INTELLECTUAL DISABILITY
• IQ less than or equal to 70
• Two functional needs
• Onset in the developmental phase
Ex: Down syndrome, Fragile X, hypoxia at birth

DEVELOPMENTAL DISABILITY
• Permanent cognitive and/or physical impairment
• Onset in development phase
Ex: Rhett syndrome, Fetal Alcohol Syndrome, Autism Spectrum Disorder

EPIDEMIOLOGY
• 2-3% of children are affected- that is 1 out of 33 newborns
• 1.0-1.5% (~4 mil. people) of intellectual/ developmental disability
• 2-3% of children are affected- that is 1 out of 33 newborns

GOALS
Adjustment of existing health screening guidelines and medical factsheets for persons with intellectual disabilities

PROGRESS
Currently, existing forms are long, complicated, and challenging for families and caregivers to complete. As a result, the individuals, caregivers and families are not receiving the necessary services and resources.

OUTCOMES
• Routine Screening Guidelines: Age and gender appropriate suggested annual medical and preventative screenings
• Emergency Medical Information: Form containing basic information including, but not limited, the patient's emergency contacts, consent status, advanced directive information, medication lists, allergy, etc., which is mean to be utilized in emergency situation
• "All About Me": Form to be carried by the individual to inform others of likes/dislikes, potential communication barriers, social skills in order to support and ensure a positive experience for the person in social settings

FIELD EXPERIENCE
• "All About Me": Form to be carried by the individual to inform others of likes/dislikes, potential communication barriers, social skills

LEARNING POINTS FOR HEALTHCARE PROVIDERS & NEXT STEPS
Healthcare providers must:
• Understand the challenges and barriers that patients with IDD face in accessing quality personalized care
• Recognize that individuals with IDD need individualized care
• Assessing and screening for abuse and trauma
• Improve interaction techniques: speaking directly to the individual and on his or her level
• Create individualized plans of care
• Modify office visits as needed, i.e. not requiring exam gowns
• Integrate interdisciplinary model of care in an effort to address the unique and dynamic needs of each individual
• Understand the importance of planning a seamless transition from pediatric to adult care
• Promote awareness amongst other healthcare providers and professionals about the local resources and services available to this population

ACKNOWLEDGEMENTS
We would like to thank all of the individuals with intellectual and developmental disabilities who we learned from, Ms. Emily Lauer, Dr. Robert Baldor, Dr. Deb Dreyfus, the staff at Seven Hills Foundation, Sherrill Hayter at DDS Wakefield, Nancy Alterio at the Disabled Persons Protection Commission, Mary Jo Wagner and Tom Mercier from Massachusetts Department of Developmental Services (DDS) Worcester Assistive Technology Center, Lorraine Murphy at Westford ABI group home, Paul Murray and Dr. Kim Schola at Hogan Developmental Center, Dr. Julie Moran at Tewksbury Hospital, Accountable Care Organizations at MassHealth, Siobhan McKay at DDS Plymouth, Kathy Torney at Wrentham Developmental Center, the staff at the Title V Division for CYSHCN MA Dept. Of Public Health, Sherrie Hayter at Danvers DDS, Edmund Manu at The MENTOR Network, and all other individuals who contributed to our experiences during the Population Health Clerkship.

REFERENCES