Adults with Special Healthcare Needs

Diverse Groups
Adults with special health care needs are a diverse group. They experience health conditions ranging from hypertension and heart disease to severe mental and physical disorders. Their levels of disability may vary from speech and motor disorders to paraplegia. The type and intensity of services they need range from the regular use of doctor prescribed medicines to round the clock nursing care. The following guideline outlines strategies to ensure high quality health care for individuals with special health care needs.

Definition
Adults with special health care needs are those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally.

Defining Adult Special Health Care Needs
There is a wide variety of physical, mental, and psychological health conditions considered to be special healthcare needs that range from relatively mild to chronic and severe. The National Center for Health Statistics (NCHS), which provides much of the data about characteristics of health insurance for those with disabilities, defines Adults with Special Health Care Needs as the following:

- A specific physical, functional, or mental or emotional disability or limiting condition
- Significant limitations in performing daily self-maintenance activities
- Need for the use of special equipment or devices, such as a wheelchair or breathing aid
- Limitation in a major or other life activity because of physical, mental, or emotional problems
- Other indicators of disability, such as poor overall health status, use of specialized programs or services, or other behavioral indicators of disability or developmental delay.
### Addressing the Needs of Adults with Special Health Care Needs

#### Preventive Screening and Immunizations
- Identify risks including fall risks, self-neglect
- Interventions for unhealthy lifestyle, habits
- Screen for domestic violence and family support
- Mental health assessment
- Use of high risk medications
- ADL’s – abilities and limitations

#### Referrals and care coordination
- PT/OT/ST
- Home Health
- Human Services
- Specialist care
- Family
- Diagnostics
- Case Management (Strive)
- RMHP Case Manager

#### Patient education and engagement
- Screenings
- Home self-monitoring
- Medications Management (side effects/adherence)
- ER utilization
- Activity Level

#### Special circumstances
- Chronic Conditions (dialysis/chemo)
- Group homes
- Transportation needs
- Adaptive equipment
- Recent hospitalization or procedure
- Recent ER visit
- Homeless
- Mental Health Provider
## Develop a Care Plan

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| **Medical Summary**   | Current diagnosis, problem list, treatment including medications, recurrent problems, past medical history and community based care. | • Emergency contact  
• Allergies and medications  
• Diagnosis and active problem list  
• Consultants and their contact information  
• Transport/equipment needs  
• Past medical history  
• Review of systems  
• Coverage  
• concerns/recurrent problems  
• Hospitalizations  
• Assets and challenges unique to individual child | Using a documentation template can be an effective mechanism to collect and organize medical summary information. Many electronic medical records (EMR) also include comprehensive medical summary templates. Building A Medical Home Care Coordination includes examples: [https://www.medicalhomeportal.org/clinical-practice/building-a-medical-home](https://www.medicalhomeportal.org/clinical-practice/building-a-medical-home) |
| **Emergency Treatment Plan** | Consider creating a separate emergency treatment plan for complex conditions and/or recurrent life threatening events. | • Primary care specialty contact numbers  
• Diagnosis, past medical history, most recent physical exam  
• Allergies:  
• Medications/Food  
• Procedures to be avoided  
• Immunizations  
• Common presenting problems/findings with specific suggested managements | Emergency Preparedness for Vulnerable Populations: People with Special Health-care Needs [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2646456/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2646456/) |
| **Adult Care Planning** | A working care plan aids focus of role in practice-based care coordination. | • Prioritize list of main concerns/goals  
• Current clinical, educational, and social information pertinent to the concerns/goals  
• Current plan/intervention for that concern/goal  
• Person(s) responsible for that intervention  
• Due date for the intervention | Building A Medical Home Care Coordination includes care planning examples: [https://www.medicalhomeportal.org/clinical-practice/building-a-medical-home](https://www.medicalhomeportal.org/clinical-practice/building-a-medical-home) |
The use of guidelines must always be in the context of a health care provider's clinical judgment in the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool to provide information and assist decision-making.

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This guideline summary is not all-inclusive of available guideline content. Please reference the full guideline for comprehensive content.