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Patient Care Management in the Home

Paul Chiang, MD

Tammy Browning, PA-C

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Agenda

Topic	Time	Presenter
Welcome	1	Raabiah
Clinical Patient Care Management	45	Paul & Tammy
Chronic Disease Management		Paul
General Medication Management		Paul
Advance Care Planning (ACP)		Tammy
Q&A/Discussion	10	All
Next Steps	1	Raabiah

Chronic Disease Management

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Congestive Heart Failure

Recognition

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

Diagnosis

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

Summary of CHF Medical Therapy

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

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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 or LABA plus prn SABA, or prn SAMA-SABA not on LAMA/SABA
- Group B: Low risk, more symptoms, 0-1 moderate or severe exacerbation history: LABA+LAMA (single inhaler may improve compliance), and SAMA-SABA not on LAMA/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 Medications 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

Diabetes Mellitus (DM)

General Management

- Discuss frequency of blood sugar testing or CGM benefits/burden, and blood sugar goals
- Ensure patient is taking medication as prescribed
- Discuss modification of diet as appropriate
- Encourage exercise as tolerated/able
- Ensure follow-up with specialists, i.e., eye, foot care
- Order cholesterol and microalbumin tests to see if additional medication is needed
- Monitor hemoglobin A1C if appropriate (8 is considered reasonable for elderly, complex patients)

Diabetes Mellitus (DM)

Medication Management

Metformin	Often used as first-line treatment for type 2 diabetes.
Sulfonylurea	An alternative to or add-on to metformin therapy.
Dipeptidyl peptidase-4 (DPP-4) Inhibitor	A once-a-day oral medication to control blood sugar. DPP-4 can be used as monotherapy or in combination with sulfonylurea, metformin, or insulin.
Glucagon-like peptide-1 receptor (GLP 1) Agonist	An injectable/oral medication for type 2 diabetes mellitus which can be used as monotherapy or in combination with other oral medications for diabetes or basal insulin.
Sodium-glucose cotransporter-2 (SGLT2) Inhibitor	Can be used as monotherapy or in combination with other oral hypoglycemic medications or basal insulin in managing type 2 diabetes mellitus.
Thiazolidinedione	A once-a-day oral agent for managing type 2 diabetes mellitus which can be used as monotherapy or in combination with metformin or sulfonylurea.
Insulin	Can be used to control hyperglycemia. The type of insulin and frequency of testing depends on the level of hyperglycemia, cost, and goal for glycemic control given a patient's condition and goals of care.

Chronic Kidney Disease (CKD)

General Management

- Optimize glycemic control in DM
- Manage hypertension
- Encourage patients to stop smoking
- Encourage weight loss, salt restriction
- Treat hyperlipidemia with statin therapy
- Manage hyperphosphatemia with phosphate binder
- Treat hyperparathyroidism with a Vitamin D supplement
- Manage acidosis with sodium bicarbonate
- Manage HTN and/or HFrEF with ACE-I or ARB, and mineralocorticoid antagonists
- Manage DM and microalbuminuria with ACE-I/ARB, SGLT2i, MRA
- Discuss goals of care regarding initiating or withdrawing RRT

General Medication Management

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What's Wrong With This Picture?

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Medication Management in HBPC

Reconcile: Have an accurate list

Justify: Have a documented medical condition that requires medication(s)

Deprescribe: De-escalate and remove unneeded medication(s)

Optimize: Have proper dosing of medication based on renal, hepatic functions, and consider drug-drug interactions

Demonstrate: Have the ability to properly administer medication(s)

Educate: Explain the why/how related to medication(s) use

Medication Management Tools

- AGS Beers Criteria (updated in 2019)
- https://onlinelibrary.wiley.com/doi/epdf/10.111/jgs.13702
- https://medstopper.com/files/StoppingMedicationInTheElderly-ABHBpracticalGuidance_May2013_NHSWales.pdf
- https://www.pharmacy.umaryland.edu/practice/medmanagement/assisted_living/Tools-to-Assess-Self-Administration-of-Medication
- Cockcroft-Gault equation (used for drug dosing)

$$eCrCl = \frac{(140\text{-}Age) \times weight(kg) \times (0.85F)}{Serum\ creatinine \times 72}$$

Workflow Considerations for Efficient Medication Management

- Develop protocols for standard refills (12 mo.) for non-controlled substances with your team
- Utilize clinical staff to verify appropriate refill dosage and pharmacy before routing to provider for approval
- Provide information on mail order or local pharmacy delivery options for patients in need
- Provider checklist for addressing refills and medication changes during visits
- Ensure medication changes are reflected on medication list within the EMR in real-time

Medication Management Documentation Impacts

Continuation of care or prescription management is considered part of Medical Decision Making (MDM) and CPT II coding; however, documentation must clearly specify the details to support accurate coding

- HTN: well-controlled (122/68) on lisinopril 20 mg, continue current dose, continue with heart healthy diet and check BP twice monthly

MEAT Acronym:

- M - Monitor (signs, symptoms, disease progression/regression)
- E - Evaluate (test results, commenting on medication effectiveness, responses to treatment)
- A - Assessed/Addressed (stable, unstable, suboptimal)
- T - Treat (Prescribing or continuing medications, therapies/referrals, education/counseling, monitoring)

Advance Care Planning (ACP)

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Defining Advance Care Planning (ACP)

- ACP is a continual process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.
- The goal of ACP is to help ensure that people receive medical care that is consistent with their values, goals, and preferences during serious and chronic illness.
- ACP discussion should be proactive, integrated into routine visits, and periodically reviewed.
- ACP can be part of annual wellness visit.

Overview of ACP Discussions

- Elicit patient's understanding of illness and care preferences.
- Present and discuss treatment options with patient or designated surrogate.
- May result in completion of advance directive document(s), but not required.
- Document and disseminate information/outcome(s) from the discussion, as needed.

ACP Document Examples

- Living Will
- Designation of health care proxy/agent
- POLST/MOLST

Advance Care Planning: Benefits

- Deliver care consistent with patient's goals.
- Reduce undesired medical interventions not consistent with patient's goals.
- Reduce anxiety and burden on family, surrogate.
- Can guide how future, unforeseen medical conditions will be addressed.

Steps in Discussing Advance Care Planning

1. Assess patient/family readiness (timing)
2. Obtain permission for discussion
3. Determine who should be in discussion
4. Determine patient capacity
5. Ascertain patient's understanding of illness
6. Deliver medical information clearly and free of jargons
7. Discuss current dilemmas/treatment options
8. Elicit ACP preference (be specific)
9. Determine plausibility of preference
10. Document ACP discussion and outcome
11. Disseminate information to relevant individuals (such as POA) or institution (facility or hospital)
12. Review periodically

Advance Care Planning and Shared Decision-Making: An Interprofessional Role-Playing Workshop for Medical and Nursing Students
https://www.mededportal.org/publication/10644/

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Ask-Tell-Ask Approach to Conversations

Ask: Build trust by learning what matters to patient, assess the patient's understanding of condition/prognosis and if medical information desired, ascertain goals of care.

Tell: Explain condition, discuss potential future complications.

Ask: If there are additional questions, assess understanding regarding what was told, ask if more time needed.

Billing for Advance Care Planning: Medicare FFS

Time Based Service:

- Codes are time-based. Only time spent specifically on ACP counts toward reaching billing threshold. Must be performed by a qualified billing practitioner (MD, NP, PA)
  - **CPT 99497:** First 30 minutes face-to-face with the patient, family member(s), and/or surrogate **(minimum of 16 minutes documented)**
  - **CPT 99498:** Each additional 30 minutes face-to-face with the patient, family member(s), and/or surrogate **(minimum of 46 minutes must be documented**, billed in conjunction with 99497)
- Time spent completing other portions of E/M visit or Annual Wellness Visit (AWV) may not be counted toward ACP time therefore if recoding total time in the E/M encounter, you need to document separate/distinct ACP conversation time from other visit time

ACP Template Recommendations:

1. **Date & Individuals Present During ACP Discussion:** (Provider to customize & Insert Text Details)
2. **Patient Preferences & Types of Advance Directives Discussed:** (Provider to customize & Insert Text Details)
3. **Total Time Spent directly with the patient/caregiver on ACP Conversation:** (Total Time in minutes X) Start Time: (X) End Time: (X)
4. **Consent:** The patient provided verbal consent for their voluntary participation in this ACP discussion to discuss their long-term goals of care and preferences on what would happen if they could not make decisions for themselves.

When a patient elects to receive ACP services outside of the AWV, practitioners are encouraged to notify the beneficiary that Part B cost sharing applies as it does for other physicians' services.

ACP Reimbursement

CPT Code	2025 CMS National Payment Rate	WRVU
99497	~$86	1.50
99498	~$75	1.40

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Q&A

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Next Steps

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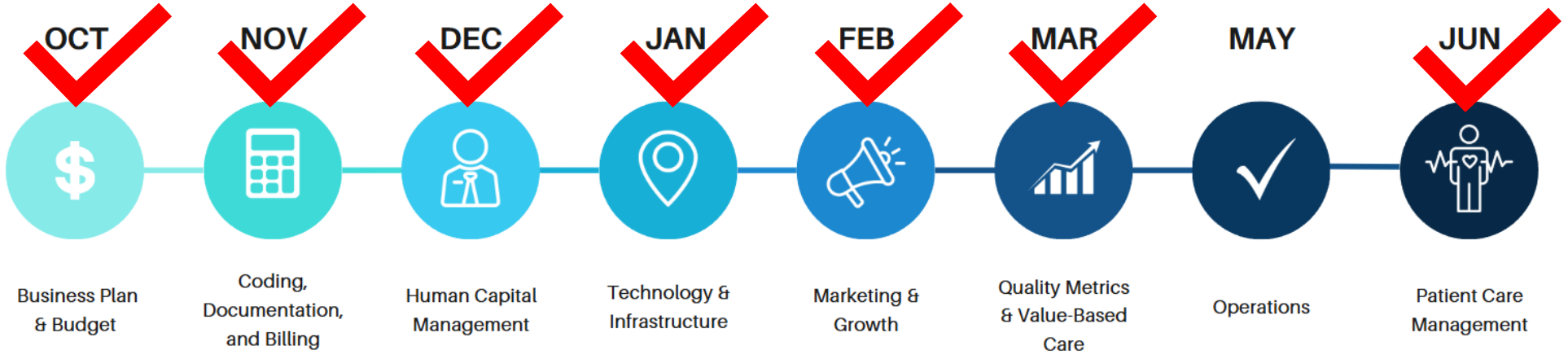
MONTHLY TOPICS



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Next Steps

ILHCP Practice Assessment Kick-off

Wednesday, June 4th 10:30 – 11:30 AM

House Call Operations: Building and Sustaining High-Quality Home-Based Care (Part 2)

Thursday, June 5th 2:30 – 3:00 PM

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Contact HCCI

Website

http://hccinstitute.org

Phone

(630) 283-9200

Email

info@hccinstitute.org

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