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Illinois House Call Project C2 – Demystifying Value-Based Care for House Calls

Module 2 – Check-In

3/26/2025

Agenda

Topic	Time (min)	Presenter
Welcome & Introductions	10	Raabiah Ali, MPH
Module 2 Review: Managing Costs in Value-Based Care ○ **Congestive Heart Failure** ○ **COPD** ○ **Medications** ○ **Wound Care** ○ **Mental Health Conditions** ○ **Behavioral Complications of Dementia**	60	Paul Chiang, MD Michael Kingan, DNP, AGPCNP-BC James Ellison, MD, MPH
Q&A	15	All
Next Steps & Conclusion	5	Raabiah Ali, MPH

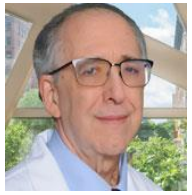
Presenters

Paul Chiang, MD

Consultant, Home Centered Care Institute

Michael Kingan, DNP, AGPCNP-BC

Wilmington VA Medical Center



James Ellison, MD, MPH

Professor of Psychiatry and Human Behavior
Sidney Kimmel Medical College
Thomas Jefferson University

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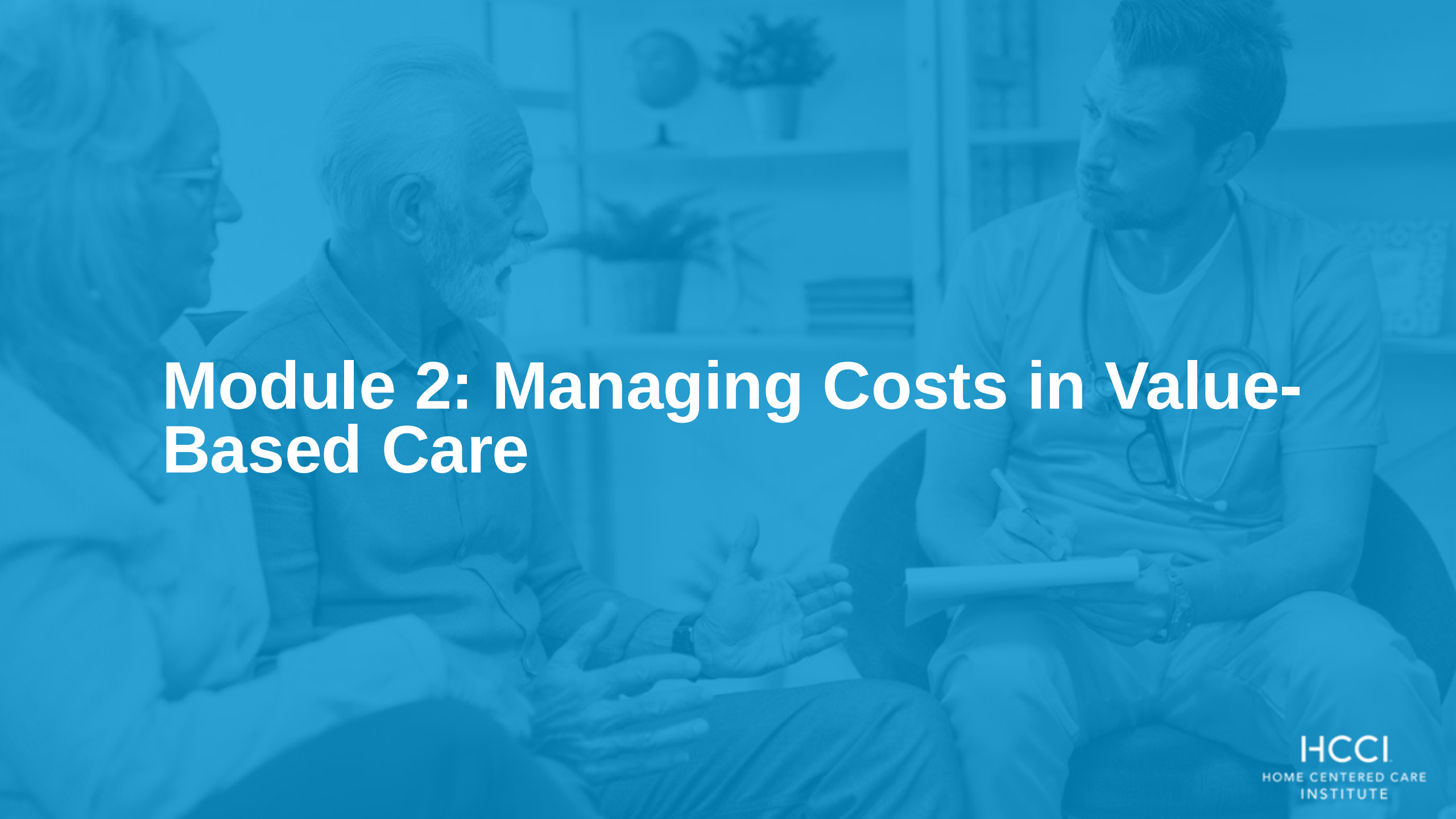

Module 2: Managing Costs in Value-Based Care

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Module 2: Managing Costs in Value-Based Care

Topics:

- Congestive Heart Failure
- Medications
- COPD
- Wound Care
- Mental Health Conditions
- Behavioral Complications of Dementia

CHF and COPD

Paul Chiang, MD

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Prevalence and Cost

- CHF, COPD common conditions in HBPC patients
- Associated with comorbidities (DM, CKD, HTN, mental illness, cog impairment)
- Cost drivers, ED/hospitalization/Readmissions

Recognition of CHF

- Leg swelling
- Shortness of breath
- Orthopnea
- Fatigue
- Anorexia, nausea, vomiting
- Increase in abdominal girth or symptoms

Heart Failure Diagnosis

- Physical exam
- Chest x-ray
- Echocardiogram
- Lab
- Implantable device

Summary of Heart Failure Medical Therapy

		HFrEF	HFmrEF	HFpEF
ARNI/ACEI/ARB		X	X	X
BB		X	X	
MRA		X	X	X
SGLT2i		X	X	X

Congestive Heart Failure (HFrEF)

Other Management Considerations

- Institute salt and fluid restrictions within the patient's goals of care
- Monitor weight; instruct patients to contact provider if weight gain >3 lbs/day or 5 lbs/week
- Ensure patients take medications as prescribed, deprescribe unneeded, harmful medications (example NSAIDs)
- Have patients report increase leg swelling, cough, shortness of breath, loss of appetite, and/or trouble sleeping flat
- Elevate legs, when possible, use compression stockings

Goals of COPD Management

- Improve symptoms
- Maintain/improve exercise tolerance
- Prevent exacerbation
- Improve mortality

Pharmacological Therapy of COPD

- Group A: Low risk, less symptoms, 0-1 moderate or severe exacerbation history: LAMA plus prn SABA, or LABA plus prn SAMA-SABA/SABA, or prn SAMA-SABA/SABA
- Group B: Low risk, more symptoms, 0-1 moderate or severe exacerbation history: LABA+LAMA (single inhaler may improve compliance), and SABA prn
- Group E: High risk, less symptoms >=2 moderate exacerbation or >= 1 severe exacerbation leading to hosp: LABA+LAMA plus prn SABA. LAMA+LABA+ICS plus prn SABA if eosinophil count > 300

Other Medication for COPD

- PDE4 inhibitor (roflumilast) improves lung function/reduced exacerbations in patients with chronic bronchitis/severe COPD-FEV1<50/hx exacerbation, but GI sx, insomnia
- Long term azithromycin can reduce exacerbation, but increase bact resistance/hearing loss/QTc
- Dual PDE-3/4 inhibitor (ensifentrine), if intolerant of LAMA LABA, but costly

Management of COPD Exacerbation

- Sudden change in frequency/severity of cough, change in sputum character/volume, difficulty breathing
- SABA, SAMA, or combination
- Oral steroids
- Antibiotic/antiviral
- O2

Barriers to Treatment

- Medication cost and complexity
- SE, intolerance
- Lack of clear instructions, literacy
- Frequent testing
- Distrust
- Cognition, depression, substance use
- Multiple providers, different recommendations
- Inertia, preference
- SDOH

CHF, COPD Quality Measures

- Readmission, cost of care
- Medication management, adherence (example: BB patients LVSD)
- Preventative care (example: vaccination)
- Symptom management, patient reported outcome

Medications

Michael Kingan, DNP, AGPCNP-BC

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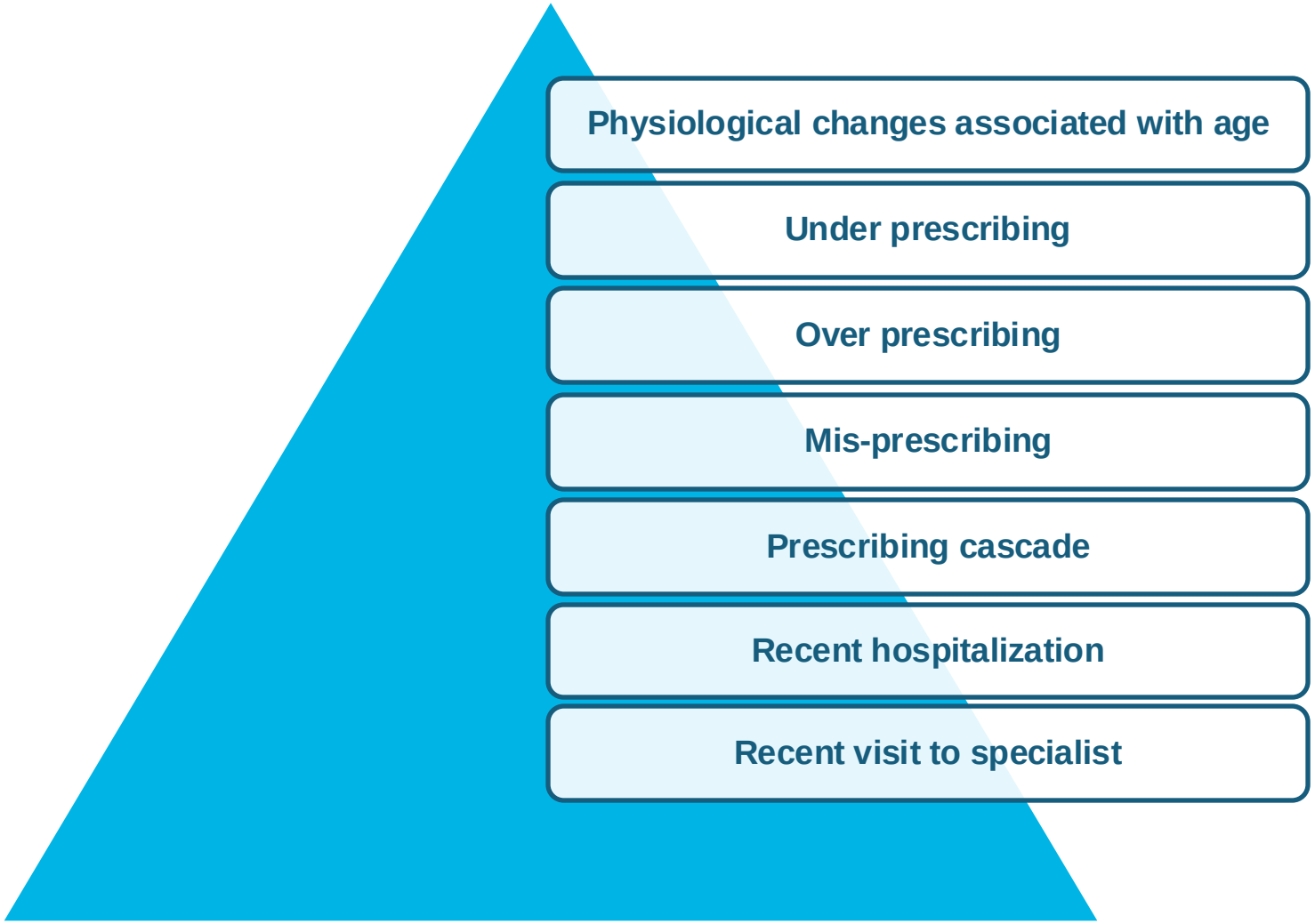
Polypharmacy

When less is more…

- Although elderly patients comprise <13% of the US population, they use almost 33% of prescription medication annually.
- Approximately 50% of hospitalized or ambulatory care patients or nursing home residents receive 1 or more unnecessary drugs.
- Adverse drug events occur in at least 15% of older patients which contributes to ill health, disability, hospitalization.

J Res Pharm Pract. 2015 Apr-Jun; 4(2): 85–88. doi: 10.4103/2279-042X.155755

Polypharmacy Associated Factors



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Key Takeaways

- Consider physiological changes associated with aging and the risks associated with polypharmacy.
- At minimum with every clinical change, change in care setting, or following specialist visit, complete a thorough medication reconciliation to determine the clinical indication for continuation.
- Utilize evidence-based tools to identify high-risk medications to de-escalate or discontinue - Beers Criteria and STOPP/START tool.
- When indicated, develop an individualized develop a de-escalation plan for de-prescribing.

Wound Care

Michael Kingan, DNP, AGPCNP-BC

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Stages of Pressure Injuries

Stage	Description
Stage I	An observable pressure noted when compared another body area. The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.
Stage II	Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to (but not through) the underlying fascia. The ulcer presents clinically as a deep crater with or without undermining adjacent tissue.
Stage III	Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to (but not through) the underlying fascia. The ulcer presents clinically as a deep crater with or without undermining adjacent tissue.
Stage IV	Full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bone or supporting structures (e.g., tendon, joint capsule).

Wound Assessment

- Location
- Stage
- Dimension (**L** x **W** x **D**) undermining / tunneling
- Exudate
- Wound base

Assessment

https://studentnursediaries.wordpress.com/tag/roper-logan-and-tierney/
October 10, 2011 abcde assessment, activities of living, admissions, advocate, assessment, assessment tools, emergency assessment, medical assessment, nmc, nursing, nursing assessment, nursing process, patients, resus council, roper logan and tierney

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Goals

Usually…

- Eliminate necrotic tissue
- Maintain a moist wound surface
- Minimize dressing change frequency

Always…

- Prevent/manage infection
- Manage drainage and odor
- Prevent pain

NHPCO Webinar Skin and Wound Care for Hospice Patients. September 4, 2013, Dorothy Doughty RN CWOCN FAAN

Prevention of Pressure Injuries

- Wounds covered healed twice as fast as wound exposed to air (1962 Univ. of London, George Winter, PhD) seminal study
- Prevention is key using:
  - Pressure redistribution devices
  - Incontinence care
  - Hydration/nutrition
  - Interdisciplinary collaboration
  - Early detection
  - Education
  - Braden Scale

Wound Care Documentation Requirements

Procedure Note: Separate area of your note template should represent

- Provider's assessment/status of the wound
- Wound location
- Instruments used (anesthesia used, if required)
- Type of tissue removed & depth
- Detail the providers treatment plan (Initial and updated treatment plan each visit)

Wound Measurements:

- The wounds should be numbered when more than one is observed and described
- Wound measurements should include length, width, and depth in centimeters
- Document **wound measurements both pre & post procedure**
- Document the total amount of tissue debrided (separate from wound measurements)
- Document the type(s) of tissue removed

Refer to resource: https://www.ngsmedicare.com/web/ngs/cert-details?selectedArticleId=1863598&lob=96664&state=97244&region=93624

Wound Plan of Care

Considerations

- Cleanse with wound cleanser
- Apply A&D ointment to wound margins
- Fill cavity with alginate rope
- Cover with gauze and secure with bordered gauze
- Identify dressing change frequency
- PRN dressing change for dressing saturation greater than or equal to 75%

Cleansers
Alginates
Collagens
Composites
Contact layers
Foams
Gauze (impregnated or wrapping)
Hydrocolloids
Hydrogels
Transparent films
Tapes
Lotions, ointments & creams
Moisturizers
Collagenase Santyl
Regranex
Antifungal agents

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Reimbursement & RVU's

CPT Code	2025 CMS National Payment Amount	wRVU
11042 (Debridement Subcutaneous tissue)	**$125.18**	**1.01**
11043 (Debridement Muscle/fascia)	**$225.46**	2.70
11045 (+ add on code for each add. 20 sq. cm., pair with 11042)	**$38.49**	**0.50**
11046 (+ add on code for each add. 20 sq. cm. pair with 11045)	**$70.52**	1.03

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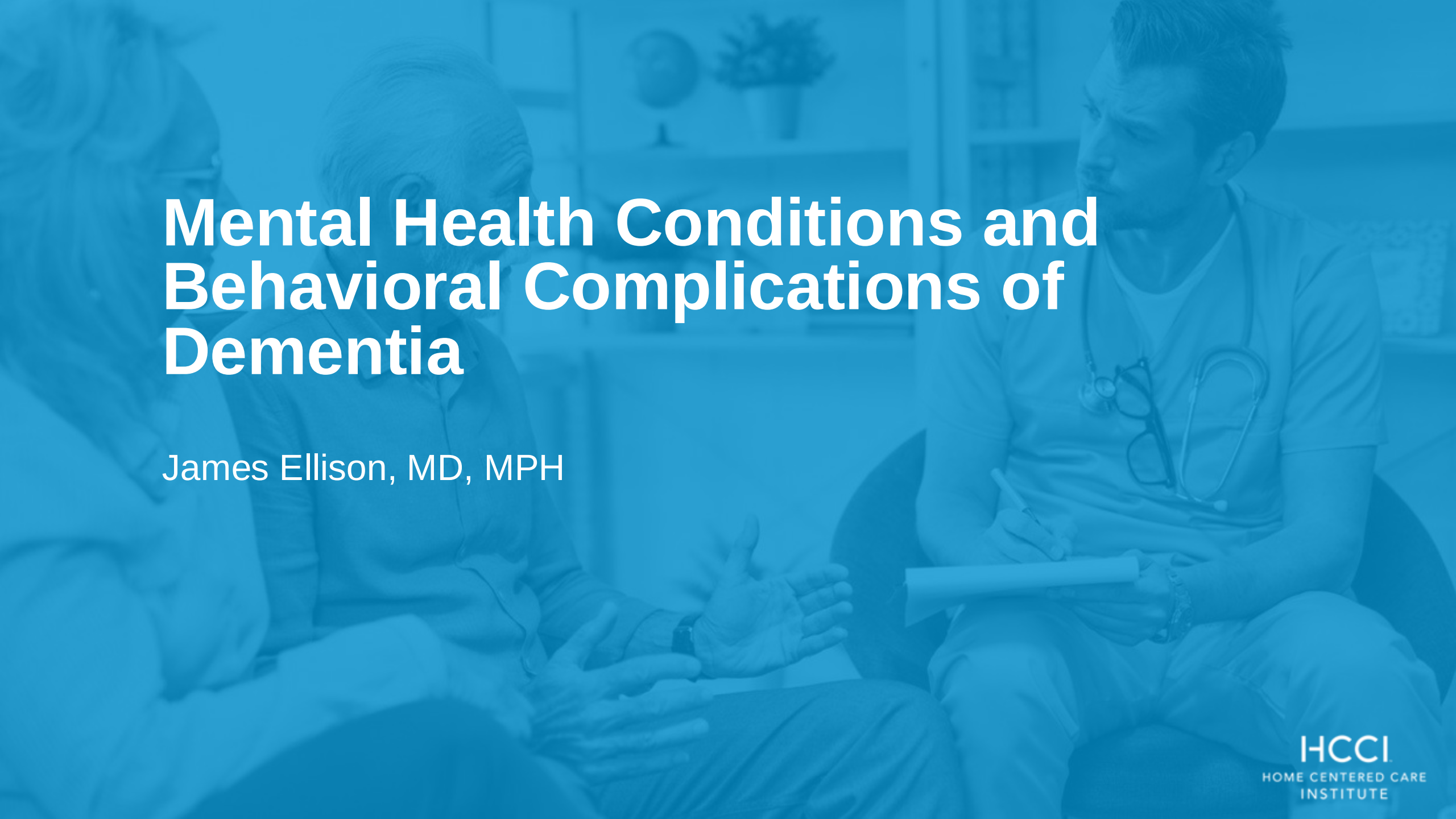
Key Takeaways

- Always remember patient goals
- Always manage pain
- Prevention is key (although not all wounds are preventable)
- Goal is to try and reduce frequency of dressing changes
- Wounds heal faster when covered
- Cleanse, fill (if appropriate), debride (if appropriate), protect margins, and cover



Mental Health Conditions and Behavioral Complications of Dementia

James Ellison, MD, MPH

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No Behavioral Health Consultant Available? Don't freak out – You can help!

Psychiatric disorders…

- Can threaten patient and caregiver safety, so they need to be addressed.
- Can interfere with assessment, but you can manage that.
- can present confusingly in older adults but you can identify them.
- cause suffering/disability that you can address.
- May require specialist consultation, but much can be done without the behavioral health specialist.
- However, it may be easier for YOU to assess care environment, caregiver support, and treatment adherence (medication bottles, pillbox, and administration schedule) in home setting than in the office and better to avoid unnecessary, more invasive care.

The Major Psychiatric Challenges in Home Care

- **Major Depressive Disorder (Diagnosis, Assessment, Treatment)**
  - Unipolar
  - Bipolar
  - Geriatric presentations
- **Anxiety (Diagnosis, Assessment, Treatment)**
  - Differential diagnosis
  - Anxiety Syndromes
- **Psychosis**
  - Schizophrenia
  - Other psychoses

Special Symptomatic Presentations of Late Life Depression (LLD)

Symptoms May Not Reach the "Major Depression" threshold

- Debilitating but too few symptoms for major depression diagnosis

"Depression without sadness"[1]

- Irritable, fatigued, apathetic, isolative

Somatic (sometimes cognitive) focus

- Preoccupation with bodily functions such as pain, movement, memory

Depression with psychotic features

- Mood congruent delusions are typical, hallucinations are more likely auditory

Depression with cognitive impairment [2,3]

- Depression slows processing speed and interferes with executive function; but cognitive symptoms can also be prodromal or comorbid neurocognitive disorder.

1. Gallo and Rabins. Am Fam Physician 1999;60:820-6; 2. Butters et al. Am J Psychiatry 2000;157:1949-54;
3. Sáez-Fonseca et al. J Affect Disord 2007;101:123-9

“Masked Depression” Seen In Persons with Dementia

Likelihood that depression is present is increased in the presence of:

- Delusions[1]
- Verbal/physical aggressive behaviors[2]
- Suicidal or self-destructive behaviors
- Disruptive vocalizations[3]
- Weight loss[4]

1. Bassiony et al. Int J Geriatr Psychiatry. 2002;17:549-56; 2. Menon et al. Int J Geriatr Psychiatry 2001;16:139-46; 3. Dwyer and Byrne Int Psychogeriatr. 2000;12:463-71; 4. Morley and Kraenzle J Am Geriatr So 1994;42:583-5.

You May See “Dementia” When The Problem Is A Treatable Depression

- Name: “Dementia Syndrome of Depression” rather than older term, “Pseudodementia”
- Patient “Can’t” or “Won’t” vs failing a sincere effort.
- Self-awareness and distress is greater.
- Onset is more sudden and severe.
- This syndrome may signal risk for later cognitive decline.

Medications to Know (1): SSRIs, SNRI

Name	Dosing	Typical Side Effects
Escitalopram	5 mg/d to start Usual range 10-20 mg/d	Changes in appetite, sleep, energy, sexual interest (in either direction); bruising, hyponatremia FDA states 20 mg/d is maximum acceptable dose for citalopram in older adult. Even at 20 mg/d, checking QTc may be prudent.
Citalopram	5-10 mg/d to start Usual range 10-20 mg/d	
Sertraline	25 mg/d to start Usual range 25-200 mg/d	
Duloxetine	20 to 30 mg/d to start Usual range 30-60 mg/d	Duloxetine has additional potential to increase anxiety, insomnia, blood pressure – and additional benefit of analgesic effect.

Generalized Anxiety Disorder (GAD) in DSM-5-TR

- Excessive worry on more days than not for at least 6 months about several events
- Difficult to control worry
- Associated with 3 or more of these 6 symptoms
  - Restlessness or keyed-up feeling, Easily Fatigued, Difficulty concentrating, Irritability, Muscle tension, Sleep disturbance
- Clinically significant distress/impairment
- Not substance, medication, medical, or other mental disorder such as PTSD, eating disorder, somatic symptom disorder, dysmorphic disorder, illness anxiety disorder (fear of having serious illness) or delusional condition

American Psychiatric Association (Ed.). (2022). Diagnostic and statistical manual of mental disorders: DSM-5-TR (Fifth edition, text revision). American Psychiatric Association Publishing.

GAD: Pharmacotherapy

SSRI is good place to start. Multiple medications are FDA-indicated for GAD treatment – here are a few good choices:

- Escitalopram:
  - Starting dose 5-10 mg daily
  - 15-20 mg daily may be required
  - Start low, go slow to avoid increase in anxiety
  - Be aware of FDA warning about citalopram and QTc (which may be true for escitalopram too)
- Duloxetine:
  - Starting dose 20-30 mg daily, may titrate up gradually to 60 mg/d
  - Avoid in hepatic insufficiency or end stage renal disease
- Buspirone
  - Modestly effective, especially useful when other medications are not tolerated.
  - Start with 5 mg twice to three times daily
  - Approved max is 60 mg/d
- Benzodiazepines? More to say about that later…

“Hoarding” with Dementia[1]

- **Linked with failure to discard**
- **Can be associated with squalor**
- **Often fills all rooms, interferes with personal care, food preparation, safety, 17% show self-neglect to point of filth**
- **Paper, containers, clothing, food books trash, less commonly purchases**

Note: “Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of a degenerative disorder”[2]

1. Kim et al. Health Soc Work 2001;26:176-84. doi: 10.1093/hsw/26.3.176; 2. American Psychiatric Association (Ed.). (2022). Diagnostic and statistical manual of mental disorders: DSM-5-TR (Fifth edition, text revision). American Psychiatric Association Publishing.

Delusional Disorder in DSM-5-TR

- Non-bizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, having a disease) of at least 1 month's duration.
- Criterion A (other than delusion) for Schizophrenia has never been met.
- Apart from the impact of the delusions(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously odd or bizarre.
- If mood episodes have occurred concurrently with delusions, their total duration has been brief, relative to the duration of the delusional periods.

Psychosis in Dementia

Psychotic symptoms are present in 30-50% of AD patients.

- Delusions:
  - Can persist for years
  - Simple and non-bizarre delusions are typical.
- Paranoid/persecutory; presumed theft of missing objects
  - Misidentification delusions can pose dangers at home.
- Hallucinations
  - Visual hallucinations are common in LBD and also in AD.
  - Seeing dead people
  - Phantom boarder

Jeste and Finkel, 2000.

Antipsychotics in Persons with Dementia: Modest Effects, Significant Drawbacks

Syndromes	Usual Agents	Evidence Says	Suggested Use
Psychosis Agitation Aggression	Aripiprazole	May have modest benefit for agitation/psychosis	Begin with 2 mg/d Increase as high as10 mg/d
	Risperidone (approved in Europe, not US)		Begin with 0.25 mg/d Increase as high as 2 mg/d
	Quetiapine	Questionable	Begin with 12.5 mg/d Increase as high as 200 mg/d
	Olanzapine	Questionable	Begin with 2.5 mg/d Increase as high as 15 mg/d
	Brexpiprazole	Only “on-label” agent	0.5 to 3 mg/d, 2-3 is best
	Clozapine	Inadequate data	Begin with 6.25 mg/d Increase up to 300 mg/d

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Yunusa et al. JAMA Network Open 2019;2(3):e190828.doi:10.1001/jamanetworkopen.2019.0828

Medications: Antidepressants – A Safer Alternative for Agitation with Dementia?

Syndromes	Usual Agents	Evidence Says	Suggested Use
Agitation Aggression Psychosis Anxiety Depression Apathy Maybe less useful for nighttime/ sleep behavior issues	Citalopram (best support)	Not worse than antipsychotics – modestly beneficial1-4	5 mg/d up to 20 mg/d. FDA recommends max dose of 20 mg/d due to QTc prolongation risk
	Escitalopram	Less data in patients with dementia but may have value as alternatives	5 mg/d up to 20 mg/d (may share QTc risk)
	Sertraline (some support)		25 mg/d up to 200 mg/d
	Fluoxetine		Not well defined
	Paroxetine		
	Vortioxetine		

ALL Antidepressants are "Off Label" in this usage

1. Porsteinsson AP, Antonsdottir IM. Expert Opinion on Pharmacotherapy 2017; 18:611-20; 2. Pollock BG. Am J Psychiatry. 2002;159:460-465; 3. Pollack BG, et al. Am J Geriatric Psychiatry. 2007; 15:942-952; 4. Porsteinsson et al. JAMA 2014;311:682-91.

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Q&A

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Illinois House Call Project: Demystifying Value-Based Care for House Calls Coursework Series

Session 3

Wednesday, April 30, 2025
2:30-4PM CST

Module 3: Ensuring Success in Value-Based Care

REGISTER HERE

For any questions, please contact
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RAli@hccinstitute.org

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HCCIntelligence™ Community Webinar Series

Telehealth 2025: What's Changing, What's Staying?

Objectives:

- Review possible updates to telehealth policies and coding under the CY2025 Physician Fee Schedule and their impact on home-based medical care.
- Identify best practices for coding, billing, and compliance to maximize reimbursement while maintaining regulatory compliance.
- Explore evolving trends in virtual care, including policy shifts, technology integration, and strategies for sustaining telehealth in home-based care settings.

Goal: Give providers actionable insights on the evolving telehealth landscape, preparing them for the key changes and enduring practices in 2025 and beyond.

Register Here

May 22, 2025
1 pm CT

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