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American Academy of Home Care Physicians

Frontiers

AAHCP *becoming* American Academy of Home Care Medicine
Home Care Medicine's Voice

The AAHCP 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

Electronic Health Record Survey Results and Strategic Considerations for EHRs

By Gary Swartz, JD, MPA, Associate Executive Director

Many Academy members have asked about EHR use, at least on an annual basis. To meet that need we have information from two surveys to which Academy members responded. EHR selection and implementation should also include strategic considerations for your practice in addition to the basic medical record documentation. These considerations are discussed after the summary of survey results. This article also includes information about selecting and implementing an EHR.

Summary Survey Results

A. EHR and Type of Use:

Is Your Practice Using an EHR?	85%
Documentation	99%
E-Prescribing	90%
Generate Patient Instructions	42%
Generate Caregiver/Family Information	30%
Coordinate Patient Care with HHA	48%
Sign HHA Orders	34%
Communicating Treatment Plans	38%
Patient Registry	49%
Other	5%

B. What EHR Product Does Your Practice Use?

Forty responses were received to one of the surveys that included questions as to which product was used. *Please note that responses primarily reflect community based practice.* Health system based housecall practices are generally on the EHR of their health system. The mode number of clinicians in practice that responded to this question was one (1). Responses are as follows:

Practice Fusion	13
EClinical Works	5
Amazing Charts	2
Greenway	2
One Touch	2
All Others (16)	1 Each

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C. Length of Time on System

Forty responses were received and these ranged from just implementing EHR systems to 8 years with an EHR system in place. Please note that recent literature provides that 30% of EHR implementations are changes from an existing EHR.

Year or less	10
One to 2 Years	9
Two or More Years	21

Strategic Practice Considerations and EHRs

The strategic considerations of EHR implementation include:

- Revenue cycle "build versus buy" analysis,
- Current and evolving payment systems; and
- The marketing of your practice.

A. Build Versus Buy Analysis

If you have not implemented an EHR, your practice is growing, or you are considering a change in EHR, you may want to consider the EHR decision in the context of your entire revenue cycle.

Is it more effective for you to outsource your revenue cycle (billing and collection), including suitable EHR to an external organization? As an example, lack of compatibility with revenue cycle system was cited as a deficit for certain EHRs in the surveys.

The build versus buy decision is understandably less relevant to health system based housecall practices that are linked to the EHR and revenue cycle staff of their health system.

For housecall practices making their own EHR and revenue cycle decisions you will want to include in your analysis:

- Opportunity Cost and Expertise - What is the cost of staffing, technology, maintaining expertise in coding and claim follow-up? How does this compare to how your time and that of practice clinicians can be expended on clinical services and developing relationships to expand the practice? Realize there is a cost to your conducting your own revenue cycle (including the human and capital resources), and you will want to keep in mind the best and highest use of your time.

On the other hand you need to evaluate the expertise, motivation and references of any potential partners in rendering revenue cycle service for primary care services that is the basis of a housecall practice. This is critical as revenue cycle companies, particularly those paid on a percentage of revenue basis, will have a tendency to want to work for medical and surgical specialties with higher charges and payment levels than is the case for primary care services.

- Regulatory and Technological Change - What is your ability to remain up to speed on changes? An outsourced partner will have the market imperative to remain current. Again, verify that they do so through references and through contractual language.

B. Current and Evolving Payment Systems

Current incentive programs, new codes, standards, and evolving payment systems require the electronic availability and sharing of the patient medical record.

As an example, there is a requirement for coverage of Complex Chronic Care Management Services (proposed for effect in 2015), in the recently published 2014 Payment Proposed Rule (Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014): "The practice must be using a certified Electronic Health Record (EHR) for beneficiary care that meets the most

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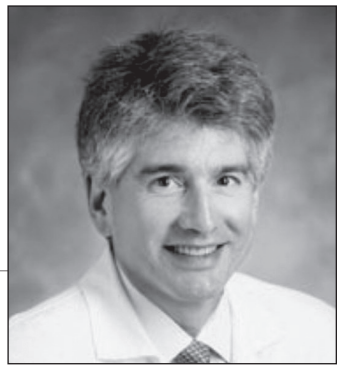
Moving Forward on Developing Quality Measures for House Calls Medicine



by Bruce Leff, MD, President

A few months ago, I used this column to introduce you all to the work led by Dr. Christine Ritchie and myself to create a National Medical House Calls Network, as the initial step in developing house calls quality measures and a national registry to perform rapid-cycle practice improvement.

An overall goal of this project is make sure we do a better job of demonstrating clearly to the public and to payors that we deliver the highest quality care, and to spur the development of our field.

I thought it would be a good idea to provide an update on that work. I am very pleased to report that the project is going very well.

We constituted the initial iteration of the Network with representatives of a dozen exemplary house calls practices, key professional societies (AAHCP, American Geriatrics Society, and the American Academy of Hospice and Palliative Medicine), and national organizations focused on consumer issues in health care (Kaiser Family Foundation, National Partnership for Women and Families, and AARP).

With substantial input from the Network members, we developed and fielded a web-based national survey of house calls practices to learn about the current state of house calls practice. One key preliminary finding from that survey is that a substantial portion of house calls practices don't use a defined quality improvement process, or collect and monitory quality indicators, but a majority would be interested in participating in a quality improvement program that would provide timely feedback to their practices on house call-specific quality indicators.

We performed in-depth interviews with Network members to understand their views concerning key house calls quality of care domains and elements. We used the Health and Human Services framework for the care of people with multiple chronic conditions as a starting point and built off of that to consider key domains and elements of quality of care for house calls medicine. We identified 10 main domains and several dozen quality elements of importance to house calls medicine.

In mid-June, we convened an in-person meeting of the Network members. We reviewed the preliminary results of the practice survey and then spent much of the day refining and prioritizing the quality of care domains and elements using a Delphi process. In upcoming Network conference calls we will be performing additional prioritization of those quality elements.

Once we have decided on the quality elements, we will map existing and already endorsed quality metrics to those quality elements. We will understand whether there are existing metrics we can use for house calls, as well as the gaps in measures, and gain a fuller understanding of the types of measures we may need to develop on our own.

We are also in the process of identifying funding sources for the next stage of the project, which is to develop the technical platform of what we hope will develop into a national house calls registry, and to pilot test that registry with several practices.

On a final note, we recently met with key officials from the National Committee for Quality Assurance (NCQA) and the Center for Medicare and Medicaid Services (CMS), and we met with great enthusiasm for our work. There is a great thirst among the key players in this space for thinking anew about how to measure quality for patients like ours. We are in the right place at the right time on this issue!

Please feel free to send me your thoughts and ideas on this work.

Save the Date!

AAHCP 2014 Annual Meeting, May 14-15, 2014

Walt Disney World Swan & Dolphin Hotel & Resort Orlando, Florida

Watch our website & *Frontiers* for details!

Update of the Home Care Literature:
May - June 2013

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 clinicians. 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

Gregory Reardon, Winnie W. Nelson, Aarti A. Patel, Tommy Philpot, and Marjorie Neidecker. Warfarin for Prevention of Thrombosis Among Long-Term Care Residents with Atrial Fibrillation: Evidence of Continuing Low Use Despite Consideration of Stroke and Bleeding Risk. Drugs Aging. 2013 June; 30(6): 417–428. Published online 2013 March 2. doi: 10.1007/s40266-013-0067-y.

The aims of the study were to evaluate usage rates of warfarin in stroke prophylaxis and the association with assessed stages of stroke and bleeding risk in long-term care (LTC) residents with atrial fibrillation (AFib). A cross-sectional analysis of two LTC was conducted. The results from two LTC databases suggest that residents with AFib have a high risk of stroke. Warfarin use increased with greater stroke risk and declined with greater bleeding risk; however, only half of those classified as appropriate warfarin candidates were receiving guideline-recommended anticoagulant prophylaxis. The authors concluded that the further research is needed to evaluate the degree to which this low usage rate represents appropriate balancing of stroke and bleeding risk or other concerns in these unique patients, or whether this represents a potentially large lost clinical benefit from otherwise preventable stroke.

Home Care Research

Linas Kumeliauskas, MD, Karen Fruetel, MD, MEd, and Jayna M. Holroyd-Leduc, MD. Evaluation of Older Adults Hospitalized with a Diagnosis of Failure to Thrive. Can Geriatr J. 2013; 16(2): 49–53. Published online 2013 June 3. doi: 10.5770/cgj.16.64.

Older adults are sometimes hospitalized with the admission diagnosis of failure to thrive (FTT), often because they are not felt safe to be discharged back to their current living arrangement. It is unclear if this diagnosis indicates primarily a social admission or suggests

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Article of the Month

Quality of Care

Elisabeth Lindberg, PhD Student, Ulrica Hörberg, PhD, Eva Persson, PhD, Senior Lecturer, and Margaretha Ekebergh, Professor. "It made me feel human" - a phenomenological study of older patients' experiences of participating in a team meeting. Int J Qual Stud Health Well-being. 2013; 8: 10.3402/qhw.v8i0.20714. Published online 2013 May 28. doi: 10.3402/qhw.v8i0.20714

This study focused on older patients participating in a team meeting (TM) in a hospital ward in Sweden. The aim of this study was to describe the caring, as experienced by the older patients on a ward for older persons, with a specific focus on the team meeting. A reflective life world research (RLR) design was used. The need for hospitalization is an emotional struggle to overcome vulnerability and regain everyday freedom. The patient has to surrender to care when vulnerability increases. The way in which the professionals are able to confirm vulnerability and create a caring relationship affects both the struggle for well-being and the possibilities for maintaining dignity. Vulnerability limits life; life is left in the hands of someone else. The result raises concern about how the care needs to be adjusted to older people's needs as lived bodies. One way, as described by the patients, is via the patient's life stories, through which the patients can be seen as a whole human being. The voice of the older patient needs to be given space, and in order to further develop a patient perspective, older patients need to be involved in the planning, implementation and evaluation of research and health care development.

CMS Proposed Home Health Payment Policy - Wrong Direction? Your Comments Needed ASAP!

by Constance Row, LFACHE, Executive Director

CMS has recently released a proposed payment policy for home health agencies that would not only again reduce payments, but for the first time, delete 170 ICD 9 codes from the HH PPS Grouper methodology through which agencies are paid. Included in the 170 codes are conditions such as uncomplicated diabetes and others deemed "too acute" to be treated in the home. Additionally two new reporting measures are to be added: a) re-hospitalization within 30 days of home health in which patients had an acute inpatient hospitalization in the five days before the start of their home health stay and b) emergency department use without readmission within 30 days of home health for cases in which patients had an acute inpatient hospitalization in the five days before the start of their home health stay.

Our initial concerns are:

- The effect of this rule will be to cut Medicare coverage for beneficiaries suffering from these disorders and substitute the judgment of CMS for the medical judgment of clinicians;
- On the one hand the proposed rule recognizes the important role home health agencies can have affecting re-hospitalizations and emergency room use but cuts payments at the very time agencies need to ramp up their infrastructure to provide complex chronic patient care;
- The thrust of the document is directly counter to the trend in medicine to move greater acuity patients to the lower cost setting of care which is the home.

We will be preparing comments on this proposed rule, but would like your comments as agency medical directors:

- Review the list of 170 codes proposed for deletion. Does your agency currently treat patients with these conditions and do you believe the patients benefit? If so, give us examples of the kinds of patients whose care could be eliminated if this rule goes into effect.
- Is your agency currently trying to increase its capacity to reduce unnecessary re-hospitalizations and ER visits? If so, would the proposed payment cut have an adverse effect on ramping up this capacity?

You can review the rule by going to www.ofr.gov/OFRUpload/OFRData/2013-15766_PI.pdf. The list of diagnoses proposed for elimination can be found on pages 23 through 28.

Our comment letter is due at the end of August, so please send your comments to edrow@aahcp.org ASAP!

Interested in the Independence at Home Demonstration? See Separate Mailing!

Many of you have expressed interest in hearing how the IAH Demonstration is doing now that it has been running for a year.

To give you a chance to hear from the participating practices and programs, all of whom are Academy members, we are sending you, as a separate mailing, the report we are sending to the Academy's IAH Learning Collaborative grant funder The Retirement Research Foundation. It was quite a start-up year. Practice transformation was required, even among experienced practices to assume the accountabilities of the IAH Demonstration. Learn the new ideas and approaches practices used by reading this report.

For those of you who are new to the Academy and not familiar with the Demonstration, please go to www.IAHNow.com for basic information about the rationale, the legislation, and the requirements.

Home Care Literature

Continued from page 4

an acute medical deterioration. The objective of this study was to explore the level of acuity and medical investigations commonly conducted among older hospitalized adults with a diagnosis of FTT. A retrospective cohort study was conducted at three hospitals in Calgary, Alberta. The authors concluded that a diagnosis of FTT may indicate health issues that are not easily evident. Patients hospitalized with this diagnosis appear to have acute medical issues. Therefore, a diagnosis of FTT suggests the need for a comprehensive assessment and initiation of an appropriate management plan.

recent HHS regulatory standard for meaningful use. The EHR must be integrated into the practice to support access to care, care coordination, care management and communication."

And the proposed standards for coverage and payment more specifically require that: "All practitioners including advanced practice registered nurses or physicians assistants, involved in the delivery of complex chronic care management services must have access at the time of service to the beneficiary's EHR that includes all of the elements necessary to meet the most recent HHS regulatory standard for meaningful use. This includes any and all clinical staff providing after-hours care to ensure that the complex chronic care management services are available with this level of EHR support in the practice or remotely through a Virtual Private Network (VPN), a secure website, or a health information exchange (HIE) 24 hours per day and 7 days a week."

These codes are considered to be an interim step to Medicare establishment of Advanced Primary Care Practice (think of this as "patient centered medical home" for Medicare beneficiaries).

Academy staff and Public Policy Committee Members are reviewing the Proposed Rule and will offer comment on behalf of Academy members. We will also provide webinars and written material on the 2014 Payment Proposed Rule and impacts to housecall practices shortly after the time you are reading this *Frontiers*.

Current Medicare and Medicaid Payment Includes Electronic Health Record (Meaningful Use) Incentive Opportunity - The federal government has multiple programs in place to encourage the adoption of electronic health records. These programs can be reviewed at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/.

Note that EHR payments are not available to nurse practitioners and to physician assistants under the Medicare program; however they are available under the Medicaid program (NPs generally, and PAs in FQHC and RHC). www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html and www.healthit.gov/providers-professionals/ehr-incentive-programs.

These programs will change in the coming years from incentive/bonus payment programs for the demonstration of "meaningful use" to those that deduct payment for not documenting use of electronic health records. The timeline for the EHR meaningful use payments is provided at www.healthit.gov/providers-professionals/ehr-incentive-payment-timeline.

How to Know if an EHR Product Should be Considered?
The federal government oversees certification that electronic health record products meet the standards to support "meaningful use." The federal organization responsible for this oversight is the Office of National Coordinator for Health Information Technology (ONC-HIT). It is less and less likely that a product that is not certified for meaningful use would be marketed. However, this should be a requirement in your review of EHR products.

What Electronic Health Records are Certified for Meaningful Use?
Certified EHRs can be found at www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl.

Implementation of an EHR - The ONC-HIT has excellent materials to assist you with the implementation of an EHR. These materials are available at www.healthit.gov/providers-professionals/ehr-implementation-steps/step-1-assess-your-practice-readiness.

The topics covered in step-by-step detail along with back-up resources include:

1. Assessing Your Practice Readiness
2. Plan Your Approach
3. Select or Upgrade to a Certified EHR
4. Conduct Training & Implement an EHR System
5. Achieve Meaningful Use
6. Continue Quality Improvement

The ONC-HIT also offers assistance through Regional Extension Centers for practices implementing EHRs. Information is available at www.healthit.gov/providers-professionals/regional-extension-centers-recs. The services of the RECs are available around the country and at a discounted rate. The RECs provide assistance not only for those beginning implementation but also to those who experience implementation challenges.

C. Marketing of Your Practice

You will want to explore and develop other revenue sources and methodologies as the Medicare fee schedule and other fees for service relationships become more and more constrained.

Academy members understand that a housecall practice is able to produce

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Member News

Medical Director Training NOW AVAILABLE!

Finally, low-cost, easy to use, web-based Home Health Agency Medical Director training is available! Don't miss out, and tell your friends. Training consists of eight modules and CME credit will be awarded for completion of the entire course. Cost is just $20 for AAHCP members! View the brochure and register on our website at www.aahcp.org › Home Care Medical Direction.

Electronic Health Record Survey

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"savings" from expected cost of care for patients. Savings results through reduction in inpatient admissions, reduction in emergency room admissions, and post-acute cost. The evidence of such savings can be found on the Academy site www.aahcp.org and also at www.IAHNow.com.

Your evaluation of EHR and revenue cycle function needs to include the ability to extract data to support the care transitions and "shared savings" marketing of your practice. This data will be required to demonstrate value to accountable care organizations (ACOs), health systems and private health plans. Such data will also be required to serve as service and outcomes back-up in these evolving service and payment relationships.

Data elements will include patient lists/attribution, volumes, referral decisions, cost of care, patient/caregiver satisfaction, etc. Such data will come from practice management systems that are integrated with EHR products. Thus, it is important for you to keep the build versus buy, evolving payment systems and marketing of your practice in mind as you evaluate electronic health records, your revenue cycle, and strategic relationship to your practice.

Welcome, New Members!

The Academy would like to welcome the following new members:

ALABAMA
Julie F. Beard, CRNP

ARIZONIA
Diane Elmore, MD
Matthew Haden, MD
Jason Steinberg, RN, BSN

CALIFORNIA
James Adams, MD
Michael T. Bowersox, MD
Sharhriar Jarchi, MD
Mary Ormonde, RN
Sunny Park, MSN, FNP
Benjamin Tilson

CONNECTICUT
J. Kevin Shushtari, MD
Lenore M. Snowden, MD

DELAWARE
Shilpa Garg, MD

FLORIDA
Scott W. Clark, MHA
Elizabeth Vidal, MD

GEORGIA
Miguel A. Jurado, MD
Marli Magnet, FNP-C
Michele A. Mitchell, LCSW
Christina Ottis

ILLINOIS
James L. Mason, PhD

IOWA
Ann K. Touney, MD

KENTUCKY
Phil Aaron, MD, JD, MPH
Tonya M. Bragg-Underwood

LOUISIANA
Dewanna Christian, ANP

MASSACHUSETTS
Deborah Kylander, MD

MARYLAND
Terry A. Mikovich, RN

MICHIGAN
Gloria Chemaly, MD
Mohammed Elbashir, MD
Amy Saeidi, RN

MISSISSIPPI
Koyia L. Figures, MD
Mary Williams, DNP

MONTANA
Mary Beth Siewert, MSN, FNP

NEW HAMPSHIRE
Ben Bulkley, MS

NEW JERSEY
Abdul-Hady Kheder, MD
Ivan Alberto Sabio, MD

NEW YORK
Marie Florence Celestin, MD
LuAnne Codella, MD
Alexandra Dow, MD
Alphonso L. Linley, MD
R. Ari Rabenou, MD
Mary Rappazzo, MD

NORTH CAROLINA
Gregory L. Candell, MD
Richard Lynch, MD
Robin H. Starr, MS, ARNP-C

OHIO
Waheed A. Adewumi, MD
Duane Kirksey, MD
Heather Mattern
Mary Taha

PENNSYLVANIA
Joy Boone, MD
Michael J. Eperesi
Valerie A. Finlan, MSN
Kelly Thear, RN

TENNESSEE
Letasha Lewis, MSN, FNP
Chris Mitchell

TEXAS
Laura Chiodo, MD
Jamai Freeman-Kee, FNPC
Kathleen K. Owings, MD
Ronald E. Williams, DO

UTAH
Paul M. Gahlinger, MD

VIRGINIA
Tiffany Riser, NP

WASHINGTON
Stephanie Wheeler, MD, MPH

WISCONSIN
Theresa L. Wendt, APNP

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Share AAHCP's mission and encourage colleagues to join

The American Academy of Home Care Physicians 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.

AAHCP 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).
- 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.

2013 Membership Fees*

Physicians	$195
Groups (MD, NP, PA or combination)	Custom**
Associate (NPs, PAs, RNs)	$115
Residents/Students	$75
Affiliate (home care agency employee)	$195
Corporate Sponsor Membership	$2,000

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

2013 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: _____