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The Intersection of Home-Based Primary and Palliative Care – Discussion Guide with Facilitator Notes

Thank you for leading a group discussion regarding key learning points from the HCCI online education activity, *The Intersection of Home-Based Primary and Palliative Care.* This guide is intended to help you prepare to facilitate this discussion.

OVERVIEW

Purpose: The discussion's purpose is to emphasize the need for and benefits of a model that includes both home-based primary care and home-based palliative care.

Audience: This discussion is intended for learners who have successfully completed the online education activity, *The Intersection of Home-Based Primary and Palliative Care.* The discussion should take no longer than 60 minutes to complete.

Materials:

- Handouts of the *Complex Illness Management Model, Key Competencies*, *Implementation Strategies,* and *Next Steps* from the course (provided as attachments).
- *Optional:* A flipchart to capture comments and ideas to help focus discussions and/or save for future consideration.

Instructions: Use the question prompts provided to initiate group discussions.

Learning 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 of, and opportunities for, bringing together HBPriC and HBPalC to provide a full-service solution for managing advanced illness and chronic disease.
- Identify strategies to successfully implement a complex illness management model incorporating both HBPriC and HBPalC services.

AGENDA

#	Topic	~Minutes
1	Definitions	5 min
2	Growing Need for HBPriC and HBPalC	5 min
3	Complex Illness Management Model	10 min
4	Key Competencies	5 min
5	Implementation Strategies	10 min
6	Case Examples	10 min
7	Debrief	5 min

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TOPIC 1: INTRODUCTION

Question prompts:

- The course defined both HBPriC and HBPalC. Which model do you think your practice most resembles based on your services and team members?
- How do your patients currently receive services your practice doesn't offer, if at all?

TOPIC 2: GROWING NEED FOR HBPriC and HBPalC

Question prompts:

- What were the three factors creating a "perfect storm" of needs for both HBPriC and HBPalC services?
- Which factor concerns you the most and how does it impact your practice? Do you think incorporating other services (HBPriC or HBPalC) will help address these concerns? How?

TOPIC 3: COMPLEX ILLNESS MANAGEMENT MODEL

Question prompts:

- *Refer to the Complex Illness Management Model handout (Attachment 1).*
- The course showed a Venn diagram that listed separate and shared HBPriC and HBPalC services. Are there any service placements that you agree or disagree with? Are there any services that you would add? *If the group is an appropriate size, you may divide the group into three smaller groups and have them discuss each section separately.*
- Two complex management models were discussed where services were provided by separate providers or the same provider.
    - What are the benefits of each model?
    - What are the challenges of each model?
    - Which model do you think might be useful for the patient population you serve?

TOPIC 4: KEY COMPETENCIES

Question prompts:

- *Refer to the Key Competencies handout (Attachment 2).*
- Which key provider competencies from the course do you think are current strengths in your practice? Which ones could be made stronger and how?
- Which key practice operations staff competencies from the course do you think are current strengths in your practice? Which ones could be made stronger and how?

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TOPIC 5: IMPLEMENTATION STRATEGIES

Question prompts:

- *Refer to the Implementation Strategies handout (Attachment 3).*
- The course discussed strategies to incorporate both HBPriC and HBPalC services. When successful, innovative house call programs enhance the patient (and caregiver) experience, improve health outcomes, and reduce costs. Review the strategies and select one or two ideas to implement them. *(1. Build a Case, 2. Establish Operating Procedures, or 3. Facilitate the Transition.)*
- Are there any other strategies that you think would be relevant for your practice?
- Are there any strategies that you think would present a challenge for your practice and why? What ideas do you have to overcome those challenges?

TOPIC 6: CASE EXAMPLES

Question prompts:

- The course provided four case examples of how programs have implemented both HBPriC and HBPalC: An academic institution model, a co-management model, an advanced practice provider model, and a private practice group model. If your program is already doing this, does your model resemble one of these case examples?
- If you have not already implemented both HBPriC and HBPalC services, which model would be the easiest for your program to implement and why?
- What are the pros and cons of each of each model discussed?
- What are other ways to implement both HBPriC and HBPalC services other than the models discussed?

TOPIC 7: DEBRIEF

Question prompts:

- Refer to the *Next Steps* handout. Review and mark which steps you would like to commit to taking next. Share your ideas for implementation.

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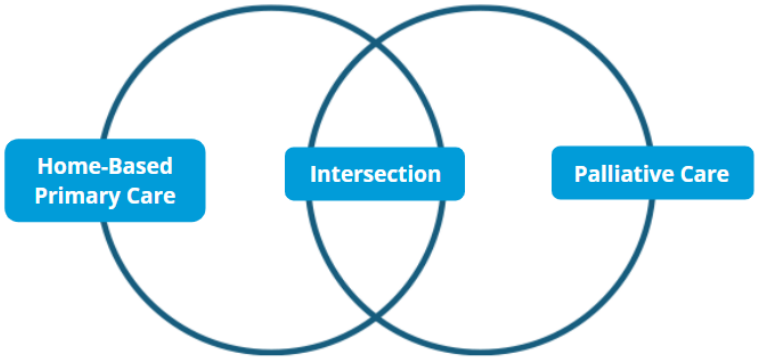
Attachment 1: The Intersection of Home-Based Primary Care and Home-Based Palliative Care – Complex Illness Management Model

Both primary and palliative care offer patient-centered home-based medical care which is critical to allowing patients to age in place. Therefore, it makes sense to provide both home-based primary care and home-based palliative care. This results in an effective **Complex Illness Management Model** that slows down disease progression while providing exceptional care and enhancing quality of life.



Home-Based Primary Care

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

Intersection

- 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

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 via Interdisciplinary Team

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

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Attachment 2: The Intersection of Home-Based Primary Care and Home-Based Palliative Care – Key Competencies

Both providers and practice operations staff must be competent in multiple areas of clinical care and business operations when treating seriously-ill homebound patients.

Providers

- Identifying goals of care
- Managing pain, stress, and other symptoms
- Managing medications for patients with multiple co-morbidities
- Demonstrating infection control and assessing safety in the home
- Managing care coordination and transitions—working with a team, if possible
- Supporting the caregivers
- Selecting and using technology to enhance patient care in the home
- Conducting difficult conversations around end-of-life and advance care planning with confidence and compassion
- Coding, documentation, and billing including HCC scores

Practice Operations Staff

- Assessing and selecting the appropriate staffing model that aligns with the vision and mission of the organization while supporting the business plan
- Identifying the target patient population for the local community and identified geographic service area
- Understanding the unique considerations for this workforce and for hiring and retaining the right providers and staff
- Implementing effective geographic scheduling and routing technology to enhance productivity, efficiency and provider satisfaction
- Developing a budget that aligns with the program's goals and managing the revenue cycle
- Establishing necessary policies, procedures, and legal considerations
- Negotiating favorable contracts with payers
- Designing and implementing marketing plans that will increase referrals and add patients to the program
- Coding, documentation, and billing including HCC scores

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Attachment 3: The Intersection of Home-Based Primary Care and Home-Based Palliative Care – Implementation Strategies

House call programs that incorporate both HBPriC and HBPalC need to be designed and managed to be sustainable over a long term, which today means being able to survive in the current fee-for-service environment and also thrive in a value-based environment. When successful, innovative house call programs enhance the patient (and the caregiver) experience, improve health outcomes, and reduce costs.

Build a Case
Consider the following activities to build a case and gain support for this new model of care:

- Perform market research to determine target population(s) and geographies.
- Determine patient eligibility criteria for the new program (e.g., What population will you serve?).
- Identify program "champion(s)"—stakeholders—who will endorse the program and move it forward (e.g., board member, clinical staff, C-suite champion).
- Determine marketing goals and strategies.
- Determine key performance indicators (KPIs) (e.g., hospital avoidance, clinical quality metrics, deaths at home and on hospice).
- Determine your unique value proposition.

Establish Operating Procedures
Consider how your practice will implement the following activities once both services are incorporated:

- Handling intake and registration for new patients and processing referrals.
- Ensuring interdisciplinary team communication.
- Servicing patients including determining standards of care.
- Handling triage and after-hours support.
- Billing and coding appropriately for house calls inclusive of incorporating advanced coding opportunities to maximize revenue for negotiating value-based arrangement that award outcomes.
- Training providers transitioning or new to primary or palliative care.
- Setting up the Electronic Health Record to properly enter data and generate reports.
- Maintaining the appropriate equipment and supplies to perform house calls and a means of transportation or a travel reimbursement policy.

Facilitate the Transition

Starting a new model of service is not always easy. Consider the following activities to help create a smoother transition:

- Market early and often. (NOTE: Enrollment generally starts slowly, and it takes time to build a productive patient census. Be patient.)
- Adapt to your patient population's needs.
- Seek training for new staff members.
- Recruit and retain the appropriate staff to ensure that the proper skill sets are in place.
- Build familiarity with your local geography.
- Select and build relationships with the right players.

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The Intersection of Home-Based Primary Care and Home-Based Palliative Care – Next Steps

Purpose: Review the following steps to apply the information and strategies you have learned in this course:

- ☐ Conduct market analysis to determine if there is a need in your area and to identify a target population.
- ☐ Determine the criteria for patient inclusion in the program.
- ☐ Narrow down a geographical area for a pilot project. Consider an area near a hospital partner where there is a large population of frail, elderly patients.
- ☐ Identify both a board/leadership champion and a clinical champion.
- ☐ Determine how you will fund a Complex Illness Management program and which payers you will work with.
- ☐ Educate the community that you are now offering both HBPriC and HBPalC including:
  - Assisted living facilities
  - Senior living communities
  - Home health agencies
  - Your own employees
  - Hospital case managers
- ☐ Determine your unique value proposition and be able to articulate it.
- ☐ Establish criteria for success (key performance indicators) such as hospital avoidance.
- ☐ Determine the best staffing model and ensure you hire the right people for the right jobs.
- ☐ COLLABORATE and COMMUNICATE with all staff, patients, and other providers.
- ☐ Optimize your EHR for the new model.
- ☐ Market early and often by developing community partners. Expect a slow start.
- ☐ Determine how you will handle intake, referrals, and front- and back-office operations, including accommodating urgent needs.