Aging with Developmental Disabilities

Southern Network of Specialized Care

December 2012

Community Networking Presentation

Why is this a Relevant Issue to Address?

- People with developmental disabilities are living longer
- Good health plays a vital role in their quality of life
- It is important that older men and women with developmental disabilities receive the health related information to promote well-being and prevent health problems

Common Misconceptions

- All persons with developmental disabilities have severe physical, cognitive and behavioural impairments
  - Truth is that many individuals have very mild disabilities
  - Even individuals with severe physical deficits may be cognitively intact

Common Misconceptions

- Primary care providers have little or no capacity to care for elders with developmental disabilities
  - Truth is most care needs of elders with developmental disabilities are the same as most elders

Age-Related Changes

Gastrointestinal Aging Changes:

- ❖ Poor dentition
- ❖ ↓ number of taste buds
- ❖ ↓ muscle strength for chewing
- ❖ ↓ saliva production
- ❖ ↓ ptyalin in saliva
- ❖ Weakened gag reflex
- ❖ ↓ gastric acid secretion
- ❖ ↓ emptying of esophagus and stomach
- ❖ ↓ intrinsic factor
- ❖ Thickened bile
- ❖ Thinned gastric mucosa
- ❖ ↓ ability of small intestine to absorb sugars and lipids
- ❖ ↓ hepatic enzymes and storage capacity

Consequences

- ↓ taste sensation
- ↓ appetite
- ↓ chewing ability
- ↓ digestion of starch
- Possible swallowing difficulty
- Indigestion, flatus
- Risk of pernicious anemia
- problems with elimination
- ↓ tolerance for fats
- Possible change in drug metabolism
- Difficulty gaining weight

Hearing Aging Changes

- ❖ ↓ number of nerve cells in 8th cranial nerve
- ❖ ↑ production of cerumen
- ❖ ↑ amount of keratin in cerumen
- ❖ Atrophy of rigidity of ossicles
- ❖ ↓ elasticity of tympanic membrane

Consequences

- Presbycusis (hearing loss due to age-related changes in the inner ear)
- High frequency loss occurs first
- Tone discrimination loss
- Difficult following conversations
- Cerumen impaction
- Social isolation

Visual Aging Changes:

- ❖ Yellowing, opacity, rigidity of the lens
- ❖ ↓ pupil size
- ❖ ↓ accommodation
- ❖ Less efficient absorption of intraocular fluid
- ❖ Narrowing of visual field
- ❖ ↓ lacrimal secretions
- ❖ ↓ number of cones in retina

Consequences

- Presbyopia –inability to focus properly
- Distorted depth perception
- ↓ colour discrimination
- Need for Stronger light
- Increased sensitivity to glare
- Drier cornea

Musculoskeletal Aging Changes

- ❖ Muscle cells atrophy
- ❖ Generalized symmetrical muscle wasting
- ❖ Demineralization of bones
- ❖ Deterioration of cartilage surface of joints
- ❖ Thinning of intervertebral discs
- ❖ Loss of cartilage in vertebral column
- ❖ Loss of elastic fibers in muscle tissue
- ❖ Kyphosis

Consequences:

- ↓ muscle strength after age 70
- Two-inch loss of height between ages 20 and 70
- incidence of osteoporosis
- ↓ joint range of motion
- ↓ flexibility
- ↓ mobility
- risk of falls
- Gait changes
- Changes in body image

Integumentary Aging Changes:

- ❖ Thinning and atrophy of epidermis
- ❖ ↓ strength and elasticity of epidermis
- ❖ ↓ blood flow
- ❖ vascular fragility
- ❖ Loss of subcutaneous fat
- ❖ ↓ size and function of sweat glands
- ❖ ↓ sebaceous secretions
- ❖ "Clustering" of melanocytes
- ❖ ↓ number of nerve cells
- ❖ Thinning and graying of scalp, pubic, and axilla hair
- ❖ Thickening of nasal and ear hair
- ❖ facial hair in women
- ❖ ↓ blood supply to nailbed
- ❖ longitudinal striations in nails
- ❖ Accumulation of "debris" under nails

Consequences:

- susceptibility to infection, trauma, malignant lesions, pressure ulcers
- Skin is dry, scaly, wrinkled
- ↓ skin turgor
- ↓ ability to maintain body temperature and homeostasis; baseline temperature may be lower than normal
- Slower rate of healing
- Slower absorption of drugs by subcutaneous route
- "Liver Spots"
- Nails thicken, grow slowly, become brittle and yellowed
- risk of splitting, infections of the nails

Respiratory Aging Changes:

- ❖ ↓ elasticity of lungs
- ❖ ↓ number of alveoli
- ❖ ↑ size of alveoli
- ❖ ↑ diameter of alveolar ducts and bronchioles
- ❖ ↓ ciliary action
- ❖ ↑ anteroposterior chest diameter
- ❖ Weakening of respiratory muscles
- ❖ ↓ coughing reflex
- ❖ Calcification of costal cartilages

Consequences

- 50% increased residual capacity
- ↓ vital capacity
- ↓ mobility of bony thorax
- ↓ arterial blood oxygen level
- ↓ oxygen uptake during exercise
- risk of infection
- amount of dead air space
- ↓ exercise tolerance
- ↓ gas exchange

Genitourinary Aging Changes

- ❖ ↓ number of nephrons
- ❖ ↓ glomerular filtration rate and tubular reabsorption
- ❖ Change in renal threshold
- ❖ ↓ blood flow to kidneys
- ❖ ↓ bladder capacity from 500 ml to 250 ml
- ❖ ↓ elasticity of bladder
- ❖ ↓ bladder tone
- ❖ ↓ muscle tone of urethra
- ❖ Benign prostatic hyperplasia common in males

Consequences:

- ↓ creatinine clearance
- ↓ ability to concentrate urine
- risk of urinary retention
- incidence of incontinence
- urinary frequency; nocturia
- Effects on drug clearance via kidneys

Cardiovascular Aging Changes

- ❖ ↑ amount of collagen and fat in cardiac muscle
- ❖ Thickening and rigidity of valves
- ❖ ↓ oxygen utilization
- ❖ Myocardial hypertrophy, but over-all heart size is not affected by age
- ❖ Coronary artery blood flow decreased
- ❖ ↑ peripheral resistance
- ❖ myocardial irritability
- ❖ ↓ blood flow to all organs

Consequences

- ↓ stroke volume, cardiac output
- ↓ ability to increase heart rate in response to stress
- aortic volume and systolic blood pressure
- No change in resting heart rate
- risk of extra systoles
- Electrocardiogram changes

Neurological Aging Changes:

- ❖ ↓ number of neurons
- ❖ ↓ weight of brain
- ❖ Histological changes in brain; ↑ intracellular pigment, ↓ protein synthesis, senile plaques
- ❖ ↓ rate of conduction in peripheral nerves
- ❖ Change in sleep patterns
- ❖ Depletion of dopamine and some of the enzymes in the brain
- ❖ ↑ accumulation of lipofuscin
- ❖ query diminished brain cholinergic reserve

Consequences:

- ↓ Adaptability
- Slower response to stimuli
- ↓ Sensation
- Impaired proprioception
- Gait changes
- ↓ deep tendon reflexes
- Slower voluntary movement
- Sleep pattern disturbances
- Susceptibility to environmental temperature changes
- ↓ short-term memory

Sources: Brown, Jeri B., Bedford, Nacy K., White, Sarah J. (1999) Gerontological Protocol for Nurse Practitioners. Lippincott Williams & Wilkins, Inc.;
American Assn. for Geriatric Psychiatry. (2005). Comprehensive Textbook of Geriatric Psychiatry. 3rd Ed. W.W. Norton & Co.
VIHA. Delirium. Age Related Changes.V3 - 01.09 www.viha.ca/mhsa/resources/delirium/

Common Concerns in Elderly and Developmentally Disabled

- Increased sensitivity of the central nervous system
- Polypharmacy common
- Unreliable or no history provided
- Medical records are difficult to obtain
- Non-verbal communication
- Auditory and visual difficulties very common
- Seizures and dysphasia common problems

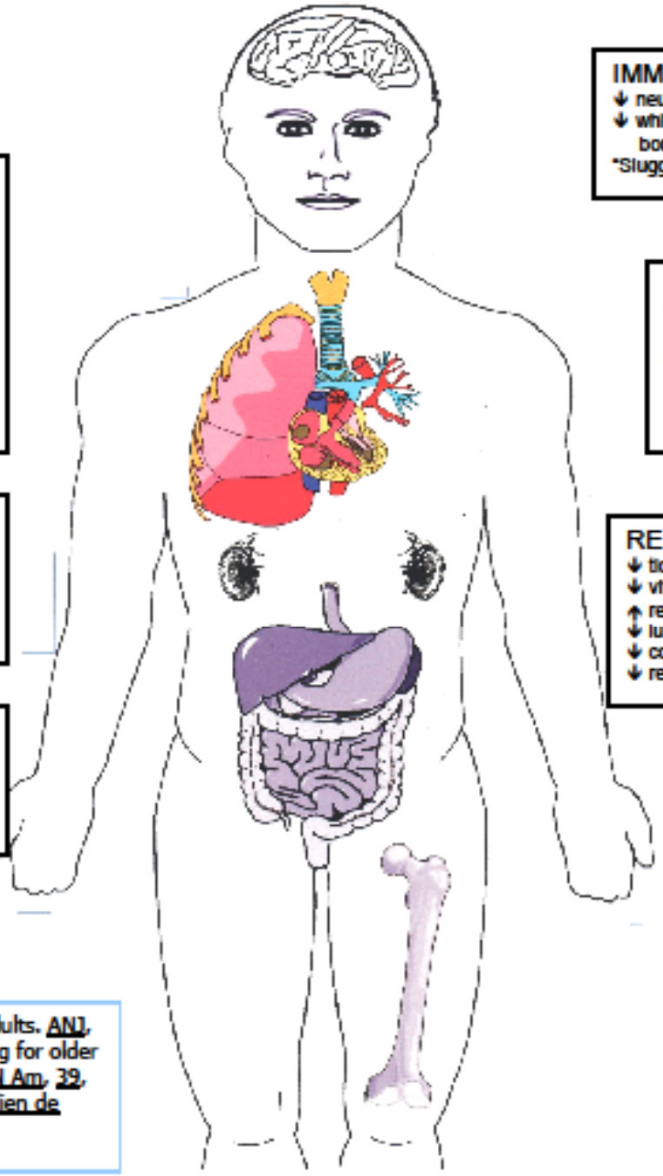
Where Developmental Disabilities and Aging Concerns Meet

- Sensitivity to meds
- Cognitive difficulties
- Fragile senses at young age
- Affect of disease on senses in later age
- Genetic, hereditary, or traumatic cerebral abnormalities
- Development of dementia with aging
- Communication difficulties

Where Developmental Disabilities and Aging Concerns Meet (con't)

- Mobility, musculoskeletal, rehabilitative issues
- Impaired cognitive and physical function with forming speech
- Associated with hearing and visual abnormalities
- Deformities, spasticity, contractures

Physiological Aging Changes



SENSORY
- ↓ salivation
- ↓ taste buds for sweet & salty: most tastes are bitter / sour
- ↓ visual acuity
- ↓ sensitivity to sound
- ↓ response to pain
- ↓ thirst sensation
- ↓ motor skills

Changes in dentition

CENTRAL NERVOUS SYSTEM
- ↓ neuronal density
- ↓ reflexes
- ↓ sympathetic response
- ↓ proprioception
- ↓ baroreceptor response (postural hypotension)

GASTROINTESTINAL
- ↓ gastrointestinal absorption
- ↓ gastric emptying
- ↓ hepatic blood flow / drug clearance
- ↓ drug absorption
- ↓ motility
- ↓ transit time

CARDIOVASCULAR
- ↑ myocardial irritability
- ↑ dysrhythmias, e.g.
  - ↑ PVC's/PAC's
  - ↑ A/V blocks
  - ↓ maximal heart rate
  - ↓ sinus rate
- ↓ arterial compliance
- ↑ systolic blood pressure
- ↓ cardiac output
- ↑ circulation time
- ↓ cutaneous/tissue perfusion

RENAL
- ↓ bladder capacity
- ↓ renal blood flow
- ↓ glomerular filtration
- ↓ renal clearance of drugs & metabolites

METABOLIC
- ↓ basal metabolic rate
- ↑ risk for hypothermia
- ↓ temperature regulation response

IMMUNE
- ↓ neurohumoral response
- ↓ white blood cell reserve (secondary to bone marrow/splenic sclerosis)

"Sluggish" T cell response

BODY COMPOSITION
- ↓ lean muscle mass
- ↓ subcutaneous fat
- ↑ overall body fat
- ↓ sweat glands
- ↓ skin pigmentation
- ↓ serum protein binding

RESPIRATORY
- ↓ tidal volume
- ↓ vital capacity
- ↑ residual volume
- ↓ lung capacity
- ↓ compliance
- ↓ response to hypoxemia/hypercapnia

ENDOCRINE
- ↑ or ↓ thyroid function

Hypo/hyperthyroidism
- ↓ insulin sensitivity

ORTHOPEDIC
Osteopenia
- ↑ risk of fractures
- ↓ range of motion
- ↑ ligamentous stiffness

Sources: Graf, C. (2006).Functional decline in hospitalized older adults. ANJ, 106(1), 58-67; Mick, DJ, Ackerman, MH. (2004). Critical care nursing for older adults: pathophysiological and functional considerations. Nurs Clin N Am, 39, 473-493; Watters, JM. (2002). Surgery in the elderly. Journal canadien de chirurgie. 45(2), 104-108.

Health Issues for People with Developmental Disabilities

- Adults with Down syndrome have a higher prevalence (15% to 40%) of early-onset Alzheimer's disease occurring 15-20 years earlier compared to the general population, and may experience hypothyroidism and sleep apnea more frequently

(McCarron, Gill, McCallion, & Begley, 2005)

Health Issues for People with Developmental Disabilities

- Adults with Fragile X may have more issues with heart problems (mitral valve prolapse), musculoskeletal disorder, earlier menopause, epilepsy, and visual problems.
- Persons with Prader-Willi have high rates of cardiovascular disease and diabetes

(Prasher & Janicki, 2002).

Health Issues for People with Developmental Disabilities

- People aging with cerebral palsy have an increased likelihood of having reduced mobility, bone demineralization, fractures, decreased muscle tone and increased pain, difficulty eating or swallowing, and bowel and bladder concerns

Health Issues for People with Developmental Disabilities

- Higher risk of developing osteoporosis (brittle bone disease)
- Tardive dyskinesia (repetitive, involuntary, purposeless movements caused by the long-term use of certain drugs)

Medical Issues Deserving Close Attention

- Premature aging in those with developmental disabilities and accelerated rate of functional decline
- Earlier development of eye and ear abnormalities
- Monitoring for the usual chronic health conditions such as arthritis, hypertension, heart disease, high cholesterol, and diabetes

Medical Issues Deserving Close Attention (con't)

- Higher incidence of seizures in elderly developmentally disabled persons
- Higher incidence of affective disorders, depression, and bipolar disorders associated with aging and mental retardation
- Unique issues of increased incidence of thyroid disease and Alzheimer's disease in people with Down's Syndrome
- Monitor for signs of abuse to individual but also to caregiver

You Can Help Prevent Delirium

What is delirium?

Delirium is a sudden confused state of mind. It is a common problem in older people in the hospital. Delirium can be prevented and treated.

What does delirium look like?

People with delirium can act confused and may:

- be restless and upset
- slur their speech
- not make any sense
- act differently
- drift between sleep and wakefulness
- have trouble concentrating
- see and hear imaginary things
- be unaware of surroundings
- mix up days and nights
- be forgetful

What can you do?

Promote Healthy Rest and Sleep

- Reduce noise, distractions and unnecessary lighting
- Add comfort with a pillow, blanket, warm drink or back rub
- Avoid sleeping medications when possible

Promote Physical Activity

- Avoid using restraints
- Help with sitting and walking
- Talk to the Nurse about how you can help with exercises and safe activities

Promote Mental Stimulation

- Arrange for familiar people to visit regularly
- Talk about current events and surroundings
- Read out loud
- Try large print or talking books

Ways to Help

Promote Healthy Eating

- After checking with staff:
  - Encourage and help with eating
  - Offer fluids frequently

Promote Healthy Hearing

- Encourage hearing aids and amplifiers when needed
- Make sure hearing aids are working
- If in doubt, talk to the speech or hearing specialist

Promote Healthy Vision

- Encourage the use of glasses and keep them clean
- Use enough light
- Consider magnify glass or eye exam

Health Promotion and Prevention Really Works!

The Delirium Prevention and Education Project Sponsored by RGPc – Regional Geriatric Program central.
An initiative of the Committee for the Enhancement of Elder Friendly Environments (CEEFE).

Comparison of Depression, Delirium and Dementia

	Depression	Delirium	Dementia
Definition	A change in mood which lasts at least 2 weeks and includes sadness, negativity, loss of interest, pleasure and/or decline in functioning.	An acute or sudden onset of mental confusion as a result of a medical, social, and/or environmental condition.	Progressive loss of brain cells resulting in decline of day-to-day cognition and functioning. A terminal condition.
Duration	At least 6 weeks, but can last several months to years, especially if not treated.	Hours to months, dependent on speed of diagnosis.	Years (usually 8 to 20)
Thinking	May be indecisive and thoughts highlight failures and a sense of hopelessness.	Fluctuates between rational state and disorganized, distorted thinking with incoherent speech.	Gradual loss of cognition and ability to problem solve and function independently.

Comparison of Depression, Delirium and Dementia

	Depression	Delirium	Dementia
Mental status testing	Capable of giving correct answers, however often may state “I don’t know”	Testing may vary from poor to good depending on time of day and fluctuation in cognition.	Will attempt to answer and will not be aware of mistakes.
Memory	Generally intact, though may be selective. Highlights negativity.	Recent and immediate memory impaired.	Inability to learn new information or to recall previously learned information.
Sleep-wake cycle	Disturbed, usually early morning awakening.	Disturbed. Sleep-wake cycle is reversed (up in night, very sleepy and Sometimes nonresponsive during the day)	Normal to fragmented

Comparison of Depression, Delirium and Dementia

	Depression	Delirium	Dementia
Hallucinations & delusions	Can be present in a severe depression. Themes of guilt & self loathing	Often of a frightening or paranoid nature	Can be present. May misperceive. In Lewy Body Dementia visual hallucinations are present.
Diagnosis	May deny being depressed but often exhibit anxiety. Others may notice symptoms first. Social withdrawal is common. Increased complaints of physical illness.	Diagnosis based on rapid onset of fluctuating symptoms. Can be mistaken for progression of the dementia.	Usually diagnosed approximately 3 years after onset of symptoms. Must rule out other cause of cognitive decline, e.g. depression or delirium.
Prognosis	Treatable and reversible condition.	Treatable and reversible with early diagnosis but can lead to permanent disability or death	Progression can be slowed but not reversed.

Comparison of Depression, Delirium and Dementia

	Depression	Delirium	Dementia
Care approaches	Identify the symptoms of depression early. Help person to follow treatment plan & offer them hope.	Early recognition is key. Keep person safe, find cause of the delirium and treat as quickly as possible.	Maintain and enhance abilities that remain. Focus on the positive and support the lost abilities.
Treatment	Antidepressants, ECT, interpersonal therapy, behavioural-cognitive therapy. Assist person to improve confidence and self esteem through conversation and activity.	Treat underlying cause. Monitor response. Be alert for relapse; occurs in 90% of cases	Cholinesterase inhibitors slow the progression of some dementias. Symptomatic treatment with environmental & staff approaches.

Delirium

Best Practice Quick Reference Guide for Care of Older Persons

This Quick Reference Guide will Assist the Team to:

- Identify older adults at risk for delirium.
- Assess causes of delirium and implement appropriate interventions.
- Reduce the person's delirium-related anxiety and fear through appropriate management of the environment.
- Employ use of non-pharmaceutical interventions whenever possible.

Key Points about Delirium

- Delirium is the *sudden onset* of altered behaviour and mental status (disorientation, decreased ability to focus and pay attention, perceptual disturbances, impaired cognition).
- It is a *transient state*—treatment of underlying cause(s) will usually reverse the alterations in mental status.
- Delirium in the older adult is frequently misdiagnosed—mental status changes are missed or wrongly attributed to dementia.
- Organic causes of delirium (medical illnesses) are often exacerbated by environmental changes and/or psychosocial issues in the older person's life.
- Sudden onset confusion can be the first or only sign of acute illness. Staff must assume that sudden changes in mental status are abnormal.
- **Almost any illness or medication can lead to delirium in the older adult.**

Is it Delirium or Dementia?

	Delirium	Dementia
Onset	Rapid (hours, days)	Slow (months, years)
Symptoms	Fluctuate over the course of the day	Relatively stable
Duration	Days to weeks	Years
Orientation	Disorientation and disturbed thinking are intermittent	Persistent disorientation
Level of Consciousness	Fluctuates, with inability to concentrate	Alert, stable
Sleep/Wake Cycle	Sleep/wake cycle may be reversed	Sleep may be fragmented

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Assessment of Delirium

Is the Person at Risk?

- Dementia
- Advanced age (> 75 years)
- Polypharmacy
- History of delirium
- Chronic illnesses
- Recovery from surgery

Is Sudden Onset Confusion Present?

- Rapid onset
- Fluctuating symptoms
- Evidence of disordered thinking
- Altered attention span
- Altered level of consciousness
- Altered ability to do ADL's

Evaluate Mental Status Changes

- Mental status examination (MMSE)
- Confusion Assessment Method (CAM)
- Collateral information from family and friends
- Assess changes in ADL's and behaviour

Common Causes of Delirium	Assessment
Drug toxicity	New prescription, multiple drugs, drugs prescribed for many years; recent discontinuation of a usual drug; consider over-the-counter drugs and herbals
Infection	Vital signs, blood work, chest assessment, urinalysis, etc.
Pain	Assess efficacy of chronic and/or acute pain management
Dehydration	State of hydration and nutrition, electrolytes, etc.
Acute illness	Physical signs and symptoms, blood work, etc.
Exacerbation of chronic disease	Physical signs and symptoms, e.g., glucose meter reading for diabetics
Elimination problems	Constipation, impaction, urinary retention, etc.
Substance abuse	Alcohol use, drug misuse, alcohol/drug withdrawal
Psychosocial problems	Recent losses, grief, relocation trauma, fear/anxiety, sleep deprivation, sensory overload

Consult with Team and develop an interdisciplinary plan of care to resolve causative factors (e.g., resolve pain, treat infection, institute a bowel protocol for constipation).

Interventions

- Develop an interdisciplinary plan of care to resolve causative factors (e.g., resolve pain, treat infection, institute a bowel protocol for constipation).
- Provide ongoing education, reassurance and emotional support to person and family. Assure them that delirium is transient and can be treated, especially if recognized early.
- Maintain a comfortable and familiar environment (e.g., provide eyeglasses, hearing aids, consistent staffing).
- Establish a day routine to reduce the person's stress level; encourage family to stay with the person if this provides

Alzheimer's Disease

- People with intellectual and developmental disabilities develop Alzheimer's disease at rates similar to older adults in the general population
- Adults with Down syndrome develop Alzheimer's disease at greater rates

Alzheimer's

- Alzheimer's is a progressive disease
- For individuals with mild to moderate developmental disabilities the changes first noticed in the early stages of Alzheimer's disease include:
    - loss of activity of daily living skills
    - personality changes
    - disorientation to time and place

Alzheimer's

- As the disease progresses the symptoms seen in the early stage increase
- Increasingly confused and their frustration may increase
- Disruptions in their sleep schedule and become very confused about day and night.
- May attempt to leave their residence and become lost

Alzheimer's

- Late in the disease process individuals are very disoriented to time and place and exhibit physical issues
- They may have difficulty swallowing, be in-continent, and have difficulty walking
- They will need total care for survival

Warning Signs of Alzheimer's Disease for Adults with Intellectual and Developmental Disabilities

- Loss of activity of daily living skills, difficulty with well-learned abilities
- Changes in personality; more withdrawn, more frustration
- Periods of inactivity or apathy, disinterest in activities the individual previously enjoyed
- Development of seizures not previously seen
- Disorientation to time and place
- Increase in stereotyped behaviours
- Hyperactive reflexes
- Visual retention deficits
- Speech difficulties, not able to use words or speech that is not clear

AGING WITH DEVELOPMENTAL DISABILITIES

WOMEN'S HEALTH ISSUES

"Normal Aging" for Women with Developmental Disabilities

- In the general population women live to around 79 years of age
- Women with a developmental disability (other than Down's Syndrome) live to around 67 years of age
- Women with Down's Syndrome live to around 57 years of age

Walsh, P.N., Heller, T., Schupf, N., & van Schrojenstein Lantman-de Valk, H. (2000). *Healthy Ageing – Adults with Intellectual Disabilities: Women's Health Issues.*

Menopause in Women with Developmental Disabilities

- There is very little research in the area of menopause and older women with developmental disabilities
- Women with Down's Syndrome may reach menopause earlier than the general population
- For some women seizure patterns change (for better or worse) around the time of menopause
- Women with developmental disabilities typically have not received information re menses or menopause

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Hormone Replacement Therapy

Potential Benefits of HRT

- Decreased risk for heart disease
- Relief from hot flashes
- Relief from mood swings
- Reduction in Osteoporosis
- May reduce the risk of Alzheimer's disease

Potential Risks of HRT

- May have a relationship with the progression of breast and uterine cancers for women who are at risk
- Women with mobility issues have a higher risk of developing blood clots
- May negatively interact with insulin and blood thinners

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Osteoporosis

- Osteoporosis is a disease in which bones become fragile and are more likely to break.
- Unfortunately, many older women become aware that they have osteoporosis only after they break or fracture a bone.

Osteoporosis: Risk Factors

- Advanced age
- Family history of osteoporosis
- Caucasian or Asian ethnicity
- Thin or small stature
- Physical inactivity; condition that limits movement
- Early menopause
- Diet low in calcium or Vitamin D
- High alcohol and/or coffee intake
- Excessive weight loss
- Smoking

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Osteoporosis Risk Factors and Women with Developmental Disabilities

- Amenorrhea
- Early menopause
- Medications
- More likely to be inactive or experience falls
- Prader-Willi Syndrome
- Kleinfelter's Syndrome
- Cerebral Palsy

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Prevention of Osteoporosis

- Diet
- Exercise
- Weight Management
- Tobacco
- Medications

Heart Disease Risk Factors and Women with Developmental Disabilities

- Undiagnosed
- Family history of hypertension
- Diabetes
- Lack of cardiovascular fitness
- Smoking
- Menopause can increase cholesterol levels which can lead to greater risk for heart disease or stroke

Warning Signs of Heart Attack

- Shortness of breath
- Pain or tightness in the chest, arm or jaw
- Dizziness
- Fainting
- Lack of energy

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Cancer and Women with Developmental Disabilities

- Breast
  - Clinical breast exam once a year, self exam if possible
  - Regular mammograms after 50 years of age
  - If a lump is found Dr should order follow-up tests

  (i.e. ultrasound, diagnostic mammogram)
- Ovarian and Uterine Cancer
  - Pelvic exam and pap smear every 3-5 years

  (more frequently if on HRT or has had an abnormal result)

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Thyroid Disease and Women with Developmental Disabilities

- Higher rate of thyroid disease among people with Down's Syndrome
  - Regular thyroid screens for older women (especially those with Down's syndrome) for early detection and treatment)

Urinary Incontinence and Women with Developmental Disabilities

- Urinary Incontinence
  - Urinary Tract Infection (UTI), increased need to urinate and a burning sensation or discomfort during urination
- Preventative Measures
  - More frequent urination
  - Make sure toilet facilities are nearby and accessible
  - Kegel exercises

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Preventative Health Care Services

- Thorough Physical Examination
- Vision
- Hearing
- Dental
- Testing for women over 65
  - Diabetes
  - Colon/rectal cancer
  - Hypertension, total cholesterol levels
  - Iron deficiency

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

Health Related Supports & Accommodations

- Watch for behavioural changes that may indicate an underlying health problem
- Ensuring access to health information that is understandable and services for diagnosing and treating age related health problems for women with disabilities
- Ensuring health professionals have accessible exam rooms & proper equipment
- Provide necessary supports to address health concerns

Brown, A., and Murphy, L. (2007). Aging and Developmental Disabilities: Women's Health Issues

AGING WITH DEVELOPMENTAL DISABILITIES

MEN'S HEALTH ISSUES

The Aging Male

- Male reproductive system changes:
  - Changes in testicular tissue
  - Sperm production

Prostate Gland

- Prostate gland enlarges with aging as some of the prostate tissue is replaced with scarlike tissue:
  - Known as benign prostatic hypertrophy (BPH)
  - Approximately 50% of men effected
  - May cause slowed urination and problems with ejaculation

Prostate Cancer

- Unfortunately a common cancer
- 16% of men (1 in 6 men) will be diagnosed with prostate cancer
- 3% of those diagnosed with prostate cancer die and the risk of this increase with age

"Management Guidelines Developmental Disability, 2005 Version 2"

- Increased risk for those men who have a family history of prostate cancer
- Often asymptomatic but symptoms could include:
  - Blood in urine
  - Frequent urination (esp. at night)
  - Inability to urinate
  - Constant pain in back, pelvis or upper thighs

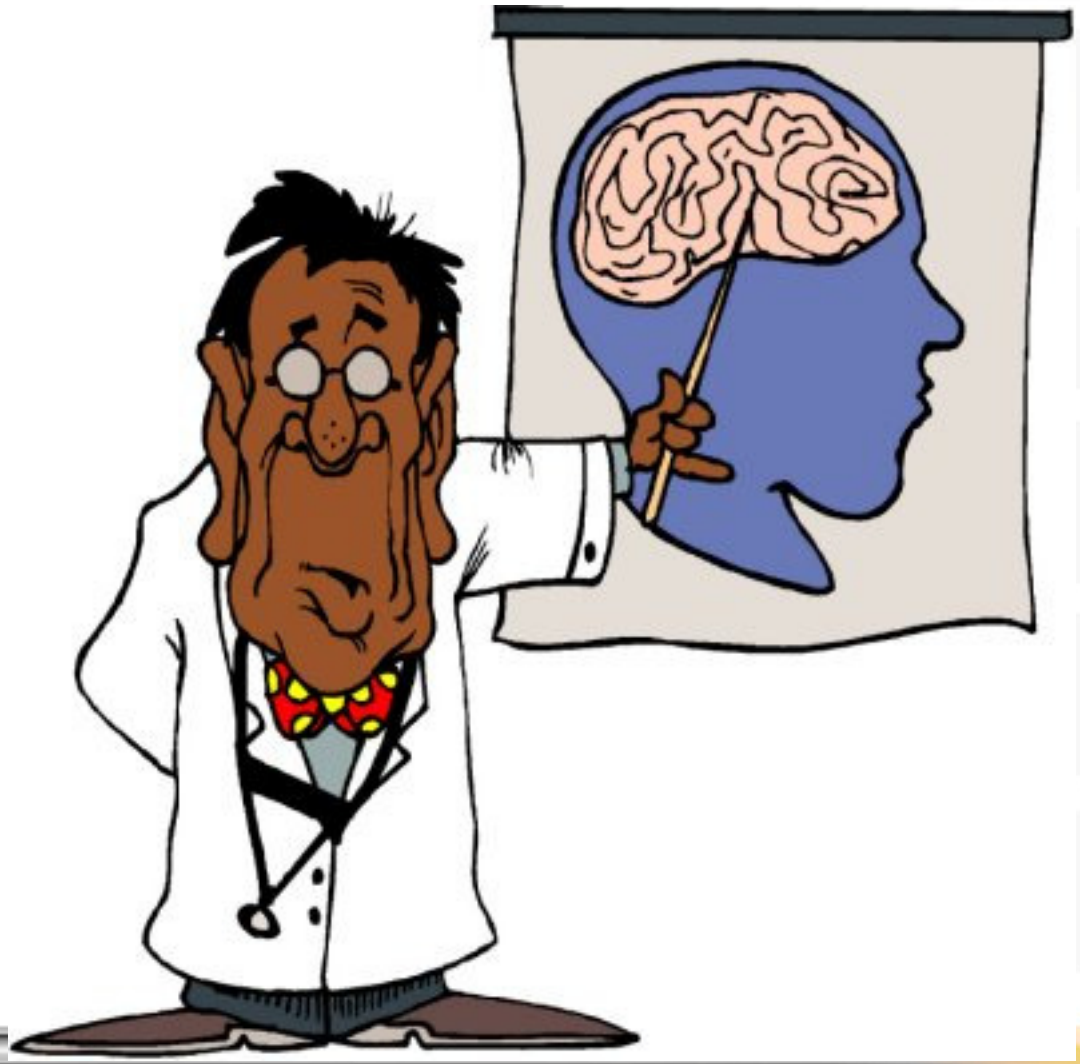
Erectile Dysfunction

- Increase risk after age 40 yrs.
- 25-45% of men over the age of 65 yrs. Have clinically significant erectile dysfunction
- Higher prevalence in men with developmental disability due to greater co-morbidities

- Associated medical conditions that should be ruled out as an underlying etiology:
  - Diabetes
  - Neuropathy
  - Vascular disease
  - Hyperprolactinemia

  - 90% of ED is thought to be a result of a medical problem rather than simple aging

Questions???



CCAC & Long Term Care

Community Care Access Centres

- 14 in the province
- 3 in the Southern Region (Erie St. Clair, South West, & Hamilton Niagara Haldimand Brant)

Connecting you with care

ccac Community Care Access Centre

casc Centre d'accès aux soins communautaires

Community Care Access Centre (CCAC) connects people with the care they need, at home and in the community:

- They can help people stay in their own home longer by providing Care in their Home and by coordinating Care in their Community, including specialized support services
- They can provide people with information about Long-Term Care Options if it becomes too difficult for them to live at home
- They are the access point for Long-Term Care and authorize admission.

Exploring Options with CCAC

- Anyone can make a referral to a CCAC – individual, family member, caregiver, friend, health care professional.
- Individual will be introduced to a Case Manager / Care Coordinator, who will:

1. Discuss needs, answer questions about CCAC and community resources
2. Conduct health care assessment
3. Develop customized care plan to meet specific needs
4. Check in regularly and adjust care plan if needs change

Care in the Home

The Care Plan can include specialized services:

1. Nursing
2. Personal support (help with bathing, dressing, etc.)
3. Physiotherapy
4. Occupational therapy
5. Speech-language therapy
6. Social work
7. Nutritional counseling
8. Medical supplies and equipment

The CCAC Case Manager may recommend care that is provided in the home by other Community Services.

Care in the Community

The Care Plan can include community based services:

- Meal delivery and dining programs
- Homemaking and home help
- Caregiver relief
- Transportation services
- Community dining
- Friendly visiting
- Supportive housing
- Adult Day Programs
- Specialized Services (brain injury, mental health & addictions, convalescent care, Alzheimer's & related dementias, Stroke)
- Community Clinics (diabetes, IV therapy, wound care, rehabilitation)

Long-Term Care – Eligibility

- 18 years of age or older
- Possess a valid Ontario health card
- Have health care needs that cannot be met with any combination of care-giving or community-based services in the home
- Have health care needs that can be met in a LTC home
- CCAC provides additional information regarding eligibility

Long-Term Care – When to apply

- People with Developmental Disability are considered no differently than people who do not (except veterans)
- There is no formula or checklist
- Each individuals situation is unique: their care needs & their resources to meet these needs
- Typically there is a CCAC supported Care Plan in place prior to LTC Application

Long-Term Care – When to apply

- Family Caregivers no longer able to provide care
- Health condition requires high level of personal support or ongoing nursing care
- Unable to return home after hospitalization
- Care needs exceed what can be provided by other services in the community

Long-Term Care - Application Process

- Contact CCAC
- Learn about options
- Visit homes you might consider
- Complete Application (includes an assessment of need)
- Wait for acceptance of application from LTC homes
- Wait for available bed
- Respond to Bed offer

CCAC Contact Information

Hamilton Niagara Haldimand Brant CCAC

1 800 810 0000

Erie St. Clair CCAC

1 888 447 4468

South West CCAC

1-800-811-5146

CCAC Long-Term Care Resources

http://www.ccac-ont.ca/Upload/hnhb/General/LTC%20Booklet/LongTerm_HOME_WEB.pdf