



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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Practice Management

ICD-9 to ICD-10: Where are You in the Transition?

By Gary Swartz, JD, MPA, Associate Executive Director

You are receiving this issue of *Frontiers* a year before the implementation of ICD-10. **This article discusses the transition to ICD-10 and ends with an outline of what you need to do now and over the next year for successful implementation.**

First, why does the implementation of ICD-10 matter? **Implementation of ICD-10 matters because for services October 1, 2014 and after you will not be paid for claims submitted with ICD-9.** CMS has stated there will be no further delay in implementation. This also means that practically speaking for a period of time you will be working off of both ICD-9 and ICD-10 as your claims for dates of service

prior to October are adjudicated along with your October, 2014 forward claims. The implementation of ICD-10 effects all "covered entities" (providers, payors and clearinghouses), under HIPAA and thus is not limited to Medicare.

The difference between ICD-10 CM and ICD-9 CM is that there are approximately 70,000 ICD-10 codes compared to approximately 14,500 ICD-9 CM diagnosis codes. ICD-10 CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM. The additional alpha numerical digits allows for greater clinical detail and specificity than with ICD-9

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What is ICD-10 and Why the Change from ICD-9?

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding across health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, and the format of the code sets is similar.
2. ICD-10-PCS is for use in inpatient hospital settings. ICD-10-PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding.

The transition to ICD-10 is occurring according to CMS because ICD-9 codes provide limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limited the number of new codes that could be created, and many ICD-9 categories are full.

Some clinical concepts recognized in ICD-10 did not even exist when ICD-9 was introduced (that will no longer be updated). Two large differences include coding that recognizes laterality and combination codes for certain conditions and common associated symptoms and manifestations.

Importantly,

ICD-9 codes will not be accepted for services rendered on or after October 1, 2014.

ICD-10 codes will be accepted for services rendered on or after October 1, 2014.

This change in diagnostic coding is also occurring at a time when public and private payment systems are relying more on diagnostic coding as a basis to determine or adjust the payment

you receive particularly for the multi-morbid patient population you treat. We will provide Webinars and other resources on the growing relationship of diagnostic coding and payment.

Are there Crosswalks Between ICD-9 and ICD-10?

CMS has posted resources on this crosswalking between the diagnostic code sets. The CMS crosswalk is known as GEMs for General Equivalence Mappings. Codes can be crosswalked from ICD-9 to ICD-10 - this is known as forward mapping. Realize there may be a one to one relationship and at other times there will be more ICD-10 codes mapped to the ICD-9 code given the greater specificity of ICD-10. Conversely, crosswalking from ICD-10 to ICD-9 is known as backward mapping. A CMS FAQ sheet on GEMs is at www.cms.gov/Medicare/Coding/ICD10/downloads/GEMs-CrosswalksBasicFAQ.pdf and the CMS area in which additional detail and the crosswalk code files themselves are found is at www.cms.gov/Medicare/Coding/ICD10/2013-ICD-10-CM-and-GEMs.html.

Use the Transition to ICD-10 as Opportunity to Improve Practice Efficiency

A recommendation is to use the change in diagnostic coding as an opportunity to enhance practice efficiency through review and improvement of your administrative and clinical throughput. This includes financial related practice aspects. Use this time to examine patient diagnosis in terms of volumes, relationships, decision making as to location and ordering/referral of patients for service, your cost to render service and of course your payment - your revenue by diagnosis and diagnostic groupings. Use this opportunity to revisit existing relationships (and payment levels) and to establish and expand relationships with hospitals, health

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President's Message

by Bruce Leff, MD, President



Time moves on, and in this, my last President's column, I would like to reflect on what has been and what needs to be.

The Academy and the field of house calls and home care medicine have accomplished much in the past two years. The Independence at Home (IAH) Demonstration, years in development by the Academy, made it into the field. This was a huge accomplishment! The IAH Learning Collaborative was developed, funded, and implemented to help the IAH practices live up to their potential and ensure a successful IAH demonstration. Academy staff assisted numerous members with practice management issues. There was substantial work to promote the development and dissemination of high-quality research to grow the evidence base for house calls. Foundation-funded work was initiated on the development of quality measures for house calls medicine. On the advocacy front, we continued to work on securing IAH as a national benefit, were able to get our members the ability to bill the Medicare Annual Wellness Visit and the Transitional Care Codes, and helped to provide relief from pre-payment audits. In addition, we were able to make the Face-to-Face regulations as patient-centered and practice friendly as possible. Finally, our name change to the American Academy of Home Care Medicine is official January 1, 2014.

This work could not have been accomplished without the tireless efforts

of Connie Row, our Executive Director, Gary Swartz, Associate Executive Director, and Academy staff Audrey McDonough and Bernie Sciuto. I want to thank the members of our volunteer Board, who serve you, our members, and our cause, with consummate skill and expertise, and sweat equity. Finally, I wish to thank all of you for your support of the Academy and for the heroic,

I wish to thank all of you for your support of the Academy and for the heroic, necessary, underappreciated work you all do, day in and day out, in the service of our patients.

necessary, underappreciated work you all do, day in and day out, in the service of our patients. It has been a true honor to work with and for such talented and dedicated people and to serve.

However, there is much work to be done. I have heard many times in my career over the last twenty years that house calls is at an inflection point, that we are about to take off. I am not quite sure of the time lags involved, but I believe that at some level, the field is approaching a do or die moment. In the context of health care reform, we must become a more viable profession or risk extinction as health service delivery evolves.

In my view, we must achieve the following goals if we are to make it in the near and long term:

- Secure adequate reimbursement for our work in the context of new

payment models such as IAH and others that evolve;

- Define quality standards for quality house calls/home care medicine. We can no longer operate in a quality desert;
- Develop credible methods to certify house call providers and house call practices - health systems and health care delivery systems will want to know that when they buy home-centered care, they are buying it for a quality practice that is staffed by quality providers who are providing quality care;
- Develop the capacity to provide technical assistance to help develop new practices;
- Develop the workforce to provide house calls;
- Build awareness of house calls with the public, policymakers, health systems, the health-related business community (I look forward to reading stories about house calls that don't begin with an anecdote about a doctor in the mid-20th century making a house call with black bag in hand).

I step down from the Presidency of AAHCP, but will continue to work hard on behalf of the organization as a Board member. I leave the academy in the most capable hands of Dr. Tom Cornwell, who will lead the Academy and our profession forward.

Be well.

A Smaller World

By Dr. Charles DeHaan

It was a sad day but mixed with the “we knew the day was coming” relief. My parents, a psychiatrist and an artist would not be traveling out of the country any more for vacation as they had been for their entire marriage. Dad’s hypertension and PAD had again landed him in a hospital on a Caribbean island. His persistent and even militant non-compliance was probably most to blame. Now their world was a little smaller. They would restrict their travel to the states where better health care access was available and where they felt just a little safer and could maintain their hold on independence as their ages advanced.

In my house call practice, I have observed over the years that people fight hard for that independence. They fight hard to show their families that they are alright staying in their home and caring for themselves even when the evidence speaks strongly against it. Recurrent health scares, disabilities and the inevitable march forward of their chronic conditions are the enemy. They even make their loved ones the enemy if they try to provide help that looks like a loss of the freedom they believe is best.

The one weapon I usually see used is that of making their world smaller. This tool can reduce the threats against their advancing age. They can control a smaller environment.

My parents, now in their 80’s, had to travel to Florida from the Midwest to attend a funeral. They arrived at the local airport 2 hours early for the 6am flight. All was in good order. As they went to check in the first problem happened. “Your flight is at 6” they were told, but it is 6 PM not 6 AM. Not to give up, this psychiatrist with a

rebellious character and Mom, who had the beginnings of her cognitive impairment, waited at the airport for their flight. Multiple events and the confusion of getting a rental, driving in unfamiliar places and the fatigue of a long day, left them almost unable to function the following day. They made it back home, but now they knew, travel out of the state was not an option even for a friend or relative’s funeral.

More health events, advancement of the clock, and fear eventually caused them to decide successively to limit travel to the state, the town, and then the neighborhood. The world was smaller, but they were independent.

The car now demonstrating a cracked headlight, scraped paint, and dents in the door were the evidence used to take the keys away. We were reluctant with this, but acted when neighbors started expressing concern for the safety of my

Our world starts small, grows into opportunities and hope but inevitably grows smaller if we live long enough. Caring for those whose independence is threatened by illness and age, gives us the opportunity to help them hold onto some dignity.

parents, knowing they really meant the safety of their own children. Avoid, as long as you

can, the confrontation to take a car - our culture’s icon of independence - away from anyone. Especially a still bright minded, retired, proud, psychiatrist who has been rebellious and malignant throughout his life. This was not a pleasant encounter.

Their world became still smaller, and

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Seeking a very experienced NP or PA to join my solo Internal Medicine practice in New York City.

Forty percent of the practice consists of house calls to the homebound frail elderly and disabled. You must be prepared to share in the 24/7 coverage of my patients and to follow them in the hospital as well. Send CVs to:

Jack Resnick, M.D.

501 Main St. Roosevelt Island, NY 10044
Jackresnick@gmail.com (212) 832-2310

Housecall Clinicians: Ready for the Dance, but with Whom?

By C. Gresham Bayne, MD, Past President, AAHCP

Value-Based Payment is the new, NEW thing in federal policy regarding how CMS intends to pay providers. Despite a confusing cacophony of nomenclatures, one can easily understand the current state of the art: nothing seems to save money in population-based studies. In a recent CBO summary of results, several lead demonstrations are analyzed: three are from the pay-for-performance (P4P) world and one is from the “bundled payments” world. It appears that failing to mandate savings in today’s healthcare marketplace is tantamount to NOT bending the cost curve.

As a paean to federal policy, little conversation occurs around actually saving overall costs in Medicare and Medicaid; rather, the term “bending the cost-curve” is used to describe a reduction in the rate of healthcare inflation, which continues to advance at higher rates than the COLA, albeit now only at triple the rate of general inflation.

Why have the detailed designs and analysis of these studies showed no savings? What does this mean for future research on savings? Are there implications for the device and technology manufacturers that are flooding the market with increasingly powerful tools to deliver care in a non-institutional setting? I have some predictions to make that will highlight the realities we face as housecall clinicians.

For healthcare policy to stimulate true reductions in overall costs to society, demonstrations must be designed at the population level. This is vastly more

difficult than selecting a small group of special patient cohorts and designing an alternative delivery system around their unique needs. Even designing studies that are restricted to one side of the payor dichotomy (fee-for-service or managed care) has proven fruitless. Of course, temporary aberrations may be created by such fiats as the administration’s prior refusal to allow the 12% overpayment to Medicare Advantage plans (which were originally proffered by Nixon’s Administration as a way of saving money compared to FFS Medicare, mind you), but such progressive politics has always led in the past to escape hatches for Medicare inflation.

It is reasonable to assume that the managed care industry will figure out a way to game the new payment restrictions by prospective risk stratification to increase the per-member, per-month paid to them by Medicare, just as they have successfully lobbied or gamed every other legislative attempt to mandate a bend in the curve.

One particularly

troublesome change is the current Administration’s fiat requiring that Medicare Advantage Plans must have no more than 20% of revenues in administration and profit; i.e. 80% of the federal dollar paid to them should actually go for healthcare. This is an impossible regulation to enforce and will create yet more administrative pressures for the payor industry to hire more actuaries to concentrate on their profit margins, rather than more providers to actually deliver needed medical care to seniors.

One must not forget that Medicare

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If you are interested in recruiting new providers, don’t forget the national newsletter *Frontiers*. All members get a copy of *Frontiers*, so you will have national coverage.

For more information on how to reserve your space and pricing go to www.aahcp.org > Advertise With Us, or contact Audrey McDonough at 410-676-7966 or audrey.mcdonough@aaahcp.org.

Update of the Home Care Literature: July - August 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 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

Arpita Chattopadhyay, Yang Fan, and Sudip Chattopadhyay. Cost-efficiency in Medicaid long-term support services: the role of home and community based services. Springerplus. 2013; 2: 305. ;Published online 2013 July 6. doi: 10.1186/2193-1801-2-305 .

Growth in home and community based

services (HCBS) has been implicated in rising long-term care expenditure in the Medicaid program. Its efficiency impact has not been tested. Using Stochastic Frontier Analysis (SFA) and panel data method the authors evaluated the cost efficiency of long-term support services (LTSS) provided by state Medicaid agencies and examined its association with intensity of HCBS use. Results indicate that increasing HCBS services targeted at “high need” population and developmentally disabled individuals would improve efficiency in LTSS delivery. The authors recommend that Medicaid agencies invest in the development of improved data sources for the estimation of cost efficiencies of their programs.

Home Care Research

Ken S. Ota, David S. Beutler, Richard D. Gerkin, Jessica L. Weiss, and Akil I. Loli. Physician-Directed Heart Failure Transitional Care Program: A Retrospective Case Review. J Clin Med Res.

2013 October; 5(5): 335-342. Published online 2013 August 5. doi: 10.4021/joc-mr1492w.

This is a retrospective review of 73 patients enrolled in our hospital-based, physician-directed Heart Failure Transitional Care Program (HFTCP). This study evaluated the 30- and 90-day readmission rates before and after enrollment in the program. The Transitionalist’s services focused on bedside consultation prior to hospital discharge, follow-up home visits within 72 hours of discharge, frequent follow-up phone calls, disease-specific education, outpatient intravenous diuretic therapy, and around-the-clock telephone access to the Transitionalist. The authors concluded that physician-implemented HFTCP reduced rehospitalization risk for patients enrolled in the program. This program may serve as a model to assist other hospital systems to reduce readmission rates of patients with HF.

Article of the Month

Quality of Care

Rachel M. Werner, MD, PhD. The effect of pay-for-performance in nursing homes: Evidence from state Medicaid program. Health Serv Res. Author manuscript; available in PMC 2013 August 1. Published in final edited form as: Published online 2013 February 10. doi: 10.1111/1475-6773.12035.

Pay-for-performance (P4P) is commonly used to improve health care quality in the United States and is expected to be frequently implemented under the Affordable Care Act. However, evidence supporting its use is mixed with few large-scale, rigorous evaluations of P4P. This study tests the effect of P4P on quality of care in a large-scale setting - the implementation of P4P for nursing homes by state Medicaid agencies. The authors concluded that Medicaid-based P4P in nursing homes did not result in consistent improvements in nursing home quality and expectations for improvement in nursing home care under P4P should be tempered.

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.

Welcome, New Members!

The Academy would like to welcome the following new members:

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Mark Alan Ward, MD

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Malon Devine, ARNP
Yosset Difo, FNP-BC
Rachel Spikes, FNP/MSN
Denis Stroker, RN

GEORGIA

Zachary Morris, RN
Jami M. Patti
Robin Pingeton, NP
Nichole Ross, MD

HAWAII

Gina I. Puen, APRN

ILLINOIS

Benjamin Guzman, MD
Michelle Jenkins
Lee Lindquist, MD, MPH
David O. Meltzer, MD, PhD

KENTUCKY

Gay Lawton, APRN, GNP
Bruce A. Snider, MD

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Russell Deluca, MD
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housecall providers

Leading the Way

Housecall Providers is a nationally recognized medical nonprofit practice in beautiful Portland, Oregon. Since 1995 we have dedicated ourselves to providing primary care to medically fragile homebound patients. Our patients, whose median age is 83, live in private homes, adult foster homes and assisted living facilities.



PHOTO: CATHY CHENEY

We are currently recruiting for the following positions:

Medical Director

The Medical Director shall be a licensed physician in the State of Oregon with a minimum of three years of clinical experience in geriatrics and/or hospice and palliative medicine, including medical home visits. Responsibilities include overseeing clinical quality as well as some direct patient care.

Nurse Practitioners or Physicians

Join our team of physicians, nurse practitioners and physician assistants who currently provide primary care to over 1,400 patients. Create your own work schedule and work independently. Clinicians meet weekly for discussion and in-service. Weekend call is shared, approximately once every 16 weeks. Supportive office staff includes care coordinators, RN's for transitions of care and a social worker. We have our own Medicare-certified hospice program.



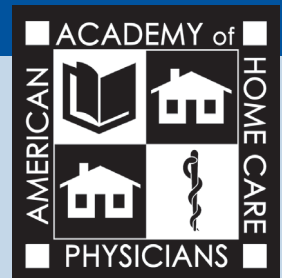
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plans and other community based providers of care.

This mandatory, material change to practice should also be used to review coding and claim compliance as well as compliance and best practices associated with (HIPAA) privacy and security requirements. This also brings up that the use of CPT for reporting of your professional services and outpatient procedures is not changing.

The practice setting for Academy members ranges from solo practice to multiple state practices to large academic medical settings. Understandably, the resources of your practice and what you have to do regarding ICD-10 implementation will vary with your setting.

CMS has excellent resources regarding the transition to ICD-10. These resources can be found at www.cms.gov/Medicare/Coding/ICD10/index.html and include Implementation Guides, Timelines, and Checklists. These are quite extensive and are even organized by size of practice. You will want to make use of this material to assess your preparation and assist in your implementation even if you do not make use of every element discussed. The CMS FAQs at www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10FAQs2013.pdf provides a good overview regarding ICD-10 implementation. We will also provide you with information about upcoming CMS calls and webinars about transition to ICD-10.

What are Concerns Regarding ICD-10 Implementation?

The fundamental concern about ICD-10 implementation relates to communication and documentation among parties that will be involved in your practice transition. Critical is the

concept of end to end testing – that is assuring that everything is in place and functioning properly along each point of the process of claim submission and acknowledgement.

Review of the CMS material noted above along with developing and implementing a practice specific transition plan as outlined below will contribute to your successful transition to ICD-10.

What to Do Now

Small and Medium Size Practices -

An effective one page time line covering planning, communications and training is available at www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10SmallMediumTimelineChart.pdf

Large Practices -

A transition checklist can be found at www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10LargePracticesChecklistTimeline.pdf.

The outline below summarizes these materials.

- Review ICD-10 resources available through CMS, your vendors, and the Academy.
- Create an ICD-10 project management team. Determine how ICD-10 will effect your practice. Develop a plan for making the transition to ICD-10.
- Review every place that ICD-9 is involved or documented in your practice and how ICD-10 will effect e.g., clinical documentation requirements and electronic health record (EHR) templates. Review and plan for each area that involves patient and caregiver interaction as well.
- Review your systems that support the medical record and revenue

cycle. Will existing systems support the implementation of ICD-10 or will changes or upgrades be required?

- Develop and secure transition budget. Plan for contingency cash flow should ICD-10 implementation effect any of the many transactions along your clinical and revenue cycle.
- Review contractual obligations regarding service and coverage of cost with vendors. MGMA survey response reflects that service and cost obligation for transition to ICD-10 remains an area of concern for about half of respondent practices.
- Ask vendors including practice management system vendor, EHR vendor, revenue cycle services, clearinghouses and payors about ICD-10 readiness, clarify financial responsibility as noted above and document these understandings.
- Develop a testing plan with each of your vendors above that outlines key dates and milestones for when testing should occur and be completed. Document and resolve any issues that arise.
- Monitor changes in documentation requirements that have been provided by CMS and vendors.
- Conduct training on ICD-10 with administrative and clinical staff. This is recommended about 6 months prior to implementation so as to avoid the need to retrain prior to October, 2014.
- Monitor and confirm vendor readiness, review practice preparedness and complete transition.

Please contact me at Gary.Swartz@aahcp.org and 410-676-7966 with any questions.

they were now restricted to the home and anything in walking distance. This was even restricted with a father who smoked with PAD and limits of medicine.

The world had become smaller for Mom. She was now in a one room apartment in an assisted living facility. She was safe and her routines made her more confident. She doesn't like having to go to the dining room and prefers resting in her bed. Eventually she will stay in bed. If she lives long enough, she will favor one area of her bed. My uncle suffered a progressive neurologic condition that left his body severely contracted and his weight reached a mere 80 pounds. His

world was the middle of the hospital bed.

Dad decided to fight to the end. He refused help unless it was a crisis. Multiple hospitalizations, CCU and ED visits over his last months. I counted 14 that I knew of in 8 weeks. He always left AMA. A call came in that he was in the ER with "flash pulmonary edema" again. It did not look good. I arrived "late". He was gone. He had chosen to do his life independently and never called to say he was in trouble.

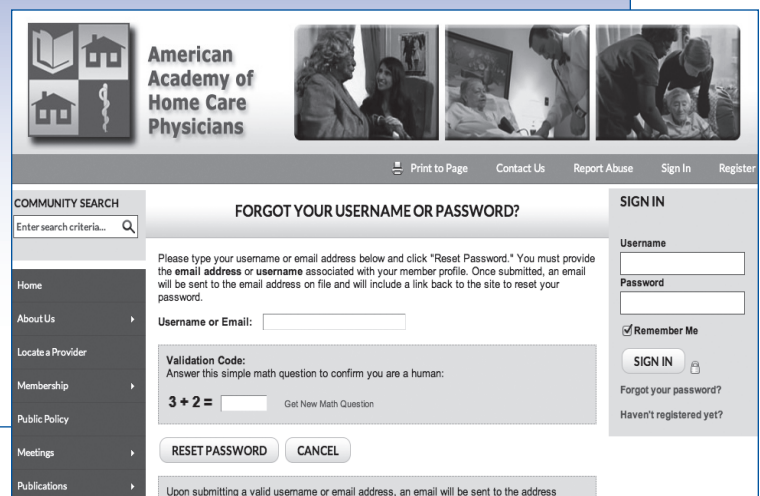
Our world starts small, grows into opportunities and hope but inevitably grows smaller if we live long enough.

Caring for those whose independence is threatened by illness and age, gives us the opportunity to help them hold onto some dignity. I have found one opportunity by providing care through hospice and house calls. There are other ways to provide this as well. We as providers need to be aware of the many assaults facing our elderly and disabled patients and provide in ways that are beyond medical care alone. Going and serving others gives more satisfaction to all involved than our other traditional methods of treatment.

If your world is still large enough, go to those whose worlds have become smaller.

AAHCP Website Updated - New Login Information!

The Academy, as some of you may know, underwent a change in site hosting on September 3rd. This was due to the purchase of the company that hosted the site by YourMembership®. With the site change your login information had to be updated. Your username will remain the same, however members now have a password of Password1. To reset your password go to our website at www.aahcp.org and click on the link under "New Website Password Reset" on the right-hand side of the home screen, or follow this link: https://aahcp.site-ym.com/general/email_pass.asp. If you encounter problems while trying to log into the website contact Audrey McDonough at 410-676-7966 or audrey.mcdonough@aaahcp.org for assistance.



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FFS remains the most efficient health insurance plan in the country, with 95% or more of every dollar being used to pay for healthcare, leaving less than 5% for administration. And this for a federal insurance plan that returns \$3.30 for every \$1 paid in by the patients receiving the care.

It is always perplexing to see one failed concept being chased by a successor methodology which builds on the mistakes made in the past. Medicare Advantage Plan was the new name for “managed care” when the public began to recognize it for what it was, and “managed care” was the new name given to “HMO” after Helen Hunt’s famous movie line (“F*** the HMO”) brought open applause in every theater in which her movie played.

Now we are to have “value-based purchasing” amidst the failure of the recent reported multi-million dollar demonstrations to show savings. Whether IT is called VBP, P4P or “bundled care,” the theory of designing healthcare payment policies around “value” has new cachet...as if it were to represent value to the patient instead of the payor.

Under the theory that the public is too dumb to value healthcare and needs a government agency or policy to define it, and hence, control payments for it, we are entering a new and accelerated conflict between insurance companies and providers. It hasn’t worked in clinical trials, and it won’t work in the future, because the precept that an unaccountable actuary can control the proper distribution of healthcare

dollars amidst the increasingly complex medical marketplace has never worked.

But we haven’t answered the question: why did the CMS demonstrations fail to show savings? Here we run into the business realities of which device, software manufacturers, and others should be aware. It has been known for years that in any payor-based community, whether Kaiser or Medicare or Wellcare, the top 10% most costly tranche of patients are responsible for 70% of the total cost of the population.

Unlike life insurance which has a hard endpoint for benefits distribution (death), medical care is infinitely variable in the ways patients can develop their multiple chronic disease and the infirmities that lead to their high-cost status. Today, even the payors with their refined data management systems sucking 20-25% of the healthcare dollar out of direct care, cannot reliably identify these patients prospectively.

The reality is that housecall providers will have to learn to live within a new and very different payment system over the next five years: instead of getting paid for housecalls, payment will be contracted in various shared risk contracts wherein the incentives to make more housecalls or use more in-home technologies may be higher (when ER visits are avoided) but non-existent when done for social reasons not backed by strict metrical accounting.

And therein lies the rub: none of us really knows what to measure to save costs, even though we remain convinced

(deservedly so) that we will know soon after we ring the doorbell. In the mobile care delivery model, bandwidth limitations make it quite difficult to passively record timed elements that might define efficiency; yet, it is currently impossible to define quality for the patients who deserve mobile care delivery so no standards exist to which “value” might be attached.

Without a value-added proposition other than the patient’s predictable satisfaction with NOT having to go out of the house for their care, housecall-payor contracting will have to go through some development pains.

That said, when board-certified housecall physicians armed with the right tools can replace a \$25,000 DRG for a patient who prefers being at home with a few \$150 housecalls, the potential to disintermediate the current payor-based downward spiral is quite exciting.

Catastrophic health insurance has never been expensive, and patients will soon self-insure the increased capacity we are developing through comprehensive housecalls. Imagine a monthly premium of a few hundred dollars (versus the current \$1,800/mo Kaiser premium for a healthy 60 year-old couple) that covers only the catastrophe coupled with out-of-pocket, inexpensive housecalls with pricing controlled by a free market.

The technology explosion will fuel the new delivery system and Big Data analytics will, for the first time, prove it is done well. It is a great time to be a mobile clinician.

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!

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.

2014 Membership Fees*

Physicians
Groups (MD, NP, PA or combination)
Associate (NPs, PAs, RNs)

\$195
Custom**
\$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

2014 Membership Application

Name: _____ Date: _____

Address: _____

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

Make checks payable to:

American Academy of Home Care Physicians
P.O. Box 1037 • Edgewood, MD 21040-0337
Phone: (410) 676-7966 • Fax: (410) 676-7980
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Please state your area of expertise or specialty: _____