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PRESIDENT'S MESSAGE

What Is Possible in 2019?

By Eric De Jonge, MD

One year ago, on a weekday morning at 8 am, we received a call that Sister M. had acute abdominal pain. She was an 87-year-old retired nun with right-side congestive heart failure (CHF), rheumatic heart disease, cirrhosis with ascites, atrial fibrillation, colon cancer, severe degenerative joint disease, kyphosis, chronic gastrointestinal bleeds, and anemia. In short, she was a typical housecall patient with extreme frailty. She had devoted, 24/7 care from other nuns in the convent. Her goals of care were palliative: to treat reversible issues and keep her at home if possible. She said, "I would rather go to heaven than the hospital."

What home-based medical care options does Sister M. have? What is her prognosis? How can such home-based medical care be financially viable?

What is possible in home-based medical care?

The first decision is whether to make a home visit or go to the emergency room. This varies based on the time of day, services and staff available, and goals of care. We talked with the chief nun and decided on a same-day house call.

The initial exam found Sister M.'s temperature of 103.5, blood pressure of 85/50, pulse of 130, and a fast respiratory rate of 35. She was drowsy, uncomfortable, and in pain. She was able to say, "I want to stay at home." Her abdomen was distended and had substantial, diffuse tenderness. Her mouth was dry but she could take sips of liquids.

Based on these signs, she was eligible for an intensive care bed in our hospital. Given her wish to stay, and if so ordained, to die at home, we decided to treat reversible symptoms, enroll her in home hospice, and make daily visits. After a 2-hour visit, we began oral hydration and broad antibiotics, same-day delivery of morphine, took a home Xray, and large doses of TLC and prayer from the convent team.

What is her prognosis?

We usually are wrong on this score. I have learned the hard way to avoid making predictions and instead focus on daily goals of care. Especially in cases with devoted caregivers, we can exaggerate the benefits of the hospital and underestimate the benefits of loving and skilled care in a patient's home. In my own mind, though, I thought she had a few days or a week to live.

How can such home-based medical care be financially viable?

In a fee-for-service world, one would need to spend much time and effort on documenting and billing every conceivable activity performed for Sister M. This includes codes for high-level E/M, prolonged visits, advance care planning, care plan oversight for hospice, and perhaps the new 99358 code for indirect services. It also helps if you see several nuns in the same convent to attain the efficiency of a "group home" or assisted living facility setting.

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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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In the value-based payment world, you could receive a high fixed, monthly fee, per member per month (PMPM) for such patients. And you'd need to track the lower hospital admission rate and total costs of your panel. With such data, you could receive a performance bonus from payors such as Medicare Advantage plans or a BlueCross Blue-Shield plan like the one run by Patrick Conway in North Carolina. Accountable Care Organizations and Medicare Advantage payors could reward you for Telehealth monitoring or offer higher reimbursement for intensive home medical services. You might even document your superb clinical outcomes and patient experience with the national registry developed by Drs. Bruce Leff and Christine Ritchie for home care medicine.

What is the role for AAHCM?

In 2019, the AAHCM will focus on priorities that support quality care and financial rewards for the care-at-home of people like Sister M. This includes intensive policy efforts with Centers for Medicare and Medicaid Services (CMS) for payment reform, developing the new leaders program with networking and training options, and holding up ethical standards for our field.

Specifically in payment reform, this will include an advanced payment model with CMS to include monthly PMPM payments, improved E/M codes, rights of nurse practitioners to sign home health care certifications, a simpler durable medical equipment process, and successful completion of a Independence at Home demo years 6 and 7.

And what of Sister M.?

Through medical, and perhaps divine, intervention, she had good year in 2018. Sister M. recovered enough to resume walking, eating, and singing hymns with her colleagues. Last week, 12 months later, we found her very ill with acute right-side CHF and massive ascites. We will monitor her closely and again do what we can to help care for her.

Please send your ideas or questions to Brent Feorene at bfeorene@aaahcm.org or me at karl.e.dejonge@medstar.net. And save the date for the AAHCM meeting in Chicago on October 17–19, 2019!

**2018 INDUSTRY RELATIONS
COUNCIL PROFILES**

In 2017, AAHCM launched the IRC, a group of key industry supporters who provide goods and services in the home-based medical care setting and share a common goal of advancing the care of patients in that setting. They provide resources, both financial and educational, to help the Academy meet its mission.

Learn more about the organizations supporting this program in this issue and at www.aaahcm.org/IRC.



Landmark



Home-Based Primary Care and the Meaning of Public Service

By Robert M. Kaiser, MD MHSc FACP AGSF

“Ask not what your country can do for you—ask what you can do for your country.”

—President John F. Kennedy

We live in a time when government service is undervalued and underestimated.

This logically leads to the following question: What is the fundamental value of what we do, and what impact does it really have?

John F. Kennedy—navy veteran, congressman, senator, and president—issued his famous call to service at his inauguration in January 1961. His idealistic words still ring true 58 years later. He challenged our citizens to summon the best within us—to offer of ourselves to help other human beings—here at home and around the world (Kennedy, 1961).

All those who work in VA home based primary care (HBPC) are privileged to care for veterans who have selflessly served the nation. These individuals go out into the community and care for the most vulnerable among us. This is no small task. They are the personification of what it means to be public servants, employing their expertise to make life better for others—to do good and to make a difference every day.

The value of clinical care typically is measured (and justified) in quantitative terms. By any yardstick, the accomplishments of HBPC are impressive. It is national in scope—spanning urban, suburban, and rural regions—with 436 programs serving 59,000 veterans (Kaiser, 2018). It is interdisciplinary, with a large, comprehensive team of professionals in nursing, medicine, nutrition, mental health, pharmacy, physical therapy, and social work collaboratively engaged in the care of complex patients. It provides access to care, at minimal individual expense, to those who need it most (Beales & Edes, 2009). It reduces costs and improves outcomes, resulting in millions of dollars of savings for the healthcare system (Edes et al., 2014).

What the HBPC program qualitatively does also maybe tremendously significant—perhaps most significant—though it is not easily measured.

When someone from HBPC enters the home of a patient and family to care for them, he or she enters a unique universe. A personal connection is made, which leads to a deep understanding of who they are, their struggles and aspirations, and how they live their daily lives. The goals are many: to stabilize chronic medical conditions, alleviate psychological stress, strengthen social support, decrease the burden of caregivers, and improve function and quality of life. HBPC makes a fundamental commitment to be present. Being present means listening, helping, and giving. It is the ultimate act of generosity.

The worth of what we do can be seen in the consequential connections we make and the individual impact we have. This is the real meaning of public service.

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

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Looking to submit your presentation or poster abstract for consideration?

Keep an eye on the aahcm.org home page for more information coming soon.

Food Insecurity

By Michele Severson, MS RD

Food insecurity is a state in which lack of money or other resources creates a situation where a household has limited access to safe and nutritious food. Food insecurity is a problem that affects households in every county across the country. According to recent data from the United States Department of Agriculture (USDA), in 2016, 12.3% of households overall were food insecure (Coleman-Jensen, Rabbitt, Gregory, & Singh, 2017). The State of Senior Hunger in America report states that in 2016, a total of 24.2% of older adults reported food insecurity within the spectrum of marginal food insecurity, food insecurity, and very low food security (Ziliak & Gunderson, 2018). Although recent trends from 2014 to 2016 show a slight improvement in food security, overall food insecurity numbers remain significantly higher when compared with reports of food insecurity prior to the Great Recession in 2008 (Ziliak & Gunderson, 2018).

Older adults who report food insecurity have lower nutrient intake of both macro- and micro-nutrients compared with food-secure counterparts (Ziliak & Gunderson, 2017). The impacts of food insecurity include worse health outcomes: older adults who are food insecure are more likely to report having chronic health conditions, poor general health, and difficulty with activities of daily living (ADLs; Ziliak & Gunderson, 2017). Furthermore, older adults who are food insecure have higher healthcare costs: a recent study reported the average healthcare cost difference between an individual who was food insecure and an individual who was food secure was \$1,863 (Berkowitz, Basu, Meigs, & Seligman, 2017).

Screening for Food Insecurity

The Hunger Vital Sign™ is a two-question screening tool that can be used to identify food insecurity (Hager et al., 2010). This is a validated tool that is easy to administer and helps quickly identify clients who are struggling to access safe and nutritious food. A response of “sometimes true” or “often true” for one or both questions indicates a positive food insecurity screen: the clinician should assist with referrals to community resources for food. In addition, it is important to address food access as well as consider any medical issues that may have developed or were exacerbated by the food insecurity (Hager et al., 2010).

Hunger Vital Sign™ Two-Question Screening for Food Insecurity

“Within the past 12 months we worried whether our food would run out before we got money to buy more.”

- Was that *often true*, *sometimes true*, or *never true* for you/your household?

“Within the past 12 months the food we bought just didn't last and we didn't have money to get more.”

- Was that *often*, *sometimes*, or *never true* for you/your household?

Food Access Resources

The Supplemental Nutrition Assistance Program (SNAP) is a well-known food assistance program. Eligibility to receive SNAP benefits is based on income. The SNAP program is federally funded, but the program is administered at the state level: each state has its own application to assess qualifications for receiving benefits. According to the National Council on Aging (2016), accessing SNAP benefits improves health outcomes by providing the recipient the equivalent of a monetary resource to allow for purchasing food.

Meal delivery programs are another resource for older adults who are food insecure. Recently published studies demonstrate a positive impact on health outcomes associated with access to meal delivery programs. A recent *Frontiers* article examined the impact of medically tailored meals on health outcomes, demonstrating a positive impact on reducing healthcare costs and reducing healthcare spending on people with CHF, COPD, and diabetes (Daly, 2018). Another recently published study looked at the impact of healthcare medical spending in clients receiving medically tailored meals compared with clients receiving home-delivered meals, that were not medically tailored. The researchers reported overall decreased healthcare spending with both cohorts; however, clients who received medically tailored meals had fewer inpatient admissions (Berkowitz et al., 2018).

Registered Dietitian Nutritionist (RDN): Food Insecurity Screening and Follow-up

Clinicians in home-based primary care practices often are kept busy with the myriad medical, mental health, and psychosocial care needs of home-based primary care clients. The addition of another screening tool may seem overwhelming. If a client screens positive for food insecurity, some type of follow-up is warranted. A registered dietitian nutritionist (RDN) can be an asset to your HBPC team. The RDN can complete the initial and annual food insecurity screening with the HBPC client. If the client screens positive, the RDN can take some initial steps to connect the client with food resources and community services. Although often thought of as a role for a social worker, it is within the RDN's scope of practice to provide referrals to community resources. Furthermore, the RDN can provide education to the HBPC client or family member on topics such as grocery shopping on a budget, recipes for using food from the local food bank, or other nutrition and health-related topics.

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CUTTING-EDGE EDUCATION BY THE LEADERS IN HOME-BASED MEDICINE

THE MOST POPULAR
SESSIONS FROM THE
2018 ANNUAL MEETING
**NOW AVAILABLE
ON DEMAND**

The well-reviewed sessions and quality speakers that were so popular at the 2018 Annual Meeting are now available for purchase! This is your chance to get up-to-the-minute education on the issues and challenges that face the broad spectrum of healthcare professionals providing in-home primary care.

Educational highlights include

- **Healthcare Transformation and Innovation** - Patrick Conway, MD MSc
- **Strategies for Serving High Risk and High Needs Populations in Changing Times** - Cheryl Phillips, MD AGSF
- **Home Care Medicine Landscape** - Bruce Leff, MD
- **Quality Standards for Home Care Medicine** - Christine Seel Ritchie, MD, and Martha Twaddle, MD FACP FAAHPM HMDC
- **Long Overdue...New Ethical Dilemmas in Value-Based Care** - Ed Ratner, MD, and Nick Schneeman, MD
- **Panels on New Payment Models**, Technology in the Home, Legislative Updates, Responding to Urgent/Acute Care events, and VHA Care
- **And more!** for a total package of 14 sessions from the 2018 Annual Meeting

On-demand sessions are available as one, cost-saving bundle. Don't miss your opportunity to improve the administrative, clinical, and operational aspects of your practice—and earn valuable CE!



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Burnout

By June Leland, MD MBA

Burnout is a syndrome of chronic stress that leads to physical and emotional exhaustion, cynicism and detachment, as well as a sense of ineffectiveness and lack of accomplishment. It affects approximately 50% of the physician workforce and can lead to inability to function both personally and professionally. Burnout leads to poor health-related outcomes for physicians (eg, problems with relationships, substance abuse, suicide) and can be dangerous for patients (eg, higher error rates, lack of compassion) and costly for organizations (eg, staff turnover, decreased productivity; Shanafelt, Goh, & Sinsky, 2017). The highest risk is for front-line physicians, but burnout affects home health workers at all levels.

Signs of burnout include (Bourg Carter, 2013):

- Signs of physical and emotional exhaustion:
 - Chronic fatigue, insomnia, forgetfulness/impaired concentration and attention, physical symptoms, increased illness, changes in appetite, anxiety, depression anger
- Signs of cynicism and detachment:
 - Loss of enjoyment, pessimism, isolation
 - Signs of ineffectiveness and lack of accomplishment:
 - Feelings of apathy and hopelessness, increased irritability, lack of productivity, and poor performance

There are a number of instruments to measure burnout in a variety of settings. The Maslach Burnout Inventory (MBI) is a 22-item survey that covers three areas: emotional exhaustion (EE), depersonalization (DP), and low sense of personal accomplishment (PA). There are multiple questions for each of these subscales and responses are in the form of a frequency rating scale (ie, never, a few times a year or less, once a month or less, a few times a month, once a week, a few times a week, every day) (National Academy of Medicine, 2018).

The 22-item version is not always practical in long surveys assessing multiple different dimensions. Investigators have identified two single questions with the highest factor loading on the EE and DP subscales in samples of trainees and practicing physicians. Two items “I feel burned out from my work” and “I have become more callous toward people since I took this job” correlated strongly with the EE and DP domains as measured by the full MBI (National Academy of Medicine, 2018).

A single item from the MBI:EE has been validated as a standalone assessment-I “I feel burned out from my work.” Responses are measured on a seven-point frequency scale ranging from 0 “Never” to 6 “Every day.” They defined “high levels of burnout” as feeling burned out at a frequency of “once a week” or more (a score greater than or equal to 4). The MBI is proprietary and carries licensing fees, posing challenges to routine or repeated assessment. Recently, a non-proprietary, single-item scale has been validated.

The non-proprietary single-item burnout measure instructs respondents to define burnout for themselves: “Overall, based on your definition of burnout, how would you rate your level of burnout?” Responses are scored on a five-category ordinal scale, where 1 = “I enjoy my work. I have no symptoms of burnout;” 2 = “Occasionally I am under stress, and I don’t always have as much energy as I once did, but I don’t feel burned out;” 3 = “I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion;” 4 = “The symptoms of burnout that I’m experiencing won’t go away. I think about frustration at work a lot;” and 5 = “I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.” This item often is dichotomized as ≤ 2 (no symptoms of burnout) vs. ≥ 3 (1 or more symptoms) (Dolan et al., 2015).

Of note, there is no clinically accepted definition or diagnosis of “burnout” and there is controversy as to whether or not burnout is a form of depression.

The practice of clinical medicine is stressful. The norm is for clinicians to put others first and to do whatever it takes to help them, at the expense of meeting basic needs such as eating and sleeping. In addition, the profession selects trainees for traits that are related to burnout such as compulsiveness, perfectionism, guilt, exaggerated sense of responsibility, and delayed gratification (Schulte, 2018). There is a lack of emphasis on work-life balance, both in training and in many employment settings. This can be made worse by lack of leadership or poor supervision.

The provision of home care creates a set of unique stresses for the physician and other health care providers. In addition to the challenge of providing primary care for the sickest, most vulnerable patients with limited resources, home care presents distinct challenges: including driving (while finding an address, eating or talking on the phone), working alone, unpredictable and sometimes unsafe points of care, long hours with work responsibilities flowing into personal time. In addition, there are regulatory and reimbursement regulations that must be met. Often, patient/provider/employee boundaries are blurred, creating excessive burdens on time management and clinical responsibilities.

Warning signs that you or a colleague may be experiencing burnout include (American Medical Association, 2018):

1. You have a high tolerance to stress.
2. Your practice is chaotic.
3. You don’t agree with your supervisor’s values or leadership.
4. You are the emotional buffer.

5. Your job constantly interferes with family or social events.
6. You lack control over your work schedule and free time.
7. You don't take care of yourself.

While self-care is important, it cannot be the total solution. In home care, one recommended approach is for the agency to communicate expectations, provide training, design processes that improve care, ensure that technology is not creating more stress, improve job satisfaction, and create team building exercises (Anderson, 2014).

However, preventing burnout should focus primarily on system-related, rather than physician-related, factors. In the list of warning signs, it is implied that burnout can be solved by changing the behavior of the individual physician—e.g., eating better, sleeping more, or exercising. This is simplistic and falls short of what is needed to solve a growing problem (Shanafelt, 2016).

For those in positions of leadership, the focus should be, in the following sequence (Perlo et al., 2017):

1. Ask staff “What matters to you?”
2. Identify unique impediments to joy in work in the local context.
3. Commit to a systems approach to making joy at work a shared responsibility at all levels of the organization.
4. Use improvement science to test approaches to improving joy in the work in your organization.

Shanafelt has enumerated these questions more practically (Shanafelt, 2016):

1. Start trusting physicians again. Eliminate intrusive regulations that do not add value to patients' medical care, and devise more accurate approaches to assessing quality.
2. Let physicians focus on doing the work that only they can do. While physicians work at the top of their licensure, mini tasks should be delegated to support staff.
3. Set workload expectations based on what it takes to provide good patient care. “The current reality of physicians working 14-hour days at the clinic or hospital and then going home to spend 2 to 3 hours charting in the EHR is not sustainable,” he states. “We have the metrics and tools to determine the time necessary to provide good care.”
4. Measure, track, and benchmark the well-being of physicians as a strategic imperative necessary to provide high-quality medical care.

The Institute for Healthcare Improvement suggests that leadership create joy in work through nine critical components, the first four of which relate to fundamental human needs: physical and psychological safety, meaning and purpose, choice and autonomy, and camaraderie and teamwork. These are followed by recognition and rewards, participatory management, daily improvement, wellness and resilience, and real-time measurement (Perlo et al., 2017).

Burnout is a system-wide problem with far-reaching implications for providers, patients, and institutions. Joy would be a welcome alternative.

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Dr. Yasmin Meah, 2017 Housecalls Educator of the Year, on Home-Based Medical Care and Education (Part 2 of 2)

By Helen Horvath, MS ANP-BC RN PHN

Dr. Yasmin Meah is AAHCM's Housecalls Educator of the Year for 2017. She is an attending physician in the Mount Sinai Visiting Doctors Program and is an associate professor in general internal medicine, medical education, geriatrics, and palliative care at the Icahn School of Medicine at Mount Sinai.

What themes about home-based care do you hope will be meaningful to your learners in home-based medical care?

It is critically important for trainees to understand that the home and community are not simply an extension of the medical system, but also where disease, illness, and therapeutics really play out. It frustrates me to see patients get discharged on numerous medications when they are admitted. I often say to residents, "Hey, listen, you can prescribe that, but I guarantee the patient won't take it." It's important to see that your therapeutics and management in a hospital-based setting does not translate in the home. In the hospital, for better or for worse, the medical system has control of the outcome. In the home, the patient, the family, and the caregivers do. And the majority of a patient's experience of illness happens in the home.

My goal when training medical students and residents is to make them appreciate that home care is challenging, arduous, messy, and necessary. It is rare for students or trainees to choose a career in home care—it's not for most clinicians. But, if they can emerge from a home care experience with a real sense of how to transition patients from acute-care settings more responsibly; if they can understand that things that we take for granted like hot water, food, willing and devoted caregivers, and transport to and from an apartment often is not easily accessible to a large number of our patients; and if they can understand that frequent and transparent communication with all providers including caregivers, pharmacists, primary care physicians, and nurses is absolutely critical to a more seamless transition, then I as a home-care educator will have accomplished so much.

How would you advise clinicians who find it to be a struggle to both take care of their patients and teach at the same time?

It's absolutely critical for home-based clinicians to teach not simply our craft but our thinking. The way we consider all aspects of medical care in a home visit needs to be made transparent to trainees by just talking out loud. We often take for granted that trainees know what we are thinking or why

we have chosen NOT to give a therapeutic or why we are being more paternalistic in certain situations and more collaborative in others, but trainees don't always get this. More than anything, dialogue during home-based educating sessions is crucial. It's also important for us to, at times, give the trainee the ability to take the reins, if even briefly. I often will ask my students to do the medication reconciliation or call a caregiver while I am witnessing the phone call. It's hard because so much of what we do is in our head—it's intuitive. But if we never give trainees the chance to experience first-hand in a supervised setting what we teach or the opportunity to bear witness to what we are thinking, they become no more than passive observers who view home care as foreign and unachievable rather than a mindset worth incorporating into practice.

What challenges and benefits have you seen with InterACT, the clerkship you started that highlights home-based care?

InterACT is a longitudinal clerkship that encompasses several venues. The Visiting Doctors Program has been a central aspect of the program. Graduates of the program have developed far more confidence and skill in transitioning patients to home and to calling caregivers without hesitation to explain care in the outpatient and hospital-based settings. Our graduates are far more able than their peers to reconcile medications and to take on a less-is-more approach with patients as those patients become more terminally ill. They are far more able to navigate and lead end-of-life discussions and goals-of-care discussions, often replacing residents and even faculty in this role. They are more attuned to the futility of certain management decisions and jump on opportunities to engage with interdisciplinary team members such as social workers to engage in high-stakes conversations and complex decision-making. Many of them have brought home visits into their other training venues, seeing it as part and parcel of good management, particularly for patients with limited resources and confused, absent, or overwhelmed caregivers.

The challenge of InterACT is that it does take a lot of time for mentors to coach medical students to become more

autonomous and skilled home-care providers. We work hard to ensure that our students are mentored throughout all aspects of care, but we also have to let them take the reins far more frequently and at a higher level than students who are not part of the clerkship. This means a lot more time spent reviewing plans of care, ensuring that their documentation is not simply precise but relevant to homecare, and coaching them through very complex decision-making when all the players are not willing to or capable of instituting the plan. We often have to undo bad behaviors that students learn in the hospital—the frequent ordering of tests and prescribing of medications that are unnecessary or risky in the homebound. That takes a lot of time, and not all preceptors are able to take on this role.

What are your hopes for the future of home-based medical care and medical education?

My hope for home-based medical care is that it is seen as a specialty worth adopting at healthcare centers across the country. I also hope that many more primary care and geriatric providers consider home-based medical care as essential to their own practices. I hope that training in home-based medical care

becomes far more pervasive in medical training, particularly at the medical student level. I certainly feel that our students at Mount Sinai have a leg up when it comes to navigating transitions of care and steering goals-of-care discussions, in large part because of their heavy exposure to home-based medical care. To that end, my hope is that medical centers also reward home-based providers with far more protected time to engage learners when making housecalls.

Home-based care is taxing, and each visit can take up to an hour or more; having a learner can really draw this out, but if we deem it essential to medical education, then medical schools and hospitals need to protect home-based medical providers from the stress of higher productivity. To do it right, home care needs to be deliberate and all-encompassing—approaching the social, medical, resource, and economic aspects of care often and with a fine-toothed comb in each encounter. Trainees need to learn to do it right but need special coaching and opportunities for mentored autonomy and coached independence. They cannot always shadow such providers, but in the same vein, providers need protected time to mentor them effectively.

Food Insecurity *continued from page 4*

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ACADEMY NEWS

Welcome, New Members

The Academy welcomes the following new members, who joined between December 1, 2018, and Feb 1, 2019.

Arizona

Lauren Shurson
Betty Suleimanov

California

Cynthia Reber

Florida

Judith Faustin

Georgia

Nancy Hurlock

Idaho

Aaron Moorhouse

Illinois

Shawna O'Dell

Indiana

Jessica Abbott*
Angela Eten*
Melissa Howe*
Alison Krauth*
Jamie Lang*
Tammy Miller*
Kimberly Robertson*
Jennifer Walker*

Kentucky

Mary (Traci) Allen*
Robbin Baldwin*
Kelly Belcher*
Kristin Boothe*

Tiffany Boston*
Larry (Chris) Bratcher*
Joseph Brooks*
Jordyn Brosmer*
Carol Broughton*
Sylvia Bundotich*
Danielle Choate*
Jinnyi Clements*
Joel Coleman*
Lou Ann Cook*
Calli Cox *
Katie Dadi*
Elizabeth Deese*
April Dempsey*
Misty Dill *
Tifanie Doninger*
Jessica Dsouza*
Kristen Fenwick*
Shelley Foord-Kelcey*
Misty Goldson*
Christine Grass*
Jennifer Hamilton*
Melissa Harmon*
Amanda Hendricks*
Sherry Herman*
Emily Hickerson*
Katherine Himmelman*
Allison Hobbs*
Jon Jarvis*
Carol Karsner*
Kaelyn Keith*
Tammy Loebker*

Virginia Marcum*
Tracy Mathis*
Tara McIntosh*
Jennifer McKinley*
Leslie McQueen*
Emily Mendel*
Vicky Moore*
Katherine Morris*
Robin Morton*
Debra (Debbie) Mudd*
Cassandra (Sandy) Mueller*
Kathleen O'Daniel*
Kathryn Overberg*
Bethany Parks*
Amanda Peach*
Adrian Pellegrini*
Cynthis (Cindy) Phillips*
Savannah Reyna*
Marisa Rigsby*
Lindsey Shelton*
Hillary Smith*
Amy Spader*
Amanda Stephens*
Robert Thompson*
Melissa Travelsted*
Jennifer Whittington*
Jamie Wilson*
Jennifer Woods*
Hillary Zega*

Maryland

Shennane Butler
Mary Koontz
Dianne Malabanan
Melissa Millard

North Carolina

Lynn Barringer*
Daniel Bernstein*
Emily Ventre*

New Jersey

Donna Silbert

Ohio

Michael Bernardon*
Shannon Kemper*
Amanda Mullins*

Texas

Valerie Dewbre
Chad Higbee

Virginia

Paul Nielson

** AAHCM welcomes our newest group member, Advanced Care House Calls*



Save the Date for the 2019 AAHCM Annual Meeting

October 17-19, 2019, at the Loews Chicago O'Hare Hotel in Rosemont, IL

Learn more at aahcm.org.



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 1987, 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

2019 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.
If you are a VA physician or other type of VA professional, please call AAHCM Member Services at 847.375.4719 for your 30% discount code.

New membership Renewing membership Please state your area of expertise or specialty: _____

Membership Application

Name: _____ Date: _____

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