OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization Initiative Design Group: Persons with Disabilities

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Agenda

Introductions	5 minutes
Purpose of Design Group and Questions from Last Session	10 minutes
Goals for Primary Care	10 minutes
Discuss Primary Care Capabilities for People with Disabilities	170 minutes
Sense of the Group	10 minutes
Next Steps	5 minutes
Adjourn	

Purpose of Design Group

Today we will focus on answering these questions:

- How can primary care can better serve the needs of individuals with disabilities?
- What services and supports should be available in all primary care practices?
- Should some practices specialize in care for individuals with disabilities?

Goals for Primary Care

Based on Last Session's Feedback and Meetings with People who have Disabilities

- Choice of provider
- Whole person-centered care
- Equitable care – people with disabilities get high quality preventive and routine care
- Accessible care:
  - Accessible equipment in exam rooms and bathrooms for people with physical disabilities
  - Communication devices for people with speech and hearing impairments and signers and interpretation services for non-English speakers
  - Practices accept patients with disabilities, including those with complex needs, regardless of their insurance
  - Ways to get care outside of the office and office locations that are accessible via public transit
- Clinicians and care teams that have experience with and understand the needs of patients with disabilities
- Ways to measure these things are happening

What are we missing?

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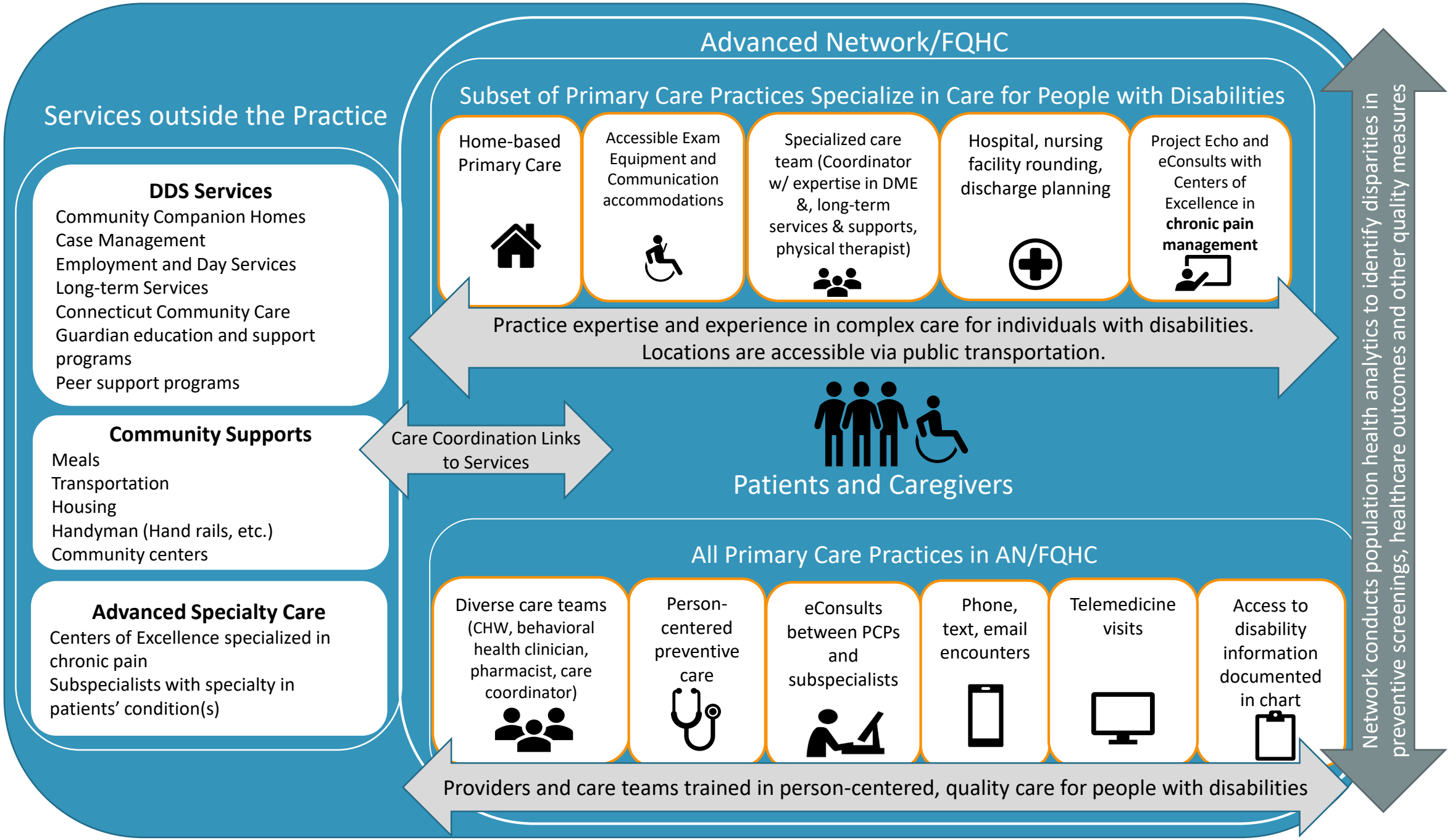
Capabilities Discussion

Learning from Other Models: Commonwealth Care Alliance (CCA)

- Healthcare organization offering health plans and integrated services for adults dually eligible for Medicaid and Medicare with complex medical, behavioral health, and social needs
  - *One Care* plan provides best in class care for adults with physical, behavioral health and/or developmental and intellectual disabilities
- CCA's clinical affiliate, Commonwealth Community Care, has specialized primary care centers that provide "comprehensive, disability-competent care to adults of all ages"
  - Expanded care teams: Physician's Assistant, nurse, social worker, health outreach worker, behavioral health specialist, physical/occupational therapist, long-term services and supports coordinator, DME coordination team, administrative services coordinator
    - Address social determinants of health needs
    - Provide behavioral health assessments, diagnosis and referrals to treatment
    - Durable Medical Equipment coordination team helps patients maintain and repair equipment
    - Care is provided at home, in community or in-office depending on patient's needs
  - Accessible exam rooms with table lifts, translation and communication assistance
  - Care team consults with specialists for care transitions for patients in hospitals or nursing facilities

Concept Map for Primary Care for People with Disabilities: Network/Practice Level Requirements



Capabilities for All Primary Care Providers

- **Diverse care teams**: Expanded care team functions and members (care coordinator, nurse care manager, community health worker, pharmacist, etc.)
- **Person-centered preventive care**: Provider training in person-centered preventive care for people who have disabilities
- **eConsults between PCPs and subspecialists**: Electronic communications between subspecialists and primary care providers before or instead of referring patient to subspecialist
- **Phone, text, email encounters**: Allow patients to communicate with the PCP and care team without an office visit for minor, non-urgent medical issues
- **Telemedicine visits**: Virtual video visits between patients and providers when appropriate.
- **Disability information documented in chart**: PCPs have access to information about a patient's disability and health status within their Electronic Health Record

Capabilities for a Subset of Primary Care Practices

Provider expertise and experience in complex care for individuals with disabilities, supported by additional capabilities:

- **Home-based primary care services**: Physician supervised care teams provide primary care services in the home for patients who are homebound or have difficulty getting to the office, or following discharge from hospital or nursing facility
- **Accessible Exam Equipment and Communication accommodations**: Additional supports (beyond ADA requirements) such as hi-lo tables, wheelchair scales, transfer equipment, lifts, specialized mammography equipment, and communication devices
- **Specialized care team**: Care coordinator has expertise in long-term services and support and Durable Medical Equipment coordination, physical and occupational therapists
- **Hospital and nursing facility rounding, discharge planning**: Clinical links to hospitals and skilled nursing facilities, rounding by primary care providers with support from the care team for care transitions
- **Project Echo and eConsults with Centers of Excellence in chronic pain management**: Specialized expertise in chronic pain management and treatments (see concept map in appendix)

Patient Story 1

Amy is 25 and has a developmental and physical disability that require the use of a wheelchair. She lives with her mother, who is her caregiver and designated healthcare representative. She is often in pain due to her physical deformities.

Amy's mom makes an appointment with a practice specialized 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 her pain and explains why Amy should get an 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 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.

Her PCP communicates with her specialists and directs the nurse and care coordinator on her home care.

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Patient Story 2

Samantha was diagnosed with Frederich's Ataxia (FA)* at age 10. At age 30, she has difficulty speaking, coordinating her movements, and needs a wheelchair to get around, but there is nothing wrong with her ability to think or reason. Samantha has a master's degree in biochemistry and currently works in medical research. She hates visiting doctors who often treat her as though she is cognitively impaired (like a 2 year-old) or as someone with behavioral health issues.

Samantha finds a practice that specializes in people with disabilities. She is able to make an appointment online, as communicating via phone is difficult.

When her PCP arrives, he notes that her chart says she has FA. He talks to Samantha directly and doesn't ask why her parents aren't with her.

The PCP offers her a tablet to clarify her responses in writing if she chooses.

Samantha shares that she is worried she hasn't had a physical in years. She and her doctor discuss some screenings she might need and other medical concerns. Her PCP performs a physical.

Samantha, her PCP and a nurse care manager develop a care plan for her and decide to follow up via email every 3 months to see how she is feeling.

*FA is a rare genetic disorder that causes progressive neurologic damage but not does not affect cognitive function

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Discussion Questions

- Are these the right services and supports for all primary care practices?
- Should a subset of practices specialize in care for individuals with disabilities?
  - Are these the right services and supports for practices that specialize?
- Should all networks and FQHCs be required to have this capability?
- What are we missing?

Provider Choice

- How would patients and caregivers know about practices that specialize?
  - Networks provide resources and education about benefits of primary care and specialized practice
  - Patients and caregivers may choose to see providers within these practices depending on their needs

- Can patients continue to see their subspecialist (e.g. oncologist) for primary care?
  - Patients have choice of provider - subspecialists are not eligible to participate in PCM and would be paid fee-for-service for patients attributed to them.
  - Networks provide education to patients about the importance of a primary care physician, especially for preventive care needs

Coordination with other Supports

- For patients with Medicaid waiver services
  - Individual with family/caregiver, PCP and LTSS care coordinator decides whether the practice's nurse care manager is needed to help coordinate medical services
  - ANs/FQHCs develop coordination protocols with Medicaid waiver programs that set mutually agreeable processes for determining who is responsible for supporting coordinating an individual's acute and chronic medical needs
  - Protocols specify how individual choice determines decisions about who leads the medical care management and how the LTSS care coordinator can participate in the primary care team process

- How can home care services be more accessible? How should primary care coordinate with these services?

Next Steps

- Incorporate today's feedback
- Recommendations to Practice Transformation Task Force

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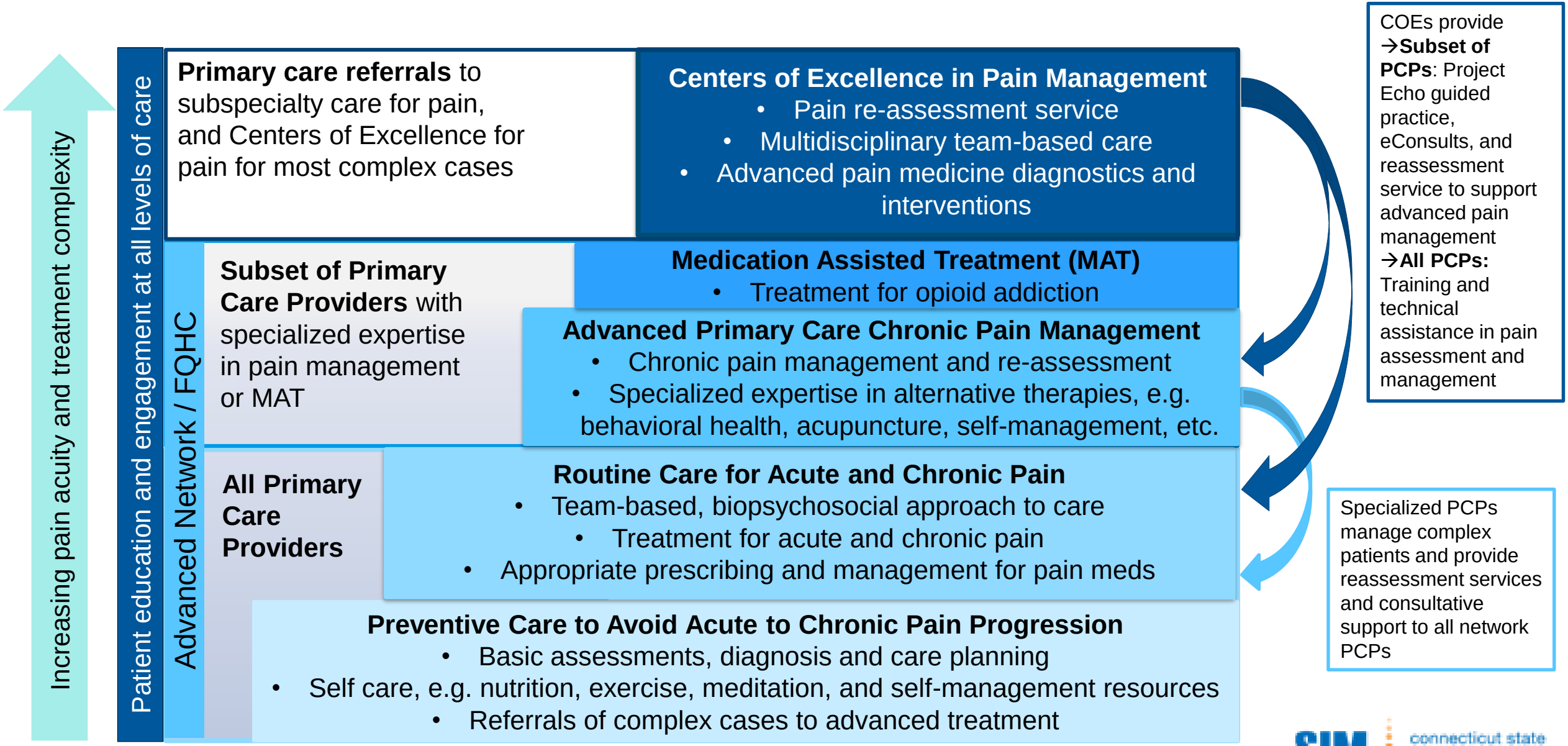
Appendix

Primary Care Modernization – DRAFT Concept Map for Pain Management



Concept Map for Primary Care for Older Adults with Complex Needs