PRESIDENT’S MESSAGE

Overcoming the Challenges of Diversity in Environment for Home Care Medicine Workers

By Mindy Fain, MD, AAHCM President

This time of year I don’t get fooled by the cool early Arizona morning and evening temperatures, which plummet to the 70s. It’s nearly noon, and the temperature outside is soaring to 110 degrees. For more than 30 years I have learned to take special care when preparing for my house calls this time of year. Before getting on the road, I check to make sure I have a cooler with lots of water, a sturdy front windshield cover, and towels to cover my car seat. Sunglasses in hand, I quickly touch the car door handle and steering wheel to decide if I need my oven mitts. I make sure to dress professionally but with a keen eye on comfort and keeping cool. Invariably, by the time the air conditioning in my car takes effect, I arrive at my patient’s home. Once inside, the temperature can range from uncomfortably warm to freezing. It’s always a gamble.

It’s summer. The landscape is shimmering. The cicadas are blasting. There won’t be any rain for a while. And most likely there won’t even be a cloud to break the monotony of the bright blue sky.

My hand on the burning car door, I think about our members across the country who emerged from winter and spring to anticipate glorious summer months. No more house calls in the freezing cold, rain, and snow. No more need to fight the environment to do good work. And no need for oven mitts.

I can’t help but be struck by the diversity of our work environments and our remarkable determination to provide the best of care for our patients and their families—wherever they live.

Our diversity extends beyond climate. Some of us are in small solo practices, and some practice in large interdisciplinary groups. Some of us have an academic connection, involving teaching and research. Some of us are in private practice, and some are part of a larger health system, such as the U.S. Department of Veterans Affairs. Some of us are in urban settings, and some are working in rural areas. Some are new to the field, and some of us have been making home visits for decades.

We represent different disciplines—physicians, nurse practitioners, physician assistants, social workers, administrators, and others. And our members, and the patients and families that we serve, hail from different ethnicities and cultures.

Although our diversity is our strength, it also is a challenge.

We are all different. And as such, we are all subject to microaggressions, whether as a recipient or as a deliverer of these unintentional, but unsettling, messages.

continued on page 9
VA PERSPECTIVES

Reframing the National Health Debate: What Is Our Responsibility to Each Other?

By Robert M. Kaiser, MD MHSc FACP AGSF
Medical Director, Home Based Primary Care Program, Washington, DC
VA Medical Center
Associate Professor of Medicine, Division of Geriatrics and Palliative Medicine, George Washington University School of Medicine

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

The ongoing national debate on expanding (or retracting) access to health care hinges on the question of individual vs. collective responsibility. Some believe that the cost of illness should be borne by each person affected, but others think those costs should be shouldered by all of us. Some are confident that the invisible hand of the free market can allocate resources equitably and efficiently, while others call on the government to ensure equal access and universal coverage through regulation and taxation.

There is no question that health care is increasingly expensive because of our rapidly aging population, the prevalence of chronic illness, advancing technology, costly drugs, and a system that encourages more—but not necessarily better—care. We now spend $3.2 trillion annually on health care in the United States, which is fast approaching one-fifth of our gross domestic product (Centers for Medicare and Medicaid, 2017). There is insufficient spending allocated for social support of the most vulnerable patients in our healthcare system, compared with other western democracies. Our system for long-term care is broken, inadequate, and imposes a considerable financial burden on elderly patients and families. We spend a lot of money on health care, but our health outcomes are not better than other countries that spend less (Commonwealth Fund, 2017).

This debate should give all Americans pause.

We need to stop and answer a fundamental question about ourselves and our priorities. If we are the wealthiest country in the world, and if we are a generous and sympathetic people, why can’t we promise and deliver affordable health care to all of our citizens, no matter their economic circumstances? Whatever your political views on the Affordable Care Act, is it right to suddenly deprive 24 million people of their health insurance (Congressional Budget Office, 2017)?

We already have made a guarantee of health care, incrementally and over time, for designated groups of Americans by enacting and implementing Medicare, Medicaid, the Children’s Health Insurance Program, the Veterans Health Administration, and most recently, the Affordable Care Act. These programs demonstrate our innate generosity and represent a longstanding social contract between the government and the people it serves. Whether we acknowledge it or not, we as a country...
have accepted for some time that health care is indeed a right for many of us, not just an individual responsibility (Emanuel, 2014).

To ultimately achieve consensus on how to reach the goal of extending healthcare coverage to all of our citizens, we need to agree upon certain fundamental facts:

- Healthy individuals help pay for sick individuals with or without insurance. There must be a sufficient number of healthy people in the total pool of insured individuals to pay for everyone and to make the health insurance system economically viable. A larger pool results in spreading the risk of care with more affordable premiums (Blumberg & Holahan, 2016). Sicker individuals cannot realistically bear the full cost of their insurance, which would be prohibitively expensive. Forgoing insurance altogether would lead to the tragic, unethical, and unacceptable consequence of higher morbidity and mortality.

- Health savings accounts might work well for the wealthiest individuals, but not for the majority of the population, who earn modest salaries and cannot save enough of their income to fund copays, deductibles, and out-of-pocket expenses for serious illnesses and hospitalizations. For the less-well-off, some degree of subsidy would be necessary for insurance to be truly affordable and accessible (Volk & Giovannelli, 2017).

- Primary care, including proper vaccinations, screening, prompt treatment of episodic acute illness, and appropriate ongoing management of chronic illness is essential to prevent illness. Enrollment in primary care reduces costs for individuals and the entire system and makes health care more affordable for the whole population (Ginsburg et al., 2012; Antonisse et al., 2017).

So, where does this leave us?

An exclusive free market system does not seem capable of reducing prices sufficiently through competition to make insurance affordable for the healthiest among us or for sicker, older, high-risk individuals with modest incomes. Yet, Americans remain skeptical of government and historically have been unwilling to pay the taxes needed to support a single-payer system, in which the government would be the only insurer, and guarantee coverage for all.

For health care to work as it should, we are required—indeed the situation demands—that we help each other. This seemingly intractable problem can be solved by collecting reliable data and proceeding with clear-headed assessment and comparison of policy solutions. If an adequate risk pool could be guaranteed (or mandated), could private insurance companies create truly comprehensive and affordable insurance plans with coverage of preventive, primary, and hospital care for all, no matter their age or clinical condition? Could public policy experts create a similar governmental proposal, funded by taxation and according to a sliding scale, depending upon annual income? And which would cost less and have a greater chance of succeeding? Or could some form of public-private partnership be envisioned, with a public insurance option, similar to Medicare, to accomplish the same goal of reducing the uninsured and coming closer to the ideal of universal coverage?

In the great healthcare debate, we too often talk past each other, rather than to each other. We live in a political environment in which objectivity and open-mindedness are in short supply. These attributes are critical if we are to devise a credible and workable health policy. It is no exaggeration to say that our national health and well-being depend on it.

References


Meet the Players on the Home Team

By Maureen Ryan, MSW LCSW

It is not uncommon for caregivers and patients to feel confused about the roles of the many professional players in their home. When I enter a home for the first time I regularly hear, “Remind me what organization you are with.” or “What exactly is it that you do?” Because of the complexity and fragility of their health, most patients have multiple providers from various disciplines and may be unclear about the role of each.

It is not unusual for a patient to be followed concurrently in the home by clinicians in primary care, palliative care, home care, and specific specialties such as podiatry or psychiatry. In addition, many patients may be undergoing physical, occupational, or speech therapy and also be seeing a dietician. Supportive services—such as a homemaker, township or village nurse, home-delivered meal providers, or visitors or volunteers from a local service or faith organization—commonly are a part of our patients’ network. Some commercial insurance companies also offer home visits from a case manager. Home delivery pharmacy services, durable medical equipment distributors, and medical supply companies also sometimes are involved in providing care for the patient.

Although layered support is helpful, it also can be overwhelming and stressful for patients if such support is not well organized. One of the key things we can do initially for our caregivers is to help them by differentiating service providers and setting expectations for each discipline. Having conversations early in the patient-provider relationship about service providers and their roles can assist both the patient and the provider going forward.

As providers, we would like to make sure our patients feel well supported and set up for success. A key component of that is using each service and discipline to its fullest. As a social worker, this may mean I must call various providers and organizations to determine exactly what they are providing for our mutual patient. Ultimately, we want our patients to have a thorough understanding of the scope of each discipline and the extent to which each provider or agency can support them. This often requires providing a “cheat sheet” in the home with agency names, provider names, and a short description of each (Table 1). Assisting caregivers in creating and maintaining a master calendar for the home also can be helpful.

Tracking and understanding with whom we are sharing the home can be useful in avoiding duplication of services. It also can help us understand gaps in service and areas of need. Unfortunately, this is not always easy to determine, so time must be dedicated to gathering this information during the intake process. Patients may not know the disciplines or agencies by their professional names, so we may need to speak to patients plainly, in jargon-free language, to elicit this information.

<table>
<thead>
<tr>
<th>Table 1. Mary Smith’s Primary Care Team</th>
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<tbody>
<tr>
<td>Visit Frequency</td>
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<tr>
<td>Physician 1-800-800</td>
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<tr>
<td>Nurse Practitioner/Physician’s Assistant 1-800-8000</td>
</tr>
<tr>
<td>Social Worker 1-800-8000</td>
</tr>
<tr>
<td>Chaplain 1-800-8000</td>
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<tr>
<td>Other Providers</td>
</tr>
<tr>
<td>ABC Supply Company 1-800-555-6666</td>
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<tr>
<td>XYZ Pharmacy 1-800-555-4444</td>
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<tr>
<td>Happiness Township 1-800-111-9999</td>
</tr>
<tr>
<td>Community of God 1-888-55-3333</td>
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Note: Scope of practice for nurse practitioner, physician’s assistant, and social worker vary by individual state regulations.
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The AAHCM Annual Meeting is now a stand-alone meeting, allowing us to focus our content on the topics that matter most to home-based primary and palliative care providers. Don't miss our keynote address: Finding Hope, Humor, and Heart in Caregiving.

Keynote
Finding Hope, Humor, and Heart in Caregiving
Elaine K. Sanchez

What’s funny about caregiving? Absolutely nothing! But based on her own experience of caring for family members, Elaine K. Sanchez knows that it is entirely too difficult to take seriously all of the time. Her keynote is based on her unflinchingly honest and surprisingly funny book, Letters from Madelyn, Chronicles of a Caregiver. You will laugh through your tears as she provides insights into coping with caregiver anger, guilt, depression, and grief, along with strategies for managing challenging dementia-related behaviors, including inappropriate sexual behavior.

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Malnutrition: Diagnosis and Intervention in Home-Based Primary Care Visits

By Michele Severson, MS RD

**What Is It?**
Malnutrition is a nutritional imbalance, which can include under-nutrition as well as over-nutrition; however, the precise definition of malnutrition varies depending on the source.

Under-nutrition "typically occurs along a continuum of inadequate intake and/or increased requirements, impaired absorption, altered transport, and altered utilization" (White et al., 2012). Starvation-related malnutrition refers to “prolonged protein energy restriction” (White et al., 2012) that results in loss of weight and functional decline without an inflammatory response.

Malnutrition often is associated with an inflammatory response, sometimes referred to as disease-associated malnutrition, and this inflammation may “contribute to suboptimal response to nutrition intervention” (White et al., 2012). Over-nutrition, as well as under-nutrition, can have a component of inflammation. An acceptable working definition of malnutrition is “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).

**Prevalence and Consequences**
A “common but frequently unrecognized problem” (White et al., 2012), disease-associated malnutrition affects 10% of chronically ill community-dwelling adults and 30% to 50% of adults admitted to the hospital (Snider et al., 2014). A recently published retrospective pooled analysis reported that 32% of community-dwelling older adults were at risk of developing malnutrition (Kaiser et al., 2010).

Numerous studies have documented poor outcomes associated with malnutrition, such as:
- decreased function
- poor wound healing
- depressive symptoms in geriatric patients
- increased frequency of hospitalization and readmissions
- increased length of hospital stay
- increased health complications
- increased morbidity and mortality.

All of these adverse outcomes result in increasing healthcare costs. A 2014 study estimates the annual burden of disease associated with malnutrition to be $156.7 billion in the United States (Snider et al., 2014).

**Diagnostic Tools**
Because of the lack of consensus on a definition, some researchers contend it may be difficult to develop a diagnostic tool for malnutrition (Matarese & Charney, 2017). Furthermore, serum albumin and prealbumin continue to be cited as measures of protein malnutrition, but these hepatic proteins are not true markers of nutrition status (Ganem, 2017); they are indicators of inflammation that do not necessarily respond to nutrition interventions if the underlying cause of inflammation is not addressed (White et al., 2012).

As home care clinicians, our access to laboratory data may be limited. However, patient history and a physical exam can provide essential information that enables the clinician to diagnose malnutrition when using a validated diagnostic tool. There is no evidence that malnutrition should be defined differently across the spectrum of care (White et al., 2012). Standardizing the definition and diagnostic criteria of malnutrition can lead to improvements in accurately capturing prevalence data, developing evidence-based interventions, and assessing outcomes.

Two of the best-known validated tools for screening and diagnosing malnutrition are the Subjective Global Assessment (SGA) and the Mini-Nutrition Assessment (MNA®).

The SGA evaluates weight, intake, gastrointestinal symptoms, and functional capacity, along with a physical examination, to determine if a patient is well nourished, mildly-to-moderately malnourished, or severely malnourished (Detsky et al., 1987). This tool has been validated as a measure of malnutrition in many settings and among many patient populations (Matarese & Charney, 2017), including older adults (Christensson, Unosson, & Ek, 2002).

The MNA® was developed as a malnutrition screening and assessment tool for adults age 65 years and older. The MNA® tool incorporates intake and weight history along with physical functioning and cognitive domains (Kaiser et al., 2010) and has extensive research to support its use in community-dwelling older adults (Nestle Nutrition Institute, 2004).

In “Consensus Statement: Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition),” published in 2012, six criteria based on nutrition history, weight history, physical examination, and the presence or absence of an inflammatory response are used to determine a malnutrition diagnosis and to assess severity (White, et al., 2012). This represents a collaborative effort to standardize diagnostic criteria for malnutrition. Though it remains a consensus statement and is not yet a validated tool (Matarese & Charney, 2017), it can be useful in the home care setting, where evaluation of each criterion is based on information accessible to the home care clinician at the time of the home care visit.

**ICD-10 Codes**
It is helpful to distinguish between severe and nonsevere (mild or moderate) malnutrition to guide diagnosis and ICD-10
coding (Table 1). The Centers for Medicare and Medicaid Services has not adopted any specific definition for malnutrition or any diagnostic criteria. Adoption and utilization of a standardized evaluation tool for use in practice, along with creation of an agency-specific policy or standard operating procedure, would help establish a standard of care for diagnosing malnutrition (Phillips, 2014).

Table 1. ICD-10 Codes for Malnutrition (www.cms.gov/icd10)

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>ICD-10 Description</th>
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<tbody>
<tr>
<td>E43</td>
<td>Unspecified severe protein-calorie malnutrition</td>
</tr>
<tr>
<td>E44.0</td>
<td>Moderate protein-calorie malnutrition</td>
</tr>
<tr>
<td>E44.1</td>
<td>Mild protein-calorie malnutrition</td>
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</table>

**Intervention and Outcome Measures**

Malnutrition has been linked to increased costs and poor outcomes. Identification and treatment of malnutrition is imperative. Straightforward interventions—such as improving food access or optimizing food and fluid intake—often can have a significant impact and result in improvements in health and independence. These outcomes are in line with the Independence at Home Act of 2017 goals and outcomes (115th Congress, 2017).

The U.S. Department of Health and Human Services Administration for Community Living provides a network for implementing nutrition policies and distributes funding to local community agencies. This network enables agencies to implement programs that assist older adults in maintaining their independence and living at home, with support if needed. Community-based programs such as Meals on Wheels or the Commodity Supplemental Food Program are a result of policies and funding provided through these or other federal agencies.

**Registered Dietitian Nutritionists (RDN) as Part of the Home Care Team**

Good nutrition is important for healthy aging and in intervention strategies for those with chronic disease (Levine, Brown, & Millen, 2014). The RDN is a professional highly trained in nutrition and dietetics. Though RDNs are held in high regard as nutrition experts, designating the RDN as the professional who should provide all nutrition therapy services across the spectrum of care and receive reimbursement has yet to be established formally in policy. The Institute of Medicine published a report in 2000 recommending that Medicare recognize the registered dietitian as the healthcare professional to provide nutrition therapy (Committee on Nutrition Services for Medicare Beneficiaries, Food and Nutrition Board, 2000), but there has been a lag in naming the RDN as the professional to render nutrition therapy services; as a result, Medicare has had limited reimbursement for nutrition counseling for patients with diabetes or predialysis renal disease.

Opportunities for the RDN to be included as a member of the home healthcare team are limited and inadequate (Committee on Nutrition Services for Medicare Beneficiaries, Food and Nutrition Board, 2000), with the notable exception of the Department of Veterans Affairs’ Home Based Primary Care program. Additional outcomes research on the impact of the RDN in the transition from hospital to home, and in home-based care, should be conducted. This could provide data on the utility and cost effectiveness of such services. Identification and treatment of malnutrition in home care may represent another opportunity for the RDN to participate in research projects and demonstrate the positive impact of nutrition therapy services on cost and quality of life.

**References**

Your new patient tells you, “My nurse helps me get to the bathroom and organizes my medicines.”

You receive a call from the hospice nurse saying, “Mr. Johnson has fallen down, but he’s OK.”

Your mother’s home-based primary care clinician introduces herself, “I’m Dr. Green. I’m a nurse practitioner.”

Your practice partner suggests, “We should hire a geriatric nurse practitioner.”

Many people understand nursing by its traditional definition: caring for the sick and injured. Today’s professional nurses continue to “nurse” while the field evolves into myriad competencies, responsibilities, and titles. In the 2015 white paper Lessons from the Field: Promising Interprofessional Collaboration Practices, the Robert Wood Johnson Foundation found “leveling the playing field” to be among the practices that foster interprofessional collaboration. The report recommended creating “a level playing field that enables team members to work at the top of their license, know their roles, and understand the value they contribute.” One of the requirements for the level playing field is understanding “what each team member actually does for the team” (CFAR Inc., Tomasak, & Fleming, 2015). In home-based care, where we routinely work together with home health teams, facility staff, and home caregivers, understanding the training and scopes of practice of different nurses will facilitate successful collaboration.

Licensed nursing encompasses three broad roles differentiated by level of education and scope of practice: licensed practical nurse (LPN) or licensed vocational nurse (LVN) in Texas and California, registered nurse (RN), and advanced practice nurse. Professional nursing is regulated and licensed at the state level, which leads to geographic variability in scope of practice, but national certification exams ensure some uniformity in training. This article focuses on the roles of LPNs/LVNs and RNs.

RNs are the largest group of nurses, with more than 3 million employed in the United States, and LPN/LVNs number about 650,000 (Bureau of Labor Statistics, 2017). Clinicians used to working in urban, non-profit hospitals, where the ratio of RNs to LPN/LVNs is about 13 to one, may not realize that in long-term care and home health settings, the nurses they encounter are just as likely to be LPN/LVNs as RNs (Bureau of Labor Statistics, 2015; Welton, 2011).

LPN/LVNs are licensed nurses who have 12–24 months of nursing education, usually through community colleges or vocational schools (Goffman, Chan, & Timothy Bates, 2015). Their education is focused on anatomy and physiology, nutrition, and nursing techniques, excluding independent decision-making regarding complex patient care (Institute of Medicine, 2011). LPN/LVN scope of practice commonly includes tasks such as measuring vital signs, giving medications and tube feedings, starting urinary catheters, and changing wound dressings, all under the supervision of an RN or physician. Managing intravenous therapy and conducting assessments are areas of wide state-to-state variation in LPN/LVN scope of practice regulation (Corazzini, Anderson, Mueller, Thorpe, & McConnell, 2013). The LPN/LVN may be the person who spends the most time with the patient and family in the course of care and may have important insight for the team based on this experience.

Although there is an emphasis on education and scope of practice, personal experience on and off the job also significantly contributes to variation in assessment abilities and other skills among nursing professionals.

Most RNs are educated with a bachelor’s degree, an associate’s degree in nursing, or, rarely, a diploma from a hospital-based nursing program. Some RNs are educated in accelerated nursing programs designed for learners who already have a non-nursing bachelor’s degree (Institute of Medicine, 2011). RN scope of practice generally adds to hands-on nursing skills by teaching nurses a sense of responsibility to independently synthesize information about a patient’s condition from multiple domains and respond to that condition. Although an LPN/LVN may report signs and symptoms, it is more likely to be in an RN’s scope of practice to decide what action is required based on that report. An RN often is responsible for giving a comprehensive nursing assessment in a facility and evaluating a patient’s response to treatment such as a wound care plan, pain medication, or breathing medication. In home health, an RN frequently functions as the case manager and is assisted by an LPN/LVN who makes independent visits. In addition, RN roles often include care coordination as well as healthcare leadership and advocacy.

Although there is an emphasis on education and scope of practice, personal experience on and off the job also significantly contributes to variation in assessment abilities and other skills among nursing professionals. Truly leveling the playing field within interprofessional teams requires familiarity with individuals’ strengths and perspectives. When this isn’t possible, understanding the fundamentals of nursing licenses is a good starting point. When giving a report to—or receiving one from—a nurse, ask what her license is, just as you identify yourself, to level the playing field with a common understanding of roles. Don’t hesitate to ask your nursing colleagues about their training and scope of practice as well as what they have to contribute to the care of the patient.
term “microaggression” refers to the casual degradation of any marginalized group. It is usually a comment or action that subtly and often unconsciously expresses a prejudiced attitude toward someone else. Microaggressions are powerful and dangerous, and they can be disruptive to building strong communities.

Although microaggressions are hurtful to the recipient, the deliverer of the comment or action often is unaware. An important first step in building a healthy team is acknowledging that microaggressions occur and the need to work together to eliminate them.

For our Academy, nourishing our broad diversity will ensure that we consider things from all points of view and that our decisions reflect the best of all possible paths. Our amazingly diverse group of passionate members actively involved in the Academy is the key to our success.

In early July in the Sonoran Desert of Arizona, the monsoon season will erupt. Dark clouds will roll in quickly in the afternoon, magnificent thunder and lightning will take over the sky, and the downpour will make everything stop.

And just as abruptly, across the full sky, a crystal clear rainbow will appear.

Whether we wear sweaters or sunscreen this June, we can unite in our commitment to honoring the gifts diversity brings to our work—not in spite of, but often because of the challenges.

What makes the desert beautiful is that somewhere it hides a well.

—Antoine de Saint-Exupery
HEALTH POLICY UPDATES

Prescribing Opioids for Chronic Pain: CDC Recommendations and Online Clinical Tools

By June Leland, MD MBA

The 2016 Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain was developed in part in response to increased opioid prescription rates and the rise in adverse outcomes, including deaths. The guideline is intended for primary care clinicians who prescribe opioids for the treatment of chronic pain (for more than 3 months) that is unrelated to active cancer therapy, palliative, or end-of-life care. The authors reviewed the available information and answered five clinical questions, which led to the 12 recommendations listed in Table 1 (Dowell, Haegerich, & Chou, 2016a). The full guidelines, including detailed background, rationale, methods, evidence, recommendations, and conclusions, can be accessed on the CDC website (Dowell et al., 2016a) or in the Journal of the American Medical Association (Dowell et al., 2016b).

The 12 recommendations fall into three broad categories listed below. They are based on The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach, which provides a system for rating the strength of the recommendation and quality of the evidence (Guyatt et al., 2008). Recommendation categories are based on evidence type, balance between desirable and undesirable effects, values and preferences, and resource allocation such as cost. Category A recommendations apply to all people, and most patients should receive the recommended course of action. Category B recommendations suggest that individual decision making is needed (Dowell, Haegerich, & Chou, 2016b). Only one recommendation is considered Category B.

Quality of the evidence falls into four categories (Dowell et al., 2016b):
- Type 1: Randomized clinical trials or overwhelming evidence from observational studies.
- Type 2: Randomized clinical trials with important limitations or exceptionally strong evidence from observational studies.
- Type 3: Observational studies or randomized clinical trials with notable limitations.
- Type 4: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

The benefits of long-term opioid therapy for chronic pain are not well supported by evidence. A study of Medicare beneficiaries found that a large proportion of those who had not been prescribed an opioid within 60 days prior to hospitalization and who had filled a prescription for an opioid within 7 days of discharge were filling an opioid prescription 90 days after discharge (Jena, Goldman, & Karaca-Mandic, 2016). Short-term benefits of opioids are small to moderate for pain, but inconsistent for function.

Depending on the home care clinician’s patient population, various risks and harms may apply. In addition to experiencing more pain than their younger counterparts, frail home-bound patients also may face as many risks from nonopioid medications as from opioid medications, and polypharmacy is an additional risk. Decreased renal clearance can narrow the therapeutic window for opioids. Cognitive impairment, falls, depression, and constipation may pose additional risks during chronic opioid use. Clinicians can consider naloxone for those at risk for overdose or those taking concurrent benzodiazepines. Nonpharmacologic approaches alone, or as adjuvants, include but are not limited to weight loss, exercise, and cognitive behavioral therapy. The pain, enjoyment of life, and general activity (PEG) score can be monitored. An improvement in 30% over baseline following opioid therapy is considered clinically meaningful. There is insufficient evidence proving long-term benefits of opioids in low back pain, headache, and fibromyalgia (Centers for Disease Control and Prevention, 2016a).

The CDC has a variety of online resources for patients and clinicians. These include links to the original publications (Dowell et al., 2016a; Dowell et al., 2016b); a variety of tools for assessing benefits and harms, prescribing, tapering, and making dosage calculations; and a mobile app (Centers for Disease Control and Prevention, 2016b).

References
### Table 1. Recommendations, Category, and Quality of Evidence

<table>
<thead>
<tr>
<th>Determining When to Initiate or Continue Opioids for Chronic Pain*</th>
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<tbody>
<tr>
<td>1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. (A3)</td>
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<tr>
<td>2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. (A4)</td>
</tr>
<tr>
<td>3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. (A3)</td>
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<tr>
<th>Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation</th>
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<tr>
<td>4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (A4)</td>
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<tr>
<td>5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to 50 morphine milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day. (A3)</td>
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<tr>
<td>6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less often will be sufficient; more than 7 days rarely will be needed. (A4)</td>
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<tr>
<td>7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. (A4)</td>
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<th>Assessing Risk and Addressing Harms of Opioid Use</th>
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<td>8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/d), or concurrent benzodiazepine use, are present. (A4)</td>
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<td>9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. (A4)</td>
</tr>
<tr>
<td>10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. (B4)</td>
</tr>
<tr>
<td>11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. (A3)</td>
</tr>
<tr>
<td>12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. (A2)</td>
</tr>
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Should Clinical Decisions Be Based on Veterans’ Needs or Their Sense of Entitlement?

By Katherine Lawson, PhD MSSW

During the 1970s, the Veterans Administration (VA) initiated a Home Based Primary Care (HBPC) program to serve veterans in the home setting (Stall, Nowacyzncki, & Sinha, 2014). The HBPC model is unique compared to the more traditional home health approach offered through Medicare and Medicaid (Edes et al., 2014). In addition, the HBPC program serves as the veteran’s primary care provider. To accomplish comprehensive care of a veteran, the team should consist of a nurse practitioner, occupational therapist, psychologist, social worker, dietitian, registered nurse, and pharmacist. Unlike traditional home health programs, there is no imposed certification period of care. This allows for consistent follow-through in the care of the veteran.

The HBPC program presents an innovative shift in the way services are provided to individuals who cannot avail themselves of services using the traditional medical model; the focus of occupational therapy is to evaluate the veteran’s functional status and to make recommendations to increase or maintain the person’s functional independence and safety in their current living environment. There are many aspects to this role including:

• assessment of the veteran’s ability to perform basic activities of daily living such as bathing, toileting, dressing, grooming, and self-feeding
• recommendation for assistive devices needed to increase independent performance of basic activities of daily living or to facilitate completion of these activities for the veteran by a care provider
• assessment of the veteran’s ability to perform instrumental activities of daily living such as meal preparation and other functions of home maintenance
• evaluation and recommendation for durable medical equipment required for functional mobility and transfers (mobility aides, wheelchairs, grab bars, transfer benches, and shower chairs)
• assessment of the need and recommendation for home health physical, occupational, and speech therapy services through an approved home health agency
• assessment and completion of the process to qualify veterans for the Home Improvements and Structural Alterations (HISA) Grant offered through the VA (Home Improvements and Structural Alterations, 2017). This grant provides medically necessary improvements and structural alterations to the veteran’s primary residence to increase accessibility (enter and exit home, bathroom, kitchen, and bedrooms; use of all necessary facilities including showers, countertops, and sinks; and necessary plumbing or electrical system upgrades needed to support installation of home medical equipment).

Although the role of the occupation seems to be clearly defined, completion of these duties is sometimes complicated by the ethical dilemma of making clinical decisions based on what the veteran truly needs versus being swayed by what the veteran may feel they are entitled to receive.

Typically, veterans accept the recommendations made by healthcare workers based on comprehensive evaluation. However, some veterans challenge the recommendations not because they are being denied equipment, home modifications, or extensions of home health therapy services needed but because they feel entitled to unlimited equipment and services regardless of need based on their functional status. Although I do not question their right to services, the ethical dilemma is weighing what is medically justifiable versus the demand for “what I am entitled to receive.” For example, a frequent request is for a motorized wheelchair when the veteran can ambulate without effort or when the veteran does not have the mental capacity or visual acuity to safely maneuver a power wheelchair. Other unwarranted requests have been for duplication of equipment (3-in-1 commode for every bedroom or two manual wheelchairs), home renovations rather than home modifications necessary for independent function, or requests for a fully modified van when they were already provided one because they were told they were entitled to a new van every 3-5 years regardless of the status of their current vehicle. What does a clinician do when presented with this ethical dilemma?

Where the American Occupational Therapy mission statement is to maximize a person’s functional level and enable him/her to live life to his/her fullest (American Occupational Therapy Association, 2017), providing services to veterans under the HBPC model sometimes can be challenged by their sense of entitlement. In those cases, explaining and demonstrating what my role as a therapist can do to improve a veteran’s self-efficacy to perform activities of daily living, mobility, and overall function has helped steer that sense of entitlement to focusing on what is needed to maintain functional independence. This is where I rely on my experience and ability to connect with the veteran through empathy and understanding to maximize his or her health and independence without unduly taxing the VA system.

References


AAHCM Recognizes Dan Gilden with New Creative Investigator Award

Background and Purpose

Dan Gilden, CEO of JEN Associates, led efforts for AAHCM to measure the value of home-based primary care. Gilden’s brilliance and successful ideas broke barriers and enabled AAHCM to publish and disseminate important results on the value of home-based medical care, leading the Centers for Medicare and Medicaid Services to revise their views on the high-need, high-cost group. It is AAHCM’s wish to support the same drive, dedication, and creativity Gilden has modeled throughout his life as an investigator.

The Dan Gilden Creative Investigator Award is given to an exceptional investigator for his or her innovative body of work advancing the field of home care medicine. This award recognizes an investigator who has made great contributions to the field of home care medicine.

Eligibility

Nominees and nominators do not need to be current AAHCM members, but they should have experience in the field of home care medicine. Self-nominations are accepted. Evidence of creative investigation may include, but is not limited to:

- demonstrated creativity and innovation in the field of home care medicine
- first author or coauthor of an original publication (not a review article) in home care medicine
- poster/speaking presentation on a topic related to home care medicine at a national meeting.

Nominations Process

The nomination packet should consist of the following materials:

- Letter of nomination: This letter, written by an individual who knows the nominee’s work, should document the nominee’s contributions and impact on the field of home care medicine. If this is a self-nomination, please document your contributions as they relate to advancing the field of home care medicine.
- Nominee’s curriculum vitae (CV)
- Letter(s) of recommendation: Nominator should submit at least one (maximum two) letter(s) of recommendation from the nominee’s peers, mentors, or colleagues. Recommendation letter(s) should not exceed one page.

All nominations packets must be submitted to Sarah Tiwana, operations coordinator, at stiwana@aahcm.org by August 31, 2017, for consideration.

Review Process

The Awards Committee and Research Committee will establish a review panel consisting of members from each committee to review applications and select an award recipient.

Nominators and nominees will be notified of a decision in September 2017.

Award

An award plaque will be presented to the awardee at the 2017 Annual Meeting in October. The awardee also will receive a $1,000 monetary award and a complimentary 1-year membership.

Nominate your colleagues today for a House Call Provider Award!

The Academy also is accepting nominations for the AAHCM House Call Physician, Clinician, and Educator of the Year. These awards recognize members who have made significant contributions to the advancement of the home care medicine profession. Each recipient will receive 1-year membership to AAHCM, recognition at the Annual Meeting, and a personalized plaque.

Nominations are due August 31. Visit www.aahcm.org to apply.
Connect with Members Through New Online Forum

The Academy is excited to announce that a new member benefit, the AAHCM Member Forum, is now available. This new online collaborative tool, designed exclusively for AAHCM members, comprises digital-friendly discussion forums that will make it easier to connect with other members and enable you to share large files without cluttering your inbox. You will be able to discuss ideas in the Open Forum or within your community or subject interest group, ask questions of the membership, share files in the Resource Library, and view Academy announcements and events.

Your member forum login is the same as your regular AAHCM website login. You can personalize your profile, network by adding contacts, and learn by scrolling through the resource library. Visit memberforum.aahcm.org/home to get started!

If you have questions, contact member services at info@aahcm.org or 847.375.4719. Also, check out the Help/FAQ page on the forum for answers to commonly asked questions.

AAHCM Past President Dr. Thomas Cornwell Named One of 100 Most Creative People in Business

The Academy congratulates Dr. Thomas Cornwell on being named one of Fast Company’s 100 Most Creative People in Business for 2017. He joins a diverse group of influential and revolutionary thinkers who are shaping the future of business in creative ways.

Dr. Cornwell is a past president of the Academy and sits on the board of directors. In 2012, Dr. Cornwell founded Home Centered Care Institute (HCCI), a collaborative nonprofit organization that is advancing home centered care nationwide through education, innovation, and research. In addition to serving as CEO of HCCI, Dr. Cornwell is a family medicine physician at Northwestern Regional Medical Group. He also is the founder of HomeCare Physicians and serves as the physician representative on the state of Illinois’s Older Adult Services Advisory Committee.

Dr. Cornwell was recognized for his vision, leadership, and commitment to improving how we care for America’s aging population, especially those patients who are chronically ill. At the forefront of home-based primary care for more than 2 decades, Dr. Cornwell has made more than 32,000 house calls. Today he continues his work to transform the nation’s health care system by advancing home-based primary care as an effective care model.

“I am passionate about the innovative work we are doing at HCCI, in collaboration with many partners, to expand house call practices throughout the United States,” Dr. Cornwell said. “I am honored that our efforts to prepare the nation for the changing needs of an older population have been commended among such an esteemed and inspiring group of creative thinkers.”
Welcome, New Members

The Academy welcomes the following new members, who joined between March 1, 2017, and June 1, 2017.

**Arizona**
Bree Johnston, MD MPH  
FACP

**California**
Que Anh Chu, MD  
Daphne T. Lo  
Marina Martin

**Georgia**
Melissa R. Pauline

**Hawaii**
Ellen Harris  
Winnie Suen, MD

**Illinois**
Jennifer Ghandhi  
Nancy Zaborowski

**Indiana**
Judy McIntosh, NP  
Gregory Rodocker  
Emily Tedrow, NP

**Kentucky**
Annie W. Williams

**Massachusetts**
Jennifer Limongiello

**Missouri**
Denise Schrader

**New Jersey**
David Carrozzino, DPM

**New Mexico**
Steph Hengle  
Joseph Bacharka III

**New York**
Younghee Limb  
Yasmin Meah, MD  
Raymond Zakhari, NP

**Ohio**
Jennifer Drost  
Wayne Myles

**Oregon**
Karyn Nelson, AGNP  
Katie Ouzounian, DNP  
Ivan Wang, PA

**Pennsylvania**
Denis Khripkov

**Nevada**
Helena F. Russell

**Puerto Rico**
Rosa Castro Avila

**Tennessee**
Daphne Beech

**Texas**
Katherine Lawson  
Aprille Marquez, FNP  
Thomas Reynolds  
Kris Pyles-Sweet

**Washington**
Vicki Bolton

**Organizations**
Landmark Health

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...so you’re not **fair game**.

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American Academy of Home Care Medicine  A Quarterly Newsletter

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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
- Clinical guidelines and communication templates
- For house call providers, listing in our online Provider Locator Directory
- Technical assistance to help with your practice management and other issues

2017 Membership Fees*

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Physicians</td>
<td>$260</td>
</tr>
<tr>
<td>Physicians Outside the United States</td>
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<tr>
<td>Nurse Practitioners/Physician Assistants</td>
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<tr>
<td>Practice Administrators/Medical Directors</td>
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<tr>
<td>Associates (RNs, Social Workers)</td>
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<tr>
<td>Residents/Students</td>
<td>$75</td>
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*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.

Make checks payable to:
American Academy of Home Care Medicine | PO Box 3781 | Oak Brook, IL 60522
847.375.4719 | info@aahcm.org | www.aahcm.org