



CONNECTICUT
Office of Health Strategy

Primary Care Modernization Initiative Design Group: Persons with Disabilities

Agenda

Introductions	5 minutes
Feedback from Consumers	10 minutes
Purpose of Design Group	5 minutes
Discuss Primary Care Capabilities for Persons with Disabilities	55 minutes
Sense of the Group	10 minutes
Next Steps	5 minutes
Adjourn	

Primary Care Needs Identified in Consumer Engagements

SIM Consumer Advisory Board (CAB) “Kids as Self Advocates” Listening Session on May 13, 2017

- SIM CAB sponsored a Social Media Healthcare Town Hall discussion with youth with disabilities at the “Building a Great Life” Summit organized by PATH Parent to Parent/Family Voices of CT and CT Kids as Self Advocates
- Highlights from report presented by Nanfi Lubogo (SIM CAB) and Quyen Truong (SIM Office):
 - Youth shared experiences battling stigma and ignorance in schools and were open about their struggles with mental health, independence, and navigating the healthcare system
 - Access to healthcare for young adults with disabilities most often involves their caregivers, who also need support
 - Transportation is a big barrier for many young adults with disabilities
 - Most youth believe they are responsible for their own healthcare: “I know myself the best and I know my issues the best” “Taking care of my health is taking care of my dreams”
 - Young adults were not completely comfortable discussing their mental health (one said “Very uncomfortable!!!”), which was related to the location of counselors at their schools, and students’ comfort with going to this location
 - Young adults wanted empathy and an understanding of people’s differences, and an awareness of different disability issues and how they can manifest.

Read the full report: https://portal.ct.gov/-/media/OHS/SIM/Consumer-Advisory-Board/Publications/CT_SIM_CAB_Kids_As_Self_Advocates_Listening_Session_Report.pdf?la=en

Primary Care Needs Identified in Consumer Engagements

Primary Care Modernization Consumer Focus Group with adults with disabilities, facilitated by Freedman HealthCare on behalf of SIM and organized in partnership with Charlie Conway, Executive Director of Access Independence

September 24, 2018

- Phone, text, email and telemedicine visits could be very helpful to patients unable to drive and in need of transportation.
- Exam rooms need to have sufficient equipment to allow for a full exam including scales and lifts to support the patient onto the exam table. If not financially feasible to have all offices set up with this equipment, have some.
- Providers need sensitivity and compassion. One way to show that sensitivity is by documenting the patient's disabilities in the chart so they are not asked to stand when they cannot stand or do other activities they cannot do.
- Providers need to recognize that a patient's disability is not their sole concern but that it may impact many other health concerns.
- Many patients with disabilities need medication management perhaps from a pharmacist. Other important capabilities include pain management expertise and coordination with providers of various services and community resources.
- All care team members need to understand behavioral health issues, social issues and how they intersect with medical issues. Just adding a behavioral health team member is insufficient.

Are there other care delivery needs we're missing?

Primary Care Needs Identified in Individuals with Disabilities

Design Group Session 1

- Lack of access to providers: Providers often do not accept patients with Medicaid coverage or because they have complex needs
- Telehealth: consumers need help overcoming transportation, cost and physical barriers to going to doctor's office
- Diversified care teams: need to help improve access, address language and social determinants of health barriers
- Continuity in care and relationship-based care: need primary care connections and care coordination for patients in nursing homes or rehab facilities
- Providers lack training and knowledge to understand and treat specific conditions and provide sufficient support for special populations. Need better communication between specialists and PCPs

A summary of the design group's discussions on the payment model options is available in the Appendix

Purpose of Design Group

- Identify how primary care can better serve the needs of individuals with disabilities
- Define what services and supports should be available across all primary care practices
- Determine if some primary care practices should have expertise and experience working with individuals with disabilities to provide specialized care and services

Opportunities to Enhance Primary Care for Individuals with Disabilities

Identified by the Department of Developmental Services

- Often multiple people are responsible for or involved in individuals' care (family members, legal guardians, group home managers, case managers, etc.)
 - Coordinating communication with patient and designee
 - Knowing who is designated representative (if applicable)
- Accessibility to healthcare services
 - Are buildings and exam rooms physically accessible?
 - Are clinicians and care teams willing to work with individuals and accommodate different ways of communicating?
 - Are individuals getting the routine and preventive medical care they need?
- Person-Centered, Quality Care
 - Treatment of the whole person, not just the disability
 - Engaging designees in care while respecting individuals' rights and decision-making abilities
 - Developing expectations for habilitation and rehabilitation together

Commonwealth Care Alliance Model

- **Commonwealth Care Alliance:** MA non-profit, community-based healthcare organization dedicated to improving care for adults (18+) who are dually eligible for Medicaid and Medicare with complex medical, behavioral health, and social needs, including those with disabilities
 - Developed One Care for adults with physical, behavioral health and/or developmental and intellectual disabilities to provide best in class care for these populations
- Commonwealth Community Care practices provide “comprehensive, disability-competent care to adults of all ages” including those who may have complex physical, developmental, intellectual, and behavioral health conditions:
 - Care team with nurse, PA, social worker, health outreach worker, behavioral health specialist, physical/occupational therapist, long-term services and supports coordinator, DME coordination team, administrative services coordinator
 - Addresses social determinants of health needs
 - Behavioral health assessments, diagnosis and referrals to treatment
 - Durable Medical Equipment coordination team to maintain and repair equipment
 - Care provided at home, in community or in-office depending on patient’s needs
 - Exam rooms with accessible equipment and translation and communication assistance
 - Consultation with specialists for discharge and transition to home and recovery for patients in facilities

Capabilities to Support Enhanced Primary Care for People with Disabilities

All primary care practices have:

- Diversified Care Teams (care coordinators, Community Health Workers, pharmacists, est.)
- Econsults with Subspecialists
- Phone/text/email encounters and telemedicine visits
- Telemedicine visits
- Access to disability information documented in chart
- Training in person-centered preventive care
- Coordination with community supports and services, and advanced specialty care

Potential model: Subset of practices within a network provide additional, specialized services:

- Home visits
- Accessible Exam Equipment and Communication accommodations (beyond ADA requirements)
- Specialized care team (Coordinator w/ expertise in DME &, long-term services & supports, physical therapist)
- Hospital, SNF, nursing home rounding, discharge planning
- Resources and expertise in chronic pain management

Patient Perspective - Clinical Scenario

Amy is 25 and has a developmental disability and physical deformities that require the use of a wheelchair. She lives with her mother, who is her caregiver and designated healthcare representative. Amy enjoys playing with her cat and helping her mom cook. She works part-time at a local grocery store. She is often in pain due to her physical deformities but doesn't like taking medication.



Amy's mother makes an appointment with a practice that specializes in care for people with disabilities.



At Amy's visit, her PCP has information about her disability and preferences in her chart.



The exam table has a lift so that Amy can more easily get on and off.



Her PCP talks to Amy and her mother about chronic pain treatment and conducts her annual physical.



A care coordinator connects Amy with the occupational therapist to help her manage her pain.



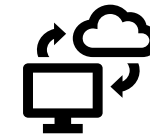
A few months later Amy ends up in the hospital and is then discharged to a rehab facility.



A clinician from her practice visits her at the rehab facility and communicates about her discharge with the care coordinator.

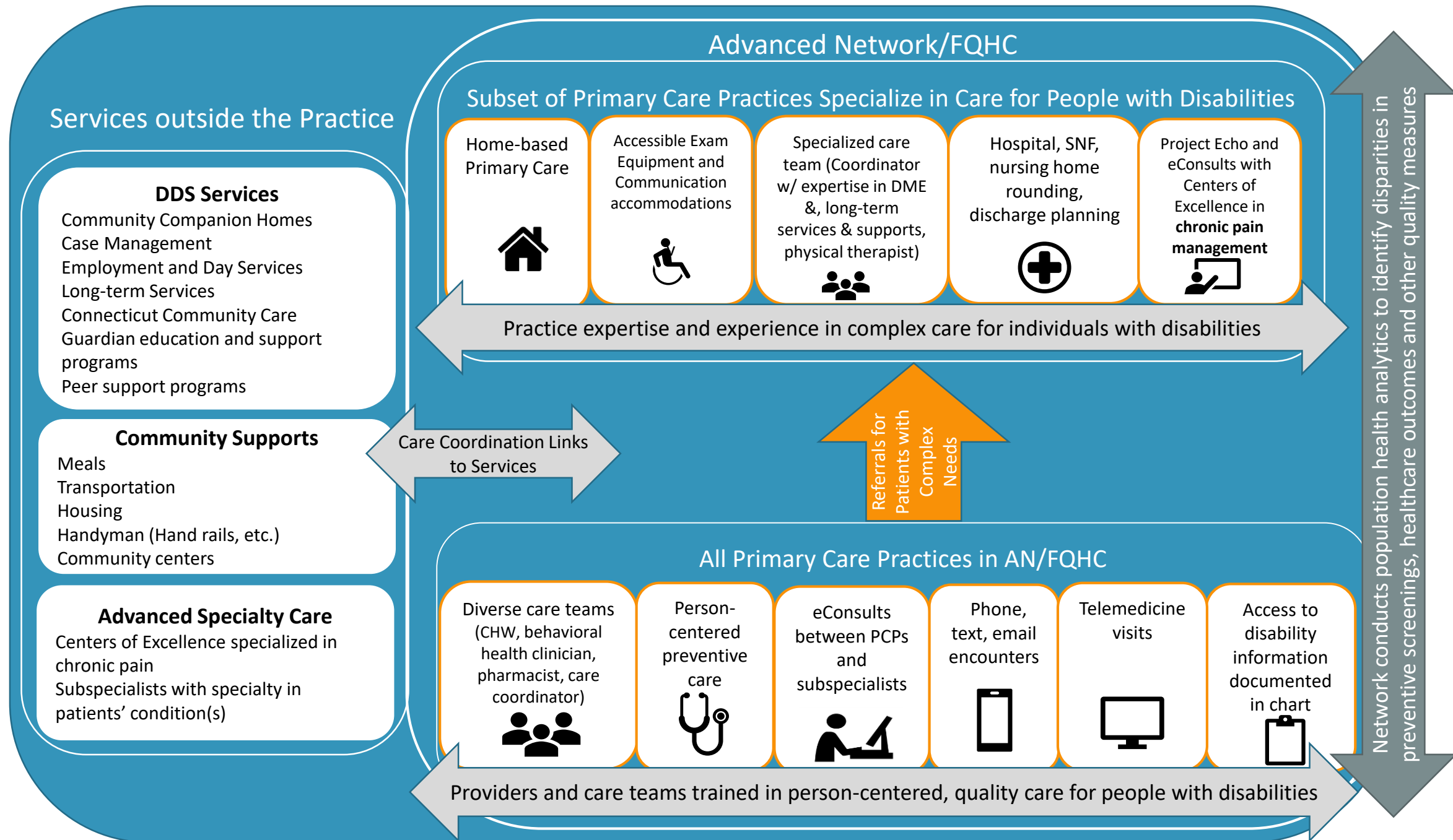


The care coordinator and a nurse from her practice visit her at home when she is discharged. The nurse does an exam and meets with her mother about care instructions.



Her PCP communicates with her specialists and directs the nurse and care coordinator on her care while she is at home.

Network/Practice Level Requirements



Discussion Questions

- What elements of this diagram do you support or would change?
- Are these the right capabilities for all primary care practices? Are any missing?
- Should a subset of practices specialize in care for individuals with disabilities who have complex needs?
- Are these the right capabilities for specialized practices? Are any missing?

Next Steps

- Incorporate today's feedback and revise materials
- Meet again via webinar
- Recommendations to Practice Transformation Task Force for consideration

Appendix

Summary of Design Group Session 1 Payment Model Discussion

Key features of model

- New primary care payment model options include upfront, bundled payments for primary care for practices in Advanced Networks and FQHCs
- Aim to double investment in primary care through savings from reducing avoidable use in other parts of the system over time
- Aiming for demonstration project with Medicare. Medicaid and commercial payers would build own models that align with Medicare model. All payer participation is important to ensure transformation is applied across a practice and patient populations.
- Staged approach to transformation would allow practices to build up capabilities over time.

Consumers' input, questions and concerns about the payment model

- How to measure that new payment model is resulting in better outcomes and not underservice for patients with higher needs
 - Electronic health records capturing all interactions with the care team even when they're not office-based
 - Risk adjusting payment amounts based on the patient's needs so providers have no disincentive to see complex patients
 - Avoiding reimbursement inflation through risk adjustment by having independent audits or conflict free billing
- Ways to address concerns with bundled payments:
 - Learn lessons from home care services that moved to bundled payments and resulted in less care and worse patient experience
 - Concerns about a capitation system in which people with disabilities get less care - new model will need to measure consumer experience and include protections to ensure people with complex needs get the care they need
 - Concerns with focusing on network structure that puts stressors on physicians - challenge with Fee For Service system and requiring billing codes for every service is that it keeps burden on providers to focus on volume and documentation
- Need ways to address social determinants of health needs, chronic conditions, and language barriers
 - Model would include expanded primary care teams with Community Health Workers and medical interpreters
 - Bundled payments provide more flexibility for primary care teams and longer appointments to address patient needs