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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...

A How-To Lesson from a Story of Success

Return of the House Call Draws a Full House in Portland

Dan Cook, Housecall Providers Inc.

Left to right: Dr. Benneth Husted, founder of Housecall Providers; and CareOregon CEO Pat Curran, and State Rep. Barbara Smith Warner

Just before 7 a.m. on a grey June morning in Portland, OR, the main ballroom at the Multnomah Athletic Club began to fill with people eager to hear the story of Housecall Providers.

The event: "Return of the House Call," featuring keynote speaker Dr. Tom Cornwell, president, American Academy of Home Care Medicine. Guests heard Cornwell's remarks and a discussion among a panel of experts regarding the resurging demand for home medical visits, the proven effectiveness of the house call, and their potential to save millions in medical expenses.

The panelists came with strong credentials. They included Dr. Benneth Husted, founder of Housecall Providers; State Rep. Barbara Smith Warner, a longtime supporter of Housecall Providers and former aide to U.S. Sen. Ron Wyden, champion of Independence at Home; CareOregon CEO Pat Curran, whose company has close ties to Housecall Providers; and Cornwell. Together, these experts drew members of different segments of the Portland community to the event.

The focus was clearly on Housecall Providers. Time and again, panelists cited the groundbreaking work of the team at Housecall Providers for helping to reinvent the house call. "You really have such a gem here," Cornwell, who lives and works outside of Chicago, said of Housecall Providers in his initial remarks. "They have made over

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Robin Moody, associate vice president, public policy, Oregon Association of Hospitals & Health Systems

100,000 house calls."

The room buzzed with anticipation well before the panelists launched into their dialogue. The audience of 300 included local political decision makers, corporate executives and healthcare professionals. It was as though Portlanders had awakened that morning suddenly aware of Housecall Providers, and eager to learn more.

How did Housecall Providers suddenly attract the attention of the audience it had long been courting? Was it a massive and costly advertising campaign? Arm-twisting and calling in favors on a large scale? Social media buzz?

None of the above. Humility is a cultural characteristic of Housecall Providers, a reflection of its self-effacing founder, Dr. Benneth Husted. Blowing one's own horn is simply unheard of.

No, the heartwarming turnout that morning was the result of years of dedication to mission, of providing quality, compassionate medical care to a vastly underserved population, of steadfastly insisting that home medical visits are in the patient's best interest and backing it up with data. And, a strong program, one that appealed to several different segments of the Portland community.

The leadership and staff of Housecall Providers did work hard to promote the event within their own networks. "We asked everyone - clinicians, board members, staff, management team - to think about who they do business with, and ask them to attend," said Executive Director Terri Hobbs. "We thought about our circles of influence - who did we want in the room? And we found a way to reach out to them."

Panelist Smith Warner invited local political leaders, and many turned out. "That was critical, because they can influence healthcare policies that recognize the value of the home medical visit," Hobbs said.

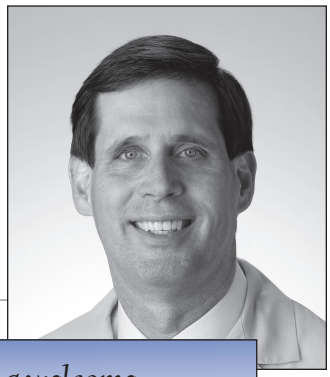
In addition, the fact that Housecall Providers is a 501(c)3 nonprofit helped too. "Housecall Providers in Portland Oregon is somewhat unique in the world of home care medicine in that we stand alone, unsupported by a university or health system," said Husted. "Being nonprofit allows us to raise funds (donations are tax-deductible) and receive grant money. Without our nonprofit status, we would not have survived. Over the years since incorporation in 1995, we have raised about 20 percent of our budget each year."

In fact, although fundraising was not a primary objective of Return of the House Call, many donors did attend and contributed thousands of dollars to a fund to purchase laptop computer.

Nonprofit status has other advantages for those driven by the desire to give back to the community.

"Being nonprofit has allowed us the 'luxury' of accepting patients who are below the poverty line - Medicaid-eligible - and not turning anyone away for inability to pay," Husted said. "If we only served those with Medicare or other private insurance we would not need to be nonprofit. But it has been part of our mission since Day One to serve those who need us most. We only accept patients who are homebound."

Continued on page 11



Why IAH Matters to ALL our Members

by Thomas Cornwell, MD, President

IAH provides a welcome opportunity to show the benefits of home care medicine in a revolutionary way...

I appreciate all the positive feedback and constructive criticism from members. It truly helps your Academy staff and board to best serve you. One concern I have heard focuses on all the time, resources and dollars we are putting into the Independence at Home (IAH) demonstration program, even though it only involves eighteen home care medicine practices. This has been our biggest legislative initiative over the past decade and it took a herculean effort by Academy staff, your board and others to get it into the Affordable Care Act. Below discusses how IAH has been a huge part of helping "the sea to rise."

First, what is IAH? It is a Federal CMS Demonstration lasting until 2015, demonstrating the value of house calls in improving care and savings costs for the highest risk, most costly Medicare beneficiaries. IAH provides a welcome opportunity to show the benefits of home care medicine in a revolutionary way - in a shared savings model in which practices that save 5% over usual costs and meet quality standards get a share - up to 80% - of the savings to fund what it takes to operate a high quality program. The Demonstration is in its second year, and encouraging results are just beginning to come out.

Why IAH matters to you:

1. **IAH got the value of home care medicine recognized on Capitol Hill.** This has been going on for the past decade and included the successful effort to attract both Republican and Democratic co-sponsors to the legislation. An IAH Day on the Hill in September, 2011 attended by co-sponsors Senator Wyden and now-Senator Markey helped highlight IAH to legislative aides and others.

2. **IAH has allowed the Academy to work with CMS at the highest levels:** Numerous high level meetings have been held with CMS. CMS' Demonstration project officers have visited IAH practices; Administrator Marilyn Tavenner has visited the Virginia Commonwealth program of Dr. Peter Boling and is aware of house calls and IAH. The Academy is respected within CMS because of its work over the years including IAH. These relationships have also helped in other areas such as the chronic care coordination codes.

3. **IAH allowed the Academy to receive large grants to form a learning collaborative:** The collaborative involves all eighteen practices in IAH where they learn from each other's best practices and providing quality care and reducing costly acute care utilization. This learning will benefit all our members.

4. **The IAH shared savings model** shows how financial sustainability can be attained for home care medicine programs, something that can be translated into the basis for growth so badly needed in this field.

The next major step is to get the IAH Demonstration converted into national legislation. This again will take a herculean effort for our small Academy in terms of time, resources and dollars. So why support IAH expansion?

1. Because IAH expansion is a significant way to provide a sustainable funding stream for practices. You benefit from the savings from your quality work. This also serves as a model for other insurance programs. IAH needs to expand from the eighteen practices and 10,000 patients to cover the estimated 1.4 million Medicare beneficiaries that need our care.

2. Because IAH will finally provide the evidence base we need to know what "best practices" are for both practice management and quality of care for the highest risk, most costly patients. It will teach us the best methods to recruit patients, track them across settings, provide care coordination and intervene before they call 911. And much more.

3. Because IAH has put home care medicine on the map in Congress, at CMS, and within the advocacy and policy community. But now we need to make it part of the mainstream. This means taking IAH-style practices to ACO's, to Medicare and Medicaid managed care, to

Continued on page 9

Preventing Professional Burnout: The Importance of Self-Care in Home Based Primary Care

by Robert M. 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

Working in home based primary care can be extremely rewarding. Veterans and their families allow us the privilege of establishing close relationships with them by caring for them at home, so that they may "age in place" and remain in their communities. Home care also can be, without question, a very demanding task. Patients have complex conditions and social problems that require ongoing, meticulous attention. Analyzing and solving these problems is intellectually and psychologically challenging, and it is time-consuming. Navigating the health care system on behalf of the patient can sometimes be frustrating for even the most talented and patient professional. Clinicians may have expectations for their own success which are unrealistically high. Failure to achieve an optimal outcome in every circumstance may lead to disappointment, even when such feelings are unfounded.

There are a number of signs and symptoms of professional burnout that should be noted immediately when they occur: fatigue, irritability, insomnia, difficulty getting along with others, and lack of satisfaction in doing clinical care. Job performance may decline as a result. Those suffering from severe burnout are at risk for clinical depression. They may also be vulnerable to problems with substance abuse. A normally congenial and enthusiastic individual may be uncharacteristically testy, lacking in energy, unwilling to collaborate, and insufficiently engaged in his or her clinical work. This may adversely affect team dynamics and hinder the team's effectiveness in caring for patients.

HBPC team members need to be aware of the signs and symptoms of professional burnout so that the problem may be recognized and addressed promptly in the affected individual. The problem may come to light in noticeable negative changes in interpersonal interactions, which were once smooth but are now problematic. Person-to-person conversations and discussions in team meetings may be more contentious and less productive. The team member in question might instead be more withdrawn and less able to contribute professionally to patient care.

Such a situation calls for candor and compassion. Individuals who are having difficulty should be approached directly, in a non-judgmental manner, by an HBPC team member or by the Medical Director or Program Director. Such inquiries may quickly lead to recognition that a problem exists, and that intervention is needed. It may require a relatively simple intervention - such as readjusting unrealistic individual expectations, cutting back on overly long hours, or seeking regular input and assistance from colleagues on patients who are especially difficult. Such a situation might also require more significant measures - such as taking a temporary leave of absence and making a referral for psychological evaluation and counseling.

Professional burnout can be prevented by consistent attention to proper self-care. Recognizing that home care is a collective, not a solitary, enterprise is fundamental in assuring that the burden of care does not fall on one individual, and that every team member is adequately supported. HBPC team members must be certain to get adequate sleep, nutrition and exercise. Sufficient time should be allocated for family activities and for other fulfilling interests outside of work. Vacations should be scheduled and taken on a regular basis. Ultimately, making proper self-care a priority is essential in assuring the highest level of patient care.

House Calls and ACO's: A Winning Combination? Two Perspectives

by Constance F. Row, LFACHE, Executive Director

This month, we focus on two different models for ACO house call participation, both of which were briefly discussed at the 2014 Annual Meeting. The first is the Beth Israel Deaconess Care Organization (Massachusetts) Pioneer ACO program whose Medical Director is Dr. Alan Abrams. The second is the Detroit Medical Center ACO program operated by Visiting Physician's Association, with Board Member and Government Relations Chief Robert Sowislo as the spokesman. Both programs have demonstrated savings, but are quite different in their structure and operation. Because many members seem interested in approaching, or are being approached by ACO's, the interviews that follow focus on two different models that have worked for your consideration.

Beth Israel Deaconess

Dr. Abrams, can you tell us about how your program started, how it is structured and how it operates?

At Beth Israel Deaconess, we have four different kinds of global contracts, one of which is a Pioneer ACO. I am medical director for the BIDCO Pioneer ACO. For the Pioneer program, we operate an all-NP model in which adult or geriatric nurse practitioners from OPTUM operate contractually to serve house call patients. They collaborate - to a lesser or greater degree - with BIDCO primary care physicians who act as their clinical supervisors. A general medical-legal supervisory function is provided by the OPTUM Medical Director.

There are two processes through which patients are referred to the program. One is claims based and uses an algorithm to help identify patients at high risk of hospitalization who might benefit from the house call service. Alternatively, primary care physicians can refer other patients whom they feel would benefit from a house call medicine program. BIDCO screens these referrals to make sure that they are appropriate. In addition, BIDCO provides RN community care managers to the BIDCO practices who manage high risk patients who at some point they may refer as well.

At BIDCO we review referrals to determine whether the patient would be more appropriate for a BIDCO community RN Care Manager or Home Health VNA services. For those who are determined to be appropriate for House Calls Medicine, OPTUM reaches out to the patient and an initial nurse practitioner visit is scheduled. From that point, each House Call patient is scheduled for one routine visit per month in addition to two check in phone calls. Urgent visits are scheduled on an ad hoc basis and there is no limit as to how often a patient may be seen each month.

OPTUM reports that their CarePlus NP House Call Program is less effective in treating patients with certain medical conditions. Patients on hemodialysis, active cancer treatment, active HIV treatment, and those with severe mental health disorder as primary drivers of health care services utilization are considered to be excluded from this program. Exceptions are made on a case by case basis. Whenever possible, patients are seen within 48 hours after hospital discharge if they are active house call patients. Care plans are developed by the OPTUM NPs and documented in an OPTUM EMR to which the primary care physicians have read-only access. BIDCO social workers, and Pharm D consults may also contribute to the overall care plan for individual patients. There is no home based mental health consulting service at this time.

Dr. Abrams, what have been the results?

While the program has demonstrated significant savings to date overall, the model currently in place is less than ideal. The lack of program integration brought about by the external contract, results in only intermittent communication from NP's to primary care doctors and better collaboration would likely achieve better results. However, even with this caveat, in studying the difference with a control group, the house call group is showing a 14% benefit over 9 months. A case/control study using propensity scoring is currently being reviewed at the Beth Israel Deaconess Medical Center IRB.

VPA/USMM

Mr. Sowislo, VPA is a freestanding organization. Why did you decide to participate in a Pioneering ACO? What was in it for you all? For them?

VPA/USMM has been serving Detroit residents for over 21 years. The Detroit Medical Center and its' Physician Hospital Organization (PHO) established the Michigan Pioneering Accountable Care Organization (ACO) in 2011 and began operations in January 2012. VPA/USMM lobbied and was recruited to the ACO by ACO leadership who saw the vision of population health and saw how home based primary care (HBPC) was part of a necessary continuum to manage a chronically ill population out in the urban community.

VPA/USMM joined the ACO with approximately 2000 patients and 14 board certified primary care physicians. VPA/USMM's immediate reason to partici-

Continued on page 10

Member News

First, listen to NPR Philadelphia for a wonderful story on house calls and IAH featuring our own Board member and health services researcher/Penn clinician and IAH participant, **Dr. Bruce Kinosian,** here: http://hereandnow.wbur.org/2014/07/28/doctor-house-calls.

Second, Board member **Dr. Theresa Soriano** and other colleagues from Mount Sinai, New York have published "The Critical Role of Social Workers in Home-Based Primary Care" in the publication *Social Work in Health Care*, here: www.tandfonline.com/doi/abs/10.1080/00981389.2014.884041#.UUN9fldUg_.

Third, Provident Hospital, Cook County Illinois physician **Anto Maliakkal** and a colleague have published further evidence of reducing hospital readmissions in patients with CHF, here: http://hhc.sagepub.com/content/early/2014/04/03/1084822314527763.abstract.

Fourth, the Mount Sinai group including **Dr. Linda DeCherrie** has documented the unreimbursed time providing care outside visits in their large HBPC program--another invaluable contribution to the public policy debate on funding for the field of home care medicine, here: http://onlinelibrary.wiley.com/doi/10.1111/jgs.12828/abstract.

Finally, AAHCM Board Member **Dr. Eric DeJonge, Dr. George Taler, MD,** and the Washington Hospital Center Medical House Call team are pleased to announce the publication of a paper titled: "Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders" published in *JAGS* here: http://onlinelibrary.wiley.com/doi/10.1111/jgs.12974/abstract.

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
Hersh Goel

ARKANSAS
Dr. Kevin Hale

CALIFORNIA
Mary Lee Gates, NP
Carmen P. Gonzales-Nate, MD
Dr. Michael H. Le
Dr. Ancel Rogers

COLORADO
Dr. Susan Bray-Hall
Dr. Kent Roberson

FLORIDA
Rita Laracuent, MD
Dr. Marisse Laurie-Goldman, MD
Dr. Tammy Thaggert

ILLINOIS
Stavros Alexopoulos, DPM
Robin Anderson, NP
Ann Arcese, NP
Adam Arendt, DPM
Patricia Armstrong
Jose Ayala, MD
Maricar Balite, NP
Sadi Cohen Barrett, NP
Tridonna Brandford, NP
Kevin Castillo, MD
Christopher Co, MD
Danilo Coite
Karim Dajani, MD
Tracey Davenport, MD
Sheila Davis, MD
Vannessa Davis, NP
Damon Derico
Arvind Desai, MD
Jahangeer Dogar, MD
Michael Doherty
Krista Dvorak
Moheed Ekbal, DPM
Patrick Felton, DPM
Henry Gonzales, DPM
Charlie Gude, MD
Augusto Guevara, MD
Devika Gupta, MD
Melissa Hetzel
Nycole Hollington, NP
Jessica Jacobs, MD
Lolichandra Kadiyala, NP
Karen Kieras
Terri King
Bess Koenigsberg, MD
Sharon Kookich
April Leddell-Hughes, DPM
Florentino W. Leong, MD
Hilda Lively, NP
Joanna Lo, MD
Mary Lohrmann, PA
Sohel Majeed, DPM
Syl Marcus
Kelley Marshall, DPM
Monif Matouk, DPM
Juachi Mbah, NP
Queen Judy Mbanuzue, DPM
David Nelson, NP
Michael Newkirk, DPM
Linh Nguyen, DPM
Tiffany Nguyen, MD
Phyllis Nyotta, NP
Chinyere Odeluga, MD
Kanayo Odeluga, MD
Catherine O'Grady, NP
Jagruti Patel, DPM
Megha Patel, DPM
Thomas Pawlowski, MD
Andrea Peach, DPM
Anthony Perez, DPM
Olusoji Peter, MD
Ena Pierce
Gary Salkind, MD
Arthur Schroeder, MD
Dr. Brett Schulte
Michael Schwarcz, DPM
Amit Sharma, MD
Kiran Srirama, MD
Deborah Sturgis-Hinton, MD
Farhana Syed, MD
Kirk Uy, MD
Bridget Walker, MD
Carol Watkins, NP
Dorothy Were, NP
Junecia White, NP
Karen Whitman, NP
Emre Yedidah, MD
Tanya Zukauskas

INDIANA
Donell Foster, Sr.

KANSAS
David Elcock, MD

KENTUCKY
Dustin Hamlin, APRN

MASSACHUSETTS
Raeann G. LeBlanc
Michelle Mlinac

MICHIGAN
Julie Hartl, NP
Robert Sandzik

MISSISSIPPI
Dr. Joe Furr

MISSOURI
Tracy L. Zackson, RN

NEW YORK
Curtis A. Blalock, LCSW, ACHP-SW
Dr. Jennifer Reckrey

NORTH CAROLINA
Kelly Carpenter, ANP
Beth Clark, FNP
Dr. Margaret A. Drickamer
Annmarie Mazzocchi, MD
Dinah Ngetich, FNP
Terri Sanchez, FNP
Dr. Anthony Sung
Dr. Michael C. Watson, Jr.

OHIO
Audrey Smith, NP

TENNESSEE
Sherry Gatewood, PA

TEXAS
Catherine Ebune, NP
Dr. Maria N. Perez

WASHINGTON
Jill Carter, ARNP, FNP-C
Dr. Serge Lindner

WEST VIRGINIA
Angela Petry

Update of the Home Care Literature:
July - August 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

Chae-Hee Park1, and Wojtek Chodzko-Zajko. Feasibility of integrating the "Healthy moves for aging well" program into home care aide services for frail older adults. J Exerc Rehabil. Jun 2014; 10(3): 191–197. Published online Jun 30, 2014. doi: 10.12965/jer.140116.

The purpose of the study was to assess the feasibility of implementing simple, safe, non-equipment evidence-based movements (Healthy Moves for Aging Well program) using an affordable and sustainable homecare-aide based delivery model that reaches the maximum possible number of frail older adults living at home in Illinois. Two local agencies were asked to identify two experienced home care aides and two inexperienced home care aides (n= 8). Each home care aide delivered the Healthy Moves to four clients (n= 16). The results showed that both interview and survey data revealed that most participants including older adults, home care aides and site directors had a positive perception and high satisfaction with the program. Specifically, 100% of older adult participants reported that they would recommend the program to others. The authors also noticed that both site directors reported that dissemination of the program in the State of Illinois employing home care aides was feasible and acceptable and study results indicate that Healthy Moves for Aging Well could safely and successfully be disseminated to frail older adults in the State of Illinois.

Home Care Research

Kenichi Yokobayashi,1 Masato Matsushima,2 Takamasa Watanabe,3 Yasuki Fujinuma,4 and Susumu Tazuma1. Prospective cohort study of fever incidence and risk in elderly persons living at home. BMJ Open. 2014; 4(7): e004998. Published online Jul 9, 2014. doi: 10.1136/bmjopen-2014-004998.

The goal of this study was to determine the incidence of fever among elderly persons under home medical management, diagnosis at fever onset and outcomes from a practical standpoint. It was a

Continued on page 9

Article of the Month

Quality of Care

Michael Bauer, Deirdre Fetherstonhaugh, Laura Tarzia, Rhonda Nay, and Elizabeth Beattie. Supporting residents' expression of sexuality: the initial construction of a sexuality assessment tool for residential aged care facilities. BMC Geriatr. 2014; 14: 82. Published online Jun 30, 2014. doi: PMCID: PMC4085662.

Sexuality is a key component of quality of life and well-being and a need to express one's sexuality continues into old age. Staff and families in residential aged care facilities often find expressions of sexuality by residents, particularly those living with dementia, challenging and facilities often struggle to address individuals' needs in this area. This paper describes the development of an assessment tool which enables residential aged care facilities to identify how supportive their organization is of all residents' expression of their sexuality, and thereby improve where required. The authors concluded that the sexuality assessment tool (SexAT) guides practice to support the normalization of sexuality in aged care homes and assists facilities to identify where enhancements to the environment, policies, procedures and practices, information and education/training are required. The tool also enables facilities to monitor initiatives in these areas over time

Home Care Literature
Continued from page 8

prospective cohort study with 419 participants aged ≥65 years who received home medical management. The causes of fever were pneumonia/bronchitis (n=103), skin and soft tissue infection (n=26), urinary tract infection (n=22) and the common cold (n=13). Fever was cured in 67% and 23% of patients at home and in hospital, respectively, and 5% of patients each died at home and in hospital. Antimicrobial agents treated 153 (67%) events in the home medical care setting. The authors concluded that fever was more likely to occur in those requiring higher care levels and the main cause of fever was pneumonia/bronchitis. Healthcare providers should consider the conditions of elderly residents with lower objective functional status.

President's Message
Continued from page 3

value-based purchasing, and on and on.

IAH is extremely important both now and for the future of home care medicine. I am extremely appreciative of all the work our Academy staff has done but even more so for the thousands of volunteer hours board members have put in over the past decade to make this happen and help "the sea to rise." Please join me in supporting our efforts to make IAH a Medicare benefit and bring home care medicine into the mainstream.

Tom Cornwell

Upcoming Member Webinars

October 23, 2014
Home Care Medicine and Contractual Relationships

November 13, 2014
Plan of Care - Chronic Care Management and Reporting

pate was to get access to a full range of claims information to prove out our belief that HBPC provided a significant value proposition to the Medicare population in general and that HBPC quality scores and patient satisfaction would rival other hospital based, University affiliated, and other large office based practices in the Detroit market. Shared Savings has become important to fund care model enhancements.

How were your patients selected, treated and what were the outcomes you can share on these patients?

The Pioneer model identifies all patients who are aligned with a provider and those patients become, upon approval by the beneficiary, part of the ACO. Our delivery model was purposely augmented with care coordination, care management, and intensive outreach resources and our results in the first two years of the program show VPA/USMM as saving CMS and the ACO more cost, with top decile satisfaction and quality performance, than any other practice in the Pioneer ACO consortium. We have shown continuous improvement year over year in our cost per case savings which approaches 17% (each year) on a Pioneer model that measures year over year cost reduction against a benchmark that has been increased each year. Our Hospital Use Rates have been reduced 30% from our 2011 baseline to a "well-managed" rate, based on our risk adjusted population measure, of approximately 500 admissions per thousand.

What was the financial arrangement and how was it negotiated? Capitation? Percent of savings? Other?

The financial arrangement for providers in year 1 of the Pioneer program was to first fund the back office which as it turned out, provided very limited reward for the PCP's in the program. Year 2, with information in hand, VPA/USMM negotiated an improved percent of savings on its population for both years 2 and 3 with the Pioneer. In a word, proving our value allowed VPA/USMM to make a case that our disproportionate savings and quality/satisfaction scores should be rewarded with an improved percent shared savings on our population.

Now that you have been in this for several years, what have been the upsides? The challenges?

After two complete years in the program; while the results are gratifying, we are most pleased with the sense of partnership with a very successful innovative program (The Michigan Pioneer ACO ranks in the top 5 in Pioneer outcomes the last 2 years) and the recognition and advocacy shown to Home Based Primary Care by the ACO leadership and affiliated practices.

Does bringing house call level patients into an ACO work for all types of ACO's?

We believe that organized and managed correctly, the Medicare Shared Savings Program (MSSP) ACO will be a viable model for HBPC. Since the Pioneer ACO model is morphing into the MSSP ACO model, from a methodological patient cohort benchmarking and financial reconciliation standpoint, the only issue materially separating the two models is financial risk, often born exclusively by the Pioneer Integrated Delivery System "sponsors".

What do you think the future for ACO's is for home care medicine providers? Would you advise participation and if so what kind, when and under what conditions? For example, what kind of infrastructure is required to participate? What data? What negotiating skills?

While a Pioneer relationship can be informative, getting data is still challenging and financially the infrastructure gets first dollar. Physician led MSSP ACO's have yet to show significant success; however, we believe the HBPC provider, once recognized from a population health and value proposition standpoint, should seek out ACO Shared Savings opportunities. Bringing data to the table or peer reviewed evidence such as the Washington Hospital Center-MedStar Study is essential to inclusion

Continued on page 11

Return of the House Call Draws a Full House in Portland

Continued from page 2

Other factors contributed to the strong attendance at Return of the House Call. Since 2011, the organization has budgeted funds for marketing projects designed to both assist in recruiting and spread the word in the community about Oregon's only stand-alone home medical visit provider. Members of the leadership team are often asked to present at regional, state and national conferences. And Housecall Providers has proudly promoted its inclusion in Independence at Home to the outside world.

The Return of the House Call theme clearly struck a chord with many community members, many of whom have faced the difficulties and expense of caring for an aging loved one.

"When we were brainstorming about the event, early on we agreed that we liked the idea of a panel of experts coming together to talk about how effective house calls can be with the population we serve," said Terri Hobbs, executive director. "Having Tom [Cornwell] as our featured speaker gave the event even greater credibility. This was more than just another fundraiser. We were offering important information to the community, and they responded."

Benneth Husted believes the event was also well timed, given the increasing awareness of the benefits of making home medical visits to those in need.

"We hope that times are changing for house call practices and that very soon, if IAH becomes part of the standard Medicare benefit, we will not need to raise money to subsidize salaries for our interdisciplinary team. Currently, only a face-to-face visit between a patient and a licensed clinician (MD/DO/NP/PA) is billable to Medicare," Husted said.

"Also, we expect it will become increasingly easy to negotiate with private insurers for monthly fees over and above visit reimbursement. Ironically, it is the same insurers whose low reimbursement forced us to do fundraising to survive, who now see the value in what we do and are willing to pay for it."

For Husted, the turnout that day, and the audience's engagement in the program, validated a dream she had long ago. As she told the audience, she felt called to minister to the homebound, and in 1992, she began to shift her practice toward that end. The road was a long one from Husted's initial home medical visit practice, run from her home, to the 100,000th home medical visit made by a Housecall Providers clinician in 2013. Finally, she was seeing acceptance of the house call as a critical component of effective health care.

Gazing out over the audience, she said,

Dr. Tom Cornwell, president, American Academy of Home Care Medicine

"Five years ago, this [turnout] would not have been possible, simply because even that recently, no one recognized the value of home medical visits. Today, all that has changed."

Long after the event had officially ended, attendees remained peppering the panelists with questions and comparing notes with one another. Housecall Providers, previously one of Portland's best-kept secrets, was a secret no more.

House Calls and ACO's

Continued from page 10

and negotiation. The Independence at Home Program has taught us that team based care with a palliative orientation and intense outreach with the goal of improved patient satisfaction, quality, and appropriate facility utilization make for a successful HBPC program; shared savings will likely be required to fund the advanced model of care.

Save the Date!

2015 AAHCM Annual Meeting

May 14-15, 2015
National Harbor, MD
Watch our website & *Frontiers* for details!

American Academy of Home Care Medicine
P.O. Box 1037
Edgewood, MD 21040-0337

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: _____