



Reimagining Models of Care for People with Intellectual & Developmental Disabilities

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December 14, 2021

NASEM: Optimizing Care for People with Intellectual and Developmental Disabilities



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1 UNDERSTAND NEEDS

More holistically understand the needs of a person and their family

3 FOCUS HEALTH CARE INVESTMENTS

Innovate how we invest resources into what matters most for individuals with I/DD and their families

2 SUPPORT AND BRIDGE SERVICES

Wrapping systems around the person and their families, rather than asking people to wrap around systems



More holistically understanding a person and their family's needs

Integrating Cross-Sector Data

- **Current state:** Data exist in siloes
- **Bringing care needs screening SDOH data alongside administrative data**



- **Finding opportunities to match individuals & cross-enroll across programs**



NCDHHS
NC Medicaid
Division of Health Benefits



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Examining Needs With an Equity Lens

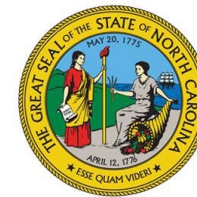
- **Current state:** Data are not disaggregated by equity variables, including race/ethnicity, disability, or language preference
- **Collecting these data is a critical first step** for evidence-based policies and effectively implementing disability-inclusive policies and programs



Supporting and bridging services for children and families

Division of Child & Family Well-Being, NC Dept of Health and Human Services

- **Current state:** COVID spurred a transformation in how we work together as a team to serve children
- **What:** Bring together complementary programs from within the NCDHHS that primarily serve children and youth to improve their health & well-being outcomes
 - **Nutrition:** Food Nutrition Services/SNAP, WIC, Child and Adult Care Food Program (CACFP)
 - **Early Intervention/**Infant Toddler Program for supports and services to young children with developmental delays or established conditions
 - **Children and Youth Programs,** including for Children and Youth with Special Health Care Needs
 - **School & Community Mental Health Services,** including for Children with Complex Needs



NC DEPARTMENT OF
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- **Why:**
 - Enhance how children and families access programs through coordination
 - Coordinate increased investments in child health and well-being
 - Elevate the value of teams supporting children and families



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Supporting and bridging services for children and families

NC Integrated Care for Kids (NC InCK)

- CMS-funded model that aims to integrate care for Medicaid-insured children birth to age 20
- Pilot in 5 central NC counties led by Duke, University of North Carolina and NCDHHS



Child is identified through NC InCK's integrated **cross-sector data** as needing additional supports

Child is assigned a **Family Navigator** to serve as their care manager

Family meets with Family Navigator to form their **integrated care team** of trusted individuals across sectors

Family, Family Navigator, and integrated care team collaborate to create a **Shared Action Plan**

Family and Family Navigator meet at least **quarterly** to discuss unmet or emerging needs

Investing in what matters to individuals with I/DD

Linking Payments to Measures of Whole Person Well-Being

- **Current state:** Measures tracked by payers and health systems focus on health care utilization (e.g., well child visits, immunizations)
- **Meaningful, holistic performance measures**



Social drivers of health: Food insecurity, housing instability, Kindergarten readiness



Quality of Life: Autonomy, sense of belonging, life satisfaction



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Shifting to Alternative Payment Models

- APMs should provide **flexibility** needed to provide whole person care and to meet changing needs
- **Person-centered design** with broad stakeholder engagement and shared governance
- New “**Cost of Health**” measures
 - **Longer time horizon** to incentivize prevention and care over a lifetime
 - **Cross-sector** to solve the “wrong pocket problem”
 - **Whole family** to incentivize multigenerational approaches



Thank you!

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