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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.

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Revenue Enhancement Opportunities

Practice Management and Revenue Certainties and Uncertainties at the End of 2012 and Beginning of 2013

by Gary Swartz, JD, MPA, Associate Executive Director

We ended 2012 with certainties as well as uncertainties for house call practices. This article will highlight some of each with service and revenue implications for house call practice. Additionally, we highlight Academy programs and resources that will support your practice operations and revenue in 2013.

2012 Year End Certainties - Constitutionality of the Affordable Care Act; Presidential Election Result

The Supreme Court upheld, for the most part, the constitutionality of the Affordable Care Act. The case had caused various participants in health care services to pause taking major actions and making strategic decisions until the case was heard and decided in favor of constitutionality.

The Independence at Home (IAH) Demonstration, important to growing the availability of house calls and members like you rendering home care medicine, was brought into being through the Affordable Care Act. And while there was the view that the Demonstration that began in June 2012 could continue without the ACA being upheld, this concern was removed with the Supreme Court decision. On a related note, the Academy is conducting a grant funded learning collaborative to support the success of IAH practices and is working to have the Demonstration expanded as a Medicare offering.

The presidential and congressional elections also had implication for the ACA and for the overall direction of health care coverage and policy. The re-election of the President and the Supreme Court decision combined provide increased certainty and clarity as relates to the provisions of the ACA.

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Editor-in-Chief: Wayne McCormick, MD, MPH. Comments on the Newsletter can be emailed to the Editor at: aahcp@comcast.net.

Registration Now Open for 2013 Annual Scientific & Practice Management Meeting!

Home Care Medicine (HCM): Best of Care, Best of Business

May 2-3, 2013 • Gaylord Texan Resort, Grapevine, TX

This highly-anticipated conference will explore key issues in clinical and practice management, presenting the best of care and best of business practices in home care medicine. Includes clinician/educator and practice management tracks, networking opportunities, IAH and health policy updates, and more!

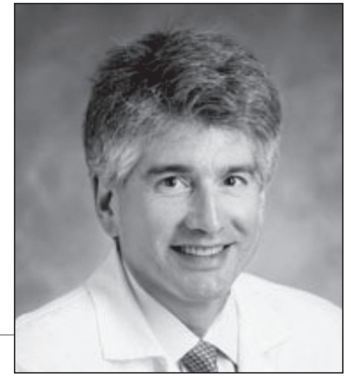
Program Highlights

- What is the Role for Home Care Medicine?
- Basics of Practice Management 101 and 102
- Challenging Cases in Home Care Medicine
- Addressing Psychosocial Needs and Difficult Behaviors
- Making Home Care Medicine Part of a Service Line and Key Elements of Business Success
- Independence at Home and Health Policy Updates
- Diagnosis and Management of Complex Wounds at Home
- Complex Pain Management at Home
- Lessons from VA Home-Based Primary Care
- Successful Transitions of Care
- Practical Use of Mobile Diagnostic Technology
- Managing Polypharmacy at Home
- Preparing for Future Home Care Medicine Standards
- Workforce Development and Retention

$375 early bird (deadline March 29); $425 on site

Registration NOW OPEN through AGS at www.americangeriatrics.org. For program summary and more information, visit our website, www.aahcp.org.

Creating a National Medical House Calls Network - A Critical Step Forward for House Calls Medicine



by Bruce Leff, MD, President

Health care delivery is moving inexorably to payment models that emphasize quality and value, rather than volume of services provided.

I believe, as I know all Academy members do, that house calls are a tremendous value for our patients and the health care system, providing high-quality, patient-centered, efficient, cost-effective and cost-saving care. I am confident that the Independence at Home (IAH) Demonstration, will demonstrate the value of house calls medicine.

That said, we, as a field need to do a better job of demonstrating clearly to payors and the public that we deliver the highest quality care. While IAH is a monumental step forward for the field, the quality metrics of IAH Demonstration are somewhat limited, focusing to a greater extent on utilization outcomes.

At the national level much work is being done by organizations such as the Department of Health and Human Services, the National Quality Forum, the Measure Application Partnership and others on developing the framework for defining health care quality across the continuum of care. House calls medicine, however, has not been a focus of their work.

Thus, it is critical for our field to develop a robust set of quality measures for house calls medicine. Capitalizing on the enthusiasm in the field engendered by IAH is the time to get started on this road.

Recently, my colleague Christine Ritchie, MD, MSPH, an Academy member and geriatrician at the University of California, San Francisco, and I were awarded a jointly funded grant from the Commonwealth Fund and the Retirement Research Foundation to create a National Medical House Calls Network.

The goals of this work are to engage medical house calls practices, providers, patients, caregivers, professional societies, advocacy groups and health care quality organizations to build an engaged working community dedicated to establishing standards for quality care in house calls medicine.

The long-term goal of this work, to be accomplished over the next few years, will be to use the National Medical House Calls Network to ultimately cre-

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Nominate Your Peers for our House Call Awards

It's not too early to begin thinking of a colleague who deserves to be named House Call Doctor of the Year or House Call Clinician of the Year. Presented to two outstanding practitioners at the Annual Scientific Meeting awards ceremony, to be held on May 2, 2013 in Grapevine, TX, these prestigious awards are meant to honor those clinicians who are pioneers in bringing house calls back into medical care mainstream.

The Academy is pleased to announce two additional awards this year; House Call Educator of the Year (may be awarded to a physician or non-physician provider) and our Presidential "Special Recognition" Award (recognition at the Board's discretion to a physician or non-physician for advocacy, research or other above and beyond work that advances the field).

If you would like to nominate a peer for ANY of the above awards, please submit your nomination to the AAHCP central office. Please make sure your nomination includes your name, phone number and email address, and the nominee's name, address, phone number and email address. Include the reasons for the nomination. These could include how the clinician has advanced the art and science of house call medicine, how they have impacted the home-limited and their community, how they have sacrificed for the sake of their patients, and how they have shown the highest integrity. Include a resume, if available, and up to five supporting documents that describe the nominee's accomplishments, and letters of support.

Nominations should be sent to the AAHCP office by March 1, 2013. Nominations may be submitted online; via mail: AAHCP, P.O. Box 1037, Edgewood, MD 21040; via fax: 410-676-7980; or as an email attachment to: aahcp@comcast.net.

Members Provide Relief and House Calls During Hurricane Sandy

by Jessica Quintilian, Assistant Executive Director

Several Academy members lent their aid during Hurricane Sandy, the devastating late-October East Coast storm that destroyed entire communities in New York and New Jersey, left tens of thousands homeless and millions without electric power. The deadliest hurricane to hit the U.S. mainland since Katrina in 2005, the hurricane caused tens of billions of dollars in damage and affected 24 states. Particularly vulnerable to Sandy's effects were the frail elderly. Academy members volunteered in Sandy shelters, made house calls to patients without power or heat, assisted with emergency preparedness and developed resources in their communities. This article features three such members, Drs. Steve Landers, Wen Dombrowski and Maria Lee.

Steve Landers, MD
VNA Health Group, New Jersey

Academy Board member Dr. Steve Landers is President and CEO of the VNA Health Group in New Jersey (VNAHG). VNAHG was originally founded because of a need to address rampant tuberculosis and establish a nursing organization. It recently celebrated its 100th anniversary and has a long history of assisting during crises and national disasters, including 9/11, Hurricanes Katrina and Irene, the n'oreasters of the 1990s and the polio epidemic of the 1940s. Since 9/11, the organization has become even more involved and prepared on both state and local levels to create disaster plans, with preparation beginning as soon as they learn a crisis is coming. Three days before Sandy's arrival, VNAHG began preparing by making sure that home care patients were put on a priority list, especially those on ventilators or oxygen. Nurses were sent out before the storm hit to ensure that patients had medications and an emergency evacuation plan. For the many elderly who live alone, these visits were crucial to ensure that they had food, batteries and the necessities for evacuation.

A VNA provider climbs over a fallen tree as she makes a house call following Hurricane Sandy

Prior to and during the storm, VNAHG cared for more than 3,500 patients, helping to evacuate them and ensure their safety. Dr. Landers' mandate to both clinical and non-clinical staff was "safety first," then do whatever possible to assist in Sandy shelters. VNA staff manned nine area shelters, mostly in Middlesex and Monmouth counties, providing more than 1,000 hours of service. Dr. Landers volunteered at Monmouth University shelter, which at one point housed 1,500 evacuees. "It was hard because many cots were set up in a gymnasium," Dr. Landers commented. "One couple in particular, both in their 90s and suffering with osteoporosis, had trouble walking to the bathroom, much less managing on a two-foot cot. Managing care in such a setting was a challenge." Some shelters were created by

A VNA employee volunteers at Monmouth University Shelter

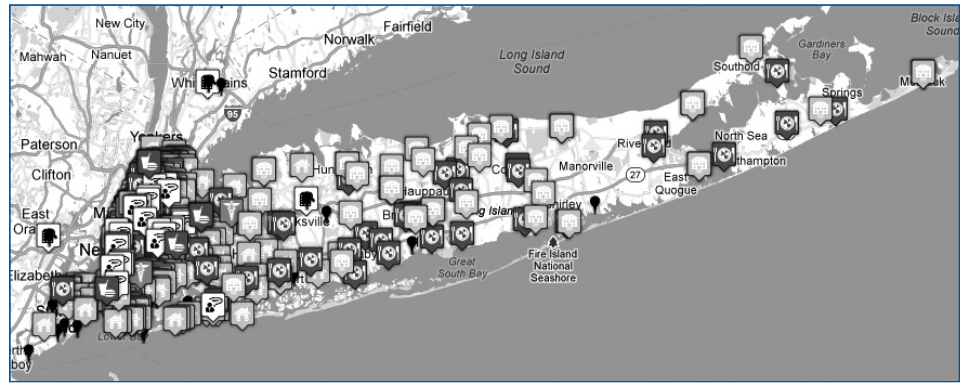
VNAHG nurses in elementary schools. One nurse voluntarily transported a patient from a shelter to the dialysis center each day. Another walked a five-mile radius to see patients, carrying all the equipment she would normally leave in her car. One nurse even delivered a baby on the streets of Newark. VNAHG staff continued to care for their patients despite damage to their own homes. Staff were particularly impressed with Dr. Landers' calm, reassuring leadership. "If staff panicked, Dr. Landers sent

Monmouth University Shelter, New Jersey

out reassuring messages, always saying 'safety first,' said Kathy McKeever, Director of Marketing for VNAHG. When Dr. Landers realized how severely impacted patients and employees were by the storm damage, he started a VNA Hurricane Sandy Relief Fund. Nearly $90,000 has been collected to date. VNA staff donated 442 vacation days valued at $16,000 to help fellow employees and patients who suffered loss and devastation from the storm. Says Dr. Landers of his VNA staff, "It was humbling and inspiring to see the resilience, creativity and dedication the staff had for helping people. They overcame their own issues of storm damage, no access to gasoline and needing to find childcare in order to help others. It was an honor to get to be a part of something like this."

Wen Dombrowski, MD
New York City

While parts of New York City were up and running in a matter of days or weeks, many seniors in the city were still in need of help as they recovered from the effects of Hurricane Sandy. Academy member Dr. Wen Dombrowski was volunteering in Sandy shelters, but wanted to do more. "Superstorm Sandy disproportionately affected older adults. I wanted to use my knowledge of senior services and background in technology to create an immediately available resource for volunteers, professionals, caregivers and older adults," said Dr. Dombrowski. During the week after the storm, she recruited technology volunteers from NYTechResponds, contacted GoogleMaps and partnered with New York City's Council of Senior Centers and Services to create a map of Sandy-specific volunteer/donation needs for older adults and ongoing senior services. The Senior Services map (pictured above) was created on Google's Crisis Map website and can be found at http://bit.ly/sssmap and http://bit.ly/sssmap2. It allows users to sort through a list of more than 600 senior services based on over a dozen categories that describe either Sandy-specific needs or ongoing programs serving older adults. The map



Senior Services Map

was shared with older adults, caregivers, senior service professionals, Academy members and volunteers as a resource, and Academy members and others were encouraged to submit information about ongoing resources and organizations in need of help. Feedback about the resource has been positive, with individuals from other regions requesting local and national maps to use as a day-to-day resource and disaster preparedness tool. Some of the early comments Dr. Dombrowski received from professionals in aging services and community leaders included, "This is absolutely amazing! An extraordinary resource!"..."We will be sure to pass this along to community members"..."I was hoping someone would take the lead on an initiative like this." Dr. Dombrowski is currently searching for collaborators and partners to help make the project sustainable and scalable. For more information about this project or other services and relief efforts in New York City, contact Dr. Dombrowski at HelpNYCSeniors@gmail.com.

Maria Lee, MD
New York City

Dr. Maria Lee, a house call physician and Academy member, volunteered at the Brooklyn Tech High School and Park Slope Armory shelters in New York. Like Drs. Landers and Dombrowski, Dr. Lee sought to do more for the residents of her city who had been affected by Sandy. She began making house calls to patients in Manhattan who were without power or heat, offered Chinese interpretation for Coney Island Chinese residents who waited in line for free food and supplies and even made home visits in the dark to patients living in housing complexes in Manhattan's Lower East Side. Many of these residents were still suffering from cold and isolation more than two weeks following the storm, and were without heat, electricity or hot water. One of the complexes where Dr. Lee made home visits was featured in *The Bronx Ink* article "Day 15 After Sandy: Elderly Chinese Residents Still in the Dark" (See http://bronxink.org/2012/11/13/26232-senior-chinese-residents-still-in-the-dark-two-weeks-after-hurricane-sandy/). Dr. Lee is the Director of Asian Division of Medical House Calls, PLLC and works closely with Chinese and Korean NPs to improve health care to the frail homebound Asian elders of NYC. She continues to volunteer whenever the opportunity permits.

The Academy gives a special thank you to all of our members in New York, New Jersey and elsewhere who provided, and continue to provide, care and relief to those affected by Sandy.

Dr. Wen Dombrowski with shelter volunteers

An Interview with Rick Griffin, CEO of CareSouth

Mr. Rick Griffin,
President and CEO of CareSouth

by Gary Swartz, JD, MPA, Associate Executive Director

Academy members are rendering valuable house calls and managing house call practices during an exciting time of health care delivery evolution. In fact, you are often leading and inventing this evolution. There are others, including those in the home health area, who are joining Academy members to lead this important change.

In the last edition of Frontiers, *we talked with Dr. Rodney Hornbake, internist and former Chief Medical Officer for Gentiva.*

This time, we talked with Mr. Rick Griffin, another change leader. Mr. Griffin is President and CEO of CareSouth. CareSouth is an important regional home health company headquartered in August, Georgia. CareSouth recently acquired the assets of AllianceCare, a statewide Florida home health entity. One of the bonus features of the June acquisition according to Mr. Griffin was the fact that AllianceCare has a house calls practice. Constance Row and Gary Swartz interviewed Mr. Griffin on September 20 to learn more about the strategic thinking that drove the acquisition and the implications of home health agencies acquiring and growing house call practices.

Mr. Griffin, how was the idea for the acquisition generated? What drove the strategic decision?
We had been interested in Alliance Care for a couple of years. We are primarily in the southeast and mid-Atlantic. While we had a presence in northern Florida, we did not have depth throughout Florida, and so this transaction helped complete our southeastern geographic footprint.

While a traditional M&A activity, there were bonuses along with the home health agency services. The bonuses included private duty nursing and also the physician house call practice. We had also been interested in starting a house call practice, and so this deal presented the opportunity to buy versus build.

Who are the internal and external market customers you are organizing to satisfy and you expect to pay for services?
We see a future where one needs to expand as a non-acute provider to both provide clinical services, but also to manage a population of patients with chronic diseases.

Having the components in place to do so will be important and we also added hospice this year for the first time. While we do not currently have a significant number of managed care contracts, we may in the future.

So you are going from episodic care to more longitudinal care?
Yes, we are going from episodic to managing sicker patients over the long term. There was a term from the 90s - being a one stop shop - which every organization wanted to be. Well, this may not have made sense at the time; however, it does make sense now.

We see there being more risk-based service and payment opportunities down the road. These include transitional care relationships.

Are there any now with real dollars contractually at issue, or are you building for a customer you believe will arrive?
Yes, we participate in two arrangements with acute care providers in Georgia where there are financial risk implications. We also have arrangements that are more conceptual that are in place. These arrangements have moved from the idealistic to reality, and we believe that those not involved in integrative models will not survive.

What are the benefits you anticipate from this acquisition? Any metrics you can share?
It is too early to measure metrics regarding the benefits of this transaction. We are all going through a phase of understanding the needs of the patients and all of the pieces of the operation.

You speak of the benefits of the physician house call practice - managing the professional practice has been a problem for others. What are you going to do about managing the physician practice?
We had within CareSouth the infrastructure to accommodate AllianceCare and the house call practice. Again, this was a buy versus build opportunity. Al-

lianceCare had a management function. We will improve this function rather than replicate the function. The physician component needs to be a prominent part of CareSouth and the integrative model.

While you have answered much of this question, how did you decide on acquisition rather then a less intensive (e.g., contractual) relationship?
We believe the historic vendor relationship for medical services is the wrong model. Patients need an integrated model. Our view is that adding multiple components of non-acute care services will produce the highest quality at the lowest cost outcomes. Another aspect is that we anticipate a fully integrated EMR where the physicians and HHA nurses are working off the same medical record sharing information and communicating. We have a vision of this fully integrated care model everywhere that we provide service.

What are your plans for the future - will this acquisition be a model for CareSouth in its other markets?
This is our first entry into employing physicians and there is a lot to learn, particularly around the mindset of the physicians, the integrative care model and financial expectations. We are pleased to see there is good response in the market for this model with physicians.

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 › Medical Director Training.

Welcome, New Members!

The Academy would like to welcome the following new members:

ARIZONA
Marty Hearyman, MD

CALIFORNIA
Joe Behymer, MD
Peter C. Benson, MD
Bert Cave, MA
Abdelsalam Mogasbe, MD
Stephen Poses, MD
Jerrod Stacy

FLORIDA
Simon C. Abelson, MD
Andrea A. Arce, BSN
Diane P. Clarke, MD
Sushma Salwan, MD
Susan Waterbury, ARNP

ILLINOIS
Joseph Ofiei, MD
Phillip J. Olsson, MD
Scott B. Phillips, MD

IOWA
Sherry Buske, NP-C
Jill L. Duffy

MAINE
Nancy T. O'Neill, MD

MASSACHUSETTS
Janet Bovaird
Karen Rowley
Akison C. Spray, MBA

MICHIGAN
Adel M. Iqbal, DPT
William D. Myles
Carlos Weiss, MD, MHS

MINNESOTA
Daniel L. Cosentino, MBA

NEW JERSEY
Lee Ann Colleton, APN-C/MS

NEW MEXICO
Robert Metz

NEW YORK
Emillia A. Rutigliano, MD

OHIO
Catherine A. Bishop, DO

PENNSYLVANIA
Richard Davis, RN
David Thimons, DO

SOUTH CAROLINA
Garrett E. Snipes, MD

TENNESSEE
Richard K. Rice

TEXAS
Tata Duval
Thien K. Hoang, BA
Assiatu Smith, NP
Diane Kim

WEST VIRGINIA
Ugoala Banks, MD

The ACA contained legislative changes and requirements that will impact house call practice and revenue for 2013 and going forward. Some of these changes and mandates are implemented in the Medicare Professional Fee Schedule for 2013. These changes are noted below and were also reviewed in the Academy webinar on November 16, 2012. Question and answers from the webinar can be found at www.aahcp.org › Meetings and Programs › Webinars.

2013 Sustainable Growth Rate (SGR) Formula Payment Reduction Resolved at Press Time

Just as this article went to press, Congress passed and the President was expected to sign the American Taxpayer Relief Act (ATRA) of 2012. The ATRA, among other items, averts the SGR reduction to the Medicare Fee Schedule (MFS) for another year by replacing the 26.5% reduction with a “zero percent update” to the MFS for 2013. The Academy had signed on to multiple letters to Congress that stressed the importance of averting the SGR reduction for 2013 and the need to resolve the SGR issue permanently. The letters that contained these recommendations can be found at www.aahcp.org › Policy, Advocacy and Regulation.

While the law was just passed as this edition of *Frontiers* went to press, the expectation is for payment of “house call” (E and M) codes to be close to the MFS allowed amounts for 2012. This would not be specific to the dollar and penny as the congressional fix is not an absolute rate freeze. New codes are added to the MFS (for example, the Transitional Care Management codes discussed below) and payment policies are adjusted. So these changes result in Medicare allowed payment rate changes, but the wholesale SGR reduction was avoided for another year.

Additionally, the ATRA also among other Medicare program modifications;

- Turned off the January 2, 2013 “sequester” for two months. This prevented various automatic cuts from occurring, including an across the board, two percent cut for all Medicare providers. Congress, as you are reading this article, may still be debating issues related to the national debt ceiling and sequester.
- Extended the Medicare 1.0 work RVU GPCI floor through December 31, 2013.
- Increased the Medicare Part B equipment utilization assumption for advanced imaging services to 90 percent effective for fee schedules established for 2014 and subsequent years, thus reducing future payments.
- Extended the Medicare therapy cap exception process through December 31, 2013.
- Increased the Medicare therapy service multiple procedure payment reduction from 25 to 50 percent effective April 1, 2013.
- Encouraged the provision of relevant and timely data to physicians to support development of new delivery and payment models.
- Allowed physician participation in clinical registries to meet Medicare quality reporting requirements.
- Increased the amount of time for efforts to collect overpayments made on behalf of deceased beneficiaries from 3 to 5 years; and
- Established a Commission on Long-Term Care to “develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such services and supports, including elderly individuals, individuals with substantial cognitive or functional limitations, other individuals who require assistance to perform activities of daily living, and individuals desiring to plan for future long-term care needs.”

We will provide additional information regarding the impact of the ATRA through publication and webinar. The legislative text is available at http://thomas.loc.gov/cgibin/query/D?c112:4:./temp/~c1125QnKuT::/.

2013 Certainties from the Final Professional Fee Schedule for 2013

The Final Professional Fee Schedule for 2013 included provisions with service and revenue implications for house call practices Again, these were reviewed in the Academy webinar (see www.aahcp.org › Meetings and Programs › Webinars) and in the question and answers from the webinar. You will want to review these materials for additional service and claim submission detail. We will also review these service and revenue opportunities at the Annual Meeting and in an upcoming webinar.

Transition Care Management (TCM) Codes - CMS adopted two new AMA-CPT codes for TCM (CPTs 99495 and 99496). The codes were developed to describe care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital stay, SNF stay, or community mental health partial hospitalization to care furnished by the beneficiary’s primary physician in the community. TCM can be rendered by physicians, NPs and PAs. Both codes require communication with the patient and/or caregiver within two business days of discharge and a face-to-face visit with the patient. CPT 99495 requires a face-to-face visit within 14 calendar days of discharge and is for patients for whom medical decision making is of at least moderate complex-

ity during the service period. CPT 99496 requires a face-to-face visit within seven calendar days of discharge and is designed for patients who require medical decision making of high complexity. TCM will have an allowed amount (provided the SGR issue is resolved) for 99495 - $164.00 and 99496 - $231.00.

Medication reconciliation and management must occur no later than the date of the face-to-face encounter. The non-face-to-face care management services may be performed by the provider and/or licensed clinical staff under his or her direction, but the provider must perform the face-to-face visit with assistance from staff. It is important to note that TCM (either code) is a 30-day post-discharge service inclusive of the day of discharge and is submitted once by one provider after the 30 days. The face-to-face encounter is not to be reported as a stand alone E and M service. Additional medically necessary E and M services can be rendered and submitted for the same time period. TCM and CPO cannot be submitted in the same month. CMS, at the time of this article, was developing the specific Medicare Carrier Manual instructions for these codes, and we will provide additional information when these are published.

Portable X-Ray - Nurse Practitioners and Physician Assistants can now order portable X-Ray Services. This provision rationalizes the services that can be ordered by these providers congruent with state scope of practice and also as relates to other diagnostic services that can be ordered by these providers.

DME - There is a new requirement for physician documentation of NP and PA face-to-face encounters that require written orders for certain DME prior to delivery.

Medicaid Expansion - Medicaid payments will be increased for 2013-4 to the 80% payment level of the Medicare Fee Schedule Allowed Amounts. Essentially, this is the Medicare portion of the Allowed Amount. The ACA provision does not require Medicaid programs to pay the beneficiary co-pay.

Academy Practice Management Services and Resources to Look for in 2013

Academy Advocacy for Coverage and Payment for House Call Services - The Academy will continue to advocate for coverage and payment of services you render for the benefit of your patients. These services include an expanding range of primary care services, preventive services, procedures and diagnostics. We will also continue to assist with broad based audit issues.

Participation with Coalitions and Work Groups to Support Primary Care and House Call Related Services - Academy committee leaders and staff are active and influential participants in formal coalitions and ad hoc work groups to encourage policy development and coverage and payment for services related to your house call patients and practice. Two recent examples include the Advance Primary Care Payment Initiative (APCPI) of CMS and CMS consideration of Complex Chronic Care Coordination (CCCC) codes.

The APCPI is a CMS initiative to support primary care though a "medical home" like approach. The Academy has submitted comment (see www.aahcp.org › Policy, Advocacy and Regulation) that IAH is a model that should be considered for the complex multi-morbid home-limited that are your patients. CMS considers the CCCC codes it approved in the 2013 Fee Schedule Final Rule to be an integral part of the Primary Care Initiative. The Academy is working to have these codes, which describe the care coordination you and your staff provide face-to-face and non-face-to-face, covered and paid by CMS ahead of APCPI as this is service you are already rendering. Dr. George Taler is leading this effort as Chairman of the Public Policy Committee.

Regulatory Review and Comment Letters - The Academy will continue to provide review and comment on the federal legislation and regulation that has the potential to impact your services and revenue.

Annual Meeting - Practice Management 101 and 201 sessions will be presented as breakfast sessions. Additionally, the An-

Continued on page 11

Unique House Call Physician in Southwest Ohio

Trusted Healthcare, Inc. is seeking BC/BE Physicians to provide hands-on quality of care to patients with multiple chronic diseases. The perfect physician candidate is one who is looking for a non-traditional setting with the temperament of giving back to the community. Benefits include competitive starting salary, health benefits, paid malpractice and tail coverage, paid holidays, paid time off, paid CME, monthly car allowance for mileage, no weekends, and an end-of-year bonus potential.

Southwestern Ohio is a fantastic place to raise a family and offers all the warmth and charm you can find only in the Midwest. Excellent school districts and a variety of private schools. We are also home to the US Air Force Museum and Wright-Patterson Air Force Base and are within an hour's drive of big-city attractions.This world-class community truly offers the "best of both worlds" - - community charm with easy access to metropolitan amenities. This is an opportunity worth considering!

Please forward CV to Audrey Harper, Physician Recruitment Manager. Email Audrey.harper@khnetwork.org or fax: 937-522-7331. Phone: 937-395-8544 or cell: 740-607-5924.

Update of the Home Care Literature: *November - December 2012*

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.

Home Care Research

Ose D, Mahler C, Vogel I, Ludt S, Szecsenyi J, Freund T. Let's talk about medication: concordance in rating medication adherence among multimorbid patients and their general practitioners. Patients Prefer Adherence. 2012; 6:839–845. Published online 2012 November 28. doi: 10.2147/PPA.S35498

Medication adherence can be essential for improving health outcomes. In this study, overall medication adherence was measured by self-report (Medication Adherence Report Scale, MARS-D) in a sample of 92 patients with multiple chronic conditions. Twelve treating primary care physicians were asked to rate medication adherence in these patients using a mirrored version of the MARS-D. Concordance between external rating and self-reported medication adherence was analyzed descriptively. Patients rate their medication adherence markedly higher than their general practitioner. Accordingly, the percentage of concordance ranges between 40% (forgot to take medication) and 61% (deliberately omitted a dose). The authors concluded that talking about medication on a regular basis and better continuity of care may enhance patient-provider concordance in rating medication adherence as a prerequisite for shared decisions concerning medication in patients with multiple chronic conditions.

Quality of Care

Rosenberg PB, Mielke MM, Han D, Leoutsakos JS, Lyketsos CG, Rabins PV, Zandi PP, Breitner NCS, Norton MC, Welsh-Bohmer KA, Zuckerman IH, Rattinger GB, Green RC, Corcoran C, Tschanz JT. The association of psychotropic medication use with the cognitive, functional, and neuropsychiatric trajectory of Alzheimer's disease. Int J Geriatr Psychiatry. 2012 December; 27(12): 1248–1257. Published online 2012 February 29. doi: 10.1002/gps.3769

The use of psychotropic medications in Alzheimer's disease (AD) has been associated with both deleterious and potentially beneficial outcomes. This study examined the longitudinal association of psychotropic medication use with cognitive, functional, and neuropsychiatric symptom (NPS) trajectories

Article of the Month

Assessment

Lazkani M and Ota KS. The Role of Outpatient Intravenous Diuretic Therapy in a Transitional Care Program for Patients With Heart Failure: A Case Series. J Clin Med Res. 2012 December; 4(6): 434–438. Published online 2012 November 11. doi: 10.4021/jocmr1106w

This article presents a case series of seven patients with an established diagnosis of heart failure enrolled in a transitional care program that were treated with intravenous diuretic therapy in the outpatient setting. The patients were treated due to the development of decompensated heart failure within 30 days of their discharge from the hospital. All seven patients stated that they would have originally presented to the emergency department for their symptoms, but consented to alternative treatment by a transitional care physician, or transitionalist. All seven patients were treated with an intravenous diuretic for hypervolemia in outpatient infusion room and experienced relief of their dyspnea the day of diuretic administration or the following day. No adverse effects or emergency department transfers occurred as a result of outpatient intravenous diuretic therapy. Through the use of outpatient intravenous diuretic therapy, they avoided the need for emergency department visits and potential hospitalization. The authors concluded that further investigation of this therapy in a non-emergency department setting is warranted as their experience with this treatment modality is limited to the case series presented.

among community-ascertained incident AD cases from the Cache County Dementia Progression Study. A total of 230 participants were followed for a mean of 3.7 years. Persistency index (PI) was calculated for all antidepressants, selective serotonin reuptake inhibitors (SSRIs), antipsychotics (atypical and typical), and benzodiazepines as the proportion of observed time of medication exposure. The authors concluded that psychotropic medication use was associated with more rapid cognitive and functional decline in AD, and not with improved NPS. Clinicians may tend to prescribe psychotropic medications to AD patients at risk of poorer outcomes, but one cannot rule out the possibility of poorer outcomes being caused by psychotropic medications.

Practice Management and Revenue Certainties and Uncertainties

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nual Meeting contains a specific practice management track on Friday, May 3 that you will not want to miss. This track will address and respond to the most challenging and current practice management issues.

Compendium of Practice Management - We will develop a compendium that provides overview of house call practice. This will be organized by service and provide coverage and payment reference that will support development of practice policies and procedures. The compendium will address questions presented through the list-serv as well as those sent to me directly, will use material from existing Academy booklets and will also reference CMS and other authorities as applicable.

Webinars - We will develop and present webinars on the following:

1. Starting a Practice - This webinar will cover the basics of starting a house call practice.
2. House Call Services, Coverage, Documentation, Coding and Payment - This webinar will discuss the range of preventive services, primary care (evaluation and management codes) to procedures and diagnostics services that house call practices can render from a current Medicare coverage and payment perspective.
3. Electronic Incentive and Quality Measure Programs - This webinar will provide information on the multiple electronic incentive and quality measure reporting programs that exist (e.g., "meaningful use," e-prescribing and PQRS). We will cover the bonus payments and penalties along with the practical challenges and solutions to meet the reporting requirements, as well as describe the exemptions that are available to house call practices.
4. Opportunities for House Call Practice and Community Based Organizations in an Evolving Market - This webinar will discuss the growth in interest of Home Health Agencies (HHAs) and other community based organizations in house call practices. We will cover practical buy versus build and regulatory challenges in addition to the opportunities for community based organizations and for house call practice(s). We will include issues and opportunities discussed on the Academy Accountable Care Organization (ACO) webinar in September (see www.aahcp.org › Meetings and Programs › Webinars) which you will want to review for ongoing opportunities in your community.

President's Message: Creating a National Medical House Calls Network

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ate a National Medical House Calls Registry. A registry will enable the field of house calls medicine to determine which practice patterns are associated with optimal patient outcomes, and to identify strategies for minimizing costs while maximizing care quality. Achieving this goal will enhance the field of house calls medicine and allow us to engage fully in the work being done at the national level on value-based care. It will also give our society a chance to better understand both the work of house calls medicine and the experiences of those persons that house calls medicine serves.

We need your help for the National Medical House Calls Network to succeed!!

Hearing from each of you will be critical to this effort. In 2013, we will field a very BRIEF web-based survey of house calls practices to describe the field and the providers who perform this important work. The survey will be sent to all Academy members in March of 2013, and our goal is to publish those data in the peer-reviewed literature as soon as possible. *Please help us and the future of house calls medicine and complete the survey.*

In addition to the survey, we will be performing interviews with key stakeholders to learn about and describe the ideal qualities of house calls practices, performing a literature review to identify relevant measures for the care of house calls patients and developing a draft set of quality indicators for use in a National Medical House Calls Registry.

Optimizing the quality of our care is a critical element in the ultimate success of our field. We deeply appreciate partnering with you in this effort. If you have any thoughts you would like to share or questions about this work, please feel free to contact me at any time.

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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:

- Practice Management publications, website and personal technical assistance.
- Public Policy representation; legislative representation such as IAH.
- 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*

Membership	Fee
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: ______________________

☐ New membership ☐ Renewing membership

Please state your area of expertise or specialty: ______________

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