AUGUST 2020

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SOLVING THE PANDEMIC VENTILATOR PROBLEM

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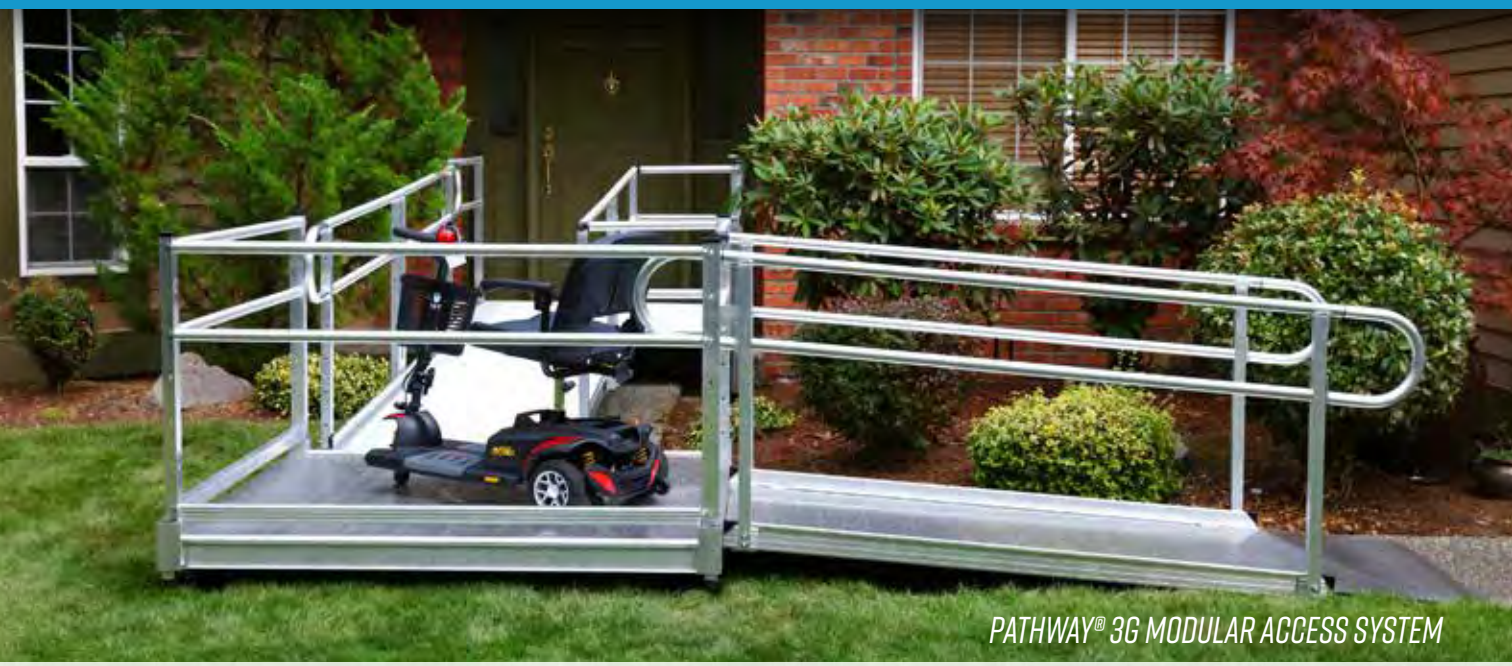

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Dear HomeCare Readers,

I've heard it over and over again in the past few months: Even in the midst of a life-altering pandemic, homecare remains one of the least appreciated parts of the health care system.

Well, we've got an idea to help change that. We're introducing a special section in November—a time for giving thanks—that will honor the unsung heroes of this industry. We'll choose a handful of honorees to highlight for their efforts to keep vulnerable people safe at home. But we need your help choosing them! You'll find a nomination form and more information at homecaremag.com/heroes.

Meanwhile, we're working to keep you informed so you can continue to do this important work. We've decided to step back in this issue and ask members of our editorial advisory board for their predictions on how the industry might be forever changed by the pandemic. The good news? Most are pretty bullish about the future, although there may be some rough sailing as we find our way there.

Also inside are a look at the latest in the respiratory market, including telehealth, how one home medical equipment provider found success with a respiratory network, and an in-depth interview with Ventec Life Systems about how they ramped up to making 30,000 ventilators for the federal stockpile in a matter of months. There's lots more in this issue as well, from audit advice to fleet management to electronic visit verifcation. We hope you enjoy it!

Thanks for reading,

Hannah Wolfson

BE HEARD **We want to know what you think** and how we can serve you better. Send your comments and feedback to Managing Editor Kristin Easterling at keasterling@cahabamedia.com. We'd love to hear from you!

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AUGUST 2020

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On the cover: An inside view of Ventec's VOCSN multi-function ventilator.

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Jackson Joins Sunrise Medical


Larry Jackson

Sunrise Medical, a provider of advanced assistive mobility solutions, announced the appointment of industry veteran Larry Jackson to the position of president of Sunrise Medical North America. Larry will report to Thomas Babacan, the president and CEO of Sunrise Medical Group. With this appointment, he will also become a member of the group's global senior leadership team.

Jackson was previously president of Permobil US and EVP Permobil group.

"Larry brings significant strategic and operational expertise," Barbacan said. "We are very fortunate to have found an industry veteran like Larry who has strong track records of developing and executing effective growth strategy ... over the past two decades. He is the ideal candidate to lead our North American business going forward, and bring our successful growth to the next level."

sunrisemedical.com

UPCOMING EVENTS

Many events have been canceled, postponed or moved online to prevent the spread of the coronavirus. Because of the changing nature of the situation, HomeCare has chosen not to highlight upcoming events.

Please check our special web page, homecaremag.com/coronavirus, to get the latest news about COVID-19, including event updates.

Homecare Homebase Integrates With Swift Medical

Homecare Homebase (HCHB), a software company for home health and hospice, is partnering with digital wound care provider Swift Medical to provide high-quality cost-efficient care through an integrated solution.

Wound care patients are often the most complex and highest risk population in home health. Wound care represents a significant opportunity for home health and hospice providers to use technology to drive quality improvement, increase patient understanding of their progress and dramatically reduce operational expenses.

Swift Medical's digital wound management solution will be integrated with HCHB software, allowing for a simpler adoption process and more effective user experience for home health and hospice providers.

"This partnership with Swift Medical helps our customers provide the most compassionate care possible," said Scott Pattillo, chief strategy officer at Homecare Homebase. "By empowering clinicians to provide high quality wound care, we enable patients to live more independently and stay healthier at home."

swiftmedical.com, hchb.com

Empath Health Earns SAGECare Credential

Empath Health, a nonprofit integrated network of care that provides health care to those with chronic and advanced illnesses, has earned the SAGECare Platinum Credential through SAGE (Services and Advocacy for GLBT Elders), a national advocacy and services organization providing training and consulting on LGBTQ aging issues in order to improve the lives of lesbian, gay, bi-sexual and transgender seniors. The Platinum Credential, the organization's highest level, acknowledges Empath's commitment to LGBTQ elders with in-depth on-going staff training that helps offer meaningful ways to support this community and create inclusive services.

"We are committed to the highest level of care for all of our patients, participants and their caregivers and families as we respect and honor their individual needs and perspectives," said Empath Health President and CEO Rafael J. Sciullo, president and CEO of Empath Health. "We also understand many LGBT older adults have experienced discrimination, social stigma and prejudice and we need to be able to meet them where they are so we can address their needs with compassion and awareness."

Empath staff and leadership completed in-depth training through SAGECare in order to earn the credential and the agency will continue to look for ways to better reach out and support everyone in the community.

empathhealth.org

CareCentrix Hires GM of Medicaid


Scott Markovich

CareCentrix, a provider of tech-enabled post-acute and home-based solutions, is expanding its service offering to Managed Medicaid health plans and has hired Scott Markovich to serve as the company's general manager of Medicaid.

Markovich, who has spent his career working for Medicaid plans and the enrollees they serve, will oversee CareCentrix's Medicaid products. He will lead CareCentrix's rapidly growing Medicaid service offering and be responsible for new product innovation in the Medicaid space.

"Managed Medicaid is a critical part of the U.S. health care system, providing millions of vulnerable Americans with access to high-quality care. As states tighten budgets payers can help states find new ways to lower costs and improve outcomes," said CareCentrix CEO John Driscoll. "Our experience supporting members across commercial, Medicare Advantage and Medicaid plans proves that more high quality care at home is possible today. We are delighted to have Scott on board to lead this effort."

These services are increasingly attractive to Medicaid plans, especially as state-funded plans face budget cuts and expanded membership. As Medicaid plans focus on

87% **of nurses who responded to a survey by National Nurses United said they had to reuse a single-use disposable respirator or mask with a COVID-19 patient due to shortages of personal protective equipment.**

tightening budgets, CareCentrix improves care coordination and reduces costs through value-based contracts and guaranteed savings for post-acute and home services.

Before coming to CareCentrix, Markovich was the regional vice president for the Midwest Region and vice president of business development at Aetna Medicaid. Markovich also served as president of Magellan Complete Care, where he led the creation of the nation's first Medicaid health plan for individuals with serious mental illness. He is a graduate of Pennsylvania State University with a degree in Health Policy and Administration.

carecentrix.com

LHC Group Forms Florida-Based Joint Venture

LHC Group and Orlando Health announced they have signed a definitive agreement to form a new joint venture to enhance home health and home and community based services (HCBS) in Florida. The joint venture will include three current Orlando Health providers and three current LHC Group providers in Orlando, Clermont, Kissimmee and Altamonte Springs.

Under the planned joint venture, LHC Group is to purchase majority ownership and assume management responsibility. LHC Group expects incremental annualized revenue from this joint venture of approximately $3.5 million and that it will not materially affect its 2020 diluted earnings per share.

Orlando Health is a not-for-profit health care network based in Orlando. The system spans nine Florida counties with nearly 450 locations, including 13 wholly-owned or affiliated hospitals and emergency departments, rehabilitation services, cancer centers, heart institutes, imaging and laboratory services, wound care centers, more than 300 physician offices for adults and pediatrics, and 11 urgent care centers in partnership with CareSpot Urgent Care.

LHC Group is a national provider of in-home health care services and the joint venture partner of choice for 350 hospitals across the United States.

lhcgroup.com

PointClickCare to Track COVID-19 Patient Data

PointClickCare, a cloud-based software platform for the senior care market, has been selected by the Society of Critical Care Medicine (SCCM) to provide de-identified patient data for the Discovery Viral Infection and Respiratory Illness Universal Study (VIRUS) COVID-19 Registry.

VIRUS tracks intensive care unit (ICU) and hospital care patterns in near real-time to enable the evaluation of safety and observational effectiveness of COVID-19 practices and determine practice variations across hospitals. VIRUS is a cross sectional observational study and registry of eligible adult and pediatric patients admitted to a hospital. The registry features a dashboard tracking data on trends including length of stay in the ICU and mechanical ventilation duration. The registry will also study mortality and health impact post-ICU.

VIRUS will partner with Lighthouse, PointClickCare's newly formed internal group with a mission to provide health care organizations, government agencies and life sciences companies de-identified data from older adults. The goal of providing data that specifically represents seniors, a population often considered to be at higher risk for severe illness, is to support research that may expedite drug discovery and development.

Lighthouse will provide the VIRUS COVID-19 Registry with de-identified data on COVID-19 diagnosed patients, including demographics, vitals, medications and health-related outcomes to help better understand their health post-ICU. PointClickCare will continue to deliver relevant data on COVID-19 patients throughout the study period.

PointClickCare has also created the Infection Prevention and Control solution, a clinical workflow and intelligence solution that helps care teams achieve ongoing resident surveillance focused on infection prevention at the facility or enterprise level. PointClickCare has also deployed a Crisis Response and Readiness solution, broadening access to telehealth services for all customers and enabling HIPAA-compliant dialogue between staff and physicians.

pointclickcare.com

Protecting Access to Post-COVID-19 Telehealth Act

A brand-new effort to keep lines open after the emergency ends

By Kristin Easterling

The COVID-19 pandemic led to a relaxing of many rules and regulations regarding telehealth, including how Medicare and other insurance providers reimburse for the service. At press time, the declared public health emergency was set to end July 25, but in a recent tweet, Department of Health and Human Services (HHS) spokesperson Michael Caputo had revealed the agency anticipated renewing the emergency for another three months. Whenever the public health emergency does end, protections for telehealth will end as well unless Congress takes action.

Enter the Protecting Access to Post-COVID-19 Telehealth Act. The Congressional Telehealth Caucus, a bipartisan group of representatives, introduced the legislation July 16, 2020, to help protect providers and patients who have benefited from telehealth services during the pandemic.

Legislation

The act works to expand the use of telehealth after the end of the crisis by:

- Eliminating most geographic and originating site restrictions on the use of telehealth in Medicare and establishing the patient's home as an eligible distant site so patients can receive telehealth care at home and doctors can still be reimbursed;
- Preventing a sudden loss of telehealth services for Medicare beneficiaries by authorizing the Centers for Medicare & Medicaid Services (CMS) to continue reimbursement for telehealth for 90 days beyond the end of the public health emergency;
- Makes permanent the disaster waiver authority, enabling HHS to expand telehealth in Medicare during all future emergencies and disasters; and
- Requires a study on the use of telehealth during COVID-19, including its costs, uptake rates, measurable health outcomes and racial and geographic disparities.

This bill includes most priorities outlined in a bipartisan letter to Congress signed by 340 national and regional organizations in June 2020; it urged Congress to make telehealth flexibilities created during the pandemic permanent.

WHAT IT MEANS »

For the millions of new telehealth users who now have access to the services and protections, particularly vulnerable Medicare patients, the services will remain in place and Medicare will continue to reimburse providers for their care.

OTHER PIECES OF TELEHEALTH LEGISLATION HAVE BEEN FILED AS WELL:

- The Advancing Telehealth Beyond COVID-19 Act aims to continue telehealth policies implemented in the CARES Act and expand access for seniors.
- The KEEP Telehealth Options Act and Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act both call for HHS to conduct a detailed study of telehealth use during COVID-19.
- The Equal Access to Care Act would allow care providers to use telehealth in any state to treat patients anywhere for up to six months after the pandemic.

DID YOU KNOW?

CMS Administrator Seema Verma shared that more than 9 million Medicare beneficiaries used telehealth during the early stages of the coronavirus pandemic, with a weekly jump in virtual visits from 13,000 pre-pandemic to almost 1.7 million in April.

STATUS >> At press time, the bill was so new it did not even have a number assigned in the Congressional record. You can follow the bill at congress.gov.

By Richard Cheng

Seeing the Big Picture on PDGM

Analyzing the new system 8 months into its use

On Jan. 1, 2020, the Patient Driven Groupings Model (PDGM) was officially implemented for home health services by the Centers for Medicaid & Medicare Services (CMS). Under PDGM, home health agencies (HHAs) have new financial incentives to consider when admitting and continuing care for Medicare beneficiaries. The financial incentives include higher rates for admitted beneficiaries after an inpatient institutional stay, such as at hospitals and skilled nursing facilities (SNFs). Lower rates are provided for admitted beneficiaries from the community, such as hospital outpatients and hospital patients in observation status, along with beneficiaries who start care from their home without a prior inpatient institutional stay.

The new PDGM case-mix system categorizes episodes into 432 payment groups based on several characteristics:

- episode timing
- referral source (as stated above in reference to hospitals or SNFs)
- clinical category
- functional/cognitive level (via OASIS data)
- the presence of comorbidities.

As was true before PDGM, low-use episodes with relatively few visits in an episode will be paid on a per-visit basis. The threshold for the low utilization payment adjustment (LUPA) will vary from two to six visits, depending on the payment group to which an episode has been assigned. However, episodes at or above the threshold will receive the full case-mix adjusted 30-day payment under PDGM.

Despite the changes associated with case-mix adjustment methodology and the unit of payment, under PDGM, eligibility criteria and Medicare coverage for home health services remain the same. If a Medicare beneficiary meets the criteria for home health services as pursuant to 42 CFR § 409.42, the beneficiary can receive Medicare home health services, including therapy services. Payment under the home health prospective payment system continues to be a bundled payment structure designed to cover all home health services under 42 CFR § 409.44, including nursing, medical supplies, home health aides and therapy services.

PDGM, in conjunction with the effects of the COVID-19 pandemic, has slowed the growth of HHAs through acquisition.

Financial & Market Impact

CMS landed on a 30-day payment rate of $1,864.03 for the 2020 calendar year. The agency predicted in its fact sheet that Medicare payments to HHAs will increase by roughly 1.3%, or $250 million, for 2020. CMS further states that this projected "increase reflects the effects of the 1.5% home health payment update percentage ($250 million increase) mandated by Congress in the Bipartisan Budget Act; and a 0.2% payment aggregate decrease (-$40 million) in payments to HHAs due to the changes in the rural add on percentages, as required in the Bipartisan Budget Act."

CMS also estimated PDGM's likely impact in the 2020 home health payment rule, predicting:

- Payments in 2020 increasing by 2.8% for nonprofit agencies and 3.7% for facility-based HHAs;
- Payments falling by 0.3% for freestanding agencies and by 1.1% for for-profit HHAs;
- HHAs in urban areas seeing a 0.5% payment decrease while those in rural areas should see a 3.4% increase;
- Payments going up for smaller providers and falling for larger providers. For example, payments would increase by 1.9% for the 2,841 HHAs with fewer than 100 episodes in annual volume and drop 0.2% for larger HHAs (those with more than a 1,000 episodes a year).

Based on these financial projections, HHAs large and small are assessing the market for growth, opportunities and market share. HHAs are generally less capital-intensive than SNFs, hospitals, assisted living communities, etc., because agencies do not need elaborate physical infrastructures, such as land, buildings or landscaping. There tends to be a smaller capital market for HHAs. Despite knowing PDGM would be implemented in 2020,

PDGM PRIMER

Need a refresher on how PDGM came about and what it entails? Here you go:

In 2018, the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1689-FC) that updated the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index for calendar year (CY) 2019. The final rule implemented several changes, including a 2.2% increase ($420 million) in payments to HHAs in 2019, rural add-on payment methodologies through 2022, certification and recertification for patient eligibility for home health services and remote patient monitoring.

The final rule also removed seven measures from the HHQRP, a regulatory text change regarding OASIS data and refinements to the HHVBP model. It also finalized payment policies for the new 2021 home health infusion therapy services benefit.

Throughout this process, the Bipartisan Budget Act (BBA) of 2018 created multiple requirements for home health payment reform, using a new case-mix methodology, starting Jan. 1, 2020. CMS stated in the final rule that PDGM "relies more heavily on clinical characteristics and other patient information to place patients into meaningful payment categories and eliminates the use of therapy service thresholds." The final rule also implemented a new 30-day unit of payment in lieu of the traditional 60-day unit and eliminated the volume of therapy visits to determine payment amount.

Before PDGM, the PPS used a series of nine payment thresholds that increased payment as the number of therapy visits in an episode increased. Through the eyes of the federal government, this incentivized HHAs to provide more therapy visits. The Medicare Payment Advisory Commission identified that HHAs tended to adjust their services to maximize financial results, and an investigation by the U.S. Senate Committee on Finance found that many agencies were targeting therapy services based on financial incentives and called for Medicare to move away from using therapy as a payment factor. Consequently, this was a major factor in eliminating the therapy thresholds under PDGM.

providers continued seeking growth through acquisitions before the new payment system was put in place (e.g., LHC Group acquired seven new HHAs and a hospice in 2018). However, PDGM, in conjunction with the effects of the COVID-19 pandemic, has slowed the growth of HHAs through acquisition because investors, private equity groups and HHAs are likely assessing the financial impacts of PDGM before attempting to acquire more HHAs.

Staff & Therapy

Because PDGM lowers the financial incentive to provide additional therapy, beneficiaries and therapy staff have been impacted. Since PDGM has been implemented, widespread layoffs of physical therapists, occupational therapists and speech-language pathologists have increased, adversely impacting patient care (there are examples of patients being told that Medicare does not pay for therapy under PDGM, which is not true) and fewer employment opportunities for therapists. CMS has issued its own position on the role of therapy under PDGM:

"The need for therapy services under PDGM remains unchanged. Therapy provision should be determined by the individual needs of the patient without restriction or limitation on the types of disciplines provided or the frequency or duration of visits. The number of needed visits to achieve the goals outlined on the plan of care is determined through the therapist's assessment of the patient in collaboration with the physician responsible for the home health plan of care. The home health Conditions of Participation (CoPs) (42 CFR 484.60) require that each patient must receive an individualized written plan of care. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s); the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care, and; the patient and caregiver education and training. All services must be furnished in accordance with physician orders and accepted standards of practice. Therefore, the visit patterns of therapists should not be altered without consultation and agreement from the physician responsible for the home health plan of care. Any changes to the frequency or duration of therapy visits must be in accordance with the home health CoPs at 42 CFR 484.60 …"

Notice Requirements & Fraud

HHAs must meet the quality data reporting requirements under the Home Health Quality Reporting Program (HHQRP). HHAs must submit this data and patient assessment data to CMS or be subject to a 2% reduction to the home health market basket percentage increase. The final rule added two additional quality measures to the HHQRP:

- Transfer of Health Information to Provider Post-Acute Care; and
- Transfer of Health Information to Patient Post-Acute Care.

CMS believes transferring health information quality measures will ensure better coordination of care, specifically increasing the likelihood that the patients' medication lists are provided to the patient and the provider upon discharge. Also, since the implementation of PDGM, CMS adopted changes to the Home Health Value-Based Purchasing Model (HHVMP). CMS

believes that reporting HHAs' performance data under the HHVMP contributes to a meaningful choice and allows patients to compare HHAs. In the final rule, CMS describes that it will publicly report each agency's total performance scores (TPS) and TPS percentile ranking from the Year 5 (CY 2020) Annual TPS and Payment Adjustment Report in the nine model states that qualified for a payment adjustment.

In an effort to address Medicare fraud, CMS has reduced the Request for Anticipated Payment (RAP) to 20% in 2020. RAP payments will be eliminated entirely by 2021. Despite the payments being zero, RAPs in 2021 must still be submitted within five days of each 30-day period or be subject to a late penalty. CMS identified fraud as a concern in October 2019, citing an "increase in RAP fraud schemes," and saying that "eliminating RAP payments over the next two years would serve to mitigate potential fraud schemes while minimally impacting HHAs due to implementation of the PDGM, which increases the frequency of payment for services to HHAs."

COVID-19 Impacting PDGM Codes

Two ICD-10 CM diagnosis codes were recently implemented by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS), effective April 1, 2020:

1. In response to the national public health emergency, NCHS is implementing a new diagnosis code, U07.1, COVID-19, into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and;
2. In response to recent occurrences of vaping-related disorders, the NCHS is implementing a new diagnosis code, U07.0, Vaping-related disorder, into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), for reporting vaping-related disorder.

More importantly, according to CMS, the clinical group assignment for both COVID-19 and vaping-related disorder and the low comorbidity adjustment for COVID-19 will be included in the PDGM grouper software.

Looking Ahead

Given the payment changes for HHAs, anticipation for changes in the home health industry should be considered. Only time will tell how the industry will adapt to PDGM. HC

Richard Cheng is a health care regulatory attorney focused on corporate transactions, regulatory and compliance matters. He represents a variety of health care providers (e.g., nursing facilities, home health agencies, hospices, assisted living facilities), investors and private equity groups. He is certified in health care compliance and worked as an occupational therapist before becoming an attorney.

By Cara C. Bachenheimer

Ready or Not, Here It Comes

What you need to know to be prepared for Competitive Bidding Round 2021

It's been a while since we have focused on the implementation of Round 2021 of the competitive bidding program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). Given that the bid window closed in September 2019 and we are in the middle of the second year of the "gap period" when there is no competitive bidding, this is understandable. Plus, there's that small issue of the COVID-19 pandemic that has been consuming our collective attention.

Nonetheless, the Centers for Medicare & Medicaid Services (CMS) plans to move forward with implementing the program on Jan. 1, 2021. Now that we are less than five months away from the scheduled start of Round 2021, it's time to dive back in and understand CMS's expected next steps and what will be different and new for Round 2021—both in and out of competitive bid areas (CBAs).

What's Next?

CMS says on its website that it will announce the Round 2021 single-payment amounts (SPAs) in summer 2020; in the fall, it will announce the contractors for the 130 CBAs that cover 100 metropolitan statistical areas across the country. If CMS is consistent with the timing of announcements for previous rounds of the bid program, it will announce the SPAs in mid-September and the contractors in October. (Summer technically ends Sept. 22, 2020.) Round 2021 was the first time that bidders were required to secure a bid bond of $50,000 for each area they submitted a bid.

Competitive bidding means that only contracted DME suppliers can provide beneficiaries residing in CBAs with items included in the bid program. Bidders submitted bids for one or more product categories in each of the 130 CBAs across the country. Contractors may win one or more product category contracts in each of the bid areas.

Here's a look at four main things you need to know about competitive bidding:

1 Products

There are 15 product categories in the bid program since CMS agreed this April to remove non-invasive ventilators, which was a victory for respiratory providers. The product categories are: commode chairs, CPAPs and respiratory assistive devices, enteral nutrition, hospital beds, nebulizers, negative pressure wound therapy pumps, off-the-shelf back braces, off-the-shelf knee braces, oxygen and oxygen equipment, patient lifts and seat lifts, standard manual wheelchairs, standard power wheelchairs, support surfaces (Groups 1 and 2), TENS units and walkers. All of these have been included in the previous round except for the off-the-shelf knee and back braces.

2 Bid Areas

There are 130 competitive bidding areas that cover 100 metropolitan statistical areas comprising about half of Medicare DME utilization. All of the bid areas that include multiple states are divided into separate bid areas so that no single bid area crosses a state line. The beneficiary residence (by ZIP code) determines whether only contract suppliers can provide the beneficiary with the competitive bid item/service, not the location of the DME supplier. These are the same bid areas that have been included in previous rounds of the program. A complete list of all the bid areas by state and ZIP code is on the competitive bidding implementation contractor (CBIC) website.

3 Payment in CBAs

Payment in the bid areas will be restricted to contract suppliers, and the single payment amounts (SPAs) will be based on the new lead item pricing methodology that CMS has implemented for Round 2021. Under the lead item pricing method, bidders submitted a bid only on the lead item in each product category. The lead item is the item in the product category with the highest total national Medicare-allowed charges from the previous year. All other items in the product category will be priced from that lead item, based on the relative payment levels reflected in the 2015 Medicare fee schedules (prior to competitive bid-based pricing). There is speculation about whether the new lead item pricing methodology will result in better pricing since bidders were able to increase their lead item bid up to the 2015 unadjusted fee schedule level. The resulting impact on non-lead items, however, was one that bidders should have been mindful of when establishing their lead item bids.

4 Payment Rates Outside of the Bid Areas

At press time, there is complete uncertainty about the 2021 payment rates in non-bid areas due to two reasons: the COVID-19 public health emergency and the fact that CMS has not yet issued its Medicare DME proposed payment rule for 2021.

Under the CARES law, which passed on March 27, 2020, Congress set higher payment rates in non-rural, non-bid areas that will be in effect through the crisis. The Department of Health and Human Services (HHS) has extended the emergency to the

end of October 2020. Depending on the COVID-19 situation in October, HHS may decide to extend it an additional three months. (Public health emergencies are established by the HHS secretary for three months and can be extended if the secretary chooses to do so.) If the emergency remains in effect past Jan. 1, 2021, then the CARES law rates in non-CBAs will be in effect through the duration of the crisis because the law takes precedence over CMS's regulation establishing payment rates in non-bid areas.

The CARES law established higher rates for DME in non-CBAs for the duration of the emergency beginning March 6, 2020. In non-rural non-CBAs, the payment rates are set at a blended rate of 75% adjusted and 25% unadjusted of the 2015 fee schedule rates. In rural non-competitive bidding areas, the payment rates are set at a blended rate of 50% adjusted and 25% unadjusted of the 2015 fee schedule rates. The CARES law also eliminated the 2020 2% CMS sequestration cut through Dec. 31, 2020.

If the public health emergency is over by Jan. 1, 2021, then CMS's rates that were established via regulation will be in effect. At press time, however, CMS had not yet published the proposed payment rule. During the last round of competitive bidding, CMS had established payment rates in non-bid areas based on an average of the competitive bid program's SPA for the item in that region of the country. (CMS has divided up the country into eight regions for this purpose.) Payment rates in non-CBAs designated as rural for purposes of DME payment received a 10% increase over the average of the SPAs in that region. Whether CMS returns to that payment methodology or creates a new one will depend upon what is in CMS's final payment rule later this year.

For more information, visit CMS's website on competitive bidding at dmecompetitivebid.com and the industry's educational website at dmecbpeducation.com. HC

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By Eugenio Jaramillo

Teach Your Employees Well

8 steps for creating a continuing education program

Many different industries require professionals to take a certain amount of training, whether as continuing education units (CEU), professional development hours (PDH) or continuing education credits (CEC). Exactly what is mandate may be dictated by law or by accreditation standards or may be up to managers to determine. What are you doing to educate your employees and keep them up to date?

The U.S. Bureau of Labor Statistics predicts that by 2015, millennials will represent the majority of the workforce; by 2030, this hyperconnected, tech-savvy generation will make up 75% of the workforce. This group was brought up with technology in their hands but are often reported as lacking the soft skills and people skills to thrive in corporate America. Plus, baby boomers are retiring with a wealth of information that needs to be passed on to the next generation of leaders.

There are 71% of Fortune 100 companies with a mentor-protégé program. Is that just a coincidence? Of course not.

Consider using your company's baby boomers to mentor your millennials and Gen Zers. Establish a formal program, but allow informal relationships to develop, too. For a chance at true success, every generation needs to continue to develop the next.

So, where do you begin? Here are eight guiding steps to initiate a training and development program.

1 Determine Needs

If programs are going to be effective, they must meet the needs of participants. There are many ways to determine these needs, but some of the most frequently used may include:

- Start with where you are now. Have human resources (HR) find out what degrees and training certificates your employees hold and what courses they have taken. Set the bar from there.
- Ask participants what they believe to be their educational needs.
- Ask management what they believe to be the educational needs of their employees.
- Ask others familiar with the job tasks, including subordinates, peers and customers, what they perceive to be the training needs of employees.
- Test participants to determine the areas in which they lack knowledge and skill.
- Analyze performance appraisal forms, which often reflect deficiencies in ability and understanding.

2 Set Objectives

It is a must to set goals and metrics—what is measured is monitored. How many people will you train? How many training sessions will you have? What results are you trying to accomplish? These results can be stated in terms, such as production, quality, turnover, absenteeism, morale, sales, profits and return on investment.

3 Determine Content

Ask which topics would meet the company's newly defined needs and accomplish the objectives. Then, limit training sessions to an hour. An easy way to do this is to schedule a lunch-and-learn once a week, which accomplishes 52 hours of training in a year.

4 Select Participants

All levels of management can benefit from training programs. Obviously, some levels can benefit more than others. At least some basic programs should be compulsory for first-level supervisors, if not also for others.

If a program is voluntary, many who need the training may not sign up, either because they feel they don't need it or don't want to admit they need it.

Those who are already good supervisors and have little need for the program can still benefit, as they can help train others. This assumes, of course, that the program includes participatory activities on the part of attendees. To supplement the compulsory programs, other courses can be offered on a voluntary basis. Remember to include any training required by local, state and/or federal training regulations.

5 Set a Schedule

The best schedule takes three things into consideration: the trainees, their bosses and the best conditions for learning. Many times, training professionals consider only their own preferences and schedules. An important scheduling decision is whether to offer the program on a concentrated basis—as a solid week of training, for example—or to spread it out over weeks or months.

One good schedule, besides the one-hour weekly lunch-and-learns, is to offer a three-hour session once a month. Three hours leaves you time for participation, as well as for the use of videos and other aids.

The schedule should be set and communicated well in advance, and the program date and time should be established to meet the needs and desires of both the trainees and their bosses.

6 Select Facilities—Or Go Virtual

Facilities should be both comfortable and convenient. Avoid rooms that are too small or that have uncomfortable furniture, noise or other distractions, inconvenience, long distances between training rooms, uncomfortable temperatures, etc.

In this day and age, more and more

training is occurring virtually, especially for groups that may not be able to maintain the appropriate level of social distance. Look at various options for online training, whether via Zoom, Microsoft Teams or various webinar platforms.

7 Select Instructors

Instructor qualifications should include extensive knowledge of the subject being taught, a desire to teach, the ability to communicate and present, and skill at getting people to participate. They should also be learner-oriented or have a strong desire to meet learner needs.

Budgets may limit the possibilities. For example, some organizations limit the selection to present employees, including the training director, HR manager and line and staff managers. In this case, there is no money to outsource, so subject content either needs to be tailored to the available instructors or the instructors will require special training before teaching. If budgets allow and internal expertise is not available, outside instructors can be hired.

The selection of these instructors also requires care. In order to be sure that a potential instructor will be effective, the best approach is to observe their performance in a similar situation.

The next best approach is to rely on the recommendations of other professionals who have already worked with the individual. Avoid interviewing potential instructors and then making a decision based on your impressions alone.

8 Coordinate the Program

There are two approaches to the position of coordinator.

Some instructors must introduce themselves, find their own way to the lunchroom, tell participants where to go for breaks, conclude the program and even ask participants to complete reaction sheets at the end.

On the flip side, some coordinators handle the logistics. They also work to ensure the instructors have ample setup time before the meeting, introduce instructors to other team members, handle breaks, conclude the session and even stay for the entire program to assist. HC

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A Win for Ventilation

Ventec Life Systems tackles the pandemic head-on

By Kristin Easterling

Ventilation made it into the public eye in March with the onset of the COVID-19 pandemic, and Ventec Life Systems was at the forefront, as the small company teamed up with General Motors to build 30,000 ventilators for the national stockpile. Ventec is the creator of VOCSN, the first ventilator that integrates five separate devices: a ventilator, oxygen concentrator, cough assist, suction, and nebulizer (that's what VOCSN stands for). HomeCare talked with Chris Brooks, chief strategy officer for Ventec Life Systems, about the move and what's down the road for the company.

HOMECARE: You've had a busy time! How did the General Motors partnership come about? Where does it stand now?

BROOKS: Yeah, it's been a very busy few months for everyone in the homecare industry, particularly those in the respiratory industry. We do all of our design development and manufacturing in Bothell, Washington, which is just about 30 minutes north of Seattle and only a few miles down the road from the initial outbreak of COVID in the United States, so we were acutely aware of what was going on; at that time it wasn't yet a pandemic but it was quickly spreading. We were very vocal in the media, discussing what is respiratory care, what does a respiratory pandemic look like, at that point—and we continue to learn today about how to care for these patients—recognizing that patients that suffer from COVID were going into full advanced respiratory distress syndrome and needed a true critical care ventilator to give them a chance to allow their body to fight this disease and get healthy again. And so we were very vocal about what is a critical care ventilator as opposed to a lot of the other devices out there … about not just needing a ventilator but needing other equipment as well, and, more importantly, needing respiratory therapists to manage these devices. The world very quickly became aware of respiratory care and what is a ventilator and what is a respiratory therapist.

We knew that while we were a growing company and we were scaling our production month over month, that when you hear Gov. Andrew Cuomo in New York say that they need 40,000 ventilators and that's nearly half of the crucial care ventilators that are created globally each year, we knew that we were going to have to massively scale our manufacturing. We were fielding calls from a wide variety of different partners who were offering their services to us, and from that we ended up being introduced to General Motors. We had our first phone call with General Motors on March 17. From that phone call, we very quickly understood that we could go from a phone call to a partnership. They were bringing together both their global supply chain, which was our biggest constraint at the time, really needing parts to build ventilators, and they also understood scaled manufacturing. We were producing on the 100s and we needed to produce on the 1,000s and we knew that General Motors could bring that to bear.

Very quickly … they identified a location in Kokomo, Indiana, where they were making advanced electronics, and we were able to replicate the facility we have here in Bothell, Washington, on a much larger scale in Kokomo and build that out to be able to have multiple production lines for VOCSN. Less than 31 days (after the first phone call), we were shipping ventilators that were made in Kokomo to frontline health care providers in the Chicagoland area who were battling COVID. In that process, we received a federal contract for 30,000 ventilators to go into the federal stockpile, which we are in the process of completing right now. That'll be done at the end of August. We're happy to report that we're on schedule with that production.

HOMECARE: Do you think that we're better prepared for a second wave of the virus?

BROOKS: We certainly have more ventilators. Ventilators are a piece of the puzzle. As we've said all along in this process, the person with ALS who wakes up in the middle of the night unable to breathe because the disease has taken over their respiratory system—that need for a ventilator is just as acute as a COVID patient. We have tried not to lose sight of the homecare market and the need for ventilators there. Ventilators are part of the public health safety net, so as we begin to open economies and people go back to work,

our hope and prayer is that we never need to use the 30,000 ventilators that are going into the stockpile. But knowing that we have access to those tools allows us to begin to reopen and allows medical professionals to have the peace of mind knowing they have the tools to take care of patients ... We certainly have not taken our foot off of the accelerator. We're still making ventilators as quickly as possible and trying to fulfill the orders that we have on backorder plus the new orders that continue to come in.

HOMECARE: What lessons have you learned since March?

BROOKS: I think you can never be too prepared. We've learned a lot about manufacturing at scale and doing it as quickly as possible. I think it has reinforced one of the core values of ours, which has been training. A ventilator is only as good as somebody who knows how to use it, and we've always been proud of the training that we've offered, whether that's a new mom who's taking care of a child on a ventilator, or that's a respiratory therapist at a facility ... All of our training is open source and available for anyone who wants on our website and that's important during a respiratory pandemic, where you're going to have a lot of people perhaps using equipment they've never used before because they're getting it from the stockpile or perhaps even non-respiratory therapists who are having to use equipment as well. I think it also kind of reinforces the idea of integration to be able to more efficiently care for patients and to be able to care for more patients with fewer people, which is typically what happens during a pandemic.

HOMECARE: Let's talk about the Centers for Medicare & Medicaid Services (CMS) rolling back competitive bidding in April. How has that helped the noninvasive vent market as a whole?

BROOKS: This is a huge win. And sadly, care for ventilator patients—the payment for that provided to the homecare companies—continues to get reduced year after year, and competitive bidding was going to do that as well. We fully support both invasive and non-invasive (ventilation) not being part of competitive bidding. Our code, E0467, was not part of competitive bidding, but regardless, this was a huge win for all ventilator users to ensure there are proper funds in place to support the care for ventilator users. We were very happy to see CMS roll that back.

HOMECARE: In a victory for your category of vent, HCPCS E0467, they removed the "same or similar" language recently. How is that going to help patients receive care?

BROOKS: Traditionally for ventilators you would have to bill for invasive or noninvasive, so E0465 or E0466; when we introduced VOCSN, it combined multiple devices into one. You can't bill multiple codes against one piece of equipment—that's fraud—and so we needed to come up with a new mechanism to reimburse for VOCSN. CMS in 2019 introduced E0467 for a multifunction ventilator, which is defined as a ventilator that also combines an oxygen concentrator, cough assist, suction pump and nebulizer; VOCSN's the only device that meets the requirements for E0467. Patients are eligible for E0467 if they have a prescription for a vent plus one of the additional therapies (oxygen, cough, suction or neb) and, as we discussed, almost every ventilator patient has a prescription for a ventilator plus one of those other therapies. ... The implementation basically precluded any patients who had previous billing history of any of that equipment. So, if you had a nebulizer that you billed for two years ago, you were precluded from getting access to VOCSN. That "same and similar" provision has been removed, and that was a big win; it really opens access to all ventilator users to have access to integrated care with VOCSN. The homecare company realizes anywhere from 15-20% higher reimbursement for that device and now they're only having to bill for one code. It significantly streamlines care for the homecare company, makes it a lot easier for patients and caregivers, and provides a lot more access to VOCSN.

HOMECARE: What are your future plans? Where do you envision Ventec being in five years?

BROOKS: This idea of integration in the health care space has certainly been much talked about ... This idea that every time you leave the house and you take your ventilator with you, you also have cough, suction, nebulizer, oxygen, so you're not intentionally leaving those therapies behind. You're becoming more compliant with them because they're easier to use and they're with you at all times. You can begin to see where the clinical benefits play into integration as well, so we're excited to continue to expand upon that.

There's a lot that we will be adding to VOCSN. We launched multi-view this year, the ability to track and monitor all five therapies, to begin to understand what is going on holistically with your patient—not just what are your breath rates and when are patients triggering the breath, but how is there secretion management with cough and suction impacting their oxygen usage and then what are we seeing as a result in their data. Building out a platform for physicians and DMEs to begin to log in and monitor those patients, not just what's going on with the ventilator but holistically what's going on with their care, and then certainly the trend for continuing to provide high-level care in the home. HC

To hear more from Chris Brooks about care integration, connectivity and data collection on the HomeCare Podcast, scan the code above with your device.

Kristin Easterling is managing editor of HomeCare magazine.

Seeing & Treating the Whole Patient

How building a respiratory network helped one HME provider find better outcomes

By Cheryl Henninger

To truly help our communities, we need to understand not only patients' clinical needs, but also any nonclinical needs or issues that impact their overall health. That can be especially important when dealing with respiratory diseases. Studies indicate that approximately two-thirds of patients with chronic obstructive pulmonary disease (COPD) with comorbid depression have moderate to severe depression, and about a quarter of COPD patients may have unrecognized subclinical depression.

One way to meet those needs is to establish a respiratory network that includes a mental health provider who is part of case conferencing and monthly network process meetings. This adds value by providing a holistic approach to care and improving outcomes.

A Real-World Example

After completing a community needs analysis amidst the changing health care landscape, my employer, Gerould's Professional Pharmacy, Inc., stepped outside of the traditional pharmacy and home medical equipment (HME) box and introduced a population health division in 2015.

Gerould's is a third-generation family-owned pharmacy, HME and home clinical services provider that has been caring for the local community for over 98 years. The company—which has five locations in Elmira, Corning and Horseheads, New York, and reaches clientele in a 15-county region in New York and Pennsylvania—believes in growing beyond the traditional services and finding innovative ways to serve the people in our communities.

Our population health division, called "Community Cares Health Solutions," places an emphasis on improving community health and originally included chronic respiratory services (in-home patient services and pulmonary rehab), community outreach and navigation services, and care transition services. The program has since expanded and now also includes remote patient monitoring, telehealth services and a customized patient engagement application.

Adding the program kickstarted a company culture change in terms of how patients and customers are served. Patient services are now holistic and focus on the patients' overall needs instead of being "prescription focused." Plus, the information we have gathered has helped us connect patients to needed community services outside of our scope of practice for better overall outcomes.

It is quite a turnaround for Gerould's, which was founded in 1921. The owner had dropped respiratory care and was considering exiting the HME industry before I came on board just as health care reform was picking up steam. We put a HME plan together and laid out what health care reform could mean with us at the table. The result has been a focus on value-based care.

Starting at Intake

Gerould's intake process now includes a health and wellness screening that assesses health inequities, mental health and substance abuse, along with a home accessibility and fall risk assessment. Any identified issues are discussed with patients and referred to providers and community agencies that can help address the identified needs. Gerould's works to identify services in the community that would benefit patients.

The most recent success of the chronic disease management program is the development of a respiratory network collaboration. The partnership, led by Gerould's clinical respiratory team, includes mental health specialists, social needs specialists, and hospice and palliative care specialists. The network partners case conference with enrolled patients to help them manage their overall health and wellness needs through assessment, education, engagement and improving self-management skills.

The launch of the chronic respiratory program grew out of a pilot program that reduced readmission rates from 24% to 9% over a 12-month period for 50 patients who were identified as "high utilizers." The success of that pilot program led to grant funding from the state to expand and to develop a population health division as well as to create a network of partners to ensure patients have access to the resources they need to successfully transition back home.

Patient services are now holistic and focus on the patients' overall needs instead of being "prescription focused."

Gerould's offers the following services as part of our health program:

- Respiratory assessment
- Pulmonary rehab
- Respiratory care education, including medication management, breathing techniques, airway clearance, the use of medical devices, nutrition and more
- Respiratory monitoring and follow up
- Home accessibility and safety assessment

Now With Telehealth

Gerould's began its own telehealth project last year, providing health care support to patients enrolled in the chronic respiratory program through a customized patient app. Telehealth visits and vitals are also captured through the app, which is accessible via a personal computer, tablet or smartphone. Clinicians can remotely monitor vitals such as blood pressure, weight, oximetry and spirometry, and they can also use video to assess, educate and counsel patients as may be necessary.

The app helps patients stay engaged and involved in their own health management and has resulted in a reduction of acute care services, improved health outcomes and improved patient satisfaction. Typically, the respiratory therapist will make an initial home visit with the patient, help them install the app and do an overall clinical, social and home assessment. Moving forward, the patient will complete daily check-ins using word clouds to help describe how they are feeling. Different levels of self-assessment are color coded, alerting the respiratory therapist when it might be time to reach out to the patient.

The patient can also message the clinical team at any time, day or night. Some patients are so connected with their therapists, they send messages just to say hello. The app now has added tracks and is being used for patients with obstructive sleep apnea and other chronic conditions. With the current pandemic, telehealth is the new normal for the respiratory care team and for patients.

Overall, the goal of the population health division at Gerould's is to establish a model that is recognized as value-based and cost-effective—and that payers will pay for

The HME industry is the perfect fit for these kinds of population health services. We are already in the home and we already have the relationships with patients. The equipment is essential for these patients but it's the services that really pull in value. HC

Cheryl Henninger, RRT, CEAC, is director of Community Cares Health Solutions at Gerould's Healthcare Division. She has more than 25 years of experience in health care including clinical services, health care management and consultation, legislation and accreditation. She is involved in the development of new health care services geared at helping those with chronic illnesses and/or disabilities remain independent and active.

Managing Health From Home

The future of telehealth in respiratory care

By Teofilo Lee-Chiong

Of the various chronic diseases, respiratory disorders are among the most prevalent, underdiagnosed, debilitating, deadly and costly to manage. Chronic obstructive pulmonary disease (COPD) affects about 250 million people globally and was responsible for more than 3 million deaths in 2015. Neurologic disorders cause significant dysfunction of the respiratory muscles in over 330,000 persons worldwide, and an estimated 1 in 160 adults suffer from respiratory failure related to severe obesity.

Although there are accurate and effective technologies for the diagnosis and therapy of respiratory disorders such as oxygen, respiratory drug delivery and ventilation devices, many of these are still underutilized in the home.

Telehealth and connected respiratory care bring resources that were once limited to medical centers into the patient's home. They enable continuous monitoring, early intervention and cross-disciplinary team care, which may be especially relevant for patients with advanced disease, multiple comorbidities or frequent exacerbations—that is, patients who require more intensive management that addresses the complexities of their disease. Connected care also offers the promise of greater access to care, more efficient and effective use of health resources, an improved patient experience and lower medical costs.

Where We Are Now—There Is No One Size Fits All

There is a disparity in the availability of respiratory health care. Many communities have well-established respiratory care systems, while others struggle to address the needs of their vulnerable populations with limited facilities. Even among the former, access to care may be hindered by geographic distance, transport limitations or financial difficulties. Furthermore, providing good care for varied patient lifestyles and choices will require individualized solutions.

Increasingly, artificial intelligence and machine learning will underpin all efforts to harness the full potential of telehealth in order to enable more precise and proactive care.

Transforming the entire care process for chronic respiratory diseases is essential. Fragmented care should be replaced by continuous and mutual engagement. Every patient must be seen in the context of his or her specific needs, individual experiences, and cultural and societal realities. Each community must develop its own unique path to telehealth, guided by its resources, values and culture.

Where We Have to Go—No More Business As Usual

Connected respiratory care can help patients be more informed of their illness and new developments in diagnosis and therapy; more responsible for their behaviors and how these impact their health; more aware of their symptoms and disease progression; more involved in the day-to-day management of their disease and long-term goals; more in touch with various members of their interdisciplinary care team; and more proactive in the event of disease exacerbations and medical emergencies. Empowered patients who are inspired to take control of their lives can become important partners in their health care journeys.

However, if done improperly, telehealth can deepen social injustices by giving greater access to those most able to use telehealth services, including the healthy and "worried well," rather than to those who need services most but lack reliable internet connections or are limited by language barriers or web illiteracy. Improper telehealth application may also incur greater health care costs by inaccurate diagnosis or overtreatment due to care discoordination.

Also under consideration are issues of data privacy, security and ownership. Cybercrime is a real threat, and health care data is among the most lucrative datamining targets. It is important to guard against biocrime, or manipulation of data or settings of medical devices over the web.

How We Move Forward—Respiratory Telecare by Design

The current problem with respiratory telecare is not one of science or technology, but of policy. It is not a problem of availability of services, but rather of their proper implementation. Providers need to understand how to fit telehealth into patients' lives, rather than fitting their lives

into existing technology. Some suggestions for this include:

Facilitate empowered self-care.
Only with effective engagement can patients responsibly choose to do what is right for themselves, rather than be forced to behave according to prescriptions or regulations. Use information to help patients make better decisions. Make data meaningful, not interruptive.

Make it personal.
It is essential that respiratory telecare be adapted (meaningful to the patient), targeted (related to the patient's difficulties and needs), intelligible (comprehensive but not overwhelming) and supportive (providing hope, solutions and options).

Shift the focus.
Care delivery should not be based merely on stressing patients' needs but also on amplifying their strengths. Transform respiratory telecare from reactive treatment of disease to proactive promotion of health.

Maximize community support.
It may seem counterintuitive, but self-care will increasingly take on a more societal character. Participation in self-care will be fueled, at least in part, by more community programs and social platforms for these activities. Family members can support a patient's quest to get better by also living a healthy lifestyle and by encouraging adherence to therapy. Local volunteer groups can plan activities that patients can join and post these on the internet.

Rethink technology.
Respiratory monitoring devices must be interoperable; technology has to be validated for reliability; algorithms have to be more transparent to ensure accountability; and device performance has to be guaranteed in different age groups, sex and medical comorbidities. Consumer wearables today are primarily designed to measure physiologic variables. Technologies should recognize respiratory symptoms as well as deliver and respond to appropriate interventions. For instance, respiratory telecare can assist patients' use of noninvasive ventilation more effectively, provide immediate feedback on proper or, more importantly, improper techniques, and enhance treatment adherence by correlating improved symptoms to regular device use. Increasingly, artificial intelligence and machine learning will underpin all efforts to harness the full potential of telehealth in order to enable more precise and proactive care.

1 in 160

Adults may suffer from respiratory failure related to severe obesity.

Mitigate the dangers of technology.
It is important to remain cognizant of potential problems that may arise with the greater adoption of respiratory telecare in order to proactively manage these issues. These may involve the patient, such as psychological dependencies, or be technological deficiencies of the testing and monitoring devices.

Eliminate the hospital vs. home rivalry.
Facilitate information sharing between the hospital and the home; this is especially crucial during transitions of care and caregivers. Involve home health care providers in discharge planning.

Foster scientific citizenship.
There is so much that is not known about respiratory telecare. A better understanding of how a patient uses telehealth and feels about using it can promote an ongoing dialogue between patients, engineers and health care providers.

Identify the choke points of care.
Address reasons for disengagement from, distrust of, or even hostility to respiratory telecare. Work with other providers, industry, businesses and government to increase access to and support sustainable telehealth programs, to advocate for equitable health resource allocation, and to remain agile for new scientific discoveries and advances in technology.

The value of telehealth lies not in the technology, but in the problems it can help solve. Done properly, telehealth can enhance the efficiency and quality of care, improve health outcomes, and help empower patients to make informed decisions. Beyond the current concerns regarding effectiveness, safety and the availability of devices and services, the promise of technology is larger—better web-based tools for education, dialogue and coaching and enhanced remote monitoring features that support more precise and proactive care. Better care for chronic respiratory disorders can prolong survival, improve quality of life, allow patients to remain active and reduce health care utilization and costs. HC

Teofilo Lee-Chiong, MD is the chief medical liaison at Philips Sleep and Respiratory Care. He also serves as a pulmonologist at National Jewish Health.

THE FUTURE of HOMECARE

Trying to predict how a pandemic changes everything

By Hannah Wolfson

The statistics are brutal—and continuing to rise. An estimated 40% of the approximately 130,000 deaths from coronavirus in the United States occurred in residents or employees of nursing homes and long-term care facilities. One in five such institutions has reported at least one death. And even those left untouched have closed for visitors, leaving residents isolated. One senior in lockdown in a nursing home was quoted by the Philadelphia Inquirer as saying "I feel like I am on death row."

Even before the pandemic, three-quarters of Americans over 50 said they would prefer to age in place, according to AARP. Others who use and provide homecare—the disability community, people with chronic disease, rural care providers—have long pushed for better remote access to care to protect those vulnerable to infection or limited by transportation issues. Now, it is on the table.

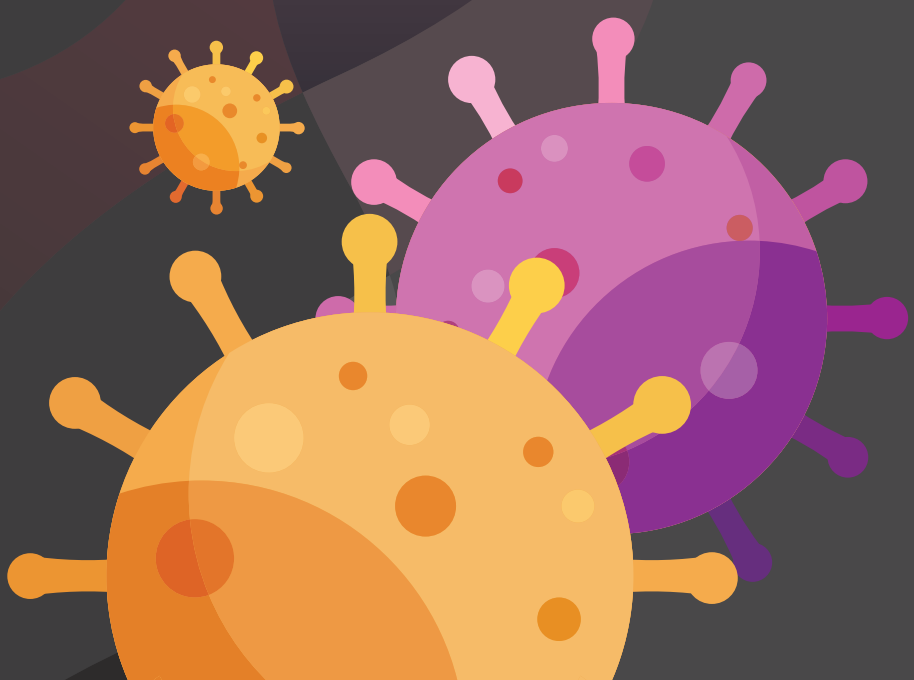
"In a strange way, this pandemic has been sort of a blessing, because it has highlighted the need for addressing issues in the health care system," David Totaro, head of governmental affairs for BAYADA and chairman of the Partnership for Medicaid Home-based Care, told HomeCare.

So just what does it all mean for the homecare industry? Will there be a sudden demand for more options for care at home? Will home medical equipment (HME) providers and home health agencies (HHAs) buck the trend of small businesses closing as Americans awaken to the value of aging in place?

There are so many questions—and many are impossible to answer six months into a pandemic very few saw coming. But we figured it was time to step back from the day-to-day news about COVID-19 in order to get a sense of how the virus might change homecare after the public heath emergency ends. We asked members of Homecare's Editorial Advisory Board to peer into their crystal balls and let us know what they think might look different down the road. Here are their thoughts.

40%

of the approximately 130,000 deaths from coronavirus in the United States occurred in residents or employees of nursing homes and long-term care facilities.



Given the pandemic's toll in institutions, will societal attitudes toward caring for elders at home change?

If there is an up side to the COVID-19 pandemic, it is the increased education and awareness of the critical role durable medical equipment (DME) providers play during a public health emergency. Many providers have been literally on the front lines risking their own lives and those of their families to provide for those in need of respiratory and other medical equipment for those with COVID-19 and/or underlying health conditions at home. The DME industry has shown that with the right medical equipment and technology, people can be treated and have their health care needs managed at home. ***I am very bullish on the future of DME and homecare as a result of this pandemic.*** The last place seniors or people with disabilities want to receive care is in a nursing homes or other health care facilities. The future is bright, and policymakers are more aware of the critical role the industry continues to serve.

» *Seth Johnson, Senior Vice President of Government Affairs, Pride Mobility/Quantum Rehab*

Considering the nursing home tolls and fear of infection cutting off families during the public health emergency, ***HME providers are poised for an untapped opportunity.*** Families will think twice about placing elders in nursing homes. Consequently, providers can and should help families keep their loved ones comfortable in their own home with the right equipment and assistance. This viable alternative to a group home setting will require an education campaign to help families understand what equipment is available and how to use it, etc. When marketing and educating, include a virtual room setup with staged equipment, similar to the way furniture stores and real estate companies show their products and homes today.

» *Miriam Lieber, President, Lieber Consulting*

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PROTEKT® AIRE 3000 SERIES
LOW AIR LOSS/ALTERNATING PRESSURE MATTRESS SYSTEM

- User friendly air flow dial offers custom weight settings.
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Product	Item #	Description
3000	80030	with standard mattress
3500	83500	with 3" safety base mattress
3600	83600	with cell-on-cell mattress
3600AB	83600AB	with side air bolsters

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- Digital pump with "Auto Compressor Sleep Technology".
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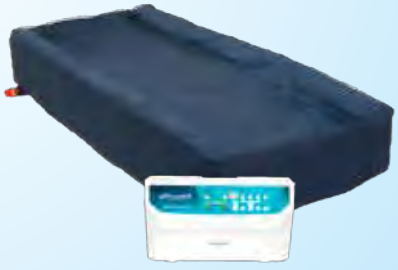
Product	Item #	Description
4000DX	80040DX	with standard mattress
5000DX	80050DX	with 3" safety base mattress
4600DX	84600DX	with cell-on-cell mattress
4600DXAB	84600DXAB	with side air bolsters

PROTEKT® AIRE 6000 SERIES
DELUXE DIGITAL LOW AIR LOSS MATTRESS SYSTEM WITH CELL-ON-CELL TECHNOLOGY

- Deluxe digital pump offers (4) alternating cycles (10, 15, 20, 25 min.)
- 450 lb. weight capacity.
- 2 Year non-prorated warranty.

Product	Item #	Description
6400	86400	with standard mattress
6450	86450	with 3" safety base mattress
6000	80060	with cell-on-cell mattress
6000AB	80060AB	with side air bolsters

PROTEKT® AIRE 7000
LATERAL ROTATION/LOW AIR LOSS/ALTERNATING PRESSURE AND PULSATION MATTRESS SYSTEM



- Lateral turn up to 40° - 10 to 95 minute cycle times.
- (5) Alternating cycle times (10, 15, 20, 25, 30 min.)
- Low air loss reduces moisture and perspiration.
- 660 lb. weight capacity.
- 2 Year non-prorated warranty.

Product	Item #	Description
7000	80070	standard mattress 36"
7000-42	80070-42	bariatric mattress 42"

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- 2 Year non-prorated warranty.

Item #	Description
80080	bariatric mattress 42”
86080AB-42	bariatric mattress w/ side air bolsters 42”
80085	bariatric mattress 48”
86080AB-48	bariatric mattress w/ side air bolsters 48”
80080-54	bariatric mattress 54”

PROTEKT® AIRE 8900
LOW AIR LOSS/ALTERNATING PRESSURE/PULSATION MATTRESS SYSTEM WITH “ON DEMAND” AIR BOLSTERS

- “On Demand” side air bolsters mitigate accidental patient roll out.
- Side air bolsters quickly deflate to allow easy exit from mattress.
- (5) Alternating cycle times (10, 15, 20, 25, 30 min.)
- Low air loss reduces moisture and perspiration.
- 660 lb. weight capacity.
- 2 Year non-prorated warranty.

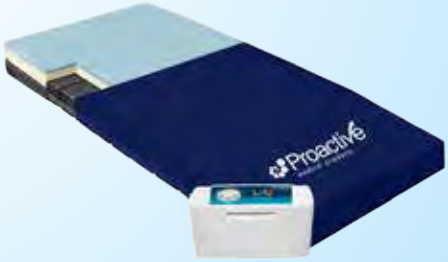
Item #	Description
80089	standard mattress 36”

PROTEKT® AIRE 9900
TRUE LOW AIR LOSS MATTRESS SYSTEM WITH ALTERNATING PRESSURE AND PULSATION

- True low air loss blower system.
- (6) Alternating pressure cycle times (5, 10, 15, 20, 25, 30 min.)
- Pulsation adds gentle stimulation to increase blood flow.
- 1000 lb. weight capacity.
- 2 Year non-prorated warranty.

Item #	Description
81090-36	standard mattress 36”
81090-36AB	standard mattress w/ side air bolsters 36”
81090-42	bariatric mattress 42”
81090-42AB	bariatric mattress w/ side air bolsters 42”
81090-48	bariatric mattress 48”
81090-48AB	bariatric mattress w/ side air bolsters 48”

PROTEKT® SUPREME SUPPORT
SELF-ADJUSTING AIR/FOAM MATTRESS WITH OPTIONAL ALTERNATING PRESSURE PUMP



- Top foam layer constructed of “Visco Gel Polymer Technology”.
- 10 interconnected cells continually equalize pressure.
- Optional user-friendly whisper quiet alternating pump.
- 700 lb. weight capacity.
- 5 Year non-prorated warranty.

Item #	Description
94001	non-powered self adjusting 35”
94003	non-powered self adjusting 42”
94004	non-powered self adjusting 48”
94001P	powered self adjusting 35”
94003P	powered self adjusting 42”
94004P	powered self adjusting 48”

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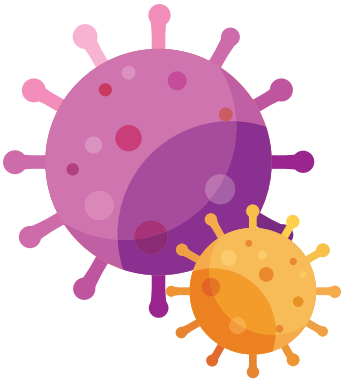
Check 101 on index.

With such a high spread in congregate living environments, we're going to change our way of thinking and the spread of infection. ***The world is going to approach things in a new way.***

» *Mary Ellen Conway, Chief Compliance Officer, US Med*



Things are already changing. Home access companies got a boost in hot spot areas where families removed their loved from isolated senior living environments. The longer Centers for Disease Control & Prevention guidelines are in place in senior living, the more likely that home-based living and care will become more highly utilized. ***We will stretch the limits of homecare to evolve to be able to take care of nursing home-level needs in someone's home.*** I believe the pandemic will affect the assisted living-level client and people will look for residential options.

» *Jim Greatorex, Vice President, VGM Live At Home*

There is no doubt there will be many, many changes in the homecare industry—not only in operations but in discussions at staff meetings. Many discussions will be about staying connected: connection with patients, patients with their families and our ability as providers to stay connected with all those involved in the care plan. ***Will we be providing smartphones to patients, setting up regular FaceTime appointments and working evenings to meet with families.*** We also need to focus on staff education, learning about how to keep our patients safe and ourselves.

» *Louis Feuer, President, Dynamic Seminars & Consulting*

Homecare has distinguished itself in many ways during the pandemic. Caregivers of all disciplines have really stepped up to the frontlines of caring for COVID-19 infected patients while continuing the serve the millions of others who benefit from home care annually. In addition, through significant media coverage, ***an increased awareness of the value of homecare has emerged*** in terms of safety, clinical efficacy, convenience and the breadth of services. That awareness has grown in both consumers and the health care community.

» *Bill Dombi, President, National Association of Home Care & Hospice*

So how will long-term life at home look different in the future?

I believe that with payers relaxing restrictions and placing an emphasis on telehealth and remote patient monitoring devices, more people will opt for care in their homes versus a long-term care facility. The challenge I see is the need for homecare clinical personnel and custodial care takers. Family members aren't always able to provide the 24-hour care that is required and a homecare partner is needed. Obstacles include the staffing shortage in homecare and the need for financial assistance for the cost of caring for loved ones in the home. Payers will need to re-look at their coverage criteria to provide reimbursement for custodial care and homecare. Not only is the health care system taxed due to COVID-19, but the baby boomers will also cause an influx to the homecare and long-term care options, highlighting the shortage of caregivers and clinical personnel.

» *Sarah Hanna, CEO, ECS North*

Daily check-in meetings with patients may be in order as we see reductions in our staff as they work to meet their own personal challenges. Children not in school full-time can alter the roles of our homecare workers. ***It is hard to believe that the school system will impact our homecare industry, but it will.*** It is hard to be a nurse full-time visiting seven or more patients a day when you are concerned about helping small children with their education at home.

» *Louis Feuer, President, Dynamic Seminars & Consulting*

We will continue to see the growth of products, services and technologies that will allow the elderly to remain in the home while being monitored by family members, other caregivers and providers. ***Initially, many of these products, services and technologies will be "cash pay."*** Over time, as third-party payers recognize the cost savings that come with people "aging-in-place," they will cover them.

» *Jeffrey S. Baird, Chairman, Health Care Group, Brown & Fortunato P.C.*

Aging in place will get more lip service once the dust settles and people welcome services in the home again. The home access industry as a whole is down about 25% in 2020, and any projects that take more than half a day to complete are down over 50%. This industry has had double-digit growth for a few years now; post COVID-19, we will have a backlog of need to address and more emphasis on the home setting. We expect lots of investment in technological advances in senior home automation and home safety upgrades in the next three years. ***Look for lots of voice-activated solutions and other senior-friendly technology and attractive home safety upgrades with a less institutional look.*** I believe that if we really want aging in place to be a "real thing," we need positive public policy that will encourage homeowners to invest in home safety via tax incentives. Keeping people in their homes is most times the winning answer. It's where they want to be, it's certainly the most cost effective and in our current public health environment, it's the safest.

» *Jim Greatorex, Vice President, VGM Live At Home*

Homecare is likely to involve a greater degree of integration with physicians during the homecare episode and with other health care sectors prior and subsequent to the homecare episode. Technological connections to patients and other health care providers will be a big part of that integration. It differs from today and 2019 in terms of the willingness of the physicians and other health care sectors to be part of that active integration stemming from an increased respect for the value of care at home.

» *Bill Dombi, President, NAHC*

How might telehealth, remote care and/or remote customer service and equipment servicing change the way the industry functions?

This is another big opportunity within the industry that could truly revolutionize health care as we know it. Telehealth has proven to be a viable option during the pandemic. The prevalence of its use, and evaluation thereof, is already resulting in signals from policymakers that the temporary relief that expanded telehealth and remote care services should be made permanent, rather than expire at the end of the PHE. ***Quality of care has not been an issue with telehealth or remote care services*** and broader use would open up the door for even more efficiencies within the health care continuum.

» *Seth Johnson, Senior Vice President of Government Affairs, Pride Mobility/ Quantum Rehab*

In addition to telehealth visits by health care professionals, HME providers will remotely train customers on the proper use of their devices. Moreover, they will troubleshoot remotely in lieu of in person service calls. With technology like FaceTime (provided it is HIPAA compliant), a provider can tour a client's home before sending equipment. ***This should save considerable time and money for the HME provider*** and reach customers who would otherwise be unreachable, particularly in remote rural areas.

» *Miriam Lieber, President, Lieber Consulting*

Over the last 20 years, third-party payers have been pushing health care providers away from the traditional fee-for-service model and towards the collaborative care/ patient outcomes model. This push has been driven by the need to control costs, which includes keeping patients out of the hospital. Commercial insurers have been much quicker than Medicare/Medicaid in paying for telehealth. ***The pandemic has brought the issue of telehealth to the forefront.*** At the end of the day, can a patient receive adequate health care without having to engage in a face-to-face encounter with a provider? The short answer, in many cases, is yes. During the pandemic, Medicare and Medicaid have relaxed a number of restrictions. Many of these relaxed restrictions will remain in place after the pandemic.

» *Jeffrey S. Baird, Chairman, Health Care Group, Brown & Fortunato P.C.*

While the pandemic has given added energy to technology-based services in the home, telehealth, remote patient monitoring, and patient services through telecommunications have been a key part of health care at home for over two decades. The current surge in health care policy reform in favor of telehealth can be expected to continue with many of the COVID-19 waivers and exceptions finding a permanent status in Medicare, Medicaid and other payers. This will allow for a better use of professional resources in homecare at a time of growing demand for care in the home and a shrinking pool of caregivers. ***Still, telehealth is a tool for health care professionals, not a clinical service itself.*** As such, home health care and hospice can be expected to continue as primarily a set of in-person services with supplemental support through telehealth. Physician and non-physician practitioner services should become more integrated with these home-based cares through the practitioners' use of telehealth to form a stronger team in home health and hospice care.

» *Bill Dombi, President, NAHC*

We've been looking at telehealth and wondering why Medicare has been so slow to accept it without so many limitations. But now ***the pandemic has required it be adopted very quickly*** and in a simple way. Hopefully it will remain in place long term.

» *Mary Ellen Conway, Chief Compliance Officer, US Med*

Who will thrive in a post-COVID-19 world? Will there be mass consolidation?

In the DME world, we are already seeing a great deal of consolidation. Several of the large players are purchasing medium and small players. And we are seeing mid-sized players purchasing other mid-sized players and smaller players. This consolidation will continue. In my opinion, the only way that a small DME supplier can compete against a national supplier is for the small supplier to (i) provide personal service and (ii) advertise the fact that it provides personal service. Approximately 70% of Medicaid patients are covered by Medicaid Managed Care Plans and approximately 35% of Medicare patients are covered by Medicare Advantage Plans. These percentages are increasing. It will be important for DME suppliers, large and small, to be added to as many plan panels as possible. It will continue to be a challenge for DME suppliers to survive based on third party reimbursement. As such, ***it will be important for suppliers to expand into the cash market.*** In doing so, they will have to compete with Amazon. Most suppliers cannot compete with Amazon based on price. However, the suppliers can easily compete with Amazon on after-sale service.

» *Bradley Smith, Managing Director/Partner, VERTESS*

Home health care has demonstrated for decades that it can handle pressure as well, if not better than any other health care sector. Home health care has faced many challenges over the years, from arbitrary claim denials to irrational payment models to staff shortages to "bad actor" incidences involving health care fraud. The outcome has been the strengthening of home health care and the expansion of its place in health care. The challenges of the pandemic have been daunting, but the outcome to date has been another step forward in the value of home health care. To thrive in health care, and particularly home health care, one must be ceaseless in exploring innovation, tireless in employing creativity, and willing to roll with the punches that inevitably come when you challenge institutionalized health care powers. That all translates to a willingness to not only embrace change, but to lead it. ***Home health care has been consolidating for many years while also growing organically.*** That will continue for a number of reasons, particularly because home health care is not burdened by the costs of bricks and mortar.

» *Bill Dombi, President, NAHC*

65%

of respondents to a Transcend Strategy Group study said COVID-19 had changed their opinion about the best way to care for seniors.

I believe ***retail outlets, backed by a strong e-commerce offering, will be a huge factor in homecare.*** As the Medicare benefit continues to deteriorate, I expect consumers to buy homecare solutions at the quality they want. The HMEs who develop a good quality product offering at affordable pricing, can execute orders and not lose all their margin to freight costs, and innovatively market themselves will find success.

» *Jim Greatorex, Vice President, VGM Live At Home*

Hannah Wolfson is editor of HomeCare magazine.

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LEGAL BRIEF

Expect Audits After the Emergency Ends

7 areas of concern related to COVID-19

By Markus P. Cicka

The Centers for Medicare & Medicaid Services (CMS) has issued temporary regulatory waivers and new rules during the COVID-19 public health emergency to allow certain health care providers flexibility in providing care during the pandemic. Some of these initiatives directly impact the home medical equipment/durable medical equipment (HME/DME) industry. Providers of HME and DME, however, should be prepared for post-COVID-19 audits. Here are some areas of concern to be aware of.

> **Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.**

1 Stark Law Waivers

The federal physician self-referral law (i.e., the Stark Law) prohibits a doctor from making referrals for certain health care services payable by Medicare if they or an immediate family member has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in general, a physician cannot refer a patient to any entity with which they have financial relationship.

On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law. These waivers apply to financial relationships and referrals related to the pandemic. The remuneration and referrals described in the blanket waivers must be solely related to "COVID-19 purposes," as defined in the waiver document; under the waivers, CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law.

For example, some of the restrictions regarding when a physician group practice can furnish medically necessary designated health services (DHS) in a patient's home have been loosened. According to CMS, any physician in the group may order medically necessary DHS that are then furnished by one of the group's technicians or nurses in the patient's home contemporaneously with a physician service that is furnished via telehealth by the physician who ordered the DHS.

Areas of Audit Concern

Anticipated areas of audit concern regarding the Stark Law Waivers include:

- Whether remuneration and referrals are solely related to "COVID-19 purposes;"
- Whether a physician group meets the definition of "group practice;"
- Whether the DHS are medically necessary;
- Whether the health services provided are considered DHS; and
- What is considered the patient's home.

2 Unusable DMEPOS

In cases where durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are lost, destroyed, irreparably damaged or otherwise rendered unusable, DME Medicare Administrative Contractors have the flexibility to waive replacement requirements under Medicare such that the face-to-face requirement, a new physician's order and new medical necessity documentation are not required.

Areas of Audit Concern

Suppliers must include a narrative description on the claim explaining the reason the equipment must be replaced and must maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the COVID-19 emergency.

3 Prior Authorization

CMS is pausing the national Medicare prior authorization program for certain DMEPOS items.

Areas of Audit Concern

When it comes to prior authorization, make sure that the supplied DMEPOS items were part of the DMEPOS Medicare Prior

Authorization program for which prior authorization was paused by CMS before forgoing prior authorization.

4 DMEPOS Accreditation

CMS is not requiring accreditation for newly enrolled DMEPOS suppliers and is extending any expiring supplier accreditation for a 90-day time period.

Areas of Audit Concern

Suppliers should make certain the expiring supplier accreditation falls within the 90-day extension time period.

5 Signature Requirements

CMS is waiving signature and proof of delivery requirements for Part B drugs and durable medical equipment when a signature cannot be obtained because of the inability to collect signatures.

Area of Audit Concern

Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.

6 Signature on Orders

DMEPOS items, except for power mobility devices, can be provided via a verbal order.

Areas of Audit Concern

Areas of audit concern regarding signature on orders include:

- A signature is required prior to submitting claims for payment but the order can be signed electronically.
- Power mobility devices require a signed, written order prior to delivery. A signature is required prior to submitting claims for payment but the order can be signed electronically.

7 DMEPOS Payment Increases

As required by section 3712(a) of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, CMS will adjust the fee schedule amounts for items and services furnished in rural and non-contiguous non-competitive bidding areas within the United States based on a 50/50 blend of adjusted and unadjusted rates for the remainder of 2020 and through the remainder of the public health emergency, which could mean that this fee schedule adjustment methodology continues into 2021 if the public health emergency is still in effect after Dec. 31, 2020.

Also, as required by section 3712(b) of the CARES Act, CMS will provide higher payments for certain DMEPOS items and services furnished in non-rural, non-competitive bidding areas within the contiguous U.S. with dates of service on or after March 6, 2020. That change will extend through the remainder of the public health emergency.

Areas of Audit Concern

Auditors will be checking the following regarding DMEPOS payment increases:

- Whether the items and services were furnished in rural and non-contiguous non-competitive bidding areas within the U.S. (for section 3712(a) relief);
- Whether the items and services were furnished in non-rural, non-competitive bidding areas within the contiguous U.S. with dates of service on or after March 6, 2020 and through the remainder of the public health emergency.

HME suppliers have received several benefits due to the public health emergency, but anticipating what comes next will help limit the pain and expense of audits. HC

Markus P. Cicka, J.D., LL.M. (health law), is the owner of the Law Office of Markus P. Cicka, LLC, a law firm based in Saint Louis, Missouri. He represents home health agencies, pharmacies, infusion companies, home medical equipment companies and other health care providers throughout the United States. He can be reached at (877) 579-9499; markus@cickalaw.com cicka-law.com; or linkedin.com/in/markuscicka.

When it Absolutely Positively Has to Be There

How mobile logistics software can streamline HME deliveries & boost business

By Mary Boyle

The COVID-19 pandemic has accelerated technology adoption across the home medical equipment (HME) industry, from e-referral to remote patient setups. And one thing has become clear: A more technology-enabled HME provider is better equipped to survive—and thrive—in this new environment of virtual care and contactless delivery.

One technology that HME companies are increasingly turning to in order to achieve business continuity and success in this time is mobile logistics software, which automates and tracks the delivery of medical equipment, supplies and services. In fact, there has been a 21% year-over-year increase in providers newly adopting a mobile delivery solution from March through June of 2020, according to data from Brightree. Providers who have already implemented and benefited from the technology are expanding their use as well, with a 40% increase in users from existing customers over the same period.

Given changes to the industry imposed by COVID-19, it makes sense that the use of these solutions is on the rise; a mobile logistics platform helps optimize productivity, improve cash flow and increase operational transparencies. It also supports contactless delivery, a feature that has become incredibly important for HME dealers, employees and patients throughout the pandemic.

New Expectations

Even before the pandemic struck, HMEs were working to streamline their delivery processes while meeting ever-increasing regulatory requirements. The need to safely deliver medical equipment and supplies to patients' homes reached an all-time high this year, however, with providers transitioning to contactless delivery methods as they shut down their retail locations in an effort to flatten the curve of COVID-19 and keep patients and staff safe.

A March 2020 study from the National Institutes of Health found that COVID-19 remained infectious for up to 24 hours on cardboard and paper. At the same time, providers transitioned back-office staff to work from home, putting more pressure on paper-based delivery process. And as one provider new to mobile delivery stated, "It's hard to disinfect paper."

In response to the pandemic—and to make sure patients at home continued to receive appropriate health care—the Centers for Medicare & Medicaid Services (CMS) announced temporary regulatory waivers for the duration of the public health emergency, temporarily waiving signature and proof-of-delivery requirements for durable medical equipment, prosthetics, orthotics and supplies when a signature cannot be obtained. In response to this new temporary guidance, an update to help providers meet demand throughout the pandemic has been the addition of photo capture as part of order service documentation within a mobile delivery solution. This has allowed drivers to take a photo that acts as proof-of-delivery, along with automatic timestamps and geocodes and a notation on the electronic delivery documentation that notes the patient signature was not available due to COVID-19. As a result, patients receive their medical supplies safely, drivers remain shielded from disease risk and HME companies can accelerate both billing and collections.

Reducing Paper

Replacing paper-centric processes with electronic workflows is nothing new to the homecare industry. That said, when it comes to managing deliveries, it's estimated that around half of HME providers still use paper. This significantly slows down operations and impacts a business's bottom line.

Mobile logistics software allows providers to run completely paperless delivery processes: Electronic delivery tickets automatically load orders onto drivers' handheld devices and wireless syncing enables automatic, real-time documentation filing. Eliminating paper-chasing means shops are able to bring cash in quicker, while minimizing the manual errors that can lead to billing disputes.

DASCO Home Medical Equipment, which provides delivery services to patients across Ohio, West Virginia, Kentucky and Indiana, was using a paper-based system for its delivery tickets. It was costing the organization more than $10,000 in paper and handling costs, and resulted in technicians making approximately more than 150 duplicate trips due to missing tickets or signatures each month. After implementing a mobile logistics platform and handheld devices across its delivery staff, DASCO has made revisits a thing of the past and increased cash flow by 14%.

When it comes to managing deliveries, it's estimated that around half of HME providers still use paper.

Similarly, Texas-based supplier Angel Medical Supply, which specializes in acute respiratory care and supplies, was able to bring its number of missing sales orders from 20 per month to zero after moving its delivery process to an electronic platform. The organization also dramatically reduced the amount of time required to confirm a sales order from 30 days to only two.

Improving Transparency & Tracking Deliveries

Mobile logistics software also offers fleet management capabilities, enabling real-time visibility into drivers, field technicians and the status of orders, as well as route optimization to decrease vehicle wear and tear, improve mileage and reduce maintenance costs. In addition, with spikes in demand for home delivery, HME providers need an efficient way to manage same-day orders and add or update orders in real-time so they're able to respond to urgent requests efficiently and minimize disruption from schedule changes.

"The amount of time ticket processing and delivery routing took previously was atrocious. With customer service being an essential part of our business, it was unacceptable to not know delivery statuses when customers would call to check on their order," said Stephen Hernandez, senior director of operations for Angel Medical Supply. "Now we have complete communication between the driver, patient and internal teams so we can work to schedule urgent requests and monitor progress. This transparency in our delivery teams has allowed us to provide updates in real time with patients and caregivers, which can often be critical to their care."

The transparency offered by a mobile logistics platform also ensures drivers are making the most of their time in the field, granting managers the flexibility to focus on other aspects of their business.

Before implementing a mobile logistics platform, DASCO was not able to properly monitor its team of 35 technicians and was concerned that drivers were taking care of personal matters while on the job. Now, dispatch managers know exactly where each delivery technician is at all times and can evaluate staffing needs. This has allowed DASCO to streamline routes and develop a daily routine for its technicians, enabling the company to complete more than 3,000 deliveries each month.

Going High-Tech

Automating manual paper processes has allowed these and other providers not only to improve service to patients, but also to streamline the entire delivery side of their businesses.

DASCO now confirms approximately 2,500 more orders per month without adding more full-time employees. And Angel Medical Supply has increased its bottom line by 40% thanks to its ability to service an average of more than 700 deliveries each month. These examples demonstrate technology's impact on HME providers who are increasingly looking for ways to do more with less.

As providers continue to grapple with changes brought on by the COVID-19 pandemic, solutions such as mobile delivery that can drive efficiency, maximize productivity, improve cash flow and increase transparency are becoming more widespread. HME providers who are equipped with such solutions are well positioned to not just meet but exceed today's market expectations. HC

Mary Boyle is senior director of product management for mobile delivery at Brightree. She joined Brightree in December 2018 as part of the company's acquisition of Apacheta and has more than 20 years of software industry experience with an emphasis in product management and product marketing. Prior to joining Brightree, Boyle held leadership positions with several healthcare software organizations including Health information Designs, Sanovia and MEDecision.

OPERATIONAL MEASURES

When an Emergency Becomes Everyday Reality

Formalize processes to make a plan for the "new normal"

By Bobbie Warner

Who could have imagined when the Centers for Medicare & Medicaid (CMS) revised the Emergency Preparedness Condition of Participation to include addressing emerging infectious disease (EID) that the entire country would be implementing emergency action to deal with an EID a short time later? And yet, here we are.

In response to the COVID-19 outbreak, agencies implemented interventions to address their operations, clinical processes and financial and personnel aspects. After many months of emergency action, it is clear that the pandemic is not the temporary situation we hoped for but one that takes us into a "new normal." It is now time to formalize these emergency interventions into standardized processes.

Putting a Plan in Action

The task of formalizing processes begins with operations that occur when an organization's administrative team evaluates the likelihood of admitting COVID-19 patients. In the early days of the pandemic, some home health or hospice agencies tried to avoid admitting COVID-19-positive patients because they were unsure of whether they could handle the special requirements needed.

However, it soon became clear that any agency at any given time could see their staff and/or patients convert to "persons under investigation" or have a positive test for the virus. Because of that, there should not be a single home health or hospice organization across the country that has not activated its emergency plan.

Implementing an emergency plan requires many operational decisions to be made. Examples include who in the organization will monitor the prevalence of virus spread in the community and the availability of personal protective equipment (PPE), what method will be used to screen staff and patients, and how many resources are available from CMS, the Centers for Disease Control and Protection (CDC), state home health and hospice associations, and others to monitor frequent ongoing changes.

In addition, decisions related to care provision include how the organization will monitor employees' contacts in case of a positive COVID-19 test for either patients or staff, manage staff who have been exposed but are asymptomatic and determine whether telehealth will be used to conduct visits and handle potential staffing shortages related to illness.

Be Flexible

Clinical processes are changing dramatically and require flexibility and communication. Not only are each agency's policies shifting, but there are other considerations. These include CMS blanket waivers, state Medicaid waivers and possible individual organizational waivers. The clinical management team is required to make daily decisions to either implement waivers or continue business as usual. A sampling of the current waivers that address both

home health and hospice include the ability to utilize telehealth to conduct patient visits and a narrowing of the focus for Quality Assessment and Performance Improvement (QAPI) activities to address infection prevention and control, as well as adverse events related to the public health emergency.

Personnel decisions also require constant changes. Some examples include:

- processes to facilitate screening for symptoms and reporting concerns
- identifying high-risk staff
- addressing the needs of high-risk staff
- ensuring the availability of alternate staff to fulfill patient needs in case of a surge in staff illness
- implementation of formalized communication to ensure employees are kept informed
- determining competency or training needs
- interventions to provide emotional support to employees during this challenging time

These examples of immediate decisions made over the past several months now need to be evaluated using the QAPI team and either formalized or altered to meet the ongoing needs of the organization.

Two Examples

Let's look at two examples of how emergency decisions need to be examined:

1. Aide supervision is a great example of how to work through how to formalize pandemic interventions. Retroactive to March 1, CMS has put in a place a waiver for on-site aide supervision that says "this would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time."

   Each organization must decide whether to continue implementing the waiver or to meet the requirements under the conditions of participation for aide services. The decision may be informed by identifying through the QAPI activities whether patients who receive aide services are having their ongoing needs met.

   Although the onsite aide supervision visit itself was waived, the purpose of that visit remains key to the care of the patient including: determining if the aide is following the established plan of care, if the patient is satisfied with services provided, and if changes in the patient's condition that required changes in the aide plan of care have been completed. If the agency makes the decision to continue with implementation of the waiver, a formalized process that ensures the responsibilities inherent to the supervisory visit are still being met should be used by everyone.

2. Another example of a pandemic intervention that may need to be formalized is the decision to use telehealth platforms. Often this decision is based upon several factors, including refusal of patients to allow clinicians to enter the home, refusal of facilities to allow access to outside health care personnel and/or the ratio of those patients with COVID symptoms and/or positive COVID tests to the number of employees who are available to care for them. Although implementation of telehealth can seem like an "easy" answer to these impediments, it is not.

   With telehealth, many aspects of care need to be formalized. A great starting point is to use the organization's QAPI activities to evaluate the effectiveness of the current process. Does analysis of care reflect that assessments done through telemedicine are truly comprehensive? Are all of the patient's needs being identified on admission? What education has been done in relation to the platform being used? How are patients and/or families educated? Is ongoing interdisciplinary coordination occurring? If contract staff are used, how are they trained on new agency processes? Does visit documentation reflect that all care needs have been addressed? When using telehealth, if changes in the patient's condition occurred, were they immediately identified? Does the care provided reflect that an appropriate number and frequency of in-person visits to meet the patient's needs are conducted? These are just a few of the questions to be answered before a formalized process can be implemented.

These two examples reflect the process to ensure that the organization's administrative team identifies emergency interventions that when formalized would result in positive outcomes. First, identify the emergency interventions (waived regulation) that were implemented. Second, evaluate the effect of the process (such as telehealth) on the quality of care. Several implemented interventions can be evaluated through a comprehensive clinical record review. Third, if the practice is benefiting the patient, formalize the process so all staff are following a standardized format. If the intervention does not seem to result in positive outcomes, then determine the next step for that aspect of care provision.

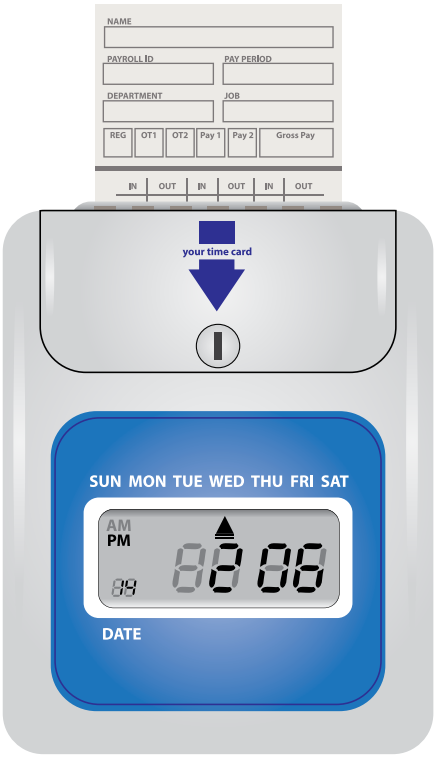
The past few months have proven challenging for everyone. As an industry, we have risen to that challenge and reflected the holistic care we embrace. Our impact is not only on the patient, but also on their families, our colleagues and the entire community. Formalizing best practices we have implemented will support us all as we stay the course. HC

Bobbie Warner, RN, BSN, is director of education for Community Health Accreditation Partner (CHAP). She has worked in the community health environment for more than 25 years in multiple capacities. Her community-based career began with providing direct patient care in home health, hospice and private duty. Warner joined CHAP in 2009 as a site visitor; she took on her current role in March of 2020.

Implementing Electronic Visit Verification for State Medicaid Programs

Benefiting fraud reduction & agency operations

By Greg Lotz



When Congress passed the 21st Century Cures Act in December 2016—which mandated Electronic Visit Verification (EVV) for all state Medicaid-funded services—EVV became a reality for many home health agencies across the country. Although EVV can bring many accuracy- and efficiency-related benefits, no business likes to have processes forced upon them.

Even though many states have chosen to fund their selected system's total acquisition cost, there are typically new operational costs associated with the chosen system. Health care organizations that bill services to state Medicaid are left with the added expense of retraining their workforce. In some cases, due to poor system configuration decisions at the state level, they are also faced with higher administrative costs and increased bill-to-cash-flow timelines when EVV should result in the exact opposite effect.

Cures Act Mandate

To meet the requirements of the Cures Act and avoid federal reduction of Medicaid annual funding by 2% for non-compliance, Medicaid-implemented systems must verify at least these items:

- Type of service performed
- Individual receiving the service
- Individual providing the service
- The date the service was provided
- Location of service delivery
- Time the service begins and ends

There are many types of EVV systems in the market that can achieve a reliable collection of this data. The most frequently used are:

1. Smartphone apps that use a global positioning system or radio-frequency identification
2. In-home devices that generate a new code every minute
3. Telephony (that is, a plain old telephone solution). With telephony, field staff use the beneficiary's home phone to call an 800 number and record start time, end time and various other data elements through multiple means that vary by vendor and state requirements.

Types of Systems

State Medicaid organizations have the flexibility of selecting their chosen method for implementation. The naming conventions used throughout the country for these methods seem to vary by location, but it all boils down to three types of implementation.

Closed System

No integrations to the contracted vendor are permitted and everyone must use that contracted system. Fortunately, there are only a few states that have chosen this path. This method makes it administratively burdensome for provider agencies to use the software they've already invested in to manage their operations and to also use the mandated other system. This also limits available technology to whatever that vendor has contracted.

Open System

Typically, the state will communicate the minimum requirements, possibly build or contract to create an aggregator for the data

Unfortunately, several Medicaid organizations have believed promises from contracted EVV vendors that they would simplify claims processing by using EVV to screen at the time of billing.

that selected systems must integrate to, and leave the acquisition up to the provider agency.

Hybrid System

This has been the most common type implemented to date. The state typically selects and funds one or more EVV vendor system(s) for provider agencies to utilize at no cost if they choose. The state then also requires the contracted vendor(s) to support integration with existing vendors that provider agencies may already be using to reduce the training and administrative burdens that forcing a new system can cause.

Many electronic medical records and agency management software on the market today already have a proprietary Cures Act-compliant EVV system. Those that don't are often integrated with an EVV vendor that is Cures Act compliant. For this reason, either an open or a hybrid system is generally preferred. It can significantly reduce the cost impacts caused by imposing a closed system upon provider agencies, the associated retraining and the potential staffing increases required to operate consistently in two disparate software platforms.

Claims Processing Issues

A further issue the industry is experiencing as EVV gets implemented across the country is that some state Medicaid organizations are implementing systems—regardless of type—that validate the claim submission before it is submitted for payment instead of after submittal and before payment. This injects a dramatic increase in complexity that, in this writer's opinion, has yet to result in gains in inefficiency. Agencies in states that currently force this requirement are experiencing large-scale failures in what should be successful claims submission. This is typically driven by contracted EVV vendors requiring claims generation within their software, often with limited access unless the agency purchases enhanced functionality from the vendor. In several state-mandated systems, the managed care organization's authorization validation process is brought up front, which further complicates the process.

The most effective configurations to date leave the existing claims submission process in place. Only after those current processes are completed does the EVV data get matched in the aggregator for final claims payment approval. This leaves the already complex claims approval and appeal processes where they were. Then, once a claim successfully navigates that existing process, EVV data is matched to determine if the claim can indeed be paid. This makes it far easier for agency billing staff to identify and fix whatever issue may be preventing the claim from being paid.

Unfortunately, several Medicaid organizations have believed promises from contracted EVV vendors that they would simplify claims processing by using EVV to screen at the time of billing. Time and again, this methodology is failing. Typically, the contracted vendors are holding the provider hostage in this process to force them to buy a full software package to alleviate the claims bottleneck. The minimal system the contracted EVV vendor has sold to the state doesn't work well for billing and claims management, leaving providers on the hook for the claims.

Benefits of EVV

Electronic visit verification, when properly implemented, can bring a host of benefits to providers, Medicaid beneficiaries, and state Medicaid funds availability. Agencies know whether or not the service provider is indeed at the home and can react and replace staff to ensure proper service provision. Agency administrative staffing in billing, payroll and scheduling can often be reduced or redeployed, and the timeline from service provision to claim submission can be reduced significantly. EVV has been proven time and again to reduce fraudulent claims submissions, often to the tune of millions of dollars per year.

When your state sends out surveys for input on what system types would be preferred, make sure to share your thoughts and to help generate a win-win in your state for EVV implementation. Remember, these initial implementations in most states are for aide services only; skilled services are targeted for January 2023. We need to get it right the first time. HC

Greg Lotz, KanTime's director of sales and marketing technology, has been engaged in electronic visit verification and health care technology for nearly 10 years. He is deeply involved in KanTime's integrations with multiple vendors to help customers meet state-mandated EVV guidelines.

How Hearing Employees Reduces Turnover in Your Home Health Organization

Mobile applications can make feedback instant & easy to implement

By Max Farrell

In-home caregivers face physically and emotionally demanding working conditions in the best of times. Add to that a global pandemic with a novel virus whose most dangerous impact is on the very individuals they are tasked with caring for, and stress and anxiety only build.

From shortages in personal protective equipment to ever-changing guidelines for a morphing virus, home health workers have been juggling a great deal more than their average caseloads over the past several months. And because of the remote nature of their workdays, most caregivers simply don't have an easy opportunity to stop and ask for advice, share frustrations, or offer constructive suggestions to their employers.

Where concerns go unheard, frustrations frequently fester. Employees lose trust in their employers when they feel in the dark, and ultimately, they leave.

Year after year, studies show that turnover in home health grows. Some stats cite turnover rates from the past several years that range from about 22% all the way up to 82%. No matter the source or study, the stats are always significant.

If turnover is a known issue, what is the industry doing to fix it? From my perspective, we need to get back to the basics of the human condition and give people a mechanism to be heard.

Feedback 101

Feedback, according to Merriam-Webster, is "the transmission of evaluative or corrective information about an action, event or process to the original or controlling source." In its most basic form, it probably seems pretty straightforward. But making feedback useful in a business context requires more than just implementing an open-door policy or performing annual evaluations.

To be effective, feedback needs to be collected in real-time—especially in the health care setting. If a caregiver is dealing with an issue that endangers his or her safety,or the safety of a patient, feedback can't wait until an end-of-year evaluation. It needs to be shared right away. Which leads to the next point: Feedback requires action.

The worst thing a company can do is ask for feedback and then do nothing with

The worst thing a company can do is ask for feedback and then do nothing with it. But if you do take action, you have to communicate it.

it. But if you do take action, you have to communicate it. Implementing change without sharing an update about the new policy or procedure is nearly as bad.

This is what is known as the feedback loop. Essentially, a successful feedback program requires:

1. a prompt for employees to share their feedback,
2. collection of feedback, and
3. action taken based on the information provided.

It's a loop because it's a continual process and not something that is ever "complete." Effective feedback programs are continual and create organizational culture shifts. They also improve retention rates.

A mobile- or email-based application that allows companies to prompt their workers regularly for anonymous feedback can help create this loop. While there can be options for workers to share their identity along with their feedback, fewer than 1% of workers prefer to do so, according to the feedback platform WorkHound.

Common feedback topics involve pay, benefits, policies and procedures—things organizations should be able to answer with relative ease. By the same token, if questions about pay and benefits go unanswered, they can become serious pain points.

The platform you choose should also enable managers to request one-on-one conversations. If a manager receives a piece of feedback that they'd like to discuss with an individual, they can request that. But it's still up to the employee to decide whether or not they are willing to identify themselves. Of those workers who are willing to reveal their identity to discuss their concerns with a manager, 90% stay at least 30 days after their issue is resolved. People often simply need to know their concerns are being considered.

Communicate regularly with your staff and share updates about which policies have changed or are under review due to feedback. Chances are, if one person shares confusion or concern over a policy, others in your organization have the same question. Keeping team members up to speed brings greater transparency and builds trust throughout the entire organization.

Don't Fear Negative Feedback

I know what that of you may be thinking. "I don't know if I'm prepared to open the flood gates on negative feedback."

In all actuality, employees who participate in feedback programs often have some truly great ideas. They're the ones in the trenches, and they often present their challenges along with solutions they have already considered. Additionally, we have found that over time, feedback trends more toward the positive—once employers have a chance to address employees' issues, they start receiving more positive feedback.

And remember that negative feedback is going to make it out into the world, whether you're asking for it or not. The problem is that if you're not providing an outlet for it, employees may go searching for one. Team members may spread negative experiences to coworkers, post details on social media, or even go so far as to leave negative reviews on platforms such as Indeed, Glassdoor and Google. It's in an organization's best interest to ask for feedback and manage it in a controlled environment.

What to Expect When Implementing a Feedback Program

The beauty of implementing a real-time feedback program is that you'll start finding out what's happening in the moment—but it may take a little time for employees to feel comfortable sharing their thoughts. Any new feedback program can be met with skepticism, whether because of previous negative experiences, natural tendencies to keep to oneself or a general fear of retaliation. That's where quick action and regular communication can really make a difference.

When employees begin to see that your organization not only responds to their concerns through regular communications but also begins to implement changes to remedy any underlying issues, they'll become more comfortable sharing feedback with you regularly.

If you commit to this plan of action, you will likely have increased participation in your feedback program and improvements to company culture at an organizational level. Like any foundational component of a thriving business or organization, a feedback program takes time, intention and effort. But think of all the time you'll save on exit interviews. HC

Max Farrell is the CEO of WorkHound, a feedback tool that allows frontline workers to share insights in real-time.

INCONTINENCE MANAGEMENT PRODUCTS

In this directory, HomeCare delivers a monthly breakdown of crucial sections of our annual Buyer's Guide, providing the most up-to-date information on the products and services your business needs. This month, we're covering incontinence management products. Here and on homecaremag.com/buyers-guide, you can find the essentials to help your business thrive. HC

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tena.us, essity.com

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prevail.com

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griffincare.com

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x-top-for-men.com

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NEW ON THE MARKET

Hand-picked by the editors of HomeCare and our team of industry experts, these products are the newest frontrunners shaping the homecare marketplace. Stay tuned in every issue for more industry-leading solutions.

1

1 Oxygen Tank Holder

ARMADILLO MOBILITY ACCESSORIES

The Armadillo Oxygen Tank Holder is made of durable fabric that holds both E- and D-cylinder oxygen tanks. The three-pocket design provides extra compartments to hold personal belongings or tank supplies. The adjustable straps allow users to customize the position of the tank on their mobility device to suit their comfort needs. The holder has a convenient carry handle at the top of the bag to allow for easy transport when not attached to a wheelchair. Available in gray or white. Visit worldsbestaccessories.com.

Check 200 on index.

2

2 Cup Holder

GF HEALTH PRODUCTS

The user-friendly snap-on cup holder is designed to provide easy access to a bottle or cup while using a mobility device. The cup holder easily snaps and adjusts onto wheelchairs, transport wheelchairs, canes, walkers and rollators with tubing diameter from 5/8-inch to 1-inch (1.58 centimeters to 2.54 centimeters). Holds beverage containers holding up to 24 ounces (.71 liters) with evenly distributed liquid. Visit grahamfield.com.

Check 201 on index.

3

3 TelScope

HOLLAND HEALTHCARE

The new TelScope is a smart telemedicine device that lets parents or home caregivers easily check for sore throats, infections and tooth problems. The TelScope works with any smartphone to fully illuminate the mouth's interior, letting the user circle and measure areas of concern down to the millimeter and then send the photo straight to a doctor or dentist. It is part of Holland Healthcare's collection of transparent medical diagnostic tools designed for the home, clinic and hospital. Visit hollandhealthcareinc.com.

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4

4 Walk-In Dream Spa

PENNER BATHING SPAS

A walk-in tub designed for user safety, the Dream Spa allows users to sit in comfort while avoiding the tripping hazards of traditional bathtubs. The Dream Spa has a wide swing-out door, hand-held shower wand and heated seat and back for added comfort. Fits standard tub space. Available in several color schemes to match any bathroom. Visit pennerbathingspas.com.

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INFECTION CONTROL

1

2

3

1 Hydroxyl Generator

SHIPP CLEANING SYSTEMS

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Check 204 on index.

2 Hubscrub

THE HUBSCRUB COMPANY

The Hubscrub is more than a wheelchair washer. The machine saves labor, time and money and is a better use of resources. It also helps prevent infection. The Hubscrub's features include: choice of liquid and/or ultraviolet (UV) disinfection, internet connection for remote maintenance and identifying issues, programmable to keep up to date, six-minute cycle (wash, rinse, UV disinfect), touchscreen for operator simplicity, uses only four gallons of water, designed for varied equipment shapes. Visit hubscrub.com.

Check 205 on index.

3 Zoey CPAP Sanitizer

SUNSET HEALTHCARE SOLUTIONS

Zoey is the easy-to-use new CPAP cleaning option. With a sleek aesthetic, quiet operation and a small footprint, Zoey is designed to fit in the home. Zoey's interface is beep-free and simple to use, and the machine uses soft lights to show what's happening. Its premium packaging looks great for retail. Ask about Zoey's new ozone plug adapter for an even simpler setup. Patients can now clean just the mask, headgear and tubing without any additional adapters. Visit sunsethcs.com.

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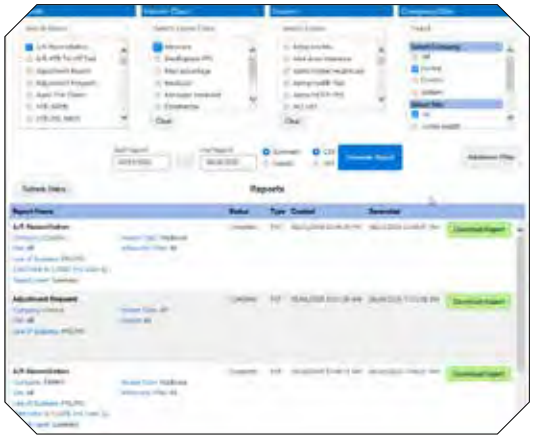
HHA BILLING

1



1 Billing Solution

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With all-inclusive billing, claims processing, remittance and collections capabilities, Casamba's solution drives improvement in cash flow and efficiency. Billing for all payer types is supported with daily, weekly, monthly and episodic billing options. E-billing for Medicare/ Medicaid and flat file transfer for commercial claims and support for room and board charges is also included. In addition, agency-defined, rules-based claim audits hold claims until clinical or insurance requirements are met. Visit casamba.net.

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2

2 Billing Solution

ALAYACARE

AlayaCare's unique platform offers a complete technology solution to manage the entire client life cycle, including referrals, intake, scheduling, coordination, client health records, clinical documentation, care worker management, billing and payroll, reporting, remote patient monitoring and a mobile caregiver app in one integrated, robust and secure cloud-based system. Visit alayacare.com.

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3

3 Revenue Cycle Management

AXXESS

Axxess has cloud-based solutions for total revenue cycle management. Axxess is a Network Service Vendor with Medicare and is also a clearinghouse, so clients can submit electronic claims and get paid up to 33% faster. A team of certified billing experts can manage all billing operations and deliver custom insights to boost payer compliance. Axxess offers no-risk recovery services to help providers recoup older claims to increase revenue and grow business. Visit axxess.com.

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4

4 EMR Software

POINTCLICKCARE

PointClickCare empowers home health care providers with the necessary tools to provide the best care, regardless of location. With a suite of fully-integrated applications powered by an interoperable, mobile friendly and regulatory-compliant electronic health record and revenue cycle management platform, PointClickCare helps providers connect and collaborate within their care network. Visit pointclickcare.com.

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SCOOTERS

1

1 Buzzaround CarryOn Scooter

GOLDEN TECHNOLOGIES

The Buzzaround CarryOn fold-flat scooter is small in stature and big on fun. This sporty portable scooter features an adjustable tiller, front and rear lighting, and 300-pound weight capacity. The heaviest piece is 47.5 pounds. The CarryOn offers long-range coverage up to 18 miles with a lithium ion battery pack. An optional airline-friendly battery is sold separately. The Buzzaround disassembles into two pieces and is easy to load into a car or SUV. Designed to take up minimal space, it's only 12 inches high when folded without the seat. Visit goldentech.com.

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2

2 Scout 3 Scooter

DRIVE DEVILBISS HEALTHCARE

The Scout 3 scooter is equipped with adjustable delta tiller, padded armrests and swivel seat with fold-down backrest for comfort and usability. Other features include quick-connect batteries, ergonomic throttle control, flat-free and non-marking tires, anti-tip wheels, free-wheel operation and easy disassembly. A large, plastic carry basket and interchangeable color panels are also included. Available with 12AH or 20AH batteries. Visit drivemedical.com.

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3

3 iRIDE Scooter

PRIDE MOBILITY PRODUCTS

The iRIDE Scooter has an array of features consisting of a height-adjustable removable seat with foldable tiller, a supplemental foot brake, an easy-to-grip tiller adjustment knob, a twist-grip throttle, a manual hand brake, a digital LCD display, an on/off switch and an air-safe lithium-ion battery pack. Specifications include a 250-pound weight capacity; a maximum speed of 3.7 mils per hour, a 1.3-inch ground clearance, a turning radius of 33.5 inches, a length of 38 inches, a width of 19.25 inches, a range per charge of up to 12.7 miles, a base weight of 32 pounds when disassembled and more. Visit pridemobility.com.

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- ◯ 03 Independent Pharmacy/Chain Drugstore
- ◯ 15 Hospital with Home Health Agency
- ◯ 05 Home Health Agency/Nursing (Medical)
- ◯ 16 Hospice Agency
- ◯ 12 Personal Care/Home Care Services (Non-Medical)
- ◯ 14 Long Term Care Facilities (SKNF, Assisted Living)
- ◯ 08 Physical Therapy/Occupational Therapy
- ◯ 07 Manufacturer/Manufacturer's Rep Firm/Distributor
- ◯ 10 Other *(Please Specify)* _____

3. What other areas of business is your company involved in? *(Check all that apply)*

- ◯ 41 Home Medical Equipment Provider
- ◯ 42 Hospital with HME
- ◯ 43 Independent Pharmacy/Chain Drugstore
- ◯ 44 Specialty Pharmacy (Compounding/Infusion)
- ◯ 45 Hospital with Home Health Agency
- ◯ 46 Home Health Agency/Nursing (Medical)
- ◯ 47 Hospice Agency
- ◯ 48 Personal Care/Home Care Services (Non-Medical)
- ◯ 49 Long Term Care Facilities (SKNF, Assisted Living)
- ◯ 50 Physical/Occupational Therapy
- ◯ 98 None
- ◯ 99 Other (Please Specify)_____

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IN MEMORIAM

A Life of Service

David E. Evans recognized as BOC's first Certificant of the Year

By Kristin Easterling

David E. Evans was a shining example of someone who turned lemons into lemonade.

Evans lost both of his legs below the knee in combat during the Vietnam War. But the injury didn't slow him down—in fact, it shaped his life and career. He became a prosthetist and traveled the world providing prosthetic legs and arms for more than 3,000 people wounded in war zones as well as victims of mining incidents, gunshots and other conflict-related circumstances.

His impact was so great that the Board of Certification/Accreditation (BOC) honored him with their inaugural "Certificant of the Year" award; Evans passed away shortly after the award was announced in early July.

"We were deeply saddened to hear of Dave's passing after we announced his selection as BOC's first Certificant of the Year," said BOC President and CEO Claudia Zacharias. "His lifelong passion for helping others inspires us all."

The award was established to honor a BOC-certified professional for his or her outstanding contributions to their profession, including commitments to service, research and outreach.

Evans, who was certified by BOC since 1998, devoted his career to providing care and support to those who suffered traumatic injuries resulting in amputation.

According to a 2017 profile in his hometown paper, the Charleston Gazette-Mail, Evans started working in the field after visiting Hangar Prosthetics and Orthotics in Charleston, West Virginia, to have his own prosthetic legs adjusted. The owner suggested he work there part-time; that led to his career.

Evans also worked to advance the impact of the prosthetics profession through training. More than 1,000 aspiring professionals benefited from his instruction on patient care techniques. He focused on providing knowledge and resources in many developing countries across the globe, with grant funding from the U.S. Department of State.

More than 1,000 aspiring professionals benefited from his instruction on patient care techniques. He focused on providing knowledge and resources across the globe.

"I have dedicated my life to helping others, based on my own experiences as a bilateral amputee," he said before his death. "I have assisted many patients who experienced something similar; enhancing their lives through prosthetics in both field and clinical settings."

He was also active in the antiwar movement, working with the Vietnam Veterans of America Foundation and the Vietnam Veterans of America. He testified before Congress and went to Vietnam and Central America with Congressional delegations.

He was chosen for the award because of his impact on people's lives and significant contributions to the field, said Matthew Gruskin, credentialing director for BOC.

"Evans has demonstrated exceptional service to patients, while also guiding and educating the next generation of (orthotic and prosthetic) professionals," Gruskin said. "He is an extraordinary individual who has gone above and beyond to make a positive difference in the lives of practitioners and patients in many areas of the world. We were proud to present him with our inaugural Certificant of the Year award and look forward to honoring other professionals of this caliber for many years to come."

HomeCare Media extends sympathies to Evans' family and to all those who knew him. HC

Kristin Easterling is managing editor of HomeCare Magazine.

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