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American Academy of Home Care Medicine

Frontiers

American Academy of Home Care Medicine
Home Care Medicine's Voice

The AAHCM empowers you to serve patients who need health care in their homes through public advocacy, clinical education, practice management support, and connections to a network of over 1,000 professionals in home care medicine.

In this issue...

Practice Management

NPs & PAs are a Growing Source of Housecall Services and Growing Representation in the AAHCM

By Gary Swartz, JD, MPA, Associate Executive Director

An important reason for your Academy becoming the American Academy of Home Care Medicine is due to the growth of nurse practitioners and physician assistants as providers and their growing membership in the Academy. This will be celebrated at the 2014 Annual Meeting in Orlando, Florida and we hope to see you there. This article will:

- Describe growth in demand for NPs and PAs in primary care and housecalls;
- Summarize what to consider when starting or expanding your practice;
- Outline housecall practice setting opportunities for NPs and PAs
- Recognize the Veterans Health Administration, role of NPs and contribution to IAH and;
- Note Academy legislative support for NPs and PAs

At the Annual Meeting, specific programming for NPs and PAs will include *Expert Seminars* and *Small Group Lunch Discussion Sessions* for NPs and PAs.

Additionally, there will also be wonderful opportunities for informal networking at the reception and throughout the meeting. Again, we look forward to meeting you and if you haven't already registered, you can

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still register on-line and at the meeting itself.

Growth in Demand for NPs and PAs in Primary Care and Housecalls - The Need is Great and the Future is Bright!

The need for more MDs, NPs and PAs to make housecalls is high. This is due to the increase in number of multimorbid home limited patients. The Affordable Care Act (ACA) and its expansion of coverage will also increase demand for primary care. Estimates are the ACA will increase annual demand for visits that will require 4-7,000 more PCPs. Fortunately, the number of NPs is predicted to increase from 128,000 in 2008 to 244,000 in 2025 and the number of PAs is predicted to increase from 74,800 in 2008 to between 137,000 and 173,000 in 2025.

The Academy receives Medicare data each year that provides the number of Medicare visits by provider specialty and licensure. We post this information to the Academy site. The most recent data (www.aahcm.org/?Number_house_calls) reflects a strong increase in the number of housecalls for both NPs and PAs year over year from 2005 to 2012. The data also reflects that the increase in visits of NPs and PAs explains a large amount of the growth in total number of Medicare housecall visits year after year.

As we know, there is research on the safety, quality and patient satisfaction for NP and PA primary care that supports this growth as well as the competitive market benefits that accrue: see www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=79. This is also recognized by organizations such as the National Governors Association www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html and The Federal Trade Commission. www.nacns.org/docs/FTC140307aprnpolicy.pdf.

Beyond the findings relative to primary care, practice attributes and strengths of NPs and PAs are aligned with evolving services and payment models, and the development of standards to be eligible for payment (e.g. chronic care management services). These practice attributes and strengths are:

- Team care;
- Screening and preventive services;
- Managing chronic conditions;
- Patient and caregiver satisfaction;
- Access and availability (24/7 and geographically across the country including underserved areas);
- Value to patients, community and referral services, and;
- Transition care management - contractual agreements.

What to Consider When Starting a Practice or Expanding Your Practice into another Area within or Outside of Your State

While there are a common set of issues for all licensed professionals to consider when starting a housecall practice there are a number of issues specific to NPs and PAs to consider. It is critical to address these issues as you consider what type and setting is realistic for your practice. These issues were discussed during an Academy webinar in March www.aahcm.org/?page=NPPAWebinar and include:

1. State corporate practice of medicine issues. These generally prohibit a business corporation from practicing medicine or employing a physician to provide professional medical services. Some states have carved out certain types of entities that can serve as employers such as hospitals, health maintenance organizations, and of course, professional corporations. Moreover, some of these laws and how they have been modified over the years may further

Continued on page 10

President's Message

From our Past to Our Future

by Thomas Cornwell, MD, President

This month a true pioneer in our field died. Dr. Philip Brickner began making house calls to New York City's most vulnerable homeless and homebound elderly in the 1970's. He wrote the first known article on house calls, "The Homebound Aged, A Medically Unreached Group" for the Annals of Internal Medicine in 1975. He influenced generations of leaders in our field through his example, writing and teaching. Included in the long list of individuals influenced by Dr. Brickner's work are Drs. Jeremy Boal and Teresa Soriano who continued and expanded the program he started at Mount Sinai in New York; Dr. George Taler, who knew him as a geriatric fellow; and Dr. Peter Boling who studied Brickner's model when establishing his own program. The New York Times obituary can be found at www.nytimes.com/2014/04/04/nyregion/dr-philip-w-brickner-who-made-house-calls-to-the-vulnerable-dies-at-85.html?hpw&rref=obituaries&_r=0, and the Academy's tribute at http://c.ymcdn.com/sites/aahcm.site-ym.com/resource/resmgr/E-news/Brickner_Press_Release.pdf.

While sad at his passing, we also have reason to celebrate. Pioneers like Dr. Brickner not only saw the need, but planted the seed that has now blossomed and grown into an entire field - the field of home care medicine. Drs. Taler and Boling established two of the visionary programs that were the backbone of the Independence at Home legislative idea, and currently are operating IAH demonstration programs. Drs. Boal and Soriano have not only grown at Mount Sinai to become the nation's largest academic housecall program, but have also moved up in rank and stature as health care leaders of this generation.

> *Pioneers like Dr. Brickner not only saw the need, but planted the seed that has now blossomed and grown into an entire field - the field of home care medicine.*

Whether we knew Dr. Brickner or not, many of us have been influenced by younger pioneers in this field, in my case, Dr. Gresham Bayne whose 1-800-Call Doc program also influenced Dr. Norman Vinn (see article, page 6). Many of this generation's leaders will be present at our upcoming Annual Meeting. Don't miss out on the chance to hear Dr. Boal speak, and Dr. Soriano present the house call awards this year. Attend the important sessions that will help you do what Dr. Vinn calls for in his article: adapt to this generation's challenges in growing this field and making it flourish. And finally, don't miss out on hearing the parting words of wisdom from Past Presidents Drs. Bayne, Boling and Taler who this year, will be stepping down from the Board of Directors after more than 20 years of service each.

Out of the past comes the future. Come celebrate the legacy, the current success and future success of our *movement* and our field, the field of home care medicine.

See you soon at the Annual Meeting!

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Managing Medications in VA Home Based Primary Care

by Robert Kaiser, MD, Medical Director Home Based Primary Care Program, Washington, D.C. Veterans Affairs Medical Center, Associate Professor of Medicine, George Washington University School of Medicine

Managing Medications: The Fundamental Questions

The proper management of medications in the home is a complex and challenging task. To manage medications well, home care clinicians must clearly understand what their patients and their caregivers know about their medications, and must be able to answer these specific questions: can the patient and caregiver identify what medications are being used, and can they tell you when they are being used and why they are being used? Are the medications effective? Is the patient experiencing any side effects? Can the patient pay for his or her medications? Can they easily obtain them from the pharmacy? Do they need help in organizing and administering them?

The Medication History: Answering What, When, and Why Medicines Are Prescribed

Each Veteran is provided with a printed list of medications at the end of each and every home visit. This list is obtained and printed from a note in CPRS, the VA electronic record, and a copy is routinely left in the home at the end of each visit or immediately mailed to the home. This list can be easily compared to the list of medications under the "MED" tab in CPRS and then be compared with the bottles of medication in the home. If the patient has been recently hospitalized, there are electronic medication reconciliation tools (some local, others national) on the "Templates" tab that can be used to generate a comprehensive list of recent inpatient and outpatient medications, including expired medications. This must then be supplemented with information about medications which are being prescribed by "outside" providers and with over-the-counter medications, herbs, and supplements which the patient or caregiver may be purchasing on their own. Patients and caregivers may not always think of OTCs as "medications" per se and may not always volunteer that information when the medication history is being taken, so they must be asked directly.

How to Verify the Schedule and Purpose of Medications

Knowing the schedule and purpose of the medication and how consistently it is being taken must also be ascertained from the patient or caregiver during each home visit. Many individuals may not always be able to pronounce the names of the medicines they are taking but may nonetheless be able to recognize them according to size and color (either by showing them the medications out of the bottles or by preparing a page with the picture of the medications with the names, doses, and frequencies written beside them). A newly-invented device, which has been tested in VA outpatient clinics, is the Medication Reconciliation Kiosk. The kiosk has a screen on which pictures of the medications appear, and patients can visually identify them. The device has not yet been widely applied in the HBPC setting but may be available sometime in the near future and could simplify the task of gathering information.

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Monitoring Medications: Adherence, Side Effects, Laboratory Tests

Responsible prescribing also requires consistent monitoring. The history provides one piece of information about adherence, although patients may not always be forthcoming about failure to take their medications on a daily basis. It has been widely reported in the medical literature that patients take their antihypertensive medications only half the time. CPRS can of course provide additional information about the frequency of use simply by viewing when the prescription in question was last filled. And the electronic record can provide information about trends for vital signs, values for laboratory tests, drug levels, serum creatinine and estimated GFR, LDL, and liver function tests. CPRS clinical reminders facilitate monitoring by alerting the clinician to tests which are indicated, such as the AIMS test for patients who are taking psycho-

Continued on page 9

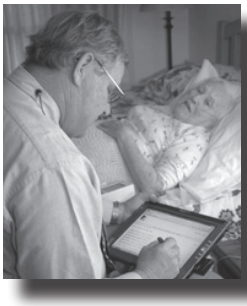
REGISTER NOW!

If Value is the Question, Home Care Medicine is the Answer

2014 Annual Meeting

May 14-15, 2014

Swan & Dolphin Hotel & Resort, Orlando, FL



Program Highlights

- Keynote Address: Past, Present, and Future of Home Care Medicine
- Expert Discussion Seminars
- Evidence for Value of Home Care Medicine (HCM)
- Home Care Medicine for Special Populations
- Moving Home Care Medicine into the Mainstream
- Creative Approaches to Complex Patients at Home
- Measuring Success in Home Care Medicine
- How to Advocate and Create Change?
- Home Care Medicine Policy Update: 2014 and Beyond
- VA Home Care Medicine Update
- Present and Future of 24/7 Care - Urgent Care/ Monitoring/Use of Paramedic Staff
- Natural Disasters, Bedbugs and Other Adventures
- What are Successful Financial Strategies for Home Care Medicine?

Earn CME Credits!

Wed., May 14, 2014: 7.5 Credits - Thurs., May 15, 2014: 4.75 Credits

Accreditation: The American Geriatrics Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Continuing Education Hours: The American Geriatrics Society designates this live educational activity for a maximum of 12.25 AMA PRA Category 1 Credit(s)TM. Physicians should claim only credit commensurate with the extent of their participation in the activity.

How to Register

To register, or for more information, visit www.americangeriatrics.org. A link to online registration is also available on our website at www.aahcm.org/?page=2014_Annual_Meeting

Cost: $445

Interview with Norman E. Vinn, DO, MBA

by Constance F. Row, LFACHE, Executive Director

An early recruit to the field of home care medicine, Dr. Vinn, who refers to his clinicians as "residentialists" founded and developed House Call Doctors Medical Group in 2002. The group serves homebound elderly in several Southern California counties. Currently President of the American Osteopathic Association, Dr. Vinn is continuing the tradition of his father, also a DO, with a commitment both to his patients and to the osteopathic medical profession. His daughter is a third generation DO.

Dr. Vinn, as a pioneer in what you call "residentialist" care, how did you come to develop a housecall practice?

Having been previously involved in IPA's and multispecialty group practice as a medical director, I first was introduced to home care medicine by Dr. Gresham Bayne, (a Past President of the now AAHCM). I joined 1-800-Call Doctor medical group in the late 1990's. After that organization met its Dot-Com fate, I decided to develop a small private home care practice. As time went on we utilized our experience in network development and contracting to build our business up to the current 6 physicians and 22 mid-level providers. We now serve four counties in Southern California. Since we did not have outside capital, we elected to expand into contiguous geographic markets because that was the most cost-effective model for expansion. Due to our deep commitment to the frail elderly, we also made a conscious decision not to limit our practice in ALFs. Besides ALF, we see patients in their private residences, and in small group homes. We have a significant managed care clientele, and also serve other categories of patients including duals, as well as a small number of Medicaid patients who are enrolled in the California Medicaid managed care programs. Through our management company, the Residentialist Group, we also have begun to look at providing MSO support (and perhaps additional services) in some other states to help in the development and operational enhancement of new and existing house call practices.

I see that you have an interest in and have embraced technology and patient-centered team-based care. Can you explain what aspects of technology you find the most helpful, and how you develop and use a health care team?

Since 2006, we have had a broadband, wireless EMR and standardized templates to enhance communication, documentation, and reporting of labs and other results. We have looked at and tested clinical technologies of a variety of kinds, but have found that the fixed costs are often not covered by optimal usage of the equipment. Instead we are using a variety of companies to provide laboratory, radiology, and other diagnostic services. At our clients' request, we are using a variety of low-cost types of on-site testing equipment to support documentation and compliance for wellness examinations. We also are looking closely at telemonitoring technologies. Clearly these technologies have the potential to transform the way we all practice as we go from volume to value-based care. However, from a cost-effectiveness perspective, we have not found any off-the-shelf, "ready for prime time" technologies for widespread use at this point. Nevertheless, we will continue to evaluate and monitor emerging technologies, and will be steadily introducing them into our clinical delivery infrastructure.

With reference to team-based care, we do believe strongly in the inter-professional care team model, and have found great success in having our NP's and PA's act as case managers for patients, working with our physicians in a collaborative approach. We also see the care team as a series of concentric circles with the patient at the center, with our advance practice case managers relating to our patients and physicians supported by our in-office professionals, and extending beyond the core clinical team to include managed care case coordinators, home health and hospice organization nurses and other social and clinical resources.

What do you see as the biggest challenges and opportunities for providers interested in this field? For example, financing, manpower. How have you overcome these challenges?

Both the challenges and opportunities are substantial, but to take advantage of emerging opportunities, change and adaptation are absolutely essential.

The biggest challenge I see for all practitioners and practice managers is adaptation. That includes adaptation to emerging patient expectations, payer expectations, new patient self-care resources, new technologies, and the new population health and payment models that are gradually replacing fee-for-service. These models require accountability for results - with payment that is focused on measurable outcomes and value, not just volume. With regard to new payment models, home care providers need to decide whether they are ready to adapt to these changes, or whether they prefer to stay within a "cottage industry" fee- for- service model. This model is simple and highly-personalized, but generally speaking, does not pay for marketing, business develop-

ment, or provide bonuses for improved outcomes. This model is also limited in resources to step up to more organized approaches to delivery, especially those that require taking some degree of risk. There are also market-limiting factors. Even if providers are interested in this adaptation, making the transition requires payers that are willing to create an aligned incentive relationship. This is not available in all markets. (The same strategic digression applies to the various constituencies within AAHCM as an organization, said Dr. Vinn, speaking as an organization President. Organizations like AAHCM must remain relevant to clinicians practicing in both models of care). Those who are able to operate in the newer environments will have to find ways to invest in scalable technologies, adapt to the population health models now being used, and be able to come forward with their own data on outcomes.

Some of our members are also Osteopathic Physicians. Do you see house calls/residential list care as being a good fit for Osteopathic Physicians?

I believe the home care medicine field could benefit from - and is a perfect fit for - those who embrace the approach and culture of Osteopathic Medicine - humanistic, whole-person- centered, a focus on health as well as disease. This is not limited to DO's, but is a strong component of osteopathic education, philosophy, and professional culture. As it happens, all six of our current physicians are DO's, and we have created a group of NP's who also practice according to osteopathic principles of patient-centered care.

You are the current President of the AOA. Both the AOA and the AAHCM are involved in many public policy initiatives. Do you think there are areas of overlap in agendas? If so are there areas where collaboration might take place?

There are many areas of potential collaboration, particularly in advocacy, development of Public Policy, SGR-reform, licensing and certification issues, tort reform, and monitoring of, and advocacy for, innovative models of care such as ACO's, value-based delivery, medical home pilots, and others.

Medical Director Training NOW AVAILABLE!

The web-based Medical Director Training developed by the AAHCM under a grant has recently been made more flexible. Now you can review individual modules, and choose between credit (a certificate), or CME-approval for completing the whole course. This means that EVERYONE, NPs, PA, administrators, health system executives can take advantage of the course, using the modules that are of interest to them covering both administrative and clinical aspects of home health agency scope of practice, operations, relationships with providers and compliance issues. The training is free, unless you take it for CME credit, in which case the charge is $20. The course is only subsidized for one more year, so use it now! For further information or to register, go to www.aahcm.org › Home Care Medical Direction.

Welcome, New Members!

The Academy would like to welcome the following new members:

ARIZONA
Dr. Monica Vandivort

CALIFORNIA
Lola Aldridge, FNP
Dr. Catherine Buchanan
Dr. Asha Pritpal Sidhu
Sarah E Stanton, MD

CONNECTICUT
Dr. Paul Drost

FLORIDA
Alison Bartfield, MD
William Clayton, BSN, RN
Teresa Lupton, ARNP, FNP-BC
Hardik Shah, MD

FRANCE
Dr. Marwan Farsoun

GEORGIA
Dr. DeAnn Bing
Christopher Richards, MD, CMD

IDAHO
Lenny Jensen, NP

ILLINOIS
James H. Collins
Ronalyn Stephen
Margherita Labson
Ronalyn Stephen

INDIANA
Dr. Todd Mann

MASSACHUSETTS
James Chingos, MD
Suzanne Corrado, MD
Nicole DePace
Emily Gorman-Melo, NP
Sepo Rapo, MD

MARYLAND
Barbara Bryden, PA-C
Michelle Divito, MD
Christine Gardella, PA-C
Angel V Shannon, NP
Stephanie Shepard, PA-C

MICHIGAN
Dr. Armand E Dixon
Deborah Gutterson
Dr. Robert J Hill, III
Tessy Jenkins, MD
Amy Starkel

MISSISSIPPI
Cecelia Bost

NEBRASKA
Nicole Dyer, APRN

NEW JERSEY
Olga Golfinopoulos, MD
Susan Wagner-White

NEW YORK
Dianne Hanson, ANP

OHIO
Dr. Kathleen Luce

PENNSYLVANIA
Lucille D. Gough
Miriam Ryan, NP

SOUTH CAROLINA
Dr. Michael Bernardo

TEXAS
Dr. Roberto Diaz
Dr. Edward Rotan, Jr.

Update of the Home Care Literature:
March - April 2014

by Galina Khemlina, MD, VA San Diego Healthcare

The goal of this column is to briefly review interesting articles appearing in the recent home care literature with a focus on articles relevant to physicians. The reviews are not meant to be comprehensive or stand alone but are intended to give readers enough information to decide if they want to read the original article. Because of the decentralization of the home care literature, there are likely to be significant articles that are overlooked and these categories are by no means set in stone. Readers are encouraged to submit articles or topics that may have been missed.

Assessment

An Vandervoort, Dirk Houttekier, Robert Vander Stichele, Jenny T. Van der Steen, and Lieve Van den Block, Ali Montazeri, Editor. Quality of Dying in Nursing Home Residents Dying with Dementia: Does Advanced Care Planning Matter? A Nationwide Postmortem Study. PLoS One. 2014; 9(3): e91130. Published online Mar 10, 2014. doi: 10.1371/journal.pone.0091130.

Advance care planning is considered a central component of good quality palliative care and especially relevant for people who lose the capacity to make decisions at the end of life, which is the case for many nursing home residents with dementia. The authors of this cross-sectional study wanted to investigate to what extent (1) advance care planning in the form of written advance patient directives and verbal communication with patient and/or relatives about future care and (2) the existence of written advance general practitioner orders are related to the quality. This study found no association between verbal communication or having a GP order and quality of dying. For nursing home residents with dementia there is a strong association between having a written advance directive and quality of dying. Where wishes are written, relatives report lower levels of emotional distress at the end of life. These results underpin the importance of advance care planning for people with dementia and beginning this process as early as possible.

Home Care Research

Susan Browne, Sara Macdonald, Carl R. May, Una Macleod, and Frances S. Mair, Fiona Harris, Editor. Patient, Carer and Professional Perspectives on Barriers and Facilitators to Quality Care in Advanced Heart Failure. PLoS One. 2014; 9(3): e93288. Published online Mar 27, 2014. doi: 10.1371/journal.pone.0093288.

Those with advanced heart failure (HF) experience high levels of morbidity and mortality, similar to common cancers. However, there remains evidence of inequity of access to palliative care ser-

Article of the Month

Quality of Care

Anne Martha Kalhovde, Ingunn Elstad, and Anne-Grethe Talseth. "Sometimes I walk and walk, hoping to get some peace." Dealing with hearing voices and sounds nobody else hears. Int J Qual Stud Health Well-being. 2014; Published online Mar 26, 2014. doi: 10.3402/qhw.v9.23069.

Our objective in this article is to add to the understanding of how people with mental illness experience dealing with hearing troublesome voices and sounds in everyday life. Fourteen people contributed through in-depth interviews and we analyzed these using a hermeneutic phenomenological approach. The authors found that the participants (a) tried to block out the voices and sounds, (b) navigated the health care services, and (c) struggled to come to terms with limitations. The participants fought desperately to find relief and avoid being overcome by the voices and sounds in intense phases. In less intense phases, they developed ways of getting along with daily life in spite of these experiences. The conclusion of this study is to emphasize the need for care providers to attempt to understand and engage in collaborative explorations with service users in search of the most helpful ways of dealing with hearing troublesome voices and sounds in everyday life.

vices compared to people with cancer. This qualitative study (involving semi-structured interviews and focus groups with advanced HF patients, carers, and professionals), examines patient, carer, and professional perspectives on current management of advanced HF and barriers and facilitators to improved care. The authors concluded that little progress is being made to improve care experiences for those with advanced HF. Even in the terminal stages, patients and caregivers are heavily and unnecessarily burdened by health care services that are poorly coordinated and offer fragmented care. There is evidence that these poor experiences could be improved to a large extent by simple organizational rather than complex clinical mechanisms. This study has potential limitations because it was undertaken within a single geographical location within the United Kingdom.

Managing Medications in VA Home Based Primary Care

Continued from page 4

tropic medications. The task of monitoring warfarin has been simplified by the advent of point of care testing, which has been adopted by many Home Based Primary Care Programs. Partnering with other VA programs, such as Care Coordination Home Tele-health, allows for placement of an electronic monitor in the home and more frequent monitoring if needed. Such data can provide crucial information on blood pressure, glucose and other clinical parameters which can facilitate timely interventions. And of course patients and caregivers may adopt a low-technology solution: checking their own BP, glucose, and weight and keeping a logbook for the clinician to review.

Assessing Organization Skills in Medication Management

But adequate monitoring means that more detailed information is needed on how well the medication is being administered. The powerful advantage of making a home visit is the ability of a clinician to observe directly how well an individual is functioning and, in the case of medication administration, how well he or she is organized. Are the medications all together in one place, or scattered throughout the home? Are any medications missing or expired? Is a pill box being used, for some, or all, medications? Is the pill box being filled correctly? Are the compartments of the pill box from previous days of the week now (appropriately) empty? And, are the medications being stored in the correct environment and at the proper temperature? If there are children or grandchildren who live in the home, or visit the home regularly, are the medications being stored safely out of their reach? And are medications also stored in a safe place in the case of a Veteran with dementia who may have poor safety awareness and at risk for taking more medication than needed? A missing medication may just mean that the Veteran or caregiver does not understand the system for refilling medications (either by mail, telephone or Internet) and may simply need additional education on the process. Lack of organization may signify a need for more assistance from a caregiver or a sign that the caregiver is not fulfilling his or her supervisory role. Veterans may miss some doses of medications, because their caregivers may not realize that it is important for them to observe and confirm that the medication has actually been taken, especially in those patients with cognitive impairment.

Solving the Problem of Cost for Medication Expenses

If medications are missing, it may not ultimately be due to negligence or to lack of organization. Older Veteran patients, like many older patients, have multiple co-morbidities and are taking many medications as a result. Many Veterans live on fixed incomes, and even a $9 co-pay for a one-month VA Pharmacy prescription may be prohibitively expensive for a non-service connected Veteran (who is charged a co-payment) if he or she must order many medications per month. The HBPC Social Worker on the team can help sort out these issues and solve these problems. The Veteran may have an annual income sufficiently low to quality for a co-pay exemption. If this threshold is not met, then Social Work can work with the VA Medical Center to set up a workable and reasonable payment schedule for the Veteran in question. Or, the provider on the team may have the option of prescribing medications from an outside pharmacy, where the co-pay might be less expensive. Recommending that the Veteran purchase over-the-counter medications for, rather than have these medications prescribed from the VA Pharmacy, may also reduce monthly costs.

Additional Resources in the VA Healthcare System

The Pharmacist on the Home Based Primary Care Team is an ongoing resource for members of the HBPC Team for prescribing, monitoring and dispensing medications. There are also other helpful resources:

- For questions regarding medication reconciliation, the VA Medication Reconciliation Initiative holds a monthly call-in session on the first Tuesday of every month at 1 PM to answer any questions that clinicians might have. Access is available by calling VANTs (800-767-1750 access code 12555#) or by Adobe Connect: http://va-eerc-ees.adobeconnect.com/medrecon/ (paste this link into your browser).
- Resources are also available through the sharepoint hyperlink: VA Medication Reconciliation SharePoint.

describe who is able to own and govern professional corporations established for the practice of medicine. Therefore it is critical for NPs and PAs to learn what practice opportunity is legally feasible in their state.

2. State scope of practice laws. These laws set out the scope of practice for licensed professionals such as NPs and PAs. State scope of practice laws set out the parameters to which an NP or PA will have the authority within the state to:

- Diagnose, prescribe, and institute therapy or referral of patients;
- Prescribe, procure, administer, dispense and furnish pharmacological agents, and;
- Plan and initiate a therapeutic regime.

Summary review of state scope of practice can be viewed on maps provided by the American Association of Nurse Practitioners: https://aanp.enpnetwork.com and the American Academy of Physician Assistants: www.aapa.org. Generally speaking there is a move among the states to permit NPs and PAs to render an expanded scope of practice.

3. State culture and professional relationships. Related to the above issues is an analysis of the climate in the state for services of NPs and PAs to practice to the full extent of their training and to the top of their license. For example, what is the availability of physician support for hospital admissions, prescriptions, HHA orders, complex diagnostics, etc? Does the state and do the hospitals in the state provide for admitting privileges or will you need to establish relationships for your patients to be admitted?

Additionally, to the extent that a collaboration agreement (NP) or employing physician agreement (PA) is required you need to have a physician(s) with whom to have such an agreement. Finally, the cost and methodology of the physician "collaboration" services vary across the states and local markets. Some methodologies to pay for collaboration include pro-ration of annual physician compensation (hourly, monthly), set fee per NP, or negotiated value for services. Readers will want to be cognizant of regulations on fee splitting that may exist in your state as you develop the basis for collaboration.

A model practice agreement for NPs can be found at www.amda.com/managementtools/crecelius_np_np_samplee.pdf. And guidance and a model agreement for NPs can be found at www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/Practice%20Agreement%20Template%202011.pdf/

The need for more MDs, NPs and PAs to make housecalls is high. The Affordable Care Act (ACA)... will increase annual demand for visits that will require 4-7,000 more PCPs. Fortunately, the number of NPs is predicted to increase...

4. Health plan relationships. Do the health plans within the state provide for the distinct credentialing such that you will be able to be part of a health plan's network, and be considered a primary care provider - with the ability to have your own panel of patients?

5. Culture as it relates to housecall practice. Academy members in general work to overcome the misunderstanding of housecall practice with the services of others, such as home health agencies that provide services in the home. Confusion is added as housecall patients do not have to be homebound as is required for the services of HHAs. While it seems that state professional boards should recognize these fundamental differences, some have not and this requires an education as to your professional role and the home care medicine services you want to render.

6. Patient population demographics and payor source. Those seeking to establish private practice need to develop a working understanding of the community demand for housecalls and how it can be efficiently grown and optimized in practice. Related is the issue of payor source. While Academy members generally see Medicare beneficiaries, there is an increasing involvement of health plans in the Medicare program through Medicare Advantage (now about 30% of all Medicare beneficiaries) and also state Medicaid managed care plans. Thus, the ability to participate in a health plan's network and as a primary care provider is growing in importance. The Academy will present a webinar on development of these relationships in the fall.

Traditional Medicare fee for service participation, claim submission and payment information can be found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Information_for_APNs_and_PAs_Booklet_ICN901623.pdf This helpful summary notes that services must be furnished in accordance with state law and the 2014 Physician Payment Rule formalized the uniform application of this requirement across the Medicare contractors.

7. Business financial factors. Develop-

ing a practice takes time and you need to have enough working capital to support yourself, practice operations, and staff as the practice grows and revenue becomes predictable. Basic elements that need to be included in your working capital calculation include:

- Professional cost of licensure, professional liability coverage, marketing, etc;
- Infrastructure cost such as communications, scheduling, transportation and medical supplies;
- Professional relationships/collaboration agreements;
- Electronic medical record and revenue cycle operation;
- Standards based requirements;
- Your compensation and income requirements;
- Practice management capacity and expertise;
- Finally, you need to consider whether you will develop and manage your own revenue cycle or you will outsource the billing and collection for your services.

Housecall Practice Setting Opportunities for NPs and PAs

There are a growing number of settings for NPs and PAs to practice and render housecalls. These include:

- Community based private practice (local, regional, national), licensed led or team based;
- Health system practice (teaching or non-teaching);
- Health plan based practice (corporate or field);
- Accountable Care Organization (ACO) based practice;
- Community based non-acute/post acute based practice with home health agencies, hospice, etc;
- Community based organization/ health center/facility practice, and;
- Veterans Affairs - The Veterans Health Administration.

Veterans Health Administration, Academy Support and Interdependence at Home

The Academy appreciates the growing interaction with all its VA members including physicians, nurse practitioners, physician assistants and social workers alike. We also look forward, thanks to the work of Dr. Robert Kaiser, MD and others, to the largest attendance of VA providers to the AAHCM Annual Meeting in Orlando.

The VA HBPC is important to the Academy not only as it relates to current membership, but also importantly as data of the success of the VA HBPC Program under the guidance of Dr. Thomas Edes who provided critical policy and legislative support for the development of Independence at Home (IAH).

IAH, by legislative design included the opportunity "to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries..."

IAH is currently entering the 3rd year of the three-year demonstration and the participating practices and the Academy look forward to the evaluation that will include discussions of the various models selected to participate.

Academy Legislative Support for NPs and PAs

The Academy takes a similar approach to support team-based care as other legislative proposals arise such as those that would deal with Medicare reform and permanent repeal of the SGR. The Academy also supports proposals for nurse practitioners to order home health agency services.

NPs and PAs are important to their housecall patients and caregivers, to the Academy, and to the country. Thank you for your Academy membership and contribution.

See you in Orlando!

American Academy of Home Care Medicine
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Share AAHCM's mission and encourage colleagues to join

The American Academy of Home Care Medicine is an organization of physicians and other home care professionals dedicated to promoting the art, science, and practice of medicine in the home. Achievement of that mission will require that providers be educated regarding home care; that they be actively involved in the evolution of home care medicine procedures, their delivery, and management; and that provider interests in the delivery of home care be voiced and protected. We urge membership and participation in the long-term future of home care.

AAHCM intends to provide the structure through which providers can evaluate home care and their position in it. It will monitor emerging technologies and appropriate delivery systems for the practicing physician, as well as the legal and regulatory environment. The Academy will be in a position to present providers' views regarding their interests and concerns in home care. Finally, the Academy will actively collaborate and cooperate with other organizations wishing to enhance the quality of home care. With these intentions for the Academy in mind, we hope to enlist physicians and home care professionals who will actively support and promote these changes in home care.

Home care medicine is one of the most rapidly expanding areas of health care. These changes are occurring because:

- Changing demographics demand a responsive health care system.
- Technology is becoming more portable.
- Home care medicine is a cost-effective and compassionate form of health care.
- Most persons prefer being treated at home.

Who should join?

- Practicing physicians.
- Nurse practitioners and physician assistants (associate membership).
- Practice administrators.
- Medical directors of home care agencies.
- Students and physicians in training.
- Other home care professionals (associate membership).
- Home care agencies (affiliate membership).
- Corporations (sponsor membership).
- Groups of MDs, NPs, PAs or a mixture; or home health agencies and their medical directors (group membership) - *Discounts available.*

Benefits:

- Public Policy representation; revenue-related regulations and legislative representation such as IAH.
- Practice Management publications, website and technical assistance.
- Information on clinical, administrative, regulatory and technology issues, and the academic literature through our Newsletter and e-Newsletter.
- Standards of excellence, including the Academy's Guidelines and Ethics Statement.
- For house call providers, listing in our online Provider Locator.
- Consulting and networking through our members-only list-serv.
- Clinical guidelines and communication templates.
- Discounted attendance to Academy meetings.
- "Members-only" prices on educational media and publications.
- Assistance for faculty who train residents in Home Care.

2014 Membership Fees*

Physicians	$195	Affiliate (home care agency employee)	$195
Groups (MD, NP, PA or combination)	Custom**	Practice Administrators	$195
Associate (NPs, PAs, RNs)	$115	Corporate Sponsor Membership	$2,750
Residents/Students	$75		

*For international membership, add $15
**Special discounts and flat rate options available - call 410-676-7966

2014 Membership Application

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

E-mail: _____

Make checks payable to:
American Academy of Home Care Medicine
P.O. Box 1037 • Edgewood, MD 21040-0337
Phone: (410) 676-7966 • Fax: (410) 676-7980
www.aahcm.org

☐ New membership ☐ Renewing membership

Please state your area of expertise or specialty: _____