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the 2013 Annual Meeting!



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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## AAHCP Offers Web-Based Home Health Agency Medical Director Training with CME Credit!

by Edward Ratner, MD,  
Past President, Course Director

Jack Henderson is a 55 year old family physician that became certified in geriatrics prior to requirements for fellowship. He maintains an office practice with several colleagues and has patients at two nursing homes. As his patients have aged, an increasing fraction of his practice is care of the elderly. He occasionally makes home visits to longstanding patients who are at the end of life. He recently gave up hospital rounds, leaving that to a group of hospitalists. He is asked to serve as a medical director for a local branch of a national skilled home care agency.

This is the introductory case study in the recently released AAHCP training program for home health medical directors. Jack is like many current or potential AAHCP members, with expanding opportunities to care for elderly, frail or disabled patients. He can help these populations one patient at a time or through medical direction of a team, thereby enhancing care for hundreds

Why should Jack accept the opportunity to be a home care medical director?

- a. It could be a source of referrals to his primary care practice
- b. It can provide hourly income comparable to other types of medical practice work
- c. Jack can have an impact on hundreds of additional patients per year, without significant paperwork or night/weekend call
- d. Jack can learn how to better use home care for the benefit of his patients and his practice
- e. Jack will have a reason to join the AAHCP and attend its annual meetings.

Correct answer(s) on page 2.

or even thousands of patients served by a home health agency each year.

Jack is almost certainly feeling unprepared

# AAHCP

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Before using procedures or treatments discussed in this publication, clinicians should evaluate their patient's condition, compare the recommendations of other authorities, consider possible contraindications, and consult applicable manufacturer's product information.

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for the role as a home health medical director. He is unlikely to know even one of the thousands of other physicians who serve in such a capacity, as there are usually only one or two physicians in this role within a network of physicians (such a hospital medical staff or a multi-specialty practice). He certainly had no formal training in home health issues during medical school or residency. It would be surprising if home health has been more than mentioned in his many years of continuing medical education.

The AAHCP has long recognized the educational challenge faced by Jack and most current home health medical directors. In the 1990s, the AAHCP offered multi-day conferences to prepare home health medical directors for their varied roles. The "Red Book" called *Medical Directorship of Home Health Agencies*, the AAHCP publication for medical directors, is now in its third edition. The newest addition to AAHCP educational offerings is a 4-hour, interactive, Web-based training for Jack and similar physicians. Each of eight 30-minute modules are formatted as narrated slide sets, which include case studies, links to regulatory documents, and references as well as

practical information geared specifically to the needs of medical directors of Medicare-certified agencies. See the table above for the list of module titles.

This program is now available to AAHCP members for the nominal amount of \$20 due to the generous financial support of the Alliance for Home Health Quality and Innovation,

a consortium of national home health care providers, including both non-profit and proprietary providers, leading academics and thought leaders in health care, non-provider health care organizations, and national associations (see [www.ahhq.org](http://www.ahhq.org)) and in-kind support of the Minnesota Area Geriatric Education Center. This Web-based program provides a tremendous value since it offers 4 hours towards AMA Category 1 Continuing Medical Education, AAFP Prescribed Credit and AMDA Certified Medical Director (CMD). Typically, home health agencies will reimburse the cost of the program and sometimes additionally compensate the physician for the time spent, under the medical director contract terms. Non-members are also welcome to take

the course for the below-market cost of \$80 due to the Alliance support and receive, in addition to CME credit, a trial AAHCP membership.

In just the first few weeks of the program being available, over 50 physicians have enrolled, with 15 graduates to date. Feedback has consistently been excellent, with requests for follow-up training. The AAHCP has a goal of having over 1000

participants by the end of 2013. To achieve this goal, we are working with the AHHQI and the Council of State Home Care Associations.

For more information about this program, go to: [www.aahcp.org](http://www.aahcp.org) and click on the Home Health Medical Direction link. And the correct answer to the case study is All of the Above.

## Module Titles

1. Introduction to home care medical direction
2. Quality and accreditation
3. Eligibility for Medicare skilled home care
4. Services and supplies included in the Medicare home health benefit
5. Reimbursement (including Fee-for visit (including LUPA); prospective reimbursement and pay for performance)
6. Attending physician roles (Cert/Recert, CPO, Face-to-Face)
7. Wound Care
8. Infusion and other complex care

# Strategic Plan Redux

by Bruce Leff, MD, President



In 2010, the AAHCP developed a strategic plan with the goal of moving to the next level as a member organization. Up to that time, the work of the organization had been largely dependent on a Board of Directors that contributed monumental amounts of sweat equity, an incredibly capable half-time Executive Director, and small part-time staff (1.6 FTE). With these resources, the Academy realized significant accomplishments in revitalizing house calls through work on reimbursement for house calls, health care policy initiatives such as the Independence at Home (IAH) Demonstration, and successful education programs.

The goal of the 2010 strategic plan was to help the Academy develop into a more robust member

organization. We transitioned to a full-time Executive Director, hired a new full-time Associate Executive Director, and expanded our capacity to serve the membership and develop more robust capabilities to provide practice management support and support the development of IAH Demonstration through dogged policy work and initiating the IAH Learning Collaborative. Also, we worked to increase communications through an eNewsletter, improved website, and educational booklets. We improved our committee structure in order to advance our mission and to develop the next generation of leaders for the field and for the Academy. And in stark contrast to just about all other professional medical societies, and in tribute to our longstanding recognition of the importance of, and commitment

to, interdisciplinary care, we voted to change our name to a more inclusive terminology.

When I look back on the goals articulated in the 2010 strategic plan, I am proud to say that the Academy has met nearly all of them. However, this work has not translated into significant increase in the membership. We are not unique among member organizations. Most medical professional societies find themselves in a similar situation - stagnant or declining membership. The etiology of this phenomenon is multifactorial. Younger generations of

*We are working to redefine the value proposition for our current and future members.*

physicians who are not “joiners,” the balkanization of medicine which has spawned a multitude of organizations (how many groups can one person belong to?), the increasing numbers of professionals who are employed by large organizations and see national professional societies are less relevant to their day-to-day professional life. Then there is general sensory overload - email inboxes full, texts coming in at alarming rates, tweets and Facebook offerings all vying for attention in our increasingly busy existence. Probably most important is that most member organizations may not have delivered on the value proposition, leaving members and potential members wondering why join or why stay on as a member.

The Academy board and management

team takes these issues very seriously. We are now engaged in a new round of strategic planning with the goal of trying to understand how, again, to move the Academy to the next level in the context of this evolving landscape. We are working to redefine the value proposition for our current and future members.

We appreciate the help you provided us in this planning process. In 2010, we performed a web-based survey and had several focus groups. Despite a relatively low response rate (about 10%), we obtained useful information to inform strategic planning. This time around, we built on responses provided by 148 of you in September, and put out a call for members to join a brief focus group to help us

understand key issues. We thought that a focus group approach would allow us to explore some of the issues in greater depth than permitted by a survey. Again, we learned a great deal from listening to our members. We also have listened to both internal and external stakeholders who have important ideas to offer.

If you were able to provide input through one of the focus groups, we thank you. If you were unable to participate in a focus group and want to share your ideas, please feel free to reach out to me or to Academy staff at any time. Our plan is to have a new strategic plan in place by the fall that will help us continue to promote the art, science, and practice and medicine in the home.

# AAHCP Working For You: Revenue Issues

by Constance Row, LFACHE, Executive Director

In every survey we do, members make clear that they value our public policy work on revenue issues very highly. Thus, the Academy looks for every chance available to make greater funding available to you through the fee for service and other payment systems as they are evolving. This year, the opportunities in the Medicare fee schedule began with work on the Medicare transitional care codes which some of you are now using. Currently, our work has focused on the Complex Care Coordination Codes, and the Advanced Primary Care Practice model. We also have been working to support the Independence at Home Demonstration which is testing a shared savings model which might become a model for a future Medicare payment model and/or benefit. Nurse Practitioners - please note our support on the Home Health Certification issue.

## Care Coordination Codes

As those of you who took the survey last summer remember, the idea of the care coordination codes was to pay for some of the services provided to patients that are not now reimbursed. A proposal went to the RUC, but was not adopted by CMS in the 2013 Medicare Payment Rule, we think primarily because of the cost of allowing all providers to bill for the service. A multi-specialty workgroup was convened by AGS with the AAHCP as a member to try to craft a recommendation to CMS that would balance the desire of all providers to be able to bill for this service with the need for cost effective use of resources. The AAHCP contributed more than its share of ideas to this effort, often including lengthy suggestions by Dr. George Taler, Chair, Public

Policy, and staff including myself and Gary Swartz. After a lengthy exchange of views, a proposal was crafted that was presented to the head of CMS's Medicare program, arguing for a focus of the code usage on the complex patients, with only providers taking care of this group being allowed to bill for the service. We will not know CMS' decision on the CCC code issue until the June, 2013 publication of the draft 2014 Medicare payment rule. It is possible that they may adopt the multi-specialty group proposal. However, it is also possible that they will either not pay the codes at all, or only pay them through PCMHs (Patient-Centered Medical Homes). In the event they chose the second route, we have

### Update:

1. *Chronic Care Coordination Codes*
2. *Advanced Primary Care Practice Models*
3. *IAH Learning Collaborative*
4. *NPs and Home Care Certification*

already begun to represent your interests by presenting our own preliminary proposal for an Advanced Primary Care Payment Model that would fit the population you serve - the complex, high cost, but home-limited elderly.

## Advanced Primary Care Practice Model

In the 2013 Medicare Payment Rule, CMS "floated" the idea of paying "Advanced Primary Care Payment Model" programs more. The model they used as their example was the Medical Home as certified by NCQA. We believe they

liked this model because it focused money on an area of need - primary care - and was easy for them to fund, since its characteristics had been outlined by a reputable outside agency, who also certified programs. For them, it was probably like JCAHO accreditation for hospitals which gives them "deemed" status and eligibility for Medicare payment.

There are several problems with this idea from our standpoint, and we pointed all of them out in our comment letter last August. First, office-based Medical Homes are not necessarily the best model for many complexly-ill, home-limited frail elderly who are also high cost. Second, becoming a Medical

home is too costly for many practices, both because of the costs of implementation and the costs of NCQA certification. Thus, the AAHCP joined with others like the AMA in recommending that CMS establish standards for what was required for such Advanced Primary Care model programs, and standards for the certification process, and allow others to apply.

While they were considering recommendations for the 2014 Medicare Payment Rule, we wanted them to remember us. So on February 7, Dr. George Taler presented to CMS the idea of having a Home Based Primary Care model which learned from Independence at Home included as an addition to PCMH to CMS officials in the 2014 Payment Rule.

We will update you as we hear more but hope that, through one mechanism

*Continued on page 10*

# Register Now for the 2013 Annual Scientific & Practice Management Meeting!

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

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



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

### Program Highlights

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

**Registration \$425**

**REGISTER NOW** through AGS at [www.americangeriatrics.org](http://www.americangeriatrics.org). For program information or registration instructions, visit our website, [www.aahcp.org](http://www.aahcp.org) > Meetings and Programs > 2013 Annual Meeting



# Are the New Transitional Care Management Codes (CPTs 99495 and 99496) Right for Your Practice? Questions and Answers

by Gary Swartz, JD, MPA, Associate Executive Director

We began the year with the uncertainty of the “fiscal cliff” and the annual sustainable growth rate formula (SGR) issue. And just when we thought the uncertainty was behind us this *Frontiers* issue goes to print with sequestration reductions in place.

While there remains political uncertainty, there is clearer certainty that future care and payment models will be more comprehensive. They will involve population health management, take account of outcomes and be more value-based. In fact, discussions of Medicare reform (and that regarding Medicaid waivers on the state level), all include discussion of moving away from paying fee for service (and for volume), to instead paying for population health management, outcomes and value.

The transitional care management codes (TCM - CPTs 99495 and 99496), that came into effect this year are part of this general and accelerating movement. Detailed information as to the code requirements and payment levels can be found on the Academy site at [www.aahcp.org](http://www.aahcp.org) > Meetings and Programs > Webinars > Housecall Revenue Opportunities for 2013, and in the Q and A follow-up at [www.aahcp.org](http://www.aahcp.org) > Practice Management > Coding and Documentation.

CMS has also just produced *Frequently Asked Question* (FAQ) materials to assist in understanding the use, service requirements, documentation and claim submission of the TCM codes. The

CMS FAQ material is found at [www.aahcp.org](http://www.aahcp.org) > Practice Management > Coding and Documentation.

Additionally, here are questions to answer whether the TCM services and codes are right for your practice.

## Clinical and Administrative Capacity

*Does my practice schedule have enough flexibility that I can contact patients within 2 business days and incorporate discharged patients to be seen within the 7 or 14 days as required into my schedule?*

If your practice has enough capacity and this is congruent with your practice model and planning, then TCM may provide the opportunity to grow your practice. Moreover, you may also be able to take your success to hospitals, ACOs, and health plans who are interested in avoiding the cost associated with readmissions.

Here is a link to a Kaiser Family Foundation posting of hospitals that have been penalized for 30 day avoidable readmissions [www.kaiserhealthnews.org/-/media/Files/2012/Medicare%20Readmissions%20Penalties%202013.pdf](http://www.kaiserhealthnews.org/-/media/Files/2012/Medicare%20Readmissions%20Penalties%202013.pdf). You will want to drill down to the hospitals in your community. Note, that as one hospital Chief Medical Officer told me; “the readmission penalties would eat into our margins, if we had any margins.” And other system leaders are telling us that readmission avoidance is one of the top priorities of their health systems.

## Frequency of Seeing Discharged Patients in the First Month Post Discharge

*What is the average number of times you see a discharged patient during the first month post discharge?*

As we know the TCM codes include a face to face encounter. And given that CPO is not billable with TCM and that one visit is also included, then one’s evaluation should include the likelihood that a second medically necessary E and M service will be required during the first 30 days post discharge. This analysis will provide you important information about your patients and volume.

That is if it is likely that you will provide a second E and M service during the first 30 days post discharge and if HHA is not ordered for the patient, then TCM may be an advantageous service as you will be paid for some of the services you are already rendering without compensation.

## Documentation

*Is my practice adept at CPO documentation?*

If your practice is adept at CPO documentation then you may want to consider TCM services as the documentation requirements are similar. If you are not adept at such documentation you will want to review the requirements and Academy materials, and meet with your staff including electronic health record support to learn how you can

become more efficient at such documentation.

## Referral Sources

*What are the key referral sources for my practice?*

If you are receiving significant HHA referrals and are providing CPO, then TCM may not be advantageous to your practice. The reason is that due to duplicity of services TCM and CPO cannot be billed in the same first month post discharge that the TCM codes are available. As a result, you may make the same or less money by using TCM codes.

On the other hand, if HHAs are not a significant referral source and you render little CPO, then TCM may be a positive new service and revenue opportunity.

*Do you want to grow your hospital and HHA referrals?*

We know there are many patients who no longer have an active relationship with a primary care practice. These uncovered patients are then utilizers of the hospital ER and inpatient service. Hospitals and HHAs seek out relationships with our members to meet the requirements for HHA certification and oversight (so the HHA will be paid for its services), and increasingly as mentioned as part of readmission avoidance strategies.

Examples of Academy members services and strategies in this area is found at [www.aahcp.org](http://www.aahcp.org) > Policy, Advocacy and Regulation > Policy News

Answering the above questions will help you determine whether the TCM codes are right for your practice now. However, as mentioned it is important

to become familiar with the codes as part of the move to new carrier and payment systems.

## Move From Fee for Service Payment and Practice Familiarity with Evolving Payment Mechanisms

If you are familiar with payment for transitional care and for coordinated care services that is terrific.

And, if you are not familiar with the migration of care and payment policy that is occurring, then the TCM service may provide you with a paying learning opportunity.

This point; "In adopting the transitional care payment policy, CMS has begun shifting more financial resources toward primary care and opened the door to further increases in primary

*Continued on page 11*

## Unique House Call Physician in Southwest Ohio

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

Southwestern Ohio is a fantastic place to raise a family and offers all the warmth and charm you can find only in the Midwest. Excellent school districts and a variety of private schools provide residents with quality educational choices. We are also home to the US Air force Museum and Wright-Patterson Air Force Base. Within a one hour drive, residents access six universities, three international airports, museums, symphonies, professional and minor league football, baseball and hockey, extensive shopping and dining, plus a wide range of housing options. This world-class community truly offers the "best of both worlds" -- community charm with easy access to metropolitan amenities. This is an opportunity worth considering!

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



# Update of the Home Care Literature: January - February 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.

## Home Care Research

J. M. Cramm, J. M. Hartgerink, E. W. Steyerberg, T. J. Bakker, J. P. Mackenbach, and A. P. Nieboer. Understanding older patients' self-management abilities: functional loss, self-management, and well-being. *Qual Life Res.* 2013 February; 22(1): 85–92. Published online 2012 February 17. doi: 10.1007/s11136-012-0131-9.

This cross-sectional research was based on a pilot study of older people who had recently been admitted to a hospital. In the pilot study, all patients (>65 years of age) who were admitted to the Vlietland hospital between June and October 2010 were asked to participate, which led to the inclusion of 456 older patients at baseline. A total of 296 patients (65% response rate) were interviewed in their homes 3 months after admission. Measures included social, cognitive, and physical functioning, self-management abilities, and well-being. The authors concluded that self-management abilities mediate the relationship between social, cognitive, and physical functioning and well-being. Interventions to improve self-management abilities may help older people better deal with function losses as they age further.

## Quality of Care

Jochanan Benbassat and Mark I. Taragin. The effect of clinical interventions on hospital readmissions: a meta-review of published meta-analyses. *Isr J Health*

*Policy Res.* 2013; 2: 1. Published online 2013 January 23. doi: 10.1186/2045-4015-2-1

The economic impact and ease of measurement of all-cause hospital readmission rates (HRR) have led to the current debate as to whether they are reducible, and whether they should be used as a publicly reported quality indicators of medical care. A meta-review of published systematic reviews of randomized controlled trials (RCTs) of clinical interventions that have included HRR among the patients' outcomes of interest. The authors concluded that despite their economic impact and ease of measurement, HRR are not the most important outcome of patient care, and efforts aimed at their reduction may compromise patients' health by reducing also justified re-admissions. Future research should also focus on the reasons for the higher efficacy of community interventions in patients with heart diseases and bronchial asthma than in those with other chronic diseases.

## Article of the Month

### Assessment

Emergency department visits for fall-related fractures among older adults in the USA: a retrospective cross-sectional analysis of the National Electronic Injury Surveillance System All Injury Program, 2001–2008 *BMJ Open.* 2013; 3(1): e001722. Published online 2013 January 24. doi: 10.1136/bmjopen-2012-001722

In this Retrospective observational study on the basis of 70,199 cases, an estimated 4.05 million older adults were treated in US hospital EDs for fall-related fracture during the 8-year period. Two-thirds of the injuries occurred at home and 69.5% (95% CI 59.7% to 77.8%) of the affected individuals were white. Fall-related fracture rates increased gradually with age and were on average twofold higher among women. Of those hospitalized, women and fractures of the lower trunk represented 75.2% and 65.1% of the admissions, respectively. The authors concluded the oldest old, women, and lower trunk fractures account for the majority of fall-related fractures among persons aged 65 years or older treated in US hospital EDs. Increasing ED visits and hospitalizations for fall-related fracture among older adults deserve further research.

# Member News

## Welcome, New Members!

The Academy would like to welcome the following new members:

### ALABAMA

Torrence L. Nicholson, MD  
Lynn J. Sexton, MSN

### ARKANSAS

Lela R. Shipman, APN

### ARIZONIA

Sarah White, NP

### CALIFORNIA

Adel A. Al-Marshad  
Susan Bodtke, MD  
Colin Hamblin, MD  
Martha Adigwe Mozia, FNP/GNP  
David Niknia, PA  
Minke WinklerPrins, MD

### CONNECTICUT

Thomas A. Brown, MD  
Brenda Renzulli, APRN

### FLORIDA

Leslie-Anne Faireshire  
Renee Fletcher, ARNP  
Kimberlie Frattini  
Paul Lowery, DO  
Eisabeth Rogers, NP  
Paul S. Wright, PA

### GEORGIA

Susan P. Robinson, MS/PA-C

### ILLINOIS

Victor Forsys, MD

### ISRAEL

Aviad Livneh

### IOWA

Tammy Conner, OT  
Benedeth Nwumeh, BSN

### KENTUCKY

Deborah Ann Onan, DNP  
L. Kelly Simms, PA

### LOUISIANA

Paula Weaver Gates, FNP-C  
Sarat Raman, MD

### MASSACHUSETTS

Ryan S. Searle, MD

### MARYLAND

Jin Gu, MD, PhD, FACP

### MICHIGAN

Frank Lawrence Amprim, MD  
Solomon Awusah, MD  
Jamie Newberry

### MONTANA

Aaron Derry, PA-C

### NEW JERSEY

Wilhelmina P D'Dumo, PhD, MSN  
Gary P. Muccino, MD  
Stefanos George Pantagis, MD  
Melissa Rubin, APN  
Roger Thompson, MD

### NEW MEXICO

Joy A. Lovette, MD

### NEW YORK

Amy Margolis  
Ron Molloy  
Christos Raptis, DPT

### OHIO

Sandra Chlad, CNP  
Susan Decker, PA-C  
Monique Howard, NP  
Mohammed Ahmed Khan, MD  
Mufeedulla Khan, MD  
Thomas Linneman, DO  
Shane T. Sampson, MD

Anu Shrestha, MD  
David Tramontana  
Maidana Vacca, MD

### OKLAHOMA

Craig N. Lamb

### PENNSYLVANIA

Aliya Ali, MD  
Marilyn Everling, RN, MBA  
Jeff M. Neary, PA-C  
Linda Small, RHIA  
Carol Struminge, DO

### TENNESSEE

Stacey Carlton, MD  
Dennis Duck, MD

### TEXAS

Anees Basha, PA  
Beth Berger  
Susan Conroy, DO  
Susan E. Ellington, MD  
LaTronica T. Fisher, DNP  
Joanna Holle, MSN  
Brett Parish  
Texas Outpatient Services, P.A.

### UTAH

Theresa Ularich, MSN

### VIRGINIA

Thomas Davies, MD  
Jim Giordano  
Torino R. Jennings, MD

### WASHINGTON

Rory Clarke  
David Deichert, ARNP  
Mary A. Nametka  
Mei Tyan, ARNP  
WISCONSIN  
Farid Ahmad, MD  
Fang Deng, MD

# Provide Your Opinion and Help Fellow Academy Members Select an Electronic Health Record (EHR) System, Assistance Available and EHR Safe Harbor

by Gary Swartz, JD, MPA, Associate Executive Director

What EHR system to select is a frequent question of current and new Academy members. Help us to provide guidance to your fellow Academy members by completing a short survey at [www.surveymonkey.com/s/WJCFYVN](http://www.surveymonkey.com/s/WJCFYVN). This will help the Academy provide guidance and to develop related services and resources on EHRs. This will also help the Academy secure the participation of EHR and related partners to support your Annual Meeting. Help your Academy colleagues and complete the survey whether you are currently on an EHR or not.

Complete the survey even if you have EHR available through an outsourced revenue cycle relationship.

Complete the survey by the end of April and we will enter you in a drawing that will occur at the Annual Meeting in May.

## Assistance Available if You are Just Getting Started on EHR Selection and Implementation

Academy members just beginning to assess EHR selection and implementation will want to see the material on “Getting Started” on the ONC-HIT site. Additionally, funding was made available through HITECH Act to support primary care practices selection and implementation of EHR through regional extension centers. This service is without cost to you.

## Extension of EHR Safe Harbor Sought

Health systems and others may be offering to assist you with EHR implementation.

Please know there is currently a “safe harbor” allowing one healthcare provider to subsidize the purchase and implementation of electronic health

records (EHRs) by another healthcare provider without triggering the federal anti-kickback statute. The safe harbor is at CFR-2010-title42-vol5-sec1001-952 (y).

Safe harbors allow remuneration in instances where no inducement is intended. However, the safe harbor, that was time limited, is set to expire at the end of the year. Organizations are now working to have this safe harbor extended.

Thank you for helping your colleagues with their selection of EHR by completing the survey at [www.surveymonkey.com/s/WJCFYVN](http://www.surveymonkey.com/s/WJCFYVN).

And we look forward to seeing you at the Annual Meeting in May where there will be additional discussion of EHRs and related practice management topics.

## AAHCP Working For You: Revenue Issues

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or another, as many of you as possible will be eligible for care coordination payments.

## Independence at Home Demonstration

Which brings us to the IAH Demonstration. You will remember that the IAH Demonstration is built on a shared savings model and that we have been able to operate a grant-funded IAH Learning Collaborative this year with all 15 of the practices/programs/collaboratives that have been approved participating. The first true “IAH Day” for Learning Collaborative program participants will

be held May 1 as a pre-conference day to the AAHCP Annual Meeting. Much has gone on this year, and I know that many of you are interested in the Demonstration. Data on whether IAH sites have been able to qualify for shared savings, and if so how much will not be available until next winter at the earliest. However, what we can promise is that a “Lessons Learned in the First Year” will be published as part of the next *Frontiers* as a supplement, thanks to the support of the Retirement Research Foundation. Please join me in wishing all the sites success. More in the next *Frontiers*.

## Certification of Home Care by Nurse Practitioners and Physician Assistants

Many Nurse Practitioner members have asked where the AAHCP stands on the issue of Nurse Practitioners (and PAs) certifying home care, pointing out that the inability to bill for this service is impeding their ability to build their house call practices. We want you to know that we signed on to support the legislation that was introduced last year to make this possible, and look forward to continuing to support this legislative goal.

**AAHCP Endorsed  
Insurance**



## Ensure you're properly insured as a home care medicine provider.

The American Academy of Home Care Physicians has selected Lockton Risk Services to provide a quality, competitively priced malpractice insurance program exclusive to AAHCP members, and tailored to the needs of home care physicians and other home care medicine providers.

### Program benefits include:

- Medical Malpractice insurance policy providing broad, portable coverage.
- Protection for your personal assets.
- Program endorsed by AAHCP and designed specifically for AAHCP members.
- Coverage underwritten by a carrier rated "Excellent" by AM Best.



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### New Transitional Care Management Codes

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care payment in return for the greater accountability and efficiency that studies suggest may be attained through a medical-home model" is made in the recent *New England Journal of Medicine* Article Medicare's Transitional Care Payment - A Step toward the Medical Home that can be found at [www.aahcp.org](http://www.aahcp.org) > Practice Management > Coding and Documentation.

The discussion is also underscored by the Society of General Internal Medicine's (SGIM) National Commission on Physician Payment Reform March, 2013 report that also views payment reform that "reward(s) patient centered comprehensive care that manages transitions between sites of care and among providers of care" as a means to fund the elimination of the annual SGR issue.

Finally, as a practice resource, a table is also found on the Academy site at [www.aahcp.org](http://www.aahcp.org) > Practice Management > Coding and Documentation that reflects the similarity and differences of the CPO, TCM, and CCCC codes (complex chronic care coordination codes - CPTs 99487/8/9, that the Academy and others are advocating for coverage and payment effective with the 2014 Medicare Fee Schedule).

*Share AAHCP's mission and encourage colleagues to join*

The American Academy of Home Care Physicians is an organization of physicians and other home care professionals dedicated to promoting the art, science, and practice of medicine in the home. Achievement of that mission will require that providers be educated regarding home care; that they be actively involved in the evolution of home care medicine procedures, their delivery, and management; and that provider interests in the delivery of home care be voiced and protected. We urge membership and participation in the long-term future of home care.

AAHCP intends to provide the structure through which providers can evaluate home care and their position in it. It will monitor emerging technologies and appropriate delivery systems for the practicing physician, as well as the legal and regulatory environment. The Academy will be in a position to present providers' views regarding their interests and concerns in home care. Finally, the Academy will actively collaborate and cooperate with other organizations wishing to enhance the quality of home care. With these intentions for the Academy in mind, we hope to enlist physicians and home care professionals who will actively support and promote these changes in home care.

**Home care medicine is one of the most rapidly expanding areas of health care. These changes are occurring because:**

- Changing demographics demand a responsive health care system.
- Technology is becoming more portable.
- Home care medicine is a cost-effective and compassionate form of health care.
- Most persons prefer being treated at home.

**Who should join?**

- Practicing physicians.
- Nurse practitioners and physician assistants (associate membership).
- Medical directors of home care agencies.
- Students and physicians in training.
- Other home care professionals (associate membership).
- Home care agencies (affiliate membership).
- Corporations (sponsor membership).
- Groups of MDs, NPs, PAs or a mixture; or home health agencies and their medical directors (group membership) - *Discounts available.*

**Benefits:**

- Public Policy representation; revenue-related regulations and legislative representation such as IAH.
- Practice Management publications, website and technical assistance.
- Information on clinical, administrative, regulatory and technology issues, and the academic literature through our Newsletter and e-Newsletter.
- Standards of excellence, including the Academy's Guidelines and Ethics Statement.
- For house call providers, listing in our online Provider Locator.
- Consulting and networking through our members-only list-serv.
- Clinical guidelines and communication templates.
- Discounted attendance to Academy meetings.
- "Members-only" prices on educational media and publications.
- Assistance for faculty who train residents in Home Care.

**2013 Membership Fees\***

Physicians  
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

**2013 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  
www.aahcp.org

E-mail: \_\_\_\_\_

New membership  Renewing membership

Please state your area of expertise or specialty: \_\_\_\_\_