

# SUMMARY REPORT

## Ontario Partnership on Aging & Developmental Disabilities



### Empowering Life's Choices and Changes Champlain Regional Conference

October 5, 2006  
RA Centre, Ottawa



A University of Ottawa and SCO Health Service Partnership

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## 1. Overview

In 2005, the Ontario Partnership on Aging and Developmental Disabilities (OPADD), invited different regions in the province to provide letters of interest for the hosting of regional workshops. The Ottawa Champlain region was selected by OPADD to host a cross sectoral (i.e., long term care, health, community, social and developmental disability services) regional workshop on aging and developmental disabilities in the fall 2006.

The mandate of OPADD is to create new provincial and regional linkages among services for seniors with developmental services. In the policy document titled "*Opportunities and Action: Transforming Supports in Ontario for People who have a Developmental Disability*", your Ministry has identified the importance of creating such linkages between different service providers from the developmental services, community care, long term care and health sectors. Improved planning, collaboration and partnership between these different sectors would facilitate the transition of individuals aging with a developmental disability.

In order to accomplish this, representatives from different developmental service agencies, community health organizations, parents, representatives of the Ministry of Community and Social Services, representatives of the Ministry of Health and Long-Term Care and the Ottawa University, met on several occasions to plan for this important Forum.

Some of the key considerations identified for this Forum are:

- Develop a workshop program that reflects regional goals and supports a sustained cross sector planning process.
- Establish and maintain a regional cross sectoral Planning Committee.
- Articulate how our plan would link with the depopulation of institutions that have housed the developmentally disabled.

The Planning Committee established expected outcomes of the Forum. These were:

- Developing short and long term plans
- Identifying a group committed to taking the project to the next level
- Identifying who does what
- Identifying a process to allow reporting back to the community (e.g., follow-up meetings)
- Establishing a steering committee from both sectors and from collateral sectors such as education, families, institutions, etc.
- Obtaining a mandate as a planning committee from the Champlain LHIN and the MCSS ERO

On October 5, 2006, more than 200 individuals participated in a full day forum with a focus on education, sharing of best practices and planning for the future. The goal of the

October 5th workshop was to promote a better dialogue between the sectors and to generate a common understanding of the needs, barriers and challenges of aging individuals with developmental disabilities. One challenge is the complexity involved for an individual moving from the developmental services sector to the long-term care sector. The education component during the day presented an ideal forum for sharing information, and finding common and concrete solutions for wider collaboration between the developmental services, the health and the long-term care sectors, and for sharing success stories. The purpose of the day was to:

1. Bring together persons working in the developmental services and long term care sectors, their relevant planning /coordination bodies, appropriate educational programs and funding Ministries in order to identify and begin to address service and policy issues pertaining to people with developmental disabilities who are aging
2. Serve as a catalyst for an ongoing and self-sustaining regional cross sector planning group that will provide a forum for dealing with aging and developmental disabilities issues at the local level
3. Support the establishment and development of local cross sector initiatives to test and demonstrate innovative methods and models of supporting older adults with a developmental disability
4. Other complementary goals as determined by the regional workshop planning committee.

The following document provides a summary of the various activities and outcomes of the day.

## 2. Forum Process and Outcomes

### 2.1 Forum Summary

Conference date: October 5, 2006  
Conference venue: RA Centre  
2451 Riverside Drive  
Ottawa

Attendees:

Attended:	149
DS Sector:	98
Health Sector:	34
Family members:	9
Person with developmental disabilities:	2
Other:	6

### 2.2 Forum Process

The Co-chairs of the Regional Planning Committee, Luc Ouellette, Service Coordination des services and Larry Chambers, Élisabeth Bruyère Research Institute, A University of Ottawa and SCO Health Service Partnership welcomed the participants and presented the Committee members (Appendix 1) as well as the Committee's objectives (Appendix 2).

Opening remarks by Marcel St-Jean, Eastern Regional Office, Ministry of Community and Social Services (MCSS) and by Jocelyne Contant, Champlain Local Health Integration Network (LHIN), Ministry of Health and Long Term Care (MOHLTC) were shared with the participants highlighting the need for cross-sector planning.

Ron Coristine, provided an overview of the Ontario Partnership on Aging and Developmental Disabilities (OPADD) with regards to other provincial initiatives and community planning forums.

The conference facilitator, Guy Thérout of Eksento Inc., presented the process for the day (See Appendix 3) and then introduced the first speaker for the morning session.

Dr. Lilian Thorpe (See Appendix 4 for a biography) topic, *Overview of Developmental Services, Health, Community Care and Long-Term Care Sectors* covered issues relating to aging and developmental disabilities. Please visit the following link to view Dr. Thorpe's presentation: [www.opadd-ottawa-champlain.com](http://www.opadd-ottawa-champlain.com)

Dr. Thorpe's presentation was followed by presented by Claude Sauvé's personal perspective as a self-advocate (See Appendix 5 for a biography).

Dr. Bruce McCreary presented issues relating to aging and developmental disabilities (See Appendix 6 for a biography). Please visit the following web link to view Dr. McCreary's presentation: [www.opadd-ottawa-champlain.com](http://www.opadd-ottawa-champlain.com)

The morning session was concluded by round table of regional success stories (See Appendix 7). This process allowed participants to hear and to discuss two issues where they feel that could learn from and contribute to through their own experience (See Appendix 8 for a summary of success stories). Each round consisted of 30 minutes where presenters shared their success story followed by a table discussion with the participants. The table host facilitated a discussion to identify key ideas and next steps related to the success stories (See Appendix 9).

In the afternoon, participants were asked to attend one of the three panel workshops:

- Education (See Appendix 10 for the full action plan)
- Direct Services (See Appendix 11 for the full action plan)
- Education (See Appendix 12 for the full action plan)

Each panel workshop commenced by presentation from four keynote speakers followed by a short question period. Following the presentation, the participant proceeded in developing action plans pertaining to their workshop theme. Each workgroup was also ask identify a key message they would share during the plenary session.

### 2.3 Forum Outcomes

The following presents a summary of the various themes identified as priorities within each panel workshop.

#### 2.3.1 Education Action Plans

Short Term Actions	Group Members
<b>THEME: Consultation / Education / Support to LTC Home</b>	
<ul style="list-style-type: none"> <li>• Support more residents in LTC homes.</li> <li>• Have training / education sessions for LTC home workers regarding IDD.</li> </ul>	Martine Robichaud
<ul style="list-style-type: none"> <li>• Within the next 3 to 6 months organize a regional meeting in a centralized area for education purposes.</li> </ul>	Gisèle Martin Community Living Glengarry
<ul style="list-style-type: none"> <li>• Sharing of info + cross-training + working as a unit.</li> <li>• Use of the internet.</li> </ul>	Unidentified members
<b>Theme: Learning Through Networking</b>	
<ul style="list-style-type: none"> <li>• Form a Transitional Educational Aging Plan Committee.</li> <li>• Formulate a strategy regarding a projection plan to curtail cross-</li> </ul>	Pat Larlee  Christian Samaal

Short Term Actions	Group Members
mentoring, supplemental courses that benefit personal development.	Kimberley Goode  Jennifer Currie-Roy
<b>Theme: To Address the Education Needs of Frontline Staff</b>	
<ul style="list-style-type: none"> <li>• Identify frontline staff education needs (staff in D.S. and LTC).</li> <li>• Identify resources in community who can brain at or minimal cost.</li> </ul>	Mark Palmer  Anouk Montpetit
<b>THEME: Partnerships</b>	
<ul style="list-style-type: none"> <li>• Set up meetings for P.D. days.</li> </ul>	Marcel Tousignant
<b>THEME: Funding</b>	
<ul style="list-style-type: none"> <li>• Environment scans (Needs Assessment).</li> <li>• Written proposal.</li> <li>• Presentation of proposal.</li> <li>• Proposal implementation.</li> </ul>	Jill Broadbent  Laurie Alphonse  Donna Quiggin
<b>THEME: Education</b>	
<ul style="list-style-type: none"> <li>• I.D. required Representation on committee (need decision makers).</li> <li>• Establish Mission, Vision, And Strategic Plan.</li> <li>• Establish how group will function i.e.: what kind of community organization.</li> <li>• Who provides leadership/share leadership?</li> <li>• Skills &amp; Knowledge Development</li> <li>• Build relationships between sectors and service agreements.</li> </ul>	No member identified
<b>THÈME : Outils de pratique collaborative pour engage le dialogue entre les intervenants de 1<sup>ère</sup> ligne pour mieux comprendre les comportements de personnes atteinte de déficience intellectuelle.</b>	
<ul style="list-style-type: none"> <li>• Lobbying pour avoir service en français (traduction).</li> <li>• Recruter partenariat auprès des intervenants qui travaillent avec déficience intellectuelle et les aînées.</li> <li>• Écrire lettre.</li> </ul>	Patrice Pilon
<b>THÈME : Sensibilisation</b>	
<ul style="list-style-type: none"> <li>• Chercher de l'aide des écoles, collèges, universités pour les inciter à créer des projets de promotion &amp; publication des histoires de succès (stages, création de projets</li> </ul>	Louise Landriault  Janine Bourgeois

Short Term Actions	Group Members
d'éducation).	
<b>THÈME : Connaissance du réseau d'éducation</b>	
<ul style="list-style-type: none"> <li>• Créer un répertoire des partenaires (services) en santé et en déficience intellectuelle.</li> <li>• Identifier les partenaires capables de sensibiliser sur les dynamiques en santé et dans le domaine de la déficience intellectuelle.</li> <li>• Journée d'information et des sensibilisations entre les secteurs (histoires et succès).</li> <li>• Dépliants décrivant les similitudes entre les personnes ayant une déficience intellectuelle et les personnes vieillissantes.</li> </ul>	Janine Bourgeois

**2.3.2 Direct Services Action Plans**

Short Term Actions	Group Members
<b>THEME: Person Centered Planning / Individualized Planning</b>	
<ul style="list-style-type: none"> <li>• Identify who needs to be involved. Determine who the stakeholders are.</li> <li>• What is the resource list?</li> <li>• Include a consumer on the committee i.e. parent, sibling, facilitator, funders.</li> </ul>	Hugh Nelson  Marge McCabe  Ann Burns  Eleanor Ryan  Rebecca Happy  Eleanor Smith  Theresa Rivera  Nancy Mylrea  Jeannette Fraser
<b>THEME: Aging in Place</b>	
<ul style="list-style-type: none"> <li>• Bring forward the notion of advocating "Aging in place" to our work environment.</li> <li>• Seek information to fill in my own gaps in knowledge with regard to dementia, geriatrics.</li> </ul>	Wendy Skinner  Darren Scott

Short Term Actions	Group Members
<ul style="list-style-type: none"> <li>Request training in geriatrics, dementia.</li> </ul>	
<b>THEME: Coordinating Services</b>	
<ul style="list-style-type: none"> <li>Consultation table: frontline staff, senior management; family members; individuals; different agencies</li> </ul>	Melissa Dullenard Josée Beauregard H. Dunne
<b>THEME: Transportation</b>	
<ul style="list-style-type: none"> <li>Go to provincial, municipal for extra funding</li> </ul> <p style="text-align: center;">Or</p> <ul style="list-style-type: none"> <li>Get other agencies together to provide a way of transportation i.e.: get together to do a route for all agencies willing to join in fundraising.</li> </ul>	Amanda Clark
<b>THEME: Education</b>	
<ul style="list-style-type: none"> <li>Build into educational programs a work placement in the other sector.</li> <li>Workshops. Frontline staff and supervisions involving the two (2) sectors/professions.</li> </ul>	David St. Patrick's Home
<b>THEME: Quality "A meaning of Day/Life"</b>	
<ul style="list-style-type: none"> <li>Talk to events (personal outcome measures for each client)</li> <li>Schedule changes according to individual needs. Keep it individualized.</li> <li>Workshops on "A Meaningful Day/Life" that target aged people and their needs and wants.</li> </ul>	Carolyn
<b>THEME: Education, Information Sharing</b>	
<ul style="list-style-type: none"> <li>Connecting with someone from CCAC.</li> </ul>	Member not identified
<b>THEME: Partnership Forum</b>	
<ul style="list-style-type: none"> <li>Identify local champion from MCSS; Health.</li> <li>Set up meeting to share info. Purpose.</li> <li>Long-term meetings with area rep. (Duesda Manor)</li> </ul>	Member not identified
<b>THEME: LTC</b>	
<ul style="list-style-type: none"> <li>Offer to try to connect doctor/team at LTC facility to experts in medical sector with expertise in D.H. sector.</li> </ul>	Member not identified

Short Term Actions	Group Members
<ul style="list-style-type: none"> <li>• Offer to set up training to assist LTC in learning more about the D.H. sector.</li> <li>• Facilitator to assist 2 sectors locally to work together, protocols, etc.</li> </ul>	
<b>THEME: Create an Atmosphere of Trust and Cooperation Between Health &amp; Developmental Services Providers</b>	
<ul style="list-style-type: none"> <li>• Share information about available services and shortcomings related to gaps and waiting lists.</li> <li>• Draft a plan identifying gaps in service and develop protocols for working together.</li> <li>• Prepare joint proposals to address gaps in service</li> </ul>	Member not identified
<b>THEME: Services &amp; Supports</b>	
<ul style="list-style-type: none"> <li>• Information package available for parents at diagnosis.</li> <li>• Update re: schools. Graduation; health care; person centered planning.</li> </ul>	Diane Seguin Peggy Lobay Karen Watts Krysia Pazdzior
<b>THEME: Communication / Networking</b>	
<ul style="list-style-type: none"> <li>• List serve network within the industry.</li> <li>• Newsletters for the public.</li> <li>• Partnership Network various branches of government (OPADD).</li> </ul>	William Peterson Suzanne Gervais Frank Sisson
<b>THEME: Partnerships</b>	
<ul style="list-style-type: none"> <li>• Sharing tools and resources.</li> <li>• Creating partnerships.</li> <li>• Developing partnerships to educate.</li> <li>• Aging "in Place".</li> </ul>	Member not identified
<b>THEME: Direct Services</b>	
<ul style="list-style-type: none"> <li>• Interdisciplinary bilingual education to bridge the gap between sectors.</li> <li>• People we are looking out for are entitled to continuity of services.</li> <li>• Money, money, money.</li> <li>• Four (4) themes: Education, Coordinated Services, Transportation and Aging in Place.</li> </ul>	Member not identified
<b>THÈME : Identifier les ressources financiers et renégocier</b>	
<ul style="list-style-type: none"> <li>• Transformation des services.</li> </ul>	Normand Charette

Short Term Actions	Group Members
	Josée Ouimet
<b>THÈME : Former un groupe de concentration</b>	
<ul style="list-style-type: none"> <li>Écrire un courriel à tous les invités qui sont venus à la conférence d'aujourd'hui leur demandant s'ils désirent participer à une classe de concentration.</li> </ul>	Member not identified
<b>THÈME : Trouver ce qui existe</b>	
<ul style="list-style-type: none"> <li>Demander au Centre d'accès pour soins communautaires.</li> <li>Faire un inventaire des ressources existantes pour personnes âgées.</li> <li>Identifier des secteurs / personnes clés pour former un groupe avec le réseau de la déficience intellectuelle</li> </ul>	Member not identified
<b>THÈME : Mécanisme d'accès et d'adaptation des ressources</b>	
<ul style="list-style-type: none"> <li>Mettre un comité en place.</li> <li>Informer / sensibiliser et former (en santé). Le but : qualité de services</li> </ul>	Member not identified

### 2.3.3 Joint Planning Action Plans

Short Term Actions	Group Members
<b>THEME: Joint Planning</b>	
<ul style="list-style-type: none"> <li>Today identify volunteers to augment steering committee. To solicit CCFAC – geography.</li> <li>Develop a TOR for Service Coordination to circulate to stakeholders for buy-in.</li> <li>Through that period. Identify who is already involved, the key issues, etc. (e-scan).</li> <li>Steering committee move forward on action in key areas based on e-scan and TOR, incl. education, funding, etc.</li> </ul>	Member not identified
<b>THEME: LTC – TR Payment</b>	
<ul style="list-style-type: none"> <li>Research what has been done.</li> <li>Who is doing it?</li> <li>Needs for agencies involved.</li> <li>Identifying roles.</li> <li>Documentation / Communication</li> </ul>	LTC TRA Citizen Advocacy

Short Term Actions	Group Members
<b>THEME: Joint Planning</b>	
<ul style="list-style-type: none"> <li>• Augment existing OPADD organizing committee to develop TOR or organize a sub-group of steering committee.</li> <li>• Task one individual / team with approaching CCAC possibly 1 from OPADD.</li> <li>• Circulate draft TOR to interested parties / possibly hold a public meeting.</li> </ul>	Ron Coristine  Diane Urquart Al Loney  Mary Frances Taylor
<b>THÈME : Formation et connaissance du réseau</b>	
<ul style="list-style-type: none"> <li>• Élaborer un portrait des services qui existent dans la communauté.</li> <li>• Formation adapté en fonction des besoins de la clientèle.</li> <li>• Identifier les besoins de formation par secteur... Flexibilité des mandats des agences.</li> </ul>	Julie Nantel Powell  Marc Richer
<b>THÈME : Valeurs et Mission</b>	
<ul style="list-style-type: none"> <li>• Retraite entre Directeurs, intervenants et participants.</li> <li>• Recueillir les besoins identifiés par les gens et établir les biens communs.</li> </ul>	Louis Renaud  Suze Lubin

### 3. Evaluation

Please identify what sector you are associated with:

Developmental services	83
Health services	13
Family member	10
Person with a developmental disability	1
Other	7
<b>TOTAL</b>	<b>114</b>

2. Please indicate your overall impression of this event by circling the appropriate number below.

Excellent	Good	Satisfactory	Poor	None
34	67	10	0	4

**3. Please indicate your overall impression for each of the morning speakers by circling the appropriate number below**

<b>Speakers</b>	<b>Excellent</b>	<b>Good</b>	<b>Satisfactory</b>	<b>Poor</b>	<b>None</b>
Dr. Thorpe	57	52	5		1
Dr. McCreary	69	38	5		3
Claude Sauv�	57	49	4		5

**4. How did you find the Success Story you attended at 11:00 a.m.?**

<b>Table Number</b>	<b>Excellent</b>	<b>Good</b>	<b>Satisfactory</b>	<b>Poor</b>	<b>None</b>
1	1	2	0	0	0
2	3	3	1	0	0
3	3	2	0	0	0
4	1	6	1	0	1
5	5	3	2	1	0
6	1	5	2	0	0
7	0	1	2	0	0
8	3	5	1	0	0
9	2	0	2	0	0
10	3	3	0	0	0
11	4	3	0	0	0
12	3	3	0	0	1
13	4	2	0	0	0
14	3	0	0	0	0
15	1	2	0	0	0
16	4	4	0	0	0
17	4	0	1	0	1

**5. How did you find the Success Story you attended at 11:30 a.m.?**

<b>Table Number</b>	<b>Excellent</b>	<b>Good</b>	<b>Satisfactory</b>	<b>Poor</b>	<b>None</b>
1	1	0	0	0	0
2	1	3	0	0	0
3	2	2	0	0	0
4	1	4	1	0	0
5	3	3	2	1	0
6	1	7	1	0	0
7	2	6	1	0	1
8	3	7	0	0	0
9	1	5	0	0	0
10	2	3	0	0	0
11	2	2	1	0	0
12	2	1	0	0	0
13	3	6	0	0	0
14	1	0	1	0	0
15	3	0	0	0	0
16	0	3	0	0	0
17	4	3	1	0	0

**6. How did you find the panel presentation you attended?**

<b>Panel</b>	<b>Excellent</b>	<b>Good</b>	<b>Satisfactory</b>	<b>Poor</b>	<b>None</b>
Education	6	8	6	1	2
Direct Service	24	33	9	0	2
Joint Planning	4	14	0	0	1

**7. Overall, did you find you had opportunities to express your views during the conference?**

<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>	<b>None</b>
43	64	6	0	2

**8. Overall, was the content of the conference appropriate and informative?**

<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>	<b>None</b>
41	63	9	1	1

**9. Overall, was the conference well organized?**

<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>	<b>None</b>
52	49	10	1	3

**10. Overall, how satisfied are you with the:**

	<b>Excellent</b>	<b>Good</b>	<b>Satisfactory</b>	<b>Poor</b>	<b>None</b>
Pre-conference organization	4	3	2	1	
Organization of the event	4	3	2	1	
Quality of the venue	4	3	2	1	
Catering	4	3	2	1	

**11. What was the best part of the day?**

The following are the participants responses categorized by major themes and frequency:

Keynote speakers (Dr. Thorpe, Dr McCreary)	25
Success Stories	20
Networking	17
Panel presentations	14
Action plan development	12
Great, well organized	8
Open discussion	4

**12. How could the day have been improved?**

The following are the participants a summary of responses categorized by major themes and frequency:

Different venue (19)

- Need a larger room because of number of participants
- Need more breakout rooms for group discussions
- Difficult to hear success stories
- Provide a facility for physically challenged persons

Needs to be a two-day workshop (13)

- Need more time for group discussion
- Need more time for developing the action plan
- Need more time to have access to speaker and panellists

Activity process (12)

- Instructions for activities were not always followed

Group organization  
Smaller work groups  
Provide opportunity to service presentation and sharing of mandates  
Not enough breaks between activities

Topics (9)

Aging process and developmental disabilities  
Importance of aging  
Some success stories presenters did not show up  
Volunteer working with seniors  
More diversity of topics  
Additional speakers  
Presentation of local case studies

Other:

More health providers  
More input from long-term care providers  
Opportunities to enhance communication between the two sectors

**13. Participants were invited to expand on their feedback. Here is what they had to say:**

On the negative side:

- I felt that the exercise at 1:00 p.m. was not clear enough and did not provide me with the proper tools to further educate me.
- I did not see a lot of representatives from the MOHLTC
- I would be nice to have some information on people with physical disabilities and not just developmental disabilities
- I think we would have made more progress if we had had CCAC representatives and more people from senior organizations and long-term care facilities.
- I would have liked to take home a resource list of publications, websites, services, etc., on people with developmental disabilities and aging.
- Disappointed that there was not a commitment to develop an official communications/information network with families. There is a sense of isolation in families which needs to be addressed and their role/value acknowledge.
- Les histoires à succès auxquelles j'ai participé étaient mal organisées. Pas assez de temps pour explorer.

On the positive side:

- Beau travail de présentation pour les histoires à succès malgré le fait qu'il y avait trop de contenu pour le temps.
- Merci pour la traduction simultanée.
- Très intéressant et pertinent.
- Make this an annual event

- Overall I am glad I came. It was nicely organized. I learned some interesting information. I would come again.
- Overall it was well organized and presented. Excellent to see everyone pulled together to bring this discussion up front in everyone's awareness.
- This is a great step to involve all important sectors, listen to concerns and successes. Great job!
- Hope to see concrete fruits of the efforts and discussions today.
- The conference gives me awareness of what the broader developmental services look like. Acknowledging the needs of training, day/night activities for individuals that are aging.
- I have a better idea today of all the steps taken to integrate individuals with developmental disabilities. I appreciate the sharing and concerns between agencies and home care, long-term care, etc.
- Very exciting beginning.
- Food great, great day, informative. Thank you.
- Hope you will help local areas continue the process.
- Beautiful people/atmosphere/facility/food/breaks. Congrats
- Very pleased with ensuring events stated and finished on time.

**Appendix 1: Planning Committee Members**

<b>NAME / NOM</b>	<b>TITLE / TITRE</b>	<b>ORGANIZATION / ORGANIZATION</b>	<b>REGION / RÉGION</b>
Debbie Boardman	Executive Director / <i>Directrice générale</i>	Community Living Dundas	Stormont, Dundas, Glengarry United Counties / <i>Les Comtés unis de Stormont, Dundas, Glengarry</i>
Sue Beaudry	Executive Director / <i>Directrice générale</i>	Community Living Renfrew County South	Renfrew County / <i>Comté de Renfrew</i>
Al Loney	Executive Director / <i>Directeur général</i>	Council on Aging of Ottawa / <i>Le Conseil sur le vieillissement d'Ottawa</i>	Ottawa
Larry Chambers	President / <i>Président</i>	Elisabeth Bruyere Research Institute, A University of Ottawa and SCO Health Service Partnership / <i>L'Institut de recherche Élisabeth-Bruyère, Un Partenariat entre l'Université d'Ottawa et le service de santé SCO</i>	Ottawa
Deirdre Luesby	Seniors Health Research Transfer Network, program manager / Réseau de transfert de la recherche sur la santé des personnes âgées, Gestionnaire de programme	Elisabeth Bruyere Research Institute, A University of Ottawa and SCO Health Service Partnership / <i>L'Institut de recherche Élisabeth-Bruyère, Un Partenariat entre l'Université d'Ottawa et le service de santé SCO</i>	Ottawa
Marge McCabe	Executive Director / <i>Directrice générale</i>	Families Matter Cooperative Inc.	Ottawa
Donna Rietschlin	Executive Director / <i>Directrice générale</i>	L'Arche Ottawa	Ottawa
Corey Beard	Program Supervisor / <i>Superviseur de programmes</i>	Ministry of Community and Social Services / <i>Ministère des Services sociaux et communautaires</i>	Ottawa
Rick McInnes	Mental Health and Addictions Consultant / <i>Conseiller en santé mentale et toxicomanie</i>	Ministry of Health and Long-Term Care / <i>Ministère de la Santé et des Soins de longue durée</i>	Ottawa
Tom Gillespie	Supervisor / <i>Superviseur</i>	Ottawa-Carleton Association for Persons with Developmental Disabilities / <i>Association d'Ottawa-Carleton pour personnes ayant une déficience intellectuelle</i>	Ottawa
Paul Wallace	Team Manager / <i>Chef d'équipe</i>	Royal Ottawa Hospital / <i>Services de santé Royal Ottawa</i>	Ottawa
Janna Willison	Psychometrist / <i>Psychométricienne</i>	Royal Ottawa Hospital / <i>Services de santé Royal Ottawa</i>	Ottawa
Luc Ouellette	Executive Director / <i>Directeur général</i>	Service Coordination des services	Ottawa
Normand Charette	Supervisor / <i>Superviseur</i>	Services aux enfants et adultes de Prescott-Russell Services to Children and Adults	Prescott and Russell United Counties / <i>Les Comtés unis Prescott-Russell</i>
Dianne Urquhart	Executive Director / <i>Directrice générale</i>	Social Planning Council of Ottawa / <i>Le Conseil sur le vieillissement d'Ottawa</i>	Ottawa
Hugh Nelson	Executive Director / <i>Directeur général</i>	Y's Owl Maclure Co-operative Centre	Ottawa

## **Appendix 2: Planning Objectives**

### ***PREAMBLE***

Individuals aging with developmental disabilities are provided services by four sectors: developmental services, health, community care and long-term care. Primary funding for the developmental services sector is provided by the Ministry of Community and Social Services. The health and long-term care sectors are primarily funded by the Ministry of Health and Long-Term Care.

### **STRATEGIC OBJECTIVE**

#### ***JOINT PLANNING***

- ***Rationale***

With the aging of individuals with developmental disabilities, there is a pressing need for joint planning between the health, long-term care and the developmental service sectors. Furthermore, the closure of institutions for individuals with developmental disabilities is adding an immediate pressure for this joint planning process.

***Objective***

Establish cross sector committee focused on aging and developmental disabilities representing long-term care and developmental services in the Champlain district by fall 2006.

- ***Rationale***

With limited collaboration, by the health, long-term care and developmental service sectors, mobility and access are unnecessarily complicated and time consuming. In light of this situation, there is limited sharing of resources, strengths, and services between the long-term care and developmental service sectors.

***Objective***

Build a strong network of stakeholders.

#### ***DIRECT SERVICES***

- ***Rationale***

With limited past partnerships and integration of services for aging individuals with developmental disabilities, there is a need to breakdown barriers, and improve collaboration in order to provide new or better services for all individuals in the Ottawa Champlain District.

***Objective***

Create a developmental services, health, and long-term care working group to improve direct residential and community based service delivery for individuals aging with developmental disabilities.

### ***BEST PRACTICES***

- ***Rationale***

With limited collaboration between the health, long-term care and developmental service sectors, lack of promotion for integration of programs, conflicting eligibility criteria, and incompatible ministerial organizational structures, there is a need for knowledge transfer and collaborative evaluation research to identify mutually shared best practices.

***Objective***

Create a developmental services, health, and long-term care working group to define, identify, and implement best practice strategies to enhance quality care in both of these sectors.

OPADD Definition of Best Practices:

Best practices refers to the most desirable or highest quality of providing support to people with developmental disabilities. The developmental services sector strives for best practices in supporting people to become included in their communities. Since the aging of people with a developmental disability is a relatively new phenomenon, there is still work yet to be done in developing best practices related to support of people as they age.

A framework for best practices and aging is provided by quality of life. Best practices must include consideration of the important aspects of each individual's life: physical, psychological, spiritual, social, daily living, leisure, community and growth. Transition planning is proving to be a central piece in building best practices.

### ***EDUCATION***

- ***Rationale***

With a lack of understanding of shared client needs, and of existing strengths in the health, long-term care and developmental service sectors, there is a need to address knowledge gaps, teach new skills, and build self-confidence in caregivers and service providers.

***Objective***

Create a developmental services, health, and long-term care working group to increase cross sector agencies' knowledge, competence, and skills in supporting aging individuals with developmental disabilities and their natural networks.

**Appendix 3: Conference Program**

<b>CONFERENCE PROGRAM</b> <b>RA Centre, Ottawa</b> <b>Thursday October 5, 2006</b>		
Registration: Coffee and muffins		
Welcome by Co-chairs <ul style="list-style-type: none"> <li>▪ Luc Ouellette, Service Coordination des services</li> <li>▪ Larry Chambers, Élisabeth Bruyère Research Institute, A University of Ottawa and SCO Health Service Partnership</li> </ul>		
Opening Remarks <ul style="list-style-type: none"> <li>▪ Comments from local Parliamentary Representative</li> <li>▪ Marcel St-Jean, Eastern Regional Office, Ministry of Community and Social Services (MCSS)</li> <li>▪ Jocelyne Contant, Champlain Local Health Integration Network (LHIN), Ministry of Health and Long Term Care (MOHLTC)</li> </ul>		
Ontario Partnership on Aging and Developmental Disabilities (OPADD) Overview <ul style="list-style-type: none"> <li>▪ Ron Coristine, OPADD</li> </ul>		
Process Overview – Guy Théroux, Eksento Inc., Conference Facilitator		
<i>Overview of Developmental Services, Health, Community Care and Long-Term Care Sectors</i> <ul style="list-style-type: none"> <li>▪ Dr. Lilian Thorpe, University of Saskatchewan</li> </ul>		
<i>Personal Perspective</i> <ul style="list-style-type: none"> <li>▪ Claude Sauvé, Self-advocate</li> </ul>		
<i>Aging and Developmental Disabilities</i> <ul style="list-style-type: none"> <li>▪ Dr. Bruce McCreary, Emeritus Professor of Psychiatry, Queen's University</li> </ul>		
<b>BREAK</b>		
Cross Sector Success Stories – Round 1		
Cross Sector Success Stories – Round 2		
<b>Lunch provided</b>		
Process Overview – Guy Théroux		
Concurrent Panels and Action Plan		
<p style="text-align: center;"><b>Panel A: Education</b> <i>Rideau Room</i></p> <ul style="list-style-type: none"> <li>▪ Dr. Lilian Thorpe, University of Saskatchewan</li> <li>▪ Dr. Bruce McCreary, Queen's University</li> <li>▪ Carmen Rodrigue, U First</li> <li>▪ Jennifer Currie-Roy, Algonquin College</li> </ul>	<p style="text-align: center;"><b>Panel B: Direct Services</b> <i>Clark Room</i></p> <ul style="list-style-type: none"> <li>▪ Jocelyne Contant, Champlain LHIN</li> <li>▪ Marge McCabe, Families Matter Cooperative</li> <li>▪ Debbie Champ, Royal Ottawa Hospital</li> <li>▪ Ginette Desmarais, ERO, MCSS</li> </ul>	<p style="text-align: center;"><b>Panel C: Joint Planning</b> <i>Court Side A</i></p> <ul style="list-style-type: none"> <li>▪ Al Loney, Council on Aging of Ottawa</li> <li>▪ Ron Coristine, OPADD</li> <li>▪ Susan Torrie, MCSS</li> <li>▪ Martha Marr, Canadian Mental Health Association (CMHA)</li> </ul>
<b>BREAK</b>		
Plenary – Report Back		
Closing Remarks – Luc Ouellette and Larry Chambers		

**Appendix 4: Biography: Lilian Thorpe, BSc (Regina), MSc, MD (Toronto),  
FRCPC**



Dr. Thorpe is a geriatric psychiatrist and professor of psychiatry (clinical) at the University of Saskatchewan. She obtained degrees in mathematics and physics before her MD degree in Toronto, which preceded her psychiatry training in Saskatoon. She completed a term as vice president of the Canadian Academy of Geriatric Psychiatry but remains the Chair of the Section on Geriatric Psychiatry of the Canadian Psychiatric Association. Dr. Thorpe was a member of the Canadian Consensus Conference on Dementia in 1998-9 that developed the published dementia guidelines, and participated in the spring of 2006 to update these guidelines. She was a member of the national CanMat group developing with the CPA guidelines for psychiatrists for the treatment of depression committee (Dr. Thorpe coordinated the section on special populations).

Dr. Thorpe practices clinically in conjunction with Clinical Gerontology, Saskatoon Health Region, at Saskatoon City Hospital. She does active nursing home and community living outreach as well as outpatient and inpatient consultations, and works with many patients with cognitive impairment: early or late onset. Her special research interest is in aging of adults with intellectual disabilities. Ethical issues related to reduced competence are another major interest.

Dr. Thorpe has been involved in many drug research studies over the years, including medications for the treatment of dementia. Current research work largely centers on analysis of a ten-year ongoing provincial population study of the progression of cognitive, affective, functional and quality of life changes with aging in people with intellectual disabilities. Related to this is international work with the World Health Organization, preparing treatment guidelines for aging people with intellectual disabilities. In active progress is an international study of vitamin E in aging adults with Down syndrome, and Saskatoon is one of the few Canadian sites in this study.

In September 2000 Dr. Thorpe changed her full-time academic position with the University of Saskatchewan to part-time, to facilitate graduate work in Community Health and Epidemiology. She has now completed all of the course work, comprehensive examinations and thesis for the PhD, and is preparing for her defense. The thesis topic is aging in Saskatchewan adults with intellectual disabilities.

## **Appendix 5: Biography: Claude Sauvé, Self-Advocate**

Who is Claude Sauvé?

I am a true participating citizen of Alexandria, Ontario who works as an inclusion advocate for Community Living Glengarry. I also sit on their board of directors as a self-identified self advocate.

I am the enthusiastic chair for the self advocate council of Community Living Ontario, where I have been involved for the past five years.

I am totally bilingual. I bring a refreshing perspective to the assembly each time I speak with passion about the issues that are important to me, like human rights, income support and equal opportunity.

In May 2005, I received the James S. Montgomerie Award in London, Ontario from Community Living Ontario. I also sit on a Francophone affairs committee, and on a government relations committee for Community Living Ontario.

I sit on the Canadian Association for Community Living as a director at large and on their Grassroots Engagement and Leadership Development Task Force. In Sioux Lookout, I was elected as a director at large for a two year term for Community Living Ontario.

I also sit as the secretary for People First Glengarry.

**Appendix 6: Biography: Dr. Bruce McCreary, Emeritus Professor of Psychiatry,  
Queen's University**



Dr. McCreary received his MD degree from Queen's in 1962 and his Royal College of Physicians and Surgeons Fellowship in Psychiatry in 1968.

He has been a member of the Queen's Department of Psychiatry since 1968. He has focused his clinical and academic efforts on developmental disabilities. Consulting clinics have been provided across the Southeastern Ontario region. Lectures, seminars and practicum supervision for medical and psychiatry students have been provided as well.

Dr. McCreary's special interests have included neuropsychiatric genetics and manpower and training issues related to the care of persons with developmental disabilities.

**Appendix 7: Cross-sector Success Stories**

<b>TABLE NO.</b>	<b>TITLE</b>	<b>PRESENTER(S)</b>
1	L'Arche: "Cecile"	Raphael Amato
2	L'Arche: "Eralda"	Kim Aker
3	Renfrew DS/School Board: Concrete Model for Cooperative Planning	Paul Melcher
4	Partnership – Renfrew County Transitional Youth	Donna Locke
5	Senior Health Research Transfer Network (SHTRN): The Challenges of Engaging Caregivers, Researchers, and Policy Makers	Deirdre Luesby
6	Person Centered Planning: Citizen Advocacy	Sheila Robertson
7	U-First: Working Together	Carmen Rodrigue
8	Total Communication Environment: "Bill"	D.J. MacDonald
9	Forest Hill: "Bill"	Sarah Ferguson-McLaren
10	Services aux enfants et adultes de Prescott-Russell	Normand Charette et Louise Landriault
11	Association pour intégration sociale d'Ottawa : Pour prendre la place qui m'appartient	
12	Bonnechere Manor: "Michael"	Donna Crodie and Gladys Bennett
13	Osgoode Township Care Centre: "Bill M"	Cheryl Banks and Carolyn Della Foresta
14	Community Living Glengarry: "Jean"	Gisèle Martin
15	Nepean Home Support: Client volunteers working with seniors	Barbara Clark
16	Résidence St-Louis Day Program	Anouk Montpetit
17	Association pour intégration sociale d'Ottawa : Reconnaissance et épanouissement d'une personne ayant une déficience intellectuelle	

## **Appendix 8: Success Stories**

Presenter Name: Kim L. Aker

Success Story Name: Erelida: Lifelong Community Builder

### **Situation**

Erelida was born in 1946, joined the L'Arche Ottawa community in 1976 and remained a vibrant and contributing member of her community until the summer of 2001 when the effects of Alzheimer's disease and a cyst on her brain began to take their toll. Erelida had accomplished many things in her life: learning to read and write, being independent in getting around the city, working, and certainly building friendships throughout her L'Arche communities and the broader community. It became clear in the summer of 2001 that Erelida's medical needs went beyond what the caring assistants at L'Arche could provide. Claire, Erelida's sister and Gerard, a long-term assistant, friend, and her Power of Attorney decided in consultation with the L'Arche community to access a nursing home for Erelida. It was a very difficult decision for all, and called on those at L'Arche to re-examine what it meant to make a "lifetime commitment" to core members. She had two very short placements prior to settling in at Medex. That choice was influenced by my own very positive and supported experience when my grandmother spent several years at the end of her life at Medex.

### **Problem Resolution**

Gerard, Claire and folks from L'Arche decided to build a Circle of Friends for Erelida to continue the "lifetime commitment". We got to know the people who worked on her floor and some of the other folks living at Medex. Whenever we went for a visit we dropped by the nursing station just to say 'hi' and often dropped by the office as well. The Garnobé Club (a Senior's group at L'Arche) was very faithful throughout Erelida's stay at Medex. It was important to the folks at Medex that Erelida was so loved and that many people were faithful to the friendship they had with her.

Of course, Erelida led the way. She was charming and smiling and happy to see people, nursing home staff and L'Arche friends alike. We decorated her room with things she loved and made lots of CDs of Elvis music. We ensured she was surrounded by things she loved and we talked about that when a staff person came into the room. We showed up from time to time at meals to help feed Erelida. Again, it supported both Erelida and the staff at Medex.

Erelida continued to be invited to events in the community. We came early to pick her up and helped if she wasn't ready. We stayed cheerful and pleasant even when she wasn't ready. If the staff had concerns about how we would support her, we would talk to them and assure them that she would have someone with her at all times.

We bought her lovely red clothes for many occasions. Again, this sent a message both of what Erelida loved and would choose if she could and that she was important and deserved to be well dressed. In the early days, Gerard was a key player in getting her a chair that met her needs and that worked for the staff at Medex.

We kept a visitors book in the top drawer of her night table so people could write a little note when they visited. It gave the next visitors something to talk about.

We talked about ways to keep Erelida connected to the community and to help core members stay connected to her. Assistants drove core members to visit. In the last 6 months, Jim and Chastity went to visit regularly on weekends. We kept Erelida's name in front of the community to help new people have a sense of who she was and how important she was to us.

### **Lessons Learned**

We were very blessed in having a nursing home where the staff cared about the people living there. We heard from word of mouth, my experience with my Granny, that it was a place where people mattered. I think the many people that kept up their friendship with Erelida during her time there also helped the staff to keep valuing her. Also, we were very intentional about attending anything we were invited to attend on Erelida's behalf and we always thanked people for the things they did for her, even if it was their job.

A phone number was available so a Coordinator could be reached at any time, especially when things weren't going well. Staff knew there was someone to call if Erelida needed something. If they told us she needed something, she got it quickly. People dropped in to visit during the day, in the evening and on weekends. I think the staff really appreciated the care and attention Erelida received outside the nursing home.

We all saw ourselves as supporting her and doing whatever it took to make it the best it could be. Nobody got territorial. I think she is the one that made the whole thing work! She kept building community to the end.

**Presenter Name: Sarah Ferguson-mclaren**

**Success Story Name: Forest Hill - Bill**

### **Situation**

Bill was admitted to our Long Term Care Centre in January 2006 from the Rideau Regional Center. Bill's application for admission to Long Term Care was received from the Ottawa CCAC & reviewed on the same basis as anyone else applying for long term care placement at our home.

A bed on one of our special care units became available this past January & was offered to Bill. We soon found out that Bill's admission would not be what we were generally accustomed to. Prior to accepting the bed, there were a number of people who came to see the home from Rideau Regional to make certain that this would indeed be a suitable environment for Bill, they took pictures of the home & our staff so that Bill could become familiar with everyone before arriving.

Bill had a lot of people involved in his transfer from Rideau. Regional (Rideau Regional Staff, Total Communication Environment Staff & Ministry of Community & Social Services), at times we felt overwhelmed by the number of people involved in his transfer & it became difficult to determine who was leading everyone involved. Our two environments could not have been more different... Rideau Regional is an institutional setting, has a large team of multi-disciplinary professionals involved in the care of its residents & seems to use case conferences as a primary source of communication amongst key stakeholders. We focus on providing a "home-like" non-institutional setting for our residents; we have 156 residents & therefore have a smaller team of multidisciplinary professionals & often communicate with one another by less formal means.

Bill also arrived at our Long Term Care Centre with enough personal supplies (courtesy of Rideau Regional & MCSS) that could have met the needs of all of our 156 residents for at least one month (i.e.: after shave, toothpaste, shaving cream, incontinence products). We were amazed! Not to mention very impressed by the thought & care that had gone into preparing Bill for his transfer to his new home by Rideau Regional & TCE staff.

### **Problem Resolution**

As previously mentioned we were initially overwhelmed by the number of people assisting Bill with his transfer & the number of requests for conferences, meetings & updates, We expressed these concerns to Total Communication Environment & they immediately responded by clarifying everyone's roles & what we could expect *in the future*.

Bill also presented with behaviors that were very different than those of a resident with Alzheimer's disease or a related dementia. Bill was prone to violently hitting his head on objects (doors, walls) when he was unhappy (something we had never experienced before), we quickly learned that while the behavior was different, the way that we

support the behavior was the same, it was during this time that we discovered how valuable Bill's supports from Rideau Regional & TCE were. They showed us what has worked in the past & what we needed to do to avoid situations that may cause frustration for Bill. Since that time we have developed a positive & collaborative working relationship with TCE & MCSS. It is our belief that Bill is at a great advantage to have so many organizations involved in his care. His transfer to LTC was very well supported & continues to be supported in the same manner. He is truly a success story.

### **Lessons Learned**

Bill's admission to our Long Term Care Home was a tremendous learning experience for us all. We currently have 3 more individuals on our waiting list from Rideau Regional and feel confident that because of our *experiences* with Bill's admission earlier this year, the number of supports available to individuals with developmental disabilities seeking LTC placement & our willingness to develop a collaborative partnership with these organizations that all future admissions will continue to be well supported.

There is certainly *a* place for individuals with developmental disabilities in long *term care* in Ontario. Further collaboration between the Ministry of Health & Ministry of Community & Social *Services in an effort* to streamline the process of admitting individuals with developmental disabilities to long term care has resulted in new recommendations recently being introduced & will serve as an excellent resource tool for future admissions.

**Success Story Name : "Nelson"**

**Situation**

Nelson was a 48-year-old developmentally delayed resident that was admitted to Groves Park Lodge. Nelson had lived in a lumber camp prior to admission and did not have a lot of contact with women, he also had poor hygiene and his language was often inappropriate. Nelson's communication skills were poor in the way that he only answered with one-word answers and he become very upset if staff did not understand what he wanted. Dining room manners were another challenge that we faced and he had to share a dining room with 74 others. Nelson also had a sister that he didn't have any contact with.

**Problem Resolution**

Originally we had set Nelson up with our maintenance person as he didn't relate to women well and he developed a strong relationship with him. With the direction of the maintenance person we were able to go to him and he assisted staff with getting Nelson to complete tasks such as bathing, changing clothes etc. As he gained more confidence in staff we were able to integrate him into community living and he was able to go to the shop and do some woodworking. Nelson also enjoyed music and was very active with entertainment. We were often able to use a reward system with Nelson and people would offer him Pepsi for good behavior. With this approach Nelson's medications were decreased, as they were no longer needed to manage him.

Later years Nelson developed a strong relationship with a social worker Jeff. Jeff was able to introduce Nelson to a whole new world; he spent 1:1 time with him, took him shopping, out for drives and out for treats. Nelson would look forward to a shopping trip with Jeff and was much more agreeable to changing clothes and discarding old things. If staff were having any problems Jeff was able to assist staff in problem solving. Jeff was also able to assist us when Nelson became ill and was dying. Jeff has assisted Nelson in making funeral arrangements and he sat with him when he was dying as Nelson didn't like to stay in bed even though he was too weak to sit up. But when Jeff was at his bedside he was content to be there.

**Lessons Learned**

Staff was very pleased of the outcome; it was an accomplishment to them. Nelson soon became par of the family and when I was speaking to them about presenting this, they all had a touching or funny story to tell. Nelson could be reunited with his sister after many years of not having contact. It was a learning experience for our staff in the fact that they learned that with a little time and adjustment period he became easier to care for and became a special part of our lives. It also allowed Nelson to spend 23 years with his family at Groves Park Lodge, and he was able to be reunited with his sister and able to spend time with her. Staff was also able to be the pallbearers at Nelson's funeral. It taught all of us that it takes time to adjust to a new place and everyone needs a special

friend. Some changes that came about through all of this is that we now have a 1:1 eight hour program to get to know the resident and make them feel comfortable in their new environment. We have also built a special bond with community living by sharing a van with them and utilizing them if we have a resident in need of their services.

**Presenter Name: Cheryl Banks**

**Success Story Name: Bill McKay, Osgoode Township Care Center**

### **Situation**

My brother lived in Toronto with my mother and father and in 1990 he moved to Ottawa with my Mom (now a widow) to live in a home together. When Bill moved to Ottawa I was able to get him into Wise Owl Workshop. Everyday Bill took the local bus, unassisted, to and from the Wise Owl location. For many years Bill worked on the “street crew”, clearing snow and cleaning the parks in the summer. He loved being outside and really enjoyed the pay cheque. That Bill enjoyed being outside which was a real surprise to my Mom and I as for the better part of his life he had just watched TV all day and wasn't very active except for his weekly bowling event.

While working at Wise Owl Bill found out that Ottawa Carleton Life Skills (OCL) had an office right above Wise Owl Workshop and that there were people there who could help him move out of his mother's home. Apparently Bill frequently visited the OCL office and asked them when they were going to get him a place. Due to his persistence they finally found Bill a place in a group home. At the age of 50 Bill moved out of his mother's home and moved into a group home environment. He really loved it. When OCL introduced a ‘home share’ arrangement, Bill once again decided that he would like to try that for a change! He lived with a wonderful women for about 8 years and then he moved to another “home share” until he moved to Osgoode Township Care Center.

### **Problem Resolution**

My brother Bill was living in a “home share” structure with Ottawa Carleton Lifeskills (OCL) from the age of 50 to age 63. Bill attended day programs at Wise Owl Workshop and other social activities such as Special Olympics. Three years ago Bill was diagnosed with Colon Cancer. He had major surgery and radiation and chemotherapy. Today Bill is Cancer free. After his surgery Bill didn't really have the desire or the energy to attend the day program. My mother, Catherine McKay, Bill's care giver, Vicki Fossie (Director OCL) and I had a meeting to discuss Bill's future living arrangements. At the meeting we were told that Bill's care giver was having a difficult time dealing with Bill's behavior. Because he didn't want to go to day program he was giving his care giver a hard time. He was also having some issues with his bowels. Since his surgery Bill has what the medical profession call “short bowel syndrome”. Individuals sometimes have no control of their bowels and they can have many accidents. Bill's reluctance to go to day programs and the amount of work (laundry, daily bed changing etc) was causing his care giver a lot of stress and anxiety. She felt she just couldn't take care of Bill any longer and that he needed to be moved either within OCL or an alternative living arrangement.

We were presented with two options.

1. Bill could move into a group home where the clients due to their physical and mental capabilities were allowed to remain in the home 24/7. In other words there was funding available to have a full time staff member. This didn't seem like a good alternative as we felt that Bill wouldn't fit into this group since he is very high functioning and has no physical limitations.
2. Bill would be assessed by the Ministry of Community Services to determine his eligibility for placement in a Long Term Care Facility.

Both my mother and I were very concerned about Bill's future living arrangements. OCL arranged for a social worker to meet with Bill and go through the assessment process. My Mom and I attended this meeting and were present during the interview. At that time Bill expressed a desire to also leave his current living arrangements. He was just as frustrated as his care giver. Bill's name was placed on a waiting list for Long Term Care Facilities. After about 6 months we were contacted by the Ministry to let us know there was an opening for Bill at the Township of Osgoode Care Center. We had 24 hours to accept the "bed" or we would be put back on the bottom of the waiting list. We agreed to accept the opening and within 48 hours my brother was moved to Osgoode Township Care Center where he resides today. When we met with the staff at Osgoode they were very kind and recognized that Bill was a very different type of patient than they had previously serviced. They immediately recognized that Bill needed to be kept busy. Right away they set up a housekeeping job for him and instructed the staff to allow Bill to assist with tasks that he could manage (clearing dishes from the tables etc.). Every morning Bill dry mops the halls of the facility and this summer they had him watering the outdoor gardens.

Bill shares a room with another gentleman, Alex, who is 97 years of age. Alex is very kind to Bill and I think they do talk a lot. Bill has adjusted very well to his new living arrangements. He never calls us to "come and get him" or refuses to return after a week-end at home. Everyone at Osgoode really likes Bill and when we visit or pick him up for the week-end they are always very friendly and caring to him. When my brother moved to Osgoode Township Care Center both my mother and I were very upset. We had always tried to keep my brother out of institutions and by leaving him at Osgoode we felt we had really failed him. I know my mother felt very guilty that she couldn't bring my brother home to her house permanently, but she is 84 years of age and she just couldn't manage his care. Although Osgoode is a very nice facility and everyone is very friendly it is still a very depressing place. Most of the people there are in wheelchairs and some of them are not capable of speaking. I feel one of the biggest challenges is to keep Bill active. It is so easy at Osgoode to become complacent. They do everything for everyone and I have noticed that Bill is getting use to the attention.

When he first moved to Osgoode he really put on a lot of weight. They eat 6 times a day (including snacks). This created a problem as none of his clothes fit, so we had to get him new clothes. When we mentioned this to the staff they put him on an exercise

routine and the dietitian reviewed his eating habits. He seems to be maintaining his weight now. But my brother Bill seems to really like it there! He never complains, except once in a while about the food. He participates in the social activities and joins any group outing. I feel my brother is very isolated at Osgoode. There are lots of people to speak to but I think he needs to have more stimulation. We are working on having him attend Wise Owl Workshops on a weekly basis. The Osgoode staff is wonderful but they are not trained to deal with individuals with developmental challenges.

Presenter Name: Total Communication Environment

Success Story Name: Bill

#### Situation

Bill is a 69 year old man who had lived at the Rideau Regional Centre (RRC) for 20 years. As a result of the government's intention to close RRC, a plan was developed for Bill to move into the community. Bill and his family were concerned that a typical community placement with a community developmental service provider might not be able to meet all of his medical needs (heart condition, diabetes, etc) and developing issues related to aging. There was also the concern that a long term care placement might not be able to provide Bill with the appropriate level of interpersonal, programming and case management support he requires as a result of his developmental disability.

#### Problem Resolution

An assessment was made by the Community Care Access Centre in Ottawa and Bill was deemed appropriate for placement within long-term care. Selection of Forrest Hills Long Term Care Facility in Kanata was made and Bill moved to this Centre into his own private room when a bed became available. TCE, a developmental services provider entered into a partnership with Bill and his family; and Forrest Hills to provide daily on-site support to Bill to meet his developmental needs. TCE's outreach worker visits Bill daily and ensures his needs are being met. They might go to the library to check out books, shop for personal needs, explore the community, advocate on his behalf, coordinate and liaise with external contacts and appointments, assist in money management and coordinate payment of all bills. TCE also liaises with Bill's family and keeps them informed of his situation. Bill has the opportunity to take part in activities within the centre i.e. bingo, tea time, entertainment in the main lounge. Bill will spend a lot of time on his own with his books ("work").

This partnership has worked well for Bill and both TCE and Forrest Hills. Bill is accessing the supports and services available to all seniors who require long-term care but also receiving the extra support from the developmental services sector that ensures his unique needs are recognized and met. This unique approach and partnership paves the way for the future. TCE has indicated it could support several other people with the support we are providing daily to Bill. A small group of people living together and receiving enhanced support to meet their developmental needs makes a lot of sense for the overall quality of life for people with developmental disability and who are aging and require the support of long term care.

## **Lessons Learned**

You need to have the 'right' partners. This means that all parties need to be open, willing, flexible and able to learn from experience and adjust accordingly over time. An understanding and agreement on how the relationship will be reviewed is important.

Clear and open communication between the LTC and DS provider re: roles and responsibilities. It's important that all parties understand their role i.e. DS provider is not doing tasks that fall within the realm of the LTC provider. Clear job descriptions are required. It's also important to understand how feedback will be communicated and to provide opportunities to do so.

A tri-partite agreement with the individual/family on who does what and how information and contact with the family occurs.

An understanding on the process of how Serious Occurrences are ported and to whom.

**Presenter Name: Gladys Bennett and Donna Crogie**

**Success Story Name: Mike**

### **Situation**

- 42 year old male, Diagnosis of Downs Syndrome with moderate to severe developmental delay
- Shared a room with an elderly man who was afraid of Mike. He felt Mike was dangerous and should be locked up
- Mike demonstrated affection to everyone i.e. kisses, hugs-in an inappropriate manner, call females "Baby Face"
- Mike liked to joke with people to get a reaction i.e. come up behind people and say "BOO!" or "Oh, a Mouse!" or grab people from behind in the rib area
- He became easily excited. He would talk loud, laugh loud, run in the corridors
- Mike liked to be involved in everything around him. He would interrupt his roommates' visits, frequently participate in their conversation, interrupt the card game, try to play with the small children
- Mike like to give hard candy to everyone causing choking risks
- Mike did not understand the boundaries of his side of the room. He would take treats, cookies etc from his roommate's stand
- Mike was focused on cutting up paper. That was his only interest. This caused concerns for his roommate re safety of scissors, fear he would attack with the scissors. Mike hoarded papers and soiled serviettes in his pockets and hid them in his room (for cutting).
- Staff lacked the knowledge of what Mike's interests and capabilities were and how to deal with his behaviours.
- Mike loved to be dressed in his cowboy attire. His boots hurt his feet and he was always more excited when dresses like Elvis or a cowboy.
- Problem Resolution
- A multidisciplinary team met to review Mike's needs, abilities, interests and behaviours.
- This included the Dual Diagnosis Consultation Team from ROH, Family and Children Services, Speech and Language Assessment, Family, Activation staff at Bonnechere Manor, and nursing staff.

A Goal was set for Mike:

- Consistent structured routine with clear boundaries,
- To have the same expectations from everyone,
- To reward positive behaviours and not punish negative behaviours

Mike was allowed to shake hands with people, not hug and kiss. Staff was encouraged to approach Mike with their arms in front of them and give an open hand wave to discourage Mike from hugging. Mike would get a hug and kiss in the AM when he wakened and when he went to bed. Mike was told "No, that is not allowed" in a firm

voice. Mike was reminded to use his "Indoor Voice." Mike had his pockets and dressers cleaned daily. If he had not hoarded paper he was given a "Ticket" that allowed him to help clean off the tables after meals.

Activities provided a focus for Mike's cutting i.e. fishing trip pictures, family, cutting out pictures for an album of things he liked. Mike wears his cowboy attire to the music programs only - not every day. Mike's scissors were kept in the activity room. He had blunt scissors in his room for cutting in the evening. Activities that Mike liked were identified: puzzles, bingo, movies, woodworking, floor hockey.

A 1:1 staff for minimal hours per week from Community Living worked with Mike. Mike is allowed to sing 1-2 songs with the entertainers at the end of the program. A yellow tape was placed on the floor of the shared bedroom to clearly show Mike the boundaries. Roommate's family was offered an alternate visiting area. There is ongoing family involvement and support.

### **Lessons Learned**

- Developmentally challenged people need a structured routine
- They need consistent expectations from everyone
- Staff need to know what activities they are interested in, that they enjoy meaningful activities and that the activities they need may be different from those geared to the elderly
- 1:1 staffing is extremely beneficial - many activities Mike enjoys but needs the 1:1 to stay focused to complete them
- Mike has bonded very well with his worker and likes to introduce him as his buddy
- Need continued observation of behaviours for signs of deterioration, dementia, depression
- Mike will be assessed yearly at the Downs Syndrome clinic
- Continued staff and resident education is necessary
- Mike loves to be needed
- Mike needs his own space. He loves to show his room to others. He likes to show his posters, his treasures, he is proud of things he has made, etc to others
- Mike's feelings are easily hurt. Need to focus on the positive behaviours
- Mike demonstrates good manners. At times he needs to be reminded of the expectation of his behaviour
- Elderly residents do adapt and learn that Mike wants to be helpful (Mike calls one lady his MOM and she loves it!). Another resident buys Mike a treat weekly
- Staff need to learn when / who is a compatible partner, table mate etc. at functions
- Ongoing monitoring of tolerance of other residents is required

**Presenter Name: Carmen Rodrigue, PRC for CSA Ottawa, UFIRST Facilitator**

**Success Story Name: UFIRST – Working Together**

### **Situation**

Carolyn Smith is a woman of 58 years old with Downs Syndrome, who lives in a long-term care home. She regularly attends a day program five days per week and can participate in activities which focus on her strengths. It was not always easy to understand her language but she communicates utilizing her hands and gestures. Over the course of two days, the staff noticed that she was refusing to eat, her mood changed, and she could not follow simple instructions as previously. She recently struck out at a familiar caregiver, which she had never done before.

### **Problem Resolution**

A case conference was called by the nurse-in-charge at the LTC home to review some of the challenges that staff were experiencing with Carolyn. The RN utilized the UFIRST collaborative tool and PIECES framework to review Carolyn's change in behaviour. By reviewing the physical, intellectual and emotional health of the client and her capabilities, the staff explored different situations that they were experiencing in working with Carolyn. In reviewing how Carolyn interacted with her environment including physical and emotional environment, they were able to understand that changes in behaviour were meaningful and further medical assessment was required. Also in considering Carolyn's support network, the staff gained a better appreciation of who were the care partners involved and who might provide additional support at this time to implement a consistent plan of care.

### **Lessons Learned**

By utilizing the UFIRST collaborative tool and PIECES framework, the staff learned the following:

- That behaviour is meaningful;
- That changes in behaviour require ongoing monitoring, documentation and reporting;
- That delirium is indicative of an acute medical emergency;
- That each care provider needs to reflect on their interaction / approach to ensure that the best care strategies are utilized;
- That these frameworks provide a comprehensive and best practice approach to assessment and care planning through a common vision, common language and common approach.

The best practices that were initiated:

- Collaborative practice is facilitated through the UFIRST collaborative tool & PIECES framework;

- Implementation of RNAO best practice guidelines:
- Client Centered Care
- Prevention of Constipation in the Older Adult Population
- Screening for Delirium, Depression and Dementia in Older Adults
- Care strategies for Older Adults: Delirium, Dementia and Depression.

**Success Story Name: Jean Robidoux**

**Situation**

Mr. Robidoux is a 73 year-old gentleman who just cannot sit idle. In 2004 when Supported Employment at Community Living Glengarry and Jean approached the Dairy Queen in Alexandria, owners Mike and Kim Major were happy to provide Jean with a custodial position. Mr. Major reveals that Jean kept the place very clean and that his job performance was exemplary. The highlight of Jean's day is that he could socially interact with customers. Mr. Jamie MacDonald co-owner of the Atlantic Hotel in Alexandria has also employed Jean to do custodial work. He gave Jean a glowing review as well. Jean has gone above and beyond the call of duty for his employers. Mr. Robidoux has worked very hard most of his life. He also worked on a road crew in Montreal where they put steel on roads. Unfortunately Jean suffered a mishap which resulted in the loss of three digits on his left hand. He purchased a house in Alexandria; here he resides with his wife Loraine.

**Problem Resolution**

Jean is also involved in many volunteer activities. He helps at La Soupiere at Sacred Heart church. He assists the organizers in preparing healthy meals where friends and families gather to share good food and a good time. Jean is a member of the Knights of Columbus 4th degree. As a Knight some of his responsibilities are amongst others to assist the parish priest with different activities at religious functions.

When asked to attend the session on healthy active aging Jean agreed. He is quite active and willing to try new things and to share his experiences. Jean is very healthy and walks every day. He has a family doctor who provides him with health care in his mother tongue French. He has recently seen a specialist and is awaiting lab results. A nurse has been visiting him at home at the request of his physician and the Glengarry Memorial Hospital is close enough for comfort, for him and his wife Loraine. Jean finds his life in Alexandria, a small community of 3500, very fulfilling and very happy. He would not have it any other way since everybody knows him and always has a friendly smile or word for him. Jean in return provides same to everyone he meets.

**Presenter Name: AISO**

**Success Story: Josée – Recognition and Personal Growth of a Person with a Developmental Disability**

**Situation**

Josée is a 58 year old woman who is developmentally disabled and who has spent some 34 years in an institutional setting. She is frail and of ill health, and because of her physical needs and mental capacity, she requires support. Public exposure that occurred in the last few years and Josée's challenging attitude made it possible for her to break barriers that are brought on by prejudicial attitudes toward the potential of people with developmental disabilities.

Thanks to her involvement and the role she has played as our Organization's goodwill ambassador at a very visible cultural event, she regained self-confidence and was able to show her wonderful artistic talent to the community. Because of this, she has been interviewed by the media and been part of stories that were broadcast in Ottawa's French community. Josée acted as spokeswoman at our press conference that had been organized to announce the upcoming cultural event. This has heightened the awareness of our partners and allowed the community to be made aware of a deinstitutionalization success story.

**Problem Resolution**

Supportive care and attention was given to Josée with the purpose of helping her regain self-confidence, bring her to believe in her capabilities and allow her to understand that there are many possibilities for her to grow personally. Several meetings and activities were set up in order for us to provide her with the facilitative tools she was to need for her role as the main player in this media event. We have remained open and sensitive to her needs, and made ourselves available in order for this project to be successful.

**Lessons Learned**

We have adapted to Josée's specific needs. We have also maintained an open attitude toward her physical and learning capabilities, and arranged for resources and support to be provided to her. We believe that it is important to finally mention the teamwork that was involved, which made it possible to bring together speech and communication practitioners.

**Presenter Name: AISO**

**Success Story Name: Patrice – I Want to Go Where I Belong**

**Situation**

Patrice is a 66 year old blind man with a developmental disability. In the course of his life, he has lived in various environments (in groups and on his own). Recently and upon his own request, he has successfully transitioned to the long-term care sector for aging individuals.

**Resolution**

Together, we have looked at the resources that were available within the community. We have also asked that significant family members take part in his new life's planning process.

We have developed a Transition Plan that took into account the support he will be needing in his new residential facility. In addition, we have developed a customized follow-up model based on his new life environment, which, namely, included supportive care and regular monitoring.

**Lessons Learned**

We do believe that it is important to plan in accordance with the person's capabilities and wishes. We also understand that cooperation and involvement by all involved, that is the intervening partners and the person concerned, will increase his or her chance for a successful transition and allow them to adapt. During our session, we will talk about what we have learned from this experience.

**Presenter Name: Anouk Montpetit**

**Success Story Name: Résidence St-Louis day program**

### **Situation**

The Résidence St-Louis day program has been welcoming the frail elderly and the elderly with Alzheimers' disease and related dementias since 1996. The main objective of this program is to provide a safe and secure environment where the elderly clients can socialize with others of the same age group; where the clients attend education sessions and/or receive information on subjects related to the aging process; where the clients participate in recreational activities, etc.

In 2003, the CCAC started to manage the references and waitlists of all adult day programs in Ottawa and for the first time in our history, we started receiving references for clients who are developmentally disabled for admission at our day program.

We now had to face the challenges of integrating this new clientele to our already well established and meshed groups.

### **Problem Resolution**

We decided as a team, including the program attendants and the volunteers, to integrate this new clientele into the Friday group. This group was traditionally the group that had been through the most changes in clients. It was a smaller group and the regular volunteer was comfortable with this clientele. At the same time, we felt that we needed the support of the agency where these clients were living. We asked for the support of a group home worker when the clients were attending our program. We felt that it was important for the day program attendants to continue their social and recreational programming, without having to tend to the self-care needs of the developmentally disabled clients. We knew that our elderly clients would resent or at least be frustrated at having to wait for activities if the day program attendant was busy helping with toileting. The agency agreed to provide us with the support we needed and two of their clients now enjoy attending the Résidence St-Louis day program on Fridays and this for the past two years. Our elderly clients welcomed these clients with open arms and have created a special bond with them.

### **Lessons Learned and Best Practices**

We realize that if given an opportunity, both the developmentally disabled and the elderly, can be accepting of each other.

We realize that it is important for us to get to know our clients and our groups' potential and needs. We also have to give them a chance to face new challenges or situations.

It is important for us to maintain close ties with service providers of other sectors, including the social service sector.

It is important for us to provide learning and training opportunities to our day program workers in order for them to be better equipped at leading social and recreational activities for clients with developmental disabilities, because they do have differing needs than our elderly clients.

At the same time, we cannot forget that this new clientele is going through the same aging process as do our other clients but with added challenges, such as having to separate from their, in many cases, lifelong caregivers...

**Presenter name : Normand Charette et Louise Landriault**

**Success story name: Prescott-Russell Services to Children and Adults (PRSCA)**

### **Situation**

The PRSCA's Mission is to help the vulnerable residents of Prescott-Russell by providing them with support as they continue living with their families and within their community, to live a good life. In 2001, the following 5 Agencies were grouped together:

The Children's Aid Society  
The Association for Community Living  
The Youth Developmental Services  
The Family Services Centre  
The Adult Developmental Services

This presentation will deal with Adult Developmental Services, which are:

Group homes, family type resources (homesharing), alternative approaches, supervised apartments (SIL), support to individuals living with their families, and day activities. Through the training that is provided to its employees and volunteer workers, the Agency's values are conveyed to each of its Services. We do emphasize the importance of our client's social integration and the roles they are meant to play socially from birth onward.

Professional training is provided by the Valor Institute's Raymond Lemay, Jacques Pelletier and Wolf Wolfenberger.

### **Problem Resolution**

Because of the Agency's values, and as a measure of improved services to be provided to our aging clients, some of our group homes have been rearranged. We have developed partnerships with the CCACs, the Region's hospitals, Ottawa's Rehabilitation Centre, and various private service providers, once again with the purpose of responding to the needs of our clients.

The PRSCA have hired a Nurse whose responsibility is to help us with medical follow-ups. We have also hired Dr André Blanchet as our Medical Consultant. Dr Blanchet provides his services on a monthly basis.

The PRSCA have also trained their own employees as Ambassadors working with their Agency's elderly.

### **Lessons Learned**

We need to gain a better understanding and improve the communication channels between Health Services and Developmental Services.

In doing so, we will be in a better position to allow our clients to remain in their homes for longer periods of time while they continue to be provided with valued and integrated services.

The number of ambassadors who are promoting the PRSCA's mission is gradually increasing: employees, volunteer workers and community residents. We hope the long-term care service providers are promoting the values that are dear to the PRSCA.

**Presenter Name: Sheila Robertson**

**Success Story Name: Person Centred Planning and Long Term Care: A Recipe for Success**

### **Situation**

- Challenges that a person with a developmental disability can face
- May be considerably younger than other residents – one or two generations
- May have interests and goals that are quite different from other residents
- May have come from a family or small home where environment and communication was adjusted to fit their needs and capacities
- May have difficulty being understood by staff and other residents
- May have difficulty with the “institutional” environment
- May either withdraw and become depressed, or may use behaviour to express wants and needs or frustrations

### **Challenges that the long term facility staff may experience**

- May not have understanding that medications can react differently in a person with a developmental disability
- May be unused to communicating with and relating to someone with a developmental disability
- May have expectations that the resident cannot meet without help
- May have assumptions or routines that frustrate (however inadvertently) the interests and choices of the resident with a developmental disability

### **Problem Resolution**

Person-centred planning is an approach that has had results.

The terms “person-centred planning”, “person-centred care” are being used a lot these days, but they mask many interpretations and applications in practice.

The approach this presentation will present is one which, for many of us, involves a fundamental shift in thinking. It is based on some fundamental ideals, principles and values that, on the surface we can all agree with. But when it comes to applying them, so often the “but”s and “can’t”s take over. This approach does recognize the “but”s and “can’t”s, but sees them as barriers to be overcome, not as restrictions on the goals or choices of the individual. The fundamental question is “How can we make this happen?” and not “Why can’t this happen?” The approach requires faith and creativity. It draws together the resources of people and their knowledge and connections – not just service providers, but also of people as members of their communities. It is not restricted to funded programs or services, but goes far beyond that.

### **Lessons Learned**

How might this approach be applied for adults with a developmental disability in long term care facilities?

Ideally, this approach would be taken with every new resident – whether with a developmental disability or not. It involves drawing together individuals involved, or potentially involved in the person's life – relatives, friends, previous caregivers, new care givers, etc. – and the individual. Together they focus on the individuals' goals and on ways these goals could be met. It challenges people to develop creative solutions, to think "outside the box". It involves commitment of the various people to take particular steps that they can toward meeting those goals. It confirms for the individual that their choices and gifts are valued and respected, and gives those who care for them a full picture of the person and guidance on how to enhance their quality of life. This process can be ongoing, with an ongoing "circle of support".

**Presenter Name: Deirdre Luesby**

**Success Story Name: Seniors Health Research Transfer Network  
The Challenges of engaging caregivers, researchers and policy makers**

### **Situation**

The quality of care delivery in Canada depends on the improvement of knowledge transfer and exchange with and within all health sectors. The increase of complex care requirements and increase of diverse services offered have brought the need to improve organizational support for the use of knowledge and best practices. This need has been recognized by Canadian funders, as they focus attention on and make investments in networks designed to help integrate health research into our healthcare policies and practices.

### **Problem Resolution**

In 2005, the Seniors Health Research Transfer Network (SHRTN) was launched with the goal of bringing together caregivers (both formal and informal), researchers and policy makers with the goal of creating a “place to go” in Ontario where they can work together and access the latest knowledge and best practices about seniors’ health and health care. During its first year, SHRNT brought together leaders in the seniors’ health care system to discuss their needs and priorities. Based on this, SHRTN has focused its energy on improving access to information through the SHRTN Library Service and on nurturing and supporting various topic specific Communities of Practice. Support for these groups includes assistance to meet, learn and work together in both face-to-face and virtual formats, and to provide access to tools that facilitate this.

SHRTN has also convened an important new group, called the SHRTN Implementation Team for Eastern Ontario which brings together key stakeholders to oversee the Network activities in this region.

### **Lessons Learned**

In order to change health care practices at the bedside, it is important to engage the healthcare system at all levels. Bringing people together in this sector and getting the latest evidence into the hands of those who need it is very challenging. In order to be successful, SHRNT has learned that we must be very proactive and engage in active and aggressive outreach in order to achieve our goals. Bringing together the people who can make a difference in the system takes energy, perseverance and dedication.

For more information on SHRTN please visit [SHRTN.on.ca](http://SHRTN.on.ca)  
or contact Deirdre Luesby at [dluesby@scohs.on.ca](mailto:dluesby@scohs.on.ca) or 613 562-4262 x 1654

**Presenter Name: Donna Locke – Service Coordinator**

**Success Story Name: Partnerships – Renfrew County Transitional Youth**

### **Situation**

Beginning in the early part of 2000, Developmental Service agencies in the county realized many of the young students with intellectual disabilities were leaving the school system without transitional planning for goals and support for life after High School.

Transitions occur throughout life. For vulnerable people who are often involved with a number of sectors and service providers, it is important to establish practices to ensure people are supported to plan and negotiate transitions to a desired conclusion, and systems are prepared and coordinated to respond effectively. A similar approach for transitions from community supports to long-term care or senior supports may prove to be beneficial.

### **Problem Resolution**

So began the partnership... Inclusion Renfrew County (a collective group of Developmental Service agencies in the County of Renfrew, consisting of Community Living Renfrew County South, Community Living Upper Ottawa Valley, Madawaska Valley Association for Community Living, Developmental Services, L'Arche Arnprior and MCSS-Employment program) invited both the local Separate and Public School boards to "Transitional Youth" meetings.

Through many discussions with this newly formed group, it was identified that students, their families, the school boards and the developmental service agencies had information to share about each others roles, community opportunities to explore and the students' goals and interest.

- Students and their families were not aware of what supports and services were available after graduation
- Developmental Services were not aware of the numbers of young people with Intellectual disabilities who would be possibly requiring supports and services from their agencies in the future.
- School personnel, who worked directly with the young students were not aware of Community services or how and when to access.
- There were questions of who was responsible to provide access and plan for these required supports.
- Questions around how we assist young people to be best prepared.
- Questions around how Protocols for Transitional planning for both the Ministry of Education and Developmental Services agencies can work together to provide the graduating student with the best outcome.
- What can be done before the actual graduation? Who can help out?

As a result of many hours of hard work, this County Transitional Youth Committee developed a thorough brochure, "Transitional Planning for Youth".

## Lessons Learned

This document outlines the following:

- Ontario Government Requirements
- Transitional Planning in Renfrew County
- Planning Principles
- When and where you should start
- Helping a student prepare
- Phases of Transitional Planning
- Names and contact numbers of all organizations involved

This document is now used as a guide for students, their families, both Separate and Public School Boards, all County Developmental Service agencies, MCSS employment program and just recently both the Children's and Adult's Community Mental Health to assist in cooperative planning for young people with Intellectual disabilities.

This document encourages planning to begin as early as grade nine, involving all the potential services that a young person may need to someday require.

This planning encourages early experiences to be explored, offering choices and opportunities to a young person while still in school as well as accessing their community and Ministry services and supports.

Several Information evenings were established to share this information with students, their families, school personnel, School Principal's meetings and Developmental Service agencies within the County of Renfrew.

This document has encouraged:

- Early planning
- Successful transition to life after school
- Stats for needed resources
- Better informed students/families and organizations

**Appendix 9: Cross-Sector Success Stories – Key Ideas for Next Steps**

<b>Table 1</b>	<b>L'Arche "Cecile"</b>	<b>Raphael Amato</b>
<b>Key Ideas</b>		
<ul style="list-style-type: none"> <li>• Dr. Louise Colombe et infirmières – soins palliatifs à la maison</li> <li>• Le droit de mourir à la maison</li> <li>• Assurer le respect de la personne</li> <li>• Avoir les outils pour les personnes</li> <li>• Création d'un document</li> </ul>		
<b>Table 2</b>	<b>L'Arche "Eralda"</b>	<b>Kim Aker</b>
<b>Key Ideas</b>		
<ul style="list-style-type: none"> <li>• Natural support (and support from both sectors)</li> <li>• Maintaining relationships</li> <li>• Natural supports</li> <li>• Wonderful story</li> <li>• Relationship good – maintaining relationships</li> <li>• Aging taking extra steps and Medex over and above, non-judgmental relationship</li> </ul>		
<b>Table 3</b>	<b>Renfrew DS/School Board: Concrete Model for Cooperative Planning</b>	<b>Paul Melcher</b>
<b>Key Ideas</b>		
<ul style="list-style-type: none"> <li>• Need emergency, LT and transitional plan (individual, parent and service providers)</li> <li>• Re transitional plan – ease everyone into new situation. Key for them, individual starting day program at LTC facility and personal care through CCAC</li> <li>• Worked out roles with LTD including no duplication except in key areas – info sharing, case planning, training both sides</li> <li>• When space come up, she stayed in LTC part-time</li> <li>• Individualized and parent funding made this possible</li> <li>• It's a big transition for parents/caregivers. Needs to work incrementally to ease them in.</li> <li>• Relationship between family, LTC and CLUV was key – agencies become mutual.</li>   <li>• The need for projection planning</li> <li>• Service Coordination, including network of supports, family, doctor, financial advisors, services DS and LTC.</li> <li>• Open communication between DS and LTC ongoing</li> <li>• Transitional contacts/steps ei. Day program at the desired facility etc.</li> </ul>		
<b>Table 4</b>	<b>Partnership – Renfrew County Transitional Youth</b>	<b>Donna Locke</b>
<b>Key Ideas – Not available</b>		
<b>Table 5</b>	<b>Senior Health Research Transfer Network (SHTRN):</b>	<b>Deirdre Luesby</b>

	<b>The Challenges of Engaging Caregivers, Researchers and Policy Makers</b>	
<p><b>Key Ideas</b></p> <ul style="list-style-type: none"> <li>• Need for more info</li> <li>• Energy</li> <li>• Technology</li>   <li>• Info</li> <li>• Caregivers involved in advising</li> <li>• Link the two ideas – network</li> <li>• Group inclusion question – join others re Alzheimer's or form new group</li> <li>• Opportunities to continue education – education re integration of disabled seniors with non-disabled</li> </ul>		
<b>Table 6</b>	<b>Person Centered Planning: Citizen Advocacy</b>	<b>Sheila Robertson</b>
<p><b>Key Ideas</b></p> <ul style="list-style-type: none"> <li>• Starting too late – families don't know where to start when person is already a senior</li> <li>• Challenging the mind set of people closest to the individual – to value gifts and abilities – not close their minds</li> <li>• The individuals are moved from place to place to keep fitting them into the system, instead of respecting their “wishes and dreams” – even though sometimes it is unavoidable especially with physical environment</li> <li>• Good resource – Person Centered Planning – to go to participate. From this forum people build relationship around Person Centered Planner</li> <li>• Important to have “unbiased” facilitator</li> <li>• Prevention – do planning before crisis occurs. Sometimes health care providers are given a list of what they can't do because of budget restraints.</li> <li>• Integration should be facilitated by the LIHN – some relationships between the two sectors would not cost \$\$\$</li>   <li>• Aging definition</li> <li>• Fundamental to look at the whole person – beliefs, values, principles. Respect of individual and their gifts, in relationship with the community.</li> <li>• Key is not to fit individuals into the system but to design system to accommodate individual.</li> <li>• Describing individual in isolation instead of in relationship with community.</li> <li>• Person Centered Planning is not static – needs to be revisited on a regular basis or as life and goals change.</li> <li>• Two Tools – Person and family's hopes and dreams and MAPS</li> <li>• Conflicting views of facilitators</li> </ul>		
<b>Table 7</b>	<b>U-First: Working Together</b>	<b>Carmen Rodrigue</b>
<p><b>Key Ideas – Not available</b></p>		

<b>Table 8</b>	<b>Total Communication Environment: “Bill”</b>	<b>D.J.MacDonald</b>
<b>Key Ideas</b> <ul style="list-style-type: none"> <li>• Broaden options – willing partners</li> <li>• Info sharing</li> <li>• Educate family members</li> <li>• Define clear roles/understanding</li> <li>• Teleconferencing for individuals to stay in their homes (for individuals/providers and physicians)</li> </ul>		
<b>Table 9</b>	<b>Forest Hill: “Bill”</b>	<b>Sarah Ferguson-McLaren</b>
<b>Key Ideas</b> <ul style="list-style-type: none"> <li>• Access to supports in long term care for individuals who are not currently in DS system</li> <li>• Training and education on developmental disabilities for long term care staff</li> <li>• Have Rideau Regional placements in other long term care facilities beyond Forest Hill</li> <li>• Volunteers trained by DS agencies who can support individuals in long term care</li> <li>• Bring CCACs to DS sector for education and informing DS staff on aging issues</li> </ul>		
<b>Table 10</b>	<b>Services aux enfants et adultes de Prescott-Russell</b>	<b>Normand Charette et Louise Landriault</b>
<b>Key Ideas – Not available</b>		
<b>Table 11</b>	<b>Association pour intégration sociale d’Ottawa : Pour prendre la place qui m’appartient</b>	
<b>Idées maîtresses</b> <ul style="list-style-type: none"> <li>• Pour transition au foyer</li> <li>• Implication de son réseau</li> <li>• Centrer sur ses besoins et choix</li> <li>• Transition lente et vraiment collaborative (les deux ministères payent à la fois)</li> <li>• Flexibilité de retourner si ça ne fonctionne pas</li> </ul>		
<b>Table 12</b>	<b>Bonnechere Manor : “Michael”</b>	<b>Donna Crogie and Gladys Bennett</b>
<b>Key Ideas</b> <ul style="list-style-type: none"> <li>• Teaching/education of staff</li> <li>• Support staff being part of team « Buddy system »</li> <li>• Biopsychosocial model evaluation</li> <li>• Accommodation for the individual</li> <li>• Funding for community involvement</li> <li>• Multidisciplinary team education</li> <li>• Supports and consistency</li> <li>• Partnership involvement</li> <li>• Behavioural techniques (learned from specialized agencies)</li> </ul>		

<b>Table 13</b>	<b>Osgoode Township Care Centre : “ Bill M”</b>	<b>Cheryl Banks and Carolyn Della Foresta</b>
<p><b>Key Ideas</b></p> <ul style="list-style-type: none"> <li>• Plan of care need to be more detailed for DS population</li> <li>• DS to come in and train long term care homes</li> <li>• Work on establishing informal relationships</li> <li>• More communication with facilities (Osgoode did not know about OPADD)</li> <li>• DS should be more helpful with the move e.g. ODSP</li> <li>• Joint planning – 2 TPA and LTC sharing costs associated with education, partnerships, admin duties</li> <li>• Placements should be close to the family for casual visits – geographic – keep in touch with family</li> <li>• Transition visit and connecting.</li> </ul>		
<b>Table 14</b>	<b>Community Living Glengarry: “Jean”</b>	<b>Gisele Martin, Jean Robidoux</b>
<p><b>Key Ideas</b></p> <ul style="list-style-type: none"> <li>• Aider les autres et recevoir de l'aide – amis – réduit l'isolement – continuité du réseau</li> <li>• Petite communauté favorise le soutien – vieillir sur place</li> <li>• Programme qui favorise les contacts – groupe social et appartenance</li> <li>• Communauté prête à l'aider pour compenser le manque de services</li>   <li>• Succès – actif/amis/soutien/vie sociale</li> <li>• Aime village</li> <li>• Habiletés sociales – respect des gens dans la communauté</li> <li>• Respecter les choix de chacun</li> <li>• L'importance de se sentir utile</li> <li>• Être modèle – voix des autres</li> </ul>		
<b>Table 15</b>	<b>Nepean Home Support : Client volunteers working with seniors</b>	<b>Barbary Clark</b>
<p><b>Key Ideas – Not available</b></p>		
<b>Table 16</b>	<b>Résidence St-Louis Day Program</b>	<b>Anouk Montpetit</b>
<p><b>Key Ideas</b></p> <ul style="list-style-type: none"> <li>• Important that both Ministry be more relaxed around regulation</li> <li>• Funding for MOHLTC and indirect support from a DS agency</li> <li>• Once a success story is identified should make it known</li> <li>• Inter-generational integration – 80 years old with DD 45 years old and over</li> <li>• Need to develop partnership between LTC and DS</li>   <li>• Partnerships for education and training</li> <li>• New protocol between MCSS and MOHLTC</li> <li>• Parents should be informed to make CCAC referrals</li> </ul>		

<b>Table 17</b>	<b>Association pour intégration sociale d'Ottawa : Reconnaissance et épanouissement d'une personne ayant une déficience intellectuelle</b>	
<b>Idées maîtresses</b> <ul style="list-style-type: none"><li>• Création d'un réseau de bénévoles</li><li>• Besoin de développer des services francophones</li><li>• Besoin de collaboration entre les 2 ministères pour répondre aux besoins de la personne</li><li>• Rôle de l'agence de soutien - l'autonomie de la personne est maximisée</li><li>• Rôle des intervenants a changé au fil des années</li> <li>• Soins médicaux appropriés</li><li>• Droits de la personne sont respectés</li><li>• Activités de jour variées</li><li>• Besoin d'une meilleure coopération entre les ministères santé et services sociaux</li></ul>		

**Appendix 10: Education Action Plans**

<b>THEME: Consultation / Education / Support to LTC Home</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Support more residents in LTC homes.	<ul style="list-style-type: none"> <li>▪ Who would benefit; which individual.</li> </ul>	<ul style="list-style-type: none"> <li>▪ LTC facilities</li> <li>▪ Agencies specialized with IDD</li> <li>▪ Service Coordination</li> <li>▪ Behaviour Management (OCTC)</li> <li>▪ Psychiatrists</li> </ul>		Martine Robichaud <a href="mailto:martinrobichaud@rogers.com">martinrobichaud@rogers.com</a>
2) Have training / education sessions for LTC home workers regarding IDD.	<ul style="list-style-type: none"> <li>▪ To be developed.</li> </ul>			

<b>THEME: Education Objective</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Within the next 3 to 6 months organize a regional meeting in a centralized area for education purposes.	<ul style="list-style-type: none"> <li>▪ Sharing of resources, because we all know that basic training is required for all caregivers (including physicians in the system) of the needs of people with DD.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Organize a committee possibly some of the people here today. Open to LTC, CCAC, etc., if available, physicians OPP. Need to look at alternative ways of delivering training.</li> <li>▪ Include individuals who have developmental disabilities.</li> <li>▪ Look to better preparation of frontline staff to be better able to have comprehensive understanding with family physician.</li> <li>▪ Communication and respect of each other's field of expertise.</li> </ul>	3 months	<p>Gisèle Martin Community Living Glengarry 613-525-4357</p> <p>All agreed to help and participate in the organizing of a regional working group on aging &amp; disability keeping the inclusion process in mind. All had open minds and willing to accept the knowledge of others. <u>No one knows it all.</u> We want to use our community network.</p>

<b>THEME: Education</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Sharing of info + cross-training + working as a unit.  2) Use of the internet.	<ul style="list-style-type: none"> <li>▪ Workshops; panels; invitations to case conferences.</li>   <li>▪ Reaching out to neighbourhood.</li> <li>▪ Job sharing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Directory of contact names for all services.</li>   <li>▪ Throughout the region.</li> </ul>		

<b>THEME: Learning Through Networking</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Form a Transitional Educational Aging Plan Committee.	<ul style="list-style-type: none"> <li>▪ Send out an invitation to other agencies to recruit staff and other professionals.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Seek supports; liaise with colleges &amp; universities + other resources i.e.: CCAC, second doctors who could be on the board to be a part of the Aging Committee.</li> <li>▪ Front line staff</li> <li>▪ Supervisors/Managers</li> <li>▪ Educational professionals</li> <li>▪ Medical professionals</li> <li>▪ Service Coordination</li> </ul>	3 – 4 months	Pat Larlee  Christian Samaal  Kimberley Goode  Jennifer Currie-Roy  Christian Horizons email
2) Formulate a strategy regarding a projection plan to curtail cross-mentoring, supplemental courses that benefit personal development.	<ul style="list-style-type: none"> <li>▪ Develop workshops</li> <li>▪ Recruiting mentoring partners</li> <li>▪ Identify key objectives</li> </ul>	<ul style="list-style-type: none"> <li>▪ Bereavement counseling</li> </ul>	6 months	

<b>THEME: To Address the Education Needs of Frontline Staff</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Identify frontline staff education needs (staff in D.S. and LTC).	<ul style="list-style-type: none"> <li>▪ Develop an instrument to identify the education needs i.e.: a poll questionnaire.</li> </ul>	<ul style="list-style-type: none"> <li>▪ EDO</li> <li>▪ Ask same of LTC</li> </ul>	3 months for questionnaire And 6 months to implement survey	Mark Palmer <a href="mailto:markpalmer@tamir.ca">markpalmer@tamir.ca</a>  Anouk Montpetit Caregiver Residence St. Louis
2) Identify resources in community who can brain at or minimal cost.	<ul style="list-style-type: none"> <li>▪ Ask EDO to identify in-house resources.</li> </ul>	<ul style="list-style-type: none"> <li>▪ EDO</li> <li>▪ Ask same of LTC</li> </ul>	1 month	Representative from Open Hands

<b>THEME: Partnerships</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Set up meetings for P.D. days.	<ul style="list-style-type: none"> <li>▪ Invite medical developmental services long-term care self-advocate and agenda with concerns.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mediator – Laurie Alphonse</li> <li>▪ University</li> <li>▪ Hospitals</li> <li>▪ Long-term care facilities</li> <li>▪ Colleges</li> <li>▪ People First</li> <li>▪ Developmental Services</li> <li>▪ Frontline staff</li> <li>▪ Media</li> <li>▪ Families</li> </ul>	2nd week of Jan. 2007	Marcel Tousignant 613-744-0040

<b>THEME: Funding</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Environment scans (Needs Assessment).	<ul style="list-style-type: none"> <li>▪ Develop, distribute, collect and evaluate.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Interested parties and governing leaders.</li> </ul>	90 days	Jill Broadbent Program Coordinator
2) Written proposal.	<ul style="list-style-type: none"> <li>▪ Research the funding bodies.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Access to funders and interested parties to distribute to.</li> </ul>	30 days	Y's Owl Maclure <a href="mailto:ysowl@magma.ca">ysowl@magma.ca</a> 613-721-1500
3) Presentation of proposal.	<ul style="list-style-type: none"> <li>▪ Set up consults and meetings.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Collaborate with all interested parties (MOH, MCSS &amp; Ministry of Education &amp; Training).</li> </ul>	30 days	Laurie Alphonse Case Manager Access Infinity Mgt. <a href="mailto:laurie@accessinfinitymanagement.com">laurie@accessinfinitymanagement.com</a> 613-288-2434
4) Proposal implementation.	<ul style="list-style-type: none"> <li>▪ Training</li> </ul>	<ul style="list-style-type: none"> <li>▪ Trainers, educators, consumers, experienced staff.</li> </ul>	On-going	Donna Quiggin  Sophie

<b>THEME: Education</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) I.D. required Representation on committee (need decision makers).	<ul style="list-style-type: none"> <li>▪ Environment scans of local situation.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Revive Best Practices re: Service delivery.</li> </ul>		
2) Establish Mission, Vision, And Strategic Plan.	<ul style="list-style-type: none"> <li>▪ Create statistical picture &amp; business plan for why change / funding required.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Need to ID, intake assessment, case coordination.</li> </ul>		
3) Establish how group will function i.e.: what kind of community organization.	<ul style="list-style-type: none"> <li>▪ Undertake research and monitoring to ID gaps e.s. transition plan.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Need to ID service / programs / housing, etc. Options needed.</li> <li>▪ Awareness raising in general community</li> </ul>		
4) Who provides leadership/share leadership?	<ul style="list-style-type: none"> <li>▪ Establish indicators of success.</li> </ul>			
5) Skills & Knowledge Development	<ul style="list-style-type: none"> <li>▪ For Staff</li> <li>▪ For students wishing to work in D.S. sector.</li> <li>▪ Parents</li> <li>▪ Volunteers</li> <li>▪ Exchange of information</li> </ul>	<ul style="list-style-type: none"> <li>▪ Online info/list serve.</li> <li>▪ Development of information docs/tasks.</li> </ul>		

<b>THEME: Education</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
6) Build relationships between sectors and service agreements.		<ul style="list-style-type: none"> <li>▪ Key messages politicians, decision makers, and media.</li> </ul>		

<b>THÈME : Outils de pratique collaborative pour engage le dialogue entre les intervenants de 1<sup>ère</sup> ligne pour mieux comprendre les comportements de personnes atteinte de déficience intellectuelle.</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles ? Veuillez les décrire ?</b>	<b>Aide requise (personnes, organismes, groupes...)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe ?</b>
1) Lobbying pour avoir service en français (traduction).  2) Recruter partenariat auprès des intervenants qui travaillent avec déficience intellectuelle et les aînées.  3) Écrire lettre.	<ul style="list-style-type: none"> <li>▪ Appel téléphonique</li> <li>▪ Lettre</li>   <li>▪ Appui des réseaux francophones</li> <li>▪ Service de santé</li> <li>▪ Présentation</li> </ul>	<ul style="list-style-type: none"> <li>▪ Guy Peppin</li> <li>▪ Le regroupement</li> <li>▪ Réseaux francophones</li> <li>▪ L'Honorable Gisèle Lalonde</li> <li>▪ AISO</li> <li>▪ L'Arche</li> <li>▪ OCAPDD</li> <li>▪ ROH</li> <li>▪ CTE / Le Patriot</li> <li>▪ SCO</li> <li>▪ Élisabeth Bruyère</li> <li>▪ Hôpital Montfort</li> <li>▪ Horizons Renaissance</li> </ul>	3 – 6 mois	Patrice Pilon <a href="mailto:ppilon@aiso.org">ppilon@aiso.org</a> 613-744-2241, poste 217

<b>THÈME : Sensibilisation</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles ? Veuillez les décrire ?</b>	<b>Aide requise (personnes, organismes, groupes...)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe ?</b>
1) Chercher de l'aide des écoles, collèges, universités pour les inciter à créer des projets de promotion & publication des histoires de succès (stages, création de projets d'éducation).		<ul style="list-style-type: none"> <li>Administration de programme scolaire collégial, universitaire.</li> </ul>		Louise Landriault  Janine Bourgeois <a href="mailto:jbougeois@scsottawa.on.ca">jbougeois@scsottawa.on.ca</a> 613-748-1788, ext 369

<b>THÈME : Connaissance du réseau d'éducation</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles ? Veuillez les décrire ?</b>	<b>Aide requise (personnes, organismes, groupes...)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe ?</b>
<p>1) Créer un répertoire des partenaires (services) en santé et en déficience intellectuelle.</p> <p>2) Identifier les partenaires capables de sensibiliser sur les dynamiques en santé et dans le domaine de la déficience intellectuelle.</p> <p>3) Journée d'information et des sensibilisations entre les secteurs (histoires et succès).</p> <p>4) Dépliants décrivant les similitudes entre les personnes ayant une déficience intellectuelle et les personnes vieillissantes.</p>		<ul style="list-style-type: none"> <li>• CCAC</li> <li>• Familles</li> <li>• Hôpitaux</li> <li>• Bénévoles</li> <li>• Hébergement en soins de longues durées</li> <li>• Secteurs de santé et vieillissement</li> <li>• Social – déficience intellectuelle vieillissement</li> <li>• Tous les partenaires</li> <li>• Comité « OPADD »</li> </ul>		<p>Janine Bourgeois  <a href="mailto:jbougeois@scsottawa.on.ca">jbougeois@scsottawa.on.ca</a>            613-748-1788, poste 369</p>

**Appendix 11: Direct Services Action Plan**

<b>THEME: Person Centered Planning / Individualized Planning</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Identify who needs to be involved. Determine who the stakeholders are.	<ul style="list-style-type: none"> <li>▪ Use list of today's participants. Ask them to identify resources available.</li> <li>▪ Contact D. Lusby re: setting up a community of practice in order to develop our working group.</li> <li>▪ Involve the media</li> </ul>	<ul style="list-style-type: none"> <li>▪ Money</li> <li>▪ Citizen Advocacy</li> <li>▪ SHRTN (D. Luesby)</li> <li>▪ LIHN (J. Contant)</li> <li>▪ Service Coordination</li> </ul>	11-30-06	Hugh Nelson <a href="mailto:hnelson@ysowlmaclure.org">hnelson@ysowlmaclure.org</a>  Marge McCabe <a href="mailto:marge.mccabe@sympatico.ca">marge.mccabe@sympatico.ca</a>
2) What is the resource list?			10-15-06	Ann Burns
3) Include a consumer on the committee i.e. parent, sibling, facilitator, funders.			11-30-06	Rebecca Happy <a href="mailto:bhapi1@hotmail.com">bhapi1@hotmail.com</a>
4) Help			After 11-30-06	Eleanor Smith <a href="mailto:Eleanor.smith2@sympatico.ca">Eleanor.smith2@sympatico.ca</a>  Theresa Rivera <a href="mailto:trivera@vonottawa.on.ca">trivera@vonottawa.on.ca</a>  Nancy Mylrea <a href="mailto:nmylrea@vonottawa.on.ca">nmylrea@vonottawa.on.ca</a>  Jeannette Fraser

<b>THEME: Aging in Place</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Bring forward the notion of advocating "Aging in place" to our work environment. 2) Seek information to fill in my own gaps in knowledge with regard to dementia, geriatrics. 3) Request training in geriatrics, dementia.	<ul style="list-style-type: none"> <li>▪ Bring info forward to staff members.</li> <li>▪ Research</li> <li>▪ Email supervisor, repeatedly.</li> </ul>	Internet, Alzheimer's Society, contact long-term care facility for info.		Wendy Skinner <a href="mailto:wskinner@ocapdd.on.ca">wskinner@ocapdd.on.ca</a>  Darren Scott <a href="mailto:ed.telci@rogers.com">ed.telci@rogers.com</a>

<b>THEME: Coordinating Services</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Consultation table: frontline staff, senior management; family members; individuals; different agencies.	<ul style="list-style-type: none"> <li>▪ Share information</li> <li>▪ Gathering ideas</li> <li>▪ Sharing of options</li> <li>▪ Establishing contacts</li> </ul>	<ul style="list-style-type: none"> <li>▪ Funding</li> <li>▪ Organizations interested to participate</li> <li>▪ Accessibility</li> <li>▪ Follow-ups (regular)</li> </ul>	<p>St – 1 mo.</p> <p>Total 1 year</p>	<p>Melissa Dullenard</p> <p>Josée Beauregard</p> <p>H. Dunne</p>

<b>THEME: Transportation</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Go to provincial, municipal for extra funding Or 2) Get other agencies together to provide a way of transportation i.e.: get together to do a route for all agencies willing to join in fundraising.	<ul style="list-style-type: none"> <li>▪ Apply for funding and grants.</li> <li>▪ Set up a committee with other agencies to see how they feel and what they are willing to go through with.</li> <li>▪ Contacting members of parliament.</li> <li>▪ Find sponsors willing to sponsor.</li> </ul>	<ul style="list-style-type: none"> <li>▪ MCSS</li> <li>▪ Service organizations within Ottawa area.</li> <li>▪ Media</li> <li>▪ Families</li> </ul>	Dependent on outcome of Step 1.	Amanda Clark

<b>THEME: Education</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Build into educational programs a work placement in the other sector.	<ul style="list-style-type: none"> <li>▪ Adding ??????? to education PSW / DSW.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Colleges</li> <li>▪ Universities</li> <li>▪ Group homes</li> <li>▪ Employers</li> </ul>	12 months	David St. Patrick's Home
2) Workshops. Frontline staff and supervisions involving the two (2) sectors/professions.	<ul style="list-style-type: none"> <li>▪ Collaboration and accessing funding for staff development.</li> </ul>	<ul style="list-style-type: none"> <li>▪ MCSS</li> <li>▪ MOH</li> <li>▪ Advertising</li> <li>▪ Agencies</li> </ul>	6 months	

<b>THEME: Quality "A meaning of Day/Life"</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
<p>1) Talk to events (personal outcome measures for each client)</p> <p>2) Schedule changes according to individual needs. Keep it individualized.</p> <p>3) Workshops on "A Meaningful Day/Life" that target aged people and their needs and wants.</p>	<ul style="list-style-type: none"> <li>▪ Staff to know about want of each person.</li> <li>▪ Get in service from LTC facility to share with us at CAS</li> </ul>	<ul style="list-style-type: none"> <li>▪ Staff interacting with clients and talking to families and caregivers about wants and needs.</li> <li>▪ Staff willingness and parents also, to change habits, thought processes when needed.</li> <li>▪ Staff availability to provide support at each activity.</li> <li>▪ LTC facility</li> <li>▪ Time to take for workshops</li> <li>▪ Staff participation</li> </ul>	<p>A.s.a.p.</p> <p>Ongoing</p> <p>2007</p>	<p>Carolyn</p>

<b>THEME: Education, Information Sharing</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
Connecting with someone from CCAC.	Speak with Julie L. see if there is a way to find out how their services work, how we can access it.			

<b>THEME: Partnership Forum</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Identify local champion from MCSS; Health.	<ul style="list-style-type: none"> <li>▪ Meet to find someone from each Ministry.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Call local agencies to find key contact person.</li> </ul>	January 2007	
2) Set up meeting to share info. Purpose.	<ul style="list-style-type: none"> <li>▪ Meet to develop a plan to share info. with each group.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Representatives from each agency to coordinate meetings.</li> </ul>	April 2007	
3) Long-term meetings with area rep. (Duesda Manor)	<ul style="list-style-type: none"> <li>▪ All joint partnership re-training.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Area long-term care</li> </ul>	December 2006	

<b>THEME:</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Offer to try to connect doctor/team at LTC facility to experts in medical sector with expertise in D.H. sector.  2) Offer to set up training to assist LTC in learning more about the D.H. sector.  3) Facilitator to assist 2 sectors locally to work together, protocols, etc.				

<b>THEME: Create an Atmosphere of Trust and Cooperation Between Health &amp; Developmental Services Providers</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Share information about available services and shortcomings related to gaps and waiting lists.	<ul style="list-style-type: none"> <li>▪ Organize forums to share information with each other and with consumer and families.</li> <li>▪ Have representatives at each other's planning tables.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Facilitation help.</li> </ul>	June 30, 2007	
2) Draft a plan identifying gaps in service and develop protocols for working together.	<ul style="list-style-type: none"> <li>▪ Follow-up 1 above by identifying gaps and forming protocols.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Facilitation help.</li> </ul>	December 31, 2007	
3) Prepare joint proposals to address gaps in service.	<ul style="list-style-type: none"> <li>▪ Form a working group of DS, Health &amp; Long-Term Care to prepare proposals to address service gaps.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Working group of DS, Health &amp; Long-Term Care.</li> </ul>	June 30, 2008	

<b>THEME: Services &amp; Supports</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Information package available for parents at diagnosis.	<ul style="list-style-type: none"> <li>▪ Gather information for packages.</li> </ul>	<ul style="list-style-type: none"> <li>▪ CCAC</li> <li>▪ CCHC</li> <li>▪ OCTC</li> <li>▪ CHEO</li> <li>▪ MCSS</li> <li>▪ APT</li> <li>▪ Support Groups</li> </ul>	A.S.A.P.	<p>Diane Seguin</p> <p>Peggy Lobay <a href="mailto:peggy@lobay.ca">peggy@lobay.ca</a></p> <p>Karen Watts</p>
2) Update re: schools. Graduation; health care; person centered planning.				<p>Krysia Pazdzior <a href="mailto:sapa@magma.ca">sapa@magma.ca</a> 613-232-3980 Cell 613-797-5941</p>

<b>THEME: Communication / Networking</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) List serve network within the industry.	<ul style="list-style-type: none"> <li>▪ Sharing ideas and solutions.</li> <li>▪ Upcoming events and fundraisers.</li> <li>▪ Workshops, seminars.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Service Coordination central clearing place where all info is sent to be managed.</li> </ul>	September 2007	William Peterson
2) Newsletters for the public.	<ul style="list-style-type: none"> <li>▪ Newsletters with info of stats, new programs, successes and needs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Service Coordination</li> </ul>	September 2007	Suzanne Gervais <a href="mailto:sgervais@centretownchc.org">sgervais@centretownchc.org</a> 613-233-5430, ext. 2186
3) Partnership Network various branches of government (OPADD).	<ul style="list-style-type: none"> <li>▪ Health- OHIP, MCSS, Municipal Affairs (housing) Local Health Integrated Network (LHIN). Determine what issues belong to which department where individuals who need various services with D.D. care access.</li> </ul>	<ul style="list-style-type: none"> <li>▪ OPADD</li> <li>▪ MPP</li> </ul>	September 2007	Frank Sisson

<b>THEME: Partnerships</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
1) Sharing tools and resources.	<ul style="list-style-type: none"> <li>▪ Share ??????</li> <li>▪ Promote sharing.</li> </ul>			
2) Creating partnerships.	<ul style="list-style-type: none"> <li>▪ Create ????? at program level.</li> </ul>			
3) Developing partnerships to educate.	<ul style="list-style-type: none"> <li>▪ Develop health care.</li> <li>▪ Develop hospitals.</li> <li>▪ Develop schools, teachers.</li> </ul>			
4) Aging "in Place".	<ul style="list-style-type: none"> <li>▪ Monitor concept.</li> </ul>			

<b>THEME: Direct Services</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help Needed</b>	<b>Due Date of Each Action</b>	<b>Group Members</b>
<ol style="list-style-type: none"> <li>1) Interdisciplinary bilingual education to bridge the gap between sectors.</li> <li>2) People we are looking out for are entitled to continuity of services.</li> <li>3) Money, money, money.</li> <li>4) Four (4) themes: Education, Coordinated Services, Transportation and Aging in Place.</li> </ol>				

<b>THÈME : Identifier les ressources financiers et renégocier</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles? Veuillez les décrire?</b>	<b>Aide requise (personnes, organismes, groupes.)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe?</b>
1) Transformation des services.	<ul style="list-style-type: none"> <li>▪ Financement individualisé.</li> </ul>	<ul style="list-style-type: none"> <li>▪ TPA</li> <li>▪ MSSC</li> <li>▪ CMHA = Ministère de la santé</li> <li>▪ Familles</li> </ul>	2006	<p>Normand Charette  <a href="mailto:ncharette@seapr.ca">ncharette@seapr.ca</a></p> <p>Josée Ouimet  <a href="mailto:Josee.ouimet@ontario.ca">Josee.ouimet@ontario.ca</a>            613-314-0667</p>

<b>THÈME : Former un groupe de concentration</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles? Veuillez les décrire?</b>	<b>Aide requise (personnes, organismes, groupes.)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe?</b>
1) Écrire un courriel à tous les invités qui sont venus à la conférence d'aujourd'hui leur demandant s'ils désirent participer à une classe de concentration.		<ul style="list-style-type: none"> <li>▪ Conférences organisées.</li> </ul>		

<b>THÈME : Trouver ce qui existe</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles? Veuillez les décrire?</b>	<b>Aide requise (personnes, organismes, groupes.)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe?</b>
1) Demander au Centre d'accès pour soins communautaires.  2) Faire un inventaire des ressources existantes pour personnes âgées.  3) Identifier des secteurs / personnes clés pour former un groupe avec le réseau de la déficience intellectuelle	<ul style="list-style-type: none"> <li>▪ Médical</li> <li>▪ Service de jour</li> <li>▪ Soins à domicile</li> <li>▪ Associations, etc.</li> <li>▪ Centres communautaires</li> </ul>			

<b>THÈME : Mécanisme d'accès et d'adaptation des ressources</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles? Veuillez les décrire?</b>	<b>Aide requise (personnes, organismes, groupes.)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe?</b>
1) Mettre un comité en place.	<ul style="list-style-type: none"> <li>▪ Comité conjoint santé et services sociaux.</li> <li>▪ Protocoles d'entente clairs</li> <li>▪ Résultats</li> <li>▪ Liste d'attente</li> <li>▪ Services disponibles</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ministère de la santé</li> <li>▪ MSSC</li> <li>▪ CASC</li> <li>▪ Personnes d'abord</li> <li>▪ Familles</li> <li>▪ Décideurs des divers prestataires de services</li> </ul>	3 mois	
2) Informer / sensibiliser et former (en santé). Le but : qualité de services.	<ul style="list-style-type: none"> <li>▪ Professionnels de la santé et déficience intellectuelle.</li> <li>▪ Formation pour intervenants en matière des besoins en santé.</li> <li>▪ Pamphlets ré : déficience intellectuelle.</li> <li>▪ Foire d'info. sur la déficience intellectuelle.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Sous-comité (sensibilisation)</li> </ul>	6 mois	

**Appendix 12: Joint Planning Action Plans**

<b>THEME: Joint Planning</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Today identify volunteers to augment steering committee. To solicit CCFAC – geography.  2) Develop a TOR for Service Coordination to circulate to stakeholders for buy-in.  3) Through that period. Identify who is already involved, the key issues, etc. (e-scan).  4) Steering committee move forward on action in key areas based on e-scan and TOR, incl. education, funding, etc.			3 months	

<b>THEME: LTC – TR Payment</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
1) Research what has been done. 2) Who is doing it? 3) Needs for agencies involved. 4) Identifying roles. 5) Documentation / Communication	<ul style="list-style-type: none"> <li>▪ Finding out needs.</li> <li>• Finding out what works.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Discussion on funding available.</li> <li>• Specialists involved</li> <li>• TPA / LTC facility</li> <li>• 3<sup>rd</sup> parties – Citizen Advocacy</li> <li>• Educate those hesitant.</li> </ul>		LTC TRA Citizen Advocacy

<b>THEME: Joint Planning</b>				
<b>Short Term Actions</b>	<b>What Describes the Actions</b>	<b>Help needed</b>	<b>Due Date Of Each Action</b>	<b>Group Members</b>
<p>1) Augment existing OPADD organizing committee to develop TOR or organize a sub-group of steering committee.</p> <p>2) Task one individual / team with approaching CCAC possibly 1 from OPADD.</p> <p>3) Circulate draft TOR to interested parties / possibly hold a public meeting.</p>		<ul style="list-style-type: none"> <li>▪ Volunteers needed from today's participants.</li> </ul>	Nov. 2007	<p>Ron Coristine</p> <p>Diane Urquart <a href="mailto:dianneu@spcottawa.on.ca">dianneu@spcottawa.on.ca</a></p> <p>Al Loney <a href="mailto:al.loney@css.gov.on.ca">al.loney@css.gov.on.ca</a></p> <p>Mary Frances Taylor <a href="mailto:Maryfrancetaylor8450@rogers.com">Maryfrancetaylor8450@rogers.com</a></p>

<b>THÈME : Formation et connaissance du réseau</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles ? Veuillez les décrire ?</b>	<b>Aide requise (personnes, organismes, groupes...)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe ?</b>
<p>1) Élaborer un portrait des services qui existent dans la communauté.</p> <p>2) Formation adapté en fonction des besoins de la clientèle.</p> <p>3) Identifier les besoins de formation par secteur... Flexibilité des mandats des agences.</p>	<ul style="list-style-type: none"> <li>▪ Visiter les agences pour connaître leurs mandats / valeurs.</li> <li>▪ Répertoire de ressources (supports / services).</li> <li>▪ Histoire à succès.</li> <li>▪ Littérature</li> </ul>	<ul style="list-style-type: none"> <li>▪ Collaboration inter-secteur face à la réalisation du plan d'action.</li> <li>▪ Service de santé</li> <li>▪ Agence communautaire</li> <li>▪ Point central d'accès (SCS, CCAC)</li> <li>▪ Ministère de la santé</li> <li>▪ MSSC</li> </ul>		<p>Julie Nantel Powell  <a href="mailto:jnantelpowell@scsottawa.on.ca">jnantelpowell@scsottawa.on.ca</a>            613-748-1788, poste 239</p> <p>Marc Richer  <a href="mailto:mricher@aiso.org">mricher@aiso.org</a></p>

<b>THÈME : Valeurs et Mission</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles ? Veuillez les décrire ?</b>	<b>Aide requise (personnes, organismes, groupes...)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe ?</b>
1) Retraite entre Directeurs, intervenants et participants.	<ul style="list-style-type: none"> <li>▪ Rassembler les 3 parties pertinentes.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Locales, repas, relèves, animateurs.</li> </ul>	1 mois	Louis Renaud <a href="mailto:lrenaud@ocapdd.on.ca">lrenaud@ocapdd.on.ca</a> 613-569-8993
2) Recueillir les besoins identifiés par les gens et établir les biens communs.	<ul style="list-style-type: none"> <li>▪ Remue-méninge. Priorisés les besoins qui reviennent le plus souvent.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Clientèle cible.</li> </ul>	1 mois	Suze Lubin

<b>THÈME : Engagement</b>				
<b>Mesures à court terme (6 à 12 mois)</b>	<b>Quelles sont-elles ? Veuillez les décrire ?</b>	<b>Aide requise (personnes, organismes, groupes...)</b>	<b>Échéance (pour chacune des mesures)</b>	<b>Qui sont les membres de votre groupe ?</b>
1) Identifier les partenaires	<ul style="list-style-type: none"> <li>▪ Tous ceux qui ont des services ou offrent des services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ MSSC</li> <li>▪ Ministère de la santé</li> </ul>	4 mois	Claude Sauvé <a href="mailto:Claude011@sympatico.ca">Claude011@sympatico.ca</a> 613-525-1118
2) Assurer participant des individus. Inviter objectifs.	<ul style="list-style-type: none"> <li>▪ Envoyer invitation aux agences avec objectifs.</li> </ul>		3 mois	John Comfort <a href="mailto:johncomfort@sympatico.ca">johncomfort@sympatico.ca</a> 613-225-8831 613-228-9176, poste 24
3) Obtenir des engagements des partenaires.		<ul style="list-style-type: none"> <li>▪ Partenaires</li> </ul>	6 mois	
4) Mettre services disponibles + lacunes.			8 mois	