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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...

VA Home Based Primary Care

Building an Effective Team in Home-Based Primary Care:

What the VA has learned that may be of interest to you

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

The VA Healthcare System has been a leader in the incorporation of interdisciplinary teams into clinical care, and providing effective interdisciplinary care has been the common goal of every VA Home Based Primary Care team since the inception of the program in the 1970s. The creation of an effective team requires patience, professionalism, mutual respect, good communication and interpersonal skills, and a shared commitment to achieve the very highest standard of clinical care. Building a good team takes significant time and effort on the part of every member. It must take place actively and deliberately and seldom happens spontaneously.

What are the hallmarks of a well-functioning clinical team in home care? Team members:

1. acknowledge each other's expertise as professionals and respect professional boundaries of authority while accepting areas of overlapping responsibility;
2. listen attentively to one another;
3. resolve disagreements by discussing differences of opinion, in a civil manner, in order to reach consensus;
4. are able to offer constructive criticism when another member's behavior is disruptive or clinical actions appear ill-

AAHCM

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considered or inappropriate; and

5. are willing to work together in the patient's best interest.

Team cohesion can occur only through consistent, careful planning and a thorough commitment to continuous improvement. When a new individual joins a team, proper integration of that individual into the team requires a well-orchestrated orientation of that individual. A number of critical objectives must be achieved:

1. understanding of his or her specific role and responsibilities;
2. mastering basic knowledge about the VA Healthcare System, including how to use the electronic record;
3. determining exactly how to best contact and confer with other members of the team;
4. understanding the structure and function of weekly interdisciplinary team meetings; and
5. knowing how to conduct a satisfactory home visit.

A successful orientation must occur over a period of several weeks. The new team member should make home visits with a professional from each discipline on the team (nursing, medicine, social work, physical therapy, nutrition, and psychology) and have a meeting with the pharmacist. This allows that individual to make a personal connection with each member of the team and to learn firsthand what each professional does and how effective collaboration takes place. The designation of a mentor for the new team member (usually someone of the same profession) is also crucial in the process of integrating him or her into the team.

There are important activities that can be helpful in building an effective team. Innovative interprofessional curricula have been developed and validated, including team building exercises, by such organizations as the Hartford Foundation in the United States (http://hartfordign.org/education/gitt/) and the Centre for Interprofessional Education at the University of Toronto in Canada (http://ipe.utoronto.ca/curriculum/facilitators/tools-resources). A comprehensive annotated bibliography on interdisciplinary team training has been prepared by the Partnership on Health in Aging and contains useful written and web-based resources (www.americangeriatrics.org/files/documents/IDT_Annotated_Bibliography.pdf). Such exercises can be incorporated into the educational programs of HBPC teams, during such times as weekly interdisciplinary team meetings or monthly staff meetings or on a separate, dedicated day for education. Other, less formal activities, may also be useful: conducting an annual retreat (planned by the team as a whole); recognizing nationally designated professional days or weeks (such as Nurses' Week or Social Work Week) with a team celebration; acknowledging and celebrating birthdays of team members or significant professional milestones, such as the completion of a training program or graduate degree. These formal and informal activities can go far toward bringing the individuals of a team closer together into a well-functioning unit, one which can be sustained over the long-term.

Upcoming Member Webinar

November 13, 2014

Plan of Care - Chronic Care Management and Reporting

Quality Indicator Reporting: Avoiding the Penalties

by Thomas Cornwell, MD, President

It is often said you cannot manage what you cannot measure. All home care medicine providers want to offer the best quality care to our patients. We want to have good patient outcomes, good caregiver outcomes and through this reduce health care costs. The question is what quality indicators show that we are doing quality work and how should they be measured? This is important for quality improvement but also will have significant financial implications in the not too distant future.

Current quality indicators are often inappropriate for the patients we serve. They are often based on age or specific condition and not applicable to our multi-morbid and often end-of-life population. Quality indicators advanced by PQRS, Medicare Advantage, and Medicaid programs are often based on process not outcomes and are often irrelevant to our patient population or, worse, could cause harm. There are difficulties in reporting using EMR's that don't often fit our practices and will not report to registries without major payments. Some practices do not have an EMR.

However, regardless of the current frustrations, we all need to be aware of the current environment, and what we need to do to avoid penalties. You also need to know what your Academy's advocacy with CMS is doing for you.

a. **Current Environment:** PQRS penalties will go into effect starting in 2015, and become more stringent over time. Further, Value-Based Payment programming could add to the problem with data collection starting in 2015. There could be up to 6% penalties between the two, starting in 2017.

b. **What We Need to Do to Avoid Penalties:** Bottom line is we need to have an EMR and report in the current PQRS system if we want to avoid penalties. I see no way around this if practices want to continue to participate in Medicare Part B.

The Value-Based Purchasing program as currently structured could penalize virtually EVERY ACADEMY PRACTICE. The Academy ... [is] writing and meeting with CMS to plead your case and offer alternative recommendations.

c. **The Academy has had tremendous past advocacy successes and you can be certain we are fighting for you here:** The Value-Based Purchasing program as currently structured could penalize virtually EVERY ACADEMY PRACTICE. The Academy staff and its member-Academic researcher (Dr. Bruce Kinosian) are writing and meeting with CMS to plead your case and offer alternative recommendations. We are fighting against potential 4% penalties.

d. **Prospects for the Future:** We are lucky to have Past President Dr. Bruce Leff and his nationally prominent colleague Dr. Christine Ritchie leading a group of house call medicine experts in the National Home-Based Primary Care and Palliative Care Network. They are developing appropriate and relevant quality measures for the field of home care medicine. They are also working with colleagues at Duke University to create a registry so that our practices can report quality data to enable practice benchmarking, quality improvement, and quality reporting for value-based care and to avoid penalties. Sometime in the next year or so, the measures and reporting system will be ready for beta testing and then for widespread use. This will result in relevant and pertinent measures for our field that we will advocate for CMS to accept.

Please help support this important advocacy work by donating to the AAHCM. We have a $25,000 matching gift again this fall so every dollar you donate is doubled! Working together we are stronger!!

Tom Cornwell

The AAHCM has received another $25,000 matching gift from the Home Centered Care Institute! Please help us reach our goal of $25,000!!

The AAHCM is a small but remarkably influential organization contributing to the national debate on how health care is delivered to the most complex and costliest patients in our society. Working together we are stronger! Help us to fight for you and your patients. Recent victories/projects include:

- Success in fighting for home care providers to participate in the 2015 Chronic Care Codes
- Successfully working at the highest levels at CMS and on Capitol Hill to advance IAH
- Working on Advance Care Planning codes for reimbursement for end of life discussions
- Successful Annual Meeting with record attendance and reviews - Please join us at National Harbor May 2015 for another exciting and educational event!!

Please consider making a Tax Deductible contribution of $25, $50, $100 or more to the American Academy of Home Care Medicine. Please specify where you would like to direct your contribution:

☐ Where Most Needed ☐ Public Policy ☐ Education

There are two convenient ways to give:

1. Mail a check to: The American Academy of Home Care Medicine, PO Box 1037, Edgewood, MD 21040-0337.
2. Fill out credit card information below and fax to the AAHCM at (410) 676-7980 or mail it to: The American Academy of Home Care Medicine, PO Box 1037, Edgewood, MD 21040-0337.

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Credit Card Type: ☐ VISA ☐ MasterCard ☐ American Express ☐ Other _____

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Thank you for partnering with us,

Tom Cornwell MD

Thomas Cornwell, MD
President, American Academy of Home Care Medicine; Chair, Fundraising Committee

Member News

AAHCM Awards the Lifetime Achievement Award

Dr. Benneth Husted received the AAHCM Lifetime Achievement Award at a ceremony on October 26, 2014 in Portland, Oregon. Please join us in congratulating Dr. Husted for her outstanding service to patients in Portland, for the growth of Housecall Providers, and for her contributions to the Academy and to the field of home care medicine.

Electronic Booklets NOW AVAILABLE!

Responding to member requests for increased speed, popular Academy publications are now available for purchase in electronic format to download and read or print. See the digital publications by going to our online store at www.aahcm.org › Online Store › Electronic Booklets.

Medical Director Training NOW AVAILABLE!

The Medical Director 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. Michael Amadei
Dr. Paul Laven
Jennifer Meiser-Hayes
Bonna Sisk, RN

CALIFORNIA
Christopher Holden, MD
Dr. Momo Kurosaka
Dr. Mark Olcott
Scott Schneiderman, DO
David Rodriguez

COLORADO
Denean Evans

CONNECTICUT
Dr. Emily Nolfo
Dr. Matthew Raider
Jennifer Ross

FLORIDA
Arthur Bautista, MD
Faith Bevan
Dr. Alex J. Brown
Pamela V. Johnson, NP
Tony Santos

GEORGIA
Dr. Mark Bradshaw

ILLINOIS
Sonny de Rama

INDIANA
Dr. James Beaudin, MD
Karen Braman
Else Cole
Donna Hagen, NP
Alyson Hollis
Dr. Michael Gilpatrick
Dr. Gregory Spangler
Tammy Weaver
Nicole Whittredge

KENTUCKY
Swaranjit K. Chani, MD

LOUISIANA
Tracy T. Gum, NP

MARYLAND
Ellen Farrell, CRNP

MICHIGAN
David Berman
Carrie Dib
Mike Smith
David Vazina
Dan Vincent

NEW JERSEY
Frederick H. Stansbury, DO

NEW YORK
Anwar Neel Aziz, MD
Dr. William Konczynin
Dr. Joseph Milano

NORTH CAROLINA
Tracy D. Chapman

OHIO
Thomas R. Breen, MD, PhD
Joseph S. Peyton, DO

OKLAHOMA
James Ferris, MD

OREGON
Dr. Tanya Stewart

PENNSYLVANIA
Dr. Dana B. Greenblatt

PUERTO RICO
Annette Acevedo, MD
Edgardo L. Gonzalez Martinez, MD

SOUTH DAKOTA
Karen Eads, CNP

TENNESSEE
Dr. Shoaib Qureshi

TEXAS
Dr. Amy Johnson
Hassanatu Michael
Katy Mosley, PA
Eberechi Solomon, NP

VIRGIN ISLANDS
Linda C. Callwood, MD

VIRGINIA
Micah N. Pacifico
Narita Snead, NP

WASHINGTON
Judith Hill, ARNP

WEST VIRGINIA
Dr. Constance Anderson

WYOMING
Joyce Archie, AGNP-C

Medicare Fee-for-Service Data Reflects Continued Growth in Home Care Medicine

By Gary Swartz, JD, MPA, Associate Executive Director

The Academy has received an annual summary of paid 2013 Medicare fee-for-service claims for housecall evaluation and management, certification/recertification and CPO services. This data is from Medicare Part B fee-for-service claims (Medicare Physician/Supplier Procedure Summary (PSPS) Master File).

This data reflects continued year over year increases in home care medicine services. The complete data set that is organized by specialty including NP and PA volumes can be found on the Academy site at www.aahcm.org › News Room. The Medicare data includes evaluation and management code distribution. This should be helpful in terms of practice compliance and is summarized on page 7.

This data does not reflect services rendered to the 30% of Medicare beneficiaries who have selected to receive their benefits through a Medicare Advantage health plan. As a result, the total number of housecalls rendered nationally for Medicare beneficiaries is more than this data reflects although we do not know the magnitude. In addition to the changes from 2012 to 2013, the charts below reflect multiple year trends for primary care specialties, NPs and PAs.

What the Data Shows

Overall, continued growth in home care medicine and housecalls is reflected in the Medicare fee-for-service program. There were 8,606,693 services in 2013 and this reflects a growth of 206,429 or 2.46% from 8,400,264 services in 2012.

Growth in Visits

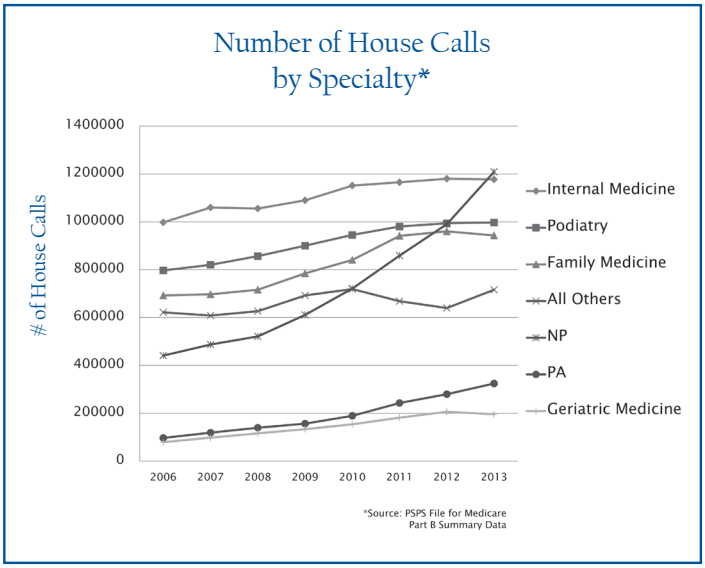
Noteworthy, within the overall growth in home care medicine are increases in visits, location of visits, and the providers who reflect the greatest increase in visits.

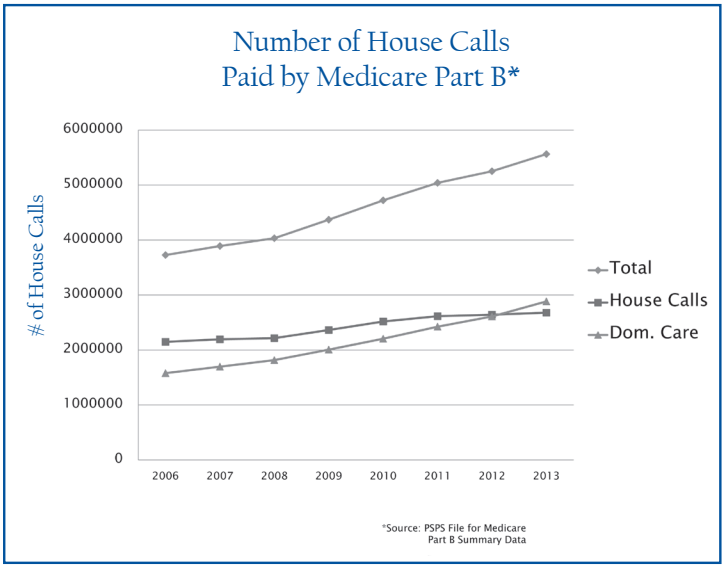
- Housecall visits (CPT codes 99341-99350) increased by 38,071 to 2,679,741 in 2013 from 2,641,670 paid claims in 2012. This is an increase of 1.44%.
- Domiciliary visits increased by 273,952 to 2,883,201 from 2,609,249 in 2012. This is an increase of 10.50 percent. The domiciliary visit total now exceeds the numbers of house calls to private residences.

The Academy notes this development and is attuned to the need to support constructive relationships between owner/operators of assisted living facilities and Academy members. This includes the benefits of home care medicine in terms of resident and caregiver satisfaction, respect for patient desires and advance directives as well as reduced cost of institutional care paid by Medicare.

Growth in Nurse Practitioner and Physician Assistant Services Continues to Lead the Way!

- Nurse practitioners (24% increase)





and physician assistants (6% increase) reflected significant house call visit growth from 2012 to 2013.

- Nurse practitioners (20%) and physician assistants (27%) reflected large increase in domiciliary visit growth from 2012 to 2013.

Growth in Psychiatry Visits

- Psychiatry was another specialty that reflected large growth from 2012 to 2013 in housecall (78%) and domiciliary (70%) visits. While this large percentage growth was on a small base, it is encouraging to see the growth in these services.

It is increasingly recognized that psychiatric conditions impact care including that for beneficiaries' multitude of physical conditions. Also that psychiatric and mental health services are critical to the ability of beneficiaries to be able to receive services in the home. We look forward to supporting a continued increase in mental health services to the home care medicine population and this will be discussed at the 2015 Annual Meeting.

Home Health-related Services Continue to Decline

- Home health related services continue to reflect recent year over year decline. Certification and recertification services decreased by 102,650 from 2,684,028 in 2012 to 2,581,378 paid claims in 2013. This is a decrease of 3.82%.

- Care Plan Oversight services decreased by 1,944 from 465,317 in 2012 to 463,373 in 2013. This is a decrease of less than 1% (.0042%).

The rendering and payment for transition care management services, CPTs 99495 and 99496, may explain some of the decrease in CPO as both CPO and TCM cannot be submitted in the same month. We may see more diversification in paid Medicare claims when the proposed chronic care management code becomes effective in 2015. The proposed G code, CPO and TCM will be mutually exclusive for the same month of service. We will review the service and documentation requirements for the chronic care management G code once the Final Medicare Physician Payment Rule is published later this year.

2013 Medicare Paid Claims Data Reflects Distribution of Housecall Code Selection

Below is the coding distribution for select specialties from this paid claims data. One can see that the most frequently paid code is the second highest level by category. This code would also serve as the top of a bell shaped curve as it does for other medical specialties. The OIG looked at the decade 2000-2010 and found the bell shaped curve moved for all specialties to the right with the most frequently selected code for all specialties being the second highest code. Your code selection should be based on the services you render and

Continued on page 9

Dom. New					
	99324	99325	99326	99327	99328
IM	2.60%	9.49%	27.29%	35.78%	24.84%
FM	3.42%	12.46%	26.66%	35.13%	22.33%
GP	12.62%	17.20%	28.38%	24.72%	17.08%
Ger.	1.42%	5.40%	24.77%	41.32%	27.09%
NP	2.12%	11.02%	25.99%	37.82%	23.05%
PA	3.33%	10.92%	38.38%	29.20%	18.17%

Home New					
	99341	99342	99343	99344	99345
IM	0.55%	3.86%	11.76%	38.99%	44.84%
FM	1.24%	4.29%	16.53%	41.89%	36.04%
GP	0.48%	3.32%	17.37%	41.52%	37.32%
Ger.	0.25%	2.78%	7.83%	48.54%	40.60%
NP	0.76%	4.49%	13.12%	46.59%	35.04%
PA	1.88%	7.50%	17.44%	30.82%	42.35%

Dom. Estab.				
	99334	99335	99336	99337
IM	13.25%	36.48%	39.72%	10.54%
FM	10.86%	32.09%	42.92%	14.13%
GP	20.80%	32.55%	40.64%	6.01%
Ger.	11.95%	29.44%	47.40%	11.21%
NP	10.43%	28.95%	46.63%	13.99%
PA	11.12%	27.34%	47.98%	13.56%

Home Estab.				
	99347	99348	99349	99350
IM	3.09%	18.13%	57.38%	21.40%
FM	3.01%	16.65%	59.82%	20.52%
GP	5.08%	21.80%	50.57%	22.55%
Ger.	1.29%	8.79%	59.48%	30.45%
NP	2.09%	12.92%	48.68%	36.31%
PA	2.74%	14.08%	55.34%	27.84%

Update of the Home Care Literature:
September - October 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

Odejide OO, Salas Coronado DY, Watts CD, Wright AA, Abel GA. End-of-Life Care for Blood Cancers: A Series of Focus Groups With Hematologic Oncologists. J Oncol Pract. 2014 Oct 7. pii: JOP.2014.001537.

Hematologic cancers are associated with aggressive cancer-directed care near death and underuse of hospice and palliative care services. The authors in this study sought to explore hematologic oncologists' perspectives and decision-making processes regarding end-of-life. Analysis suggests that hematologic oncologists need better clinical markers for when to initiate EOL care. In addition, current quality measures may be inappropriate for identifying overly aggressive care for patients with blood cancers. Further research is needed to develop effective interventions to improve EOL care for this patient population.

Home Care Research

Herrick JE, Bliwise DL, Puri S, Rogers S, Richards KC.. Strength Training and Light Physical Activity Reduces the Apnea-Hypopnea Index in Institutionalized Older Adult. J Am Med Dir Assoc. 2014 Oct 4. pii: S1525-8610(14)00539-8. doi: 10.1016/j.jamda.2014.08.006.

The goal of this study was to determine the effect of 7 weeks of resistance training and walking on the apnea-hypopnea index (AHI) in institutionalized older adults compared with a usual care control group. Secondary analysis of data from a randomized controlled trial with ten nursing and 3 assisted living facilities in Arkansas. The authors concluded that supervised resistance training and light walking reduced the severity of obstructive sleep apnea in institutionalized older adults.

Article of the Month

Quality of Care

Boling P, Leff B. Comprehensive Longitudinal Health Care in the Home for High-Cost Beneficiaries: A Critical Strategy for Population Health Management. J Am Geriatr Soc. 2014 Oct 7. doi: 10.1111/jgs.13049.

A variety of subtypes of the in-home care team model for complex vulnerable individuals is reflected in this synopsis, and a variety of care models is probably needed based on local care system circumstances, yet they share core principles that are essential and are fundamentally patient-centered. Sick, function-limited individuals are better served when care is organized in the home using a team-based, technology-enhanced delivery strategy; this is not your grandfather's house call. While the health system is being improved in many different ways, home-centered care models should be available to all such individuals. Given national policy priorities, it is time to move ahead boldly, aligning strong financial incentives to drive growth of the care models needed.

document. https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf

CPT Code Selection by Percent of Total within Specialty for Select Specialties, NPs and PAs - 2013 Medicare Paid Fee-for-Service Claims (below)

CMS Contractors and Identifying Practices for Medical Record Review

Please note that the Medicare Program is increasingly applying "big data" and predictive modeling analysis as a means to avoid erroneous payments (also known as "pay and chase"). These tools are also used to identify specialties and practices to recommend for medical record review and audit. Thus, presenting as a statistical outlier is one way a practice would be flagged for review.

However, there also may be reasons your coding distribution differs from this national data. This could be your practice location, your practice capacity and orientation e.g., 24/7 coverage – urgent care response to the sickest high risk patients (admission/readmission avoidance), longitudinal primary care, transition care management, or elements of each.

CMS evaluation and management guidelines can be found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html. Please note that rather than serving as a continuum the highest level codes for both home and domiciliary place of service (CPTs 99345, 99350, 99328 and 99337) include patient instability or a new problem requiring your attention. Thus, if your practice is oriented toward response to unstable patients and response to new problems, then you will want your documentation to reflect the nature of these patients and the services you render under these circumstances.

We conducted a webinar Compliance for Home Care Medicine (www.aahcm.org › Webinars) that discussed the elements of evaluation and management services, documentation of the history, examination and medical decision making and importance of code selection based on this documentation.

Also noted during this webinar was that Section 6401(a)(7) of the Affordable Care Act mandates a compliance plan for providers who treat Medicare beneficiaries. Compliance plan resources

Continued on page 10

are available at https://oig.hhs.gov/compliance/101/index.asp.and include the seven core components previously established for voluntary compliance programs. The seven components are:

1. Conduct internal monitoring and auditing;
2. Implement compliance and practice standards;
3. Designate a compliance officer or contact;
4. Conduct appropriate training and education;
5. Respond appropriately to detected offenses and develop corrective action;
6. Develop open lines of communication with employees; and
7. Enforce disciplinary standards through well-publicized guidelines.

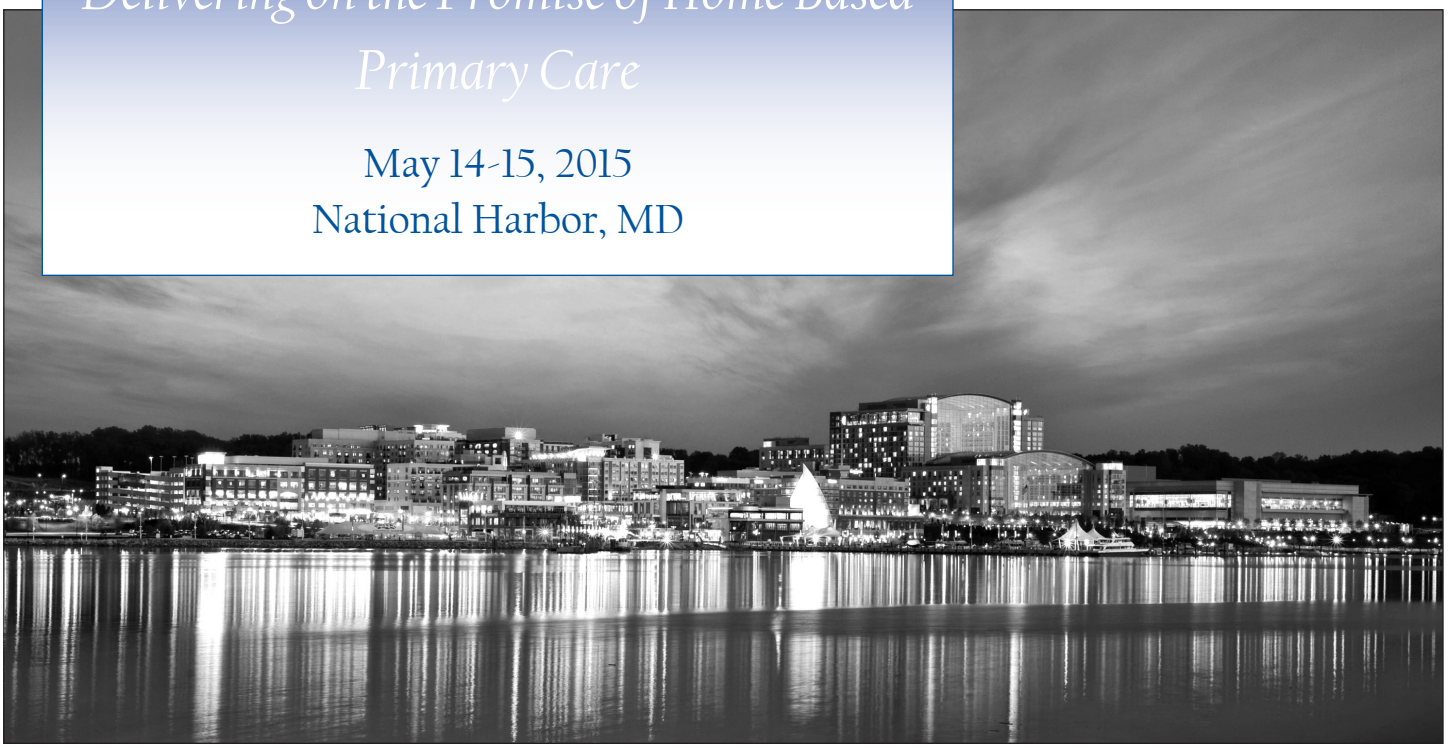
These components are reviewed in webinar format at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/MLN-Compliance-Webinar.pdf. Please let us know of questions about this code distribution, coding and compliance information.

Plan Now to Attend 2015 Annual Meeting for Clinical, Practice Management and Policy Update

Make plans now to attend the 2015 Annual Meeting (May 14-15, 2015, National Harbor, MD) where documentation, coding, and compliance will be expertly discussed among other practice management, policy, and clinical topics. An expanded Home Care Medicine Services and Compendium of Federal Regulations: Medicare Part B Coverage, Payment and Compliance including compliance plan materials will be available among other materials to support the growth and success of your practice. See you there!

AAHCM Annual Meeting
Delivering on the Promise of Home Based Primary Care

May 14-15, 2015
National Harbor, MD



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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: _____

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☐ New membership ☐ Renewing membership

Please state your area of expertise or specialty: _____