Event ID: 2348230

Event Started: 5/12/2014 12:57:13 PM ET

Please stand by for real-time captions.

Good afternoon. My name is Lisa Zimmerman from RRTI in Albany, New York. Thank you for joining us for today's webinar, aging in place, developing appropriate community supports. These webinars are presented in collaboration with RRTI, the Lewin Group and the Medicare Medicaid office, MMCO and CMMI

A little housekeeping before we get started. Your microphones will be muted drop the representation. There will be a question-and-answer portion during this webinar. If you do have a question please click the race hand feature on your control panel as a -- at the designated time and will be unmuted by a -- an administrator. You can also put your question in the chat window and your question will be asked out loud during the designated time. There will also be poll questions about the presentation. A window will appear with the questions and you can submit your answers at that time. At the conclusion of the webinar, a tablet. In your browser continue to complete the evaluation survey. [ Background Noise ] complete this evaluation survey in order to receive free contact hours -- three contact hours each from the Michigan social work continuing collaborative, New Hampshire nurses Association, national Association of social workers and the national Board for certified counselors. Please note these are not the EU's but contact our second be translated to CEU's. You need to check with the organization as to what would apply for your requirement -- it also should be noted that contact hours for the national Association of social workers is not ignite in the states of California, Michigan, North Carolina or West Virginia. If you are unable to complete the survey at the end of the webinar, you will receive an e-mail tomorrow with a link to complete the survey at that time if you have not already done so. At this time I would like to into.-- Jill Dorsey is a licensed clinical social worker who has over 30 years’ experience working with individuals with mental illness and developmental disabilities including [ Indiscernible ] family-based residences. [ Indiscernible ] recovery focus practices. Linda Anderson is a registered knows greater -- nurse strainer for was confident house where she meets her patients at all area hospitals as potential we have candidates and is TRIN screener certified. She was bloodlessly employer -- employed as a [ Indiscernible ] family care unit and 15 years -- at Helen Hayes Hospital [ Background Noise ] [ Muffled Audio ] IVR study on fragile X and down syndrome and Alzheimer's disease they're we can now begin.

Hello everyone. I am Jill Dorsi and I am a licensed social scared -- shall services officer. We are happy to be here today. When we designed this presentation, we try to incorporate the nursing perspective along with the social work eight -- social working and counselor perspective. This is a more comprehensive approach to all practices. The presentation will also have a comprehensive approach. We will integrate two things, providing supports for people with individual -- intellectual disabilities who are aging and we will take this from a strength-based focus. We are going to look at oversight while preserving quality of life. We will be taking this approach to accomplish this. The goal is to assure that the wishes and goals for himself or herself remain a focus of all the interventions. There is a great deal of research available on these initiatives. We will look at some of it and also provide resources for you to use while continuing to learn more. There are PDFs of the handouts that have been included with the presentation as well as suggested reading and resources. We can also download these from the resources for integrated care website

The learning objective today is to describe the benefits of aging in place. Also we want to you come from a year with symbols of determination and person centered planning. We want to identify staffing support necessary to design a community-based requirement for in aging adult with intellectual and developmental disabilities. We want to be familiar with the affordable care act and the Americans with disabilities act.

Learning objectives continued. We want to identify resources for [ Indiscernible ] nudity faith-based communities and become from a year with issues caregivers confront in providing [ Indiscernible ] intellectual and develop mental disabilities. Identifying and delivering -- delivering supports for aging people with intellectual disabilities it has become increasingly necessary [ Indiscernible ] him increased life expectancy across the board for people with intellectual and develop mental disabilities.. For example there were 641. For example there were 641,000 -- [ Indiscernible ] people with iDVD now have an average life expectancy of 66. Some shows that it is high is 72 years old. People down syndrome who are typically more facile, once had a very limited life expectancy. 1930, most were expected to live to about -- nine years old. That life expect as he has now increased to 60. Concurrently, caregivers are also aging. Living longer also means that individuals who need to support [ Indiscernible ] in order to address the changing needs. Changes in living situations may also become necessary as well, particularly for those individuals who have lived with family members and statistics indicate that about the 5% of people with IDDD are living with family members and that estimate is about 480,000 individuals. As family ^ servers are great [ Indiscernible ] in some situations there are two generation elderly camera -- members [ Indiscernible ] over at risk from [ Muffled Audio ] associated with aging. Caregivers may longer be able to give the same level of care to family members in fact in some cases [ Background Noise ] receive care become the care giver to the aging parents and the result is often a need for a residential arrangement. We want to look at how to avoid doing that in a way that [ Indiscernible ] the crisis. [ Indiscernible ][ Indiscernible - low volume ] [ Muffled Audio ] Essar people in the general population. These people aged the same age and rates as people in general population. Aging affected by [ Indiscernible ] medication use age-related changes often include reduced hearing and vision [ Indiscernible ] discomfort due to menopause, age-related conditions, much the same as the normal population. Some people experience accelerated aging [ Indiscernible ] people with down system -- down syndrome often experience hypothyroidism, [ Indiscernible ] [ Muffled Audio ] 25% will be affected by dementia after 840. 50 to 70% after eight the. People with cerebral palsy age associated consultations as a result of chronic [ Indiscernible ] increased fractures comp additional ability challenges as they age. [ Indiscernible ]

Problems increase with Ainge environmental support and modifications will be necessary to allow aging [ Muffled Audio ] is the wage it is likely they will need [ Indiscernible ] personal-care skill including those skills that you used to be very independent with. [ Muffled Audio ]

May also require and then a muscle -- environmental accommodations or having increased difficulty with ambulation or in. Cognition or hearing or vision. In the beginning you should be discussing strategies for supporting individuals SAH. It is important to consider the need for additional info support because they will need help with bathing, dressing, even eating and a more structured residential setting. Perhaps one that is more designed specifically to serve people of age-related concerns. It may be a residence with 24 hour nursing care ability, extra staffing, for example.

A lot of environmental modification such as [ Indiscernible ] appropriate level of support to help people maintain their existing skills as long as possible while avoiding accident and injury that may jeopardize aging [ Indiscernible ]

Where do we want to begin with implement in practices that support people who are aging in ways that respect individual taking the -- integrity and toys in short safety and focus on community life and community based support. The Edinburgh group which convened in 2001 in Edinburgh, Scotland, was a collaboration between three universities, University of Albany and Albany New York, the University in Chicago. The Edinburgh [ Indiscernible ] [ Indiscernible ] [ Muffled Audio ] for propelled -- developing community supports with people with IDDD and dementia. [ Muffled Audio ] specifically on dementia, these principles offer values with working with all individuals with IDDD for aging. There is a link on the slide where you can access the Edinburgh principles. You can also Google these on your computer. They are pretty compensation -- comprehensive. [ Muffled Audio ] providing care.

The Edinburgh whispers are based on the four-point approach, adopting the workable [ Indiscernible ] of care. Service delivery [ Indiscernible ] [ Muffled Audio ] promoting relevant research. Our presentation will focus on one, two and three of these principles. It is important to note that relevant research is going on in this field all the time and that new information tools and support are being identified regularly. It is important to stay knowledgeable on the research and results [ Indiscernible ] for your practice.

I am going to review the Edinburgh principal. [ Muffled Audio ] philosophy that promotes call to life. Affirmed that individual strengths [ Muffled Audio ] making. This is also what we call a strength-based approach. Involve the individual and family with all planning and services. Ensure availability of appropriate diagnostic services. Plans and provide support to optimize remaining in the community.

In sure that people within those intellectual disability have access to the same dementia services provided to people who are not disabled in the population. In sure that community dementia services planning also involve a focus on adults with IDDD . Ensure him [ Muffled Audio ] across relevant OC, provider and advocacy groups. In involves consideration of the current and future needs of adults with IDDD who are affected with dementia.

Are there any questions. --'s --?

If you do have questions as we are going forward on please type them in. There will be an opportunity to unmute and ask a question personally also.

Using the Edinburg proposes guidelines, we are going to focus specifically on quality of life. Strength base person centered planning [ Indiscernible ] [ Indiscernible ] we are going to focus on having a workable [ Muffled Audio ] commitment to quality of life instead of focusing mainly on the purpose -- [ Indiscernible ] coordinate diverse system.

Quality of life is an important consideration with someone with aging. We are going to be considering the negotiable element in developing and into Monday the support and how the individuals quality of life can become the guiding principle in this process. -- Individual's quality of life can become the guiding principle in this process. The most important part of ensuring this is respecting what is called these -- the person's personhood. I will read this quote because it captures everything that we have time to accomplish.

Being a person is a fundamental philosophical and sociological position of a human being with value intelligence, [ Indiscernible ] and [ Indiscernible ] the talents of dementia is to constantly seek for and not dismiss a person. Even though this was spoken specifically about the mental I think this applies to all IDDD individuals. Keep that in mind.

Keep -- consider each individual in the context of their personhood, not as a member of a group of residents or an old person etc. Each person is tied to their life with their connection their family conference, spiritual beliefs, the legions, hopes, dreams comp aspirations, goals. Each of us is a person and we are defined more by what we have loved more than what we have [ Indiscernible ] interest, talents, abilities and our relationship to the people that we love and by the things that we can't do. Preserving [ Indiscernible ] is a weight to preserve personhood. This is integral to assuring all the other aspects. One way to identify quality of life is to remain active, doing things they enjoy in cleaning work, hobbies, skills and strengths. [ Muffled Audio ] social relationships with friends and family, sharing their lives of others, having a community support around them. People who share their interests. Staying involved in community life. Living in their own homes whether it is a group home or with the family or their own residence. [ Muffled Audio ] quality of the lives. Is important to announce things like managing my disability, taking the medication, going to the doctor are not the first thing people consider when and the finding quality of life. [ Background Noise ]

Quality of life is impact by aging, consultations of aging, create cognitive challenges and often involve a loss, loss of function, loss of friends. A close friend of the family made I -- may die. They may need to move to another home. There is a whole grieving process around the change in the environment. [ Muffled Audio ] routines and environments. Age-related [ Indiscernible ] loss of independence and they may no longer be able to continue their work needs associated with aging cannot be avoided. These will impact considerations in assuring that elements associating with quality of life remain intact.

Additional challenges. Aging processes can be very difficult to understand for everyone. -- Especially someone with an individual -- an individual with an intellectual or developmental disability. They may have trouble cooperating with rehabilitation and environmental support. They don't understand the benefits. They don't like the discomfort. Declining abilities [ Muffled Audio ] people may feel anxious and frustrated without understanding why.

The individual may be able to talk about the things that are important to his or her personhood and quality of life yet still have difficulty understanding the implications of growing older. How aging may create challenges and walking, vision [ Background Noise ] confidence and self.

[ Background Noise ] Linda and I worked together [ Background Noise ] rehab facility and they would have something like a rogue and leg or some amputation issue that could've been addressed with rehabilitation that the struggle was not so much in getting it to heal but getting the person to feel like it was okay to go along with the [ Background Noise ] during the rehab process. They didn't understand that this would help the process in getting better. They don't understand the benefits that outweigh the discomfort of doing the therapy.

Another thing that may happen as people ages that new behaviors emerge. Individual struggler -- struggle [ Background Noise ] they may express fears, that does, anxiety that is through new behaviors that is not their usual behavior. This is something that shouldn't just be manage but the person is time to cope with their understandings and feelings of grief or loss or fear about what is happening. Some of the behaviors that you may see is a person that used to be very functional, they might again to isolate themselves and avoid social contact. People may become self abusive. They may become self injurious. --, Hitting themselves, biting themselves. You may see anxiety and outbreaks of anger with the person that used to be a type of person who could get along very well with other people. He may become aggressive and argumentative. They may lose interest in their favorite activities. It is important that you not focus on the behavior per se but part of the person so that both of you can try to understand what is going on and what the person is trying to express with those behaviors.

[ Muffled Audio ] tool for orientation. Sometimes people tell time by is it breakfast, lunch, dinner. [ Muffled Audio ] aging individual to feel at home. Telling time for a young man on my class load by Jeff,& His father. Had a specific routine. Is bed time was associated with watching the 11:00 news. At was when that time occurred. When his father was hospitalized, hit a difficult time when he had to stay with his sister in her house because bedtime in that house because there were young children and routines to get to school was 10 PM. Embedded himself on the couch and was not going to leave until the 11:00 time showed up because that was his routine. That was reassuring to him. Eventually she had to bend a little and rearrange the routine until dad got that are and could come home. This is what made him comfortable.

In protecting quality of life would want to be able to support personhood or keep in mind that our identity, how we see ourselves and prefers this to see us -- others to see us as one of the ways we are defined as individuals. The social identity [ Indiscernible ] how others understand how we are perceived as individuals. As aging begins to impact a person's relationship and abilities to interact with the world around him, both the person or the people in his life might lose sight of who that person is as an individual.

You want to support the individual's right to make choices and decisions. By doing that, you are supporting a person's ability to advocate for himself. Encourage individuals and their Ferran -- family members, friends and caregivers to talk about what is happening. Bring the aging elephant out into the room and really look at it. Listen carefully to their impressions about what growing older means. How are they experiencing it? Do they talk about not being able to see as well? Is that why they are spending more time in a familiar situation? They are not as eager to go out into the community and do things that they once enjoyed. Are they not sleeping well because I have aches and pains? Are they sad because they have to move to a new living situation and they are missing a beloved family member or even a pet your --? You want to guide the conversation to consider things that will be helpful.

Avoid giving advice. Listen actively and suggest giving options and alternatives for it the person to consider. -- For the person to consider.

Changing appearances and abilities are a challenge in the way a person think about themselves. For each individual, personhood is defined in a personal way. Charlie was a young -- a 70-year-old man on my caseload that had mild IDDD. [ Muffled Audio ] [ Indiscernible - multiple speakers ] [ Indiscernible - multiple speakers ]70 years old is still young. He still worked in the community. He took a great deal of pride on his personal periods. He was always well groomed and well-dressed. One day he had a sudden loss of vision and he had to go to the doctor. It was a melanoma in the eye. It was isolated to the I bought the solution was [ Indiscernible ] of the eye. Charlie ended up wearing a patch, going to serve the, all the discomfort. He tolerated everything. Never once complained or talked about what this was doing to him until we took him -- and many people on my does that work with me said, what does he need a prosthetic eye for. He can just wear the patch. He doesn't need to have it. How is he going to learn how to maintain a prosthetic eye? This was an example of not respecting Charlie's personhood.

But you were a strong advocate.

We took into an ocular us -- Abdallah rest and he was fitted for a temporary I. -- eye. He was devastated by the change of his appearance. No one ever thought until that moment to ask Charlie what he wanted or how he felt about the changes in his appearance. He did learn very well have to take care of that aesthetic guy. He liked -- prosthetic eye.

I heard that story many times and it always gets me going emotionally. It made a change in Charlie's life to have the prosthetic eye.

Also in providing strength-based support to people, you want to collaborate with the menu also want to take advantage of peer support I can be very powerful. -- Which can be very powerful. People are very compassionate creatures. That is in our nature. If you have read any of the anthropological studies of human beings, by our nature we like to take care of one another. We worry about things together, share challenges and experiences with people who have encountered similar expenses and challenges. This is invaluable. You cannot overestimate how important this can be. Small-group discussions and provide more support than you anticipate because we are such social creatures. Being prompted to share and be empathetic when we understand that someone else's suffering, can really help. We want to convert people -- encourage people to talk about their fears and discover ways they can help each other. Many times working in these group settings, it appears understand that this person is having trouble in the bathroom. The peer would come to me and say can you help him. He has trouble seeing. She has trouble reaching something. They are buddies and they look out for each other.

Don't be afraid to talk about death and dying. These are issues that everyone confronts. Is another elephant in the room. It is going to happen to everyone. Is important to talk about it and let people voice their fears and their concerns and share them with each other.

The natural human process. Another thing that you can do [ Indiscernible ] circles of support.

They are natural efforts that everyone relies on as a part of the community. One of the challenges associated with age and is isolation including isolation from our typical supportive group, increased -- decreased mobility [ Muffled Audio ] we aren't -- we have the chance of losing contact with our social group work [ Muffled Audio ] [ Indiscernible ] friends and family members healthcare professionals, community members, caregivers. Provide an opportunity for the circle to come together on a regular basis, formally or informally. The frequency of that circle coming together can be driven by what the individual wants, the availability of the circle members. It doesn't have to be every third Thursday of the month your let it be natural. Our circles of support are natural. We come together naturally with people in our own rhythm. This can support people to support their interests, preserve their strength and abilities pair

A common function could be vacation the person can get to church every Sunday if that is what the person wants to do. It can also provide advocacy as needed. Are there any questions?

With a question from John. Is there an established correlation between the degree of quality of life, link of quality of life and setting [ Indiscernible ] i.e. ICF, large group home, small-group home, their own home.

I can't quote statistics for you but I have statistics about people aging [ Muffled Audio ] some of you may have been from year with an initiative that was a grants program a few years ago called, I can't remember the name of it year, the study was that people were allowed to age in place. Funding was provided to natural caregivers. For example, if a wife became ill. If she had a stroke. It wasn't limited to people who had IDDD although they were part of the study. If a person became L, a family member could access funding to provide direct care. The results of that were very positive. People felt more comfortable with getting intimate care from someone I already knew. People were covered and recovered rehabilitation quickly because they weren't allowed to pursue rehabilitation in the natural environment. At the break I will look up the name of that initiative. It is no longer in place but I am sure you can look at the research and get more details on it.

I think it was called passion counseling. I think there were 11 states in the country that did pilot programs on that. If you go to Google and search for passion counseling I think you'll find this.

Person centered planning. This plays a starring role in developing and adopting a workable philosophy of care. [ Muffled Audio ] individuals personhood which is an essential piece of preserving the persons it -- autonomy and integrity as an individual. Often theaters -- caregivers and others think that the needs are defined as what the person is no longer able to do. This actually serves to increase dependency. It is important to balance safety concerns. I am saying that you need to balance them with supports that are designed to preferred -- preserve and enhance existing strength and to help the person to manage [ Muffled Audio ] age related issues especially fear is, anxieties and losses. This is a huge part of the quality of life.

What is person centered planning? The person is involved in all -- all aspects of his or her care planning. You can also choose to be in short -- included in that. ATBF staff members, community members, family copiers, the person really has that capacity to identify the people that he wants to help plan his care. The plan is [ Indiscernible ] [ Muffled Audio ] preferences. It is strength-based. If the person likes to go out shopping on Saturdays and they see a movie, that should be something that is addressed in the plan of care. You should be looking for supports that are going to enhance and facilitate that work if the person needs to do this safely, the support should be put in place. Does the support enhance the ability for the person to do what they would like to do? Your providing support but doing it in a way that focuses on what the person likes to do and what the person can do as opposed to matching them up with what the person cannot do. The person can't walk. I am going to give them Walker. That is one way of looking at it but you can also say, the person likes to go into the shopping mall every Saturday but it is hard for him to walk. He gets very tired. I am going to explore getting a wheelchair that I can pick up when we get to the mall so that he doesn't have to walk so far.[ Indiscernible - low volume ] [ Muffled Audio ]

I love working with Linda because she knows all of the other options that there are.

As well working with home and community based [ Indiscernible ] services. Medicaid requires that anyone who is providing eight CBS workers services is doing not -- HCBS waiver services is doing this in a way that is strength base.

[ Muffled Audio ] outcome focus. What I mean by that is the person identifies, I want to go to the mall on Saturday. What you are going to be measuring is that person's capacity to have gone to the mall every Saturday if he wants or two Saturdays per month. That is sure out come, your strength-based outcome. It includes the people that the person is identifying as being important to him and it supports the person who directs the process as much as he or she is able to dupe your -- is able to do.

You want to guide the person to consider and address important issues in his life. As I said, we do not want to ignore health and safety issues but we want the person to be a partner in the identifying what they are so that the person is more likely to understand them and comport -- cooperate. If the person understands that if they do not wear their glasses they might fall on the stairs because they don't see the stairs coming. Then they will be more likely to use her glasses. You want to include the safety protocol within the person centered planning that you want to cooperate with the person as a part of that.. You want to support the person as much is possible to choose how they would receive dues support and from whom they will receive the supports. One is asking the question earlier and I was talking about the [ Indiscernible ] counseling program. One of the things that come out of that was how important it is too heavy for my dear individual providing intimate or support or having someone that the person enjoys being with, going to the movies with him. If you go to the movies with someone who is really interested in the movie is having a good time, is going to be more pleasurable than if you go with someone was only going to that movie because they're getting paid to do that. You want to review the person centered plan regularly.

You should have a protocol for how long they want the plan -- how often they want the plan of care review. It should be at least annually I would recommend more often. It should be at the individuals into the -- convenience. You want to have the support members there and the individual being there as well. Be sensitive to the person's cultural background and spiritual beliefs. Some people may need assistance with language turkey want to provide that work you want them to have access to translation if necessary. You want to use the foregoing which. Avoid using clinical terms and acronyms. They may be meaningful to us as practitioners but they may be very intimidating to that person or their camel -- family or caregivers.

To review Person-Centered Planning empowers the individual to be more autonomous, make more choices for themselves, including end-of-life plans. They ensure that persons rights to privacy [ Muffled Audio ] because they are putting the person in the driver seat. That person has control over his or her life. They support and facilitate the individuals faces around services [ Muffled Audio ] [ Background Noise ] providers and caregivers.

That is the real value of Person-Centered Planning . The principles of self-determination form the foundation of Person-Centered Planning. Consider these as part of developing a plan for a person who is aging. The principal [ Indiscernible ] [ Muffled Audio ] authority over resources, their choice and their ability to choose. Supports build a life in the community of toys to [ Muffled Audio ] offer support and respect [ Muffled Audio ] responsibility and the fiscal -- fiscally responsible act back [ Muffled Audio ]

What is self-determination? It refers to a characteristic were of a person -- characteristic of a person that they need to make the decisions based on their own preferences and interests, to monitor their own actions and [ Muffled Audio ] a person acting in a self-determined way has a voice in the decisions that affect them and [ Muffled Audio ] happening in their own life. [ Background Noise ] this is a nice quote

This conceptualization of Person-Centered Planning represents the person [ Indiscernible ] reaching out to capture the things that are most important to him or her. These represent the person's relationships cause spiritual and religious beliefs, hobbies, [ Muffled Audio ] [ Background Noise ] immunity, friends. I want to point out that the arrows are going out. You are not defining the person by the things that he needs. The person making choices for the things that he wants to reach out and in -- incorporate into his or her life. For people who are aging, age-related challenges have a significant impact on the choices the person makes and the supports the person needs.

When you look at the graphics, all of the things going outward are their choices and the challenges are the arrows coming in. If you have health -- you want to have good health as a choice your but then you have health related care issues and they start to impact how you make those choices. If you want to live at home and you have an aging caregiver, that may not be able to continue in that home. Someone would have to work with adapting to a different setting.

Do want to be with your friends but your friends live in an area that has steps and you need a walker and you can't get there. There is a fall risk involved there. Those are things that you need to look at maybe there is a different place where you can meet you friends. If one of your friends has passed away or your care taker -- caretaker has passed away, that involves bereavement and would require additional support. There are many syndrome specific issues such as cerebral palsy and the mobility challenges. That affects where you can go, where you can work out where you can live, we can go visit when you want to see your friends, where you can visit them. What kind of activities you can do because you have been impacted by mobility challenges. As you age, there can be visual challenges were visual impairments. I will call them, Charlie, we talked about him with the melanoma and retinal detachment. He had to adjust to a much smaller field of vision. We had to adapt the environment for him. He lost his depth perception because now he only had one eye to see out of instead of two. Is visual field that change. There are to medication challenges with people with IDDD .

They may already have had speech difficulties and as they age dementia can impact what the capabilities of communication or. Memory loss can affect -- communication are. Memory loss can affect these challenges as well. Age causes challenges to yourself and your environment.

I believe in Person-Centered Planning what you want to do is create a balance. You keep in mind the things that are very desirable outcomes for the individual. To visit the friends or to have the [ Muffled Audio ] if they have lost a friend or family member, you want to provide support around those health issues so that the person can continue to enjoy the things that are really important to him.

Empowering and individual to make informed choices about his care in life may be compromised by health and cognition issues associated with aging. It is important to start all of those conversations about what kind of adjustments you may be facing early while the person is still -- still has their cognitive skills and can comprehend what you're discussing. Empowerment to make decisions maybe impacted by health and cognition issues associated with aging. Initiate those collaborative associations -- conversations [ Muffled Audio ] health issues in the planning.

[ Background Noise ] as we mentioned earlier, when you're talking with people and you are developing a Person-Centered Planning -- person centered plan of care, you want to develop person centered by which. The person is not a person with IDDD , in the language you put their name -- the person first not the disability. You want to make sure -- make sure when you're talking with the person of the category -- caregiver to describe the issues that they are confronting [ Indiscernible ] avoid using clinical terms and acronyms that may be confusing and intimidating. To review what is on the slide, if you say to someone, I think you have cognitive impairment, that may not be as meaningful as if you say, are you experiencing some confusion. You seeing you are confused as to where your bedroom is in you used to be able to know how to get there. Instead of [ Indiscernible ] talk about difficulty walking. Is it her when you walk. Are you having trouble maintaining a balance? Instead of depression, are you feeling sad. You're feeling lonely. [ Indiscernible ] don't say the word agitation use words like are you getting upset. Some of our typical clinical terms may not be understandable to these people and they are experiencing it firsthand and they're going to her right now. When you are working on Person-Centered Planning you will share this with individuals and the caregiver and the family but you still want to remain in compliance with the regulations and compliance with your agencies. Is another balancing act. If you want to [ Indiscernible ] use very specific diagnostic terms to justify a plan of care and indicate that the person [ Indiscernible ] if you're justifying medical necessity of course, you have to use those terms are you may want to combine them with the decision of what that means so that you are providing care because of a cognitive impairment. That is going to justify ethical necessity and you're going to explain that this is because the person is easily confused they're when navigating in his residence. That way person understands it and you also meet the regulations and requirements of your agency.

It is important to discuss future plans as much is possible to accommodate declining health and cognition of individuals and their caregivers. There are a variety of tools that are available for developing advanced directives for people with IDDD work these available -- these are available from several sources. They provide sources on guardianships and advanced directives and documents designed for people with IDDD and for their caregivers and families. Five wishes is a step by step manual developed. And advanced health care directive is an informational booklet on health care decisions. You can receive a from WWW.[ Indiscernible ].org. We will discuss more of this as we go further on the in the presentation about these tools.

Advanced directives are different depending upon what state you come from. Checked the state requirements of your state.

Remember who the person is to preserve their personhood. The aging and challenging to associated with changes in things that happened with the person [ Muffled Audio ] [ Indiscernible ] that person's identity is most often expressed by using sentences with I [ Indiscernible ] some age-related illnesses challenges make it difficult to pursue the individuals personhood particularly if the person is no longer to interact and socialize with other people. Personality traits often defined of the person -- with the person is in our minds and the way that the person presents themselves socially defined insult to others and these become discouraged do you listen dementia. The person becomes someone who is sick or someone was a lot of needs. We really want to avoid that because it is going to impact the person's personhood. It is going to impact the quality of life we remain the people we are through life even though illness happens to us even though we are no longer competent in an area where we used to be. Keep those things in mind.

Keep the person act the center of their support. Aging and dementia is not the person, is what happens to the person. [ Muffled Audio ] while he is able to expand actively in those plans while they are able to self advocate and communicate. [ Indiscernible ] [ Muffled Audio ]. Pain anxiety cognitive territory for person the practitioner., -- Look at a new behavior as a possibility that something is going on. Into two communicate with the person even when it becomes difficult to communicate. We talked earlier about demystifying death in the aging process. Begin those conversations as soon as possible and do it in a straightforward way. Early intervention is the best. Duo while the person can still engage in a conversation. Be Frank. Be open. Be clear. Talk about how aging is affecting the person. [ Muffled Audio ] if he looks different. Charlie, we have patch over his eye, he felt like he wasn't himself anymore. How do they feel about their health cause stamina? Are they noticing that they are getting a little[ Indiscernible - low volume ]

Initiate discussions about the persons wishes about living arrangements and other supports. This is going to include conversations with the caregiver. Encourage caregivers to discuss their own aging issues and their concerns and how this is going to affect their future ability to care for the person. Many caregivers may have a ready identified a sibling or a cousin who would want to step in and care for the person or at least be an advocate for the person. It is important to find out what these are and documented before because of prices. [ Indiscernible ] their own aging issues and abilities if --. If they are starting to have mobility problems or heart issues, where they want to move to a different climate, you want to know about that because you want to prepare them for their change in my. Maybe he will not be able to see his family members every week or as frequently as he used to.

Rather than springing up on the person on a whim, you want to start that conversation those -- so the person is prepared. Where to begin? Talk about where do you want to live if you can't live with mom or dad. Do want to live in a small house? You want to live with another family? Do you want to live with people you know from work, with your friends? What things are important for you, where you live? Do you want to have your own room? Is it important for you to live with people you already know or do want to make new friends? Do you want to be close to shopping? Do you want to have your own TV? Talk about who are your closest friends. Who do you eat lunch with that work? How important is it for you to have them -- to be able to visit them often. Remember that dementia and [ Indiscernible ] contains how a person socializes. A person that used to be really social, may now want to have more quiet time. Be aware that isolation may be a symptom of depression and try to tease that out when you are talking to the person.

If you're talking about their closest friends and how often they want to see them and they say I don't want to see them anymore, that is a clue that something else is going on that you're going to want to examine with the person a little bit were closely. Talk about what things the person likes to do. They like music? Is it important for him to have an iPod that he can listen to? Does he like to do crafts? Crochet? Play video games? Is it important to have something that they are living with who also likes to play video games with them or do they like to play them on their own? Ask what they like to do during the day. Do they like to work at today want to have a quieter life? AV they want to spend some of their free time going to yard sales or concerts or the movies.

You want to develop a retirement plan. There are options in many communities for people to go to geriatric day care centers or they have -- "dayhab".

[ Indiscernible - low volume ] [ Muffled Audio ] people with IDDD and aging people . Many times they have a lot in common. [ Indiscernible - multiple speakers ]

You are dealing with the same issues. You are dealing with issues of aging and the ability to change --[ Indiscernible - low volume ] Talking to people, put everything out on the table and look at all of the options that are available. Be as creative and open-minded as you can be. Encourage people that you are working with to do that as well.

Another thing you can do is create a time capsule with the person while they are able to express who they are or what they like. -- The interests they have. You are creating a personal legacy from the person and to the person to prepare before dementia starts. Individuals experience is, there pictures, memories, a scrapbook of things that are important. If that person develops dementia down the road, I have something that they can look back to. Everyone enjoys looking to a family problem.

So does this person. Is is a catalog of their accomplishments, the friends I had, family, the things that interest them, the places they have been. Cultural and religious beliefs should be catalog. Or attitudes about death and dying. What do they want? How do they want this handle? Who do they want to be with? Demystifying it, make it something they can freely discuss and feel comfortable about, not a frightening experience that they are dreading. Talk about issues around and of life care -- end-of-life care and advanced directives.[ Indiscernible - low volume ] Do they have certain things they don't want done, no feeding tubes or IDs or do they understand what those things are. Those things would have to be described so they would know what they are. Ideals, arts, nature, things that appeal to them. Keep them in that time capsule that you are creating. Is their legacy of what they can pass on and that other people can discuss with them. We have a patient that was on my caseload, Kirwin.

He had to go to the hospital because he had a clot in his carotid artery. The surgery is a little risky. The risk is the possibility of a stroke and if you don't do anything there is still a risk of stroke and there is also the possibility of dying after the procedure. It got everyone to sing the song, Jesus loves me, as he was going into the hospital. We thought that we had successfully remove the clot and five days went by and it look like he was ready to be discharged. But he did not make it. And when he passed away, family and friends got together at the funeral and that song was sung, Jesus loves me, in honor of Irwin because that was something that was special to him.

It meant a lot to his friends because they had lost a great friend. He was a very nice man. And it was very sad when he died there in fact, I got the call and Linda was on the way to the hospital to pick them up.

It is important to know what is special to someone. It is respect for the person but it also also -- it can also help the people that are left behind to mourn.

This is not a bad story. One of the people we worked with was named Teddy. Teddy only liked to eat white food. This was something that I don't even know what the origin was. It is a bright man. He was able to be. His individual -- intellectual disability was mild. Had a lot of uptight interest. What he refused to eat anything that wasn't right. He would be pasta, white rice, chicken, fish, shrimp. He would not eat roast beef. He wouldn't eat any dark food. It was so important that people that were working with him do that because if he went to the hospital and he was served something that was not white, he would not eat it. He would throw it and become quite active -- agitated. He was a good self advocate and he knew what he wanted. But it was better that it wasn't seen as a behavior problem. It was better to see it as, this is the kind of food that Teddy likes to eat. If he doesn't have this available, you will be hungry and angry and he will feel like you are not respecting his wishes. This is another example of how important it is to know who the person is and to really put that person at the center of your planning for him and get him to participate. Patty was -- Teddy was adamant that he wanted white food only and that needed to be in his plan of care.

We talked earlier about [ Indiscernible ] advanced healthcare directives that are designed for someone with IDDD so that they are easier to manage and explain. They provide information and in -- in an easy-to-read format about choosing a health care agent, being able to ask my mentor person and these are all things that we need to do when that person has her cognitive skills and they understand what you're asking is why. Choosing a healthcare agent, life-support treatments, like a talked about before. What is a G-tube? So what does it mean to have the feeding tube? Do you want to have this if you are unable to swallow? These are choices that someone has to make advance -- has to make in advance in order to have his wishes respected. Signing and witnessing the document. How to explain it, what it means to have it signed and witnessed. Changing the information, updating choices. They have the right to change the information. If they resend they specified in that document, has to be done in writing. They need to know that they have the right to change their wishes. Maybe they change their mind. Maybe they want everything done whereas previously they had a do not resuscitate directive. You need to share what those advanced directives are with other staff and other people.

I wanted to let you know that we are eight New York state agency and this is an important document to make sure that what you put into place is accessible -- acceptable in the state that you are practicing in.

The other form we discussed is the five wishes which is also a New York State form but it also happens to be accepted in 15 other states.

It is not actually a New York State form. It was designed by a Florida organization called aging with dignity and some of you may have tried to send -- print out the PDF and you discover that you can't print it. But if you go to the website, aging with dignity.com, you will be able to purchase if you want to use it. You have the option if you are actually filling one out for somebody of doing that online and I believe that one is free.

I am going to have to go on.

What the five wishes are in this form is, the person that I want to make decisions for me when I can't. Identify the kind of method will -- medical treatment that I want or don't want. How comfortable I want to be kept. How I want people to treat me and what I want my loved ones to know, what those wishes are.

It is in 40 42 states, it is respected as such. In some states you have to combine that form along with a healthcare [ Indiscernible ] [ Muffled Audio ][ Indiscernible - low volume ] To have accepted. If you visit the aging with dignity website and you do the document, you will be able to access it as Jill said. It can be used as a legal document in 42 states and added to the DNR in the other eight states.

Even if you are in a state where the five wishes is not seen as a legal advance directive, it is still a useful document to go through with someone because it was the individual through step-by-step. Some of the issues that would be typically considered in providing some kind of end-of-life care are on this form.

Do you want to review what is on the form?

I can. I am going to pull it up on the screen.

Like Jill said, if you want to utilize the storm, it is a form that you have to get to -- from the website to download.

There is a section here that helps you to talk with your family and friends and doctors about how you want to be treated if you are seriously ill. Your family members will not have to guess about what you want. It really generates a conversation around those end of life issues that can be tricky and difficult to talk about. You can also know what your mom and dad and your spouse want your you can be there for them --. You can be there for them. I could be someone who is not a carries the and. If you go on the website, it will list the states. There are 42 states as Linda said that consider this a legal document for advanced directives. It talked about how OSHA talks about how you can designate a healthcare policy decision-maker. Someone who is ill or may have diminished intellectual capacity can be walked through this. The language is very person centered. Even though this is my iPAQ, I will share my screen with you -- iPad I will share my screen with you. This is very clear. It is one which anyone can understand. -- Language which anyone can understand. It talks about who to make your healthcare ancient. That can be tricky.

You want to our health care agent to be someone who can put aside their own emotions and make a decision that may be painful for them but they know that it is what you want.

You sign -- it can happen that you assign someone to be your healthcare agent and you have a wish to not be resuscitated under certain circumstances and they are not able to follow through with that. And you are not able to speak for yourself. So it has to be someone that you designated that is able to follow through with your wishes.

Part of it may also be that the person would need to sign the consent for the healthcare process -- proxy to be able to sign the person into hospice if it look like they would not be able to recover.

Many other problems that occur is when you pick them to be your healthcare agent, they move out of state. Are they still appropriate to help you? Or do you need to have a secondary person on there as an alternate?

Another section of this is wish number two. My wish for the kind of medical treatment that I want or don't want. Do I want to be on an IV? Do I want to have resuscitation if I -- if my heart stops? I don't want to be in pain. I want to make sure that I can get a medicine so that I am not in pain. Then maybe you can talk about what the life-support treatment is.

Life-support can mean any medical procedure or medication to keep someone alive. Maybe that is not what they really want. Maybe all they want is, access to food, they want to be fed your do they want a feeding tube or don't want a feeding tube? Do they consider CPR something they want? Do they want blood transfusions? Do they want to be put on dialysis, explaining what dialysis is? Do they want an IV of antibiotics? A lot of these things are things that slow down the dying process and if the person is terminal, do they want those things followed or do they want to limit what care is given? Do they understand what that really means?

That is also -- the tricky part is practitioners because working with someone who has an individual -- and intellectual disability, you will have to work closely with them to make sure that they are not saying something that they think they want without really understanding what it is. One of the things that I found to be helpful is when explaining something to stop and say, can you explain to me what I just asked you about. Many times -- you don't want the person to just parrots back your words. You want to hear from the person that they really have a sense of what you said and that they are thinking about it and understanding it.

How you want to be treated also includes things like, I have had someone told me that they don't want to be alone when a guy. They wanted to know that someone was going to be there with them to hold their hands and talk to them. That was important to them. Do they want to die at home? So they want to be in the hospital? These are all considerations that may or may not be possible.

This also has wish number five, what I want my love wants to know. That is the list of messages to people that are important. -- People in these up Ward Circle that have been meaningful to the individual. You can also including here, wishes that the person may have about ceremonies for funeral arrangements.

Do they want to be buried, cremated, there are all kinds of considerations. They should be specified. The question should be posed if the person is capable of those decisions. Is

This is a very helpful document that you can use to help start conversations with individuals. Hospices also a choice and it is a choice like in the five wishes that can be presented along with that form.

Hospice takes care of difficulties with making decisions that does not preclude president patient of advanced care planning. Houston -- [ Muffled Audio ] better end-of-life care. As the person having worked with the person on your caseload, you need to be proactive about policy barriers. Do not resuscitate orders for instance. Or right to refuse -- life-sustaining care. If that's person has cognitive skills to make a decision to not have a feeding tube, and they determined to have the capacity -- and it is determined that they have that capacity, you need to actively promote that decision because that is what they wanted.

In your state I am sure there are big and policies about how to determine if an individual does have the ability to make an informed choice about his hair. -- His care. You want to be aware of what those are in your state so that you can be not only an advocate but also an advocate who can do this accurately.

Even if the person does not have capacity to make decisions around a DNR, decisions may be made through surrogate court or other means. Be aware of regulations in your state. If a person doesn't have capacity. He or she can still participate in working with hospice and making other end-of-life choices. What ever those decisions are, they need to be promoted with collaboration between the caregiver and the person. Caregivers also have opinions about death and dying and they may not be the same as the person who is taking care of them.

We cannot stress this enough. You need to have a frank and open discussions even though in many situations this is difficult. In my experience, and I think in Linda's as well, on to start talking about it, this is an experience that all of us go through. Once you do start talking about a, ultimately it gets easier.

It is not a happier discussion but it is in easier discussion.

I want to share a story of Shannon. Shannon was a bright woman. She was in her mid-70s just after she was diagnosed with cancer. Shanny Was told that she could add to her life by several months by doing chemotherapy but that it would cause her a lot of discomfort. She felt like [ Indiscernible ] she had a mild intellectual disability but yet a good sense of what she wanted and was she was. She decided that chemotherapy was not for her because it wouldn't compromise -- it would compromise the quality of her life during those last few months. She was open about the fact that she didn't want to spend the last month she had unearthed feeling worse than she already -- that she had on earth feeling worse than she already had. Fanny chose hospice. We were able to support that choice. We had to go to the -- to the medical directory and we had to have her interviewed by a psychologist who determined that yes, she did have capacity to make that informed choice. She had that capacity to choose hospice instead of the chemotherapy that may have prolonged sunlight but it was going to seriously impact your quality of life. -- Impact her quality of life. The other thing we talked about with Fanny was what she wanted to do with the rest of her life.

She was such a delightful person. And so happy that I get to be with her in those last months. She loved spaghetti and meatballs. So we went out several times a week to have spaghetti and meatballs. In the beginning of her illness, she actually had a very robust appetite and I was amazed. She was a tiny lady and she could eat huge portions of spaghetti and meatballs and then she would be ready for dessert. She also really liked ice cream. She also talked about what she wanted in terms of funeral arrangements. Fanny had been placed in [ Indiscernible ] care when she was 10 or 11 years old. Shadow best friend. More than anything she wanted to be buried near her best friend. Her case manager spends a lot of time discovering where her best friend had been very. He was able to not get her exactly in a plot next to the friend but very nearby in the same cemetery. That was also a wonderful experience for her because she got to visit with -- you got to find out where her friend was buried. And she also got to see where she was going to be laid to rest. Some people may feel that is morbid. But Fanny was actively thinking about what was going to be happening and what she wanted. Fanny was Jewish. She wanted to have her service done at the gravesite with a rabbi. We were able to put that all into place for her. When the nine died, it was so sad. I get emotional just talking about it. But she did have what you wanted. I feel like we really respected her choices. -- What she wanted and I feel like we really respected her choices.

We are going to ask you if you have any questions there

--.

How do you differentiate between someone who's becoming isolated due to morbidity versus a personal choice of wanting to take things easier, retire from daily activities and commitments they have participated in for most of their lives.

That is a good question. Again, you are going to want to talk to the person. That is a very insightful question, Jackie. I think you probably have good relationships with the people that you are working with. We want to spend some time working up -- talking about what the person is trying to accomplish with isolation. You can really talk about it in that way. When you go to your room to be alone and to close the door and you don't want to have anybody bother you, what are you doing there? The person might say, they make a lot of noise in the living room. I want to sit in my room and listen to my music quietly. Or I am crocheting and people are ways asking me what they are doing in a bother me. I lose count of my stitches. If someone is giving you the kind of an answer, you are going to realize that is probably a choice the person is making.

But if the person doesn't know why they want to be alone and they are shrugging their shoulders, maybe they are having difficulty engaging with you in the conversation. To me, that would be a sign of depression. Could also be early dementia. Those are things that --

I would suggest that that person be a -- evaluated by a psychiatrist to make that determination. Are we dealing with depression or dementia? There are medication choices that can be offered. There are pros and those programs that can be put into place to get a person to reengage. Knowing the reason why they want isolation, that is how you start the process of what to do about it

Linda makes a good point. You may of right way the person, in the case I would've value we do person within the scope of my practice as a social worker but I would certainly want to make sure that the nurse and the medical professionals I was working with were aware of the concerns that were being raised. I may say, Linda you are the nurse. I think she is just feeling like she wants quiet time. People around her are too noisy. What do you think? That is another part of the circle of support. You want to get input from people who have different perspectives and different relationships with the individual. That way you can get a more complete picture.

I think we have a break now. We will return in 10 min. We will return in 10 min. That will be at 2:30 PM Eastern standard Time. We will see you guys in 10 min.

Thank you.

[ Session is on a ten minute break. Session will reconvene at 2:30PM Eastern Time. Captioner is standing by. ] Please stand by for real-time captions. --

[ Captioners Transitioning ]

[ Captioner on standby ]

Welcome back. We are going to look at adaptive axes at the point of service delivery and how it can support aging in place. It's likely you develop persistent it plans to discuss individual twisted around where they would like to age and what things are most important to them. You will see that people prefer to remain in places that are most familiar to them. And they probably will not select that they would like to move to a different or new home. We will discuss how individuals can be supported to aging in place when this is their choice.

Aging in place, the ability to live in one's home and community safely, independently, and comfortably regardless of age, income, or ability level.

This is a definition that is provided by the centers for disease control, CDC, so you can access the online.

Aging in place principles. Individual planning, continuity of personal relationships, continuity of community, that's if you're staying in the same apartment with the same friend you are near, or family want to be near and integration with generic supports.

Supports can be adaptive equipment, ramps, a variety of different things to make an environment safe

Jill is going to talk about safety.

So safety really has to come first and it's a primary goal of supporting a person to age in place. Safety considerations include resources are in place to minimize the risk of falling, compensating for the missed sight and hearing, -- diminished sight and hearing, routines that are understandable and respectable, you also want to consider safe relationships make sure family members appear -- peers and caregivers understand how aging is affecting the person's ability to behavior -- and behavior. You want to validate the community that spends time and, if a person goes to a day program or to a work site. Make sure they are -- there are environmental modifications in place. So that there is sufficient oversight, if the person it loses mobility, hearing, vision may be declining.

You want to create safe environments for individuals, says as sustained mobility, social mobility. Ramps, wider doorways, raised toilet seat and toe rails. The Americans for disabilities act, these can be provided at places that are not necessarily designed to meet the needs of someone's with disabilities the person that's working in a community location, you can request that accessibility be provided for the individual. You can also look at lighting for people with dementia and visual impairments. Avoid patterns and the flooring, reduce shadows, address depth first session -- deck perfect -- perception and issues around chairs, and pay attention to ensuring opportunities for privacy and [ indiscernible ] moment so that persons can spend time in the boys confusion associated with noise and activity. This is particularly important for people living in small care settings where noise and busyness is a part of everyday life. These can be to stimulating and they can be upsetting to the person. The person can also feel it's too much if they are having a difficult day. Room dividers can also help with this by creating spaces, privacy and one-on-one activity.

Keep the home understandable to avoid confusing layouts, provide cues to navigate. Some people learn how to navigate because a particular end table or chair in a certain walkway, they use those as their cues on how to navigate around the room. Changing layouts can also be very confusing. Use adequate lighting and limit disruptive noises. Selects 30, simple, and versatile furniture. Secure lightweight objects such as Lance that are easy to knock over. Secure them. Make it something that is either heavy enough to not knock over or secured to the table. Use red or yellow, more accurately perceived colors than others. I can speak to that as well. I have a pair of glasses that are dark room, as an experiment I put my might countertop I don't have dementia, but I had a difficult time seeing them. But if I put them on my table, with the light there was no problem finding there. things can blend into -- something to consider, don't put an object that will blend into the background. Someone needs to access object.

Used large print signs to label familiar items.

And home safety. Attract -- address clutter and trip out to -- hazards, install railing, handgrips at the top of stairs or stairways. Use reflective tape to call attention to steps. If it's possible, replace steps with ramps. Use adequate lighting, limit disruptive noises, replace door sills with flat plates. And most important of all, keep areas free of clutter. It's a huge issue with people who are aging. Somebody is living in a house that has stairs they have to navigate daily, make sure things aren't left on the stairs that they can trip over. For people who are losing their vision, you can also access information from the American Council of the blind, which will provide you with resources and information about making a living area accessible for someone with a visual impairment.

To have a specific area that is for seniors who have been cited for most of their lives and are losing their vision associated with aging.

Be alert to all risks. This information is coming from the CDC. You can see the website listed there, www.CDC.gov. I had to encourage you to visit the site and search part of it, type older adults or the seniors. There's a wealth of information. Falls are the leading cause of injuries for people who are older and most all can be preventable. Most fractures in older adults are caused because of false. Someone who is older and may be experiencing osteoporosis may take a long time to recover from a fracture. They may develop secondary illnesses as a result of the fracture. You want to avoid those. The most common factors are spine, hip, leg, arm, and pelvis. We will be looking at ways you can evaluate an individual for their risk of falling.

Another thing I want to add. With someone with intellectual disability, sometimes recovery from a fracture and regaining their ability to walk is difficult to regain. We had a young lady with down syndrome on our caseload that fell, fractured her hip, and she went to subacute rehab and she never regained her ability to walk. She was capable of walking, but she had gotten so used to being in a wheelchair and wheeled around and was so frightened of standing on her leg after the fracture, that she never retrained -- retrieved the ability. And ultimately unable to get back to the home she came from because it was a home with stairs and she had to reconsider her environment.

Why do fall risks increase? Falls, the risk of a fall increases when vision changes, as you age, glaucoma, cataracts, diabetic retinopathy, or not wearing your glasses. Very important when someone goes to bed, make sure the glasses are next to the bed. As you age, sometimes you want to get up more frequently to go to the bathroom and the glasses are not there, you will not -- it will increase the possibility for fall risks. Medications, sedatives, blood pressure, muscle relaxers are, medicines as you age. And they all have sedatives. Sometimes you do that to ambulate at night. So you need to be aware that may be there should be a call they'll -- call bell for someone to check. Depending on the home setting. It, make urination more frequent.. --.Your strength may be diminished or your capability of walking is diminished. You can still walk but you need to walk with assistive devices. And not using assistive devices that if you need at night is also a frequent problem. Put on the right shoes. Don't just throw on slippers that don't fit right and you're scuffling a wrong, it's a trip hazard. If you need a walker or cane to ambulate, it should be nearby. People with IDDD may not understand the dynamics of aging so you need to consider safety.

To the degree you can partner with individual and discuss how to protect themselves, we are talking about coming from a strength-based focus. You want to work with the person on preserving the strengths they have. Ambulation is a huge asset as you age. Encourage the person to think first. To think about safety before they get out of bed and ignore the Walker or ignore the cane or put on the comfortable slippers instead of something that supports ambulation.

To minimize for risk. Make sure there is proper lighting. Avoid cluttered spaces. Provide handrails and grab bars. Secure area rugs, but don't use area rugs because they are a pretty -- trip hazard. Secure electrical cords. It's common to see electrical cords one from the couch to the chair, 2 feet or 3 feet away and someone walks between their. It's a trip hazard. Run them behind furniture along the wall spaces, not across room spaces that someone has to pass. Keep eyeglasses, assisted devices close to the person and encourage use.

Do weight-bearing exercises to strengthen someone. Take calcium, vitamin D screen for osteoporosis which increases the fracture with the fall. The risk of a fracture with the fall. And peer support to talk about what is happening to me. I'm aging. Things are different. I don't see as well. Do have this problem, too?

So you want to assess fall risks regular. The graphic was adapted from the CDC. When you are looking at people to identify who is at risk for falling, you want to consider if they have fallen in the past year. If they feel unsteady when they are walking or standing or even if they just worry they are going to fall. It's indicative that they may be at risk. So that is a point where you want to have their gate, strength, and balance evaluated. It up there is no problem when you have an nurse or other medical professional evaluate them, then you want to make sure the person is educated and has the opportunity to go to an exercise program so they can work on balance, fitness, and fall prevention. These are not really rehab programs, but they are preventive programs and that -- and are incredibly valuable and helpful and can preserve the person's strength and conserve their ability to stay at home in a living situation that they would prefer.

This is a chart to indicate ways to respond to gate or balance problems. Based on a number of false. If someone has no falls in the past year, you will educate the person and refer or gait balance retraining or fall prevention programs because they may have criteria that puts them at risk. If a person has one ball in the past year, determine the circuit is as of the fall. Was it a simple accident that may not recur or is it because they have a vision loss or a change in mobility that is putting them at a higher risk of falling. Do they have osteoporosis. Have you assessed the reasons that contributed to the fall. And once you determine the conduct a risk assessment, fall history, physical exam, cost your hypertension could be a problem. Postural dizziness, cognitive screening, is there a change in mental status. Review the medic they are taking. Are they taking things that make them drowsy or fall. Are they confused? Proper footwear, like we talked before. Assess what they are wearing. Look at all the slings. Mobility aids, access to mobility aids, do they need them and are they available and used it to get to? Visual acuity. If you have more than two falls or fall injury, determine the circumstances and go back and do a risk assessment.

Key interventions, going back to that our education, education of the person and caretaker, enhancing strength and balance, and proving functional mobility, managing meds, addressing foot problems, adding vitamin D and calcium, optimizing vision with glasses. Optimize home safety.

The CDC has a nice fall risk checklist that you can -- we provided the PDF?

Yes, you should have the PDF.

If you look at that, it's a simple form to assess what the risks are. Looking at fall history like we talked about. Yes or no checkoff. Has there been any falls? If there has been, complete no. Worries about falling, scared when standing or walking, indicated its yes or no. Medical conditions these are all things that can contribute to fall problems, so you want to know if they exist. Heart rate problems, arrhythmia problems, cognitive impairment, incontinence, depression, foot problems? Surgeries sometime can correct the reason you are having a ball problem because you are having an anomaly with your feet. Other medical conditions. Cerebral palsy, things you have as you age. They bring mobility issues. Noting that. A cassette, medications can contribute, so what medications are they on? Are they on psychotropic meds? Are they on sedatives? Are they on onto cholinergic, are they on diuretics that would make them go more frequently to the bathroom? And then there's gate, strength, and balance, several test we will talk about as we go along on how to a set -- says gate, strength, and balance. We will review those tests in a moment. Vision acuity. Less than 20, 40, or no I examine the past year. You want to note that it's time to send them for an eye exam. There's a decrease in systolic BP -- BP and change when you go to chant -- stand up. postural hypotension means you feel lightheaded when you stand up and that the fall risk.

Like I said we can get you the PDF so you can look at it that way.

We did not include these tests we are going to go over now and the PDF, but they are accessible from the CDC. You can go to the CDCGovernor website and then you site -- type in said a will, which is an acronym for [ indiscernible ]. There's a toolkit that you can download and use in your practice. One of the tests we will look at is the tug test. And this is a mini evaluation. It may not be something to use as a diagnosis tool, but it can certainly be something that can indicate, depending on what you discover when doing this, you may want to or for the person to a healthcare professional. The directions of our you will use a stopwatch or if you have a smart phone you can use that, that's what I would use. And you'll ask the person to wear the regular footwear and if they normally use a walking aid, they can use that as well. You can begin by asking the person to sit back and a standard armchair and identify a line about 10 feet away on the floor. Then say to the person, when I say go, I want you to stand up from the chair, walked to the line on the floor, at your normal pace. Turned, and walked back to the chair at your normal pace and sit down again. As soon as you say go and the person begins to get up, you will start your stopwatch and you will time them. Somebody who takes more than 12 seconds to complete this test is at high risk for falling. So you will want to refer them further. You will look at the person's postural stability. The way their data is visited regular date or does it seem like they are -- is a regular Gait or does it seem like they are struggling? Are they walking with quick, fast steps or are they shuffling. Or is there balance compromised? Circle anything that you think is a concern slow, Senator. paid, love the balance, short strides, not swinging their arms, if they are using supports like walls or furniture. If they are turning in an odd fashion when walking. I'm not sure how to explain that. Or if they have an assistive device, if they're not using it properly. That they have a walker and they are grabbing onto it and not really putting their weight forward, is there a birthday will fall backward. You want to make note of all of that. You want to make sure you're using an armchair because looking at people when they age, there may need of me replacing. You should be using a walker to pull yourself up. You push in an armchair, you come to a stand up right position and utilize your walker or cane or no device.

Pastry chair with arms, you can put up -- push-up on those arms and that accessible.

We are going to talk about the poor state balance test.

This is to assess static balance, which is standing balance. You will need a stopwatch. There are four progressively more challenging positions. Patient should not using this is the device for this particular test like a cane or walker. And you want to keep your eyes open. Describe and demonstrate each position. Stand next to the patient, hold his or her arm, and help them assume the correct foot position. When the patient is steady, Lego, but remain ready to catch that person in the event they did lose their balance. That the patient can hold the position for 10 seconds without moving his or her feet, or needing support, go to the next position. If not, stop the test at that point. You will at each stage ask, ready, begin, and begin timing until you say stop you you will demonstrate those for positions. What they are is on another page that you can get from the website when --

When you download it's a two-page adobe.

We didn't put in the PDF.

The positions you are testing for and only they can progress from one to the other is stand with both feet side-by-side, and counting 10 seconds. The next position would be placed the instep of 1 foot so it's touching the big toe of the other foot and if you can stand in that position for 10 seconds without falling over, you can move onto the next. The third position is placed 1 foot in front of the other and stand. And the fourth position is to stand on 1 foot, either right or left. And count 10 seconds feet if you can maintain the balance, you are doing well.

The next one is the chair stand test. This is a 32nd chair stand test. This is going to be testing like strength and endurance. So you want to get a chair with a straight back, so it would be like a dining chair, but it doesn't have armrests. It should be about 17 inches high. Again, you need a stopwatch or a smart phone with the app on it. you let the person sit in the middle of the chair and paste -- place their arms on the opposite shoulder across of their chest. You keep their feet flat on the floor, keep their back straight, and keep their arms straight on the chest and when you say go, you will ask them to come to a full standing position. They are not going to be using their hands to push themselves up from the chair. Have them repeat this for 30 seconds. If the person has to use there aren't to stand up, then stop the test because they are not able to do it and are at risk the if the person is able to sit down and come to a full standing position and 30 seconds, the patient is over halfway to the standing position when the 30 seconds have elapsed, then you can count it as a stand. There's a space to record the number of times he they are able to stand up.

And when you look this on the website it's a two-page PDF. For someone who is age 60 or 64, they have a truck that goes over a. It breaks down how many times the person should be able to come to a standing position with their arms crossed at the wrist and holding onto their shoulders. Somebody aged 60 to 64 they should be able to do it 14 times, if they are man and 12 onto there are woman. Eight decreases with age. Between the ages of nine the and 94 I'm a man should be able to do it seven times and a woman at least for. -- Number four.

These are indicators. They are not absolutes. If they indicate that may be you were for someone to an occupational therapist, physical therapist, Dr. For further evaluation. These are tests that you can do in your practice that are indicators --

More like [ indiscernible ]. If you are concerned and they say I don't like to go out anymore because I'm scared I will fall, this might be a way of partnering with them to evaluate what they need to take it to the next step. You want to work collaboratively but the people on your team and the people in the circle support to make sure that the person has expressed concern about falling and you are doing some screening and may be referring the person further.

We will go on to home safety and bathrooms. Safety rails, shower, tub rails are helpful. A raised toilet seat or a bar on the wall that can assist with getting upright walk in showers, use of the shower chair in your bathroom. Shower mats that have suction cups so you don't slip. Adjustable shower hoses and nozzles. So if you were using a shower chair, you pose. -- You pose. And skull protection -- scald protection devices in the shower. They may not know they are being scalded.

Safety in the bedroom. Talk about avoiding falls at night. They are common as we have been discussing. People often need to get up to use the bathroom and they may not put the glasses on or use their walking aids. So we want to be as safe as possible in the bedroom. Some things you can do to assure safety is to remove the wheels from the bed. It's one of those bed frames that has wheels. If you cannot remove them, you can lock them. Depending on the person's needs, you may want to get an adjustable high hospital bed. And also a bad light -- bedside lamp which is probably something you should have in any case so the person can turn the light on if they need to get up in the middle of the night or if they like to lay in bed and watch TV and listen to the radio if they fall asleep, have the promotes nearby for the radio and TV. At intake, or bedside phone could be helpful if the person needs help getting out of bed or if the person has some issues with mobility and it's compromised getting up at night, you may want to keep a commode or urinal at the bedside.

Safety in the kitchen. The focus is to maintain independence of functional mobilities for as long as possible. Assure safety without limiting autonomy and it's a balancing act. The important thing to remember is putting these supports in place, you want to do that with the person included in those decisions. Talk about why you are doing it so that someone who has been living in their own apartment doesn't feel like they are being diminished or disrespected if you start putting things like an auto shop or electronic or you suggest that they should have Meals on Wheels come. Everyone today. You want to make this a partnership. Some other things to consider are to put things that they used commonly or most often in the reach so they don't have to go up and down the stepladder or strain to reach a high shelf. Increase the number of lights. Is preferable to have lighter countertops so that if they put something down they can see them on the counter as Linda was explaining. It could be a challenge for someone who is experiencing the climbing vision. Use contrasting color in China or placemats. Some of these things are supports but they also make the environment more pleasant. The person could sit down and see everything on bright colored handles on utensils. You are helping the person to think actively about safety. Or what they can contribute to maintaining their personal safety.

Safety in the living room area. Automatic seat lift chairs, press a button that brings you up right so that you are not struggling to get upright in and ambulate it [ indiscernible ]. Good armor is to push on. Room back and seat cushions. Avoid rocking chairs. Because of the far risk of a moving tear. Relocate furniture so pathways are not obstructive. Touch sensitive light switches, contrast color for light switch places.

Managing stairs. You can use stair lifts are ramps if necessary. Make sure there are handrails to hold onto when going up and down steps. If you're unable to climb stairs, keep a second Walker available at the top or bottom of the stairs. If you're using is there to get up and then you need a walker to walk, have one of the top and bottom of the stairs so you're not trying to carry the Walker in your chair master going up the stairs and creating another kind of trip hazard. Remove loose rugs or just don't use throw rugs at this point in time if there is a trip hazard. Mark edges of each steps with bright colored tape.

Fire safety. A sure fire safety for someone who's losing hearing or has a visual impairment. You may want to have blinking lights or vibrating surfaces if the person wakes up in the far long goes off, you also want to provide an alternate exit in case of emergency is tape of an emergency and you want to practice a fire drill plan if thinking about alternative exes, make sure they are accessible to somebody who may have trouble with mobility. If they are exiting forum -- from a doorway, a ramp or something make sure it's kept clear of ice and snow. And have them practice on it so that they are aware of it. they are aware the areas block and they have to go to the other exit. I don't Inc. you can practice to frequently especially a people get confused easily. You want to provide adequate lighting in stairs and hallways and make sure that you have not lights and always make sure that the bolts are changed on a regular basis. Use door handles instead of doorknobs because they open more easily.

Level door handles.

Medical alert programs and community settings. Wander guard or bed chair alarms and hospitals or rehab facilities. Provide supervision and or secure area walk to walk indoor and outdoors. Is a person -- so the person doesn't feel like they are tracked and they can get to see other places and move about freely without feeling trapped. Keep the person involved in activities. We direct pacing a restless behavior and use calming techniques, quiet areas, was it, arts and crafts, things to do.

Is they age you will change the focus of habilitation. At the person -- as their need to increase their skills with the client. Sustainable programs are those designed to accommodate changing needs. Remember your focus is really maintaining the skills that a person has when you are designing activities, that the person is going to work on, you want to think more about memory appropriate activities rather than age appropriate activities. Again, don't try to teach new skills that will probably, for somebody who is experiencing cognitive issues. It's going to be frustrating and be something that makes a person feel less than they used to be, it will highlight that he's using skills. You want to maintain skill and focus on providing activities that are enjoyable. Versus activities that require active participation. You don't want to force the person to do anything. But you want to engage them in things they like to do. As the person we -- ages, routine settings become more important than ever. Provide rehabilitation services in that area that is similar to the individual.

Additional considerations, declining skills may affect the person's ability to self medicate. MimeOLE loss is difficult to remember, they made use pillboxes a reminder calls. Or an alarm that goes off. Impaired vision means difficulty reading labels. Use larger print, watcher labels, do your numbers -- bigger numbers, amount of medical -- medicine to take. Dexterity becomes difficult to, having difficulties opening bottles or breaking tablets or difficulty handing inhalers are they may need additional help with those things. They may have difficulty swallowing large tablets or capsules. Some pills can be crushed in applesauce and taken that way. Some pills are coded and then cannot the crushed, but they can be taken with some ice cream to make them slide down easily. Additional consideration for supporting a person to age in place includes support around the person's medication skills and scheduling medicines or profit they can be confusing. Unite the schedule method to schedules that are more condensed into shorter time period the less amount of time.

In that situation, you are going to want to partner closely with the person -- with their doctors. In some cases maybe they cannot swallow large tabular Castle and maybe it's available in a liquid or different form.

Now there's a lot of tablets absorbed under your tongue. There are sometimes other choices.

As we mentioned earlier, the demographics of CareGroup is are also changing. The person's ability to age in place may be seriously affected by the HR his or her caregiver. 65.7 million or 29% of US population are caregivers of someone who is ill or disabled. It's not necessarily someone with an intellectual disability, but it is a significant number of people who are providing care to family members. Any of these caregivers are over age 63 and they may be facing their own health issues. Again, what you want to avoid is a situation where you have a two generation elderly family where the caregiver and the care recipient are both experiencing issues around aging and are not able to work together anymore. In some cases the child is actually providing care for the parent. By 2030, the expectation is that they -- there will be 641,000 the with and as actual disabilities. That is what it is now and is expected to double in 2030. That is why these issues are current and why it's so important to be aware of them and to think about supports that will be provided.

49% of aging caregivers report that they must use assistance themselves in order to continue providing care. Working with caregivers, those are conversations you will want to start having as soon as possible.

Engage caregivers and conversations and gradually introduce in the conversation what it is they are worried about. Talk about maybe their ability to provide care and becoming reduce. Is it becoming difficult for them to take care of the person because their own needs are so huge. Do they have personal healthcare concerns. Does the caregiver find themselves to be emotionally or physically exhausted at the result of giving care. If the person is in a relationship with somebody that they are providing care to, but all of their energy is into assuring the person is safe and providing care to the person, and impacts the quality of the relationship that's another consideration. It's a sensitive issue and will be difficult for you as a practitioner to negotiate with somebody, but it is important because you don't want it to be a crisis. You don't want the parent or caregiver to have a sudden health crisis and then the individual who is receiving care feels abandoned or that it is their fault. So you want to make sure that there are community supports in place and that you have planned for other residential options and other supports in the event that the caregiver can no longer provide care.

You also want to help caregivers understand what the person is going through and to teach strategies to support and preserve the person strengths. Again these are things we've been talking about, but in this situation, you are actually approaching them as teaching the caregiver. You want to talk about how caregivers should be individualizing activities based on the person changing needs. Encourage them to provide activity that is coming in stimulating. The aging individual may not want to go shopping with the parent. And may just be too much. May be too confusing. You need to understand that those things may need to change. Talk about simple exercises that are most effective for supporting the individual like music, art, or a aromatherapy.

How can you help caregivers plan for of alternative? -- Plan for alternatives? Ken Simmons takeover? A brother or sister? Can they take on the care when that aging parent is no longer able to provide care. What are the abilities of alternate caregivers? Someone to give you a break and come in and take over so you can go shopping. Go get a few items from Macy's or where ever. Or just to have a little breathing room and have time to yourself, have an alternate takeover. In the event of illness of the caregiver. We talked about earlier. Just father went into the hospital for cardiac surgery, his sister to go over and was adjusted for both of them. Committee supports to continue current placement.

Many companion services in various communities that they may be helpful to the caregiver if somebody can just come in as Linda said, spend an hour or two so that the caregiver is able to get out and take them shopping or have lunch with a friend.

One of the ways to initiate discussions of caregivers is to include them as part of person centered planning so the consideration, future supports providing something that is sustainable and viable is always part of a conversation. And you can also be considering the caregiver's concerns as part of their everyday care. Encourage them to identify what they want for the person that they are caring for but also what they want for themselves. Is there a plan always been to retire and move something warmer, for example? Where -- as Linda said, talk about what their plans are for their family members care. Who will take care of them if they are no longer able to do so? This is something that can be discussed or planned over time, doesn't need to be decided immediately. Help family members to develop a wish list and to privatize and actualize wishes they have. They should be wishes that are not just for the person they are giving care for, but their own personal wishes because quality of life is a balancing act, is a two-way street. Of the caregiver is unhealthy or ill or not happy, it is not going to be a good placement for good situation for the individual either. Again, collaborate to identify community be sources. There's a lot of support out there for the elderly. These are things you can make use of.

There's also the caregivers when they are aging, some of these caregivers that have had people with IDDD in the house for 25 years. They consider them their best friends. I had a caregiver that was aging and no longer able to take care of this person and she didn't want to let her go, she was her friend. We have to take that into consideration when we ended up helping her realize that she was no longer able to provide the care, but we help to maintain the contact with the person that no longer could care for her.

And to the point. You want to talk about how to sustain a relationship -- identify community resources. The resources you look for do not have to be specifically designed for somebody with an intellectual disability. There are resources that can be appropriate for the person's needs. Again, you are coming from the faith-based focus. It can be reasonable for the way [ indiscernible ] many times the [ indiscernible ] for an intellectual disability who is also aging.

We will tell you a story now about a woman named Louise. Her wishes was a taken yellow icing. I will let Linda tell the story.

Linda was diagnosed with multiple issues. She had physical mommy such as scoliosis and which was impacting her breathing. With all the other problems. At this point in time, and mood have reached the point where she was at a limited a might -- amount of time to live. Her greatest wish was to stay and die at home with a caretaker. The caretaker had been her take -- caretaker for many years. This caregiver, unfortunately, cannot handle someone dying in her home. She had her own superstitious beliefs. It was something that she could not do, even though as much as she lovelies, it was something she could not give her. So we have to work with Luis to help her understand that this was something that was not going to be possible. She made it clear, she didn't want to go to a nursing home. We took her to one to see what it was like. It was not for her. It was not -- she had lived in a community her whole life and work in the community, she was mild intellectual disability and very verbal and aware of what was going on around her. It was a big deal for her to deal with that she could not stay in the home she knew so well. To help her we started looking for choices that she was going to be comfortable with. We found the caregiver that we introduced lose we OSHA lead to and she felt comfortable with her and this person was able to keep her in the same work setting, keep her near her friends and would allow her the ability to choose hospice and die at home, which was her wish.

We were able to support her choices. We involved hospice and worked with the hospice team to set up a DNR. She had capacity to make that choice. Her greatest wish was to be able to have time to go say goodbye to all of her friends and her work setting, which we did. With, David her and took her to the program and she knew it was eminent, death was eminent but we were able to take her to a wheelchair to say goodbye. And her other wish was she talked about having a yellow cake with yellow icing. This was around her birthday. So we knew that death was probably coming soon. So we got Louise's friends and caretakers and the people she loved to the caregiver's home and we brought him her special birthday cake and she couldn't eat much of it, but she had her last wish granted. She passed away that night. We were able to give her her birthday cake. It was her last and she wished to have. By working around what we could give her and helping her to understand what her caregiver that she lived with so many years was not able to offer her, she was able to move on and make her farewells and that was what happened to Louise.

The thing that I remember about that was that Louise really died with dignity. I was at her last birthday party with the cake and yellow icing. As ill as she was, she did not know me well, it -- and she was very aware. She didn't have any dementia or diminished cognitive capacity. She made an effort to get to know me and express her gratitude that I came to her party. It was an intimate OSHA it was an amazing experience. She's got that light, as Linda said. -- She died that night as Linda said. It was very sad but it was a warm feeling because she was able to get her wishes honors -- honored.

We have a hand raise from Marie Smith. Mary, I'm going to -- Mary, we are not able to hear you. Can you type your question and?

And since you are smelled -- self muted.

Thank you Marie. No more questions.

So we are going to take the next while to talk about how to manage specific issues talking bouts person centered approaches. This is in line with adapting services with service delivery.

Bereavement is a natural part of growing older as we age it's increasingly likely that we will experience painful losses. We will lose people we love and we will no longer be able to engage in activities that are giving us pleasure. We may not be able to live the way we normally live. It's nor actual -- it's natural to mourn those losses.

What is grief? A complex response to loss or threatened loss of a loved one. A person may also group the loss of a thing or place to which he or she is attached. And inability to participate in activity are aware. Grief and grieving can be prolonged and complicated. Like the situation with Luis, she was grieving for the loss of her home and her caretaker, she knew her life was ending soon and it -- she went through a process of sadness, anger, we had to sit with her and work through all of that. To make her comfortable with her loss that was eminent.

Don't overlook or minimize the person is grief process. Individuals with intellectual disabilities are as gullible to morning and feelings of sadness as anyone else. They may struggle with what is happening and may take longer to process confrontation that a loved one is gone. I worked with a man who was right and work independently in the community. His dad passed on when he was fairly young, and his mother lived into her 80s, maybe even early 90s. When she passed away, he really struggled with understanding where she was, he spent a lot of time going to his church and was very involved in a community church and talking with his minister about what had happened to his mom. It's important to give the person that space to do that. Is normal for a grieving process to take on -- go on for weeks and months and it's important to support the person and to honor the feelings and to make accommodations for the person and speak frankly with them about what they are going through. You may want to further person for grief counseling. Part of the agreement committee and the local agency. I know people find it hard to talk about leaving issues.

-- Grieving issues.

People with IDDD , we struggle to integrate the loss of daily -- in their daily lives. Many times the loss is -- distrusts the whole worldview and they begin to feel like the world no longer the place that is safe or predictable. So you want to be alert to emotional changes that may signal the person is suffering. You may want to isolate themselves and they may have trouble sleeping at night. And may be indications that the person is having a difficult time Danzig grief at that point we want to call him someone to do some grief counseling and you may want to collaborate and referred to a healthcare professional and speak to the nurse working with you and make sure the person has supports in-place. And support for people taking care of people. For the caregiver and staff that have experienced loss of someone they have taking care of. There needs to be time to discuss with all of the people involved with the loss. Not just the person experiencing the loss.

People who have lived in Concord of -- nope [ indiscernible ] care setting, it's hard for the people who work there and have lived there. it may have been a roommate, or staff person they had a relationship with and spend time with here when they are gone, they are grieving as well. They need time to express that.

It's important to keep in mind that bereavement -- the person may lose a caregiver but they may want to move or have a different date service they go to. They may live in a different community. They may also experience of grief reaction over losing a common routine. Leaving old friends and meeting to develop new relationships to keep discussions going and we stopped at the person and talk to them about what is happening to them and how they feel and reach out to the person in the network for grief counseling and spiritual guidance. There are resources available and it's important to look for those and to provide them to the person.

, And grief responses are fatigue, appetite disturbances, emotional changes, anger, anxiety, sadness. Cognitive changes, confusion, disorientation. Social changes, withdrawal from friends, isolating yourself.

You need to score the person. Help a person understand the loss, encourage the person to take part in ceremonies and rituals to honor the the the these. Be aware that the expression of grief can be delayed. The person may need time to understand the permanence of a loss. Especially someone with ID. The loss is an experience -- isn't experienced until time goes by and they don't see the person Demi Moore and they don't realize the person is gone until they see they are going to the worksite or home and the person is no longer here and then they start to ask the question, what happened. Then they will grief it could be months later that they are grieving. It takes time to realize the loss happened. Beware that they can be a delayed response. Therapy can help. See professional grief counselor, trained in helping people with ID/DD. Not everyone understands that the grieving process is someone with a cognitive problem. It takes them longer to comprehend what the losses.

-- What the loss is.

Individual issues with dementia, it's important to take behavior change seriously. With a circle of support including healthcare professionals to discuss if the behavior is actually an attempt to communicate stress.

Behaviors may be -- change in behaviors is how someone is communicating peer challenging beavers are, for people with dementia. People with ID/DD may not know how to communicate discomfort associated with common aging problems. Behavior may be a response to pain, depression, confusion or some other issue. You have to keep prodding the questions and looking at what is going on. Is someone is an easy-going individual that was socially appropriate and all of a sudden they are going things, -- throwing tings I'm a there may be a loss or pain they are experiencing and are not expressing there. asked those questions. The person is often struggling to communicate a need or an attempt to change something in his or her environment.

How to cope with difficult behaviors. Resource is from the hot -- Vermont agency of human services. They have a comprehensive overview of how individuals respond to aging and dementia with behaviors. One of the most useful sections in this handbook is a discussion of common behaviors that individuals experience. It provides step-by-step suggestions for understanding what the behavior means. The focus of this is that you are not trying to manage the behavior, as much as you are trying to understand it. to understand it in terms of whether it creates problems or if it's really something the person is trying to communicate, so you will not manage the person or the behavior. You will try to understand what it means. You are going to think about what cost or what were the antecedents, when did this happen? Is this something that happens every evening? Is the sum down syndrome or people with dementia get agitated in the evening. If you do provide an intervention, dated help? -- Did it help? Who is really affected by this behavior? Is it someone that distrusts the routine of the household? Is it something that can be accommodated if you change your own behavior. If the person is allowed around five o'clock every night, does that help if other people put on earphones and listen to music, for example.

Hostility can be treated by fear, anxiety, noisy environments, crowds, confusion, there are meanings to behaviors. Hostility and aggression may be an attempt to isolate or expressed frustration. Agitated attention seeking, person may need companionship or maybe frightened, anxious, or in pain. Property the structure and is an attempt to self sues. Tearing paper is a way of soothing. Disrupting others' activities often responds to noise and confusion in their online it. so it's a response back.

Sometimes a person becomes resistance -- resistant and doesn't want to cooperate in care. They may indicate pain or discomfort. Wandering is a, behavior. They could indicate restlessness that a person can be bored with the current environment. One we are talking about how to accommodate living situations, we talk about providing a safe place of the person to walk around and get them to stimulation and do something more interesting. Chording and rummaging is another, behavior. That can educate -- indicate if you are lost or have anxiety. If a person loses interest or begins to isolate themselves. We talk about that could be depression and could be a sign of the onset of dementia. And it's important to evaluate that. Delusions are often, with people with the mentor peer review should be response thing -- responding with reassurance and redirection. You may want to refer for site theatric evaluation or medications.

Any questions? No questions at this time but we encourage anyone that does have a question to please either use the raised hand teacher on the compose -- control -- rate can feature on the control panel or the chat feature. You can set it to me, Lisa Zimmerman directly and I will make sure that Linda and Jill will answer the question during the next Q&A session. At this point, there are no questions. Continue.

The final section of our presentation is coordination of diverse systems that we will talk about how you can access resources. As we've talked about, you want to build a circle of support for the individuals that you are providing care for. It's also important to build a circle of support for yourself. Wind out as much as you can about current resources and research in your area and share this with caregivers and individuals that you are working with. Talk to people who are doing the same job as you are doing. And other regions of your stay, it's good to rub salt with people that understand that you may be confronting as a practitioner. Try to go to conferences and symposiums like this one that focus on aging and related issues. Baser to rejuvenate you and review new ideas on your practice.

It helps you to stay excited about you work. We also provided a person directed dementia care assessment tool. If you do suspect that somebody is experiencing a decline in cognition, you can use this tool. It is not a diagnostic tool, but something that provides some indication that a person is having some cognitive decline and you can discuss this with other healthcare professionals in your circle as part of routine wellness visits, especially if the results indicate changes. This could be to retrieve -- this was retrieved from the Department of human services at Wisconsin. Learn about local options. Explore residential settings in your community that may offer what is called progressive supports, that would be supports that can be modified as an individual's needs increase. They devolve into a response and increasing needs. Find out if there are any caregiver networks in your area. Encourage caregivers to be involved as well. Caregivers who are providing ongoing support can be very stressed out. There is such a thing as caregiver stress and caregiver burnout. Having a circle support for the caregiver can also be helpful. Develop relationships with other healthcare professionals. Network with other healthcare professionals who have a person centered approach. Opus. Focus them to -- encouragement to participate encircled of support for individuals they serve and build a team, person centered care team. An occupational therapist, physical therapist, social workers, nurses, hospice, Dr., Dr. Work -- check things out with each other and discuss what your alternatives are. What would help is person? What kind of ways you can fulfill the wishes of that person.

DJ was a young man with cerebral palsy and was nonverbal, but was not -- intellectual elite compare. At a normal thank you and he was nonambulatory and ABL dependent. This communication method was with a checkerboard or computer assisted technology. He had scoliosis that was quite advanced and he ended up hospitalized and during the hospitalization, hospitals have reported he couldn't communicate. We did share with them that he used the chatter board, which one we went to visit we found in the corner of the room. Non-access -- not accessible to him. He was not able to -- they were assuming that he was developmentally disabled, intellectually disabled and was incontinent and he was quite upset because he was not getting a you're no, he wasn't getting help you needed to use the bathroom and ended up left to be in soiled bedsheets when this was not normal for him. You would normally able to communicate his bathroom needs. He had to be fed, people were not realizing that how much help he needed. We would come visit and his trade would be sitting there, ice cold, it was jars of baby food, which was not something he a peer he could eat a normal diet. You just have to be chopped and said to him. He was quite upset. It taught us a lesson that each time hospital staff change, you thought you could cover the fact that he was able to indicate with the chatter board and was normally continent. He normally eight chopped food. Or if he was in pain he was not able to to communicate to anyone that he was because he couldn't reach the buzzer and couldn't use it. He had to have a different kind of device because he only had a thumb and forefinger that worked. So he would have to have something he could press against, not something to squeeze. He wasn't able to do that. Every time we talked to one shift of staff, the net shift came on and the communication never went through. No one realized that there were specific needs he had to be able to take care of him. Ultimately, we ended up working out that we moved him back to community home he came from sooner than because we were able to take care of him there. we never got through as shift change to his level of care. That speaks to having a network of professionals that are person centered and would've taken time to learn about the date what he needed.

You want to stay informed about federal initiatives. We are living in changing times. The supports and people with disabilities, particularly people with the individual disabilities who are eight -- aging are in the form part of federal support that this time. Pay attention to initiatives that are becoming available. I will talk specifically about the Affordable Care Act, Olmsted, and I will not talk so much about the waivers, but I will mention that if you are providing services to the HCBS waivers they require that you do person centered planning.

One of the things about the Affordable Care Act that is remarkable is it identifies 10 categories of potential health benefits and included in these are rehabilitation and habilitation services as well as durable medical equipment, such as orthotics and others like prosthetics. The implications of this is significant because benefits can't be denied out -- denied on the basis of disability and there's a focus on quality-of-life. Rehabilitation is defined as services designed to assist people in requiring, retaining, and improving [ indiscernible ] socialization and adaptive skills necessary for them to rent the -- preside in the community. It supports aging in place and is in line with person centered planning and is a valuable focus for people with intellectual and developmental disabilities.

Olmsted is another issue that is in the forefront right now. It is based on 1999 litigation and George up. two women were in a psychiatric institution, and patient state run facility and they actually brought litigation against the Commissioner because they felt they should be allowed to live in the community. The litigation went all the way to the Supreme Court and was decided in favor of the two women. It was based on the American disabilities act. People who have mental illness or development of disability could not be kept in a mental institution or psychiatric institution unless there was justification for the continuing needs of care. What emerged from Olmsted was integration mandate for all state and local governments to provide services in the most integrated setting appropriate to the needs of individuals with disabilities. They were quiet than to develop an Olmsted plan to put that transition of individuals from a large congregate care facilities into [ indiscernible ].

The Olmsted as -- act as a force about the country. The office of civil rights investigates complaints that allege there is a violation of the omission disabilities act integration revelation which states with people with disabilities are entitled to receive public services and supports in the most integrated setting appropriate for their needs. The impact of this has been significant for many people with disabilities including those with iDVD. People that have lived in institutions for many years cannot return to their communities with in their own homes and received needed supports and services that they fully integrated community member. Of the above graphic illustrates the number of all such cases over 10+ years. Since the Olmsted rolling. Total of 851 investigations with corrective action being obtained in 61% of the cases. And no violations found in 39%. The office of civil rights upstate -- updates the [ indiscernible ]

There are also aging and disability resource centers created as a collaborative effort with the administration on aging and centers for Medicare and Medicaid or CMS. These are local centers that can provide information to you are other caregivers about resources and benefits that are available in the community including information on benefits management and connection to wellness programs you can find out where they are located in your community by going on the web and you can just put in a DRC and you should come up with the information.

In conclusion, we are going to talk about tools that you can use. I'm going to review the foundation that we have been talking about, the Edinburgh principles would be trying to adopt up workable quality of care, work a coronation of diverse systems and promote development resources. You can do this by using the four C's, collaboration, partnership with community groups, faith-based groups, Oka communities the provider agencies. Communication, develop network the circles of support, not just for the individual to that you're working with but for the caregivers that you know about and for yourself identify health care professionals were good listeners, advocates, and use a person centered approach. Teach them about who the person is. If the person is hospitalized or being cared for by people who know them. Creativity, explore new ways to maintain a person's quality of life and personhood. We are open to ideas and new suggestions and take the time to discover new resources. And be a strong and purposeful advocate. Sometimes that is the most important thing. And commitment. Be proactive in researching and developing and accessing support. Find out what is out there and find out what is going on and try to get the best support for the people that you are working with, for yourself, so that you can be a better practitioner.

We are going to move on to our questions. There are no other questions.

We do have some questions for you. We will move on to the test. Most individuals, 75% with --

Lisa is going to set these up and give us a heads up.

You can drink your water and take care of yourself. The first question, most individuals of 75% with IDDD live with family members. Is that true or false?

We will pause while you answer the question and we will move on to the second question.

Person centered planning is not appropriate for aging individuals? True or false.

This is false because what we have been focusing on is person centered planning being the most appropriate for aging individuals, include them in all things you are designing.

I forgot to say the answer to the first question was true, most individuals with IDDD [ indiscernible ] family members.

The Enberg principles upon practices for community supports for people with IDDD with -- who are affected with Alzheimer's disease and or other dementias and are useful in designing supports for all individuals with IDDD who are aging. Is that true or false? We can go ahead. That should be true for --

Lindner, do you want to do number four ?

Why did you? These are printers -- practices that were designed by workgroup in 2009 and they developed the principle that we've been talking about that talk about how you should design practices that will enhance community support. They were talking specifically about people with Alzheimer's disease and other dementias, but I think the principles are very comprehensive and broad and they can be useful concepts for working with all individuals who are aging.

Individuals with IDDD should be booted from participating in rituals and ceremonies associated with a loved one step that they don't understand? Stroke off -- is this true or false?

That is false, talking about death and dying demystifies it and allows the person to participate in the rituals and ceremonies with the loved one step Houston to cope with the death and understand that person has moved on and they can voice behavioral problems.

Mobility risks can be addressed through an barman, modifications, including handrails and ramps -- through environmental modifications such as handrails and ramps? True or false?

The answer is true. You want to provide support to minimize ball risks and sustain a person's mobility as long as possible.

People with cerebral palsy are more likely to develop dementia than people with down syndrome. True or false?

That is false. People with down syndrome have a higher incidence of developing Alzheimer's or dementia. People with several falsely are more likely to develop mobility problems as they age.

Porting and rummaging may be a common behavior for someone experiencing dementia. True or false? -- Porting and rummaging may be a common behavior for someone experiencing dementia?

The answer is true. Someone with them -- dementia may express feelings of fears or anxiety by hoarding and rummaging.

Individuals with IDDD should not be included in developing an advanced directive because it's too upsetting . True or false?

The answer to that is false because, yes, people should be included in their advanced directives. Remember the five which is. We want to talk about what somebody wants and what their riches are and it is less upsetting to the participants in planning what is to come rather than to have everything work around you.

A DRC's provide information and assistance about local resources for aging individuals. True or false? The answer is true. A BSEs or cooperative effort between the office of aged and CMS and provide local information about resources for individuals who are aging.

The Olmstead decision includes an integration mandate for all states. True or false?

That is true because the Olmstead decision was specifically developed to integrate people into the community.

We've included the answers for your information. If you get something wrong, you can find the information in the PowerPoint. I get people can do their questions -- direct their questions to Lisa. Are there any discussion or questions?

We will move to the valuation survey. Inc. you for your time.

Once I close out of the webinar, you will see that I survey will pop up in your browser if you can, please answer the questions at this time. If not, no worries, you will receive a follow-up e-mail tonight at midnight. You can take the survey then. If you already took the survey and still receive the e-mail, don't worry about it. You don't have to do it again. We've got it. If you have any questions or concerns or have any questions for Jill Olinda about the presentation or any of their other presentations, please do not hesitate to ask. My name is Lisa Zimmerman, you can reach me at leave the at and light we have reach me at leave the@andlightwehave.org -- nyrehab.org

[ Event Concluded ]Actions