Disability Competent Care Planning Tool for Oregon's Primary Care Homes/Providers Offices

Dual Eligibles Fall Forum - Care Coordination to Improve Health for High Need Members Across the Lifespan: Aging and Disability, 9/21/16 - Salem, OR

Oregon Health Authority

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Harris Family cdhp Center for Disability and Health Policy

Adding value to service through increasing access

ADA
ARC
AAR
CDA
CDSS
CDDS
CDPH
CERT
CIL

CFILC
CME
DHS
DME
EMSA
FAST
FEMA
FMSS
ILC

JFO
OES
P & A
REOC
SILC
SOC
SOP
TCL
TSA
VOAD

Cover

- Objectives
- Intent -3 As identifying gaps
- Drivers
- Who is this population
- Tool Description
- Feedback Process
- Real World Applications
- Next Steps

Objectives

To reduce access barriers by strengthening disability practice competencies:

1. **<u>Attitude</u> - be aware of & control your disability-related biases**
2. **<u>Ask</u>, listen, learn, respect & use information from members**
3. **<u>Attend</u> to details**

Another 3 As
Attitude, Ask & Attend

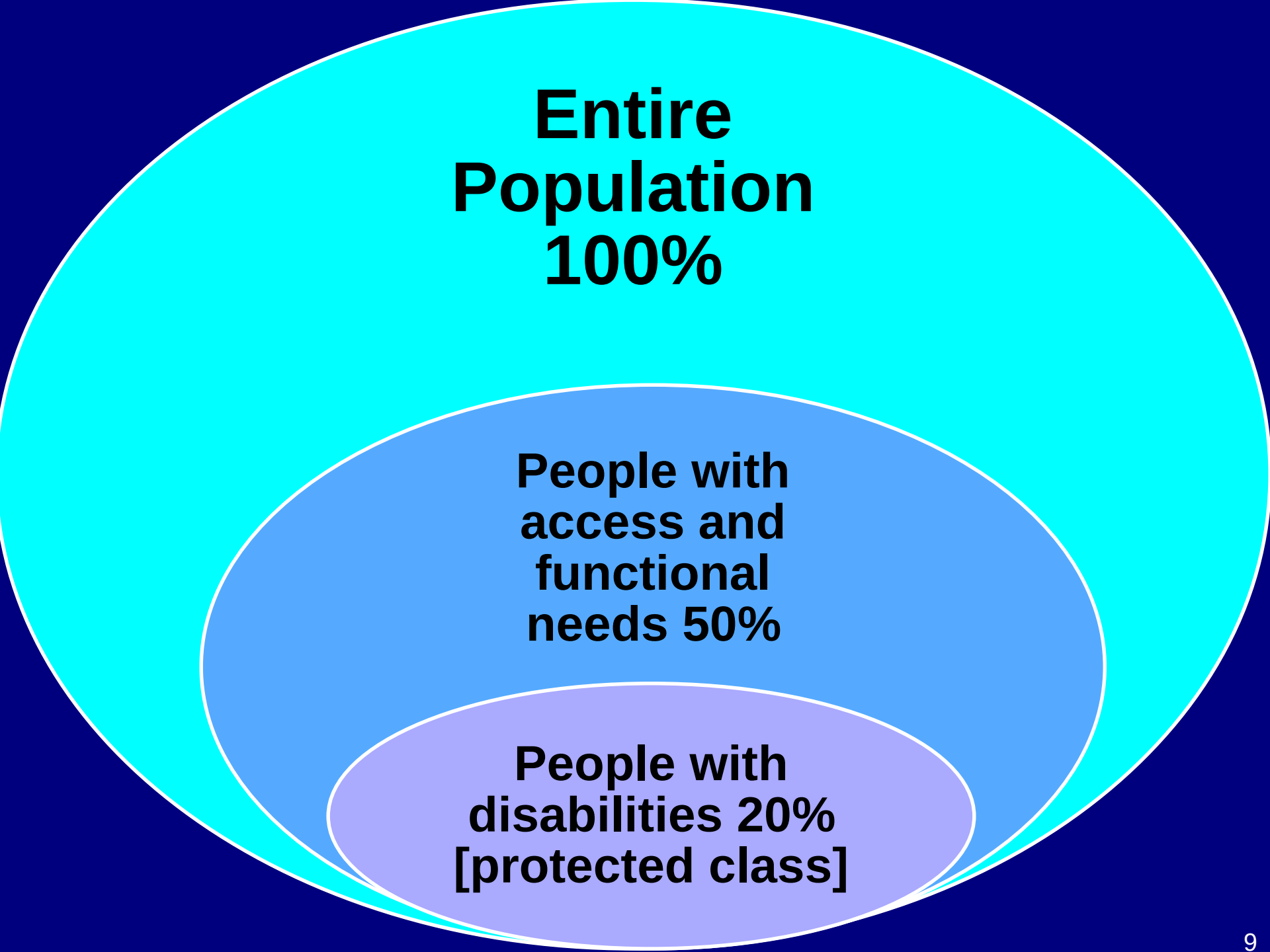
1. Reduce costly:
   a) Barriers
   b) Health disparities
   c) Appointment failures
   d) Unequal treatment
   e) Adverse events
2. Increase:
   a) Equitable, effective & quality care & services
   b) Improved health

Drivers

- Federal & State Civil Rights Laws
- State Contracts
- Affordable Care Act
- CMS Regulations
- Legal Actions
- Improve Performance/ Quality Metrics
- What else???

Drivers

Content of CMS Regs & its compliance obligations are NOT NEW. What's new is that CMS has reinforced need to comply with well-established Federal civil rights laws.


Entire Population 100%
People with access and functional needs 50%
People with disabilities 20% [protected class]

What is a Disability?

Disability is the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, developmental, or some combination of these. A disability may be present from birth or occur during a person's lifetime.

Vision

- 10% of population [18 & older] experiences difficulty seeing even when using glasses or contact lenses
- 0.7 million people (0.3%) are blind
- More than two-thirds of adults with vision limitations are over age 65

People who are deaf or hard-of-hearing

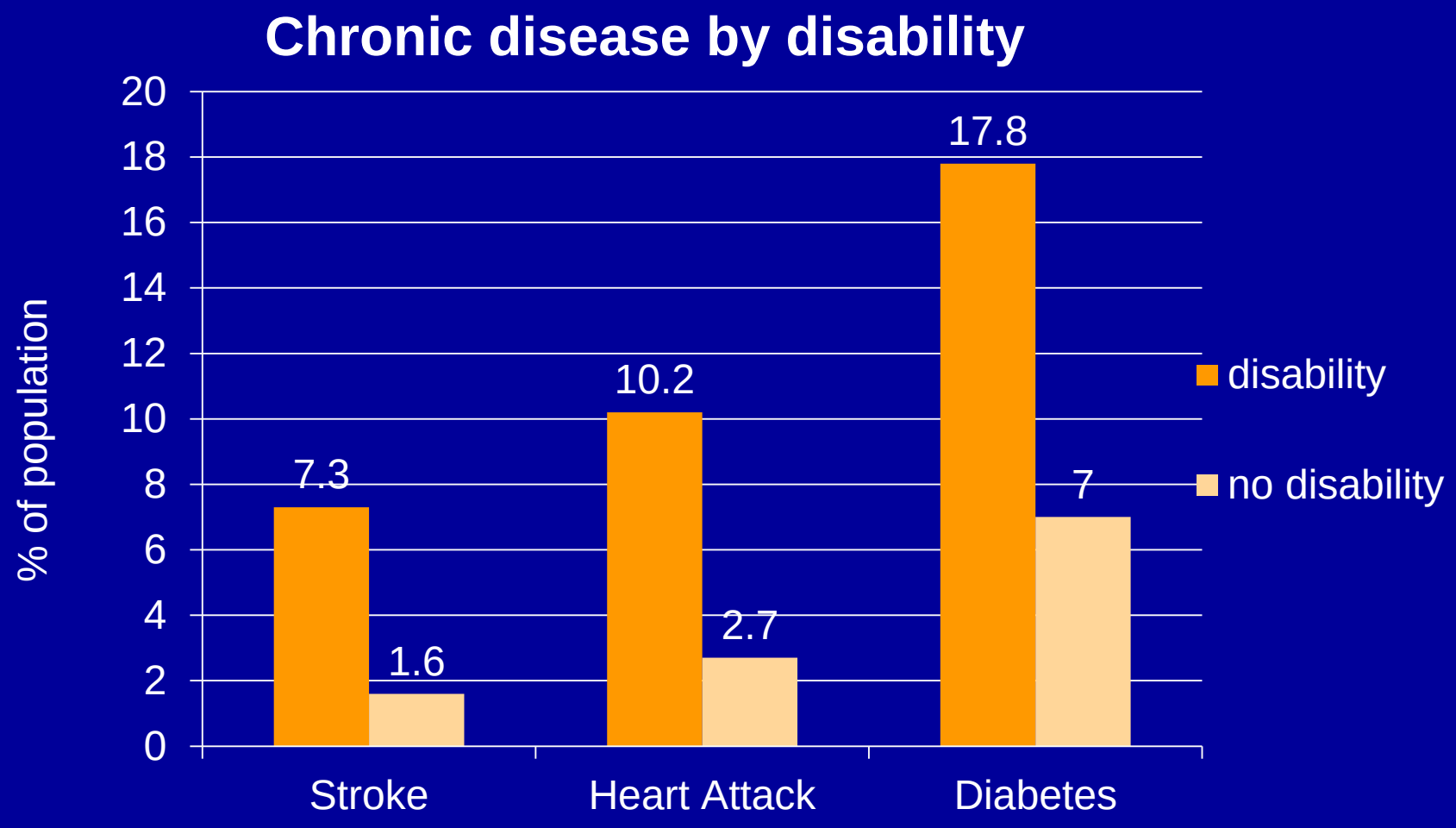
- 6th most common chronic condition in civilian population

Per 1000 people in USA, how many have some kind of hearing loss?

- 10 per 1000
- 35 per 1000
- 140 per 1000

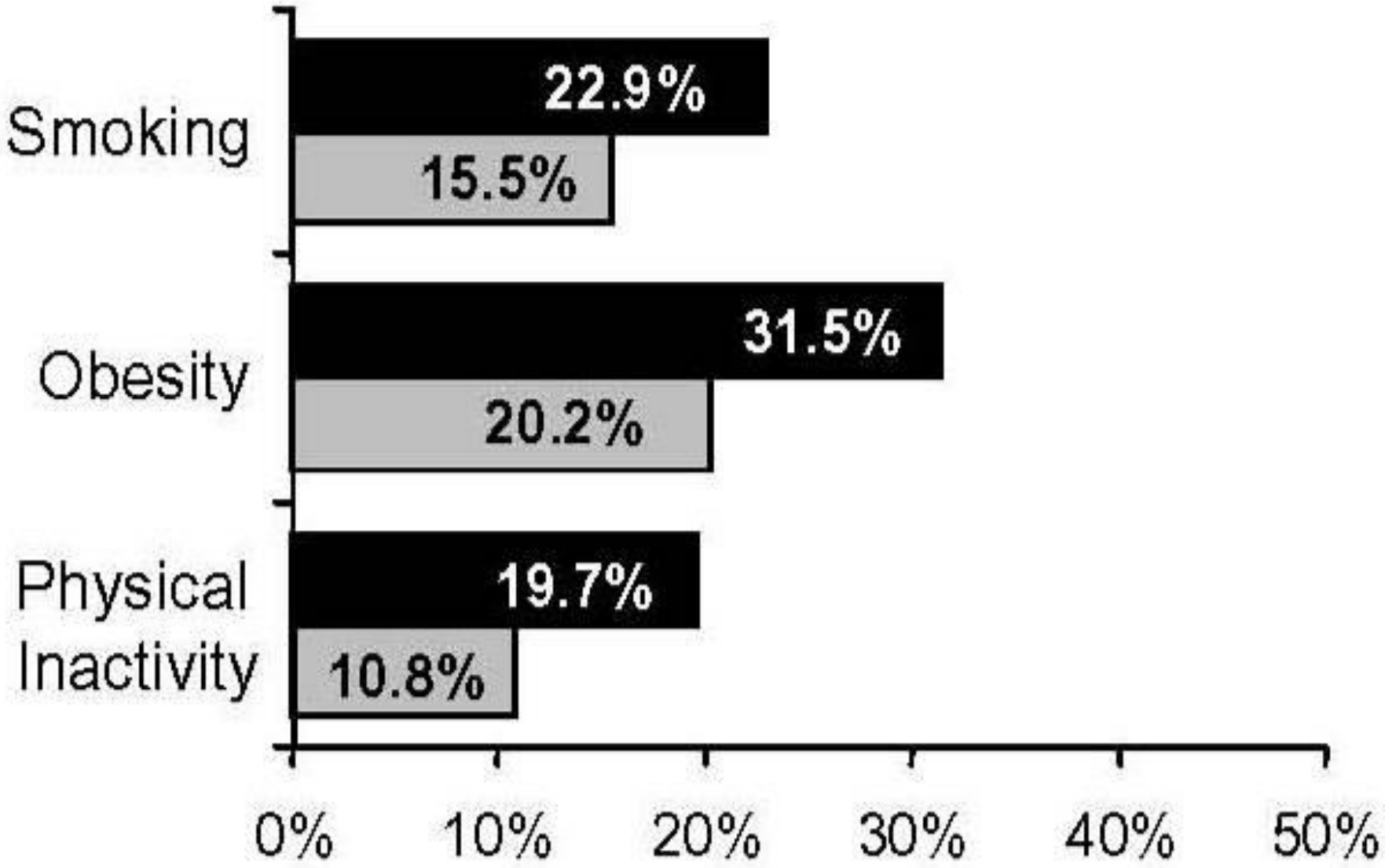
Health Disparities

BRFSS 2010



Disability = activity limitation due to health problems

Figure 4a: Health Behaviors



Providing Health Care for Participants with Disabilities: Competency Planning Checklists at:

http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx

Vague & Legalese Terms

Tool

- Gap Analysis
- No Score
- Answer Options:
  - Yes
  - No
  - Unsure
  - Comments & Follow Up
- 6 Checklists
- Definitions & Resources

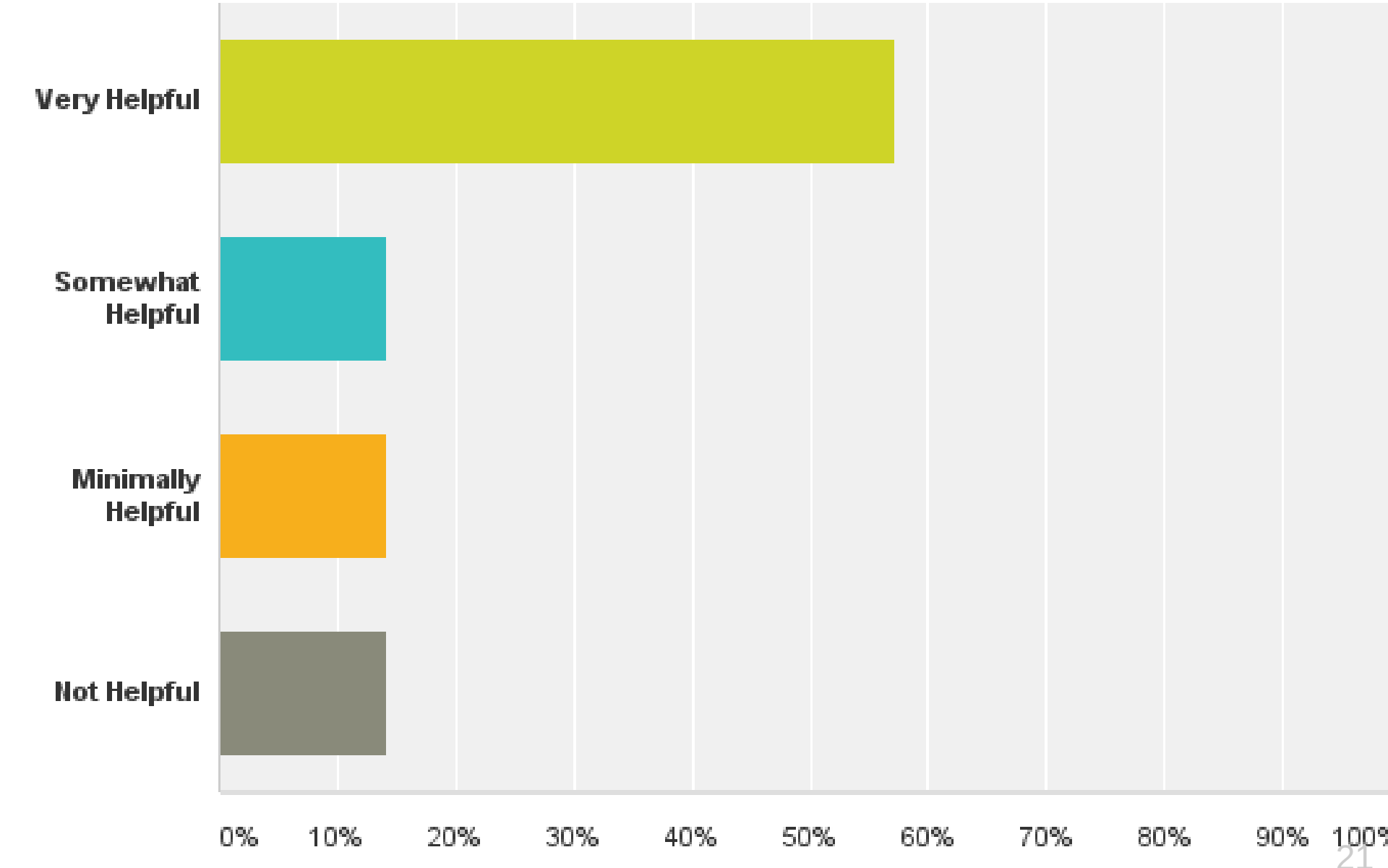
Tool: 6 Checklists

1. **Attitudes 1 p**
2. **Physical Access 1 p**
3. **Accessible Medical Equipment 1 p**
4. **Communication Access 5 p**
5. **Case Management / Care Coordination 3 p**
6. **Preventive Care & Health Education 1 p**

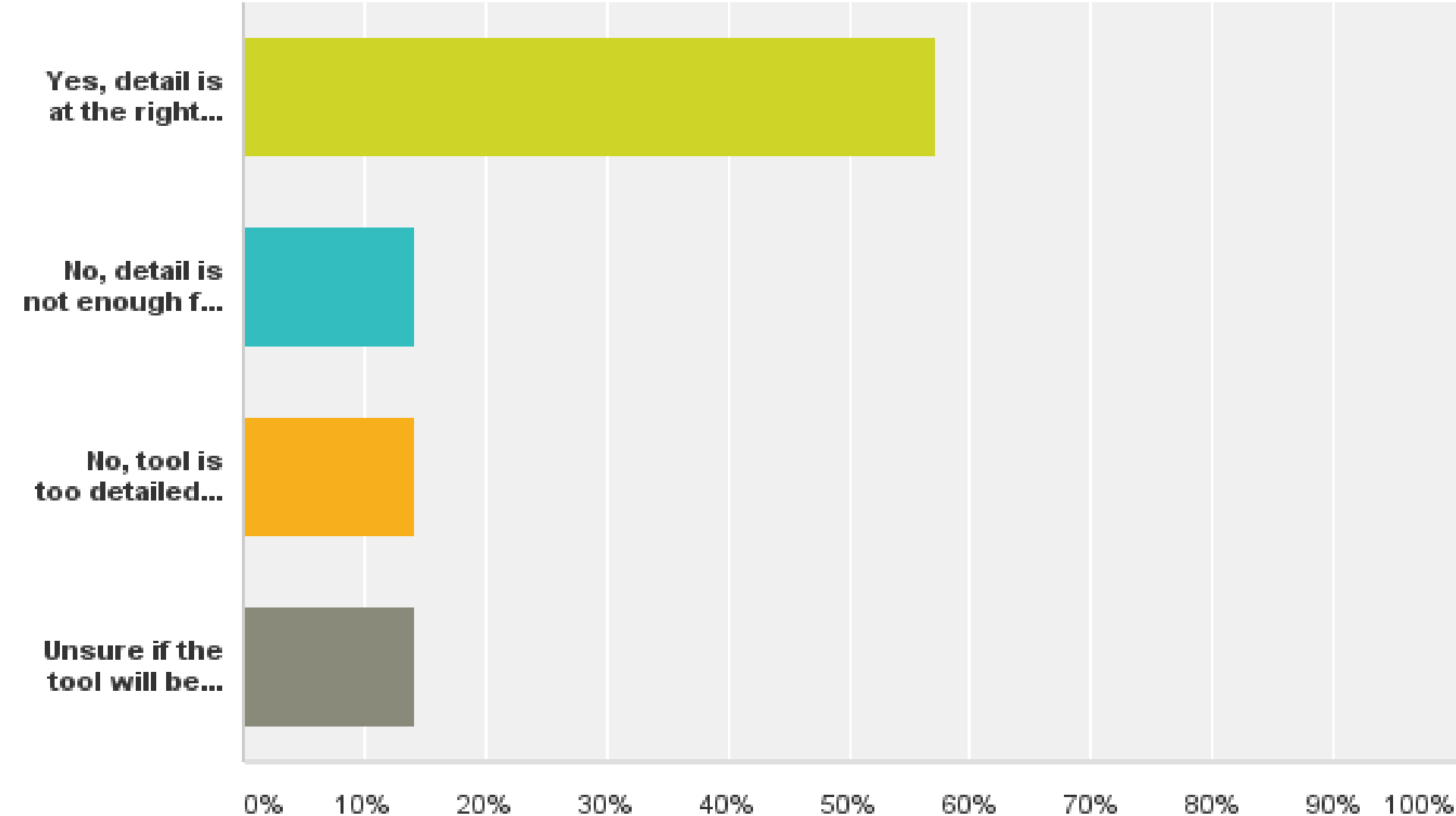
Tool Feedback Process

- Sought via e-mail request to OHA Patient Centered Primary Care Home Program distribution list 8/8/16
- Sent in statewide e-newsletter distributions from Patient-Centered Primary Care Institute (PCPCI) & Oregon Rural Primary Care Research Network (ORPRN)
- Lists include a couple of thousand.
- Requested feedback via survey monkey by 8/23/16
  - Responders 7
- Offered two webinar focus groups in morning 7-8 am & lunchtime. Cancelled due to lack of sign-ups.
- Edits/Review provided by OHA Communications incorporated plus some specific language from reviewers.

Survey Question 2: In general, do you find it helpful to have some guidance to improve your medical practice/office capabilities to address care needs for those you serve with disabilities?



3: In general, as you review the tool, do you find the detail provided adequate for your medical practice/office team to easily use the tool?



TOOL APPLIED TO REAL WORLD

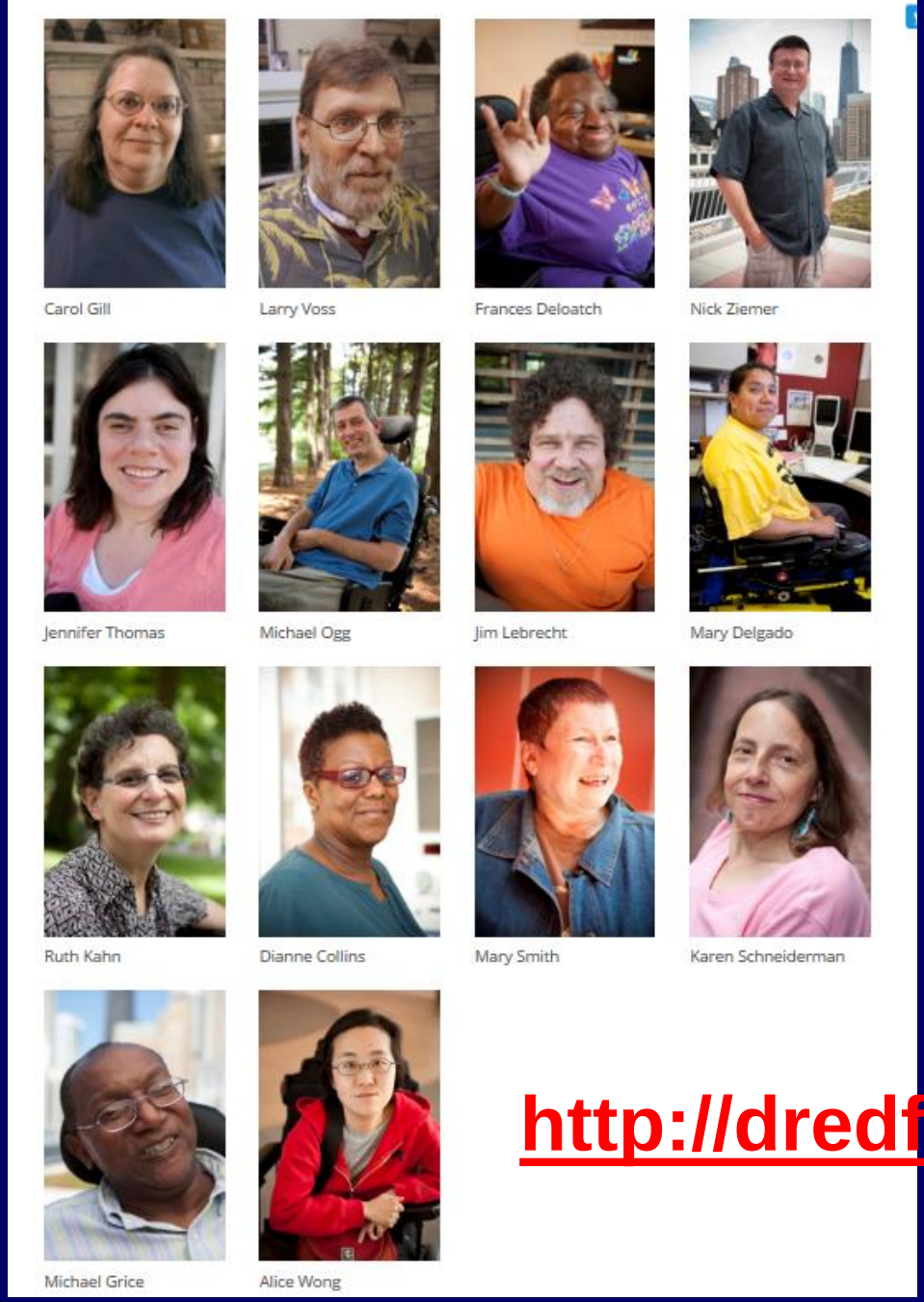
DIRECT CONNECT BETWEEN TOOL & PARTICIPANTS

Attitudes / Biases HOW DID YOU FEEL?

2013 June Isaacson Kailes
Disability Policy Consultant

Attitudes

- We are aware that our attitudes toward participants with disabilities can:
  - Influence quality of care participants receive.
  - Be expressed through tone of voice, choice of words, & questions.



Healthcare Stories

Because we experience unequal healthcare every day, out of necessity we have become experts in what must be done to remove barriers and increase access to the care we need.

Downloadable videos

http://dredf.org/healthcare-stories/

Critical Questions:

- How will you determine what assistance & accommodations are needed?
  - i.e. access needs:
    - Communication
    - Medical equipment
    - Physical
    - Other
- How will these needs be met?
  - Are policies, procedures & processes in place to meet these needs or that need to be clarified, revised or created?
    - If yes, what are they?
    - If no, what's needed?

Prepare routine questions to ask

- Will you need any assistance with (getting on & off table, walking, seeing, reading, hearing, filling out forms, communicating, speaking, during your appointment?
- Will you need an interpreter?
- Or …
  - I just want to confirm that you still need …

Maria

- Maria, age 60, is blind & hard of hearing.
  - her husband Mario is also blind.
- She arrives by bus with Mario for her 1st primary care appointment.
- She needs a series of tests (including a colonoscopy & endoscopy) involving:
  - Complex pre-test preparation for the procedures.

Communication Access

- We have processes, procedures, policies focused on how to provide accessible communication. In meeting communication access request, it is clear:
  - Who is responsible for what
  - How will this happen
  - How long will it take too meet the request


DIGITAL ANSWERING SYSTEM
PLAY/STOP
ANSWER ON/OFF
DELETE
REPEAT
SKIP
IN USE
VOLUME
HANDSET LOCATOR

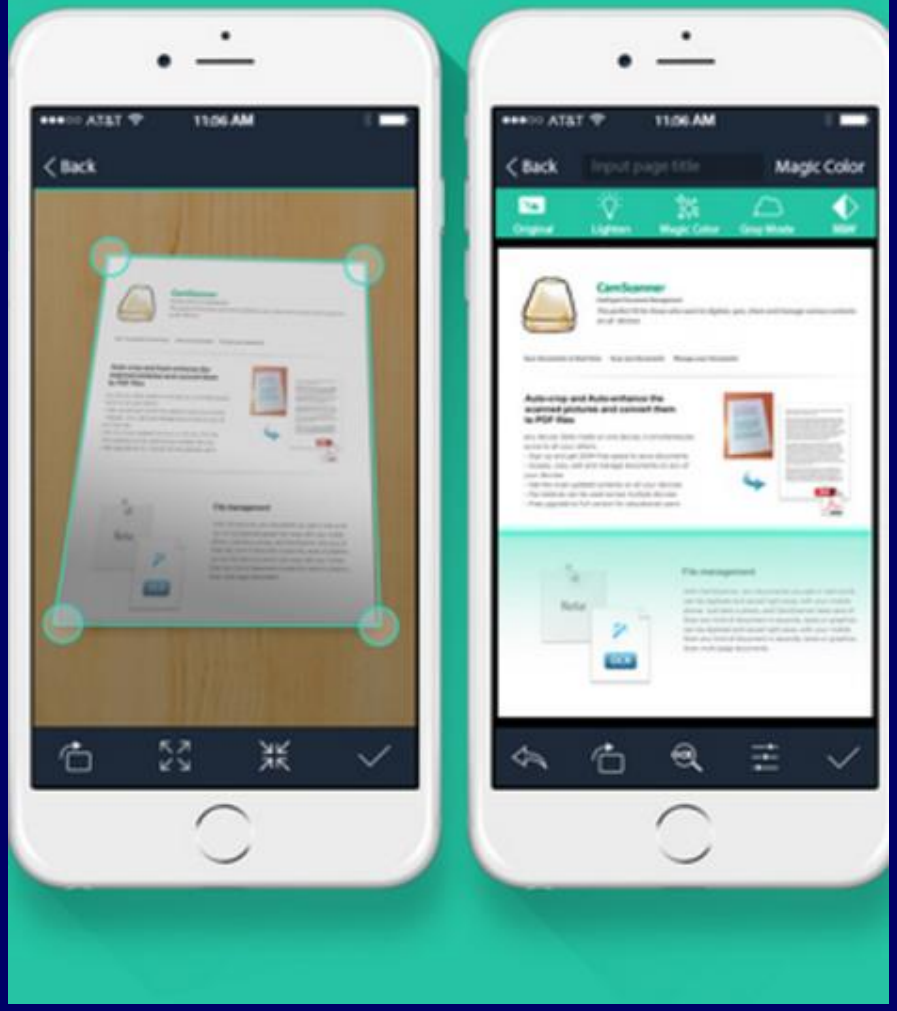

Voice Memos


Record
00:04
00:05
00:06
00:07
00:08
00:09
00:07.05
New Recording
8/27/13
Done


Voicemail

Mobile Scanner

Auto-crop & smart-enhancing
make the contents more readable



Cho

- Age 50, she uses a walker.
- Arrives alone for 1st primary care appointment.
- Her speech is very difficult to understand due to cerebral palsy. You understand only a few of her words.
- She has a mild intellectual disability
- When making her appointment the receptionist thinks Cho said that she felt a lump in her breast.

Communication Access

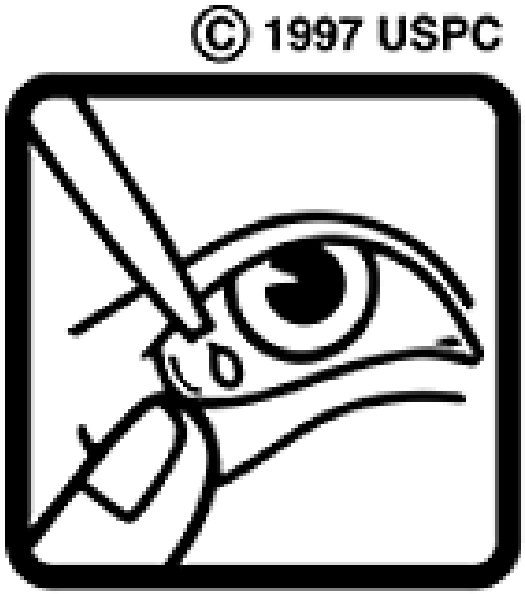
- We schedule **longer appointments** when participants are identified as needing additional time to communicate with health care provider.

Latisha age 68, wheelchair user

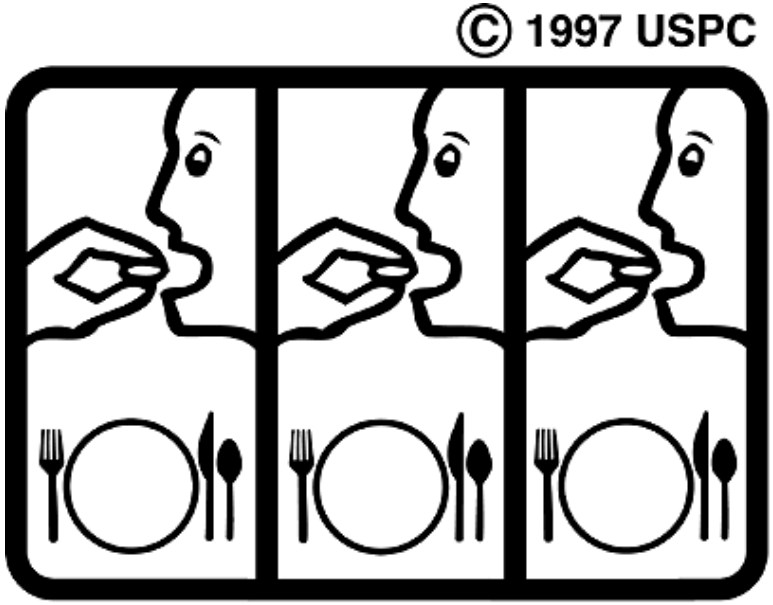
- Arrives for her 1st primary care appointment
- African-American with multiple chronic conditions
  - (obesity, diabetes, hypertension, coronary artery disease, & rheumatoid arthritis) affecting mobility & vision
- Over many years she has been labeled a "noncompliant" because she continually ignores prescribed diets & does not reliably take prescribed medications.
- She has been lectured repeatedly about these problems.

Take in the morning

Take at bedtime



Place drops in lower eyelid

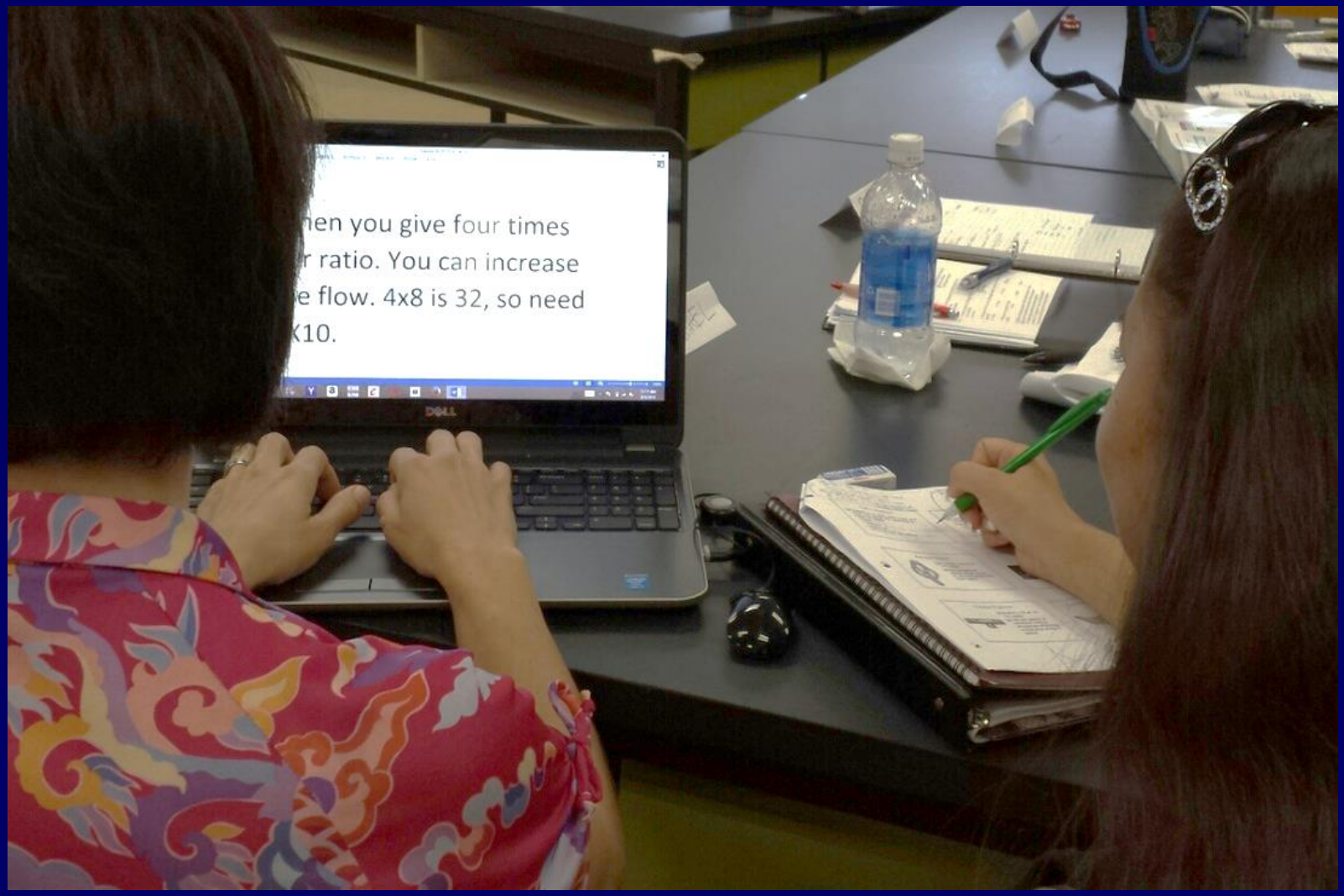


Take 3 times a day with meals

Deva

- Deva, age 55 and newly deaf, is requesting CART [computer-aided transcription service] for her next several appointments with her new oncologist. She has many questions before needing to begin treatment for breast cancer.

Computer Assisted Real Time Transcription (CART):



Communication Access

- We have clear process & staff know how to schedule, provide &/or arrange for (in timely way):
  - Computer Assisted Real Time Transcription (CART)

Kiva

- Kiva's primary care provider told her to call member services. She needs an urologist and an Ob-gyn doctor that is physically accessible, has an accessible wheelchair scale and a height adjustable exam table so she can transfer independently.

People will need to know about physical access.

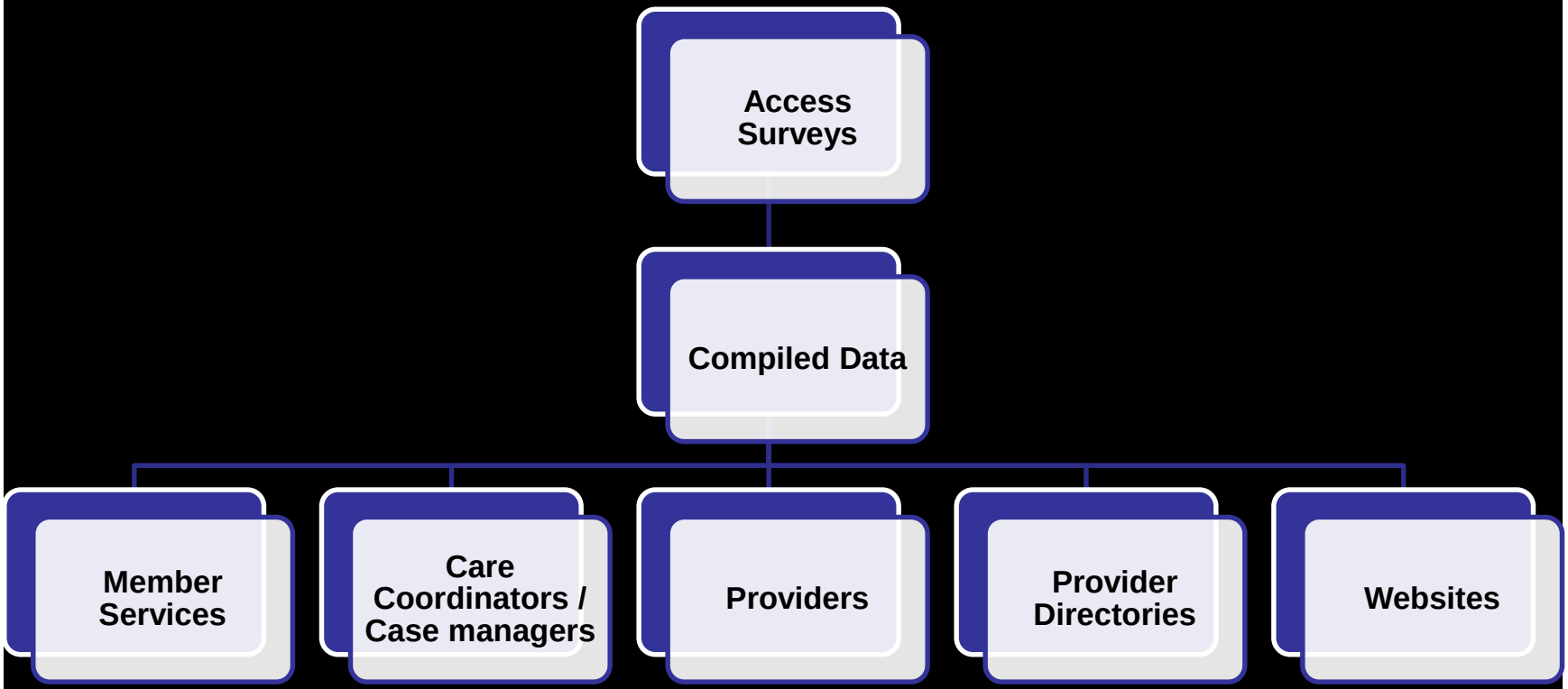
- **Parking**
- **Routes**
- **Offices**
- **Restrooms**
- **Equipment**
  - **Exam / diagnostic**

43

Physical & Equipment Access

- We can make usable referrals to other providers whose offices meet accessibility needs of participant. Referrals are made for auxiliary/specialty services & not to avoid making needed access & accommodations in our facility.
- For participants with mobility limitations, we use **exam ,procedural tables & chairs** & **scales** that:….

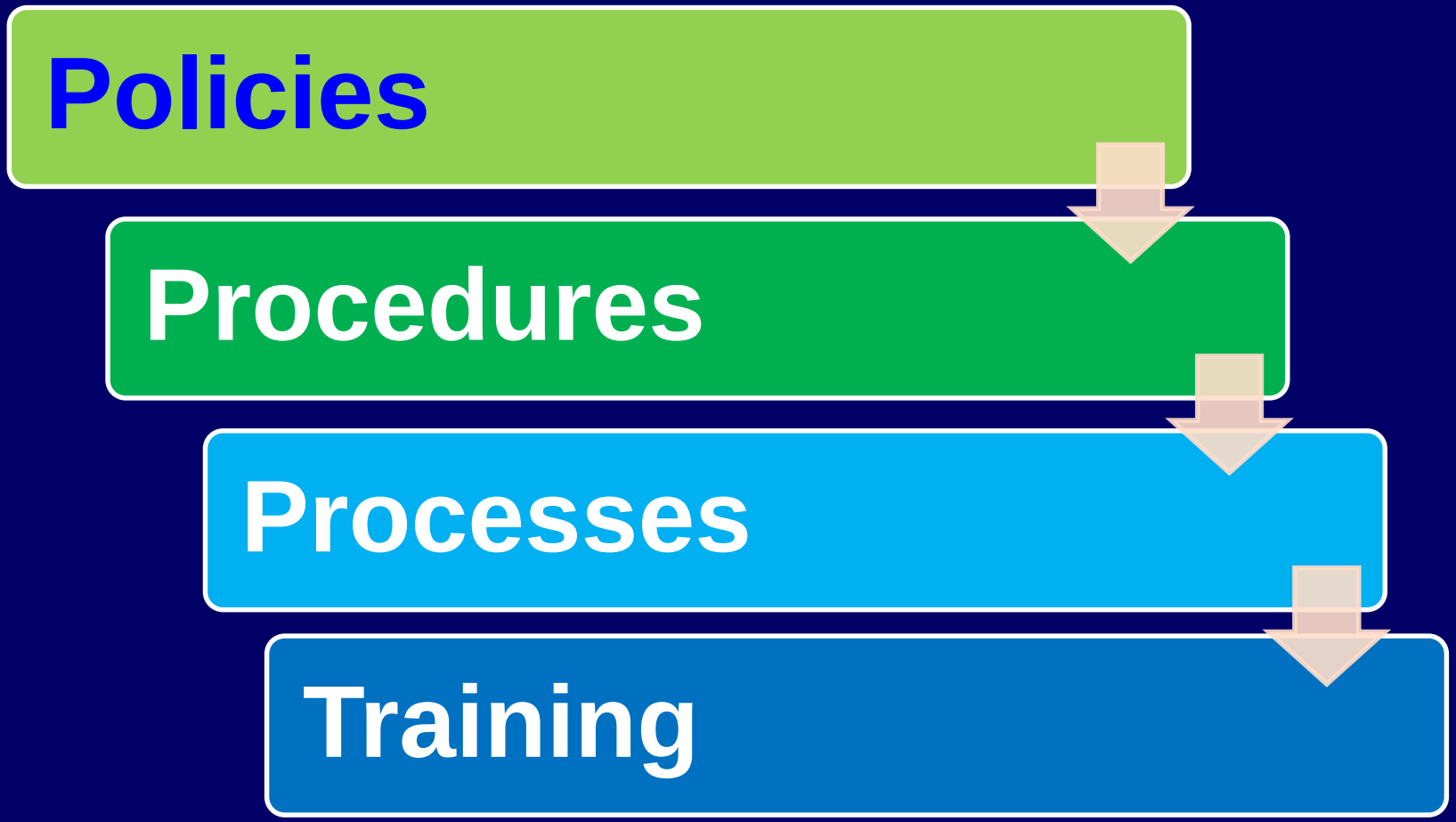
Intent of Information Flow



Real access is not just installation!

The best access, without attention to details, may never get properly used!

Making it Happen



Disability Competencies

- Work on opportunities to strengthen:
  - –Access elements offered smoothly without
    - Unnecessary disruption
    - Wait time & delay
    - Appointment failures!

Part 2: Roundtable Discussions

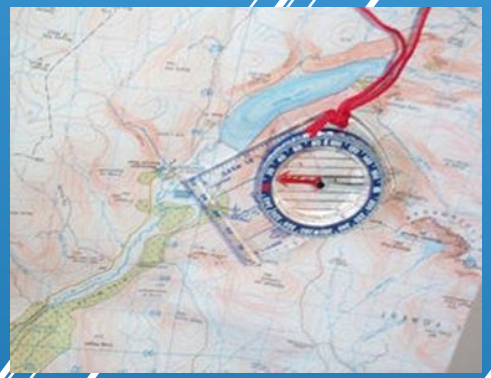
- Opportunity to look at tool
- Provide feedback
- Discuss areas you feel most overwhelmed by?
- Strategies for piloting tool

Reference Slides Only

Disability Competent Care Tool Feedback Process

- Feedback sought through e-mail request to OHA Patient Centered Primary Care Home Program distribution list sent on August 8th.
- Also sent in statewide e-newsletter distributions from Patient-Centered Primary Care Institute (PCPCI) and Oregon Rural Primary Care Research Network (ORPRN) same week.
- Lists include a couple of thousand.
- Requested feedback via survey monkey by August 23rd to be able to incorporate suggestions.
- Allow direct e-mail or document edits/notes
- Received minimal feedback in survey monkey and by e-mail.
- Offered two different webinar focus groups in morning 7-8am and lunchtime. Cancelled focus groups due to lack of sign-ups.
- Edits/Review provided by OHA Communications incorporated plus some specific language from reviewers.

DISABILITY COMPETENT CARE & THE NEW MANAGED CARE RULE

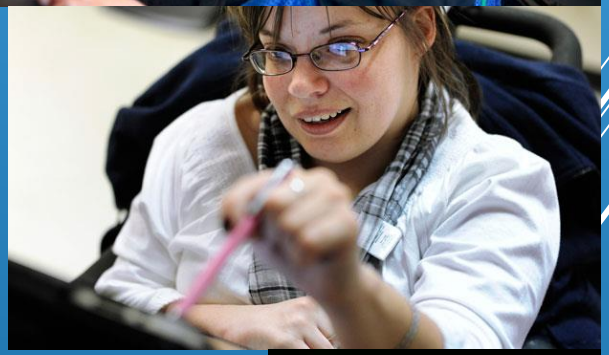


Excerpts from CMS 2390 – F,

Oregon Health Authority September 2016

VALUE OF THE DCC CHECKLISTS:

- Health Plan professionals can use these checklists to check if their policies and procedures, as well as the training they offer is inclusive of these access elements.
- These questions are not meant to be graded, but rather to be used as a planning tools to help identify opportunities for improvements, set priorities, and to track improvements over time.



REQUIREMENTS FOR CCOS:

Managed Care Rule CFR §438.10 Information requirements.

- **Written materials must include taglines in the prevalent non-English languages in the state, as well as large print which is defined as size 18 by CMS in the rule, MCO's, PIHP's, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the CCO's member/customer service unit.**
- **Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost.**
- **Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost.**

REQUIREMENTS FOR CCOS:

Managed Care Rule CFR §438.10 Information requirements.

- Require CCO entities to provide, all written materials for potential enrollees and enrollees consistent with the following:
- (i) Use easily understood language and format.
- (ii) Use a font size no smaller than 12 point.
- (iii) **Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.**
- (iv) **Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats.** Large print means printed in a font size no smaller than 18 point.

- **Readily accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions**

MANAGED CARE RULE CFR §438.10 INFORMATION REQUIREMENTS. (A)DEFINITIONS.


This program includes
closed captions for the
hearing impaired.


Braille
cc

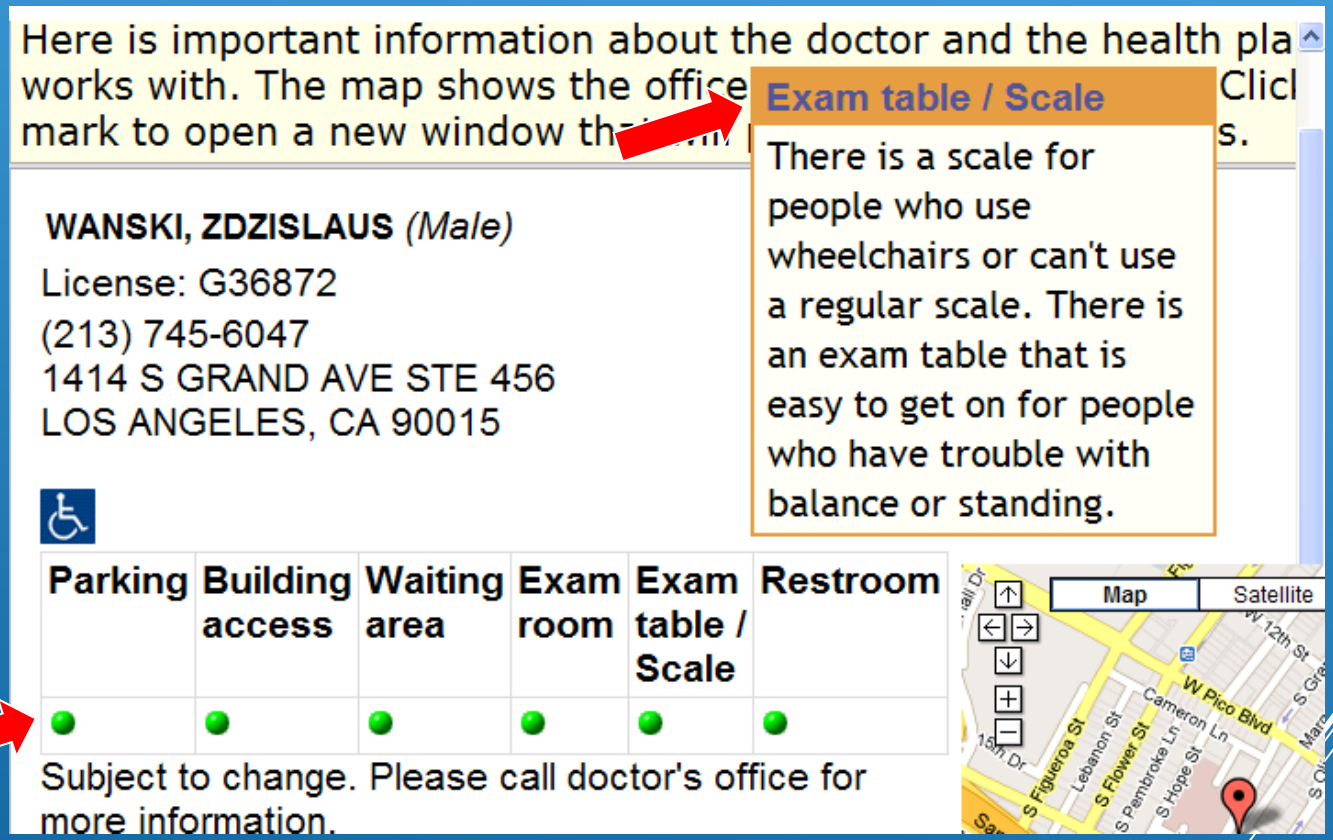
PROVIDER DIRECTORY

Managed Care Rule CFR §438.10 Information requirements.

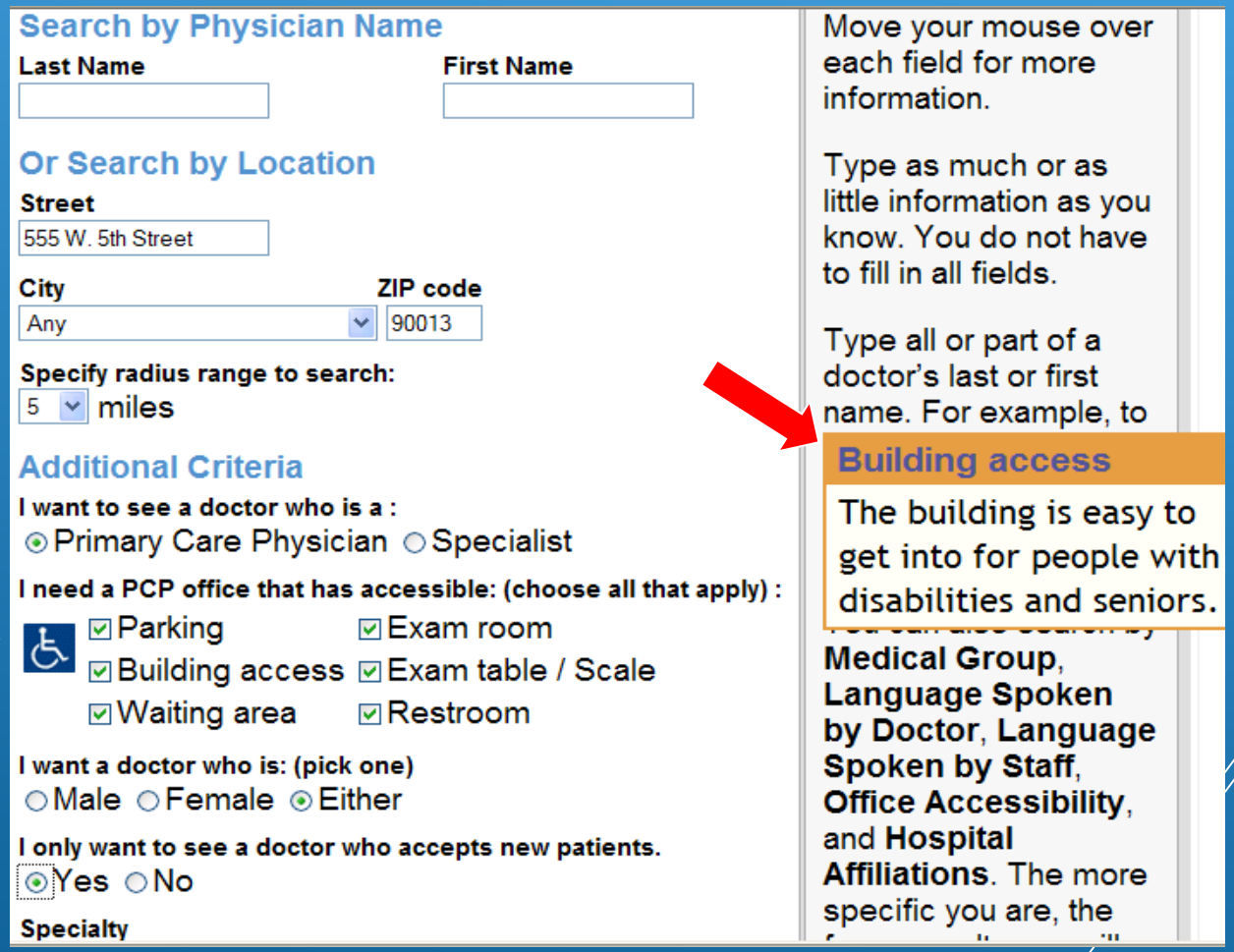
(1) Each CCO must make available in paper form upon request and electronic form, the following information about its network providers:

(vii)The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

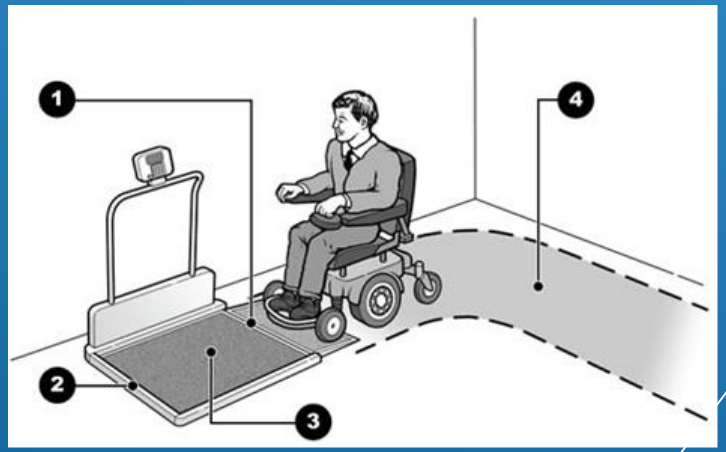
(viii)Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.


Here is important information about the doctor and the health pla
works with. The map shows the office
Clicl
mark to open a new window th
s.
Exam table / Scale
There is a scale for people who use wheelchairs or can't use a regular scale. There is an exam table that is easy to get on for people who have trouble with balance or standing.
WANSKI, ZDZISLAUS (Male)
License: G36872
(213) 745-6047
1414 S GRAND AVE STE 456
LOS ANGELES, CA 90015
Parking
Building access
Waiting area
Exam room
Exam table / Scale
Restroom
Subject to change. Please call doctor's office for more information.
Map
Satellite
W 12th St
W Pico Blvd
Cameron Ln
S Figueroa St
Lebanon St
S Flower St
S Pembroke Ln
S Hope St

Getting the word out: “Find a Doctor” search, L.A. Care’s website



LINKED RESOURCES TO ENSURE CLARITY FOR ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES STANDARDS



Disability Competent Care & The New Managed Care Rule

Oregon Coordinated Care Organizations can use these completed checklists for supportive documentation for primary care/provider requirements for network standards outlined in CMS 2390 F or CFR 438.10 Information Standards.

Consider: Using the checklists to help you define the requirements for required information fields needed in provider directories

What does accessible mean?
What do members need to know?
How can providers support sharing NEMT processes?
How can we be assured providers are meeting language and interpreter access standards?

Other valuable tools for access : Checklist for Medical Clinics and Facilities in Oregon, 2010 ADA Standards For Accessible Design Oregon State Building Code, 10/2013, Northwest ADA Center University of Washington, **http://nwadacenter.org/toolkit/accessibility-checklists**

DISABILITY COMPETENT CARE AND OREGON CCO'S INTENSIVE CASE MANAGEMENT

OAR 410-141

- (31) **"Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled who have complex medical needs including**:
- (a) Early identification of members eligible for ICM services;
- (b) Assistance to ensure timely access to providers and capitated services;
- (c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;
- (d) Assistance to providers with coordination of capitated services and discharge planning; and
- (e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

INTENSIVE CARE MANAGEMENT AND CONNECTION TO DISABILITY COMPETENT CARE

Oregon Health Authority September2016

DISABILITY COMPETENT CARE AND OREGON CCO'S INTENSIVE CASE MANAGEMENT

OAR 410-141-3220

- (2) **CCOs shall make intensive care coordination services available to members identified as aged, blind, or disabled, who have complex medical needs, high health care needs, multiple chronic conditions, behavioral health issues, and for members with severe and persistent behavioral health issues receiving home and community-based services under the state's 1915(1) State Plan Amendment.** The member, member's representative, provider, other medical personnel serving the member, or the member's Authority case manager may request intensive care coordination services.

DISABILITY COMPETENT CARE AND OREGON CCO'S INTENSIVE CASE MANAGEMENT

OAR 410-141

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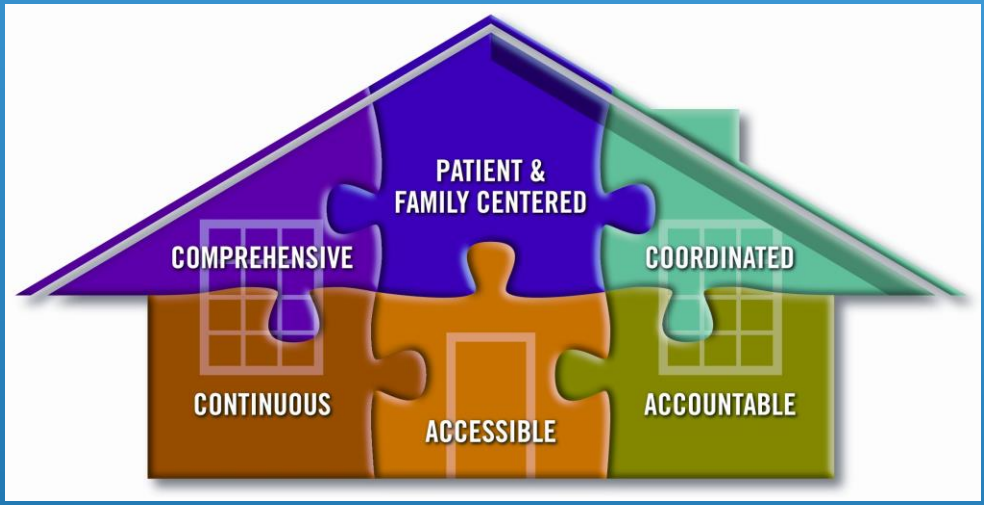
- (d) Assistance to providers with coordination of capitated services and discharge planning; and
- (e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

PATIENT CENTERED PRIMARY CARE HOMES AND CONNECTION TO DISABILITY COMPETENT CARE

Oregon Health Authority September 2016



Core Attributes of the Oregon Patient Centered Primary Care Home Model

Access to care: Patients get the care they need, when they need it.
Accountability: Recognized clinics are responsible for making sure patients receive the best possible care.
Comprehensive: Clinics provide patients all the care, information and services they need.
Continuity: Clinics work with patients and their community to improve patient and population health over time.
Coordination and integration: Clinics help patients navigate the system to meet their needs in a safe and timely way.
Patient and family-centered: Clinics recognize that patients are the most important members of the health care team and that they are ultimately responsible for their overall health and wellness.

- **There are many places where the DCC tool will assist providers in working to meet the spirit and intent of the PCPCH Standards!**

PATIENT-CENTERED PRIMARY CARE HOME STANDARDS

HTTPS://WWW.OREGON.GOV/OHA/PCPCH/PAGES/STANDARDS.ASPX

SOME EXAMPLES CONNECTIONS TO DCC CHECKLISTS

Standard 2.C) Patient and Family Involvement in Quality Improvement

Standard 3.D) Comprehensive Health Assessment & Intervention

3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors

Standard 4.C) Organization of Clinical Information
4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.

Standard 5.A) Population Data Management

5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population.

5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.

Standard 5.C) Complex Care Coordination

5.C.1 PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.

5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.

5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness

Standard 5.E) Referral & Specialty Care Coordination

5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.

5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).

5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non - traditional health workers and pharmacy services.

Standard 6.A) Language / Cultural Interpretation

6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.

6.A.1 PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.

Standard 6.B) Education & Self-Management Support

6.B.1 PCPCH has a process for identifying patient - specific educational resources and providing those resources to patients when appropriate.

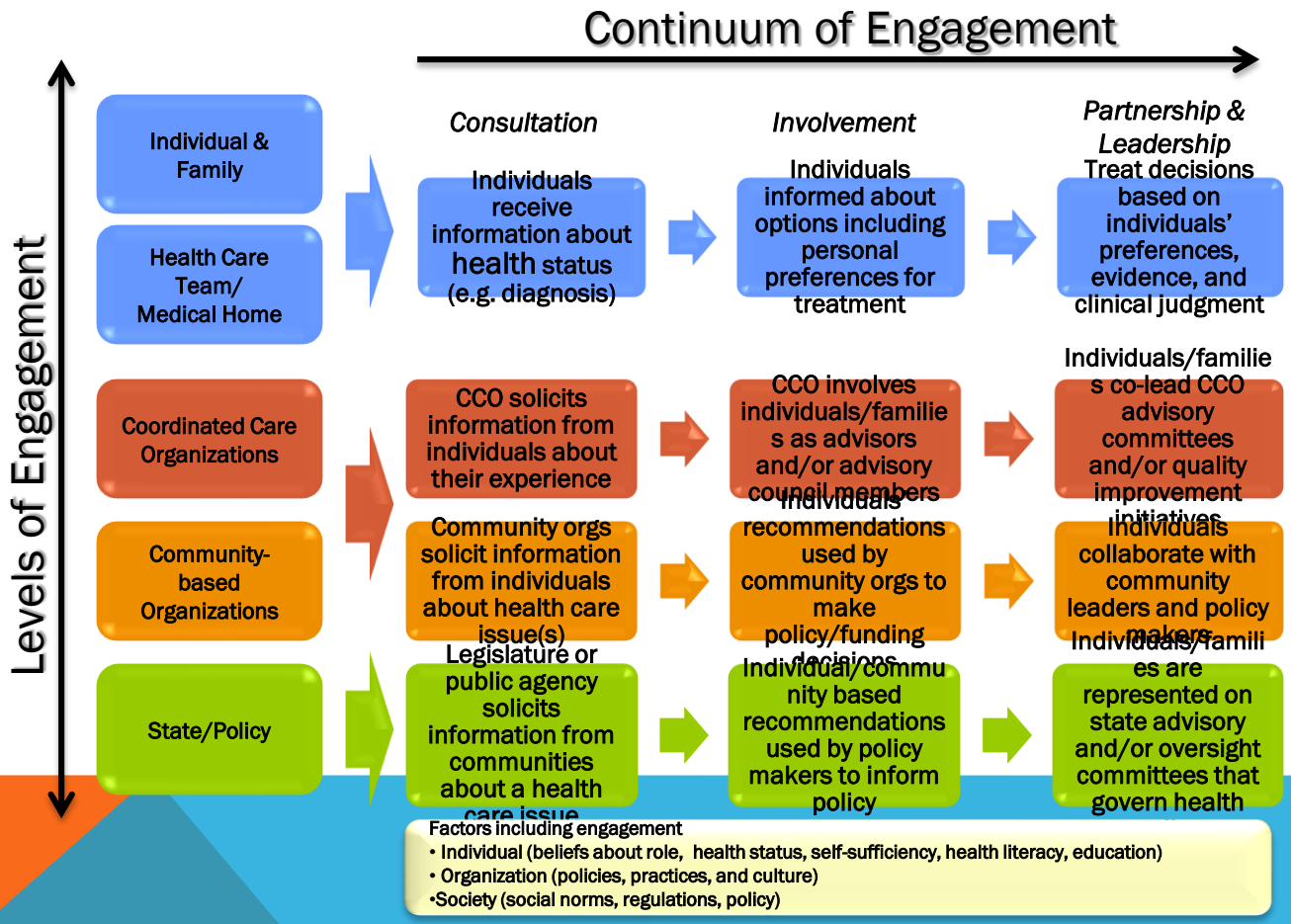
6.B.2 More than 10% of unique patients are provided patient- specific education resources

6.B.3 More than 10% of unique patients are provided patient - specific education resources and self - management services.

THE 2017 OREGON PCPCH TECHNICAL ASSISTANCE AND REPORTING GUIDE (TAGUIDE)

HTTPS://WWW.OREGON.GOV/OHA/PCPCH/DOCUMENTS/TA-GUIDE.PDF

A Multidimensional Framework for Individual And Family Engagement In Oregon



Adapted from Carman K L et al. Health Aff 2013;32:223-231

- **There are many places where the DCC tool will assist providers in working to meet the spirit and intent of the Oregon PCPCH Standards!**

PATIENT-CENTERED PRIMARY CARE HOME STANDARDS

HTTPS://WWW.OREGON.GOV/OHA/PCPCH/PAGES/STANDARDS.ASPX

Communication Access Section

- G1. When scheduling appointments, we always ask participants to identify or reconfirm assistance and accommodations needs. We ask "will you need any assistance with getting on and off a table, walking, seeing, reading, hearing, filling out forms, communicating, speaking, during your appointment? Will you need an interpreter?"
- Q2: We follow guidelines noted in Section K, L, M and strive to ensure notes, handouts, brochures, consent forms, health education materials, instructions and other materials where needed to ensure patient care standards are translated and available in prevalent languages and alternative formats.

DCC TOOL & PATIENT CENTERED PRIMARY CARE HOME CROSS-WALK EXAMPLES

6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.

Care Management / Care Coordination

R.8.	Comprehensive and Multidimensional Assessment
R.8.1.	The initial assessment is comprehensive and multidimensional, incorporating all aspects of the participant's life. Areas to cover include, but are not limited to: • Participant's strengths, goals, and priorities • Demographic, contact, financial, and eligibility information • Social activities • Functional assessment (activities of daily living [ADL], instrumental activities of daily living [IADL], or copy of assessment participant provides that was completed already (ASK!) • Medical diagnoses and history • Behavioral health screening (s). • Nutrition (food access, preparation, diet, etc.) • Document all health-related services (including behavioral management, exercises, medications, equipment use, skilled therapies, rehabilitation therapies) and all current providers • Long-term services and supports (LTSS) • Home and community environment, safety, accessibility, and health risks • Formal, informal, and social supports

DCC TOOL & PATIENT CENTERED PRIMARY CARE HOME CROSS-WALK EXAMPLES

COMPLEX CARE COORDINATION

5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness

And COMPREHENSIVE HEALTH ASSESSMENT

3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors

Care Management / Care Coordination

R.5.	**We ensure that participants can designate a family member or other person to be involved in IDT-related communications including program planning and implementation.**
R.5.a.	• We document this in the individual plan of care (IPC) and communicate this to all IDT members.
R.5.b.	• This designated person can include a guardian, conservator and other designated lead.

DCC TOOL & PATIENT CENTERED PRIMARY CARE HOME CROSS-WALK EXAMPLES

5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness

Care Management / Care Coordination

S.7.	The participant plan of care (IPC) includes a health and wellness plan, including:
S.7.a.	• Accessing primary care
S.7.b	• Routine preventive health services and screenings
S.7.c.	• Prevention of secondary conditions of disability
S.7.d.	• Management of conditions associated with existing disability and chronic conditions/referral to programs to strengthen management of chronic conditions
S.7.e.	• Opportunities for appropriate and accessible physical activities/referral to community programs for physical activity.

DCC TOOL & PATIENT CENTERED PRIMARY CARE HOME CROSS-WALK EXAMPLES

5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness

INTENSIVE CARE MANAGEMENT AND CONNECTION TO DISABILITY COMPETENT CARE

Oregon Health Authority September2016

DISABILITY COMPETENT CARE AND OREGON CCO'S INTENSIVE CASE MANAGEMENT

OAR 410-141-3220

- (2) **CCOs shall make intensive care coordination services available to members identified as aged, blind, or disabled, who have complex medical needs, high health care needs, multiple chronic conditions, behavioral health issues, and for members with severe and persistent behavioral health issues receiving home and community-based services under the state's 1915(1) State Plan Amendment.** The member, member's representative, provider, other medical personnel serving the member, or the member's Authority case manager may request intensive care coordination services.

OAR 410-141

- (31) **"Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled who have complex medical needs including:**
- (a) Early identification of members eligible for ICM services;
- (b) Assistance to ensure timely access to providers and capitated services;
- (c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;
- (d) Assistance to providers with coordination of capitated services and discharge planning; and
- (e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

DCC TOOL, INTENSIVE CARE COORDINATION & PATIENT CENTERED PRIMARY CARE HOME CROSS-WALK EXAMPLES

R.3.	**The primary care home IDT coordinates with care managers involved with individuals outside of the primary care homes (such as at the coordinated care organization (CCO) or APD/AAA staff (Aged and people with disabilities, Area Agencies on Aging) to ensure services are integrated and coordinated.**

Standard 5.E) Referral & Specialty Care Coordination

5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.

5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).

5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non - traditional health workers and pharmacy services.

Quality Services for Persons with Disabilities

- 4-part training (https://www.hfcdhp-training.org/index.jsp for a sneak peek):
  1. Defines “disability”
  2. Americans with Disabilities Act of 1990 - how it impacts health care services
  3. How health care worker's attitudes & beliefs may affect quality health care
  4. Physical, communication, and medical equipment trying to obtain health care.