HCCI™
HOME CENTERED CARE INSTITUTE

Bridging the Gap with Home-Based Primary Care

(Session 1 of 4)

Crossroads of Care: Managing Serious Illness in the Home

June 13, 2023 • Schaumburg, Illinois

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Advancing home-based primary care to ensure medically complex patients have access to high-quality care in their homes

EDUCATION | CONSULTING | RESEARCH | ADVOCACY

What We Do

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HCCIntelligence™ Resource Center

Hotline

Call 630.283.9222 or email Help@HCCInstitute.org
9:00 am-5:00 pm (CST)
Monday through Friday

Webinars

HCCI hosts free and premium webinars on topics relevant to Home-Based Medical Care. Visit the HCCIntelligence™ Resource Center for upcoming dates and topics.

Tools and Tip Sheets

Downloadable tools, tip sheets, sample forms and how-to guides on a variety of Home-Based Medical Care topics.

The John A. Hartford Foundation

HCCIntelligence™ is funded in part by a grant from The John A. Hartford Foundation.

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HCCI gratefully acknowledges support for this activity from:

Elea Institute is dedicated to advancing care for people with serious illness.

Learn more at eleainstitute.org.

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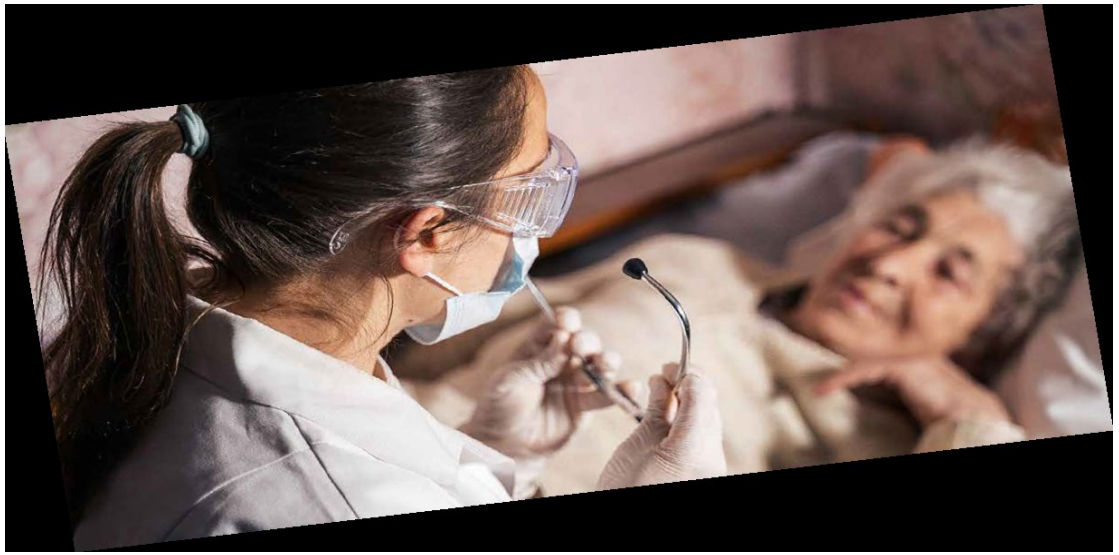
The Intersection of Home-based Primary Care and Palliative Care



Thursday, September 14

3:00-5:00pm

1900 E. Golf Road, 4th floor

Schaumburg

Future Sessions:

- Optimizing Efficiency in House Call Operations
- Contracting with Payers to Demonstrate the Value of Home-Centered Care

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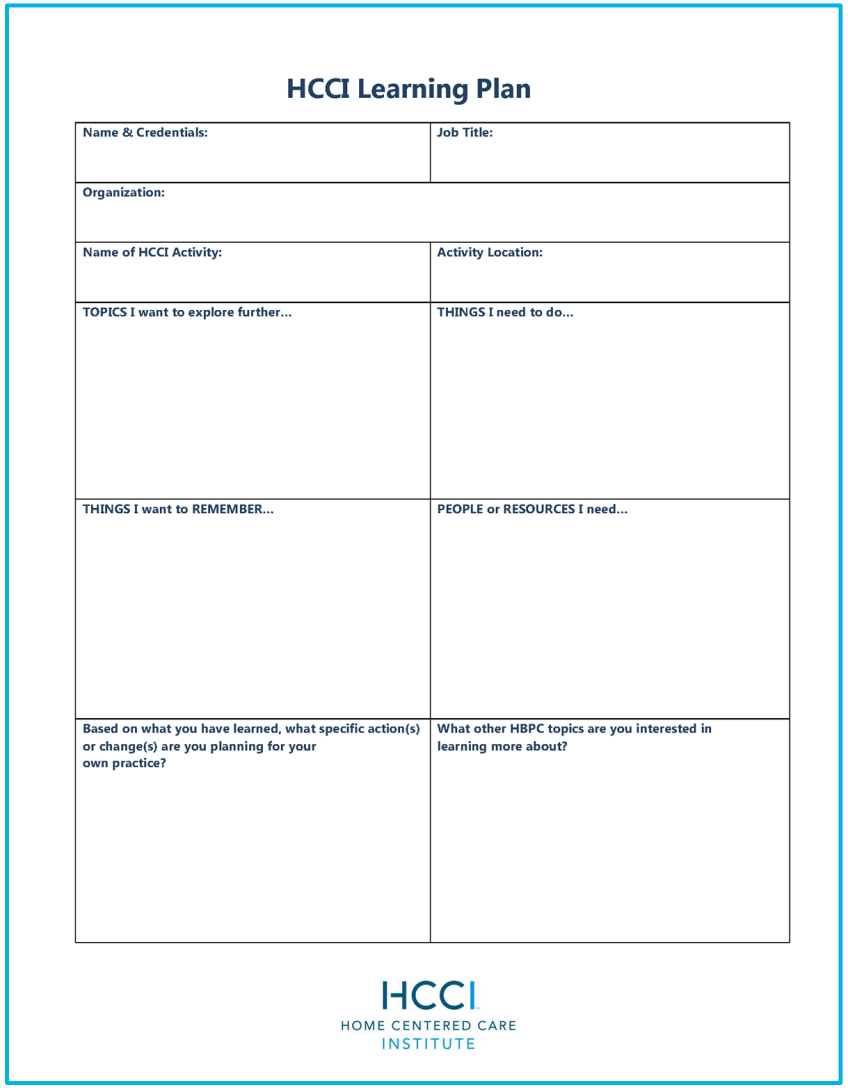
Objectives

- Describe the unique aspects of Home-Based Primary Care (HBPriC) and Home-Based Palliative Care (HBPalC), as well as the ways in which these two models of care are aligned.
- Discuss the value and opportunities of bringing together HBPriC and HBPalC to provide a full-service solution for managing serious illness and chronic disease.
- Identify strategies to successfully implement a complex illness management model incorporating both HBPriC and HBPalC.

Your HCCI Learning Plan



HCCI Learning Plan

Name & Credentials:	**Job Title:**
Organization:	
Name of HCCI Activity:	**Activity Location:**
TOPICS I want to explore further…	**THINGS I need to do…**
THINGS I want to REMEMBER…	**PEOPLE or RESOURCES I need…**
Based on what you have learned, what specific action(s) or change(s) are you planning for your own practice?	**What other HBPC topics are you interested in learning more about?**

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Speaker

Paul Chiang, MD

Medical Director, Northwestern Medicine, HomeCare Physicians

Senior Medical and Practice Advisor, Home Centered Care Institute

- Boarded in Internal Medicine and Hospice/Palliative Medicine
- 37,000+ house calls to more than 3,600 patients

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Home-Based Primary Care

How does it help patients with serious illness?

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What is Home-Based Primary Care (HBPriC)?

- A model of care that brings providers and modern technology to patients in the comfort of their homes
- Improves quality of life for medically complex patients and their caregivers
- Prevents avoidable hospitalizations and nursing home placements
- Dramatically reduces health care costs

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What Does HBPriC Offer?

The Quadruple Aim

- Better outcomes
- Improved patient experience
- Lower cost of care
- Greater job satisfaction for providers and staff

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HBPriC Comes in Many Forms

- Academic Medical Centers
- Large Health Systems
- Community Hospitals
- Independent Group Practices
- Home- and Community-based Veteran Services
- Community-based Hospice and Palliative Care Organizations
- Value-based Managed Care Organizations

Clinical Care Models in HBPriC

- **Transitional Care**
  - Short-term interventional support
  - Often for patients with target diagnoses or with high readmission risk
- **Longitudinal Care**
  - Long-term medical oversight
  - Often for patients age 65+ and/or high ED utilizers with no PCP

HBPriC Patient Characteristics

- **Transitional Care**
  - Seniors with high likelihood of admission/readmission
  - Chronic or non-adherent patients of any age
  - High-risk patients of any age
- **Longitudinal Care**
  - Seniors with advanced and chronic illness
  - Younger people with chronic conditions, physical or emotional disability
  - Disruptive to PCP office flow

The Recipe for a Rise in Home-Based Care

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The Recipe for a Rise in Home-Based Care

Changing Demographics: Aging and Chronic Illness

Healthcare Reform/ Medicare Fiscal Crisis

Advances in Technology

COVID and Reimagining Care

Health Care's Perfect Storm

https://www.hccinstitute.org/about/health-cares-perfect-storm/

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The Aging Demographic

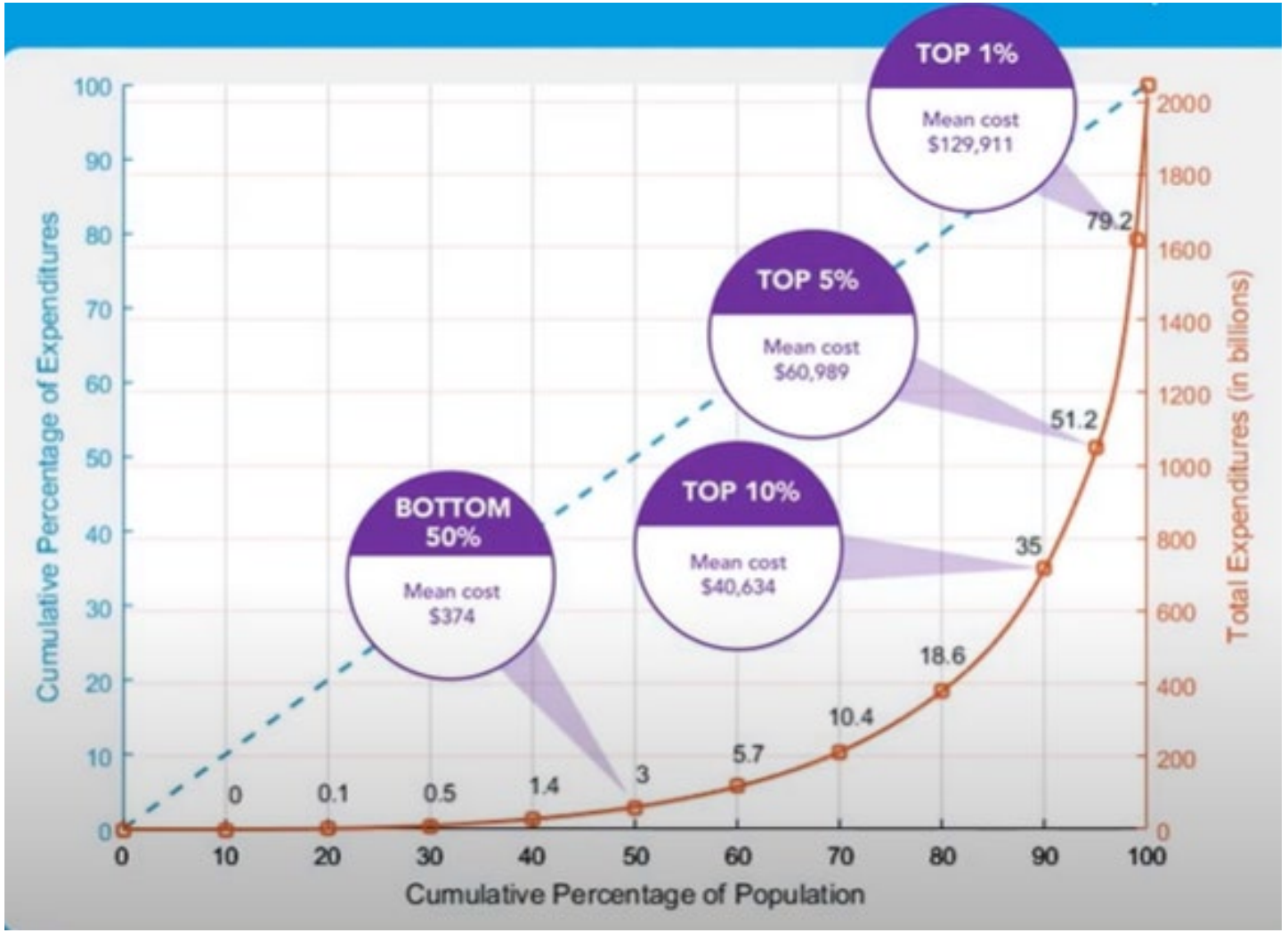
It is estimated that by 2050, people over 65 will represent more than 20 percent of the population.

That shift may not sound significant, but it represents about *40 million additional* Medicare-age patients flooding the already beleaguered U.S. healthcare system.

This surge will be driven partially by advances in medicine that are helping people live longer, but also by the Baby Boomers.

Cost of Aging and Chronic Illness

Health Care Spending is Highly Concentrated Among a Small Portion of the US Non-Institutionalized Population



Source: AHRQ, MEPS 2019

research@hccinstitute.org

Sept 2021

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Health Care Reform

- Growing interest in value-based care
- Models of home-based medical care have emerged as clinically effective and cost saving
- The increasing cost of health care may lead to the Medicare insolvency by the year 2029

2016 Medicare Trustees Report

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Learnings from the VA HBPriC program (11,334 patients)

Improves Care, Lowers Costs

Site of Care	Before HBPriC	During HBPriC	Change
All home care	$2,488	$13,588	$11,100 (+ 460%)
Outpatient	$6,490	$7,140	$650 (+ 10%)
Nursing home	$10,382	$1,382	**($9,000) (- 87%)**
Hospital	$18,868	$7,026	**($11,842) (- 63%)**
Total cost VA care	$38,228	$29,136* *includes HBPriC cost	**($9,092) (- 24%)** P < 0.0001

Better Access, Quality and Cost for Clinically Complex Veterans with Home-Based Primary Care; Edes, et al JAGS 10/14

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Payment Reform: Value-Based Models

Independence at Home (IAH) Medicare Demo

Programs

- Experienced and ≥ 200 patients

Patients

- ≥ 2 Chronic Conditions
- ≥ 2 ADL deficiencies Emergent hospitalization and post-acute care in past year

Payments

- First 5% of savings to Medicare
- Additional savings: 80% practices/20% Medicare

RESULTS

↑ Quality
↑ Patient Satisfaction
↓ Hospital/ED
↑ Savings

$8,342 PBPY (Year 7) saved over usual care group

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The Impact of a HBPallC Program in an ACO[1]

Retrospective analysis of 651 decedents: 82 enrolled in HBPallC and 569 receiving usual care

- Cost of care last three months ↓ $12,000 ($20k vs. $32k)
- Medicare Part A costs ↓ 35% ($17k vs. $26k)
- Medicare Part B costs ↓ 37% ($3.1k vs. $4.9k)
- Hospital Admissions ↓ 34% in final month
- Hospice Admissions ↑ 35%
- Median Hospice LOS ↑ 240% (34 days vs. 10 days)

1 Lustbader D, et al. The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization. J Palliat Med. 2017 Jan 1; 20(1): 23-28.

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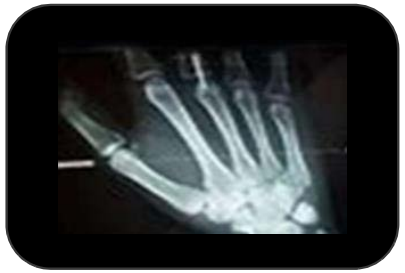
Technology

Smart Phone

X-rays



Ultrasound

Labs

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COVID Pandemic

Medical care outside of traditional brick and mortar facility, including telehealth

Access to medical care, reducing barriers

Patient and caregiver comfort and satisfaction

The Workforce: A Key Ingredient

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Providers Making Home Visits

Approx. 3,000 Providers make 1,000+ visits annually

12,000 providers are needed

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Characteristics of a Successful HBPriC Provider

The 8 C's

- Competent with Complexity
- Communicate Comprehensively
- Character and Composure
- Charm and Charisma

HBPriC Providers are Mission-Oriented

- A “calling” to care for older adults and other vulnerable patients with chronic and serious illness.
  - Complex medical conditions
  - Extensive medication lists
  - Multiple labs and diagnostic testing
  - Psychosocial complications
  - Challenging family dynamics

Key Competencies for HBPriC Providers

- Advanced clinical knowledge and reasoning skills; competent in assessment, diagnosis, and various procedures.
- Commitment to integrity in order to provide safe and quality care for the patient within a home setting.
- Able to work independently, but also skilled in relationship building, interpersonal communication, and collaborative teamwork.
- Keen attention to time management, organization, and handling of multiple priorities.
- Excellent written and verbal communication skills.

Members of the Primary Care Team – (HBPriC)

- Physicians/PA/APN
- MA
- RN
- Scheduling Coordinator
- Case Manager
- Pharmacist
- Dietitian
- Community Worker

Members of the Palliative Care Team – (HBPalC)

- Physician/PA/APN
- Nurse
- Chaplaincy
- Social Work
- Hospice Collaboration for Chaplaincy Services or Bereavement
- Other Counseling Services
- Music Therapy

The 4 Ms in the Care of Older Adults

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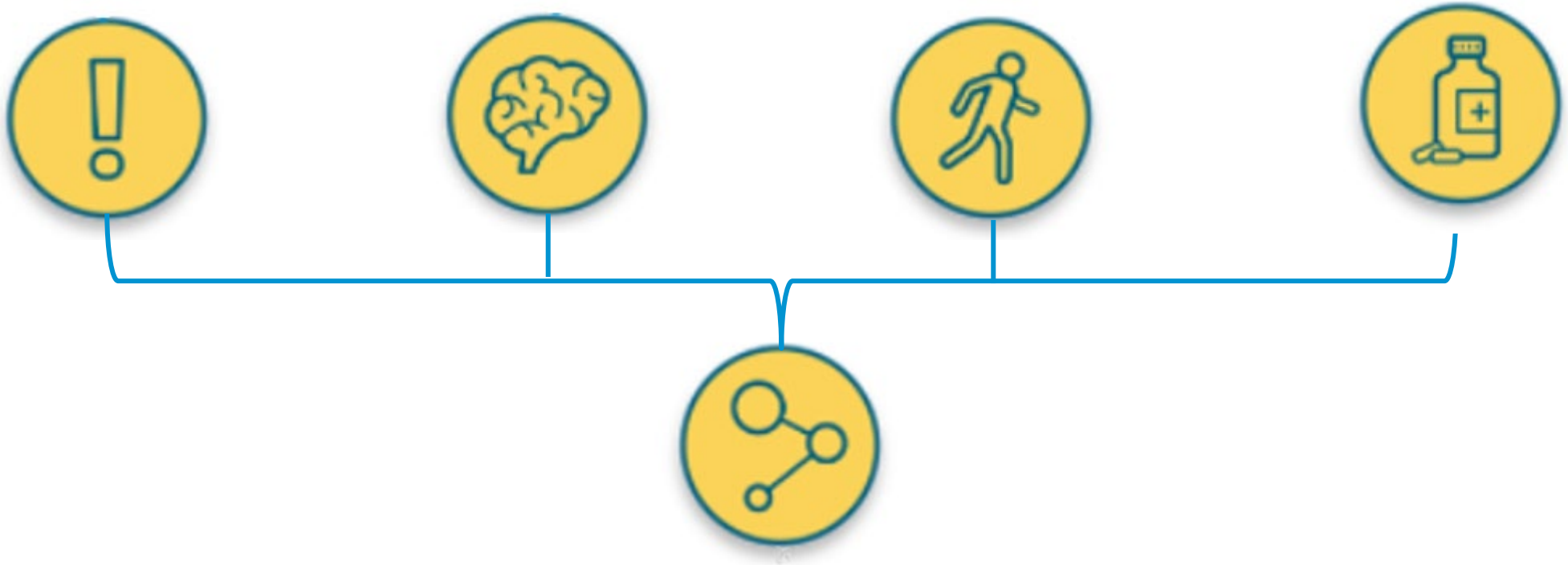
The 4Ms in the Care of Older Adults



The 4Ms in the Care of Older Adults framework is part of the Age Friendly Health Systems, a collaborative initiative of The John A. Hartford Foundation, and the Institute for Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association of the United States. The Geriatric 5Ms (Frank Molnar & Allen Huang, University of Ottawa; Mary Tinetti, Yale University) incorporate the additional dimension of Multicomplexity.

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Applying the 4Ms as a Framework…

… in caring for seriously ill patients

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What Matters

- Understand health goals and preferences
- Applying prognosis in medical decision-making: context of risks, burdens, benefits, functional status and quality of life
- Making sure a person's goals and care preferences are reflected in treatment plans and honored
- Coordinating advance care planning and communication of this clearly
- Adjusting and updating goals and preferences with health changes

Mentation

- Maintaining mental activity
- Identifying and addressing social isolation and stressors
- Monitor mental and cognitive well-being
- Identify and address cognitive impairment, considering their goals of care, and changing your care to support their needs over time
- Caregiver wellbeing
- Helping to prevent, identify, treat, and protect individuals with delirium
- Working to evaluate and treat mood disorders

Mobility

- Maintain the ability to walk or be mobile
- Optimizing their mobility and supporting independence in ADLs and IADLs
- Minimizing risk of falls by addressing risk factors and optimizing the home environment
- Allow creative solutions from interdisciplinary team members to improve home environments that facilitate mobility and safety

Medication

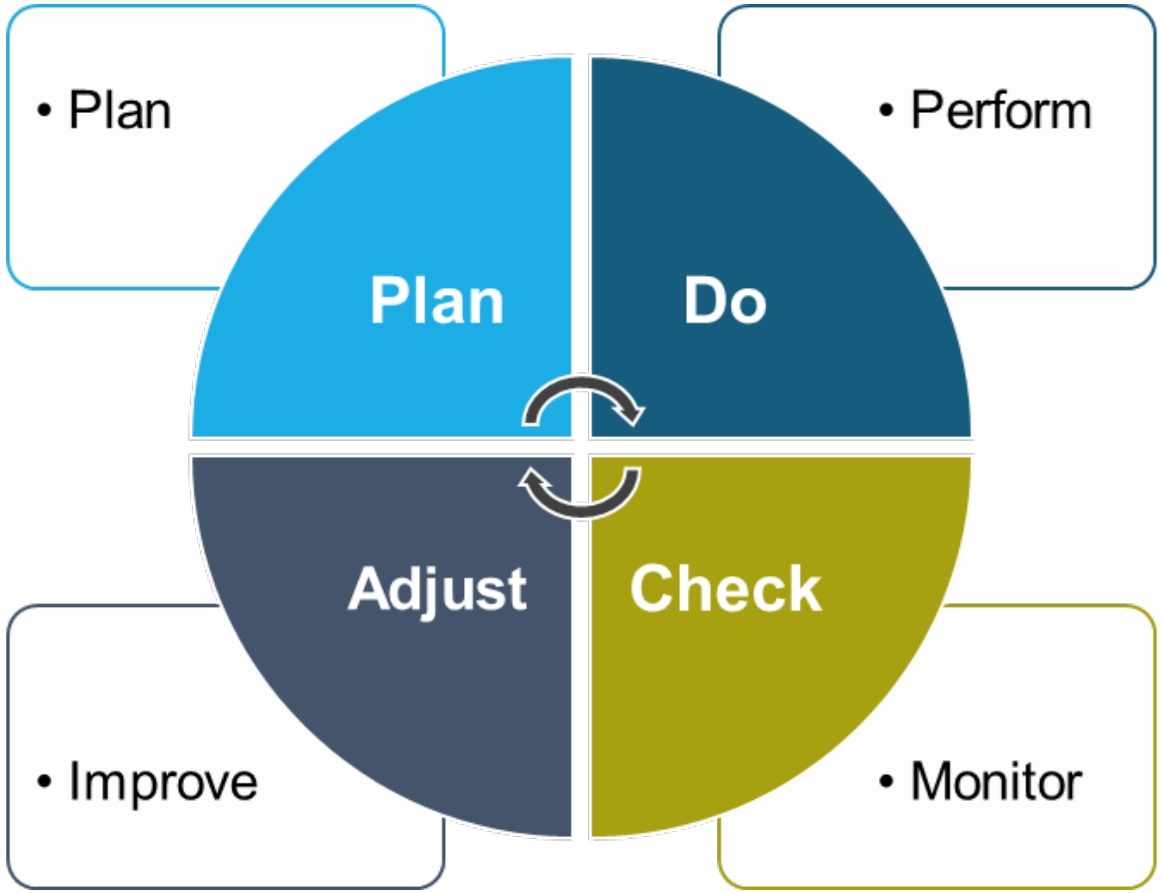
- Reducing polypharmacy appropriately
- Realigning medication dosing with the person's individualized needs, through continuity of care
- De-prescribing: duplication and the side effect chain of medications
- Optimizing medication at geriatric friendly dosing
- Utilize the opportunity to personally review medications in the home
- Patient and care partner education on benefits and side effects of medications

Multicomplexity

- Helping older adults manage multiple conditions
- Assessing living conditions impacted by age, health conditions, and social drivers of health; being on guard for elder abuse/neglect
- Optimize therapies and care plans: Choose therapies that optimize benefit, minimize harm, enhances function, and quality of life
- Integrate care partner support for their availability and wellbeing
- Incorporate different philosophies of care as appropriate
- Coordinating and integrating the recommendations of specialists, weighing risks and benefits

1 https://www.healthinaging.org/tools-and-tips/5ms-geriatrics

Multicomplexity (cont'd)



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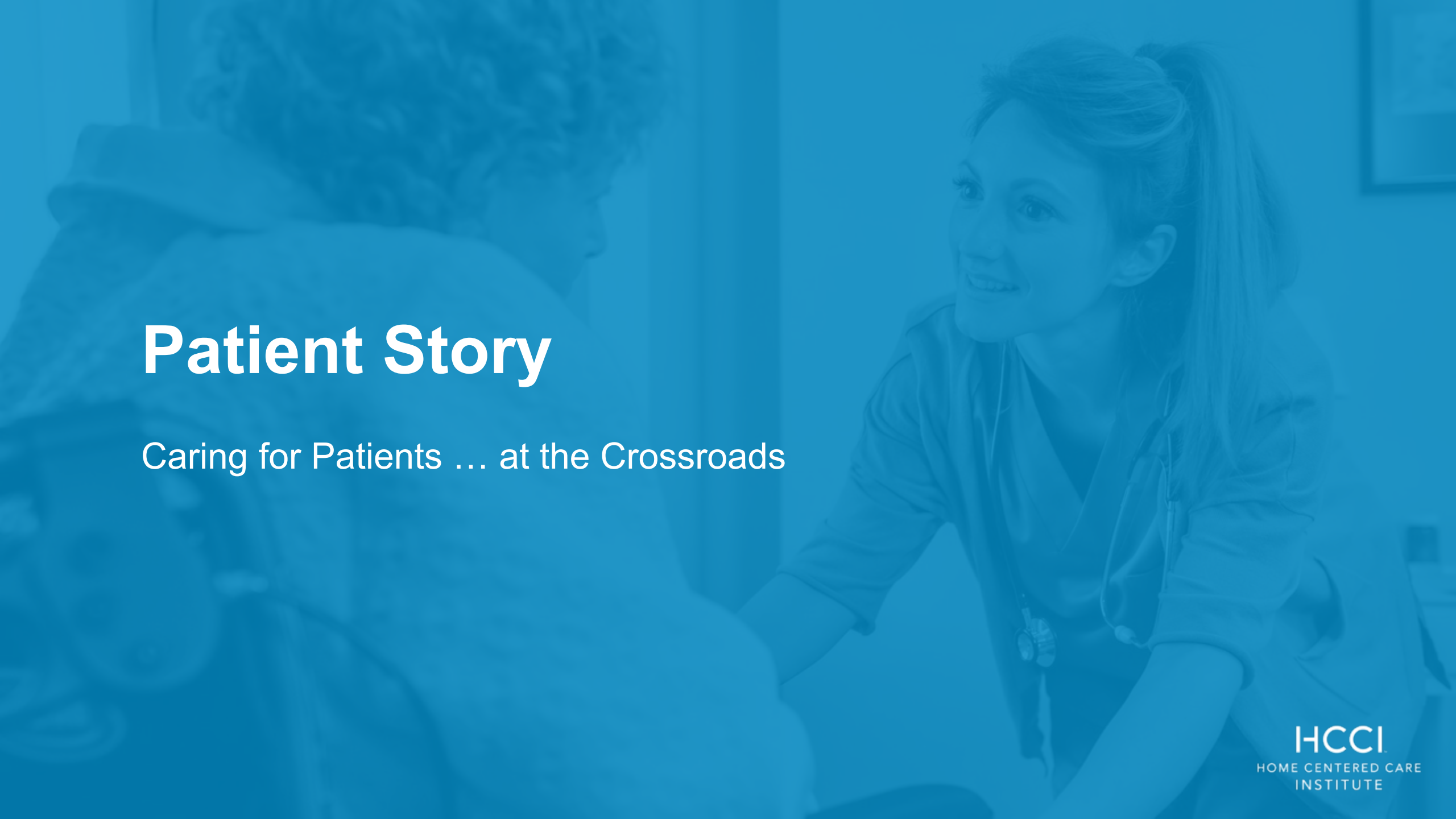

Patient Story

Caring for Patients … at the Crossroads

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Meet Christina

Christina is a 68-year-old Romanian woman who lives with her 50-year-old daughter, Veronika, an experienced hospital Med Tech. You are asked to see Christina by the Home Health agency that has been in the home following her surgery and hospital discharge three weeks ago. Up until three years ago, Christina lived in Romania, but after she became ill for several months, her daughter brought her to the US because of the lack of what Veronika considered adequate care.

At that time, Christina was seen in the ED for evaluation of significant abdominal pain, nausea, and obstipation. Her abdomen was somewhat firmly distended with a protruding umbilicus; there are prominent lymph nodes around the umbilicus as well. She had evidence of ascites on exam. She was diagnosed with Stage 3 Ovarian Cancer, underwent debulking surgery and then subsequently had chemotherapy for about six months. She did well for a period of many months, but her tumor markers had lately begun to increase. She had a recent surgery for small bowel obstruction caused by adhesions.

Meet Christina (cont'd)

Christina's functional status has remained limited, and she is very fatigued; if she goes to see her primary care provider, she is exhausted. Her care has been managed only by an Oncologist; she does not have a primary care provider.

CHIEF COMPLAINT (CC)

Seeing patient at home due to increasing weakness, fatigue, 3 weeks post abdominal surgery as well as a rash that started yesterday. Language translator was used during the visit since the patient speaks only Romanian.

HISTORY OF PRESENT ILLNESS (HPI)

68 year old patient with history of stage 3 ovarian cancer s/p debulking surgery and chemotherapy who is seen at home 3 weeks post op for small bowel obstruction and lysis of adhesions. She is complaining of exhaustion and fatigue. Patient also noted a rash on her chest that started yesterday. She has a history of ovarian cancer, hyperlipidemia, hypothyroidism, and hypertension.

PAST, FAMILY, AND SOCIAL HISTORY (PFSH)

Limited information as grew up in Romania; Hypothyroidism; Hypertension; Hypercholesterolemia.

Immunizations: Influenza - no; Pneumovax - no; Prevnar - no; Tdap before the age of 40; Zostavax/Shingrix - no

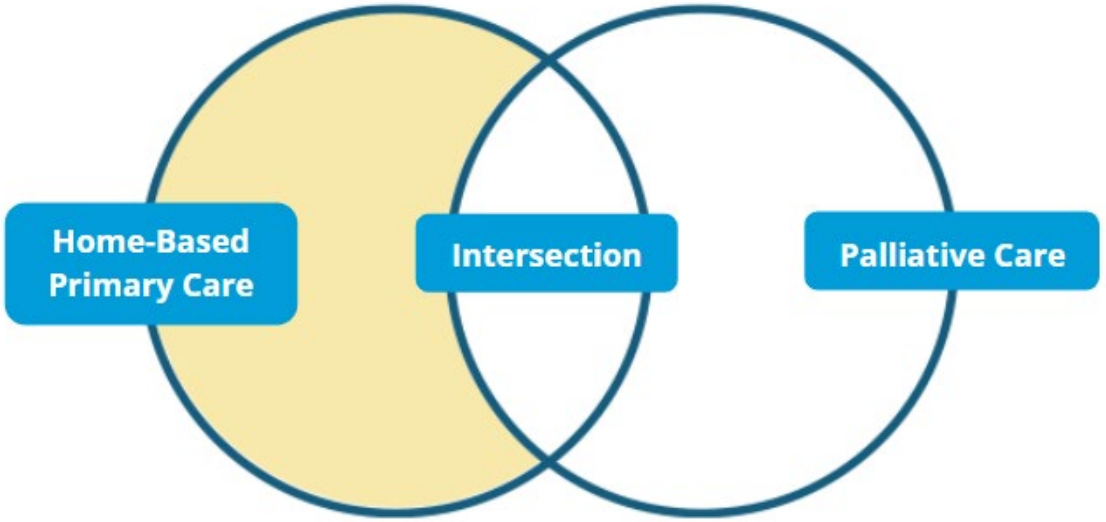
Past Surgical History: TAH/BSO 3 years and debulking surgery 3 years ago; Repeat debulking surgery 3 weeks ago.

Family History: Father died in WW2; Mother died at 80 probably of breast cancer; Sister-72, alive and well in Romania; Daughter Veronika 50 works as a lab tech; Son Constantin 48, lives in California.

Social History: Nonsmoker, no ETOH; Worked as a secretary in Romania.

Home-Based Primary Care (HBPriC)

- Primary Care
- Geriatric Syndromes
- Chronic Disease Management
- Medication Management
- 24/7 Availability, Acute/ Urgent Care
- Post-Acute Care and Management of Transitions
- Preventive Care, Annual Wellness Visits, Immunizations
- Wound Care and Other Procedures
- Coordination of Ancillary Services
- In-Home Laboratory and Diagnostic Testing



Adapted from the New England Journal of Medicine (NEJM) Catalyst (The Intersection of Home-Based Primary and Palliative Care).

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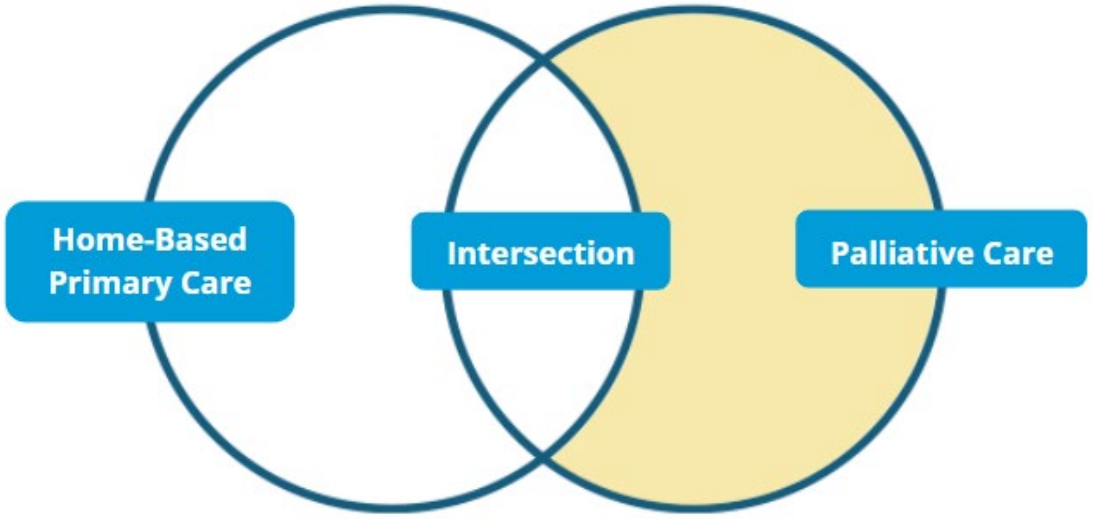
Home-Based Palliative Care (HBPalC)



Adapted from the New England Journal of Medicine (NEJM) Catalyst (The Intersection of Home-Based Primary and Palliative Care).

- Hospital Consults
- Outpatient Consults
- Nursing Home Care
- Pain and Symptom Management Consults
- Refractory Symptoms in Serious Illness
- Complex Family Meetings
- Patient Advocacy
- Assistance Through Complex Enrollment Processes
- Care Delivery with a Focus on Financial and Non-medical Needs
- Psychosocial and Spiritual Support Through Interdisciplinary Team

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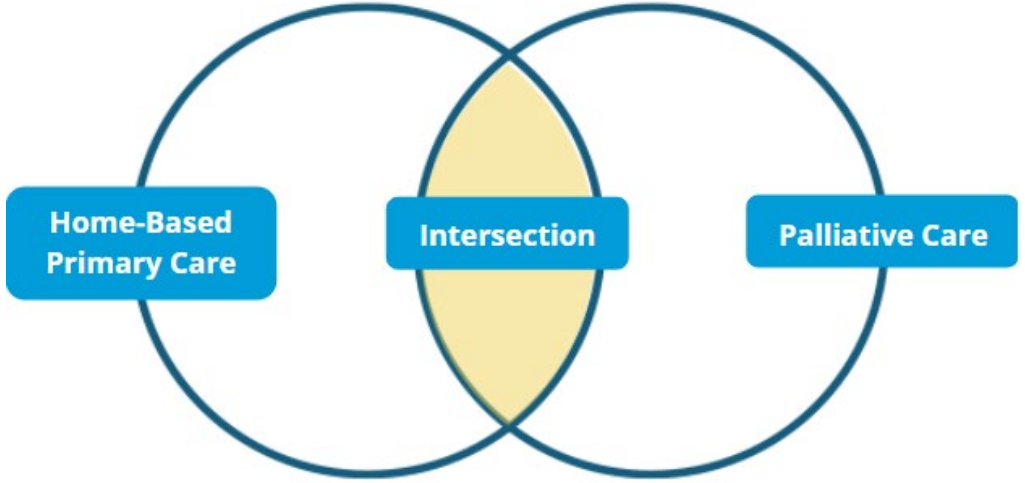
The Intersection of HBPriC and HBPalC



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- Patient/Family/Caregiver Support
- Social and Spiritual Needs
- Communication and Care Coordination
- Symptom Management
- Diagnostic and Prognostic Support
- Functional Support and Safety
- Interdisciplinary Team Meetings
- Referrals to Hospice
- Goals of Care
- Advance Care Planning and End-of-Life Discussions

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Christina – Goals of Care

What is the full-service solution for Christina's care?

… Christina speaks Romanian almost exclusively, so Veronika shares….

- Veronika hopes for Christina to have more energy and improved functional level
- Veronika want Christina to restart chemotherapy as soon as possible as the CA-125 is not as low as they hoped post-operatively
- Veronika needs to return to work full-time; she used FMLA and then returned part-time, but needs the health insurance

Christina – Social Determinants of Health

What is the full-service solution for Christina's care?

Social Determinants of Health (SDOH)	
Access to medical care, medicines, supplies	Patient depends on Veronika to pick up medications from pharmacy.
Health literacy	
Family or social support	Daughter, Veronika Popa is emergency contact and a seasoned Med Tech in the hospital for the past 15 years.
Communication capabilities *(phone, computer, video)*	Phone (Veronika)
Preferred language *(potential barriers)*	Pt. speaks Romanian almost exclusively; Daughter speaks English and Romanian.
Adequate housing and functioning utilities *(in COVID, separate bedroom for patient)*	Patient sleeps in a separate bedroom from Veronika.
Financial status	Patient is dependent on daughter's income, but daughter is not able to care for pt. and work full-time. Daughter has exhausted FMLA and must continue to work at least part-time to keep health insurance.
Transportation	Increasingly difficult to get patient out of her home due to increasing weakness.

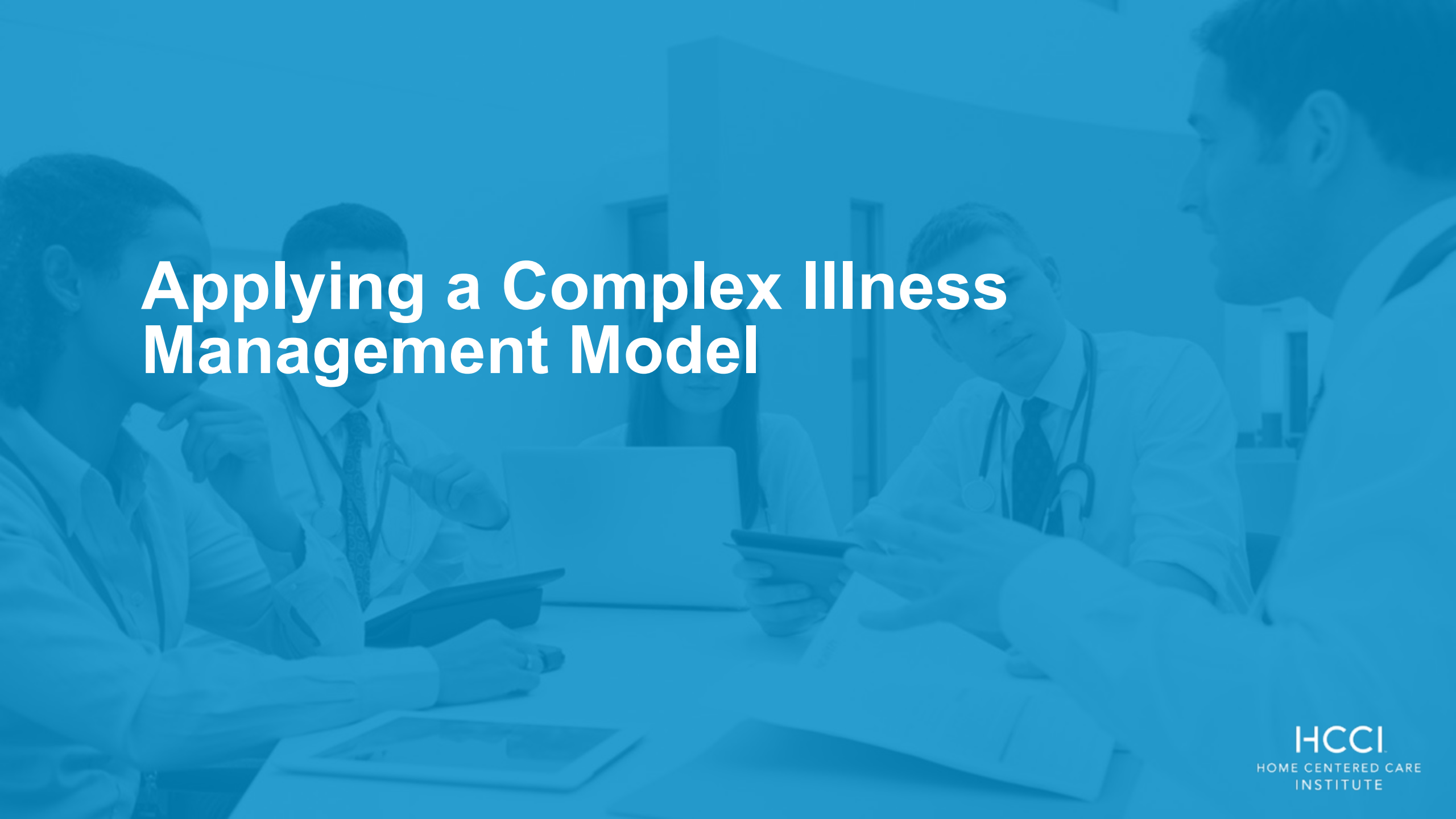
Christina – Other Factors

What is the full-service solution for Christina's care?

- **ADLs:** Needs help in the shower, feels unsteady, everything is slow. No longer cooking, not even if she can sit down on a stool. Too tired.
- **Environment:** Throw rugs in hallway; no bars or bath bench in shower.
- **DME:** bedside commode, walker, and wheelchair.
- **Spiritual:** Part of Orthodox faith community, which is important to her.
- **Caregiver:** Veronika's Zarit Burden Interview Short Form scored at 12, indicating mild to moderate burden.

Table Discussions

1. In what way(s) would Christina be supported by palliative care in the home?
2. In what way(s) would Christina be supported by primary care in the home?
3. Are there other types of patients who might benefit from receiving both palliative and primary care in the home?
4. How might having a “full-service solution” for seriously ill patients impact providers and other members of the interdisciplinary care team?



Applying a Complex Illness Management Model

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Benefits of Complex Illness Management Model

1. Serve broader population, additional revenue opportunities [e.g., chronic care management (CCM),transitional care management (TCM)]
2. Fully meets the needs of patients and caregivers over time by coordinating all medical services
3. Focus on what matters most to patients, symptom management, caregiver support, advance care planning
4. Appropriate and timely referral to hospice services

Case Example: Quality End-of-Life Care

- **25%** of **$556B** Medicare dollars for care in final year[1]
- U.S. Deaths 2009[2]
  - At home 33.5%; Hospice 42%
  - ICU last 30 days 29%; Hospitalization last 90 days 69%
- Northwestern Medicine HomeCare Physicians 2014-18: 1,022 Deaths
  - 76% died at home
  - 77% on hospice
  - Median house call LOS 1.3 years
  - Reduced hospital mortality: 435 additional deaths at home (Total hospital deaths = 1,280)
  - ICU use 30 days before death 8.15%; Hospitalization 90 days 42% (2017-18)

1 Riley, Lubitz; Health Services Research 4/2010
2 Teno: Change in End of Life Care for Medicare Beneficiaries JAMA 2/20/13

Questions

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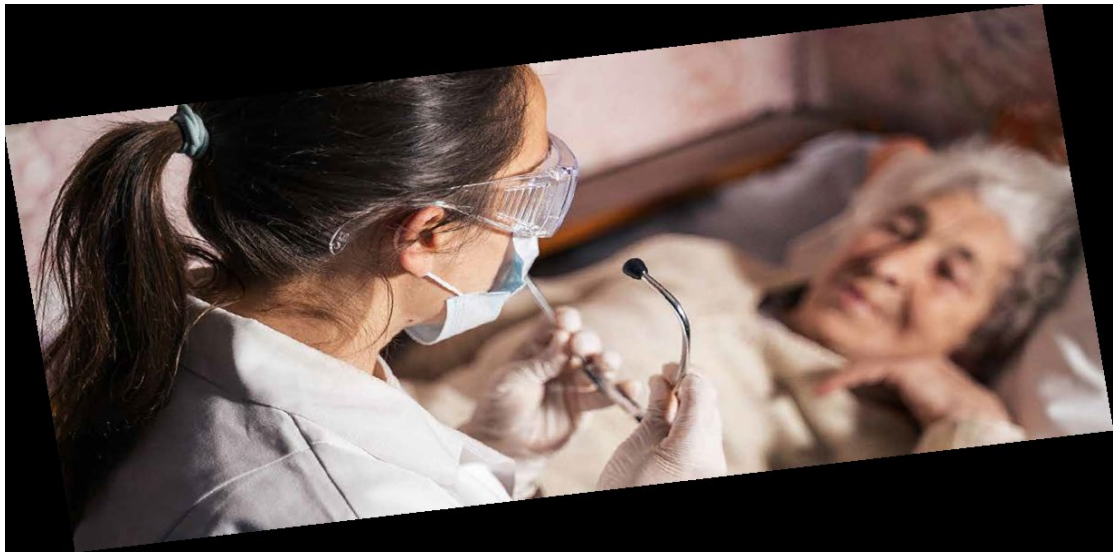
The Intersection of Home-based Primary Care and Palliative Care



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Future Sessions:

- Optimizing Efficiency in House Call Operations
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Our gift to you: 5 Free Online Courses + 1 Video

1. House Calls 101: Introduction to Home-Based Primary Care
2. Patient Assessment in HBPriC
3. Managing Multicomplexity in the Homebound Patient
4. The Intersection of HBPriC and HBPalC
5. Diversity, Equity, and Inclusion for Home-Based Care; plus

- The Value of Home-Based Primary Care (video)

HCCI Learning Hub™

All courses are designated for *AMA PRA Category 1 Credit*™

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Join us now for a Celebration of an important HCCI milestone… and network with Colleagues!

Optional Reception:

Bronze/Maize Rooms

(next door)

6:00 to 7:30pm

Meet the Champions from HCCI's Illinois House Call Project

THE ILLINOIS HOUSE CALL PROJECT

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