North Jersey Health Collaborative
health matters

Coordination of Complex Care

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Care Coordination

- Interventions to assist the patient and caregiver to manage chronic health conditions and psychosocial influences that impede patient's overall health.

- Driven by a need to control costs; improve outcomes; compensate primary care providers for actions generally not reimbursed; improve patient (and caregiver) satisfaction.

Care management team

- Nurses
- Social workers
- Behavioral health
- Informatics
- Pharmacists
- Clergy/Chaplains/ faith-based organizations
- Community organizers

Care-management programs

Insurance

Hospital-based

Community-based

Accountable care organizations

Integrated care delivery systems

Medical homes

Target population

- Multiple chronic co-morbid conditions
- Frailty / increased risk of functional decline & inability to live independently
- Low health literacy
- Polypharmacy
- Multiple specialists

Interventions

- Coordinate resources
- Empower patients (patient focused goals; health literacy)
- Ease of access (appointment availability; telehealth)
- Coordinate transition of care
- Risk stratifying the population (Milliman risk score Lace score)

Outcomes

- Decrease mortality
- Reduce health care costs
- Support primary care provider
- Improve health outcomes
  - Cancer screening guidelines
  - Healthy lifestyle (screening for obesity, tobacco use)
  - Diabetes management
  - Medication compliance
  - Immunization
  - Advance directives

Care Coordination and implication for adults with developmental disabilities

I. Collaborate with care management teams for support & advocacy

II. Utilize techniques/ skills / lesssons developed from care coordination

III. Advocate for adoption of programs specific to those with developmental disabilities.

I *Collaborate with care management teams for support & advocacy*

- Medication compliance
- Orders for clients living in group home are generally completed. (imaging, blood tests, immunizations)
- Clients receiving the DD benefit have designated support coordinators.
- Potential for access to programs (nutritionist, exercise, social functions)
- Patients are already risk scored (NJ CAT – evaluates behavioral, medical, and self-care needs)
- Access to transportation

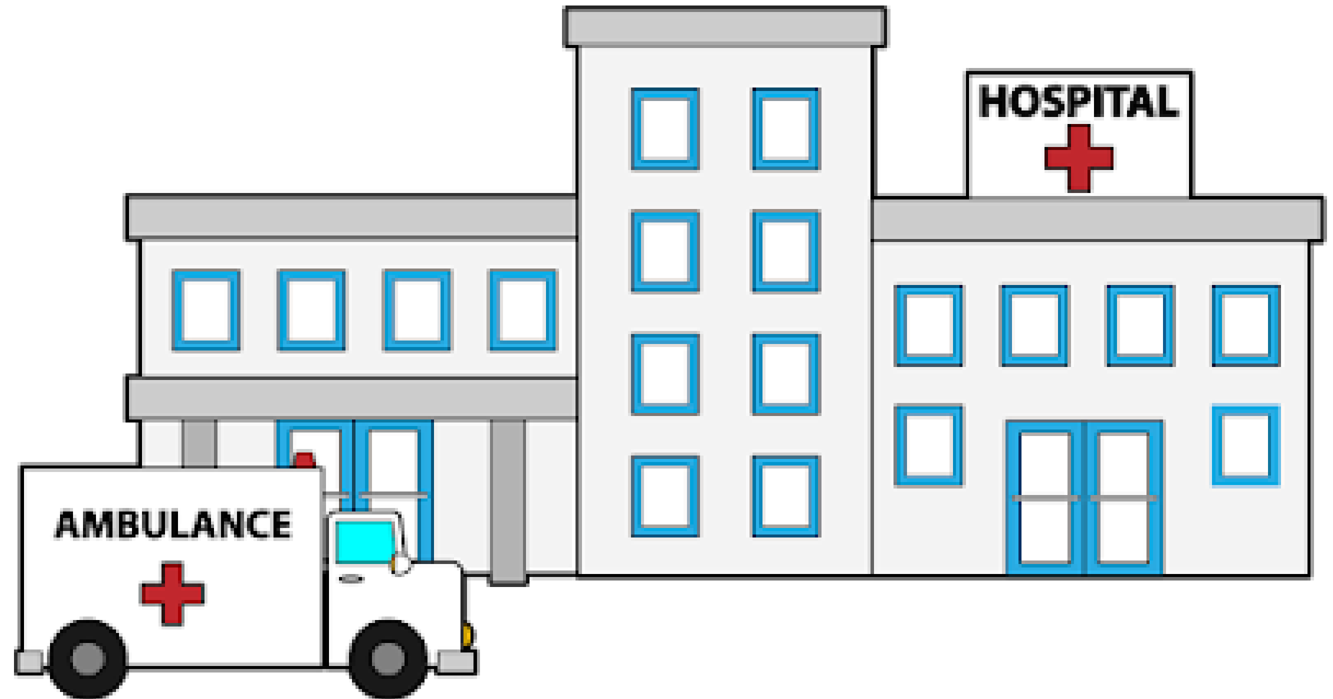
II *Techniques/ skills/ lessons learned from care coordination*

1. Health literacy
    - Patient-centered goals
        - Confident/ important
    - Patient engagement (not the guardian nor caregiver)
    - Culturally sensitive
    - Support from peers
    - Compromise
    - Rewards are important
        - Short gain is often better understood than long term gain

II *Techniques/ skills/ lessons learned from care coordination*

2. Improve transitions of care

- "TCM" visit reimbursed by Medicare – only qualifies if the provider has a phone encounter within two business days of discharge. (and a follow up visit within 7-14 days)
- Medication reconciliation
- Address frailty & incontinence



II *Techniques / skills / lessons learned from care coordination*

3. EMR is the linchpin for communicating among providers

- Multiple health systems in NJ is a challenge
- HIPPA is a necessary barrier
- Dependency on archaic systems (fax machines, binders)

III *Advocate for adoption of programs specific to those with developmental disabilities.*

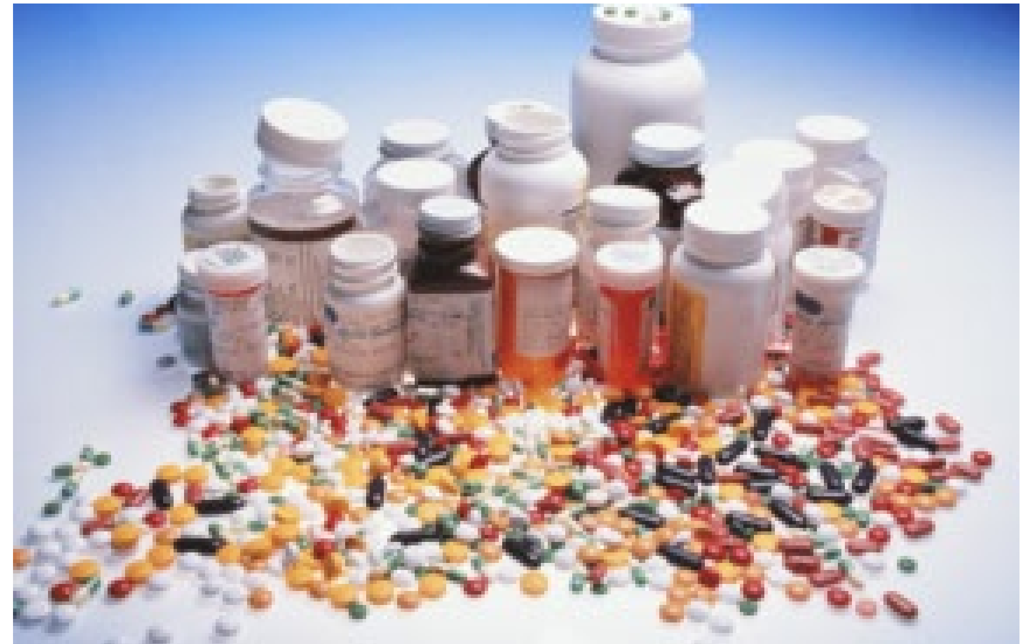
1. Cancer screening
   - Cologuard for adults 45-50 years old
   - STD screening
   - Tobacco use
   - How long to screen for?

III *Advocate for adoption of programs specific to those with developmental disabilities.*

2. Obesity
    - Access to exercise programs
    - Poor diet choices
    - Side effect of medication
    - Behavioral/ compulsive eating

III Advocate for adoption of programs specific to those with developmental disabilities.

- Polypharmacy
  - Increased risk of drug interaction
  - Poor compliance
  - Increased side effects (constipation, urinary retention, mood changes, electrolyte imbalances, anemia, thrombocytopenia)
  - Prescribing cascade
  - Fear of discontinuing medications



III. *Advocate for adoption of programs specific to those with developmental disabilities.*

4. Challenge of the diagnosis

Poor historian – vulnerable to misdiagnosis

Lack of specialists

Difficulty self-advocating

Much research needed on disease presentation in populations with developmental disabilities (autism and bowel concerns. Dementia and Down syndrome)

Multiple caregivers and a regulated environment can challenge a trial of interventions

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Complex Care

1. Key concepts and tools should be used to the population of adults with IDD.

2. Advocates for individuals with IDD should be contributing to this evolving field.

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