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INSTITUTE

Introduction to Home-Based Primary Care, Home-Based Palliative Care, and Chronic Care Management

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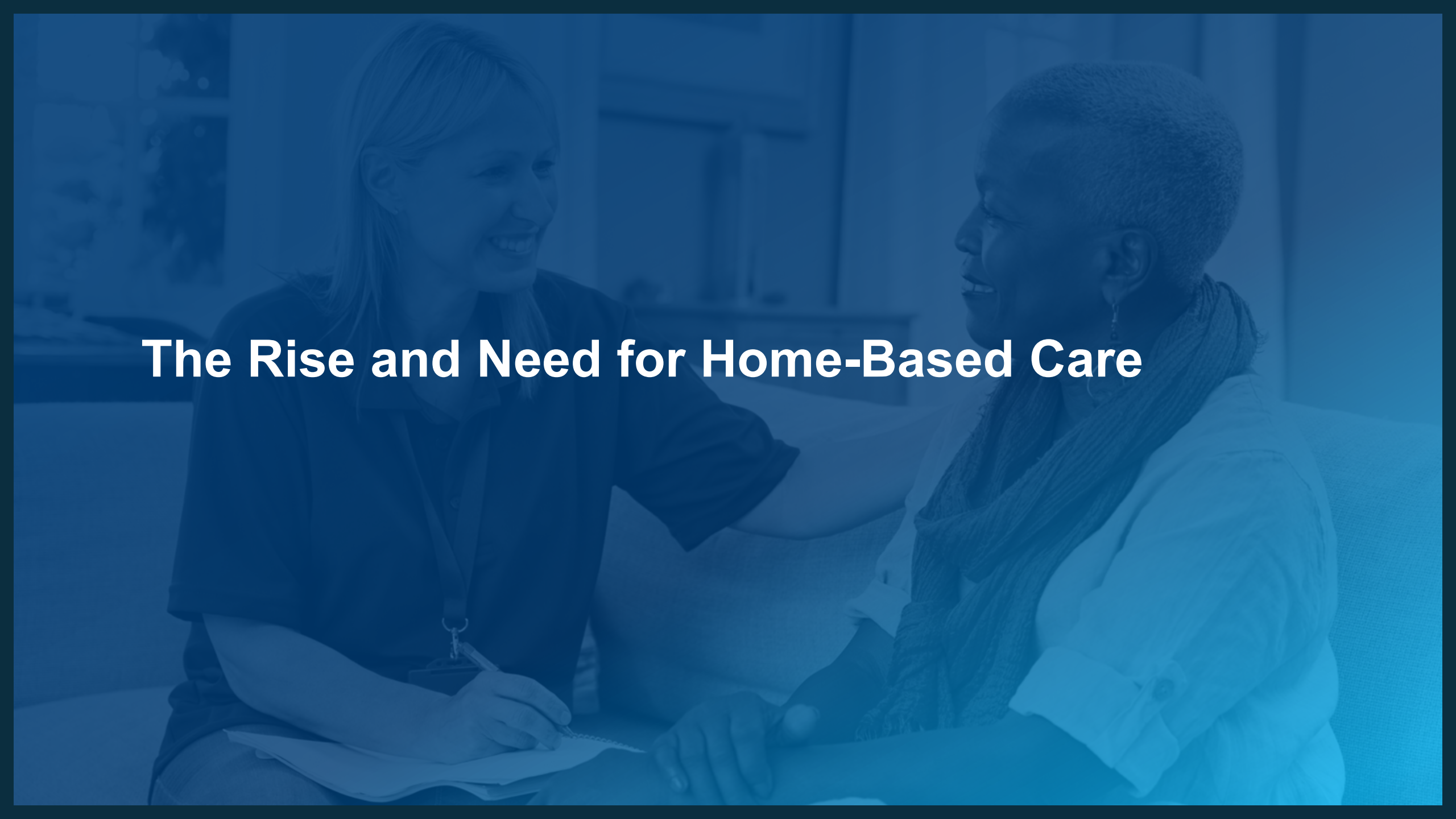
Agenda

1. Objectives
2. The Rise and Need for Home-Based Care
3. Overview of Home-Based Primary Care (HBPriC)
4. Intersection of HBPriC and HBPaiC
5. Fundamentals of CCM
6. Q&A
7. Next Steps

Objectives

- Describe the unique aspects of Home-Based Primary Care (HBPriC) and Home-Based Palliative Care (HBPaiC), as well as the ways in which these two models of care are aligned.
- Discuss the foundations of Chronic Care Management (CCM), including eligibility criteria, core service requirements, and documentation expectations.



A photograph of a caregiver, a young woman with blonde hair, sitting and smiling while assisting an elderly Black woman. The caregiver is holding a pen and a notepad. The elderly woman is wearing a white shirt and a patterned scarf. The entire image is covered with a semi-transparent blue overlay. The text "The Rise and Need for Home-Based Care" is centered in white.

The Rise and Need for Home-Based Care

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.

Providers Making Home Visits

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



A healthcare professional, likely a nurse or doctor, is sitting on a couch next to an elderly patient. The professional is wearing a dark blue polo shirt and a lanyard with a badge. She is smiling and looking at a document she is holding. The patient is an elderly woman with short grey hair, wearing a light blue button-down shirt and a grey scarf. She is also smiling and looking at the document. The background is a blurred indoor setting, possibly a home or a clinic. The entire image has a blue tint.

Home-Based Primary Care

How does it help patients with serious illness?

What is Home-Based Primary Care (HBPrIC)?

Key Components

- Brings providers & modern technology to patients in the comfort of their homes
- Improves quality of life for medically complex patients & caregivers
- Prevents avoidable hospitalizations & nursing home placements
- Reduces health care costs

Forms of HBPrIC

- 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

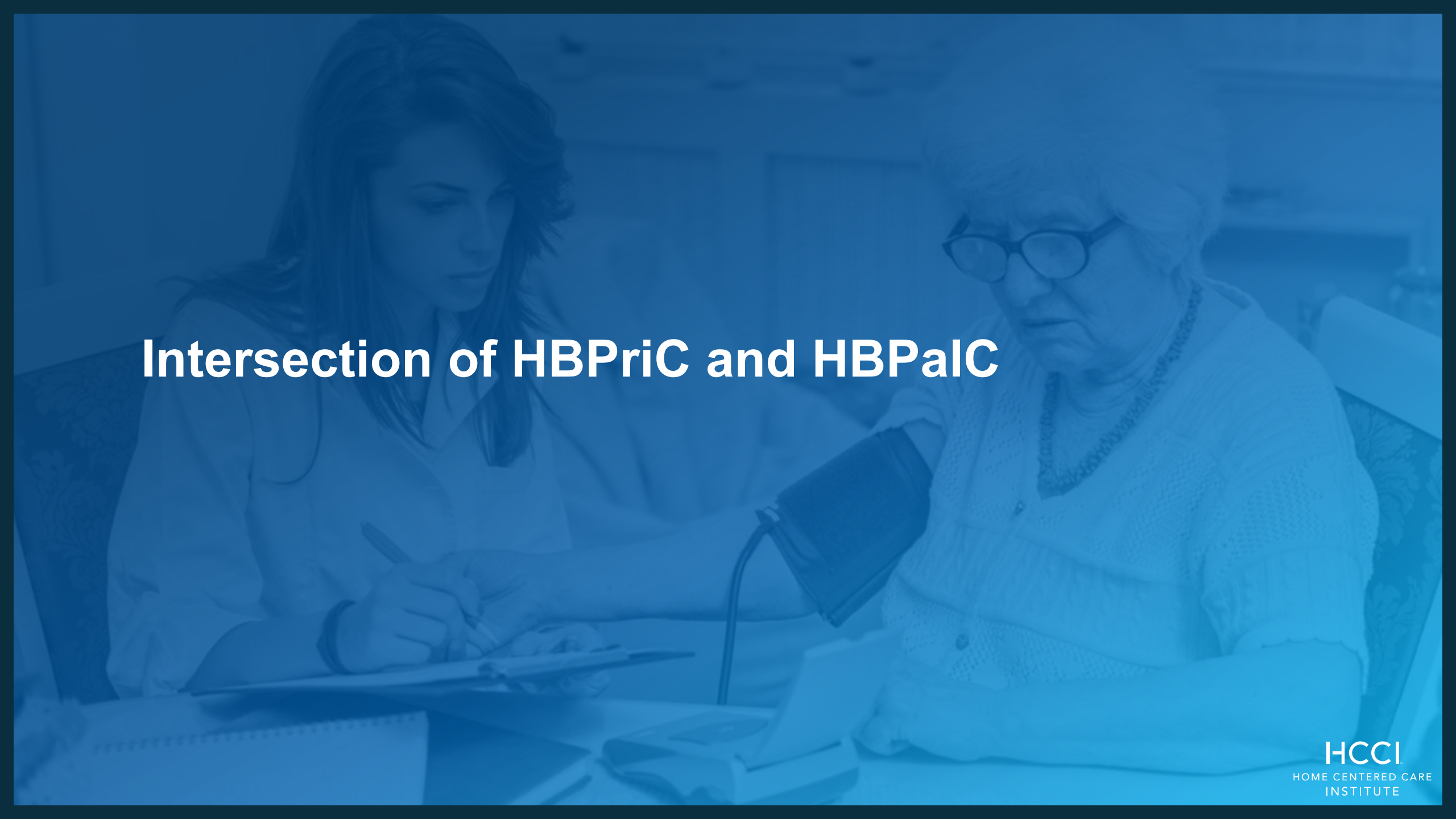
The HBPriC Model

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

Clinical Care Models in HBPriC

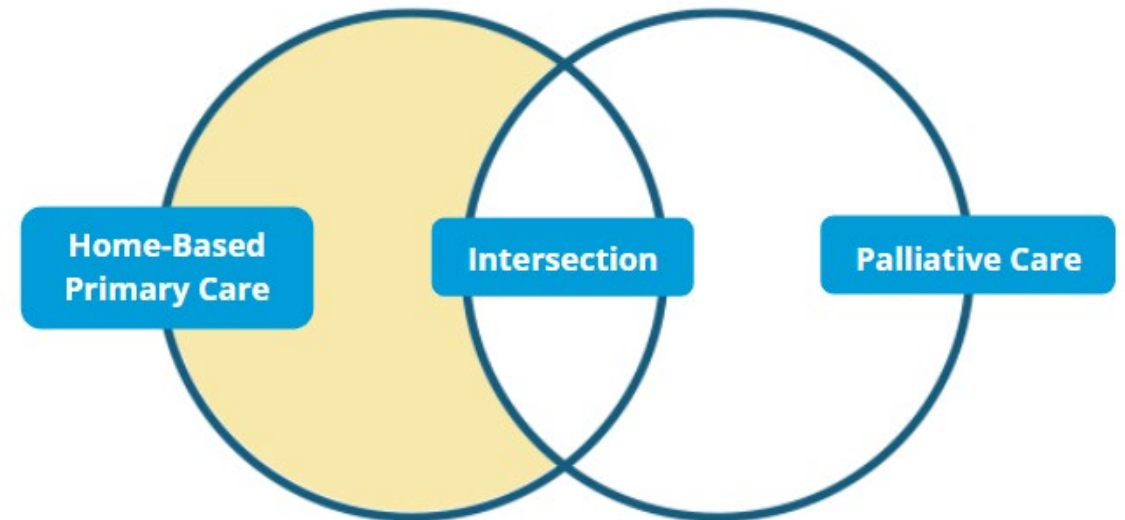
- **Transitional Care**
 - Short-term interventional support
 - Often for patients with target diagnoses or with high readmission risk
- **Longitudinal Care**
 - Long-term medical oversight
 - Often for patients age 65+ and/or high ED utilizers with no PCP

A caregiver, a young woman with long dark hair, is seated at a table and taking a blood pressure reading from an elderly woman. The elderly woman has short white hair and wears glasses. A blood pressure cuff is wrapped around her upper arm. The caregiver is holding a clipboard and a pen, looking down at it. The scene is set in a home-like environment with a window in the background. The entire image is overlaid with a semi-transparent blue filter.

Intersection of HBPrIC and HBPaiC

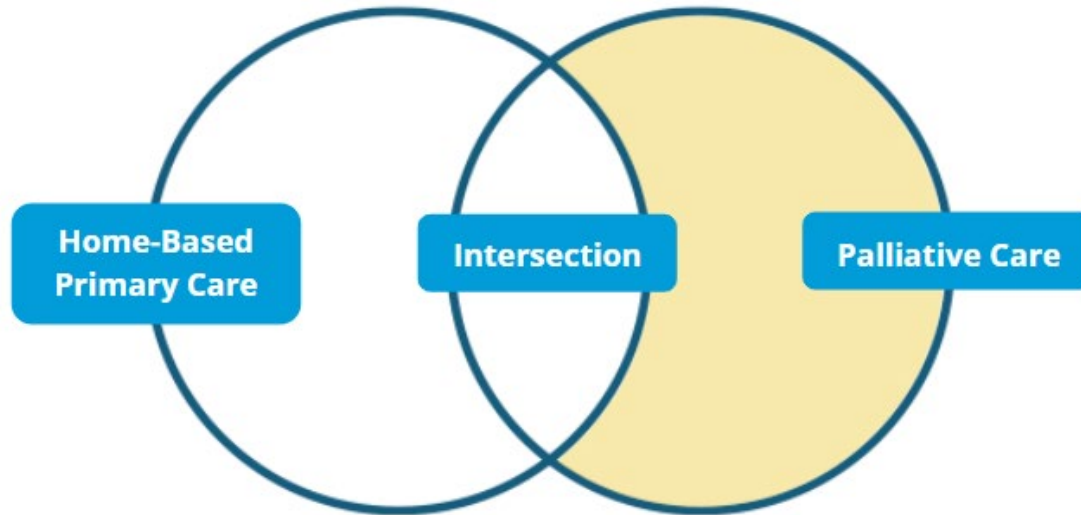
Home-Based Primary Care (HBPriC)

- 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).

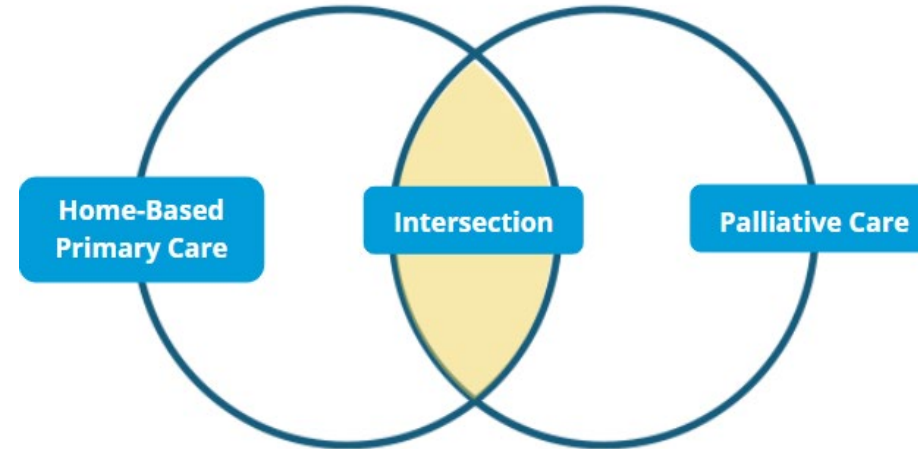
Home-Based Palliative Care (HBPaIC)



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

- 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

The Intersection of HBPriC and HBPalC



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

Meet Maria T.

Maria is enrolled in a home-based palliative care program and receives monthly visits from a palliative APRN. She has been hospitalized twice in the past six months for CHF exacerbations. Her medications include a diuretic, beta-blocker, insulin, and an antidepressant. Medication reconciliation and adherence remain a challenge. She often forgets to schedule follow-up labs or misses telehealth appointments due to technical difficulties. Her daughter is involved but overwhelmed managing her own family and work schedule.



Patient Profile		
Name	Maria T.	
Age	72	
Location	Lives alone in a small apartment; daughter lives 45 minutes away	
Primary Dx	Congestive Heart Failure (CHF) – NYHA Class III Type 2 Diabetes Mellitus	Chronic Kidney Disease (Stage 3) Moderate Depression
Palliative Needs	Symptom burden (fatigue, dyspnea, and lower extremity edema), high anxiety about disease progression, and increasing isolation	

Chronic Care Management Opportunity

Maria qualifies for CCM because she...

- ☐ Has two or more chronic conditions expected to last at least 12 months
- ☐ Faces a significant risk of functional decline and hospitalization
- ☐ Is not enrolled in hospice and continues to pursue disease-directed therapies
- ☐ Requires ongoing coordination across specialists, home-based providers, and social supports

CCM Implementation Benefits

Maria will receive...

- ✓ **Care Coordination**
- ✓ **Medication Management**
- ✓ **Advance Care Planning Support**
- ✓ **Social Needs**

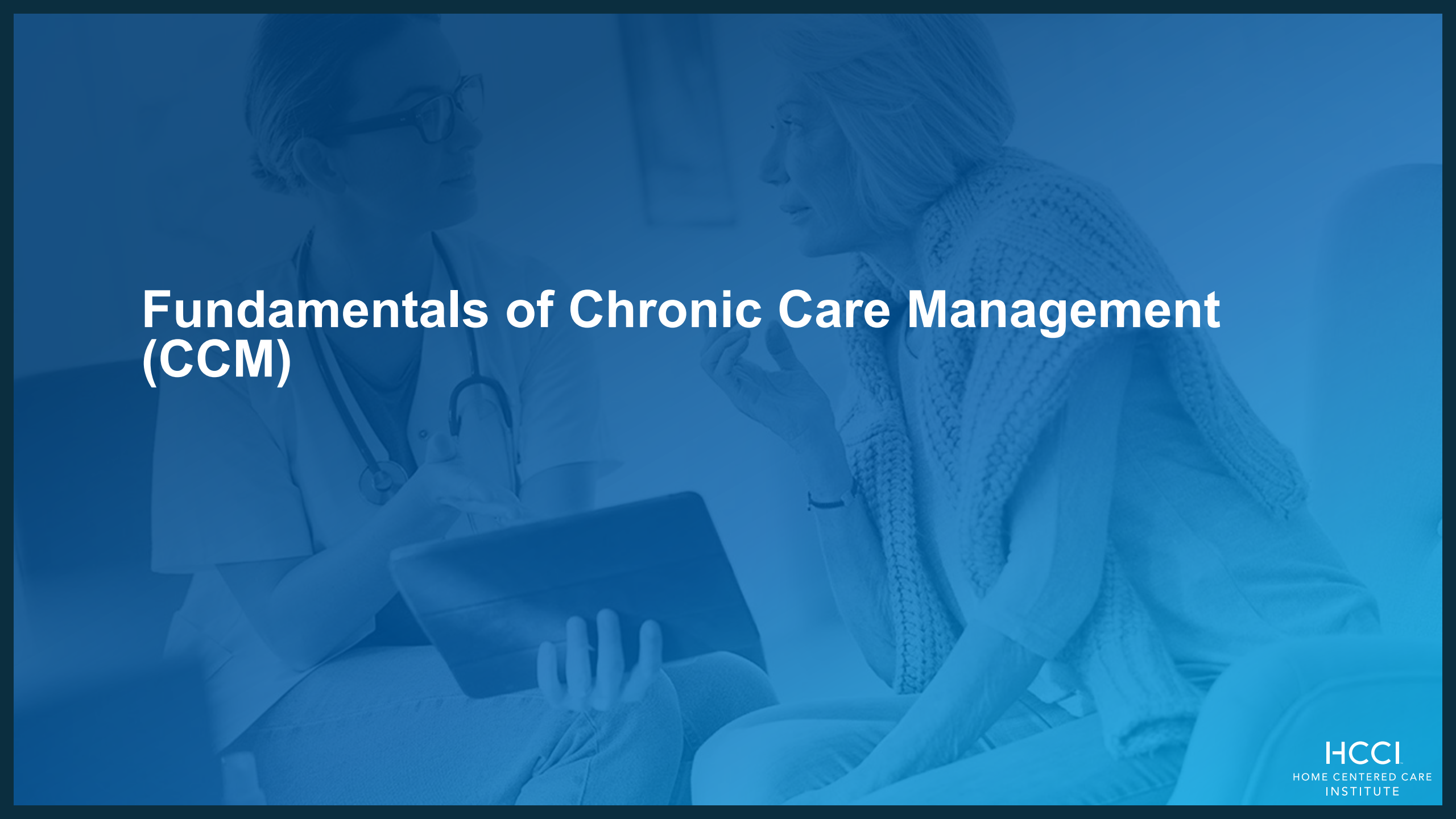
Projected Outcomes with CCM

Through CCM, Maria's outcomes could include...

- Reduction in hospitalizations and ER visits
- Better medication adherence and fewer adverse events
- Improved mood and decreased feelings of isolation
- A stronger care network with increased support for the daughter

Discussion

1. In what way(s) would Maria be supported by palliative care in the home?
2. In what way(s) would Maria 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 providing Chronic Care Management for seriously ill patients impact providers and other members of the interdisciplinary care team?

A healthcare professional, likely a nurse or doctor, is seated on a couch, wearing a white lab coat and glasses. They have a stethoscope around their neck and are holding a tablet computer. They are engaged in a conversation with an elderly woman who is also seated on the couch. The woman is wearing a light-colored, textured sweater and is gesturing with her hands as she speaks. The background is a simple, light-colored wall. The entire image is overlaid with a semi-transparent blue filter.

Fundamentals of Chronic Care Management (CCM)

What is Chronic Care Management (CCM)?

CCM is care coordination outside of a regular office visit for patients with 2+ chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.



It provides access to care outside of and in between doctors' visits.



CCM services can also help reduce geographic and racial or ethnic health care disparities.

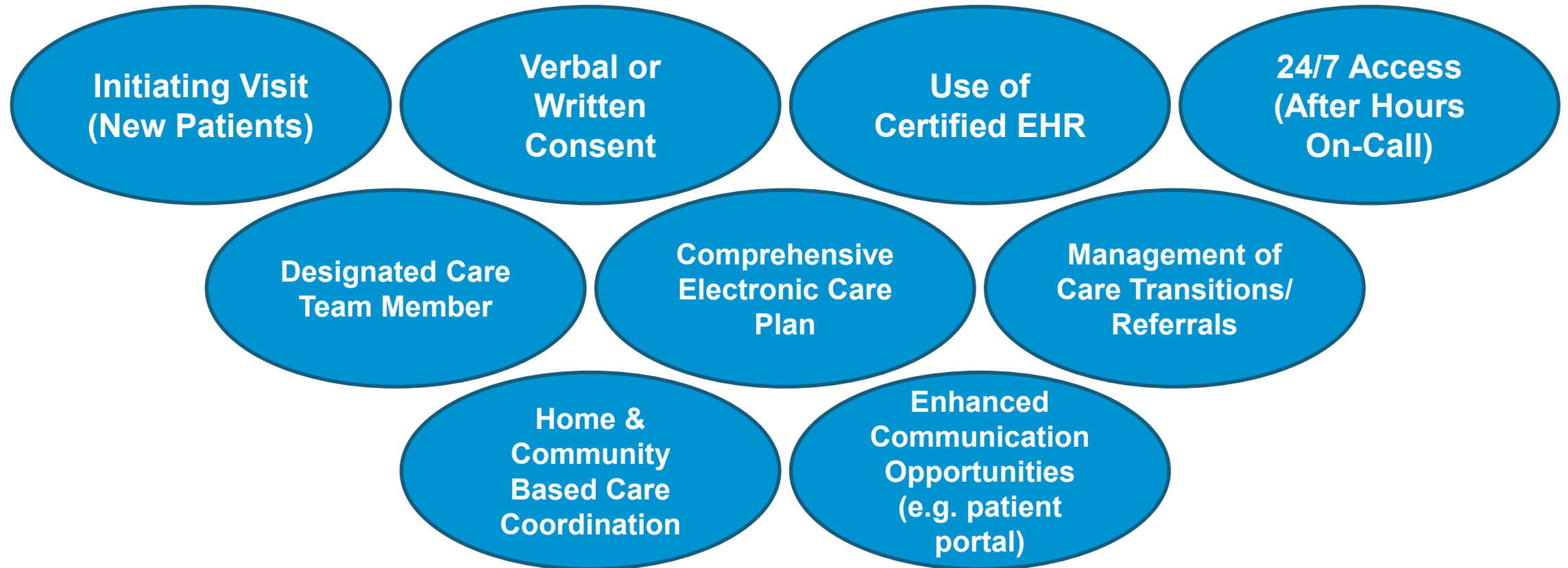


CCM can be billed by Physicians and certain Non-Physician Practitioners (Physician Assistants, Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners)

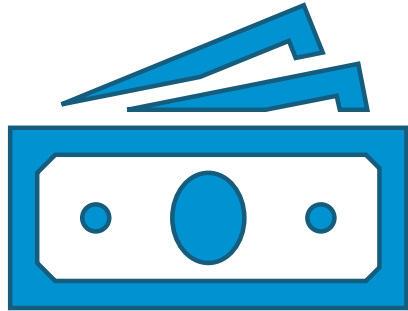
Why CCM Matters for Palliative Care

- **Holistic and continuous care aligns with palliative goals**
- **Captures non-face-to-face work already being done**
- **Provides reimbursement for important supportive services**
- **Enhances patient satisfaction and continuity of care**

CCM Requirements



Who Can Bill For CCM?



- Only **one** eligible practitioner can furnish and be paid for CCM services during a calendar month.
- Physicians and certain Non-Physician Practitioners (Physician Assistants, Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners) can bill for CCM
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospitals, including Critical Access Hospitals



CCM Coding and Reimbursement

CPT Code	2025 CMS National Non-Facility Payment	Description
99490	\$61.49	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month
99439	\$45.93	Add-on code, can only be billed in conjunction with traditional CCM (99490). CCM each additional 20 minutes of clinical staff time directed by a provider per calendar month.
99491	\$82.16	Provider CCM, 30 minutes per calendar month by the billing provider
99437 (add on for 99491)	\$57.58	Provider CCM Add-on Code: Each additional 30 minutes of CCM time personally spent by the billing practitioner.
99487	\$131.65	Complex chronic care management services, at least 60 minutes of clinical staff time as directed by a physician or qualified health care professional per calendar month.
99489 (add on for 99487)	\$70.52	Complex CCM Add-on Code; Each additional 30 minutes of clinical staff time as directed by the physician or other qualified health care professional
G0506 CCM Initiating Visit	\$60.81	Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services. Billed separately from monthly care management services. * This is only used for new patients or patients not seen within the past 12 months that require an initiating visit to enroll in CCM services

CCM Implementation

Clinical Staff

Does your practice have designated clinical staff to support CCM efforts (Care Plans, capturing time, main point of contact.)

Time

How will you track your time

MACRO

Develop care plan template and other customizations such as MACRO for documenting patient consent

Care Plan

Process to provide a copy of care plans to patients/caregivers

Billing Process

To capture month end revenue

Benefits of CCM

Patients

- Team of dedicated health care professionals to assist with individualized care planning.
- Comprehensive care plan to support disease control and health management goals, including outside resources, community support, referrals, and educational information
- Additional support between visits and more frequent communication with providers

Practice

- Improved care coordination and health outcomes
- Increased patient satisfaction, compliance, efficiency, and connection
- Decreased hospitalization and emergency department visits
- Improved resources to care for high-risk, high-needs patients
- Improved operational revenue providing the ability to sustain and grow your practice

Key Takeaways

Best Practices

- Use technology to streamline documentation
- Regularly update care plans with input from patients and caregivers
- Leverage interdisciplinary team strengths
- Ensure seamless handoffs and 24/7 support structures

Common Pitfalls to Avoid

- Missing proper consent documentation
- Care plan is outdated and/or nonspecific
- Failing to document time spent
- Not coordinating with billing compliance teams

Q & A

Next Steps



Next Steps

- ❑ **Watch *Crossroads of Care: Managing Serious Illness in the Home***
 - **Session 1: Bridging the Gap with Home-Based Primary Care**
 - **Session 2: The Intersection of Home-Based Primary Care and Palliative Care**
- ❑ **Review Marketing Toolkit & Innovation Award Promotion Guide**
- ❑ **Attend Monthly Consult Meeting**
- ❑ **Register for Webinar #2**

Innovation Award: Webinar #2

Designing & Implementing CCM Services

- General project plan to implement CCM
- Patient identification, enrollment, and consent
- Patient education
- Use of EHR data extraction techniques to identify eligible patients
- Patient consent
- Enrollment workflows
- Time tracking

Tuesday, June 24, 2025
10 – 11AM CST

Enrolled

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