Primary Care Modernization Capability: People with Disabilities

High-quality and comprehensive preventive, acute and chronic care focused on the needs of people with disabilities to support them in achieving their best health and quality of life.

Improving Care:

Consumers:

- Primary care doctors' offices are more accessible
- Phone, text, email, video and home visits make care more convenient
- Care teams support patients going from the hospital or skilled nursing facility to home
- Accessible equipment like table lifts and communications devices aid people with disabilities in receiving needed care
- Primary care doctor, specialists and other providers talk to each other and with patients and caregivers
- Care teams connect patients with food, housing and transportation

Primary Care Team:

- More patients receive recommended preventive care
- Avoidable emergency department and hospital visits decrease
- Support from care teams gives primary care doctors more time to focus on patients' clinical needs and more support to address non-clinical needs
- Additional training, support and experience improves care for individuals with disabilities

Improving Health Equity:

People with disabilities tend to receive necessary preventive care less often than people without disabilities. To reduce this disparity, primary care will change in the following ways.

- More phone, text, email, video and home visits will give patients other ways to receive care without going to the office.
- More accessible equipment and communication devices will help individuals with disabilities receive care and share their concerns and preferences.
- Additional training, support and experience will improve care teams' ability to address the needs of individuals with disabilities such as chronic pain.

Capability Requirements:

How:

All practices:

- Expanded care team (care coordinator, nurse care manager, community health worker, pharmacist, etc.) are required.
- Establish system and staff workflow for eConsults between subspecialists and primary care providers

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- Enable phone, text and email encounters and telemedicine visits
- Access to disability information documented in chart
- Coordination with Department of Developmental Services waiver services, community supports and advanced specialty care
- Training in person-centered preventive care for people with disabilities

A subset of practices within the network:

- Establish system and staff workflow for home-based primary care
- Provide accessible exam equipment and communication accommodations
- Clinical links to hospitals and skilled nursing facilities, rounding by primary care providers with support from the primary care team for care transitions
- Specialized care team (coordinator with expertise in durable medical equipment and long-term services and supports, physical/occupational therapist)
- Coordinate resources and expertise in chronic pain management
- Practice expertise and experience in complex care for individuals with disabilities
- Accessible locations via public transportation

Health Information Technology Needed:

- Access to electronic health record for all care team members, and from remote locations
- Scheduling system accessible to all members of the patient's care team
- Remote patient monitoring technology as needed
- Accessibility technology in exam rooms such as table and toilet lifts
- Communication devices for patients with speech impairments or who are non-verbal

Patient Example: Amira has a physical disability, uses a wheelchair and has a neurological condition that affects her ability to speak. Amira is not cognitively impaired. Amira is often in pain due to her physical disability. She lives with her mother, who is her caregiver and designated healthcare representative. Amira's mom makes an appointment with a practice specialized in care for people with disabilities. When Amira arrives in the office, the team support staff talks directly to her, making appropriate eye contact at her level. The primary care doctor has information about Amira's physical disability and communication preferences in her chart. The exam table has a lift so that Amira can more easily get on and off. The primary care doctor talks to Amira and her mother about chronic pain treatment and conducts her annual physical. A care coordinator connects Amira with the occupational therapist to help her manage her pain. A few months later Amira ends up in the hospital and is then discharged to a rehab facility. A clinician from her practice visits her at the facility and communicates with her care coordinator. Her care coordinator and nurse visit her at home when she is discharged. The nurse does an exam and meets with her mother about care instructions. Amira's primary care provider communicates with her specialists and directs the nurse and care coordinator on her home care.

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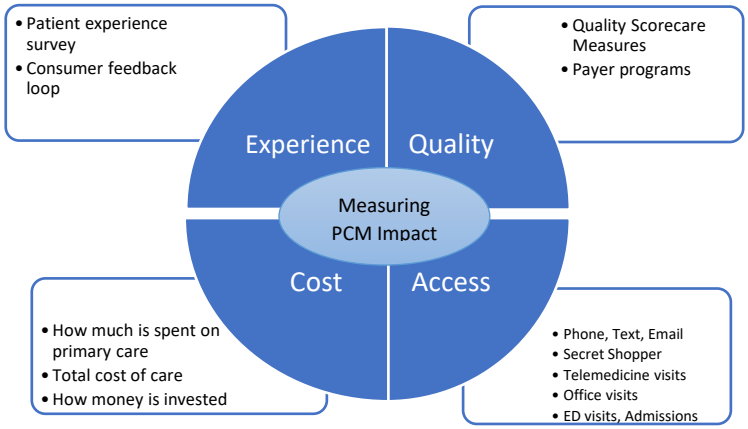
Measuring Impact:



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