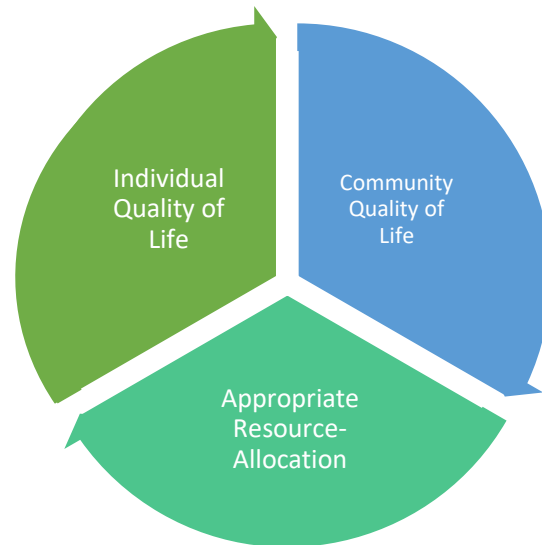




WHAT IS IDD CARE MANAGEMENT? And What Does It Mean To Me?



Everyone has a “health-resource community” -- those individuals, organizations, entities and environments (including the patient and their family) that have any involvement or influence -- actual, virtual or potential -- on the variables that influence their health and well-being.



In our current systems of practice, the responsibility for the elements of any patient's care is apportioned independently among different professional disciplines (primary care and specialist physicians, nurses, case managers, therapists, social workers, etc.) who, based on the mental model of their discipline, contributes insights and any related orders or action items.



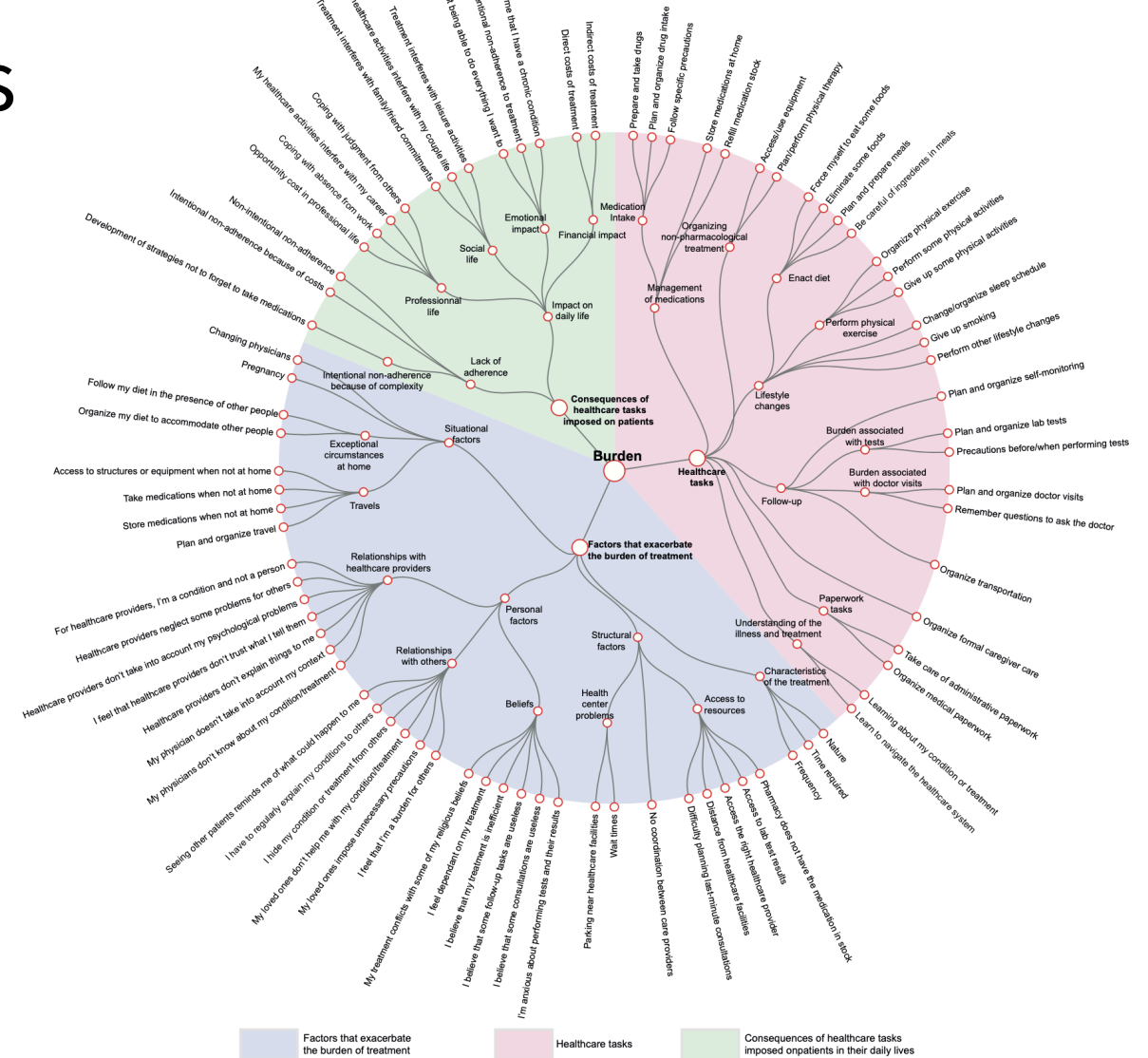
Unfortunately, when decisions are made in isolation of other members of the patient's health resource-community, this can result in conflicting priorities, limited on sharing knowledge, redundancies, mis-communications and even clashes.

Taxonomy of Burden

A multi-country web-based qualitative study of patients with chronic conditions

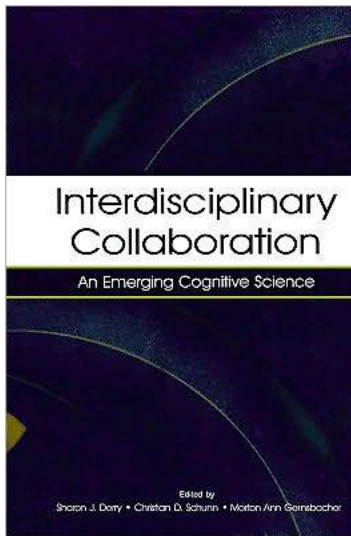
Tran VT et al., BMC Med, 2015

bit.ly/TaxonomyOfBurden



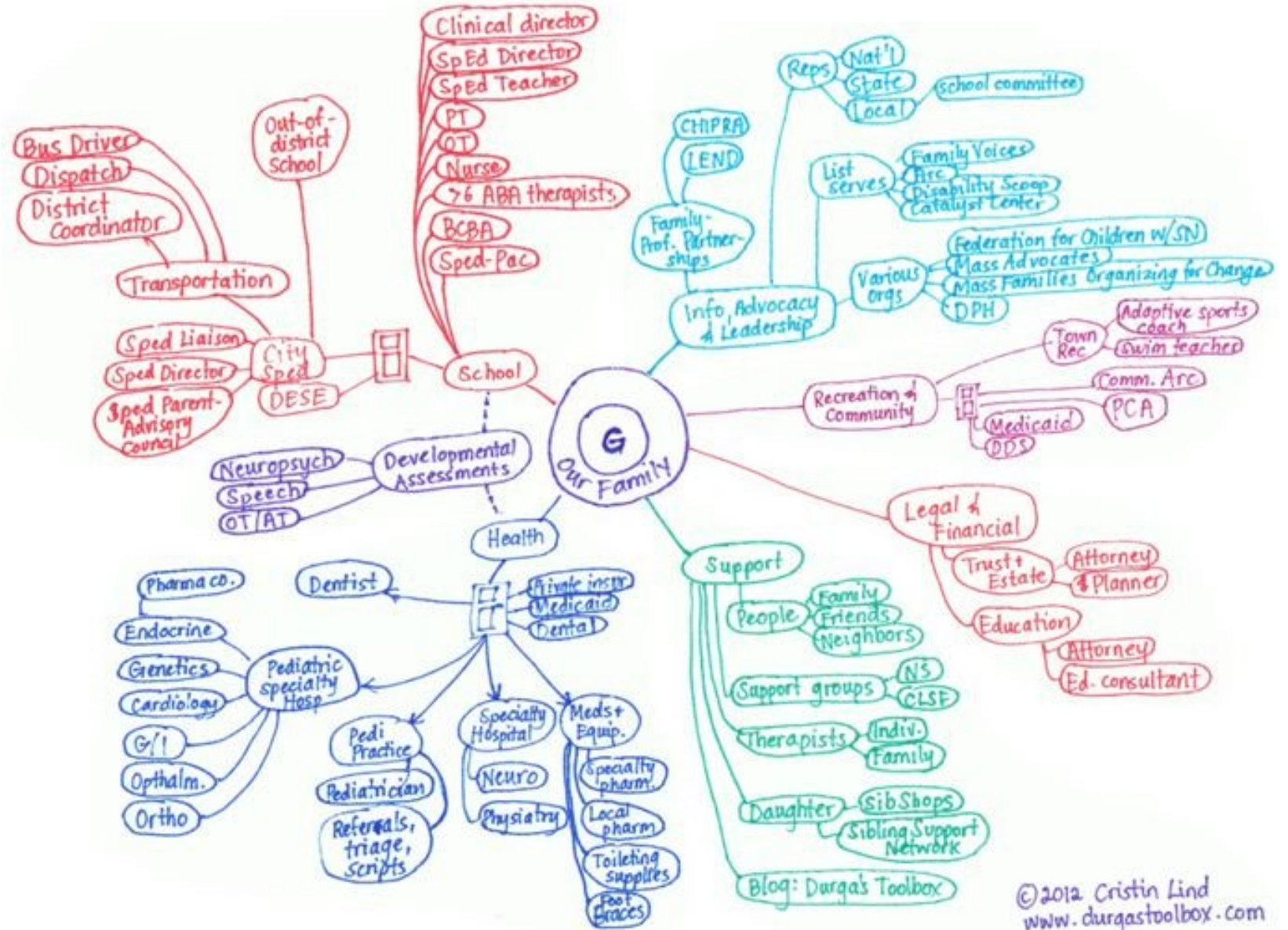
Just because everyone is at the table, does not mean they are connected or coordinated.





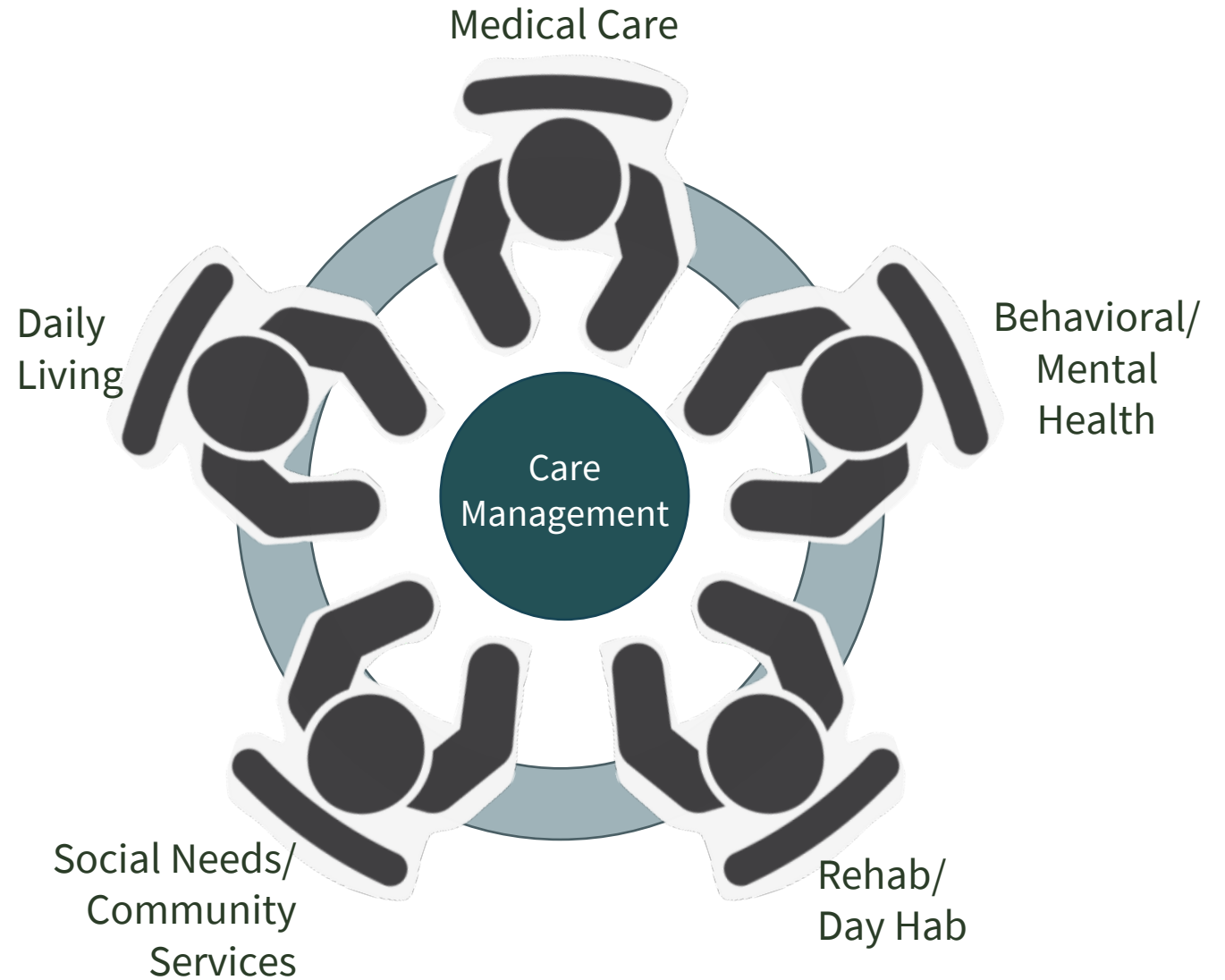
Interdisciplinary is not
synonymous with
integrated.

This is especially true for individuals with IDD



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Integration is the critical success factor for optimal outcomes



Example: Polypharmacy

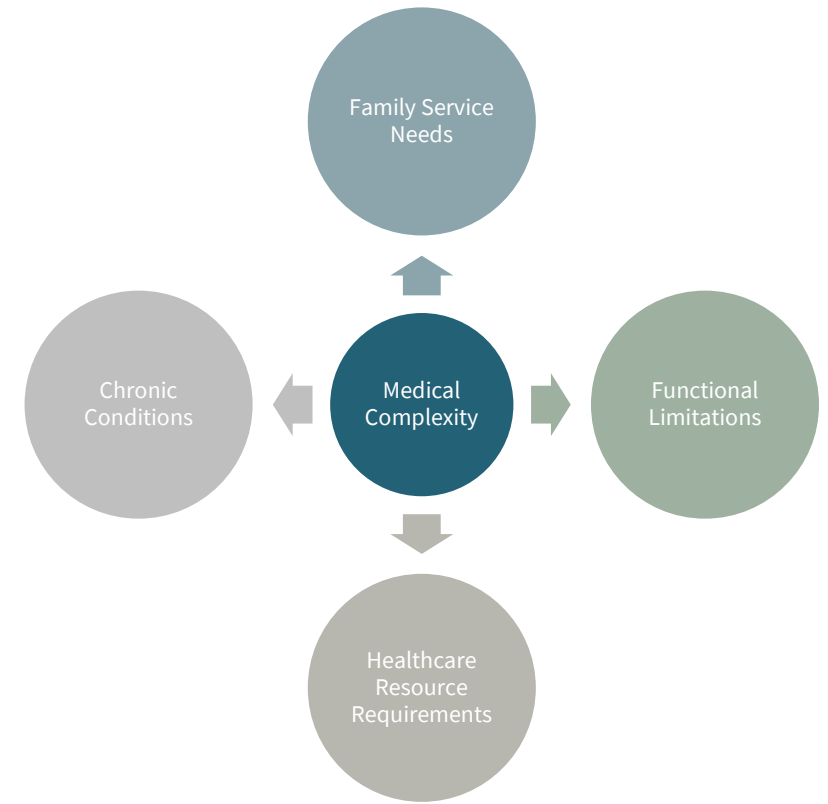
- Of a cohort of 700+ individuals with intellectual or developmental disability (IDD), 20% of them had significant polypharmacy, defined as being on 10 or more prescription medications
- Individuals with IDD are 2.5 times more likely to be admitted to the hospital for an adverse drug event than the nondisabled population
- In an analysis of the 20% group, 57% were found to have moderate or high risk for known adverse drug-drug or drug-disease interactions
- That group also had an average of X.Y prescribers
 - Over 50% of the members of their resource community were otherwise unaffiliated, other than their relationship to the patient

Health Disparities in Individuals with Intellectual and Developmental Disabilities

- Individuals with intellectual and developmental disabilities (IDD) face a number of social and systemic challenges to their health, well-being, and quality of life.
 - The National Council on Disability has called on HHS and the NIH to recognize people with IDD's as a distinct health disparity group

- In addition to shorter life expectancy and prevalence of chronic conditions, they face stigma, exclusion, and inadequate access to disability-competent services that accommodate common challenges

- Communication/Cognitive
- Sensory
- Adaptive Functioning
- Capacity for Self-Care
- Mobility



Individuals with IDD are, by definition, medically complex.

By Monika Mitra, Linda Long-Bellil, Ian Moura, Angel Miles, and H. Stephen Kaye

OVERVIEW

Advancing Health Equity And Reducing Health Disparities For People With Disabilities In The United States

ABSTRACT Definitions of *disability* have evolved over time. Consistent with the biopsychosocial model used by the World Health Organization, we conceptualize disability as an interaction between a person's functional impairments or chronic health conditions and the physical and social environment. Having a disability is not synonymous with poor health, and maintaining and improving health is equally important for both people with and people without disabilities. In this article we review estimates of disability prevalence in the US and present evidence of differences in prevalence by race, ethnicity, and sexual orientation; health disparities by disability status and type of disability; and health disparities for people whose disability intersects with other forms of marginalization. We suggest policy changes to advance equity, reduce disparities, and enhance the health and well-being of all Americans with disabilities.

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NO. 10 (2022): 1379-1386
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While the IDD community champions a “person-centered” approach to life and care planning, the fact is that there are some common patterns and challenges facing individuals with IDD and their circles of support that could be addressed at the systems level with “disability-competent” care and services tailored to their needs

The data is quite clear: we can increase the scope and power of care...and ensure better outcomes...by orchestrating the actions of an individual's health resource-community (irrespective of any formal affiliations or lack thereof) and actively manage the system-level context in which they work.



Care Management is....

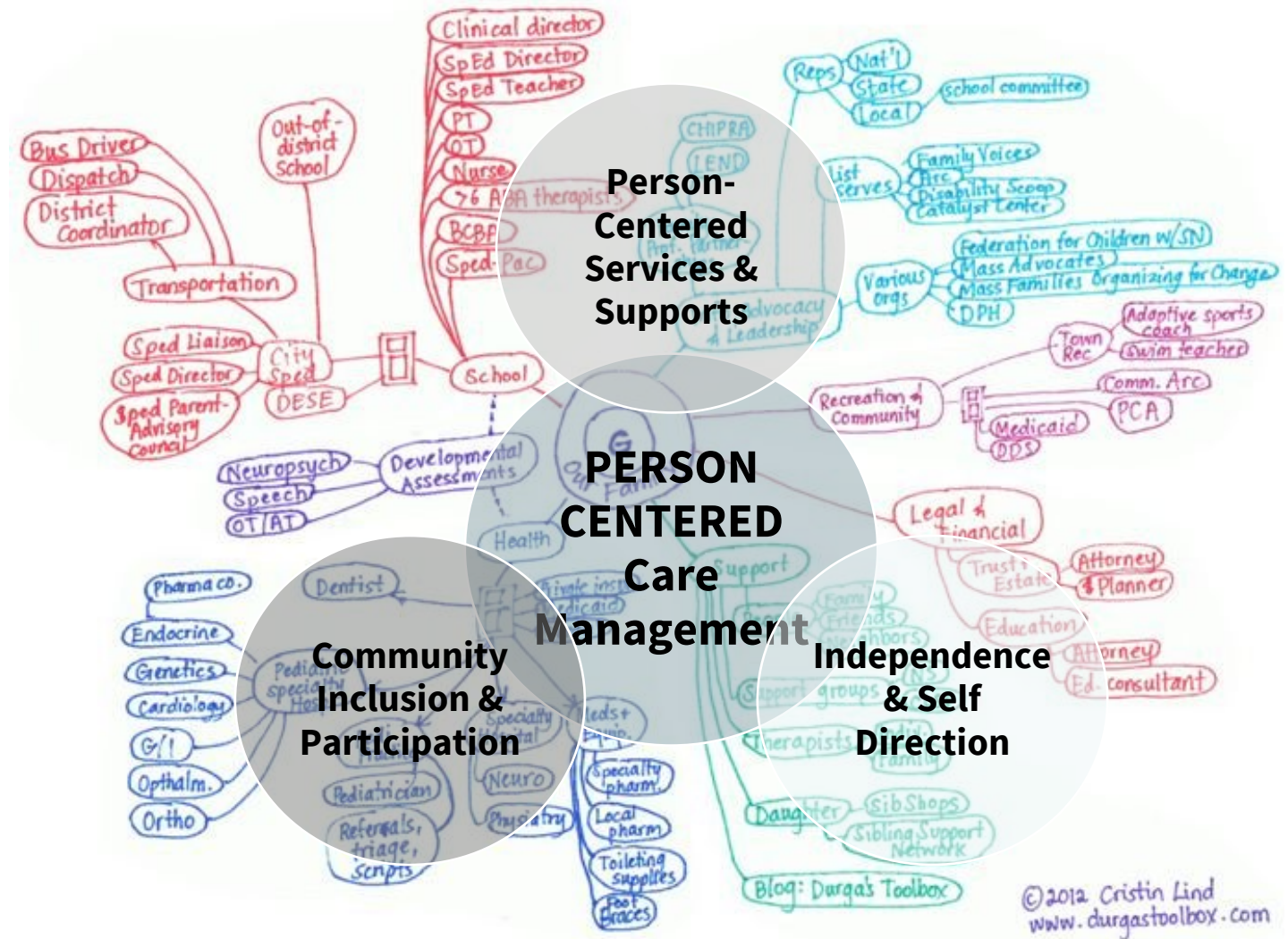
- A team-based, approach designed to assist patients and their support systems in managing their conditions more effectively
 - Condition is generally refined as a gap, shaped by one or more etiological determinants, between the current state of their health, well-being or quality of life and some aspirational future state
 - These conditions care relate to lifestyle, prevention, risk reduction, condition management, or palliation
 - It encompasses those activities needed to assess,, plan, access and orchestrate the resources necessary for condition-related goal achievement
- In general, care management is driven by one or more key strategies
 1. Identify population(s) with modifiable risks;
 2. Align CM services to the needs of the population(s); and
 3. Identify, prepare, and integrate appropriate personnel to deliver the needed services.

Core Care Management Competencies

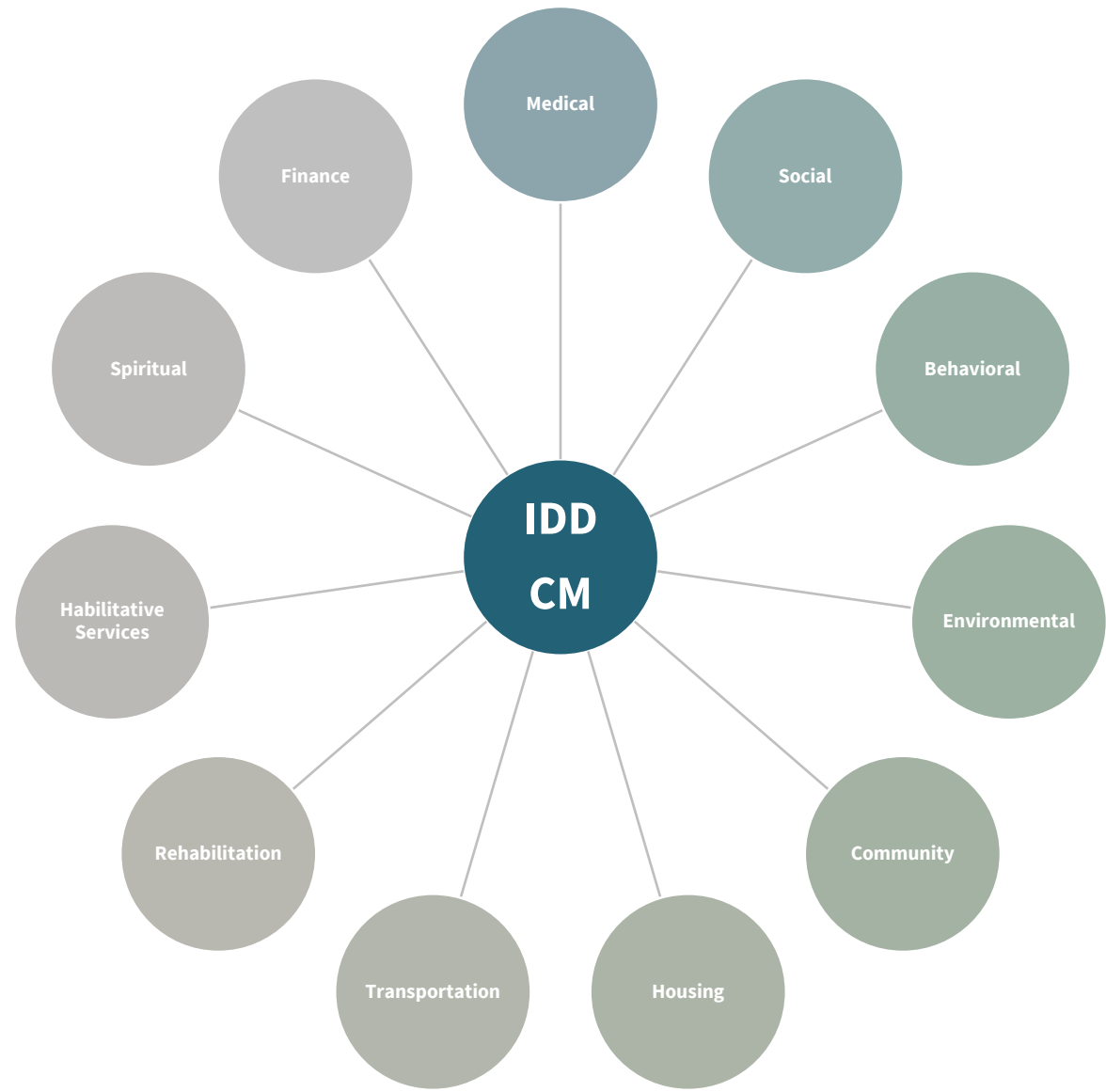
- **Assessments** of multiple domains of the patient and family conditions, and aggregation of other assessment data from other members of the patient's health resource community
- **Comprehensive care planning** that takes into consideration all data, observations, and collateral information identified in the assessment process, including patient aspirations and wishes.
- **Knowledge of the patient's benefits and resources,** including entitled and accessible resources as well as the breadth and depth of their health-resource community
- **Advocacy** as demonstrated by tenacious efforts to access, procure and orchestrate the benefits and resources required for care plan goal achievement

Care management activity	Disease Management	Utilization Management	Health care Navigation
Main Function	<ul style="list-style-type: none"> Provision of evidence-based care 	<ul style="list-style-type: none"> Reduction of unnecessary health care utilization 	<ul style="list-style-type: none"> Removal of structural barriers to care
Target Population	<ul style="list-style-type: none"> Patients with chronic conditions 	<ul style="list-style-type: none"> Patients at high risk for frequent emergency department, hospital, and postacute care use 	<ul style="list-style-type: none"> Patients facing difficulties accessing and/or coordinating care
Core Competencies	<ul style="list-style-type: none"> Translate clinical knowledge into care processes Ability to support patients' self-management 	<ul style="list-style-type: none"> Data analytics Clinical triage 	<ul style="list-style-type: none"> Resource identification Customer service
Risks and limitations	<ul style="list-style-type: none"> Little focus on social determinants Little emphasis on cost performance May not involve patient-centered processes 	<ul style="list-style-type: none"> Inadvertent reductions in appropriate or necessary care Under- or overemphasis on "super-utilizer" patients • May not involve patient-centered processes 	<ul style="list-style-type: none"> Excess resources expended without benefit. Little emphasis on cost performance May emphasize patient-centeredness at the expense of quality or cost performance

How is IDD Care Management Different?



**IDD CARE
MANAGEMENT
ORCHESTRATES
ASSESSMENT
PLANNING, AND
RESOURCE ACCESS,
and ADVOCACY
FOR THE PERSON**



Core IDD Care Management Competencies

<p>Assessment</p>	<p>In addition to aggregating assessment data from the members of a patient's health resource community, IDD Care Managers use IDD specialized assessment tools to review of the individual's physical and emotional health, cognitive abilities, housing, environment, finances, functional status, and social support system, preferences and aspirations</p>
<p>Care Planning</p>	<p>Care planning uses the assessment data under a shared decision-making model to prioritize goals across all the person-centered domains, including but not limited medical, behavioral health and rehabilitation but also skills development, support for strengths and interests, security, community, relationships, choices, and goals.</p>
<p>Benefits and Resources</p>	<p>IDD Care Managers are resource-neutral, and simply seek to bring all available resources to bear in their clients needs and goal achievement; as such they are intimately aware of all available benefits and resources, independent of public, non-governmental or private locus of control</p>
<p>Advocacy</p>	<p>IDD Care Managers prime directive is to support and advocate for the needs and rights of their clients under appropriate regulation, contractual obligation or , even if in conflict with their employers organizational policies.</p>

Working with an IDD Care Manager

- IDD Care Management is grounded in a “shared care” person-centered model independent of institutional affiliation
- IDD Care Managers augment your staff with specialized skills and experience
- Treat them as resources available to support your decision and actions
- Leverage their knowledge to improve efficiencies and effectiveness of your operations
- Trust them to communicate and be accountable for their actions



IDD Care Manager Core Competencies

1. Comprehensive Care Management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services as appropriate
6. The use of information technologies to link services, as feasible and appropriate.

Comprehensive Care Management

- A comprehensive health assessment that identifies medical, mental health, chemical dependency, developmental disability and social service needs.
- The individual and their family/representative and those chosen by the individual should play a central and active role in the development and execution of their Life Plan. Parties should agree with the goals, interventions, and time frames contained in the Life Plan.
- The individual's Life Plan
 - integrates the continuum of medical, behavioral health services, rehabilitative, long term care, developmental disability and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), developmental disability providers, Care Manager and other providers directly involved in the individual's care.
 - clearly identifies primary, specialty, behavioral health, developmental disability, and community networks and supports that address their needs.
 - clearly identifies family members and other supports involved in their services. Family and other supports are included in the Life Plan and execution of care as requested by the individual.
 - clearly identifies goals and timeframes for improving their health and health care status, independence and community integration, and the interventions that will produce this effect.
 - must include outreach and engagement activities that will support engaging the individual in care and promoting continuity of care.
 - includes periodic reassessment of their needs and clearly identifies the individual's progress in meeting goals and changes in the Life Plan based on changes in need.

Adapted from: NYS Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. Version 2018-1 August 2018

Care Coordination and Health Promotion

- The IDD Care Manager provider is accountable for engaging and retaining the individual in coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating the individual's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, developmental disability, long term services and supports, and social and community services where appropriate through the creation of an individualized Life Plan.
- The IDD Care Manager
 - will be responsible for coordinating all aspects of their care and overall management of the Life Plan.
 - must communication with clinicians on an as needed basis, changes in the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
 - will document care decisions when conflicting treatment is being recommended or provided.
 - supports effective collaborations between primary care, specialists, behavioral health and developmental disability providers, referrals, follow-up and consultations that clearly define
 - supports continuity of care and health promotion through the development of a treatment relationship with the individual and their Interdisciplinary Team (IDT), known as the care planning team.
 - supports care coordination and facilitates collaboration through follow-up consultations the establishment of regular case review meetings (i.e. Life Plan review), including all members of the care planning team on a schedule determined by the IDD Care Manager and the individual.
 - ensures twenty-four (24) hour/seven (7) days a week availability to a Care Manager to provide information and emergency consultation services.
 - will ensure timely access to appointments for individuals to medical and behavioral health care services within their IDD Care Manager provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
 - promotes evidence based wellness and prevention by linking individuals with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on the individuals needs and preferences.

Adapted from: NYS Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. Version 2018-1 August 2018

Comprehensive Transitional Care

- The IDD Care Manager
 - has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the IDD Care Manager prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
 - has policies and procedures in place to support individuals experiencing transitions from school to adult services, life changes (employment, retirement, other life events), or when an individual is electing to transition to a new IDD Care Manager provider or to a new Care Manager within the same IDD Care Manager.
 - has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/habilitation providers and community-based services to help ensure coordinated, safe transitions in care for individuals who require transfers in the site of care.
 - utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the individual and/or their family/representative, and local supports.
 - has a systematic follow-up protocol in place to ensure timely access to follow-up care post discharge that includes at a minimum, receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, Care Manager verification with outpatient providers that the individual attended the appointment, and a plan to outreach and re-engage the individual in care if the appointment was missed.

Adapted from: NYS Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. Version 2018-1 August 2018

Individual and Family Support

- The individualized Life Plan must reflect the individual's and their family/representative's preferences, education and support for self-direction, self- help, and other resources as appropriate.
- The individualized Life Plan is accessible to the individual and their family/representative and is based on the individual's preference of either electronically and/or via mail.
- The IDD Care Manager
 - utilizes peer supports, support groups and self-care programs to increase the individual's and their family/representative's knowledge of their disease, engagement and self-management capabilities, and improves adherence to prescribed treatment.
 - discusses advance directives with individuals and their family/representative.
 - communicates and shares information with individuals and their family/representatives with appropriate consideration for language, literacy and cultural preferences.
 - gives the individual, and if they agree, their family/representative access to the Life Plan and options for accessing clinical information.

Adapted from: NYS Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. Version 2018-1 August 2018

Referral to Community and Social Supports

- The Life Plan should include community-based and other social support services as well as healthcare, long term supports and services and developmental disability services that respond to the individual's needs and preferences and contribute to achieving the individual's goals
- The IDD Care Manager
 - identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
 - has policies, procedures and an accountability structure (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

Adapted from: NYS Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. Version 2018-1 August 2018

Use of Technology to Link Services

- IDD Care Management service must
 - promote access to a Certified Electronic Health Record (EHR) for select care team members
 - participate in a Regional Health Information Organization/Qualified Entity (RHIO/QE) for select health care delivery organizations
 - provide of access to a singular electronic care plan for any care team member/organization consented to by the client
 - have structured information systems, policies, procedures and practices to electronically create, document, execute, and update a Life Plan for every IDD Care Manager enrollee.
- IDD Care Manager has
 - a systematic process to follow-up on tests, treatments, services and referrals, which is incorporated into the individual's Life Plan.
 - an electronic record system which allows the individual's health information and Life Plan to be accessible to the care planning team and which allows for population management and identification of gaps in care including preventive services.
 - make use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.
 - provide the capability for individuals and/or their family/representative, providers, and the State to access, via a secure web-based portal, the Life Plan and to view or upload documents and input information to the Life Plan, including but not limited to, clinical notes, progress notes and other related documentation.
 - provide access for individuals and their family/representative to the Life Plan and other related documentation via a secure portal that includes digital signature

Adapted from: NYS Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. Version 2018-1 August 2018

Why do we need teams?



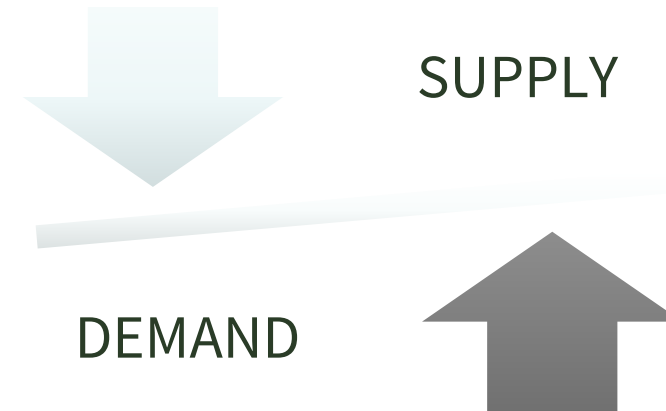
Cross-Role Collaboration Is The Best Practice for System-Level Goal Achievement



Collaboration is a mutually beneficial relationship between individuals or organizations who work toward common goals by sharing responsibility, authority and accountability for achieving results.

Quality requires that demand = capacity

- Demand: number of patients in need of services
- Capacity: number of patients we can serve



Teamwork supports our ability to add capacity

- Improves efficiency
- “Share the care” improves efficiency and revitalizes the experience of care for patients and professionals
- Requires us to think differently

Supported by Professional Associations

Annals of Internal Medicine

POSITION PAPER

Principles Supporting Dynamic Clinical Care Teams: An American College of Physicians Position Paper

Robert B. Doherty, and Ryan A. Crowley, for the Health and Public Policy Committee of the American College of Physicians*

The U.S. health care system is undergoing a shift from individual clinical practice toward team-based care. This move toward team-based care requires fresh thinking about clinical leadership and responsibilities to ensure that the unique skills of each clinician are used to provide the best care for the patient as the patient's needs dictate, while the team as a whole must work together to ensure that all aspects of a patient's care are coordinated for the benefit of the patient. In this position paper, the American College of Physicians offers principles, definitions, and examples to dissolve barriers

that prevent movement toward dynamic clinical care teams. These principles offer a framework for an evolving, updated approach to health care delivery, providing policy guidance that can be useful to clinical teams in organizing the care processes and clinician responsibilities consistent with professionalism.

Ann Intern Med. 2013;159.

For author affiliations, see end of text.

This article was published at www.annals.org on 17 September 2013.

www.annals.org



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Collaboration in Practice: Implementing Team-Based Care

*Report of the American College of Obstetricians and Gynecologists'
Task Force on Collaborative Practice*

Executive Summary

Introduction

Quality, efficiency, and value are necessary characteristics of our evolving health care system. Team-based care will work toward the Triple Aim of 1) improving the experience of care of individuals and families; 2) improving the health

Why is the American College of Obstetricians and Gynecologists taking the lead on this report?

The American College of Obstetricians and Gynecologists (ACOG) felt it was critical that obstetrician-gynecologists take the lead in bringing these diverse but integral specialties

“A unique strength of multidisciplinary teams is that different disciplines and specialties bring distinct training, skills, knowledge bases, competencies, and patient care experiences to the team, which can then respond to the needs of each patient and the population it collectively serves in a patient- and family-centered manner.”

“Team-based care will improve the experience of care of individuals and families but also respond to emerging demands and reduce undue burdens on health care providers. Team-based care has the ability to more effectively meet the core expectations that care be safe, effective, patient centered, timely, efficient, and equitable.”

Good for Patients...

JAMA | **Original Investigation** | INNOVATIONS IN HEALTH CARE DELIVERY

Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost

Brenda Reiss-Brennan, PhD, APRN; Kimberly D. Brunisholz, PhD; Carter Dredge, MHA; Pascal Briot, MBA; Kyle Grazier, PhD; Adam Wilcox, PhD; Lucy Savitz, PhD; Brent James, MD, MStat

IMPORTANCE The value of integrated team delivery models is not firmly established.

OBJECTIVE To evaluate the association of receiving primary care in integrated team-based care (TBC) practices vs traditional practice management (TPM) practices (usual care) with patient outcomes, health care utilization, and costs.

← Editorial page 822

+ Supplemental content

+ CME Quiz at jamanetworkcme.com and CME Questions page 876

American Journal of Preventive Medicine

COMMUNITY GUIDE REVIEW

Team-Based Care to Improve Diabetes Management: A Community Guide Meta-analysis

Timothy W. Leventhal, MPH,¹ Yanan Peng, PhD, MPH,¹ Ka Zang Xiong, MPH,¹ Ziwei Song, MPH,¹ Randy Elder, PhD, MPH,¹ Mohammed K. Ali, MD, MSc, MBA,^{2,3} Marshall H. Chin, MD, MPH,⁴ Pamela Allweiss, MD, MPH,² Christine M. Hunter, PhD,⁵ Alberta Becenti, MPH,⁶ and the Community Preventive Services Task Force

2:00 PM
Time chan

Check for updates

“Among adults enrolled in an integrated healthcare system, receipt of primary care by team-based care practices vs traditional practice management was associated with higher quality of care, lower rates of acute care utilization, and lower cost of care”

“...patients with Type 2 diabetes, team-based care improves blood glucose, blood pressure, and lipid levels.”

Great for Providers

WEB EXCLUSIVE 

Engaging primary care physicians in care coordination for patients with complex medical conditions

Elizabeth Lockhart MSc Gillian A. Hawker MD MSc FRCPC Noah M. Ivers MD CCFP PhD
Tara O'Brien MD Geetha Mukerji MD FACP FRCPC MSc Pauline Pariser MSc MD CCFP FCFP
Ian Stanaitis Laura Pus MBA G. Ross Baker PhD

Abstract

Objective To explore the dynamics of primary care physicians' (PCPs) engagement with the Seamless Care Optimizing the Patient Experience (SCOPE) project.

Design Qualitative study using semistructured interviews.

Setting Solo and small group primary care practices in urban Toronto, Ont.

Participants A total of 22 of the 29 SCOPE PCPs (75.8%) were interviewed 14 to 19 months after the initiation of SCOPE.

Methods Qualitative semistructured interviews were conducted to examine influencing factors associated with PCPs' engagement in SCOPE. Transcripts were analyzed using a grounded theory-informed approach and key themes were identified.

Main findings The SCOPE project provided practical mechanisms through which PCPs could access information and connect with resources. Contextual and historical factors including strained relationships between hospital specialists and community PCPs and PCPs' feelings of responsibility, isolation, disconnection, and burnout influenced readiness to engage. Provision of clinically useful supports in a trusting, collaborative manner encouraged PCPs' engagement in newer, more collaborative ways of working.

Conclusion The SCOPE project provided an opportunity for PCPs to build meaningful relationships, reconnect to the broader health care system, and redefine their roles. For many PCPs, reestablishing connections reaffirmed their role in the system and enabled a more collaborative care model. Strategies for connecting community-based PCPs to the broader system need to consider contextual factors and the effects of new linkages and coordination on the identities and relationships of PCPs.

DISCUSSION PAPER

Implementing Optimal Team-Based Care to Reduce Clinician Burnout

Cynthia D. Smith, MD, FACP, American College of Physicians; **Celynne Balatbat**, National Academy of Medicine; **Susan Corbridge, PhD, APRN, FAANP**, University of Illinois at Chicago; **Anna Legreid Dopp, PharmD**, American Society of Health-System Pharmacists; **Jessica Fried, MD**, Hospital of the University of Pennsylvania; **Ron Harter, MD**, American Society of Anesthesiologists; **Seth Landefeld, MD**, University of Alabama at Birmingham School of Medicine; **Christina Y. Martin, PharmD, MS**, American Society of Health-System Pharmacists; **Frank Opelka, MD, FACS**, American College of Surgeons; **Lew Sandy, MD**, UnitedHealth Group; **Luke Sato, MD, CRICO**; and **Christine Sinsky, MD**, American Medical Association

September 17, 2018

High-functioning teams have tremendous potential to promote clinician well-being, which is foundational to effective and efficient health care. Team-based care presents a unique opportunity to achieve key aims of a high-quality health system. Successful teams have the capacity to improve patient outcomes, the efficiency of care, and the satisfaction and well-being of health care clinicians.

Is this a 5-person team?



Team-based care: culture shift

- Instead of: “What can I do to optimize the care of my patients today?”
- Think: “What can we do to maximize the care of the IDD patients in our network?”



Team-based care

- Culture shift: Share the Care
- Stable “teamlet”
- Transcend location
- Standards of care and operations
- Defined workflows and roles – workflow mapping
- Training, skills checks, and cross training
- Ground rules
- Communication – messaging, task tracking

Discussion

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