

# Strategies for Delivering Person-Centered Care for Individuals with I/DD

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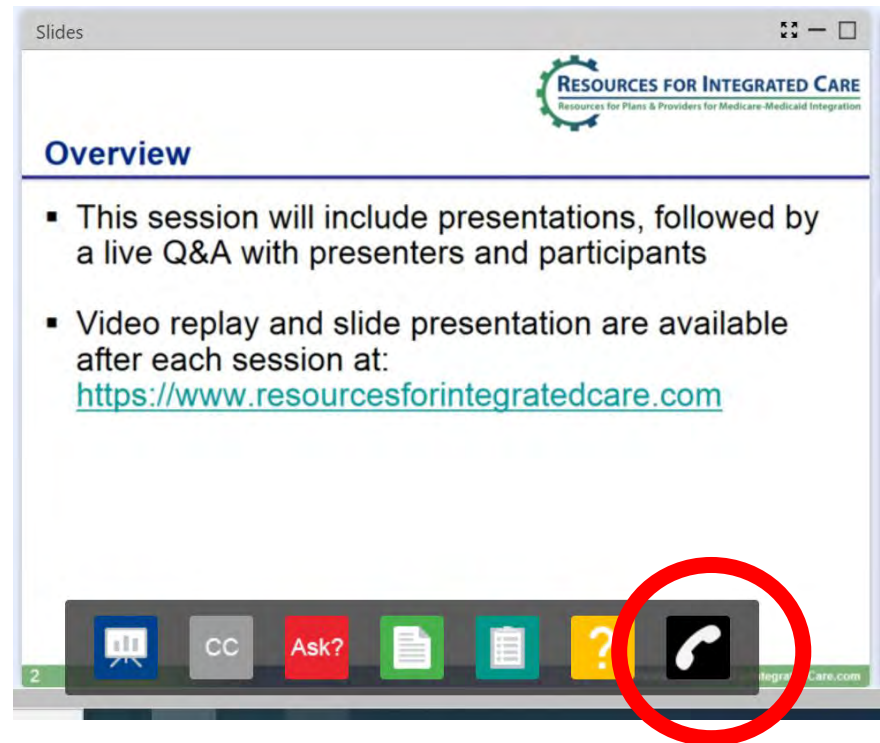
August 9, 2022

# Strategies for Delivering Person-Centered Care for Individuals with I/DD



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**RESOURCES FOR INTEGRATED CARE**  
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## Overview

- This session will include presentations, followed by a live Q&A with presenters and participants
- Video replay and slide presentation are available after each session at:  
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# Overview

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- This session will include presentations and moderated discussions with three subject matter experts in I/DD
- Video replay and slide presentation are available after each session at: <https://www.resourcesforintegratedcare.com>

# Accreditation

- **Individuals are strongly encouraged to check with their specific licensing boards or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.**
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# Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.
- To learn more about current efforts and resources
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# Webinar Outline

- Introductions
- Learning Objectives
- Audience Polls
- Impacting Health Outcomes for People with I/DD by Dr. Emily Lauer, followed by Q&A
- The START Model by Dr. Joan Beasley, followed by Q&A
- A Managed Care Approach to Improve the Quality of Care for Persons with I/DD by Dr. Steve Deutsch, followed by Q&A
- Closing Remarks



# Introductions

## ■ Emily Lauer, PhD

Director, Center for Developmental Disabilities Evaluation and Research (CDDER), Eunice Kennedy Shriver Center



## ■ Joan Beasley, PhD

Director, National Research Consortium on IDD-MH, National Center for START Services



## ■ Dr. Steve Deutsch

Chief Medical Officer, Partners Health Plan of New York



# Moderators

## ■ **Melanie Norris**

Senior Consultant, The Lewin Group



## ■ **John Jansa**

Senior Consultant, The Lewin Group



# Learning Objectives

- Describe the current gaps in care for individuals with I/DD
- Provide strategies for delivering person-centered care for individuals with I/DD through use of innovative care coordination models
- Understand the impact of these strategies on outcomes of care

# Impacting Health Outcomes for People with I/DD

 **UMass Chan**  
MEDICAL SCHOOL | Eunice Kennedy  
Shriver Center

Center for Developmental  
Disabilities Evaluation and  
Research (CDDER)



**Emily Lauer, PhD, MPH**

Director of CDDER

Assistant Professor of Family  
Medicine and Community Health

# I/DD and Health Challenges

- Worldwide, people with intellectual disabilities are known to experience widespread health inequalities and basic human rights violations
- Compared to people without I/DD, people with I/DD are more likely to<sup>1,2</sup>
  - Live with complex health conditions
  - Have poorly managed chronic conditions, such as epilepsy
  - Have limited access to high-quality health care and health promotion programs
  - Receive preventive screenings at lower rates than the general population
  - Experience obesity
  - Have undetected vision, hearing, and dental problems
  - Have mental health problems and be overly-prescribed psychotropic medications

# Current State of Health Care for People with I/DD

- Individuals with I/DD face a multitude of access barriers including:
  - Limited number of specialists who accept Medicaid and Medicare
  - Provider reluctance and lack of education about I/DD
  - Need to navigate complex systems of care
- Inclusion of persons with I/DD in managed care varies; early models have struggled to adequately serve this population
- There are pockets of excellence in community-based care for individuals with I/DD
- Gaps in quality measures for populations with I/DD remain

# Health Service Utilization for People with I/DD

- Individuals with I/DD experience:
  - Greater utilization of emergency department and inpatient services
  - Greater suboptimal utilization (preventable conditions, ambulatory care sensitive)
  - Greater need for community-based care and crisis response for mental and behavioral health conditions
- Reasons why people with I/DD have lower rates of receiving health screenings<sup>3</sup>
  - Fewer referrals for screenings by clinicians
    - Some guardian hesitancy
  - Challenges in physical accessibility, need for desensitization to reduce anxiety
- Creative individualized recommendations can leverage newer technologies and screening options
- Assist beneficiaries and their supporters to understand why they need screenings, what the screenings will entail, and how to make screening appointments that suit their needs

# Managing Health for People with I/DD

Important components in managing health for people with I/DD include:

- Listen to the beneficiary to understand their strengths and needs
- Educate and motivate beneficiaries; improve health literacy
  - [Communicate CARE: Clearly, Attentively, Responsively, Engaging with the patient and others as needed](#)
  - Consider interpersonal influences
- Understand behavior as communication: [HELP model](#)
  - 1) Is it a medical condition? 2) An environmental issue? 3) An aspect of lived experience? If no to all 3, only then is psychiatric disorder considered
- Assess and manage risk
  - Assess for and understand history of adverse life experiences, including abuse and trauma
- Promote patient advocacy

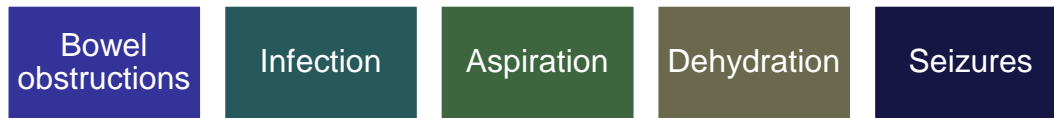


# Management of Chronic Conditions

- Important aspects of chronic condition management include appropriate beneficiary education and inclusion of the beneficiary's circle of support
- Individuals with I/DD need increased assistance to manage chronic conditions, including:
  - Lifestyle changes (e.g., improved diet, daily exercise, smoking cessation)
  - Treatment administration
  - Monitoring
- There are a limited number of chronic condition management programs applicable to people with I/DD
  - As a result, individuals with I/DD experience higher risk of adverse downstream consequences (e.g., Fatal 5, polypharmacy)
- Physicians adhere to key quality components of clinical management of chronic conditions (e.g., diabetes<sup>4</sup>) at lower rates for people with I/DD
  - It is important to ensure people with I/DD are treated with evidence-based practices

# I/DD and Higher Risk of Particular Conditions

- The **Fatal 5** refers to the top five disorders linked to preventable deaths of individuals with I/DD. They include:



- Individuals with I/DD have substantially higher risk of morbidity and mortality due to the Fatal 5, driven by:
  - Comorbidities, prescribed medications, lifestyle factors, need for support from other people for self care, and limited access to medical care
- Preventing the **Fatal 5** requires recognizing:
  - Risks: Assess and mitigate; Educate and support beneficiaries and their caregivers to manage risks
  - Preventive approaches: Ensure hydration, maintain bowel health (diet, exercise, etc.), limit unnecessary medications that sedate, contribute to constipation, infection prevention
  - Signs and symptoms: Recognize, seek prompt care of constipation, infections, aspiration, dehydration
  - Ensure high quality ongoing management of these risks

# I/DD and Polypharmacy

- Polypharmacy prevalence is high among people with I/DD
  - Particularly psychotropic polypharmacy (intra- and interclass)
  - Suboptimal or contraindicated prescription combinations or doses
- Contributing factors include:
  - Additive prescribing across encounters
  - Communication difficulties, labeling or medicating of “behaviors” rather than the root causes
  - Complex presentations of mental health conditions among people with I/DD (e.g., symptoms can be expressed differently compared to the non-I/DD population)
  - Challenges in diagnosing, managing mental health conditions
  - Secondary medications prescribed to manage primary prescription side effects
- There are multiple downstream effects of polypharmacy, including increased morbidity and mortality

# Improving Access, Quality, and Care Coordination for People with I/DD

- Address multitude of access barriers
  - Increase the number of specialists who accept Medicaid and Medicare
  - Overcome provider reluctance by improving provider education and support for caring for people with I/DD
  - Increase resources available to help navigate complex systems of care; simplify systems of care where possible
- Access is not sufficient; Quality of care issues abound (e.g., physician adherence to evidence-based practices)
- Greater need for skilled care coordination within the I/DD population

## Question & Answer



**John Jansa**  
Senior Consultant  
The Lewin Group



**Emily Lauer, PhD, MPH**  
Director of CDDER,  
Assistant Professor of Family  
Medicine and Community  
Health

# The START Model



**NATIONAL CENTER  
for START SERVICES**  
*Institute on Disability / UCED  
University of New Hampshire*

Institute on Disability/UCED



**Joan B. Beasley, Ph.D.**

Research Professor

Director, National Research

Consortium on IDD-MH

National Center for START Services

# Disparities Among People with I/DD and Mental Health Needs

- People with I/DD experience numerous health disparities, including higher rates of mental health symptoms and behavioral challenges, compared to their typically developing peers<sup>5,6</sup>
  - These difficulties are often misdiagnosed, under-diagnosed, or undiagnosed, and even when detected, few evidence-based treatments exist<sup>7,8</sup>
  - This gap has translated into use of costly and ineffective care, resulting in frequent emergency department and psychiatric hospital visits,<sup>9,10</sup> poorer quality of life, and earlier age of mortality<sup>11,12</sup> for individuals with I/DD
- There is little research on best practices for individuals with I/DD, and the population is often misunderstood, underserved, and underestimated

# Systemic, Therapeutic, Assessment, Resources, and Treatment (START) Background

- START is a tertiary care, evidence-based, and evidence-informed model of community-based services for individuals ages 6 and older with I/DD and mental health needs (I/DD-MH)
  - Developed in 1988
  - Cited by David Satcher, MD (2002) in the US Surgeon General's report on mental health disparities for people with I/DD<sup>13</sup>
- Many of the people served through START are dually eligible beneficiaries
- The [National Center for START Services \(NCSS\)](#) trains local community providers in the START model
- START teams provide cross-systems crisis prevention and intervention planning, network partnerships, mental health assessment and coaching, 24-hour crisis response, outreach, and training
  - There are START [program locations](#) in 12 states and 10 state network partners
  - In 2021, START programs served 4,029 people with IDD-MH across the lifespan



# Public Health Model & START: Building Capacity Across the Lifespan

- START is a three-tiered care model that uses a public health approach to build capacity and reduce the use of emergency and crisis services for individuals with I/DD-MH needs

## Stage 1: Prevention

- Determine the level of acuity and address the individual's immediate needs
- Provide hands-on training to providers of direct support, caregivers, professionals, and community participants (e.g., police, emergency room staff)
- Share information and advice among beneficiaries, families, and service providers
- Ensure there is a coordinated continuum of care in place to respond to individuals' needs

## Stage 2: Intervention

- Identify triggers that lead to crises for an individual
- Conduct ongoing assessment of all biopsychosocial factors
- Engage in robust cross-systems crisis prevention and intervention planning
- Integrate health and wellness activities

## Stage 3: Crisis management

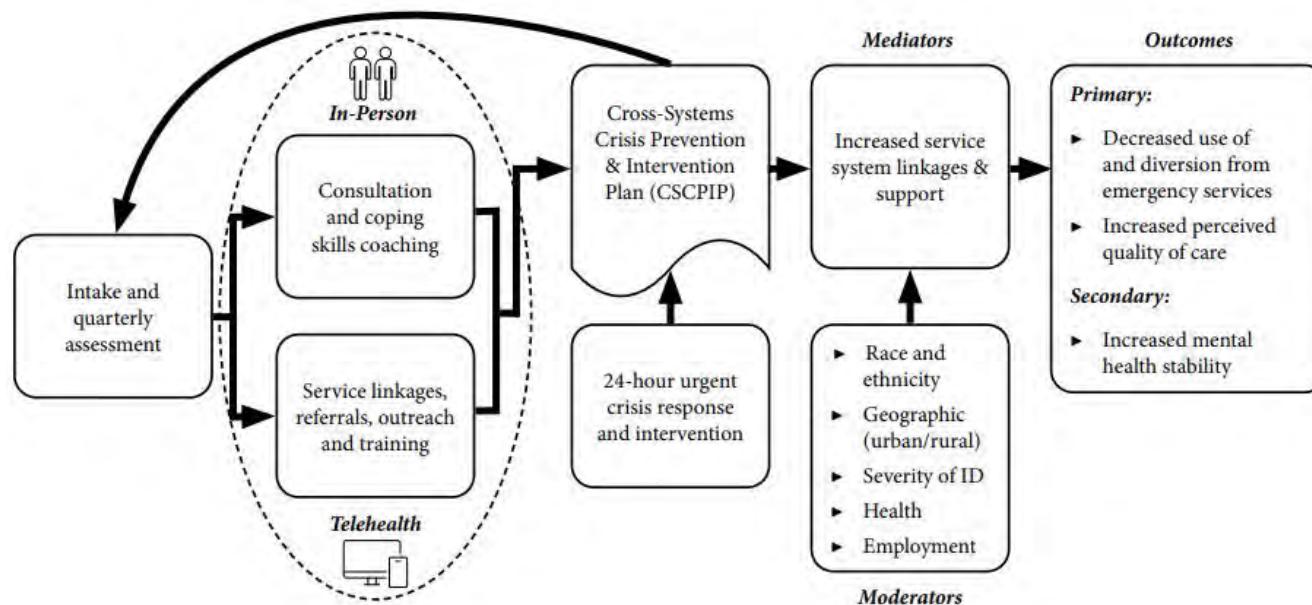
- Proactively manage crises when they do occur through use of:
  - After-hours crisis response
  - In-home emergency supports
  - Crisis stabilization units
- Provide ongoing support, training, and development of newly identified interventions

# START Systems Linkage Model

- START focuses on community linkages and capacity building across the system of care rather than segregated or duplicative service development
  - It is key to build linkages across clinical teams, training and consultation providers, therapeutic resources and services, first responders, policy makers, and other key stakeholders
- By bridging linkages across the system, we can break the siloed care that dually eligible beneficiaries often face, particularly those with I/DD-MH needs
- As a result of these linkages, both Medicare and Medicaid can experience efficiencies and cost savings
  - Acute care utilization is reduced
  - More cost-effective long-term support services can be identified

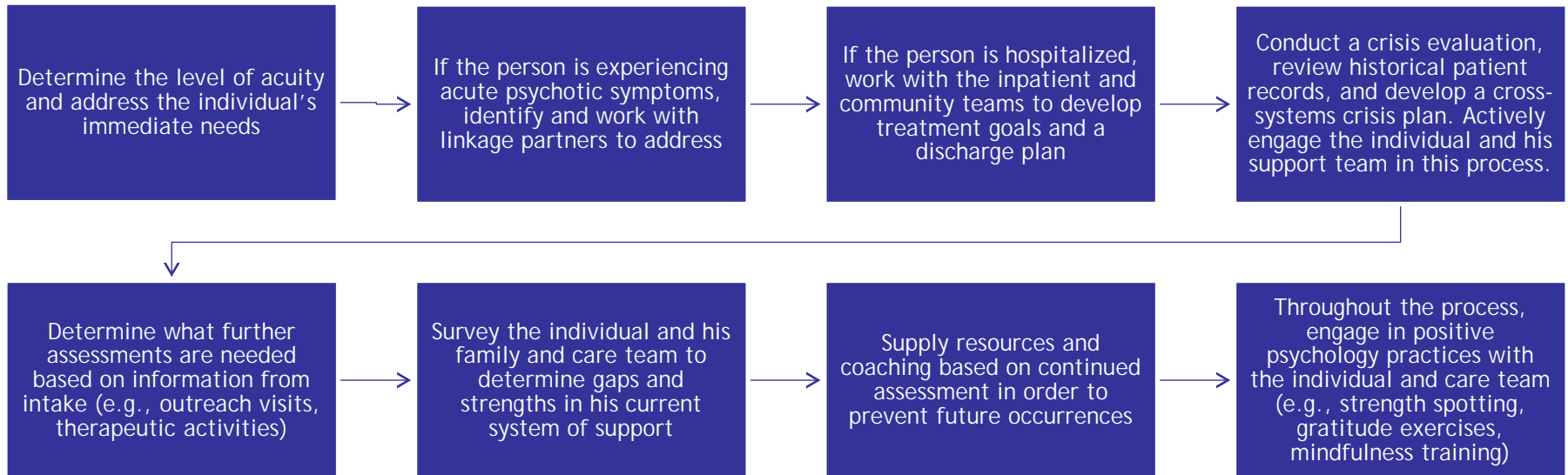
# START Clinical Team Practices Framework

- START is a complex, multi-component intervention with four core components:
  - 1) Intake and quarterly assessments
  - 2) Consultation and MH skills coaching
  - 3) 24-hour urgent crisis response and intervention, and
  - 4) Service linkages, to include referrals, outreach, and training
- The research outcomes include increased capacity in the system of care, decreased use of crisis services, increased satisfaction with services received and increased mental health stability



# Care Study

- **Background:** Mr. D is a 30-year-old male diagnosed with I/DD since age 2, and schizophrenia since the age of 17. Mr. D has periods when he is unable to sleep followed by dysregulation and aggression. The police often bring him to the emergency room.
- **Intervention strategies:**



- **Outcomes:** Mr. D was never readmitted to a psychiatric inpatient unit, although he did use crisis beds at times. His provider and psychiatrist coordinated and adjusted his medications; as a result, his aggressive episodes decreased (they were more likely triggered by seizures than psychosis). Mr. D learned to recognize when he was having an episode, and this helped guide his system of support.

# Improvements in Research & Evaluation

- Health plans should actively engage in data collection and outcomes to ensure best practices for individuals with I/DD
  - For example, collect demographic, clinical, and service outcomes for every person that receives care services
  - Over time, identify best practices based on beneficiaries experiencing positive outcomes
- Working in partnership toward improved research practices is key to improving care services for individuals with I/DD
  - Refer to the [National Research Consortium on Mental Health and Intellectual and Developmental Disabilities \(MHIDD\)](#) which aims to advance research on best practices and policy toward positive outcomes among individuals with I/DD-MH
- Consider funding research about well-being promotion and health and include individuals with I/DD-MH needs in the research

# Useful Resources

- [Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities](#)
  - This guide can be used to improve provider education on important concepts such as:
    - The lived experience perspective of individuals with I/DD
    - Psychiatric assessment considerations
    - Medical assessment considerations, and
    - Best practices in I/DD diagnosis and treatment
  
- [Evaluation of Telehealth Services on Mental Health Outcomes for People with Intellectual and Developmental Disabilities \(PCORI\)](#)
  - This research study (currently underway) compares the outcomes of in-person vs. telehealth START for youth and young adults with I/DD
  - The study engages youth and young adults with I/DD, their family members, and service providers throughout the entire process
  - The results will include practical guidelines on what does or does not work to engage beneficiaries with I/DD and effective crisis intervention methods

# Key Takeaways

- We must attend to what defines the 3 A's of effectiveness:

Access
<ul style="list-style-type: none"><li>• Care must be inclusive, timely, and community-based</li></ul>

Appropriateness
<ul style="list-style-type: none"><li>• Outreach, training, and collaboration are key to improving appropriateness of services</li></ul>

Accountability
<ul style="list-style-type: none"><li>• Outcome measures must be clearly defined, and review of data must be frequent and ongoing</li></ul>

- There is evidence of great improvement when we work together to improve capacity
  - Strength-based approaches and integrated health, cross systems collaboration are key
  - A solution-focused approach builds capacity through primary interventions, includes secondary interventions with expertise for specialized approaches, and includes a safety net for emergency interventions

## Question & Answer



**John Jansa**  
Senior Consultant  
The Lewin Group



**Joan B. Beasley, Ph.D.**  
Research Professor  
Director, National Research  
Consortium on IDD-MH  
National Center for START Services



# A Managed Care Approach to Improve the Quality of Care for Persons with I/DD



**Dr. Steve Deusch**  
Chief Medical Officer,  
Partners Health Plan  
(PHP)

# About Partners Health Plan (PHP)

- Partners Health Plan is New York State's first managed care plan exclusively dedicated to serving persons with I/DD
- PHP is the only MMP nationwide that exclusively serves dually eligible individuals with I/DD
- PHP serves over 1,600 members in nine counties surrounding New York City



# PHP Managed Care Approach: Overview

- Managed care provides an appropriate setting to gather key data elements regarding health issues, utilization, and cost
  - This data helps PHP identify sub-optimal health outcomes among the I/DD population
  - This data also provides the building blocks for PHP to develop programs or care processes aimed to improve the identified outcomes
- Based on data, the needs of individuals with I/DD are best met when they receive care through a collaborative clinical approach across key areas, including:
  - Hospital and Skilled Nursing Facility (SNF) management
  - Medication management
  - Care management, and
  - Telemedicine outpatient management

# Hospital and Skilled Nursing Facility (SNF) Management

- Clinical rounds serve as the basis for hospital and SNF management
  - The interdisciplinary team holds a weekly virtual meeting to review members who are inpatients in hospitals and SNFs
- The interdisciplinary team participating in hospital and SNF management includes:

Physician

Clinical Team  
Leaders  
(Nurses and  
LMSWs)

Clinical  
Pharmacist

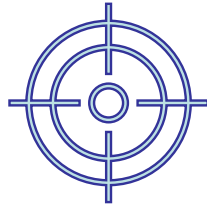
Utilization  
Review Nurses

Chief of Quality  
Initiatives

# Hospital and SNF Assessment for Individuals with I/DD

- The clinical rounds team assesses a variety of factors pertaining to the individuals' medical history and current management approach
  - Medical status
    - Past medical and functional history and needs
    - Chief complaint and current medical history
    - Current medical diagnoses and data including laboratory test results, image studies, consultations, current treatment regimens
    - Preadmission medication regimen and current medication regimen
  - Management approach
    - Appropriateness of admission or level of care
    - Progression and appropriateness of care (e.g., receiving correct diet, support with mobility, etc.)
    - Social issues
    - Incidents related to care
    - Advanced directives
    - Discharge needs and potential barriers
    - Issues related to a readmission

# Clinical Pharmacy Medication Management Program



## Program Objective

A Comprehensive Medication Therapy Review (CMTR) performed by a Clinical Pharmacist

- Based on current outpatient or inpatient medications
- Based on prescription drug event (PDE) files showing fills and refills
- Based on review of clinical medical record
- Patient profile built from claims data

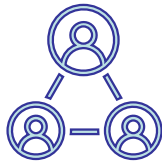
## Program Applications

- Transitions of care
- Polypharmacy
- Management of chronic conditions
- Statin use for individuals with diabetes
- Staff or provider requests

# Care Management

Care Management provides a comprehensive, integrated, and prospective approach aimed at ensuring individuals receive the right type of services and support at the right time regardless of their circumstance

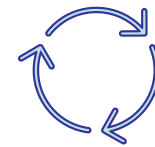
## Key Elements of the Care Management Model:



Assignment of two-person care coordination team with distinct, yet collaborative roles to each member



Person-centered, prospective planning, including assessment and dynamic risk stratification to drive interventions



Ongoing collaboration between care management and medical management or healthcare programs to support member needs

# Telemedicine Outpatient Management



- PHP leverages a partnership with StationMD to provide telemedicine outpatient management to all their beneficiaries
  - StationMD specializes in the prospective management of chronic, urgent, and emergent care for individuals with I/DD
  - StationMD's physicians are Board Certified Emergency Room Physicians, who also have additional training in caring for individuals with an I/DD diagnosis
  - Through the StationMD App members can initiate video conference calls with a StationMD Physician 24 hours per day, 365 days per year
  - StationMD physicians have immediate access to electronic member profiles built by PHP, updated biweekly with members' diagnoses, hospitalizations, emergency room visits, medications, etc.



# Telemedicine Outpatient Management



- If medically appropriate the StationMD physician will treat the patient virtually, including prescribing the appropriate medications
  - When this occurs, the treating physician will follow up with the patient after treatment is started
- If the physician advises that a member should be transferred to the ER, they will call the ER ahead of time and notify them the member is on the way, why they have advised the member to go, and what tests or treatment they recommend
- The telemedicine outpatient management program has reduced unnecessary ER visits for individuals with I/DD
  - Since 2020, the estimated ER and admission cost avoidance from the StationMD program is greater than \$5.7M

# Key Takeaways

- Data is key to understanding and managing the healthcare and social needs of people with I/DD on a population and member centric basis – managed care is the ideal platform to collect data
- The achievement of high quality medical, behavioral, and social outcomes for the I/DD population requires an integrated multidisciplinary approach
  - Since 2018, the described programs have reduced hospital admissions by 42% and 30-day hospital readmission rates by 30%
- Many hospital admissions for members with I/DD are inappropriate and have devastating and lasting physical and behavioral effects
- Appropriate medication management in the I/DD population is a key component for quality outcomes
  - 60% of 500 medication regimens reviewed in 2021 had significant findings that could affect the member's health or potentially result in a hospital admission
- Telemedicine has been a highly effective reactive tool for outpatient management of the I/DD population
  - Going forward it will also be used proactively for specific members and specific diagnoses

## Question & Answer



**John Jansa**  
Senior Consultant  
The Lewin Group



**Dr. Steve Deutsch**  
Chief Medical Officer,  
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- We would also like to invite you to provide feedback on other RIC products as well as suggestions to inform the development of potential new resources:  
<https://www.surveymonkey.com/r/MeasuringImpact2021>

# Resources

- Addressing Polypharmacy in Dually Eligible Individuals with I/DD: A Spotlight on Partners Health Plan - **Coming Soon!**
- Individuals with I/DD: Telehealth Brief - **Coming Soon!**
- Promoting Disability-Competent Care During COVID-19  
[https://www.resourcesforintegratedcare.com/promoting\\_disability-competent\\_care\\_during\\_covid-19/](https://www.resourcesforintegratedcare.com/promoting_disability-competent_care_during_covid-19/)
- National Association of State Directors of Developmental Disability Services <https://www.nasdds.org/nasdds-knowledge-center/>
- SNP Alliance <https://snpalliance.org/>
- Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities  
<https://centerforstartservices.org/IDD-MH-Prescribing-Guidelines>

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