columbia**

**Regional and Provincial Health Authorities**

**Ministry of Health Services**

*and*

**Ministry of Housing and Social Development**

**January 2010**

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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. This commitment also included funding to the Ministry of Health Services 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 Ministry of Children and Family Development devolved Community Living Services to a new provincial authority, Community Living BC (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 (MHSD) 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 Community Living, BC to best meet the needs of this population and achieve government's vision for improved quality of life for individuals with developmental disabilities.

## **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 specialised services for adults with developmental disabilities. They define the roles and responsibilities of the service partners as outlined in the following appendices:

**APPENDIX 1:** Case Coordination and Client Response

**APPENDIX 2:** Specialized Nursing and Rehabilitation Supports

**APPENDIX 3:** Nutrition and Specialized Dysphagia Support Services

**APPENDIX 4:** Dental Health Services

**APPENDIX 5:** Developmental Disabilities Mental Health Services - age 14 and above

**APPENDIX 6:** High Care Need Intensity Clients

**APPENDIX 7:** In-Hospital Supports

**APPENDIX 8:** Medical Consultant Services

**APPENDIX 9:** End-of-Life Care

**APPENDIX 10:** Adult Guardianship

### **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
- 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 age 14 and above who have both a mental illness and developmental disability, some of who 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 FASD/ PDD) 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 (CLBC):***

- Provide individual planning, support and service coordination for eligible adults;
- Provide relevant care, service and financial information to health authorities and Ministry of Health Services (MoHS), as appropriate, to facilitate individual service delivery and to effectively plan for services to this population;
- Provide information to the 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, MoHS, 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, MoHS 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;
- Provide information to other service partners included in these guidelines on the type and volume of health services delivered.

***Ministry of Housing and Social Development:***

- Work with Ministries of Education, Health Services, Children and Family Development, Advanced Education, Public Safety and Solicitor General, and CLBC, BC Housing, and the Office of the Public Guardian and Trustee and 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.

- Provide information and be a resource for Provincial Working Group members on disability benefits; medical, dental, and other.

### ***Regional CLBC/ 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 understandings 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 joint educational opportunities.

## **6.0 FUTURE DEMAND AND SERVICE LEVELS**

### **CLBC, Health Authorities, MoHS, and Ministry of Housing and Social Development 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 B.C. 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. 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:
  - 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 (PAC)**

The Provincial Assessment Centre provides multi-disciplinary mental health services for referred individuals ages 14 and up with a developmental disability and it 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 individual's 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 liaison with other professionals as needed to ensure appropriate coordination of health services. When required, HSCL clinicians will develop individual specific healthcare plans consistent with College of Registered Nurses of British Columbia (CRNBC) standards of practice.

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

5. HSCL will coordinate access to specialized support services including seating, nutrition, and dysphagia through the relevant interdisciplinary services.
6. Health authorities will maintain an individual's specific information and monitor service delivery indicators with respect to HSCL services.
7. The Ministry of Health Services will continue to provide program policy and standards direction to 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 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 by 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 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 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 Ministry of Health Services.
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 Ministry of Housing and Social Development.

## **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 MoHS 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, HCC, 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 healthcare services as appropriate.

## **APPENDIX 6: High Intensity Healthcare Need in Adults with a Developmental Disability**

### **Preamble:**

Adults with complex functional and medical issues require a collaborative approach to successfully support them in living inclusively in their community. In 2001, MCFD and MoHS committed to providing consistent and coordinated services for those adults with developmental disabilities assessed as having a need for complex integrated care planning. The Ministry of Housing and Social Development, health authorities and MoHS are committed to continue with these approaches and supports.

### **Services:**

1. Adults with developmental disabilities will be considered to have high intensity care needs where a clinical assessment by the health authority identifies complex clinical care needs which require collaborative, interdisciplinary planning to address.
2. Clinical assessment criteria established for home and community care will form the basis of this eligibility. Clients meeting the requirements for augmented supports will have clinical indicators that would place them at very high risk for institutionalization, and a requirement for augmented personal care supports directly related to a medical or functional condition. See Clinical Guideline to Appendix 6.
3. Daily living supports required as a result of the individual's developmental disability and case coordination will be the responsibility of Community Living BC.
4. Health Services required to augment an individual's high intensity care needs will be the responsibility of the Health Authority.
5. Where an adult with developmental disabilities is assessed by the health authority as having complex clinical and functional care needs, CLBC and health authority staff will meet to collaboratively develop an individual care plan, and identify appropriate community living and health care services or funding contribution to address the goals of care and specific health supports identified.
6. Where a funding contribution from the health authority is identified as the most effective way to augment the provision of care by CLBC for an adult with complex clinical needs, such funding will be based on health authority service guidelines applicable to the relevant program or service.
7. Health authorities agree to accept referrals for assessment and transitional planning for individuals expected to be in receipt of community living services and support at least one year prior to the individual turning 19 years of age, in accordance with the Cross-Ministry Provincial Transition Planning Protocol for Youth with Special Needs.
8. CLBC will be responsible for coordination of the overall service plan when health services are being provided in conjunction with CLBC supports. When CLBC contracts for health related

supports that are funded by the health authority, CLBC will provide regular information to the health authority on the expenditure and outcome of the service.

## **APPENDIX 7: In-Hospital Services for Persons with Developmental Disabilities**

### **Preamble:**

Some adults with developmental disabilities require one-on-one support during hospital stays, as well as appropriate nursing and medical care. As agreed to in the 2001 agreement between the Ministry of Children and Family Development and Ministry of Health Services, health authorities agree to work collaboratively to ensure that individuals who require extra in-hospital support are provided with one-on-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-on-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: Medical Consultant Services for Adults with a Developmental Disability**

### **Preamble:**

The medical consultant functions, formerly delivered by the medical consultant for Health Services for Community Living (HSCL) will be delivered provincially by a qualified physician and clinical nurse lead on behalf of all health authorities, under a single contract:

### **Services:**

1. Consultation regarding appropriate health care needs for adults with developmental disabilities.
2. Consultation regarding complex health issues, health care consent and ethical decision making for adults with developmental disabilities (to PGT, Coroners, Licensing, Health care providers, regional health professionals and service providers).
3. Review and tracking of all Do Not Resuscitate orders placed on adults with developmental disabilities.
4. Review of all serious hospitalizations of adults with developmental disabilities.
5. Completing a written report to CLBC and Licensing on unexpected deaths.
6. Debriefing support to family members, support network and inter disciplinary teams as appropriate in relation to an unexpected death.

### **CLBC will:**

- Advise the medical consultant of deaths of adults supported by CLBC, and
- Ensure that the medical consultant is provided with all information concerning the circumstance of the death and other relevant information.



## **APPENDIX 9: 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 (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, Community Living BC 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. Community Living BC 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 10: Adult Guardianship – Response to Issues of Abuse, Neglect and Self Neglect**

### **Preamble:**

Both Health Authorities and Community Living B.C. 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 dependant 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 Ministry of Health Services, Community Living BC and the Ministry of Housing and Social Development 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:



John Dyble  
Deputy Minister  
Ministry of Health Services

Dated this 19th day of January 2010



Rick Mowles  
Chief Executive Officer  
CLBC

Dated this 2nd day of February 2010



Cairine MacDonald  
Deputy Minister  
Ministry of Housing and Social Development

Dated this 28th day of February 2010

## Clinical Guideline for Appendix 6 High Intensity Needs Clients

### Rationale

Adults with complex functional and medical issues require a collaborative approach to successfully support them in living inclusively in their community. Home and community care health services may be provided as appropriate to augment supports provided by CLBC, in a manner consistent with Ministry and health authority policies.

### High Intensity Needs Clients

Adults with developmental disabilities will be considered to have high intensity care needs where a clinical assessment by the health authority identifies qualifying criteria. The InterRAI Home Care assessment instrument provides the necessary standardized objective clinical information and scores to identify a combination of medical complexities and physical dependencies which require comprehensive and collaborative interdisciplinary planning. These would be identified through identification of Resource Utilization Grouping (RUG) and Activities of Daily Living Index (ADL Index) scores as outlined below:

- Clinically Complex, Rehabilitation and Physically Reduced Functions with an ADL index of 11 or higher
- Extensive Care and Special Care with an ADL index of 12 or higher

The ADL index provides an objective score which indicates client performance and degree of dependence on others in four basic activities of daily living. These include bed mobility, transfer, toilet use, and eating (including whether a client receives enteral tube feeding). Calculation of the ADL index allows for variation amongst clients, who may have different combinations of dependence in these areas. ADL index scores of 11 or higher indicate a shift to weight bearing assistance, consistent with client characteristics in the higher RUG groupings.

A description of the five groupings follows. The algorithms behind these groupings are derived from data elements in the RAI-HC assessment, which is the standard clinical assessment tool in British Columbia, and internationally. Resource Utilization Groupings categorize like-clients based on similar resource utilization and intensity into seven categories. Of these seven categories, only five have subgroups with ADL index scores (indicating level of dependence) high enough to qualify as high intensity care need.

### Qualifying ADL Index of 11+

- **Clinically complex**, grouped clients will require skilled professional care for treatments as well as symptom management for any of the following: dehydration, stasis ulcer, end-stage disease, chemotherapy, blood transfusion, skin problems, hemiplegia/hemiparesis, urinary tract infection, dialysis or pneumonia. In addition to at least one of the above symptoms or treatments, the client would have further need for skilled care due to having at least one of the following: tracheostomy, respirator or other respiratory treatment. Furthermore, care coordination would also be paramount due to the additional complexity of the client who has one or more of the following: stage 3 or 4 pressure ulcer, enteral tube feeding, multiple sclerosis, 2nd or 3rd degree burns, radiation or who has a central

IV/peripheral IV/fever and one or more of the following; dehydration, pneumonia, vomiting, unintended weight loss.

- **Rehabilitation** grouped clients will require skilled professional care to provide at least 2 hours of speech, occupational or physical therapy per week.
- **Physically Reduced Functions** grouped clients will require skilled professional care and the care provided may vary greatly as clients in this category do not meet any other RUG category criteria although they do have the required increased physical dependence to qualify as high care need intensity. These clients may require more intensive care coordination due to cognitive or behavioural issues compounded by the extent of client physical dependence and the additional health risk considerations related to that dependence.
- **Special Care** grouped clients will require skilled professional care for treatments as well as symptom management of clients with one or more of the following: stage 3 or 4 pressure ulcer, enteral tube feeding, multiple sclerosis, 2nd or 3rd degree burns, radiation or who has a central IV/peripheral IV/fever and one or more of the following: dehydration, pneumonia, vomiting, unintended weight loss. The care coordination for these clients is more intensive due to the extent of client physical dependence and the additional health risk considerations related to that dependence.
- **Extensive Care** grouped clients will require skilled professional care for clients who have at least one of the following: tracheostomy, respirator or other respiratory treatment. Care coordination for these clients is more intensive due to the extent of client physical dependence and the additional health risk considerations related to that dependence.

## Principles for Service Planning

The following principles will guide the planning of health services for high care need intensity clients:

- ❖ *Home health services are provided to augment the efforts of clients, families, caregivers and responsible agencies to meet the needs of the individual, not to replace them.*
- ❖ *Health services provided shall be based on professionally assessed needs and goals for care.*
- ❖ *Health services provided will include clinically necessary services which are not included in the care and services received by the individual in their home setting.*
- ❖ *Health services will be provided on either an episodic or long term basis, as indicated by the unique needs of the individual.*

## Sample Scenarios

The following scenarios are outlined to provide examples of individuals who may be presented for consideration of a collaborative approach. These examples outline common situations, and are not considered comprehensive.

### **1. Complex young adult living with family**

A 20 year old client is living with his mother and teenaged sibling in the family home. Mother works variable shifts, which creates some stress for caregiving. Client requires total care for ADLs and IADLs, currently managed by mother and siblings and is wheelchair dependent. Client is able to navigate an electric wheelchair in home and school settings, and requires assistance for all transfers. He is on medications for seizures and is reviewed by his specialist physician annually.

#### **Client's Key Needs**

- Appropriate residential setting for care needs.
- Respite services for family caregiver.
- Support and teaching to caregivers for management of ADL's and transfers.

#### **CLBC Responsibility**

- Provide appropriate supports for daily living for the client.
- Arrange respite services as appropriate for family caregiver.

#### **Health Authority Responsibility**

Assistance with development or revision of care plan and teaching as required for management of ADL's and transfers, consistent with HSCL program. (see Appendix 2)

### **2. Complex Young Adult Living in Home Share Arrangement**

Young adult living in a home share provider home has recently turned 19, and has completed school. The funded home share provider works outside the home, and transition planning for adult services has been completed. The provider is requesting access to the health authority day program to facilitate the caregiver working outside the home.

#### **Client's Key Needs**

- Respite for caregiver

#### **CLBC Responsibility**

- Residential arrangements and respite as appropriate (See Appendix 1)

#### **Health Authority Responsibility**

- None for this client at this time

### **3. Complex Older Adult with Dementia**

A 40 year old adult is living in a group home setting and has developed dementia which is progressing.

Client is now prone to wandering, is incontinent and requires considerable assistance for dressing, bathing and cueing for eating, medications management. Group home provider has requested assessment and support planning.

#### **Client's Key Needs**

- Assessment and care planning
- Determination of appropriate services and care setting

#### **CLBC Responsibility**

- Request collaborative care planning process for this client.
- Identify goals for the individual and options for care and support within current group home setting.

#### **Health Authority Responsibility**

- Provide clinical assessment of the client's care needs and cognitive status.
- Develop collaborative care plan, in conjunction with CLBC and family, if available.
- If client is able to be appropriately supported in the group home setting, provide specialized nursing and rehabilitation services (see Appendix 2) as appropriate.
- Augment current home living services with home support or funding for augmented caregiver support as appropriate.
- Where the exceptional circumstances exist that make it impossible to support the client within the group home setting, access to residential care may be considered.

### **4. Client with Complex Needs, Palliative Condition**

A client who has recently turned 19, has significant medical and clinical issues including ineffective airway clearance, and requires regular suctioning, nebulizer treatments and nightly ventilation. He has frequent acute respiratory attacks, and has been considered palliative in the past. Client is non-verbal and unable to support his head and body independently. He is fully dependent for all moving, lifting and ADL's.

#### **Client's Key Needs**

- Clinical assessment and services
- Collaborative care planning
- Appropriate residential setting
- Palliative care

#### **CLBC Responsibility**

- Request collaborative care planning for this client.
- Identify CLBC staff member as single point of coordination for the client. (See Appendix 9)
- Identify care and support options within client's current residential setting.

#### **Health Authority Responsibility**

- Provide complete assessment of clinical and functional needs, with referral to hospice palliative care team as appropriate.



- Provide care plan representing palliative approach to care as needed. (See Appendix 9)
- Provide home support staff or augment current caregivers as appropriate to address needs for respiratory support, suctioning and positioning.
- Provide nursing support for monitoring and palliative care as required.

### **5. Independent Living Adult with Mental Health Issues**

A 38 year old client who has a progressive disease which increases the cognition deficit over time has recently moved to an apartment after living in a group home for many years. She is able to walk independently with the assistance of a walker. The client has a history of mental health issues, and has periodic psychotic outbursts. CLBC is assisting with home living services in the apartment in which the client lives. CLBC has requested that the health authority provide rehab assistance to adapt the current living space and has requested that the health authority support the client to relocate to health authority funded assisted living.

#### **Client's Key Needs**

- Appropriate housing and care environment
- Home adaptation
- Mental Health assessment and planning

#### **CLBC Responsibility**

- Assess and arrange residential setting appropriate to client's ability.
- Request assessment from health authority for rehabilitation and mental health needs.

#### **Health Authority Responsibility**

- Provide rehabilitation assessment and home adaptation as appropriate. (See Appendix 2)
- Provide access to mental health services for persons with developmental disabilities for assessment and development of a treatment plan. (see Appendix 5)