



**HCCI**<sup>™</sup>  
HOME CENTERED CARE  
INSTITUTE

# ***The Intersection of Home-Based Primary Care and Palliative Care***

**(Session 2 of 4)**

**Crossroads of Care: Managing Serious Illness in the Home**

**September 14, 2023 • Schaumburg, Illinois**



**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



# 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](http://eleainstitute.org).

# Optimizing Efficiency in House Call Operations



**Wednesday, December 6**

**3:00-5:00pm**

**1900 E. Golf Road, 4<sup>th</sup> floor**

**Schaumburg**

## **Future Session:**

- **Contracting with Payers to Demonstrate the Value of Home-Centered Care**

# Objectives

- **Examine the forces behind the rise of home-based primary care (HBPrIC) and home-based palliative care (HBPaIC) and review the ways in which these two models of care intersect.**
- **Assess new opportunities available to HBPrIC and HBPaIC through recently introduced advanced payment models.**
- **Discuss case examples of how HBPaIC and HBPrIC were brought together to provide a full-service solution for managing serious illness and chronic disease.**

# 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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# Speakers



## **Rebecca Ramsay, MPH, BSN**

CEO, Housecall Providers / Care Oregon

- 30+ years in public health – as both a practitioner and leader
- Career focus on addressing SDoH faced by at-risk and underserved populations



## **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

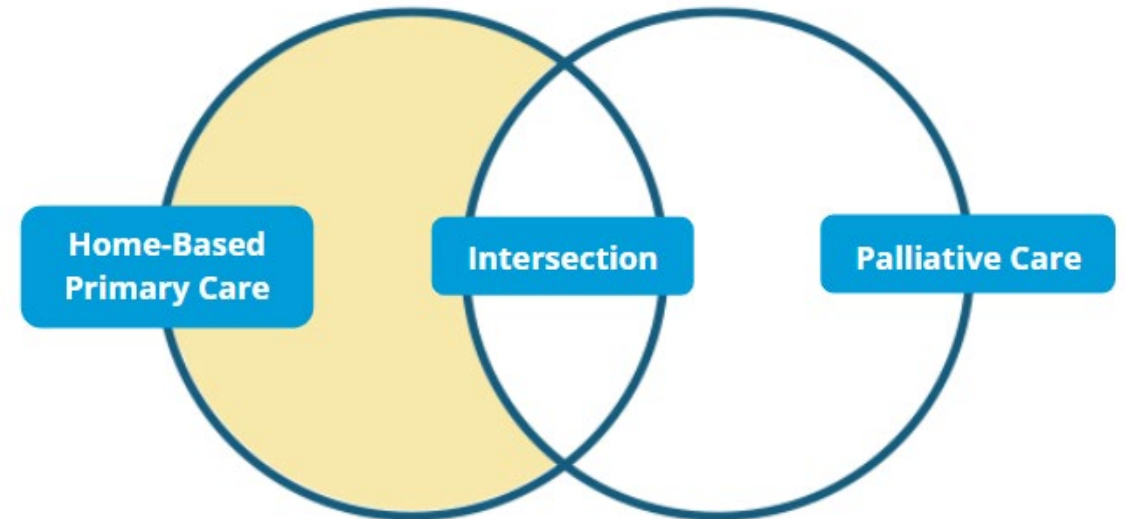


# Home-Based Primary Care and Palliative Care

How do these care models come together to help patients with serious illness?

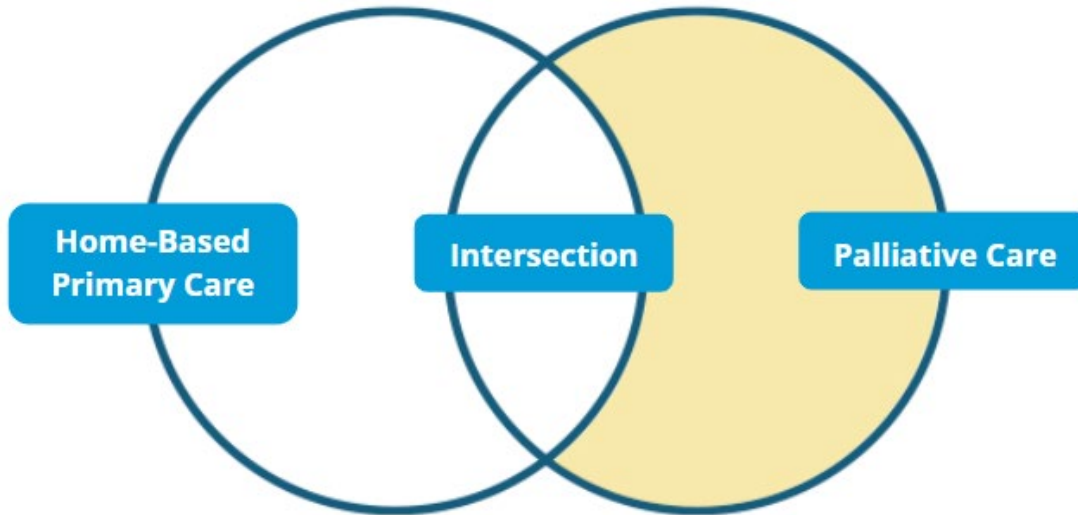
# Home-Based Primary Care (HBPrIC)

- 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).

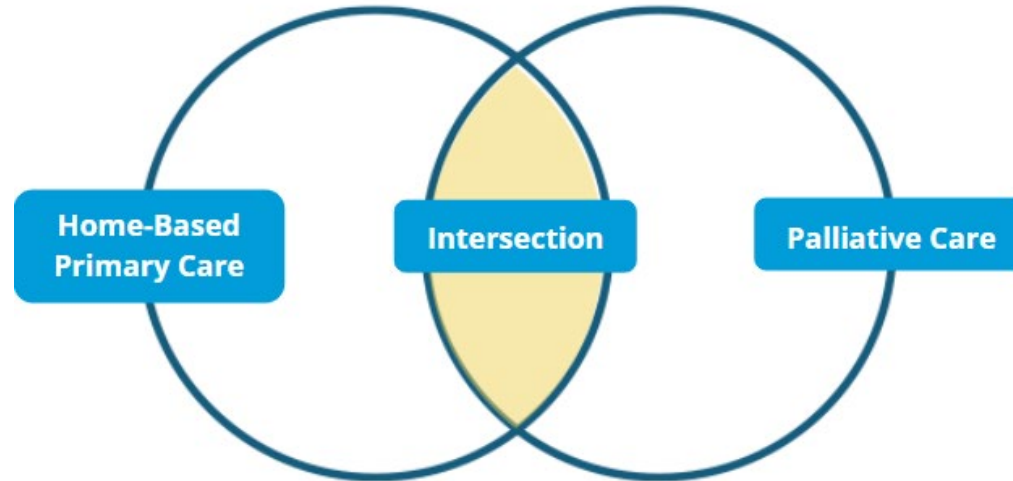
# Home-Based Palliative Care (HBPaIC)



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

- 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

# The Intersection of HBPrIC and HBPaIC



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

- 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



# Benefits of a Complex Illness Management Model

- **Serve a broader population**
- **More fully meet the needs of patients and their families**
- **Focuses on “what matters most”**
- **Enhanced reimbursement opportunities, including value-based contracts**
- **Earlier referrals to hospice**

# Combining HBPrIC and HBPaiC

## A Complex Illness Management Model – 2 Options:

1. Co-Management or Consultation Model (Separate Providers)
2. Fully Integrated Model (Same Provider)



# Co-Management or Consultation Model (Separate Providers)

- **Independent, collaborative service lines with separate providers that are part of the same program**
- **Wraparound support**
- **Optimal communication between HBPriC and HBPaIC**
- **Appropriate for patients of all different care needs**

# Staffing: Co-Management or Consultation Model

There is no right answer....

- Palliative physician/NP
- RN
- SW
- Chaplain
- Outreach worker/community health worker
- Palliative care pharmacist
- Others??

# Fully Integrated Model (Same Provider)

- Each provider is trained in all disciplines of integrated care competencies to deliver both HBPrIC and HBPaiC
- Ensures patients can receive both services despite any workforce shortage
- Minimizes miscommunication and care redundancies
- May result in higher patient and caregiver satisfaction due to enhanced continuity of care with one provider for all their medical needs

# Staffing: Fully Integrated Model

## Supported by a health system

### HomeCare Physicians

- **Medical Director – board certified in internal medicine and hospice/palliative**
- **0.5 Physician**
- **4 NPs**
- **2.5 RNs**
- **2 MAs**
- **2.8 PSRs**

### Housecall Providers

- **Medical Director – board certified in internal medicine and hospice/palliative**
- **Assoc Medical Director – Geriatric NP with 20 years exp**
- **13+ PCPs – mostly NPs**
- **Field staff: 4 SW, 4 RN, 1 behavioral health spec, 1 chaplain, 1 PharmD**
- **Office staff: 8 care coord, 2 intake, 2 schedulers, 2 MAs, 1 office-based nurse**



# Key Competencies

## Providers and Clinical Team

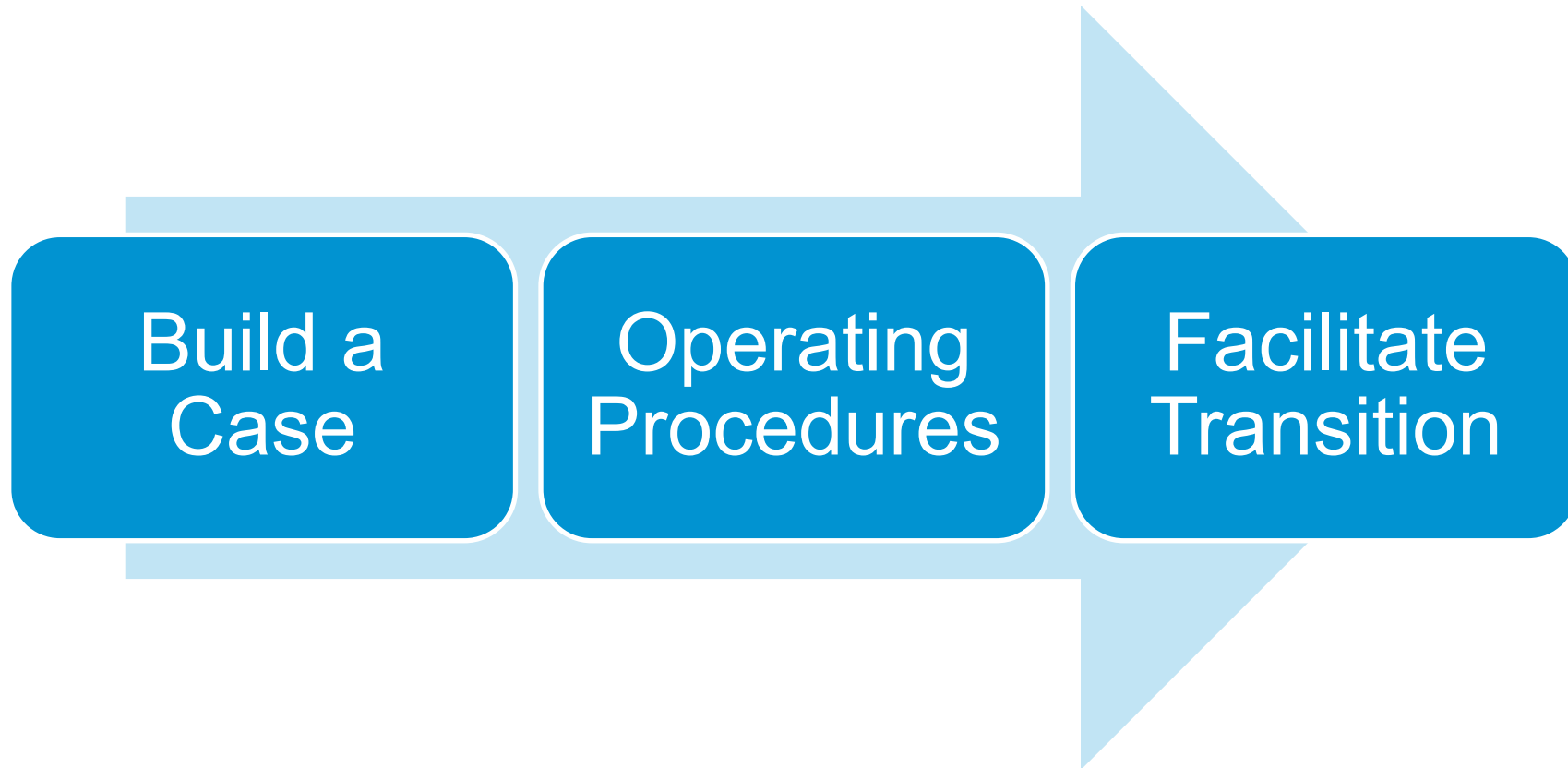
1. Managing multicomplexity, symptom management
2. GOC conversation
3. Supporting the CG
4. Manage care coordination
5. Comfortable with technology
6. Documentation and coding skills

# Key Competencies

## Practice Operations Staff

1. Assessing and selecting appropriate staffing model that aligns with mission/vision of organization and supporting business plan
2. Identify target population and geography served
3. Understand the unique demands of this work and hiring/retaining right staff
4. Effective geographic scheduling and effective use of technology to enhance productivity, efficiency, and staff satisfaction
5. Developing budget that aligns with program goals
6. Establish policies and procedures
7. Negotiate favorable contracts with payers
8. Implement marketing plans that will increase referrals

# Practices Looking to Incorporate Both Services





# 1. Build a Case (and Gain Support)

- **Conduct market research**
- **Define patient eligibility criteria**
- **Identify program “champions” – stakeholders – who will endorse the program and move it forward**
- **Determine marketing goals and strategies**
- **Establish key performance indicators (KPIs)**
- **Articulate your unique value proposition**

## 2. Establish Operating Procedures

How will you implement the following activities?

- Handling intake/registration for new patients and processing referrals
- Scheduling and route planning
- Ensuring interdisciplinary team communication
- Servicing patients including determining standards of care
- Handling triage and after-hours support
- Billing and coding
- Provider training
- EHR configuration
- Managing transportation and supply/equipment inventory

### 3. Facilitate the Transition

- **Market early and often**
- **Adapt to the needs of your population**
- **Seek training for new staff members**
- **Recruit and retain the appropriate staff**
- **Build familiarity with your local geography**
- **Select and build relationships with the right payers**



# Case Examples



- **Founded in 1995 as a home-based primary care (HBPriC) program serving frail elders in private homes, assisted living, senior living, and adult foster homes**
  - Over time this program became a fully-integrated home-based primary and palliative care program where all interdisciplinary staff are trained to provide serious illness care as part of the primary care model when appropriate and needed.
  - The target population served has broadened over time (not just frail elders) as the interdisciplinary team has diversified and expanded and as the demand for our services has increased.
  - This program was one of the original participants of the Independence at Home (IAH) Medicare Shared Savings program and is now participating in the ACO Reach value-based demonstration program operated by CMMI.
  - IDT includes PCP, SW, RN, PharmD, chaplain, behavioral health counselor, care coordinators, scheduling and intake coordinators, billing specialists; Avg census is 1550.



- **Opened a home-based hospice in 2011 and a separate, home-based palliative care (HBPaIC) program in 2017**
  - The HBPaIC program was designed to wrap-around the patient's existing primary care provider (usually a brick-and-mortar clinic provider) and offer additional support and services.
  - The target population is Medicaid and Dually-eligible beneficiaries with complex social health and physical health needs; about 10-15% are homeless or unstably housed.
  - IDT includes RN, SW, SDOH specialist, chaplain, triage and intake coordinator, billing specialist; Avg census is 145.



# Discussion

## Founded in 1997

- Brings compassionate, comprehensive medical care to homebound patients of all ages. Our team approach utilizes primary care physicians and nurse practitioners to provide the following services through house calls throughout the western suburbs of Chicago.
- Fully integrated model – home-based primary care and palliative care
- A 2<sup>nd</sup> program in the south suburbs of Chicago that is a co-management model.

# Discussion

# Questions?



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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 HBPaiC
5. Diversity, Equity, and Inclusion for Home-Based Care; plus
  - The Value of Home-Based Primary Care (video)



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