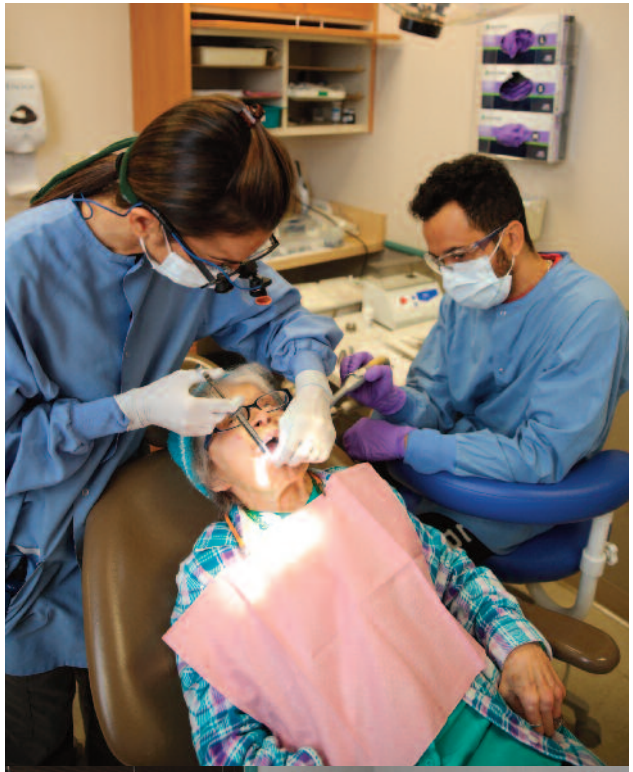

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Office for People With Developmental Disabilities

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Providing Medical Care for People with Developmental Disabilities

(866) 946-9733 | NY Relay System 711

www.opwdd.ny.gov

When people with developmental disabilities need medical care, the following information can make the visit a success.

In some cases, individuals with developmental disabilities may need others to communicate with their health care providers about their abilities, needs, diagnosed condition(s), and current or prior treatments. For example, an individual may rely on others to communicate their current medication/medication dose regimen and medication allergies. Communication with the individual, with the individual's friends and family and/or with their providers of services is critical for gathering this information.

Health care staff may also reference information contained in a document called the **"Ready to Go"** packet. "Ready to Go" packets, which provide vital details about a person's medical status, contact information, ability to consent to treatment and other critical information, are available to healthcare providers when a person receiving services from the Office for People With Developmental Disabilities (OPWDD) visits the hospital for care.

What is a Developmental Disability?

A developmental disability is a lifelong condition that results in the individual experiencing significant deficits in adaptive or daily functioning. Various conditions constitute a developmental disability and therefore people with developmental disabilities may present with a wide range of skills, abilities, needs, and symptoms. Examples of developmental disabilities include intellectual disabilities, cerebral palsy, epilepsy, neurological impairment, Prader-Willi syndrome and autism.

Following are factors to consider when providing medical services to a person with developmental disabilities:

- They may have trouble understanding and following directions or difficulty communicating their thoughts or experiences.
- They may or may not be able to take care of their physical needs independently (e.g., may require assistance with bathing, eating, taking medication).
- They may have difficulty with mobility (e.g., may need support to stand, or may rely upon adaptive equipment).
- They may have behavioral needs and demonstrate unusual behaviors.
- They may have complex medical support needs due to other co-occurring health conditions or simply due to the aging process.

Baseline Functioning and Current Health Status

Upon admission it is important to understand the person's "baseline information or functioning." The healthcare provider should receive information about the person's:

- current medical condition(s)
- allergies
- medications and how they take their medications
- preferred method for communicating (e.g., uses sign language, communication board)
- ability to communicate pain or discomfort
- ambulatory status
- typical behavior
- ability to make decisions
- contact information for the person who provides consent to treatment (this person may be the patient or someone who provides consent on the patient's behalf)

All treatment plans and goals should be designed to help the person return to their baseline, or typical level of functioning.

In rare cases, a person may need a staff person to be present when they are receiving inpatient care. In such instances, a staff member from the residential provider may be present with the individual while they are in the hospital. If staff is present, they may perform duties such as communicating on behalf of the individual, but the staff may not perform duties that fall under the responsibility of hospital staff. If a staff person is not present, the hospital will be informed of the point of contact at the individual's home or place of residence so that this point of contact can assist the hospital in designing a plan that will support the person as they return to their typical level of functioning.

Hospital Discharge Planning

Discharge planning requires communication and collaboration between the hospital's patient care team and the person's residential and support team to reduce the risk of readmission.

This includes:

- identifying any changes in the patient's level of functioning
- identifying conditions that require coordination of care, such as acquiring adaptive equipment
- medical supplies and ambulatory devices
- preparing for dietary or medication changes.

Advanced planning and coordination is critical for the patient to access appropriate supports and treatment, and to ensure that caregivers have the necessary training to carry out discharge orders prior to the person returning to their home. A copy of the full discharge summary must be provided by the hospital to the patient and to the point of contact for the patient.

For additional information contact Nursing/Health Services at OPWDD at 518-474-5673