

Providing Disability-Competent Primary Care

Leading Healthcare Practices and Training: Defining and Delivering Disability-Competent Care

Effective primary care for adults with disabilities can support early diagnosis of treatable diseases and reduce hospitalizations and poor outcomes. It is built on a strong provider-participant relationship that involves active listening, shared problem solving, and developing preventive strategies and a comprehensive care plan. The **care plan addresses the integrated health and social constraints** that can worsen the participant's lived experience with a disability and consequently their physical health, as well as the disability or related medical issues.

The **primary care team composition** includes professionals who work together to provide primary health care to a participant base. The idea of a primary care team is part of a vital evaluation of health care providers in various communities. The primary care team is made up of doctors, nurse practitioners or physician assistants, as well as skilled administrators and clerical workers, record keepers, and those involved in managerial work or other aspects of the medical office.

It should be noted that this is different than an interdisciplinary team which consists of practitioners from different professions who share a common participant population and common participant care goals and have responsibility for complementary tasks. The team is actively interdependent, with an established means of ongoing communication among team members and with participants and family members to ensure various aspects of participant care is integrated and addressed.

The table below indicated several **key challenges faced by primary care providers that work with participants with disabilities**. Often times challenging situation can be mitigated by embracing fundamental changes in an approach.

Challenges in Primary Care	Opportunity through the Disability-Competent Care Model
Inadequate, discontinuous, unengaged care delivery	 Team approach The provider-participant relationship is a partnership where both sides are active in the participant's health care Staff training
Inappropriate dependence upon emergency departments	 24/7 access to care team, supported by participant's clinical record to inform decision making
Difficulty of getting to physician offices/clinics for care; Inability of physician to assess home environment	 Capacity for home visits and transfer of clinical decisions to the home or other care settings as necessary; full "picture" of needs
Traditional "disempowered role" of participant in the relationship with busy physicians	 Meaningful participant involvement in care management and care design
Fragmented relationships with specialists, hospital and institutional providers	 Coherent and fully organized hospital, institutional and specialist network centered



	around the interdisciplinary care team (IDT)
Insurance coverage restrictions and service authorization requirements	 Fully empowered primary care team that can order or authorize all needed services
Lack of continuity and shared information among medical, behavioral health, and long-term care providers	 Fully integrated network of providers with the primary care team as the "hub" to promote information sharing and effective care transitions
Incoherent "picture" of totality of the participant's medical, behavioral health, and support service needs	 Fully integrated clinical record and state-of-the- art data support

Additional Resources

Please visit the *Resources for Integrated Care* website (https://www.resourcesforintegratedcare.com) for the "Defining and Delivering Disability-Competent Care" webinar series which served as the basis for this brief and for other Disability-Competent Care-related resources including an interactive self-assessment tool.