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PRESIDENT'S MESSAGE

Member Action—See the Results

By Eric De Jonge, MD

I want to highlight the remarkable impact of action by AAHCM members. By the end of this column, I hope you will decide to make an even greater difference by getting more involved with the Academy.

Every day, we serve very ill and disabled patients in their own homes, which takes courage, teamwork, and complex clinical skills. We bring dignity and compassion to people who are gravely ill and struggling to get the help they need, making a huge difference at a personal level.

AAHCM is your vehicle for making a difference for your patients and practice at a local and national level. Here are a few examples:

- Payment Reform: A total of 25 Academy members serve on our policy steering committee and our regulatory, legislative, and payment model design work groups. This year, the group co-chairs and members are working on a new advanced payment model for monthly PMPM payments to home care medicine practices, improved E/M codes, rights of nurse practitioners to sign home health care certifications, a more rational durable medical equipment process, and extension of the Independence at Home demonstration.
- Annual Meeting: 10 Academy members, led by co-chairs Dr. Kris Smith and Alex Binder, have spent the past 7 months creating a superb program for the Annual Meeting being held October 25–27 in Chicago, IL. This includes an informative 1-day preconference from the Home Centered Care Institute and many educational sessions to support us in advancing our mission. Attendees will have a chance to present, speak up, and ask questions of colleagues from across the country.
- Awards: We have national awards for clinicians, teachers, physicians, investigators, and lifetime achievement. Recognize the outstanding service of a deserving colleague by nominating them for an award.
- Strategy: Dr. Bruce Leff recently led a task force of seven Academy members to ensure that, in addition to our public policy work, we fulfill the two other top priorities of leadership development and serve as an ethical/moral compass for the field.
- Board of Directors: In June, 19 people were nominated for five open AAHCM Board positions. The nominations committee, chaired by Dr. Theresa Soriano, chose seven finalists for the election ballot. All seven members generously offered their service to guide the direction of our field.
- Membership: Six Academy members, led by Aaron Yao from the University of Virginia, are working to revise the definition and pricing of AAHCM membership to adapt to changes in provider size, global interest, and the interdisciplinary nature of our field.

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AAHCM empowers you to serve patients who need health care in their homes through public advocacy, clinical education, practice management support, and connections to a network of hundreds of professionals in home care medicine.

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VA PERSPECTIVES

NPs and MDs in Home-Based Primary Care: Working (Better) Together

By Robert M. Kaiser, MD MHSc FACP AGSF, Medical Director, Home Based Primary Care Program, Washington, D.C. Veterans Affairs Medical Center; Associate Professor of Medicine, Division of Geriatrics and Palliative Medicine, The George Washington University School of Medicine

Nurse practitioners (NPs) and physicians have worked in productive collaborative relationships in the Veterans Affairs (VA) Home Based Primary Care (HBPC) program for many decades. The Veterans Health Administration first began incorporating nurse practitioners into key clinical roles in the early 1970s, shortly after the HBPC program was started in 1969 (U.S. Department of Veterans Affairs, n.d.), and this partnership continues to succeed. It would be worthwhile to consider the reasons for such longstanding success and how it might be sustained in a clinical universe where NPs are gaining more autonomy and independence and have less need to rely on physicians.

I argue that NPs and physicians are not mutually exclusive or redundant but instead are essential and synergistic to each other when it comes to caring for veterans in the VA HBPC program.

In the past year, the Veterans Health Administration has initiated a new national policy that authorizes NPs to be independent practitioners throughout its health system. In the private sector, NPs also have achieved more authority. In addition to being able to prescribe all medications (including scheduled drugs that require a Drug Enforcement Administration license), NPs can sign do-not-resuscitate orders as well as Medicare and Medicaid Home Health orders in many jurisdictions in the United States.

Within the VA HBPC program—which frequently, but not always, falls administratively under geriatrics and extended care—NPs function independently. Their notes, medication orders, and consultation requests do not require a physician co-signature. However, their relationships with physicians are nonetheless complementary. Physicians serve as clinical mentors and consultants as well as crucial links to inpatient teams and outside physician practices. They can be sounding boards for daily clinical decision making in medically complex cases. They are a consistent presence during monthly interdisciplinary team meetings about patients, where they serve as a helpful resource in reviewing current problems, establishing goals, and crafting care plans. They serve as a critical link to outside clinics and hospitals as well as within the VA Health System when practitioners are difficult to reach and critical medical information is needed expeditiously but may not be immediately forthcoming.

The VA has long fostered a strong, healthy, interdisciplinary clinical culture and has led the nation in emphasizing team-based care. When I first joined the Philadelphia VA Medical Center as a general internist in 1993, I worked side-by-side with NPs in the general internal medicine clinic. I also was involved in training and mentoring NP students from the University of Pennsylvania and LaSalle University, who rotated

through our clinic and later joined our staff. These were daily, constructive, and amiable interactions, characterized by gentle guidance, not authoritarian oversight. Our clinical lives were professionally linked in valuable and productive ways.

These professional alliances continued when I joined the HBPC program as medical director in 2003, after completing a mid-career geriatric medicine fellowship. When I first arrived, NPs (as well as registered nurses and other HBPC professionals) were critical in orienting and familiarizing me with this new clinical setting. They were my mentors, teaching a relative neophyte about how to most effectively work together to care for vulnerable, homebound older adults. They instructed me in putting together a system of care, designing and implementing care plans, reassuring caregivers, and working with patients sensitively and respectfully in their own homes. I brought newly acquired geriatric expertise to the table and they brought clinical wisdom and familiarity with the health system. We believed that our professional success was dependent on our close connections with each other.

There are numerous examples that illustrate the benefits of my working in tandem with NPs to achieve better clinical outcomes including

- communicating with a VA emergency room physician and hospital cardiologist to speed the evaluation and admission of a patient for urgent pacemaker placement after being informed by an NP of a markedly abnormal Holter result
- speaking with an admissions director of an assisted living facility about a veteran's pending application, filed by an NP, to allay concerns about why sporadic, abnormal behaviors should not preclude his admission
- consultation in real time with an NP regarding a patient with amyotrophic lateral sclerosis who was experiencing recurrent, unexplained fevers after multiple courses of antibiotics
- reassuring an NP, after learning that her patient had a rare diagnosis, that she could defer to the hematology specialist and need not know about every aspect of the disease.

This list could be considerably longer and fill several pages.

Caring for homebound patients is particularly complicated in a health system that remains fragmented and in which communication can be difficult. Physicians can help navigate this unduly convoluted, seemingly impenetrable system in order to succeed in making it work better for patients when NPs, who are invariably busy working in the field, may not always have the time to do so. Physicians also have extensive training and well-developed skills in treating patients with multiple co-morbidities and clinical complexity. This breadth can be easily drawn upon by nurse practitioners working in conjunction with physicians within the structure of VA HBPC to solve clinical problems. Such a powerful collaboration should be seen as positive and worth continuing into the future.

The views expressed in this article are those of the author and have not been endorsed by the Department of Veterans Affairs or the American Academy of Home Care Medicine.

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CLINICAL PEARLS

Muscle to Mend: Nutrition and Pressure Injury Prevention and Healing

By Michele Severson, MS RD

Patients enrolled in home-based primary care often have chronic medical conditions that put them at risk for developing pressure injuries or complicate the healing process. The optimization of a patient's nutrient intake is a crucial component to pressure injury prevention and healing, but in cases of malnutrition with associated inflammation or a significant loss of lean body mass (LBM), the positive impact of nutrition intervention may be diminished or eliminated. A registered dietitian nutritionist (RDN) may be key to supporting the optimization of nutrition intake and status, while the home-based primary care team addresses the medical interventions to support wound healing and improvement in skin integrity.

This article will discuss malnutrition, inflammation, and loss of LBM in relation to pressure injury prevention and healing and review dietary protein requirements and protein quality.

Malnutrition, Inflammation, and Lean Body Mass

Malnutrition can be defined as "a subacute or chronic state of nutrition in which a combination of varying degrees of over- or under-nutrition and inflammatory activity have led to a change in body composition and diminished function" (Soeters et al., 2008). A recent *Frontiers* article, "Malnutrition: Diagnosis and Intervention in Home-Based Primary Care Visits," provided a framework for identifying malnutrition and listed several tools for screening and diagnosing (Severson, 2017). Inflammation increasingly is understood to be a critical factor in the development of malnutrition because it is associated with a catabolic and hypermetabolic state (White et al., 2012) "coupled with anorexia and pathologically altered utilization of nutrients" (Litchford, Dorner, & Posthauer, 2014). Even when nutrient intake provides optimal calories and protein, active

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Muscle to Mend: Nutrition and Pressure Injury Prevention and Healing

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inflammation from acute or chronic conditions may still compromise LBM (Jensen, Bistrian, Roubenoff, & Heimburger, 2009). It is necessary to identify the underlying source of the inflammation and attempt to address the cause in order to promote maximum benefit from the nutrition intervention.

LBM comprises all the protein content in the body. LBM is highly metabolic: protein is involved in myriad activities including those that support cell structure and function, immune function, and tissue repair. In healthy adults, the body prioritizes the preservation of LBM through homeostatic processes that promote anabolism and prevent catabolism (Demling, 2009).

Loss of LBM negatively impacts clinical status and may exacerbate clinical conditions, leading to impaired immunity, decreased healing, thinning of the skin, and pressure injury development. Wound healing is directly related to the degree of LBM loss and restoration (Demling, 2009). LBM loss of less than 20% allows the body to prioritize wound healing over LBM restoration and maintenance. With a loss of approximately 20% of LBM, the body prioritizes wound healing and LBM restoration and maintenance equally, thereby slowing wound healing. Any loss of 30% or more of LBM causes the body to shift priority to restoration of LBM over wound healing, thereby preventing healing (Demling, 2009).

A Word on Body Composition and Weight

There are a variety of methods that can be used in the home to measure body composition. Simple methods include measurements of waist, mid-arm, and calf circumference. A nutrition-focused physical exam by a trained clinician can characterize muscle mass loss and subcutaneous fat loss as mild, moderate, or severe as part of an evaluation for malnutrition utilizing the Academy of Nutrition and Dietetics (the Academy) and American Society for Parenteral and Enteral Nutrition (ASPEN)'s Malnutrition Diagnosis Guide (White et al., 2012). In addition, serial weight measurements are simple methods for monitoring status over time. Standardized guidelines for determining if weight loss over a given time period is significant are also outlined in the Academy/ASPEN Malnutrition Diagnosis Guide. Loss of LBM inevitably accompanies unintentional weight loss, although the exact loss of LBM cannot be quantified.

Protein, Protein, and More Protein

Nutrition recommendations to support wound healing often include increased intakes of protein. However, overall caloric intakes also must be adequate to support the hypermetabolic state that occurs with illness and pressure injury development. If overall caloric intake is inadequate, the body will not prioritize protein intakes toward wound healing or LBM restoration.

A second consideration is the distribution of protein intake throughout the day. Current research supports serving a moderate amount of high-quality protein ideally at three meals per day to promote optimal skeletal muscle protein synthesis (Paddon-Jones & Rasmussen, 2009). Consulting with the RDN can help determine the patient's optimal protein requirements while considering laboratory data and other medical conditions; a general guideline of 1.2–1.5 grams of protein intake per kilogram of body weight per day is recommended (Niedert & Dorner, 2004).

Finally, protein quality also should be considered. High-quality protein sources contain higher levels of essential amino acids (EAAs). EAAs cannot be synthesized by the body and must be consumed in the diet. Consuming foods containing high-quality proteins and limiting or avoiding highly processed foods will support optimal protein utilization and provide the required EAAs.

Home-Based Primary Care (HBPC) Interdisciplinary Team

Pressure injury prevention and healing can be complex and compounded by malnutrition, inflammation, and changes in body composition. An RDN can work with at-risk patients or those who have pressure injuries to conduct a thorough nutrition evaluation, including screening and assessing for malnutrition, and implement a thorough nutrition care plan in collaboration with the HBPC multidisciplinary team. The collaborative effort of the HBPC team versed in pressure injury prevention and treatment modalities can have a positive impact on promoting healing and improving or maintaining skin integrity.

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Medication Two-Box System for Medication Optimization in VA Home-Based Primary Care (HBPC)

By Nina Ferguson, MD; Cristina Byrd, PharmD GEC/HBPC; James A. Haley, VA Hospital, Tampa, FL

It is widely believed that medication reconciliation can reduce adverse drug reactions. However, according to the Agency for Healthcare Research and Quality, there is a lack of evidence to support that belief. Part of the issue is that accurate medication reconciliation strategies have been a challenge. In an effort to optimize patient safety and comply with Medication Reconciliation guidelines recommended by the Joint Commission's National Patient Safety Goal #3 (Improving the Safety of Using Medications Standards), a Tampa-based VA HBPC interdisciplinary team used focus groups and patient surveys to generate the medication two-box system. The primary goal was to optimize medication use among HBPC patients while maximizing patient health benefits. The secondary goals were to improve the medication reconciliation process and reduce polypharmacy in HBPC patients.

The project team comprised PharmD, MD, NP, PA, LPN, KT, and RD. They used a Lean Six Sigma approach to analyze medication reconciliation processes and issued a randomized patient survey on medication satisfaction. The team identified medication reconciliation barriers, leading to the creation of the medication two-box system, the implementation of medication management grand rounds, and the improvement of electronic templates. The two-box system used only two clear plastic shoeboxes: one labeled in green with "medications currently in use" and another labeled in red with "medications NOT used in the past 3 months. Please call your provider for use." Written and verbal instructions were given to the Tampa HBPC program and boxes were provided. A Microsoft Excel spreadsheet was created for the providers to enter patient information, dates, and feedback. Data on medication from June 2014-2015 were collected for comparison to 2013 data. Inclusion criteria consisted of the patient currently being admitted in the HBPC program, living in a home setting (not in a facility that manages the medications), and agreeing to use the system. Forty-nine of 370 Tampa VA HBPC patients were identified as eligible by their providers. Of these patients, 31 accepted the two-box system; an additional nine patients agreed after changing the boxes to large clear zip-lock bags. This change was implemented in response to patient feedback and preferences. Random sampling of HBPC patients revealed that Tampa HBPC patients take 20 medications on average, including prescriptions, supplies, and over-the-counter (OTC) medications within the home, whether they are actively used or not. The red boxes yielded a minimum of two medications removed from the medication profile for each patient, translating to a ten percent reduction in known medications. However, patients also revealed previously unreported medications for addition to the red box.

The medication two-box system was accepted by 82% of eligible patients. Patients suggested using bags instead of boxes, which increased participation by 29%. HBPC staff reported that the system worked best in patients who were fearful of stopping medications, had duplicate medication bottles, or had multiple cluttered areas of medications. For example, Mr. N., a patient in the study, was fearful of stopping his narcotic and the two-box system helped him feel more comfortable. In addition to pill counts, the red box was taped all the way around to allow for improved detection of medication use. Mr. C. was found to have the medication error of duplicate medications; he was taking both gabapentin and pregabalin, which was causing fatigue and falls. The two-box system helped prevent the duplication and made him feel safe. Mr. H. was noncompliant with his medications and had multiple medications scattered in various areas of his home. He had combined bottles of different medications that he thought were the same. The HBPC team and he appreciated the two-box system. Over time, he became comfortable removing unused medications, which allowed him to remain independent in the ability to self-administer his medications successfully.

Benefits of the two-box system include high participant satisfaction and improved accuracy and efficiency of medication reconciliation. Unfortunately, polypharmacy was not reduced significantly. The number of known medications on the medication profile was reduced, although there was no reduction in overall medications. Patients did stop taking medications, but the amount was over shadowed by the number of newly reported OTC medications. The implementation of the medication two-box system could benefit patients and home health programs by saving time in medication reconciliation processes after initial set up, improving accuracy in medication reconciliation, and helping resistant patients reduce use of difficult to stop medications.

Code of Ethics Versus Cultural Competence

By Katherine Lawson, PhD LMSSW OTR

I always have been fascinated by the concept of ethics and how each medical professional defines his or her standards of practice based on the profession's established codes. As an occupational therapist, I define ethics as a set of moral principles based on established values and judgments that I consider when making clinical decisions. My professional code of practice ensures I uphold my professional behavior, responsibility, practice, and decision making. For the purposes of this article, I will reference the code of ethics from the American Occupational Therapy Association (AOTA; American Occupational Therapy Association, 2015) and then provide a case study. The purpose of this case study is to demonstrate an interdisciplinary resolution to an ethical conflict.

AOTA follows seven core values: **altruism**, demonstrating concern for the welfare of others; **equality**, treating all people impartially and free of bias; **freedom**, the process of integrating the values and desires of the client into our intervention; **justice**, the process of inclusiveness by which diverse communities are inclusive, organized, and structured such that all members can function, flourish, and live a satisfactory life; **dignity**, treating patients with respect in all interactions; **truth**, providing accurate information in oral, written, and electronic forms; and **prudence**, the process of using our clinical and ethical reasoning skills, sound judgment, and reflection to make decisions in professional and volunteer roles (AOTA, 2015).

Case Study

During an interdisciplinary meeting, the case manager wanted to discuss a patient who was referred to our program because of non-compliance with his diabetes management. The patient was a 76-year-old Hispanic male who was low income, had an elementary-level education, and was married. The case manager was unsure how to achieve her goal of medication and meal compliance with the patient considering his history of high blood sugar levels, progressive weight gain, increased dependence when performing his activities of daily living, weakness, and debility. In fact, his latest blood work indicated he was in renal failure. Using an interdisciplinary approach to the patient's care, each professional provided insight into what they felt needed to be addressed and how we could intervene collectively.

As an occupational therapist, I discussed how I would take into consideration the patient's cultural upbringing and education level to identify his values and desires for a treatment plan. I wanted to be able to evaluate how functional the patient was and why dependency had increased. In addition, I wanted to work with the patient to return him to an independent level of functioning by ordering home health occupational and physical therapies to address his overall debility and weakness. Of course, this goal would not be achievable unless the patient understood the urgency of the intervention and ultimately wanted to contribute to and participate in his plan of care.

To the disbelief of participants in this meeting, one team member prefaced her intervention plan by stating: "What do you expect from a patient with a Hispanic mentality?" She then stated that she "did not have confidence that the patient would ever get better and that he would never comprehend any intervention from the team."

I remember each team member's face and the total silence after hearing her statements. Her lack of empathy and acceptance floored all of us and seemed to fuel our determination to develop an effective treatment plan for this patient.

The second team member to present was the dietitian. The dietitian discussed his plan for a home visit to review the patient's food intake, discuss how meals were to be prepared, and design a meal plan the patient and his spouse could easily work with. The pharmacist planned to review all of the patient's medications and explain the importance of adherence with both him and his spouse. In addition, the pharmacist would be working directly with a home health nurse who would see the patient twice weekly for diabetes education. The nurse practitioner stated she would perform a physical examination of the patient and review the medications with the pharmacist and case manager to make any needed changes. She would also refer the patient to a nephrologist to further assess his new-onset kidney failure. The nurse practitioner would oversee each of the other team members and would closely follow the patient's progress with input from the case manager. Each professional on the interdisciplinary team came together as one to develop a comprehensive and successful plan of care that we felt would meet all of the patient's needs.

This case study displays how quickly our code of ethics can be ignored or upended when someone is not culturally competent. It represented stereotypical biases and demonstrated how cultural incompetence can lead to nonacceptance of differences among people. In addition, this entire interaction opened my eyes to how "professionals" give short shrift to cultural empathy and sensitivity. We may say we understand our code of ethics, but we must demonstrate through our actions that we truly stand by these codes.

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Closing the Health Literacy Gap with Teach-Back

By Helen Horvath, MS ANP-BC RN PHN

Health literacy is commonly understood as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health care decisions" (Institute of Medicine, 2004). Limited health literacy has been associated with myriad negative health outcomes. When compared to people with higher health literacy, people with lower health literacy have poorer quality of life, worse overall health status, and increased mortality (Berkman et al., 2011). The definition of health literacy continues to evolve, and now attention has turned to the role of the healthcare system in providing information in a way that is understandable and usable to clients (Rudd, 2015). The concept of low health literacy can be more broadly understood as a mismatch between the health information presented by professionals and the capacity of patients to use it.

The 2003 National Assessment of Adult Literacy (NAAL), the most recent large-scale study that included those older than 65 years, evaluated overall literacy as well as health literacy. The NAAL found that low health literacy is common, with about half of the U.S. adult population characterized as having limited health literacy skills and only 3% of those older than 65 characterized as "proficient." Members of disadvantaged groups, including people with less education, public or no insurance, and poor health; non-native English speakers; older people; and members of racial and ethnic minority groups were found to be more likely to have limited health literacy (Kutner, Greenberg, Jin, & Paulsen, 2006; Rudd, 2007, 2017). Studies also have found that clinicians frequently overestimate the literacy of their patients (Bass, Wilson, Griffith, & Barnett, 2002; Dickens, Lambert, Cromwell, & Piano, 2013; Kelly & Haidet, 2007).

Given the prevalence of the mismatch between health messages and the capabilities of patients to use them, health consequences, and the role of health professionals, it is incumbent on health professionals to examine and improve communication with patients. The Agency for Healthcare Research and Quality (AHRQ) and others recommend a "universal precautions" approach to health literacy in the clinical setting (Brega et al., 2015; Paasche-Orlow, Schillinger, Greene, & Wagner, 2006). This means communicating in a way that everyone can understand and confirming comprehension with all patients, regardless of their perceived level of literacy.

The AHRQ's Health Literacy Universal Precautions Toolkit provides strategies to improve communication and conduct structured quality improvement efforts. One technique that is effective regardless of the patient's literacy level is the "teach-back" method. Teach-back, or asking the patient to repeat in their own words back to the clinician what was communicated, is a way of "closing the loop" to ensure that professionals have shared information in a way that is meaningful and useful for the patient. The Always Use Teach-Back! Training Toolkit, an online package of resources for implementing teach-back, includes these steps in the teach-back process:

- Ask the patient to explain back, using their own words.
- Use non-shaming, open-ended questions.
- Avoid asking questions that can be answered with a simple yes or no.
- Emphasize that the responsibility to explain clearly is on you, the provider.

It is important to set up teach-back so that patients do not perceive it to be a quiz. Asking permission to use teach-back and framing the discussion as an assessment of the clinician's success in presenting the information, rather than as a test of the patient, can help to ensure it is well-received (Brega et al., 2015). Although many clinicians may know about this technique and intend to use it, they might not employ it as often as they could in actual practice. One study of primary care clinicians caring for patients with diabetes found that they checked for patient understanding and recall in only one of five visits and for fewer than one of eight new concepts (Schillinger et al., 2003).

Busy clinicians will be happy to know that improving health communication does not fall solely on their shoulders. The U.S. Department of Health and Human Services' Action Plan to Improve Health Literacy includes a wide range of systems-level and societal goals. Under the goal identified as "promote changes in the health care delivery system that improve health information, communication, informed decision making, and access to health services," one recognized area of deficiency is "insufficient time and incentives for patient education" (U.S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion, 2010). Resolving the mismatch in health communication will require multi-level advocacy and interventions, including patient-centered structural changes such as allowing sufficient time for meaningful communication during the health care visit. As health professionals, we can start by aiming for universal teach-back to confirm comprehension.

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Join Us for the
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2018 AAHCM Annual Meeting

October 25–27 | Loews Chicago O'Hare | Rosemont, IL

Top 10 Reasons to Attend the 2018 AAHCM Annual Meeting

10. Enjoy a beautiful fall weekend in the great city of Chicago.

9. See how we all are "Driving the Change to Value-Based Care."

8. Attend the superb preconference by HCCI, "Care of the Complex Patient in the Home: Staying Ahead of the Curve," with clinical and practice management sessions.

7. Learn about the "Home Care Medicine Landscape" in the address by Dr. Bruce Leff of JoŸs Hopkins.

6. Attend the keynote address by Dr. Patrick Conway, former head of Center for Medicare and Medicaid Innovation (CMMI), now CEO of North Carolina Blue Cross/Blue Shield.

5. Attend the keynote address by Dr. Cheryl Phillips, past-president of AGS and AMDA, and national leader in care of Medicare/Medicaid populations.

4. Gain understanding of approaches to urgent and acute care at home.

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As of August 15, 2018

President's Message *continued from page 1*

- Public Service: Two close colleagues of AAHCM, Adam Boehler from Landmark Health and Gary Bacher from the Healthsperien policy group, recently took leadership positions at the Centers for Medicare and Medicaid Services. They chose public service, at personal sacrifice, to pursue a vision of improving Medicare and Medicaid. They have a special interest in value-based payment models for our patients.
- New Leaders: AAHCM is supporting a new generation of leaders who are growing creative programs in the nonprofit, academic, and private business worlds. In New York, Dr. Linda DeCherrie and her team are building a new service line called Mount Sinai at Home to expand home-based medical care across the city. In Baltimore, Dr. Mattan Schuchman has organized a collaborative of regional house call providers to gather and share best practices. Teams at Centene, Landmark Health, and Aspire Health are all growing successful, large home care medicine businesses and bringing hundreds of new providers into the field.

The list of ways to get involved could go on and on! Please know that your involvement with AAHCM helps to build the foundation for our field. Brent Feorene, our executive director, the board, and I encourage all members to volunteer any way you can. Please contact Brent directly at bfeorene@aahcm.org to help us build a stronger AAHCM.

I look forward to seeing you in Chicago for the Annual Meeting. Please feel free to email me with any questions or feedback at karl.e.dejonge@medstar.net.

Closing the Health Literacy Gap with Teach-Back *continued from page 7*

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Welcome, New Members

The Academy welcomes the following new members, who joined between May 1, 2018, and August 1, 2018.

Arizona
Ricky Mack
Piyush Gupta

California
Sophia Chang, MD

Florida
Carrie Baker, MD
Michelle Bandurka
Pamela Couture
Shabnam Fard
Lashaniqua Hamilton
Christopher Howard
Ivy McQuirter
Radu Mercea
Austin Moody, MD
Ashley Rukeyser
Peri Sard, MD
Susan Wolfe

Illinois
Angel White

Indiana
John Lopshire, MD
Korissa Thomason
Morgan E. Woods, MD

Michigan
Badawi Abdellatif
Joji Alex
Lana Bretz
Kinda Hayek
Janet Jones
Vida Klott
William Mangan
Marie Mateo
Edgar Pou
Bridget Ross
Aleisha Rosso
Raafat Shehata, MD
Michael Smith
Karen Thornburg, MD
Kenneth Tobin, DO
Kirk Wojno, MD

Montana
Lisa Grasing, DO
Bernard Miller
Cathy Sellers

New York
Jean Louis Max Dupiton
Goldy Pascal

Ohio
Terri Andrews
Douglas Eppley
Mihaela Iovi, MD
Mark Kimborowicz, MD
Muyuam Ma, MD
Grace Maina
Susan McElroy-Marcus
Fallan Pryor
Jenna Speziale

Pennsylvania
Christopher Hwang

Tennessee
Paul Miranda

Texas
Krystal Alvarado
Louisa Asare
William Dobie, MD
Tambra Guinn
Jessica Marshall-Moreno
Kathleen McCoy
Emily Sard
Rosaria Taimouri

Virginia
Tia Barr
Brian Gruber, MD
Sara Gunnink, MD
Gernita Lee

Washington
Anne Gitchel
Carolyne Kitur
James Rice

Wisconsin
Muhammad Asad Khan
Rose Vidmar

Myanmar
Aung Pyi Soe

Saudi Arabia
Sultan Alamri

Taiwan
Chih-Yuan Shih

AAHCM
AMERICAN ACADEMY OF HOME CARE MEDICINE

Are You Passionate About Improving the Care of Patients in the Home?

Join AAHCM and make home-based primary care a reality for all in need.

Since 1984, AAHCM has been the premier professional association for healthcare professionals who deliver or manage comprehensive primary care services to patients in the home by removing barriers, setting standards, providing education, facilitating networking opportunities, and fostering the development of legislation to facilitate growth.

Home care medicine is one of the most rapidly expanding areas of health care.

These changes are occurring because

- changing demographics demand a responsive healthcare system
- technology is becoming more portable
- home care medicine is a cost-effective and compassionate form of health care
- most people prefer being treated at home.

Who should join?

AAHCM represents all members of the interdisciplinary home care medicine team, including

- Physicians
- Medical Directors
- Nurse Practitioners
- Physician Assistants
- Nurses
- Social Workers
- Practice Administrators
- Residents/Students
- VA Professionals
- Home Care Agencies

Member Benefits

- Public policy representation, revenue-related regulations, and legislative representation such as IAH
- Members-only discounts on Annual Meeting registration, publications, and webinars
- All-new Career Center (members receive one free 90-day posting)
- Newly updated educational booklets
- Information on clinical, administrative, regulatory, and technology issues, and academic literature through *Frontiers* and the e-newsletter
- Consulting and networking through our members-only AAHCM Member Forum
- For house call providers, listing in our online Provider Locator Directory

2018 Membership Fees*

Physicians	$260	Practice Administrators/Medical Directors	$205
Physicians Outside the United States	$265	Associates (RNs, Social Workers)	$125
Nurse Practitioners/Physician Assistants	$210	Residents/Students	$75

*Group memberships are available with special pricing! Contact Member Services at 847.375.4719 or info@aahcm.org for more information. Price subject to change.

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