PRIMARY CARE MODERNIZATION

People With Disabilities

CORE CAPABILITY

Enhanced primary care for people with disabilities including experienced primary care teams, access to preventive screenings and care, accessible services, and home- and community-based services and care teams.

HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Access to primary care teams who are experienced in supporting individuals with unique physical, cognitive, and communication needs
- Get more convenient care via phone, text, email, and video visits
- Get support transitioning from the hospital or skilled nursing facility to home
- Have accessible equipment like table lifts and communications devices
- Have the primary care team coordinate with specialists and other providers to keep up to date on their well-being and preferences
  - Connect to support services for food, housing, and transportation with help from the care team

PRIMARY CARE TEAMS CAN...

- More effectively address disability related health disparities including chronic illness outcomes and preventive screening
- Spend more time addressing patients' clinical needs and supporting their non-clinical needs
- Get training and support to improve care and the experience of care for individuals with disabilities
- Engage patients in their preferred style with options for phone, text, email, and video visits, and home visits when circumstances require
- Collaborate with the Department of Developmental Services and long-term services and supports to help patients formulate care plans

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Fernanda has a physical disability due to a car accident that left her unable to speak. She uses a wheelchair and is often in pain due to her injuries. She goes with her husband to a primary care provider who specializes in care for people with disabilities.

Fernanda appreciates that staff make eye contact and speak directly to her. The team has paid special attention to ensuring that she receives preventive care including routine colon and breast cancer screenings.

The provider has information about Fernanda's physical disability and communication preferences in her electronic medical record and offers a tablet so that she can answer questions. The exam table has a lift so that Fernanda can more easily get on and off.

To help her manage her pain, a care coordinator connects Fernanda with physical and occupational therapists who conduct home visits and coordinate with state and community agencies regarding other services and supports that Fernanda receives.

HOW

Networks will be required to propose an implementation strategy that will achieve the following requirements over a five-year demonstration.

Care Team and Network Requirements

All primary care practices

- Expanded care team (care coordinator, nurse care manager, community health worker, pharmacist, etc.) is required
- Establish system and staff workflow for eConsults between subspecialists and primary care providers
- Enable phone, text and email encounters and telemedicine visits
- Electronic Health Record (EHR) contains information about the person's disability, preferred communication style and long-term services and supports
- Collaborate with all appropriate state and community agencies that provide long-term services and supports to help patients formulate care plans
- Receive training in person-centered preventive care for people with disabilities

Subset of primary care providers specialize in care for people with disabilities

- Establish system and staff workflow for home-based primary care
- Enhanced accessibility solutions for exam equipment and communication support
- Establish clinical links to hospitals and skilled nursing facilities, rounding by primary care providers when possible and support from the primary care team for care transitions
- Provide a specialized care team (coordinator with expertise in durable medical equipment and long-term services and supports, physical/occupational therapist)
- Ensure care team training, expertise and experience in providing care to individuals with disabilities
- Situate practices in locations accessible via public transportation

Health Information Technology Requirements

- 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
- Analytic capabilities to support identification of disability-related health disparities
- Accessibility technology in exam rooms such as table and toilet lifts
- Communication devices for patients with speech impairments or who are non-verbal
- Remote patient monitoring technology as needed

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to care team's caring, concern and respect, communication, behavioral health services, shared decisions, provider support and overall satisfaction with provider
- Improved experience through more convenient, timely, coordinated, and accessible care

★ Quality

- Improved preventive care (e.g. immunizations, screenings)
- Improved chronic illness outcomes
- Earlier diagnosis and treatment for some conditions
- Reduced avoidable emergency department (ED) visits and hospitalizations for ambulatory care sensitive conditions

$ Cost

- Reduced urgent care, ED, nursing facility and hospital utilization
- Lower out of pocket costs for services in primary care and by non-billable team members

Access

- Easier to find a primary care provider that will accept a new patient with disabilities
- Access to practices with appropriate experience, expertise and resources
- Easier access to expertise of a specialist

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:

✓ **Options for phone, text, email, and video** will improve patient engagement and associated preventive and chronic care outcomes.

✓ **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.

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Joy is a young teenager with Down Syndrome. She has congenital heart disease and frequent upper respiratory illnesses. Recently she seems tired all the time.

Concerned about Joy's recent weight gain, Joy's parents bring her to a primary care practice with special expertise in treating people with disabilities.

At the visit, the clinician talks with Joy about how she's feeling. Joy gets a full physical and they talk about getting more exercise and handling stress at school.

Lab tests suggest that Joy is at risk of developing diabetes. The primary care team meets with Joy and her family to discuss a monitoring plan, healthy eating, exercise and what to expect during Joy's teenage years.

NETWORK/PRACTICE LEVEL REQUIREMENTS

ADVANCED NETWORK/FQHC

Patients & Caregivers

Network conducts population health analytics to identify disparities in care, healthcare outcomes and patient experience and empowerment

ALL PRIMARY CARE PRACTICES IN AN/FQHC

Providers and care teams trained in values-based care for people with disabilities

- Diverse Care Teams (CHW, behavioral health clinician, care coordinator)
- Person-centered care
- eConsults between PCPs and specialists
- Disability information sharing with patient consent
- Phone/text/e-mail encounters, telemedicine visits

SUBSET OF PRIMARY CARE PRACTICES

Patients and families/caregivers may choose practices and providers with additional expertise and experience in complex care for individuals with disabilities

- Home-based Primary Care
- Specialized care team (coordinator w/ expertise in DME, long-term services & supports, & physical therapists)
- Hospital, nursing facility rounding, discharge planning
- Accessible exams equipment and communication accommodations
- Project Echo and eConsults with centers of excellence in chronic pain management

SERVICES OUTSIDE THE PRACTICE

State Supports & DDS Services
Community Companion Homes
Case Management
Employment and Day Services
Long-term Services
Conneticut Community Care
Guardian Education and Support Programs
Peer Support Programs

Community Supports
Meals
Transportation
Housing
Handyman (handrails, etc.)
Community centers

Advanced Specialty Care
Center of Excellence specialized in chronic pain
Subspecialists with specialty in patients' condition(s)

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