HCCI
HOME CENTERED CARE
INSTITUTE

HCCI House Call Practicum™

Navigating the House Call

Learner Guide
2024 - 2025 edition

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GETTING STARTED

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HCCI
HOME CENTERED CARE INSTITUTE

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Dear HCCI House Call Practicum™ Participant,

On behalf of the Home Centered Care Institute (HCCI), thank you for participating in the *HCCI House Call Practicum*™ - just one component of the comprehensive, high-quality training program we've designed for home-based primary care professionals.

The *HCCI House Call Practicum*™ is a two-day field experience in which you will shadow expert Preceptors who are serving in either a clinical or a practice management role at the HCCI Practice Excellence Partner (PEP) site. The *HCCI House Call Practicum*™ is designed to enhance your knowledge and skills in HBPC practice operations and efficiency, as well as to guide you in applying effective strategies for providing optimal, patient-centered care for medically complex patients in the home. This curriculum integrates topics that HCCI also addresses through classroom workshops and online courses – everything from staffing, scheduling, and productivity to infection control, provider safety, and management of urgent issues in the field. The difference, of course, is that at the *HCCI House Call Practicum*™, you will observe up close how one of the nation's leading house call programs puts each of these topics into practice.

As an HCCI Practice Excellence Partner (PEP), the program you are visiting is recognized nationwide as a premier provider of home-based primary care. We are grateful to our PEP sites for facilitating this unique field training experience for our learners.

Sincerely,

Dana Crosby
Vice President, Education and Practice Development

GENERAL INFORMATION

Practice Excellence Partner (PEP) Qualifications

HCCI Practice Excellence Partners (PEPs) are home-based primary care practices that have met or exceeded recommended standards as measured through a comprehensive Practice Assessment using the *Home Centered Care Institute (HCCI) Scorecard*™.

Learning Objectives

Upon completion of the *HCCI House Call Practicum*™, learners will be able to:

- Describe the day-to-day practices of one of the nation's premier home-based primary care programs.
- Demonstrate enhanced knowledge and skills in HBPC practice operations and efficiency.
- Apply effective strategies for providing optimal, patient-centered care for medically complex patients in the home.

CME Credit

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of PeerPoint Medical Education Institute and the Home Centered Care Institute. PeerPoint Medical Education Institute is accredited by the ACCME to provide continuing medical education for physicians.

PeerPoint Medical Education Institute designates this live activity for a maximum of *12 AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Acknowledgment

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WHAT YOU CAN EXPECT

Schedule Overview

Each day is an estimated 6 hours of observation/teaching

Day 1 Conducting the HBPC Visit Ride-Along	Day 2 HBPC Operations Management Office Observation
• Opening Discussion • Provider Competencies • Prior to the Home Visit • During the Home Visit • Assessment of Patient Health, Function and Safety • Managing Urgent Issues in the Field • Communication with Staff, Patients and Community Resources • After the Home Visit	• Scheduling, New Patient Intake, and Appointment Confirmation • Preparing/Maintaining Supplies and Packing the Medical Bag • Triage and Communication • Billing, Coding, and Revenue Cycle Review • Analytics • Target Patient Population and Service Area • Marketing and Outreach Activities • Provider Productivity and Practice Breakdown • Staffing (Roles and Responsibilities, Types of Credentials) • Optional Content (as available): Telemedicine

DAILY SESSIONS

Day 1: Opening Discussion

A. Patients who typically benefit from Home-Based Primary Care (HBPC) include:

- Frail, home-limited older adults who live in their own home or an assisted living facility.
- Individuals with serious chronic conditions, balance or mobility issues that may lead to falls, and/or late-life depression, dementia, or memory disorders.
- Anyone who may have difficulty getting to/from a provider's office and may have missed or cancelled appointments.
- Patients who were recently discharged from a hospital, skilled nursing facility, or rehabilitation facility.

What type(s) of patients are served by this program?

Notes:

B. HBPC Providers must possess key competencies and personal qualities and need to establish credibility in their community. Some examples include:

- **Requisite Knowledge and Skills**
  - Medical Knowledge: Able to manage a range of chronic illnesses, including CHF, COPD, Dementia, HTN, Afib, DM, CKD.
  - Technical Skills: There is value in being able to perform certain procedures in the home, including G-tube, trach and Foley catheter changes (the latter usually done by home health), as well as wound debridement and joint injections.
  - Interpersonal Skills: Able to engage in difficult conversations involving complex medical and social situations, end-of-life/advance care planning, prognostication, and goals of care.

- **Objectivity and Judgment**
  - Able to apply medical knowledge, skills, and guidelines to craft an effective care plan that is driven by the patient's goals of care, considers the patient's and family's social and emotional factors, and helps implement it in a sincere and sensitive manner.

- **Honesty and Integrity**
  - When delivering care in the homes of patients, many of whom are frail and/or vulnerable, it is essential that providers are trustworthy and demonstrate high ethical standards.

- **Empathetic**
  - Able to use verbal and nonverbal communication to connect with the patient, family, and caregiver(s) who are often in difficult circumstances.

- **Affiliations and Achievements**
  - Anticipate that patients and/or family may have anxiety or suspicions about receiving a provider (a stranger) in the home. Come prepared with handouts, brochures, talking points to describe the provider's qualifications, affiliations, and/or endorsements.

What other key competencies or personal qualities do you see as important for HBPC Providers?

Notes:

Day 1: Conducting the HBPC Visit – Ride Along

Your PEP Preceptor(s) will demonstrate and discuss how each of the following steps associated with conducting the HBPC visit is implemented, if applicable to this practice.

A. Prior to the Home Visit:

- ☐ Pre-visit preparation (e.g., medical record review, gathering supplies, anticipated lab tests)
- ☐ Specific instructions or circumstances for any of the day's scheduled visits (e.g., the need for a family member to be present, a misleading or confusing address, family's request to use the back door)
- ☐ Use of GPS and route planning, if necessary
- ☐ Handling inclement weather or unexpected travel conditions
- ☐ Gathering of necessary paperwork for visits [e.g., Advanced Directives (DNR), POLST/MOLST, 5 wishes, consent, communication choice, welcome packets]
- ☐ Preparation of equipment and house call medical bag

Notes:

B. During the Home Visit:

- ☐ Completion of the comprehensive HBPC Assessment
- ☐ Assessment of caregiver understanding and distress
- ☐ Development of the care plan and effective use of prognostication
- ☐ Patient/caregiver education materials
- ☐ What to do if pests are identified in the home (e.g., bed bugs, roaches, or other vermin)
- ☐ What to do if firearms, pets, and cigarette smoke are encountered in the home (e.g., patient/provider rights and responsibilities)
- ☐ Medication reconciliation in the home (e.g., gathering and checking all prescription bottles, including over-the-counter medications, and review how medications are kept and administered)
- ☐ Inspection of living arrangements and safety assessment (e.g., inspecting refrigerator, cupboards, personal hygiene, and unsafe environment/APS referral)
- ☐ Patient exam (where and how) (e.g., sofa, bed, positioning)
- ☐ Wound care
- ☐ Procedures that can be done in the home (e.g., gastrostomy tube and tracheostomy tube changes, urinary catheter insertion and removal, joint injections)
- ☐ Process for ordering diagnostic and/or laboratory testing and for administering immunizations
- ☐ Process for ordering and documenting necessity for durable medical equipment (e.g., wheelchair, hospital bed, oxygen)
- ☐ Process for completing documentation while in the patient's home
- ☐ Handling prescription refills including controlled substances
- ☐ Management of in-basket messages, refills, and urgent calls during the day

Notes:

C. Assessment of Patient Health, Function, and Safety:

Useful tools and assessments (if applicable to this practice):

- ☐ Functional assessments
  - Activities of Daily Living (ADLs) / Instrumental Activities of Daily Living (IADLs)
  - New York Heart Association (NYHA)
  - Karnofsky Performance Scale Index, Eastern Cooperative Oncology Group (ECOG), Palliative Performance Status
  - Mobility [e.g., Timed Up and Go (TUG)]
  - Edmonton Symptom Assessment System (ESAS)
- ☐ Cognitive [e.g., Mini-Cog, Mini-Mental State Exam (MMSE)]
- ☐ Depression [e.g. Patient Health Questionnaire (PHQ-2/PHQ-9); Geriatric Depression Scale]
- ☐ Behavioral [e.g., Functional Analysis Screening Tool (FAST)]
- ☐ Decision-making capacity
- ☐ Nutrition screening [e.g., Mini Nutritional Assessment (MNA)]
- ☐ Spiritual screening [e.g., FICA (Faith, Importance, Community, Address)]
- ☐ Alcohol screening [e.g., CAGE; Alcohol Use Disorders Identification Test (AUDIT)]
- ☐ Abuse or neglect screening
- ☐ Financial hardship screening
- ☐ Environment assessment, including oxygen safety
- ☐ Advance Care Planning discussions and documentation [e.g., DNR, POLST/MOLST, Power of Attorney for Health Care (e.g., 5 Wishes), Living Will]

Notes:

D. Managing Urgent Issues in the Field:

- ☐ Protocol(s) for clinical emergencies:
  - When to call 9-1-1
  - Caring for the patient until emergency services arrive at the scene
- ☐ Protocol(s) for addressing acute allergic reactions from injections or immunizations
- ☐ Protocol(s) for handling a patient's death at home

Notes:

E. Communication with Staff, Patients and Community Resources:

- ☐ Communication with staff when leaving the office or starting the day, including how you share information about your route and/or progress through the day.
- ☐ Avoiding risky situations.
- ☐ Handling of incoming call triage and communication with nursing staff.

After-hours Coverage:

- ☐ Protocol(s) for after-hours coverage including use of an answering service and provider call schedule.
- ☐ After-hours messaging and paging, including which messages or concerns are directed to the on-call provider vs. being held for the next office day.

Care Coordination:

- ☐ Process and protocols
- ☐ Use of community resources
- ☐ Managing transitions of care
- ☐ Arranging hospice or home health services

Notes:

F. After the Home Visit:

- ☐ Provider's end-of-day tasks
- ☐ Selection of appropriate billing codes
- ☐ Consideration of other services beyond E/M (e.g., transitional care management, advance care planning, chronic care management)
- ☐ Other end-of-day clean-up, such as returning temperature-controlled items (e.g., vaccines), disposal of contaminated supplies and disinfecting of equipment
- ☐ Process for peer-to-peer review or consultation with other specialties
- ☐ Process for training students or accommodating other observers
- ☐ Quality Improvement (QI) projects
- ☐ Inter-disciplinary Team (IDT) meetings

Notes:

Day 2: HBPC Operations Management – Office Observation

Your PEP Preceptor(s) will demonstrate and discuss how each of the following steps associated with practice operations is implemented, if applicable to this practice.

A. Scheduling, New Patient Intake, and Appointment Confirmation:

Scheduling:

- ☐ Development of providers' schedules for routine, follow-up, and urgent visits
- ☐ Protocol(s) for urgent/acute add-on visits
- ☐ Communication to providers of final daily schedules, including any last-minute changes
- ☐ Process for geographic scheduling
- ☐ Process for coordinating visits for patients who reside at the same facility

New Patient Intake:

- ☐ Process for accepting new patients, including the person responsible for this function
- ☐ Scripting and standard information collected
- ☐ How and when insurance is verified
- ☐ Time allotted for new patient visits

Appointment Confirmation:

- ☐ Protocol(s) for handling appointment reminders/confirmations
- ☐ Process for no-show/no-response
- ☐ Handling behaviors such as frequent cancellations

Notes:

B. Preparing/Maintaining Supplies and Packing the Medical Bag:

- ☐ Storage/organization of providers' medical bags and equipment
- ☐ Vendor selection process for purchasing supplies and equipment
- ☐ Supply inventory management process
- ☐ Use of Personal Protective Equipment (PPE)

Immunizations and Injections:

- ☐ Supply storage
- ☐ Supply transport

Venipuncture:

- ☐ In-home: storage of lab equipment, pick-up schedule and protocols, getting results in EHR
- ☐ Outsourced: storage of lab equipment, pick-up schedule and protocols, getting results in EHR

Notes:

C. Triage and Communication:

- ☐ Handling of daily clinical messages and patient needs
- ☐ Triage components and process, including:
  - ☐ Staff type(s) or licensure required to perform triage for providers
  - ☐ Written protocols established and how they are followed
  - ☐ What, if any, type(s) of orders can be authorized without provider approval
- ☐ Emergency procedures or safety plans in place both in the home and in the office
- ☐ Ordering/coordination of durable medical equipment (DME) (e.g., requirements for various supplies, working with Medicare bid vendors)
- ☐ IDT meetings and how these enhance communication and patient care

Notes:

D. Billing, Coding, and Revenue Cycle Review:

Optimal documentation and coding for services, including:

- ☐ E/M Coding and pertinent modifiers
- ☐ Advance Care Planning (ACP)
- ☐ Face-to-face prolonged services
- ☐ Non-face-to-face prolonged services
- ☐ Chronic Care Management (CCM) or other care management services such as Care Plan Oversight (CPO)
- ☐ Transitional Care Management (TCM)
- ☐ Remote Patient Monitoring (RPM) or Virtual Services provided
- ☐ Cognitive Assessment & Care Plan Visits
- ☐ Annual Wellness Visits (AWV)

☐ Process for selecting code(s) based on provider's progress note

☐ Provider's responsibility to complete and lock/sign their progress notes

HCC Coding

- ☐ Ensure HCC codes have been billed each year.
- ☐ Coding to the highest level of specificity and the impact of risk adjustment (e.g., EHR is modified to identify HCC diagnoses codes, providers are given a comprehensive and current HCC list)

☐ Claims Submission: Process and protocols

☐ Annual Billing Reports: Type(s) and frequency

Audit Review:

- ☐ Process for and frequency of internal and external chart audits
- ☐ Process for educating providers on coding and documentation
- ☐ Process for tracking and monitoring code usage, such as chronic care management and transitional care
- ☐ Process for reviewing denied claims to ensure they are appropriately worked and resubmitted with additional documentation
- ☐ Use of billing company, if applicable
- ☐ Process for staying up to date on new coding opportunities or coding changes

☐ Shared savings programs

Notes:

E. Analytics:

- ☐ Impact of value-based payments at the practice level and preparation for MACRA/MIPS/APM and/or bundle payment models
- ☐ Accountable Care Organizations (ACOs)
- ☐ Tracking of reduced admissions and/or readmissions as a mechanism for documenting success/value
- ☐ Tracking of various measures (e.g., Clinical Quality Measures, Practice Management Measures, such as provider visit ratios, RVUs, annual equipment expenses, billing reports, budget comparisons, employee and provider satisfaction)
- ☐ Process for identifying and implementing quality improvement activities
- ☐ Data registry participation

Notes:

F. Target Patient Population and Service Area:

Determination of target population, e.g., patient selection criteria, qualifications

- ☐ Age, IADLs, ADLs, number of chronic diseases
- ☐ Any payer restrictions or ACO requirements

- ☐ Determination of geographic service area
- ☐ Strategies for targeting assisted living facilities (ALFs)/senior apartments

- ☐ Approach to measuring patient volume, and considerations for expansion

Notes:

G. Marketing and Outreach Activities:

Marketing/outreach activities:

- ☐ Area Agency on Aging
- ☐ Division of Aging for cities in the service area
- ☐ Assisted Living Facilities
- ☐ Senior Apartment Buildings
- ☐ Religious organizations (e.g., places of worship, Catholic Charities)
- ☐ Non-profits serving the homebound
- ☐ Home health, hospice agencies, or other community agencies
- ☐ Health System
- ☐ Health Fairs
- ☐ Flyers/promotions
- ☐ Use of designated company (branded) vehicles, if applicable

Notes:

H. Provider Productivity and Practice Breakdown:

- ☐ Productivity targets and metrics (e.g., number of visits completed per day vs. big picture including ER/readmissions by provider patient panel, coding utilization)
- ☐ Travel approach (e.g., program owns/leases vehicles vs. providers drive their own cars)
- ☐ Care model(s) used (longitudinal, transitional, or both)
- ☐ Provider type(s), ratio(s), and team structure
- ☐ Standard care agreement between an Advanced Practice Provider and collaborating physician
- ☐ Patient panel size per provider, including how this number is determined and monitored
- ☐ Number of patients per FTE and how geography and zip codes impact this ratio

Notes:

I. Staffing (Roles and Responsibilities, Types of Credentials):

- ☐ Team composition (e.g., front vs. back office, administrative vs. clinical, specific position titles, full-time equivalency for each position, and roles/responsibilities)
- ☐ Role of the Practice Manager, if applicable, including day-to-day responsibilities, impact on practice decisions, and reporting outcomes
- ☐ Role of medical assistant(s) on the team, if applicable
- ☐ Role of social worker(s) on the team, if applicable
- ☐ Role of community worker(s), if applicable
- ☐ Role of LPNs or RNs on the team, and if applicable:
  - *How was it decided what license to hire?*
  - *What established triage protocols are in place for use by the nurses?*
  - *How do they help the providers be more productive [e.g., ordering equipment and community resources, filling out forms (DME, FMLA), triaging, call backs, refills, prior authorizations, etc.]?*
- ☐ Role of Advanced Practice Providers (APPs), and if applicable:
  - *How do the APPs work collaboratively with physicians on the team?*
  - *How are patient panels distributed – physicians vs. APPs?*
- ☐ Process for APPs managing or working with physicians for the following orders or referrals:
  - *Certain orders requiring physician signature or SNF requirements*
  - *Schedule II drugs (if you're in a state that does not allow APPs to prescribe certain classes of drugs or co-signatures are required)*
- ☐ Productivity requirements for APPs vs. Physicians
- ☐ Policies for reimbursement of license renewal, continuing medical education, and insurances, including parameters and process for requesting reimbursement
- ☐ Team building

Notes:

J. Optional Content: Telemedicine [available at selected site(s)]

Your PEP Preceptor(s) will demonstrate and discuss how the Telemedicine Program is implemented.

- ☐ What is the difference between Virtual Visits and Remote Patient Monitoring?

  Virtual Visits: _____

  _____

  Remote Patient Monitoring: _____

  _____

- ☐ Describe some of the benefits of telehealth.
  - ☐ Saves time
  - ☐ Saves money
  - ☐ Saves lives
- ☐ Discuss potential barriers that can be encountered when implementing telehealth.
  - ☐ Cost and reimbursement
  - ☐ Technology issues
  - ☐ Legal liability
  - ☐ Privacy/confidentiality
- ☐ Discuss some examples of Remote Patient Monitoring in home-based primary care.
  - ☐ Blood pressure
  - ☐ Oxygen saturation
  - ☐ Heart rate
  - ☐ Temperature
  - ☐ ECG
  - ☐ Blood glucose
  - ☐ Weight scale
  - ☐ Wireless recording of sleep/wearables

Notes:

Telemedicine - Ride-along with Paramedics (if applicable)

- ☐ Transportation and route planning
- ☐ Training of paramedics
- ☐ Team meetings
- ☐ **Observe 2-4 paramedic visits; debrief afterward**
- ☐ Paramedics' role in patient assessment, e.g., taking vitals
- ☐ Technology used in the home
  - ☐ Type(s)
  - ☐ Set-up
  - ☐ Live transmission only; no recording
  - ☐ Use of smart phone
  - ☐ Resolving unexpected challenges, e.g., poor cellular signal
- ☐ Concluding the virtual visit and paramedic's departure
  - ☐ Managing the "just one more thing" after the connection with the provider has ended

Notes:

Telemedicine - In-Office

- ☐ Factors to consider prior to implementation of telemedicine program
  - ☐ Program goal
  - ☐ Start-up costs vs. ongoing costs
  - ☐ Selection of the virtual visit model
  - ☐ Determination of the type(s) of telehealth to be offered to patients
  - ☐ Determination of the cases or conditions to be treated using telehealth
  - ☐ Ability to integrate telehealth into daily workflow/EHR
- ☐ Staffing
  - ☐ Physician(s)
  - ☐ Paramedics
- ☐ Scheduling patients for virtual visits
  - ☐ Types of patients
  - ☐ Types of visits
  - ☐ Typical number of patients seen per day
  - ☐ Time per visit
- ☐ Technology
  - ☐ Evaluation of vendors
  - ☐ Selection of appropriate technology, including the following considerations:
    - ☐ Size/weight and portability
    - ☐ Interface between user and EHR
    - ☐ Durability
  - ☐ Utilization of remote patient monitoring; ordering and implementing the necessary device(s)
- ☐ Assessing patient and caregiver satisfaction
- ☐ **Observe 2-4 virtual visits; debrief afterward**
- ☐ Reimbursement considerations
  - ☐ Provider documentation

NOTES

HCCI staff will follow-up with you after you finish the *HCCI House Call Practicum*™ with instructions to complete your evaluation, learning plan, and claim credit. Use this space to take notes that will help you complete these forms.