Primary Care Modernization Initiative
Design Group: Persons with Disabilities
## Agenda

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductions</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Purpose of Design Group and Questions from Last Session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Goals for Primary Care</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss Primary Care Capabilities for People with Disabilities</td>
<td>170 minutes</td>
</tr>
<tr>
<td>Sense of the Group</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Next Steps</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
Purpose of Design Group

Today we will focus on answering these questions:

• How can primary care 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?
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

**Advanced Network/FQHC**

**Subset of Primary Care Practices Specialize in Care for People with Disabilities**

- Home-based Primary Care
- Accessible Exam Equipment and Communication accommodations
- Specialized care team (Coordinator w/ expertise in DME & long-term services & supports, physical therapist)
- Hospital, nursing facility rounding, discharge planning
- Project Echo and eConsults with Centers of Excellence in chronic pain management

Practice expertise and experience in complex care for individuals with disabilities. Locations are accessible via public transportation.

**Services outside the Practice**

- **DDS Services**
  - Community Companion Homes
  - Case Management
  - Employment and Day Services
  - Long-term Services
  - Connecticut Community Care
  - Guardian education and support programs
  - Peer support programs

- **Community Supports**
  - Meals
  - Transportation
  - Housing
  - Handyman (Hand rails, etc.)
  - Community centers

- **Advanced Specialty Care**
  - Centers of Excellence specialized in chronic pain
  - Subspecialists with specialty in patients’ condition(s)

**All Primary Care Practices in AN/FQHC**

- Diverse care teams (CHW, behavioral health clinician, pharmacist, care coordinator)
- Person-centered preventive care
- eConsults between PCPs and subspecialists
- Phone, text, email encounters
- Telemedicine visits
- Access to disability information documented in chart

Providers and care teams trained in person-centered, quality care for people with disabilities

Network conducts population health analytics to identify disparities in preventive screenings, healthcare outcomes and other quality measures

**Patients and Caregivers**

- Care Coordination Links to Services
- Network conducts population health analytics to identify disparities in preventive screenings, healthcare outcomes and other quality measures
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.

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

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

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

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

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 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.

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

*FA is a rare genetic disorder that causes progressive neurologic damage but does not affect cognitive function.
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
Appendix
Preventive Care to Avoid Acute to Chronic Pain Progression

- Basic assessments, diagnosis and care planning
- Self care, e.g. nutrition, exercise, meditation, and self-management resources
- Referrals of complex cases to advanced treatment

Routine Care for Acute and Chronic Pain

- Team-based, biopsychosocial approach to care
- Treatment for acute and chronic pain
- Appropriate prescribing and management for pain meds

Advanced Primary Care Chronic Pain Management

- Chronic pain management and re-assessment
- Specialized expertise in alternative therapies, e.g. behavioral health, acupuncture, self-management, etc.

Medication Assisted Treatment (MAT)

- Treatment for opioid addiction

Centers of Excellence in Pain Management

- Pain re-assessment service
- Multidisciplinary team-based care
- Advanced pain medicine diagnostics and interventions

Subset of Primary Care Providers with specialized expertise in pain management or MAT

All Primary Care Providers

Primary care referrals to subspecialty care for pain, and Centers of Excellence for pain for most complex cases

Primary Care Modernization – DRAFT Concept Map for Pain Management

COEs provide
→ Subset of PCPs: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management
→ All PCPs: Training and technical assistance in pain assessment and management

Specialized PCPs manage complex patients and provide reassessment services and consultative support to all network PCPs

Increasing pain acuity and treatment complexity

Patient education and engagement at all levels of care

Advanced Network / FQHC
Concept Map for Primary Care for Older Adults with Complex Needs

All Primary Care Practices in AN/FQHC

- Diverse care teams (CHWs, pharmacists, care coordinators, BH clinicians, etc.)
- eConsults between PCPs and subspecialists
- Phone, text, email encounters
- Telemedicine visits
- Remote patient monitoring for CHF, post-acute care

Advanced Network/FQHC

- Subset of Primary Care Practices Specialize in Geriatrics for Patients with Complex Needs
  - Home-based Primary Care
  - Dementia Care
  - Palliative Care
  - Advance Care Planning
  - Acute care setting rounding & care transitions support
  - Specialized expertise supported by Project Echo guided practice, practice experience, expertise and technical assistance for Advance Care Planning

Health Neighborhood

- Specialty Care
  - Subspecialists (e.g. cardiologist, pulmonologist, etc.)
  - Acute care settings

- Community & State Services for High Risk Older Adults
  - Home care/aides
  - Hospice providers
  - Assisted Living Facilities
  - Connecticut Community Care
  - Caregiver support programs

- Community Supports for all Older Adults
  - Meals
  - Transportation
  - Housing
  - Handyman (Hand rails, etc.)
  - Community centers

Primary care teams link to services and work with other service providers as appropriate, coordinate between PCP and subspecialists.

Patients and families choose primary care providers depending on needs, and level of provider expertise and practice capabilities to meet those needs.