Manitoba
Families

Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

Community Living disABILITY Services (CLDS) &

Winnipeg Regional Health Authority (WRHA)

Protocols for Hospitalized Adults

July 5, 2017

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1.0 Overview:

In 2016-2017 a joint working group of WRHA and Department of Families representatives met and recommended protocols be adopted with the intent of improving the transition process and length of time from admission to point of discharge for CLDS participants who become hospitalized.

The working group identified that the biggest barrier to the safe and timely transition of CLDS participant occurs when their health, physical status or behavior changes significantly. This often results in the need to develop or revise the individual's care plan, ensuring that care providers and agency staff have the required training and capacity to implement the care plans once the individual is transitioned back to the community. Changes to the individuals functioning may also result in a need to make modifications and/or staffing adjustments to their existing home to ensure the individuals and care provider's safety and to meet Residential Care Licensing requirements. The more complex and timely situations to resolve are those where the individual cannot return to their home, resulting in the need to find an alternative placement and/or agency, or the development of a new resource. It is hoped that the protocol and attached planning tools will help identify barriers as well as resolutions to discharge planning that will result in timely transitions while supporting the Staff and Managers in the WRHA and Department of Families.

Winnipeg CLDS Centralized Services and Resources (CSR) have developed a central tracking spreadsheet of CLDS participants hospitalized in Winnipeg facilities. This tool is meant to support resource development within CSR and advise Senior Management of the status of hospitalized CLDS participants. It remains the responsibility of the individual community areas to notify Community Area Directors/Executive Directors of the status of hospitalized CLDS participants.

Working Group members:

Pat Younger, Community Area Director, Seven Oaks/Inkster
Ryan Quilty, Social Worker, Grace Hospital
Trish Bergal, WRHA Transition and Support
Susan Vovchuk, WRHA Long Term Care Access
Joe Puchniak, WRHA Specialized Contracts
Greg Reid, WRHA Community Mental Health Director
Randy Abbott, Area Director, Downtown Community
Cheryl Busch, CLDS Program Manager, Winnipeg Centralized Services and Resources
Pat Biglow, Utilization Manager, Grace Hospital
Vicki Verge, WRHA Regional Director of Social Work
Tim Herkert, CLDS Supervisor, St James/Assiniboia
Cecilia Ellis, Supervisor Residential Care Licensing
Marylea Mooney, CLDS Program Specialist

2.0 PURPOSE OF PROTOCOLS

The following protocols were prepared to provide the Department of Families and the WRHA with a process for providing timely case coordination and case management to adults with intellectual disabilities (as defined by the Vulnerable Persons Act) and complex physical, behavioral or medical needs who have become hospitalized.

3.0 DEFINITIONS:

"A Person with Complex Medical Care Needs" refers to an adult individual with an intellectual disability who requires support to manage complex care routines and who without that support would be at risk of personal harm or deterioration. In this document an individual with these needs will be referred to as a CLDS participant

"Care Plan" refers to a written support plan addressing an individual's unique care needs. Care plans detail why the plan is needed and includes an assessment of psychosocial, medical and physical care needs as well as behavioral support needs where applicable. A care plan should identify the specific supports and equipment required, as well when they will be provided and by whom. The care plan should identify those tasks/supports that can be provided by the care provider/agency staff as well as those that must be provided by a regulated health care provider. The care plan should also identify those tasks/supports that can be delegated/assigned to the care provider/agency staff (unregulated healthcare provider) by the regulated health care provider.

"**Case Conference**" is a formal, planned, and structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the individual and family members/close supports. Case conferences can be used to identify or clarify issues regarding an individual; needs and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans. Case conferences may be face-to-face or by phone/videoconference, held at routine intervals or during significant change. Case conferences are documented in the individual's health or service record.

"Case Coordination" includes communication, information sharing, role clarity and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging assessment, access to services, reducing barriers to obtaining services, establishing linkages, and other activities recorded in progress notes.

"Case Management" is a method of providing services whereby the Community Service Worker collaboratively assesses the needs of the CLDS participant and their care providers when appropriate, and arranges, organizes, monitors, evaluates, and advocates for services to meet these assessed needs..

"CLDS participant" an individual who is a vulnerable person under "*The Vulnerable Person Living with a Mental Disability Act*" and has been deemed eligible for the Dept. of Families CLDS program.

"**Community Service Worker" (CSW) is** the lead staff of the Community Living disABILITY Services Program who is charged with the responsibility of case managing a CLDS participant's care and support and assisting that individual with applying for and participating in services as recommended by the Case Coordination Team.

"Hospital Social Worker" (HSW) is the lead staff of the Winnipeg Regional Health Authority Social Work program who is charged with the responsibility of coordinating a CLDS participant's assessments, care and support and assisting that individual while admitted in a hospital or health care setting.

"Vulnerable Person" under "*The Vulnerable Persons Living with a Mental Disability Act*" an adult living with a mental disability who is need of assistance to meet his or her basic needs with regard to personal care or management of his or her property. A mental disability means significantly impaired intellectual functioning, existing concurrently with impaired adaptive behavior and manifested prior to the age of 18 years, but excludes mental disability due exclusively to a mental disorder, as defined in Section 1 of "*The Mental Health Act*".

4.0 OBJECTIVES OF USING CASE COORDINATION FOR HOSPITALIZED CLDS PARTICIPANTS:

4.1 Individual Related Objectives:

1. To ensure the CLDS participant, their substitute Decision Maker (where applicable) and his or her family/caregivers/support network, is involved in the case planning process and that their needs and wishes are taken into account during their hospitalization and planning process;

2. To improve functioning and/or prevent further decline in the CLDS participant's well-being;

3. To ensure timely sharing of information with the right people;

4. To provide services in the least restrictive ways to safely manage high-risk behaviors of a hospitalized CLDS participant;

5. To ensure the CLDS participant has a care plan that can be safely implemented in a timely manner both within the hospital/health care facility and upon transition;

6. To ensure the right people are involved;

7. To improve the safety and quality of life CLDS participants within the hospital and community; and

8. To ensure each CLDS participant is assessed from strength based perspective. The team needs to assess what are current strengths; what are current un-met needs; what is needed to meet unmet needs and what can complement existing strengths.

4.2 System-Related Objectives:

1. To improve patient safety and timely transitions;

2. To ensure a coordinated interdepartmental and inter-jurisdictional approach to service delivery;

3. To ensure information-sharing among service providers in accordance with applicable privacy laws;

4. To ensure that transitional planning from the hospital / facility to community living is undertaken in advance of an expected discharge date (EDD), and that necessary community supports and funding for services has been secured prior to a CLDS participant being ready for discharge;

5. To ensure that a Case Coordination Team has been created with relevant stakeholders, decision makers, the CLDS participant, their Substitute Decision Maker (where applicable) and his or her family/caregivers/support network, who will all case conference regularly;

6. To ensure a process is put in place to ensure as short a stay in hospital or health facility as is necessary to address the acute care needs that brought the CLDS participant into hospital for care. We want to ensure the right care is being provided at the right place at the right time.

5.0 GUIDING PRINCIPLES:

In developing and implementing case coordination for CLDS participants, the following guiding principles will be adopted:

1. CLDS participants are presumed to have the capacity to make decisions affecting themselves, unless demonstrated otherwise. CLDS participants are to be encouraged to make their own decisions with the support of their network. If the individual is not able to make a decision regarding their health care, either on their own or with their support network, they may require a Substitute Decision Maker appointed under Section 25 of The Vulnerable Persons Living with a Mental Disability Act.

2. Management of, and provision of services to CLDS participants are multi-system responsibilities.

3. Treatment and a care plan appropriate to the CLDS participant's condition should be considered in service planning.

4. Case coordination for CLDS participants is best developed in consultation with health services, social services, and other appropriate community agencies as partners in service at the earliest possible opportunity.

5. Services planned and delivered should provide for a continuum of services from hospitalization, through transition and ongoing community living.

6. Services, treatment and care should consider the safety and vulnerability of the individual and care providers.

7. All CLDS participants will receive services in a manner that is consistent with their rights under the *Charter of Rights and Freedoms*. Sharing of information among service providers will be in accordance with *The Freedom of Information and Protection of Privacy Act, The Personal Health Information Act, The Vulnerable Persons Living with a Mental Disability Act* and any other relevant legislation. (See Appendix A for sample consent form). WRHA staff should review relevant consent policies such as policy # 110.000.005 Informed Consent (for Procedures, Treatments and Investigations) http://home.wrha.mb.ca/corp/policy/files/110.000.005.pdf. See also WRHA PHIA polices at http://home.wrha.mb.ca/corp/policy/files/10.40.020.pdf

Service planning should be approached in the following way:

1. Focused on the individual needs of the CLDS participant;

2. Be holistic in approach;

3. Be strength based;

4. Be a cooperative and collaborative effort among all service systems;

5. Be undertaken to minimize risk to the CLDS participants and care providers; and

6. Ensure that communication and decision making is done with the Hospital Social Worker and Community Service Worker who are jointly accountable for the interdepartmental process.

6.0 RESPONSE TO AN ADMISSION OF A CLDS PARTICIPANT INTO A WINNIPEG HOSPITAL:

When a CLDS participant is admitted to a Winnipeg Hospital, the CSW and HSW are expected to develop a case coordination approach following the algorithm outlined in **Appendix C**.

7.0 RESPONSIBILITIES UNDER CASE COORDINATION:

7.1 The role and responsibilities of the Hospital Social Worker (HSW):

Consulting with the CLDS participant, and their substitute decision-maker (if applicable), or committee (where applicable) to obtain consent for the involvement of the CLDS participant's support networks (i.e family, friends, advocates and other service providers and professionals) who are able to provide expert advice related to the needs of the CLDS participant, and ideally who know the CLDS participant best.

- With the CLDS participant, complete the WIS Consent Form (Appendix A).
- Share information and to coordinate a care plan to inform the safe and timely transition from the hospital with the proper supports in place in the community;
- Identify and contact stakeholders to gather relevant information concerning the CLDS participant so that a Case Coordination team can be formed and a package of relevant information prepared for all team members before the first case conference.
- Prepare a comprehensive psycho-social assessment (Social History) and ensuring other relevant assessments are done;
- Invite relevant health care team members (e.g. Hospital Based Home Care Coordinator, Occupational Therapy, Physiotherapy, Nursing); appropriate community service provides, service systems, clinicians, and support network (with the CLDS participants consent where necessary) to the first case conference. Invited key members need to make themselves available in a reasonable time frame, or appoint a delegate.

- Chair the first case conference, coordinate the following :
    - review the consent process
    - share relevant information,
    - facilitate discussion among all participants,
    - ensure an action log is kept of the meeting using the WRHA Interdisciplinary Rounds Action Log (see appendix B Interdisciplinary Rounds Action Log) ,
    - record the decisions made at the meeting and the timelines,
    - ensure clarity on the follow-up actions and responsibilities of Case coordination team members,
    - review the expected date of discharge (EDD) and ensure all conference participants are aware of the commitment to this EDD,
    - provide feedback (both written and verbal communication) to the health care team about any revisions to the EDD based on team conference,
    - ensure Interdisciplinary Rounds Action Log is distributed after the meeting
    - record an Interdisciplinary progress note (IPN) in the health care record
    - The HSW is responsible for ensuring that there are regularly scheduled opportunities for the HSW and CSW to discuss the progress of planning. This can occur via email, phone call or meetings but should be discussed in advance and a commitment made to a timely check in.

- Establishing future meeting timeframes and locations.

7.2 The role and responsibilities of the Community Service Worker (CSW):

- Provide ongoing case management services for the individual while in hospital and in community;
- Ensure Supervisor and Centralized Supports and Resources are advised of individual's hospitalization and ongoing status;
- Participate in case coordination/case conference meetings as a team member and take responsibility to complete agreed–upon tasks;
- Ensure that the individual's care plan is appropriate to their current needs and can be safely implemented in the community. This may include identifying care provider/agency training, additional staffing resources, equipment needs or modifications to the home, and potentially the need to explore a new living situation;
- Together with the HSW, identify appropriate community based health care resources and referral to same (ie. training such as lifts and transfers, tube feeding, etc) ;
- Together with the HSW, identify tasks/supports that must be performed and identify community resources;
- Together with the HSW, evaluate and monitor the implementation and progress of the care plan within defined time lines;
- Identify potential barriers to planning to the HSW and request systems meetings when necessary to problem-solve;
- Maintain inFACT case notes ;
- Immediately refer situation to management when there are barriers to discharge identified or further consultation is required (see 8.3 Potential Solutions to Common Transition Barriers).

7.3 The purpose of the Systems meeting and the role of team members

- Resulting from the first case conference, the HSW is responsible for ensuring that there are regularly scheduled opportunities for the HSW and CSW to discuss the progress and planning. This can occur via email, phone call or meetings but should be discussed in advance and a commitment made to a regular and timely check in.

- Future case conferences should be scheduled to assist team members with staying on task as well as for communication purposes. It is recommended that bi-weekly case conferences be scheduled at minimum.

- Case conferences should result in recommendations for service planning and support the work of the HSW and CSW. Hospital Social Workers can find further details on facilitating system meetings or family conferences at http://home.wrha.mb.ca/social-work/files/Guideline_FamilyConference.pdf

- Case conferences are an opportunity to review the pyscho-social assessment , complete or update consent form(s) and collect materials and documents relating to the CLDS participants history or diagnostic needs;

- Recommend other appropriate individuals who should attend future case conferences;

- Provide advice on the need for further assessment of the CLDS participant if required;

- Provide advice based upon professional expertise on potential or alternative interventions;

- Identify timely and appropriate services and resources within their individual field of expertise;

- Proactively facilitate and participate in problem-solving;

- Follow-up on any agreed upon action;

- Develop timely transition plan, considering whether an interim option will timely expedite a safe transition;

- After the initial sharing of information for the first case conference, other members of the team may work directly with the CLDS participant, gather more information from health or case records and distribute further information at the subsequent team meetings in order to most effectively coordinate services; **however it is imperative that the HSW and CSW are kept informed.**

7.4 Ongoing Responsibilities of the HSW and CSW:

- Coordinates a service plan based upon the recommendations from the case conferences;
- Ensures team members are assigned or take responsibility to complete agreed upon tasks, referrals, etc. to appropriate service providers and helps arrange for service delivery. If this is not being done in a timely fashion, the HSW will inform and/or consult his or her relevant Manager(s);
- Shares information with the interdisciplinary health care team and community members and other service providers as authorized, organized and required;
- Consults, with the CLDS participants' consent, regarding service provision, other needs, and progress on a regular basis;
- Consults, with the CLDS participant's consent, with participant's family, friends and support networks on a regular basis;
- Consults with service providers on a regular basis;
- Evaluates and monitors the implementation and progress of the service plan within defined time lines;

- Reports progress and presents findings back to the CSW and health care team if the plan requires adjustment, especially if the EDD changes or if the CLDS participant has been assessed as ready for discharge;
- Ensures accurate recording of information in the CLDS participant's health record ;
- Ensures all team members are clear on who is responsible for decision making, funding requests, etc;
- When there is conflict or delays, ensure timely consultation with respective Manager(s).

8.0 SOLUTIONS AND BARRIERS

8.1 Urgency in the Emergency Department

If a CLDS participant is in an Emergency Dept and will not be admitted to the hospital or health facility, but upon assessment there appears to be significant issues, for example the patient is not admitted to the hospital and the care provider is declining to take the individual home, the HSW will escalate the situation to his or her Hospital Manager (s) who will contact the relevant CLDS office for urgent case conferencing.

8.2 Potential Solutions to Common Transition Barriers

Potential Challenges	Possible Solutions-Community Community Service Worker (CSW) Lead	Possible Solutions-Acute Care Hospital Social Worker (HSW) Lead
No timely disposition and/or discharge	• Follow algorithm/escalation process • Case conference (in person)	• Follow algorithm/escalation process • Case conference (in person)
No community placement identified	• Explore vacancies in consultation with CSR (rural CSW will consult with Regional Program manager), Residential care licensing to be consulted to ensure licensing and city by-laws are considered. • CSR/Regional Program manager approach appropriate agency to develop a new placement if participant cannot be accommodated in existing vacancies. Residential Care	• HSW may explore WRHA Home Care or Mental Health program options if individual is eligible for these programs *Home Care/Community Mental Health program can offer the following potential services, where relevant:(1) act as a case manager, (2) help explore what services are required and by whom, (3) provide a monitoring role in community, (4) or be available for clinical discussion, and/or clinical expertise at a case*

	Licensing to be consulted to ensure licensing and city by-laws are considered. • If all community placement options have been exhausted, CSW to consult with Supervisor and Program Specialist regarding possible referral to St. Amant or the Manitoba Developmental Center (* a court order is required for placement in a developmental center) • If the participant's mental health is considered too unstable to be managed by care provider/service provider, consult with HSW and team in regards to a referral to Selkirk Mental Health Center. • Identify when a participant's care needs appear to exceed CLDS and community resources and request that they be assessed for long term care (i.e. personal care home) http://www.gov.mb.ca/health/pcs/) .	*conference.* • If CLDS participant requires 24 hour nursing services and meets the eligibility requirements, refer for assessment to Long Term Care (see: http://www.gov.mb.ca/health/pcs/).
• Significant training of caregiver/community agency staff required	• CSW will assist HSW in coordination of caregiver/agency staff training while participant is hospitalized. CSW and team will identify ongoing training needs that may be required after transition is completed and the resources	• HSW to arrange with Clinical Manager when staff can come into hospital for training or when hospital staff could go into community, and/or with Home Care arrange training

	required to address those needs prior to discharge.	
• Planning is delayed or plan changes	• Follow algorithm/escalation process (if appropriate) • Case conference (in person) • CSW to discuss concerns with CLDS supervisors and consult with appropriate departmental and agency staff as appropriate.	• Follow algorithm/escalation process • Case conference (in person) • HSW to discuss concerns with relevant Manager(s)
• Difference in opinion of readiness for discharge due to medical, behavioral or mental status	• CSW to discuss concerns with CLDS supervisors and consult with appropriate departmental and agency staff as appropriate. • Explore: can the care provider/agency safely manage the participant's current medical needs. Do they require additional resource? Identify these concerns and possible solutions to the HSW	• HSW to discuss concerns with relevant manager. • HSW to discuss with hospital collaborative team and explore behavioral planning for 2 week period, bringing results back to the next conference. • Case conference after 2 weeks of consistent monitoring.
• Questioning of participant competency and/or capacity	• Review concerns with HSW.	• Team discussion of pros/cons of requesting psychiatric assessment.

9.1 APPENDIX A

WIS SERVICE COORDINATION CONSENT FORM

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

SERVICE COORDINATION CONSENT FOR RELEASE OF PERSONAL INFORMATION AND/OR PERSONAL HEALTH INFORMATION

Section 1. Purpose of the Consent

I consent to sharing of my personal information and/or personal health information between the agencies indicated below. The purpose of sharing information about me is to allow the service providers from each agency to discuss my situation and develop a complete service plan that will address my health and social service needs.

Section 2. Confidentiality

I understand that the information shared will be on a need to know basis only. It is also my understanding that each of the participating agencies will maintain confidentiality over the information in accordance with standard agency policies, legislation such as *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA) and other applicable legislation.

Section 3. Organizations/Agencies Included in the Planning Process

Please specify organization/agency (e.g. Family Services and Housing, Winnipeg Regional Health Authority, or other agency) and program (e.g. Child and Family Services, WRHA Home Care) within each organization/agency and name of service provider:

Name of Organization/Agency:	Program:	Service Provider:

Section 4. Expiration of Consent

This consent shall start on the date that I sign this form and will automatically end one year later. I know that I can withdraw my consent or make changes to it at any time by contacting my lead service coordinator. I also understand that none of the organizations/agencies can share my personal information or personal health information without obtaining another consent from me unless required by law.

Section 5. Questions

Should you have any questions about how your personal information or personal health information is being used, please discuss your concerns with your service provider.

Section 6. Signature

Service Recipient Name: _____ DOB: _____

Street Address: _____

City: _____ Postal Code: _____

Service Recipient Signature: _____ Date: _____

Section 7. Consent on Behalf of Service Recipient in accordance with Section 60 of the Personal Health Information Act.

I _____ am exercising the rights for the service recipient in accordance with *The Personal Health Information Act*, Section 60.

A by any person with written authorization from the individual to act on the individual's behalf;

B by a proxy appointed by the individual under *The Health Care Directives Act*;

C by a committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf;

D by a substitute decision maker for personal care appointed for the individual under *The Vulnerable Persons Living with a Mental Disability Act* if the exercise of the right related to the power and duties of the substitute decision maker;

E by the parent or guardian of an individual who is a minor, or if the minor does not have the capacity to make health care decisions; or

F if the individual is deceased, by his or her personal representative.

Consent on Behalf of Service Recipient in accordance with The Freedom of Information and Protection of Privacy Act.

I _____ am exercising the rights for the service recipient in accordance with *The Freedom of Information and Protection of Privacy Act* Section 79.

A by any person with written authorization from the individual to act on the individual's behalf;

B by a committee appointed for the individual under *The Mental Health Act* or a substitute decision maker appointed for the individual under *The Vulnerable Persons Living with a Mental Disability Act*, if the exercise of the right or power relates to the powers and duties of the committee or substitute decision maker;

C by an attorney acting under a power of attorney granted by the individual, if the exercise of the right or power related to the powers and duties conferred by the power of attorney;

D by the parent or guardian of a minor when, in the opinion of the head of the public body concerned, the exercise of the right or power by the parent or guardian would not constitute an unreasonable invasion of the minor's privacy; or

E if the individual is deceased, by the individual's personal representative if the exercise of the right or power relates to the administration of the individual's estate.

Signature: _____ Date: _____ Telephone # _____

9.2 APPENDIX B

INTERDISCIPLINARY ROUNDS ACTION LOG

Interdisciplinary

Rounds Action Log
Approved Initiative of the
Winnipeg Regional Health Authority

Admitting Diagnosis: _____

Hospital/Facility Admission Date: _____

Admission Unit: _____ / _____
(expected length of stay)

Transfer to:

_____ / _____ / _____
(location) (date) (expected length of stay)

_____ / _____ / _____
(location) (date) (expected length of stay)

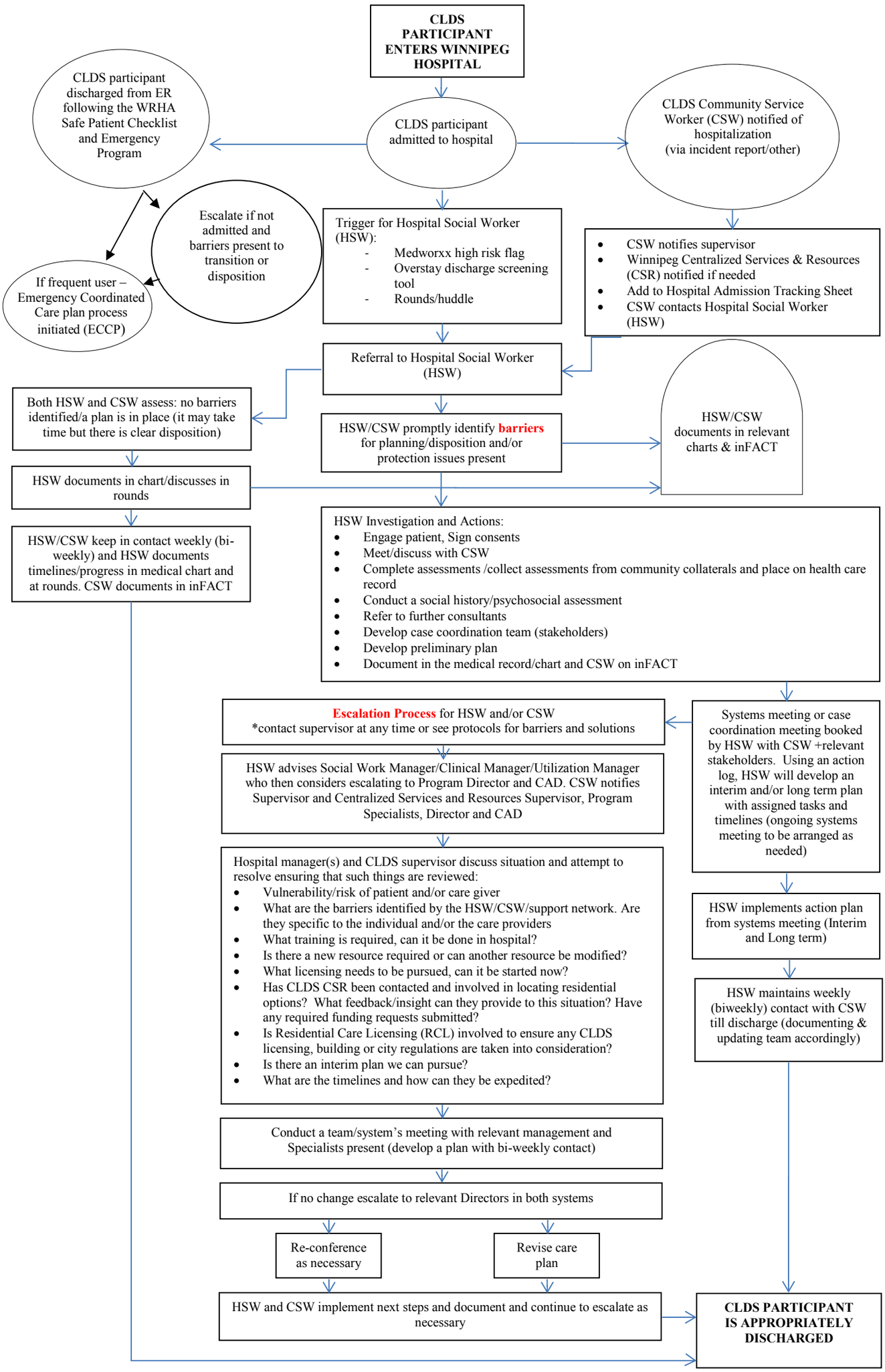
_____ / _____ / _____ Page: _____ Discharge Date: _____
(location) (date) (expected length of stay)

Date/ Time (M/D/Y)	**Issue(s)/Recommended Action(s)** (Signature/Classification)	Assigned **Date(s)** (M/D/Y)	**Discipline(s) Responsible**	Date(s) Completed & Signature(s) (M/D/Y)

Date/ Time (M/D/Y)	**Issue(s)/Recommended Action(s)** (Signature/Classification)	Assigned **Date(s)** (M/D/Y)	**Discipline(s) Responsible**	Date(s) Completed & Signature(s) (M/D/Y)

9.3 APPENDIX C

CLDS WRHA ALGORITHM



9.4 APPENDIX D

GOING TO THE EMERGENCY ROOM DEPARTMENT

My Participant is Going to the Emergency Room
How Can Case Managers Be Involved?

Someone you are supporting will be imminently visiting the ER →

→ You have concerns about the complexity of the situation and want to support health concerns to be assessed during the ER visit

-I'm concerned about other symptoms or behaviors that may not be obvious
-there is a lot going on in community that the staff may need to know
-there is history that impacts the success of care…

←

STOP

Do you have consent to share information?

↓

Options:

Attend the ER and connect directly with staff and assist the individual to share what they want the staff to know

Call the ER: request to speak to: 1) the Emergency Room Physician 2) Emergency Room Social Work →

Fax ER Social Work with written information to attach to the chart (can be sent prior to or after arrival)

"I have some information that may be useful in your assessment of _____."

- Describe your role, what you've noticed, your concerns, related prior medical or social information, medications, and information on living conditions if impacting the health concern
- Regular doctor's name and contact information
- Contact information for yourself and family or other supports
- Information on available medical reports or assessments that have been done (*provide copies if possible*)
- Explain what you hope will come from the assessment in hospital

↓

If the ER visit connects to an issue that a Doctor in community can emphasize or explain, contact the Doctor so they can contact the Emergency Room Physician if they wish.

Strategies to Prepare for Collaboration with Hospital Staff

- Have participants sign consent to share information with hospital staff. Identify any information the participant does not want shared.
- Have information on all involved supports including family easily accessible. Know who has information that is useful for assessments.
- Regularly document your interactions with participants *(acts as historical information to assist assessments)*.
- Connect the participant with a Doctor in community and develop a strong working relationship with involved health providers.
- Gather hospital contact information, including fax numbers.

→ **Your Participant's Chart**

-Planning and goals
-Risk assessment
-Behavior changes
-Changes in ability to complete tasks
-Participant concerns
-Other supports & contacts