MAY 2020

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How the pandemic is changing everything
Does HIPAA still matter?
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Plus:
COVID-19
Getting ventilators where they're needed

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HME
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IN-HOME CARE
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Dear HomeCare Readers,

Part of the HomeCare team in our new way of working remotely. From upper left: Managing Editor Kristin Easterling, Editor Hannah Wolfson and Associate Publisher Jim Harmon.

I just received the kindest thank you note from a reader in response to the latest issue of HomeCare. It really boosted all of our spirits just as we're working to put this month's magazine to bed. The fact that you all are out there reading and relying on us for information keeps us going during times like these.

Soon, I hope, we'll be through the worst of this public health emergency so we can step back to look at how it will forever change our industry. Because it will. That may mean more of you will be serving patients virtually, there could be a new wave of people needing long-term respiratory care, costs for equipment and protective equipment might increase or that there may be a surge in demand for aging in place. The only thing that's certain is change.

Meanwhile, we're trying to answer some more urgent questions in this issue, including tips for navigating the realities of life during a pandemic and how new rules and laws coming out of Washington will affect your business. We look at changes in telehealth, OASIS coding under coronavirus, the latest on ventilator production, and even how COVID-19 might impact infection control. Plus, there are stories inside on documentation, training, billing for sleep testing and more. If there's anything else you'd like us to cover, please let us know; our email addresses are below. Stay safe out there.

Thank you 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 Editor Hannah Wolfson at hwolfson@cahabamedia.com or Managing Editor Kristin Easterling at keasterling@cahabamedia.com. We'd love to hear from you!

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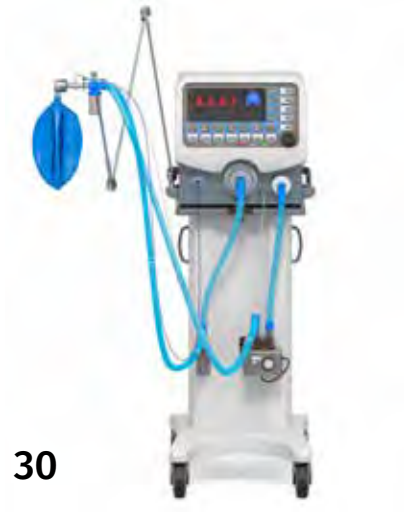

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Fisher & Paykel HEALTHCARE

Nielson Joins VERTESS Team

The health care mergers and acquisitions advisory firm VERTESS announced that Chris Nielsen, an experienced advisor and entrepreneur in the durable medical equipment (DME) and home health marketplace, has joined the company as a managing director. Nielsen started his career as a securities broker and investment advisor before focusing solely on transactional work in the health care space. As managing partner of Four Capital, he helped numerous clients maximize the value of their companies over the past 20 years.

"I am excited by the opportunity to broaden my advisory and consulting services and draw upon the experience and depth of the entire team," Nielsen said. "It was a natural fit for me as a healthcare business advisor. This is a great opportunity that will enhance my ability to better support our clients."

Brad Smith, VERTESS managing director/partner, said Nielsen and the company share a common desire to provide ethical, knowledgeable advice to clients.

"Chris brings a wealth of experience that will allow us to expand our reach," he said.
vertess.com

UPCOMING EVENTS

Many events are being cancelled, postponed or moved online to prevent the spread of the coronavirus. Because of the fast-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.

WellSky Launches Care Coordination Platform

WellSky, a global health and community care technology and services company, has launched WellSky Care Coordination—an analytics-driven platform that delivers care coordination between payers, health systems and post-acute care providers to safely treat higher acuity patients in the home.

As the rapidly accelerating spread of novel coronavirus puts pressure on the U.S. health care system and hospitals are short on beds needed to treat COVID-19 patients, WellSky has activated its expansive care coordination network to preserve limited resources and provide safe, in-home care to non-COVID-19 patients who would typically use those beds.

"Home-based care models can reduce the burden on the health care system by freeing up hospital beds for severely ill patients and allowing those who are less critical to recover safely and comfortably in their homes," said WellSky CEO Bill Miller.

The initiative grew out of collaboration between Amedisys, the nation's second largest provider of home health care, and ClearCare, a subsidiary of WellSky, announced in July 2019. The Care Coordination Program works to connect high-quality home health care with the growing demand for personal care at scale through WellSky's platform connecting thousands of personal care providers. Through the ClearCare platform, Amedisys has connected more than 1,300 personal care agencies to its more than 320 home health agencies in 34 states.

By leveraging WellSky Care Coordination, hospitals, payers and accountable care organizations can collaborate with qualified local home-based providers to deliver coordinated care management protocols and gain insight from built-in analytics.
wellsky.com

Dmetrain Offers COVID-19 Training

The company dmetrain, an employee education provider for home medical equipment providers, is offering a free training course on COVID-19. The online course will be updated about weekly to stay current on the quickly evolving public health crisis.

"Our goal in releasing this course to the public at no cost is to try to get this information out to everyone in our industry and help them in any way we can," said dmetrain President Jon Jasperson. "We want everyone to know in real time about the safest way to conduct business and keep themselves and their customers healthy."

The course includes information on how the virus spreads, infection control measures, advice for companies dealing with clients and more. Future versions will address more specific information such as billing and changing documentation requirements. The company is also gathering feedback from participants to determine additional topics.

Jasperson said dmetrain decided to start working on the course in early March when the company realized several exhibitors were not at Medtrade Spring in Las Vegas due to the global pandemic. They started researching coronavirus information—but found it difficult due to conflicting guidance from the World Health Organization, the Centers for Disease Control and Prevention and other sources.

While most of dmetrain's courses apply for industry accreditation and/or continuing education, this course is not for credit, a decision the designers made to allow for speed and flexibility.

"We want everyone to benefit from it, and if there's anything we can do to advocate for the industry, we want to do it," Jasperson said.
dmetrain.com

Aeroflow Jumps into Private Equity

Aeroflow Healthcare, a durable medical equipment (DME) provider, announced the launch of Aeroflow Ventures, a new division within the organization focused exclusively on mergers and acquisitions, joint ventures and private equity investment in DME companies nationwide.

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partnership, sales or spin-off opportunities, there are so many ways to achieve an outcome that works for everyone," said Aeroflow Chief Financial Officer Scott Sonnone. "Whether the interest is in a quick path to liquidity or the desire for a broader partnership, we are open to the full spectrum of possibilities."

Aeroflow Ventures' investment decisions will be driven by financial metrics, but also will weigh intangible concerns such as patient care and transition, cultural fit, employee retention and other integration-related issues.

Aeroflow Ventures is a critical piece of the company's overall strategic vision and growth strategy. Significant capital and resources have been dedicated to this initiative, with particular interest in the areas of sleep therapy, urology and incontinence and maternity care.

aeroflowinc.com.

Axxess Releases Coronavirus Survey

The coronavirus pandemic has had a significant impact on home health care providers' ability to see or care for patients, and the much-publicized lack of personal protective equipment (PPE) is a very real issue, according to a survey conducted by health care technology provider Axxess.

More than 80% of respondents said the virus has had an impact on their organization's ability to see or care for patients, and 75% said they do not have adequate PPE for staff.

The survey of thousands of home-based care providers from organizations of all sizes between March 25 and 30 confirmed that agencies have a critical need for PPE, including N95 masks, other face masks, gloves, gowns and hand sanitizer. Billing or cash flow has been interrupted for nearly 60% of respondents' organizations, and more than half indicated their organization has experienced staffing challenges.

The survey, which included respondents from all levels of organizations, including management and caregivers working directly with patients and clients, showed that nearly half of respondents have a negative view of coronavirus' (COVID-19) eventual impact on their business.

"I am incredibly proud to be part of such a caring community," said John Olajide, founder and CEO of Axxess. "We can't know how long this crisis will last, but it should be reassuring to all of us that we are all working together and demonstrating leadership, providing expertise, displaying innovation and sharing resources."

axxess.com

PlayMaker Health Issues Industry Data

PlayMaker Health, a post-acute sales enablement and business intelligence platform, announced its Q3 2019 Post-Acute Market Data Update, which includes home health and hospice data released in February 2020 with claims through Sept. 30, 2019.

"The beginning of 2020 has brought the official implementation of the new Patient Driven Grouping Model (PDGM), and providers are finding themselves navigating new waters. It is more vital than ever to understand the competitive landscape and gain expanded visibility into market trends," said Holly Miller, chief revenue officer for PlayMaker Health.

Here are some of the findings:

Home Health Insights Year-Over-Year Growth

- Nationally: 3.38% decline in home health admissions, based on volume
- By state: range of 15.6% decline to a 12.6% increase, with eight states over 0%

PDGM Admissions Source

- Nationally: 59.9% of home health referrals were from community sources, while 41.1% of referrals were from institutional sources
- By state: 40.2% to 76.6% of home health admissions came from community sources

Hospice Insights Year-Over-Year Growth

- Nationally: 3.8% increase in hospice admissions, based on volume
- By state: range of 7.7% decline to a 19.3% increase in hospice admissions

Average Length of Stay

- Nationally: average hospice length of stay was 55 days, with a median of 16 days
- By state: average hospice length of stay ranged from 35 to 72 days.

playmakerhealth.com

HME Merger Creates Spiro Health

America's HealthCare at Home, Cape Medical Supply and Health Complex Medical have merged to form a new company called Spiro Health. The combined entity will have operations across seven states and the District of Columbia: Connecticut, Maine, Maryland, Massachusetts, New Hampshire, Rhode Island and Virginia.

The company will focus on total sleep health and wellness and respiratory care. The leadership of each organization will remain involved and make up the Spiro Health management team. Spiro Health's focus will be on delivering a market-leading patient experience in each market it operates in, and on deploying leading technology solutions to provide its patients and partners a seamless experience for ordering home medical equipment and supplies.

"Our leadership team is wholly focused on building a best-in-class patient and referral partner experience, utilizing our collective experience and an innovative technology platform ready for robust growth," said Gary Sheehan, president and CEO of Cape Medical Supply and the newly appointed CEO of Spiro Health.

Each company will continue to operate under its existing name in each of its local markets but will do so under the umbrella of Spiro Health.

spirohealthservices.com

Proactive Denial Management During & After a Health Care Crisis

HomeCare WEBINAR

Wednesday,
June 10
1 p.m. EDT

Reimbursement in the home health and durable medical equipment (DME) segments is challenging, with rising healthcare costs, complex payment models, high deductible health plans, supply and demand, customer service agreements and more. The COVID-19 pandemic is making it even more difficult for organizations to collect revenue owed to them for providing high-quality service to customers and patients. With nearly one in five claims submitted to marketplace plans being denied, organizations are often willing to write off these claims rather than diagnose the root causes or make the necessary shifts to change course.

LEARNING OBJECTIVES:

Moving from a reactive to a proactive claims denial management strategy can help home health agencies and DME companies not only recover revenue, but also get ahead of denials. Learning objectives: This webinar will focus on how home health and DME organizations can:

- **develop and execute a proactive claims denial management strategy that increases net revenue;**
- **improve claims management efficiency;**
- **leverage data and technology most effectively;**
- **enhance staff competencies; and**
- **maintain their overall loyalty and commitment to providing stellar customer service.**

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Families First Coronavirus Response Act

HR 6201

By Kristin Easterling

This act provides paid sick leave, tax credits and free COVID-19 testing; expands food assistance and unemployment benefits; and increases Medicaid funding.

Section 3102 of the act allows employees to take leave through Dec. 31, 2020 due to the public health emergency and the coronavirus pandemic, including to care for children due to school closures. Employers with fewer than 500 workers must provide up to 12 weeks paid leave for an employee who cannot work because their school or child-care provider is closed as a result of a public health emergency.

Section 5102 of the act requires employers to provide paid sick leave to employees unable to work due to COVID-19 infection. Full-time employees are entitled to 80 hours of paid sick time if the employee:

- is subject to a governmental quarantine or isolation order,
- has been advised by a health care provider to self-quarantine to avoid infection,
- is caring for an individual who is subject to governmental or self-quarantine,
- is caring for their child because the child's school or child-care provider is closed, or
- is experiencing a substantially similar circumstance related to COVID-19 as specified by the Department of Health and Human Services in consultation with the Department of Labor.

EMPLOYERS MUST PAY THE REGULAR RATE OF PAY UP TO »

- **$511 per day, and $5,110 in aggregate, for paid sick time used by an employee who experiences symptoms of COVID-19 or is required or advised to self-quarantine; or**
- **$200 per day, and $2,000 in aggregate, for paid sick time used by an employee to care for their child or another affected person.**

EXCLUSIONS

Health care providers may be excluded from the provisions of the act. On March 23, the National Association for Home Care & Hospice reached out to the Department of Labor (DOL), arguing that nurses, therapists, home health aides and personal care aides be classified as health care employees. A March 28 clarification from the DOL said a health care provider "is anyone employed at any doctor's office, hospital, health care center, clinic, post-secondary educational institution offering health care instruction, medical school, local health department or agency, nursing facility, retirement facility, nursing home, home health care provider, any facility that performs laboratory or medical testing, pharmacy, or any similar institution, employer, or entity."

DID YOU KNOW?

This act also ensured school lunch programs could continue delivering meals to students outside of school hours, meaning thousands of hungry children were fed.

STATUS **President Trump signed into law on March 18. Public Law No. 116-127.**

Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

HR 748

By Kristin Easterling

The CARES Act provides a $2 trillion stimulus for the American economy. Many Americans received checks to help with bills, groceries and other items. American small businesses received payments to help keep employees on payroll.

Small Business Loans
The Small Business Administration (SBA) is authorized to guarantee paycheck protection loans to businesses, nonprofit organizations, veterans organizations or tribal businesses with fewer than 500 employees or the applicable SBA size standard for the relevant industry. In addition, individuals who operate as a sole proprietor or as an independent contractor, as well as certain self-employed individuals, are eligible to receive a paycheck protection loan.

Other Benefits
Section 3703 allows the Centers for Medicare & Medicaid Services (CMS) to waive any requirements relating to coverage of telehealth services under Medicare (rather than only certain requirements).

Section 3708 allows Medicare payments for home health services ordered by non-physician practitioners, something the industry has been advocating for.

Section 3709 temporarily exempts Medicare from budget sequestration.

Section 3712 mandates that CMS must also apply specified payment adjustments for durable medical equipment under Medicare for the duration of the public health emergency, that is, the 50/50 blended rate for rural suppliers and a 75/25 blended rate for suppliers in non-rural non-bid areas. It became effective March 6, 2020.

MEDICARE SUPPLIERS

The act also provides additional relief to Medicare suppliers, including home health and home medical equipment providers. A $100 billion fund was set aside for health care, $30 billion of which went to Medicare suppliers. The Department of Health and Human Services emphasized these were not loans, but payments.

Congress made this appropriation to "to prevent, prepare for, and respond to coronavirus ... for necessary expenses to reimburse ... eligible health care providers for eligible health care related expenses or lost revenues that are attributable to coronavirus." This program is separate from the accelerated payment program that was also enacted in the CARES program.

DID YOU KNOW?

In response to the coronavirus outbreak and changing legislative policy, CMS issued an interim final rule on March 30. The rule extended several provisions, including enforcement on national coverage determinations for several categories, removing face-to-face exams, aligning Medicare and Medicaid prescribing regulations and advancing payments to Part B providers.

STATUS: Signed into law March 27. Public Law No. 116-136.

LEARN MORE: congress.gov and homecaremag.com/coronavirus

By Tom Ryan

What Will HME Look Like After the Crisis?

Change will be here for the long term

As leaders in the home medical equipment (HME) industry prepared to depart from Medtrade in Las Vegas on the first Thursday in March, the number of confirmed COVID-19 cases in the United States stood at 204, with three-quarters of those cases located in Washington state. Five weeks later, the number of positive tests nationwide stood at half a million, and more than 20,000 Americans had been struck down by the pandemic. By the time you read this, those numbers will have grown even larger.

This crisis hits close to home for me, given my background in respiratory care and my current work-from-home location in Farmingdale, New York—just 30 miles from downtown New York City and the current epicenter of the outbreak in the U.S.

This pandemic has strained hospitals and medical professionals in large cities and small towns to the breaking point and has stressed other segments of our health care infrastructure, including HME providers. I've heard from suppliers across the country who are facing this crisis head-on and providing exceptional care under the most challenging of circumstances, and I couldn't be more proud of our industry's collective response. By all reports, suppliers are adjusting operational and delivery practices to help limit exposure to the virus for both patients and HME personnel. This work is absolutely essential in helping alleviate burdens on hospitals by facilitating discharges and keeping vulnerable patients safe at home. HME manufacturers and distributors are also rising to the occasion by revving up their capacity to meet swelling demands for critically needed respiratory products and personal protective equipment.

As the HME community has stepped up to play a major role in this crisis, we've received much-needed support from the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS) and Congress though policy changes and legislation that will allow us to make our strongest possible contribution during the outbreak. These actions are primarily designed to bolster suppliers and streamline regulations and requirements in the near term—but some may have positive impacts for HME providers even when the pandemic is behind us.

By the end of March, HHS and CMS approved Medicare coverage for the home-based treatment of acute respiratory conditions, including COVID-19 and pneumonia, which is critical to efforts to reduce hospital overflows. They have also allowed for accelerated payments to suppliers, paused prior-authorization requirements, suspended most audit programs, waived face-to-face requirements for most items and dropped the need for a patient signature as part of proof-of-delivery. In the second week of April, the regulators reversed course on plans to include non-invasive ventilators in Round 2021 of the competitive bidding program, to the great relief of both respiratory suppliers and patient groups.

The $2.2 trillion COVID-19 stimulus bill that passed in March included substantial Medicare relief, as well. It extended relief

for rural suppliers and added some new assistance for non-rural suppliers outside of bidding areas for the duration of the public health emergency. All Medicare suppliers will see the across-the-board 2% Medicare sequestration cuts paused for eight months. And on April 10, HME suppliers started to see their portion of the $100 billion set aside to support health care providers appear in their bank accounts.

The AAHomecare team, in concert with the VGM Group, the Council for Quality Respiratory Care and other HME stakeholders, has been consistently engaged with CMS, HHS and Capitol Hill to help secure those gains for our industry—including working with HHS to ensure that HME suppliers were included in the definition of "eligible health care providers" to receive a share of relief. Every major suggested policy change that we shared with regulators and with our Congressional champions has been adopted, save for a one-year delay for the 2021 competitive bidding round.

While I'm proud of these efforts by AAHomecare and our industry partners, I believe the most important factor in obtaining this level of regulatory and financial relief for HME providers is the persistent and passionate advocacy work from leaders across our industry over the last few years. I'm confident that the industry's strong response in this crisis will bolster relationships with state and federal regulators and legislators, major third-party payers and managed care organizations.

When the COVID-19 pandemic is finally behind us, we'll return to making sure that relief for rural suppliers is extended for a longer term and obtaining relief for other suppliers in non-bid areas. The fact that Congress has provided this relief in the CARES Act sets a positive precedent for a more permanent fix. Likewise, getting non-invasive ventilators removed from the next bidding round gives the respiratory community time to advocate for permanent exclusion for this high-service product that is a poor fit for the bidding program.

In the nearer time frame, AAHomecare will continue to press HHS, CMS and Congress to delay implementation of the next bidding round for at least a year. Even as the COVID-19 caseload diminishes, this virus is unlikely to be extinguished until widespread vaccine deployment—probably sometime in 2021 at earliest.

When HME suppliers learn later this year whether they've been selected and the bid-price results, they will likely still be dealing with significant operational challenges and possible flare ups of COVID-19. Survivors who required intubation or other respiratory support to recover may need longer-term respiratory care. And the costs for a range of HME and other needs like personal protective equipment may be different from when suppliers submitted bids in October 2019.

We simply don't know the challenges homecare will be facing come Jan. 1, 2021. But what should be clear is that asking the HME community to effectively respond to this crisis while facing that uncertainty—and the inevitable disruption that implementing a new bidding round entails—is, at best, a risky idea.

HME suppliers are displaying courage and compassion in meeting the demands of the crisis. Serving vulnerable patient populations can be a daunting task and a heavy responsibility even in the best of times; the challenges are magnified several times over in an unprecedented health emergency like this one. Even if you are not directly involved in respiratory support, your work in providing home-based equipment and care is helping limit the spread of the coronavirus and keeping patients out of overburdened hospitals, skilled nursing facilities and independent- and assisted-living retirement settings.

HME is playing a major role in limiting the impacts of this virus, helping protect the health and well-being of millions of people and moving us closer to a time when schools and businesses are fully open and handshakes and hugs are warmly accepted. AAHomecare is proud to do our part to make it easier for you to serve your patients and communities under these extraordinary conditions, and we're committed to fight for this industry in the better days that lie ahead. HC

Tom Ryan is president and CEO of the American Association for Homecare. Learn more at aahomecare.org or follow him on Twitter @TomRyanHME.

By Wayne Ferrin

Cracking the Code

PDGM & COVID-19 strengthen the case for outsourcing OASIS coding

In the past year, there have been 20,000 searches for OASIS review and coding on Google. Many people in homecare are looking for answers on how to navigate the uncertainty that the Patient Driven Groupings Model (PDGM) has brought. Add in the COVID-19 public health emergency, the ongoing shortage of available caregivers and the recent regulatory changes and blanket waivers out of Washington, and things can get confusing quickly.

PDGM, the First Quarter

PDGM and the relationship between OASIS and coding is still misunderstood by many home health agencies (HHAs). PDGM requires coding with the highest level of specificity and symptom codes are not acceptable primary diagnoses. Many clinicians still have questions about this, and doctors continue to refer to home health for non-compliant reasons such as pain, weakness, unsteadiness, etc. The face-to-face order needs to match and/or be directly related to the primary diagnosis in M1021.

For example, a patient is referred to home health for muscle weakness and shoulder pain. The patient also has Alzheimer's and as a result is unsteady on her feet; she spends a lot of time in a chair at home. The patient recently had an undocumented fall. Previously, coding muscle weakness was acceptable. Under PDGM, this requires a query to the doctor to confirm that Alzheimer's is the underlying cause of the weakness and unsteadiness and that shoulder pain is a comorbidity.

Take the Long View

The novel coronavirus outbreak has created a short-term emergency with potential long-term benefits. In response, Congress passed the CARES Act, which eases some burdens on HHAs and allows for more flexibility in how to help patients. Yet while the homecare industry is thrilled that the Centers for Medicare & Medicaid Services (CMS) now allows nurse practitioners, clinical nurse specialists or physician assistants to order, sign for and follow home health patients, many challenges remain. For instance, some states still do not allow these practitioners to act in these roles under their licensure laws. Remember that you are required to follow the most restrictive laws, whether state or federal. Hopefully all states will work to match the new law.

> **When the public health emergency for the COVID-19 pandemic is lifted, CMS may conduct medical reviews if there is an indication of potential fraud.**

In another example, video-enabled telehealth is also now available to meet face-to-face requirements—relieving HHAs of one of their largest bottlenecks—but a phone call without video is not acceptable. (Note: all references to legislation, regulations and guidelines were current at press time but may since have changed.)

These changes may be good in the long run. It has long been difficult to track down physicians to verify diagnoses and certify and sign documentation, and they haven't understood all of the rules of home health in the past. Some doctors avoided home health referrals because of the potential for headaches. With these new rules in place, it is likely that access to home health care will increase.

As anticipated, we have noticed an increase in additional documentation requests (ADRs) from CMS. Agencies that embraced PDGM early, learned as much as possible and leveraged experts in OASIS review and diagnosis coding have come out ahead. The easiest flag for denial is the face-to-face order not matching M1021. We've seen several denials because of this simple thing since PDGM kicked in.

However, CMS has given the home health industry a blanket pass for a short time (until the end of the second quarter or the end of the public health emergency due to COVID-19). CMS announced that the Department of Health and Human Services "will not conduct audits to ensure that only physicians signed during the public health emergency" and that ADRs "issued before the public health emergency pause will be released and processed as normal." However, when the public health emergency for the COVID-19 pandemic is lifted, CMS may conduct medical reviews if there is an indication of potential fraud.

Partnering Together

Many HHAs have been forced to dedicate all of their available resources to addressing COVID-19. Office staff may be at home, and

those who are able to work are likely needed to handle other responsibilities and take care of patients.

In conversations with agencies we ask, "Who does your coding and OASIS review?" The answers range widely and include internal staff, contract workers, outsourced, remote, the director of nursing, administrators and even CEOs. The next question is usually the same for agencies that do not outsource. "Who does the work when that person is sick, goes on vacation or quits?" The answer is often "No one." This is a giant bottleneck that disrupts cash flow and reimbursement. If OASIS is not reviewed and coded in a timely manner, then agencies are missing out. Days to Request for Anticipated Payment (RAP) should be about six to optimize claims and cash flow, so having a backlog of charts awaiting diagnosis coding and OASIS review jeopardizes cash flow.

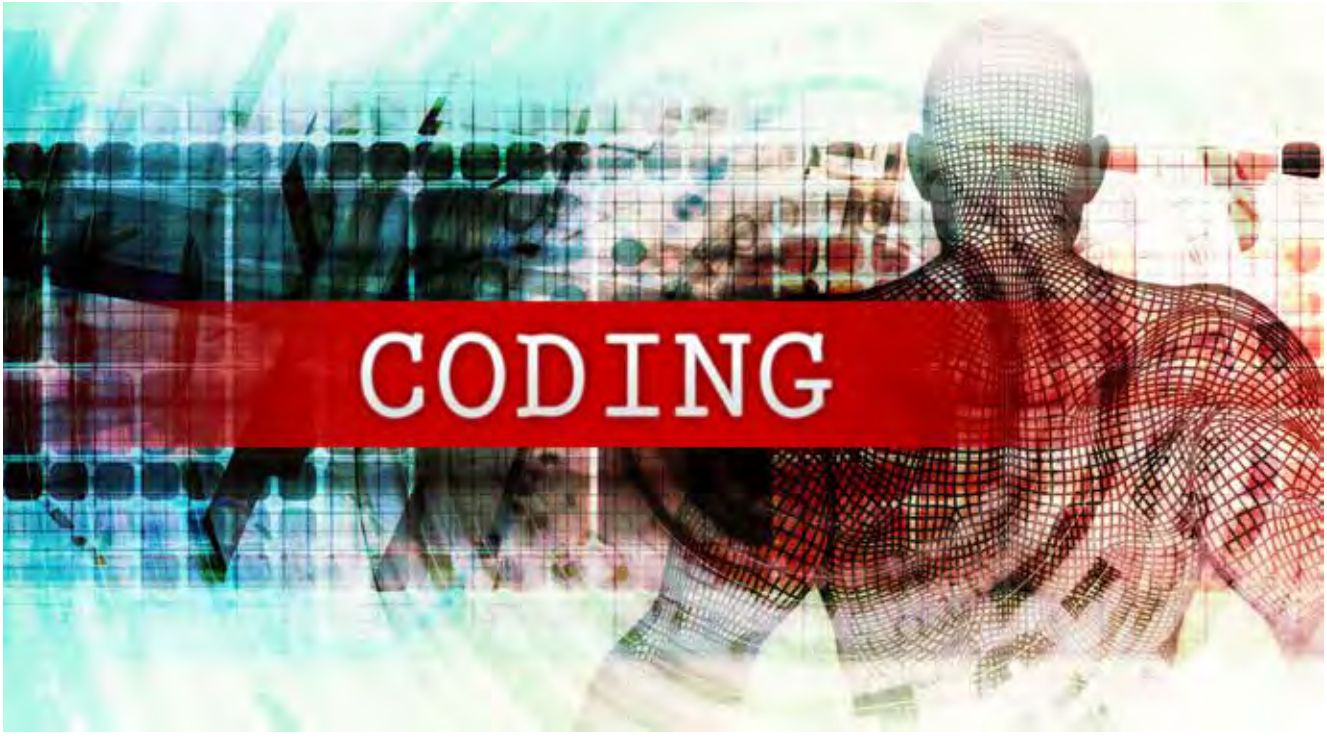
With RAPs going away in 2021 (pending regulation changes), agencies will need to submit Notice of Admission (NOA) within six days for reimbursement. If late, penalties will apply at a rate of 1/30th of payment per day late. This can really damage cash flow and business viability and shortens the timeline significantly for each member of the team. Clinicians need to have charting and notes complete within a day of start of care; OASIS and coding need to be complete within three to five days of start of care; and billing can handle submission of NOA on day six. This leaves a tight window with a lot of moving parts. If no one is available to continually process claims, agencies will suffer and could lose thousands of dollars in fines for late NOAs.

Fixed & Variable Expenses

Many people who code internally are hourly employees with urgent priorities that require their time and attention. Many are not certified in coding or OASIS review; they just make it work. These are fixed costs for a business.

Outsourcing OASIS and diagnosis coding can be beneficial for agencies in many ways:

1. Many outsourcing agencies are paid by the chart; you pay only for what you use.
2. There is continuous flow of quality assessment review and nothing is put on hold, so cash flow is not interrupted.
3. Outsourcing agencies can uncover additional revenue that would be otherwise unclaimed; it may cost less than the total salary, taxes and benefits of employees.
4. The cost of salaries, taxes and benefits can be offloaded entirely, freeing up fixed costs, reducing overhead for the short term and creating additional revenue in the long term.
5. Outsourcing agencies don't go on vacation.
6. With expected growth, can internal teams handle any anticipated volume?
7. Ask yourself, "Am I missing out on reimbursement, outcomes and compliance because my team is overwhelmed with other



tasks, too much volume or a backlog of charts to be reviewed?"

Any time a fixed expense can be replaced with a variable expense, it is usually a good thing for the long-term health of the business. You only pay for what you use. Salaries that are paid without having adequate volume can affect cash flow and profitability. Agencies that are thriving under PDGM have become experts on cost controls. Managing the costs of care and overhead and optimizing cash flow are the keys to financial success in the PDGM era.

Here are a few questions to ask potential outsourcing partners:

1. Where are your reviewers located? Many agencies are turning to overseas labor to provide coding and OASIS review. Agencies charge normal pricing but often pay pennies on the dollar. You usually get what you pay for. In our view, having a reviewer based in the United States is best practice.
2. How do your reviewers interact with my teams? There should be interaction at some level to answer questions or concerns between agencies.
3. How long is the turnaround time? This varies by outsourcing company, but should be no longer than three days, and ideally just one to two days.
4. Can you provide details on how you create value to my company beyond coding and OASIS review? Hopefully agencies can show how they do this for agency partners by showing errors, financial gain (or loss) reports, etc. Data is essential.
5. Can you provide reporting that identifies necessary training as well as quality assessment and performance improvement opportunities?
6. Can you show the return on investment (ROI) of your services? Numbers rarely lie, and with them you can make data-driven decisions. For example, if a chart review costs $60 and the average gain per chart per month is $200, then there is a net profit of $140, or a 233% ROI.
7. What is your denial rate and quality assesment process? ADRs and subsequent denials cost a lot of time and money.
8. Do you have a minimum spend on the contract? If so, the contract should be renegotiated to remain a variable cost.

Outsourcing diagnosis coding and OASIS review is becoming more important as agencies realize that what has been the status quo for the last 20 years has drastically changed, first with PDGM and now with the COVID-19 public health emergency. Focusing resources on patient-facing tasks and offloading fixed costs is a wise decision. If the variable costs create more revenue than the cost itself, then it is a win-win-win situation. The agency, the staff and the patient all win—and you can focus your energies on patients and positive outcomes. HC

Wayne Ferrin, RN, HCS-D, is the owner and CEO of Home Care Answers. He has been in home health since 1993 in various roles from home health nurse to administrator and in corporate leadership roles. He began focusing on coding in 2000. His focus and passion is to educate agencies and help them get OASIS and diagnosis coding correct, allowing them to gain unclaimed revenue that results from coding errors. Visit homecareanswers.com.

By Bryan C. Porter

4 Ways to Handle Business Uncertainty

Best practices for managing risk & worry in a fluctuating economy

With everything going on right now, it is difficult to ignore the feeling of looming uncertainties—political uncertainty, pricing uncertainty, labor uncertainty, financial uncertainty.

If given the chance, these fears can create tremendous anxiety and cause illogical decision-making. A key factor in preparing is to have a strong business strategy focused on your company's core competencies that also allows for flexibility and real-time adjustments. The following are some items to consider when planning to position your business for success in an uncertain marketplace.

1 Define Your Business Strategy

A defined business strategy is the most crucial component for ensuring the long-term viability of your homecare company. Due to the daily demands and fire drills of running a company, many overlook this step. Those who do develop strategies often diminish their success by ignoring crucial operational components of the business—rendering the strategy obsolete as soon as it's completed. A properly designed business strategy weaves the mission of the company into the monthly, weekly and even daily activities of employees tasked with carrying out the corporate mission and includes:

- Adequate input from relevant company stakeholders
- A realistic assessment of the company's short- and long-term objectives
- Identification of achievable steps toward specific objectives and a system to measure progress
- Periodic review of the progress toward objectives and immediate steps for alteration where appropriate
- A means of communicating the evolving plan to employees

When possible, organizations should obtain outside input throughout the strategic planning process and as the plan moves toward completing short- and long-term goals. This input could come from an informal board of advisors familiar with the field in which the company operates, a professional business advisor or an internal executive who is charged with the performance of an unrelated geographic location or sector. A well-developed strategy helps identify internal and external risks to avoid financial strain.

A well-developed strategy helps identify internal and external risks to avoid financial strain.

2 Get Your Team on Board

Even the most strategic plan will only be as successful as the individuals who work toward its goals. Employee buy-in and ownership of the plan during daily responsibilities are critical to its success. At this time and always, a large uncertainty for any homecare business is labor retention.

Developing a culture in which the rank and file understand the mission and why things are done the way they are will go a long way toward retaining employees. Arguably, an executive's most significant responsibility is to create an environment in which each employee has the resources to contribute at their highest level, including access to technical and appropriate financial training, and recognizes what their daily tasks are and how they contribute to the corporate mission.

Employee satisfaction directly affects your bottom line. Creating an environment in which the team can thrive is key to achieving financial success. If your employees are leaving or underperforming, it becomes harder to compete in an economic climate in which qualified workers are scarce.

Executives also need to be mindful of how compensation packages motivate employee behavior as the business and industry evolve. Many firms have a standard package that has been in place for years, despite

significant changes that may have taken place in the competitive landscape. These dated compensation packages often limit growth or are even detrimental to the overall goals of the company.

A review of how the company motivates its staff through compensation, completed in appropriate detail, may result in a better use of assets as you work to achieve the strategic mission. A properly aligned compensation program will improve company culture and create a sense of ownership, which increases participation from those employees who have firsthand knowledge of how to improve the day-to-day processes.

3 Understand the Impact of Technology

An unavoidable consideration for any homecare firm is the use of technology for effective revenue cycle management, documentation and general communication. The proper use of software and other technology can be a major asset that allows companies to maintain ideal cost structure by delaying or replacing personnel costs and maintaining the company's ability to achieve proper margins.

Technology can improve the experience and understanding of clients, employees, vendors and other contractors. A wide range of techology options should be considered to see how they can contribute to the business strategy.

Focus on solutions that allow for timely and accurate sharing of information, which can help limit excessive remediation costs should a major problem surface. But ultimately, technology's effectiveness depends on the buy-in of the executive team and the customizing of solutions to meet the needs of stakeholders.

4 Monitor Your Cash Flow

Periodic financial results are usually communicated to executives and outside stakeholders on the accrual basis of accounting. Although these financial reports are useful in determining the financial health of the company, they are based on historical results.

Homecare companies should develop and regularly analyze a cash flow model that incorporates seasonal or cyclical trends, anticipated market conditions, changes in key customer and vendor relationships, known capital investments or expansions, costs to comply with new regulations, merger and acquisition opportunities, and tax consequences. The model should then be compared to rolling budgeted results to help leadership identify necessary changes to the existing budget for the future.

Perhaps the most important component of the cash flow model is understanding available financing options. Having proper financing when the company is not under financial strain makes navigating a bump in the road more manageable and allows for the negotiation of financing options from a position of strength, not desperation. HC

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Providing Care at Arm's Length

Telehealth options have expanded. Will they remain after the epidemic?

By Hannah Wolfson

It's tough out there right now for homecare providers. There's a dangerous virus, not enough protective gear, fearful clients and mounting pressure to keep patients out of overrun hospitals.

There is a possible solution: expanding digital health tools to allow home health agencies (HHAs) to reach patients safely during the coronavirus crisis and beyond.

"Many home health care agencies are overwhelmed by the COVID-19 pandemic while also attempting to address (Patient Driven Groupings Model) changes and staffing shortages. These forces are unfortunately disrupting agency operations and the ongoing delivery of care—while also putting an agency's patients, staff and (personal protective equipment) supply at risk," Lee Horner, CEO of the digital health company Synzi, said in an email. "Telehealth and virtual care are no longer seen as a more convenient way to engage patients; for home health agencies, this technology is essential to enabling staff to 'go out into the community' without putting themselves (nor their patients) at further risk for infection."

Indeed, one of the first actions the government took was to waive most telehealth requirements during the public health emergency. Previously, Medicare only allowed routine visits via telehealth under certain conditions—like those in rural areas, or if conducted from a medical facility—but now telehealth can be provided anywhere, including at home.

A Crisis Brings Change

The Trump administration and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma have both pushed telehealth in the past, although they have resisted reimbursing remotely-delivered care in the home.

12% of those age 55 & older had ever had a telehealth appointment

"Telehealth is changing the very face of healthcare," Verma said in 2018, specifically citing, among other benefits, that remote connectivity would benefit elderly and disabled people with transportation barriers, those managing chronic conditions, and those receiving care outside hospital settings. "Telehealth innovations could help usher in a new world of health care that is embraced by both patients and providers, that identifies new avenues of care delivery, and that improves the value of care by increasing its quality while lowering its cost."

During the coronavirus outbreak, CMS opened mental health counseling, physician office visits and preventive health screenings up to telehealth. Telehealth also isn't connected to a specific diagnosis, because the goal was to keep patients away from medical offices and hospitals. Here are some of the changes as relates to homecare:

- Home health agencies can provide more services via telehealth within the 30-day episode of care, as long as virtual visits are listed in the plan of care and don't replace necessary in-person visits ordered in the plan of care.
- HHAs can perform initial assessments and determine whether a patient is homebound remotely or by reviewing the medical record. "This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long-term facilities," CMS wrote.
- CMS is waiving the requirement for an on-site nurse visit every two weeks to supervise home health aides and encouraging HHAs to use "virtual supervision" during the temporary suspension of this requirement.
- For home medical equipment (HME) providers, the face-to-face (FTF) examination requirement is waived for items where the FTF is required by national and local coverage determinations. The FTF requirement for power mobility devices can be fulfilled via telehealth.
- Signatures are not required for proof of delivery; suppliers should write "COVID-19" on the signature line.

The Fight Isn't Over

That's a start, according to home health advocates—but not enough.

"We didn't get what we wanted," said Bill Dombi, president of the National Association

Now telehealth can be provided anywhere, including at home.

for Homecare & Hospice (NAHC), which has been pushing for reimbursement for telehealth for home health and hospice providers. "We made a dent in CMS's view towards telehealth and home health. They seem to have embraced it; now it's time for them to pay for it."

According to a NAHC fact sheet, even though providers can communicate with patients remotely, CMS hasn't indicated that these contacts qualify as covered visits under Medicare. And while care can be established by a physician or other practitioner using telehealth, the agency's start of care date has to be based on a reimbursable visit—and therefore telehealth visits apparently can't start an episode of care.

"Medicare will temporarily pay practitioners to provide telehealth services for beneficiaries," the fact sheet says, but questions remain about what's actually covered. NAHC said HHAs may find some relief because physicians can use telehealth for the initial face-to-face encounter, and CMS is still considering what telehealth means for hospice providers.

Dombi said increasing telehealth opportunities is a way to keep more patients out of hospitals and keeping intensive care units clear for those hardest-hit by the current pandemic.

"Home health can and is doing its part to care for COVID-19 positive patients," he said. "Telehealth is one of the best tools that they could have, so we'll be making another run at getting payment for those telehealth services."

Call Me—Or Maybe Don't

But even if CMS opens the throttle, are patients ready?

Maybe not. A survey by the outsourcing and customer relations firm SYKES found that of 3,400 people spoken to, only 2,000 knew what the term meant.

"A significant portion still are not very familiar with what telehealth is," said A.J. Hanna, vice president of client advocacy for SYKES.

When it came to the oldest demographic, those 55 and older, only 12% of respondents had ever had a telehealth appointment and 43% weren't sure whether their providers offered telehealth as an option. Older respondents were also more likely to say that, although they might have experienced or would consider telehealth, they'd prefer an in-person visit in some cases.

"There's a perception, as we know, that health care is personal—the relationship between the caregiver and the patient is very personal—and so for those who expressed some concern about whether the quality of health care that you receive via telehealth is on par with what you would get in person, it's mostly around that idea that people are most comfortable in a setting with a doctor, with a nurse, who's able to do a hands-on assessment," Hanna said.

In the long run, however, the choice may be made for them—SYKES also documented around a 1,300% increase in the number of telehealth calls during just a two to three week period of the outbreak.

"The current crisis makes virtual care solutions like telehealth an indispensable tool," Lee H. Schwamm, director of the Center for TeleHealth at Massachusetts General Hospital, wrote in a blog post.

At Synzi, for example, Horner said that utilization volume for their two-way video communication tool has increased ten-fold from existing clients and others are calling to ask about signing on. He predicted that remote patient monitoring will also jump post-pandemic and stay there.

"This is a critical time for home health. And this is a watershed moment for telehealth," Horner said. "In order to effectively serve as the front line, home health should embrace telehealth and its ability to safely provide clinical and compassionate care—when needed most during these times … Regardless of how or when we reach the tipping point, telehealth is poised to move into the mainstream."

And that may mean that telehealth in the future will look very much like it does today, said Nicole Keane, a project director and registered nurse who focuses on CMS for the consulting and research firm Abt Associates. She said clinicians are being pushed by need to provide care the best way they can—including remotely—without worrying too much about the details.

"The genie's out of the bottle," she told the Intersect Podcast. "Telehealth will be used because this will go on for longer than probably the short term. Will clinicians go back and say, 'Okay, I was able to use that one time, but you're not going to let me use that now?' Especially when it was very effective." HC

Hannah Wolfson is editor of HomeCare magazine.

WHAT COUNTS AS TELEHEALTH?

Telehealth, remote monitoring and virtual visits all are counted as approved telehealth during the coronavirus public health emergency.

WHAT DOCUMENTATION IS REQUIRED FOR TELEHEALTH VISITS?

CMS says telehealth visits must be included on the home health plan of care with an explanation about how they will help achieve the plan's goals without substituting for an in-person visit, but there are no specific requirements for documenting the content of the visit or recording it.

WHAT TECHNOLOGY CAN BE USED?

CMS says that, during the public health emergency, public-facing two-way video tools like Zoom and Facetime may be used for telehealth and HIPAA enforcement will be relaxed (read more on p. 21). NAHC said that telehealth also includes telephonic visits because those are allowed for HHAs during the emergency.

Privacy Rules, Redefined

Understanding telehealth & HIPAA during COVID-19

By Kristin Easterling

The coronavirus crisis has flipped the world on its head. Patients are staying home, often under government order, and health care providers are extending the reaches of telehealth in order to provide care. What does this mean for the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act?

On March 30, the Office of Civil Rights (OCR) issued guidance to health care providers—including home health agencies and home medical equipment providers—extending leniency towards video conferencing applications that had previously been banned under the act due to patient privacy concerns, such as FaceTime, Google Hangouts, Zoom, Skype and others.

The notice reads: "A covered health care provider in the exercise of their professional judgement may request to examine a patient exhibiting COVID-19 symptoms, using a video chat application connecting the provider's or patient's phone or desktop computer in order to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Likewise, a covered health care provider may provide similar telehealth services in the exercise of their professional judgment to assess or treat any other medical condition, even if not related to COVID-19, such as a sprained ankle, dental consultation or psychological evaluation, or other conditions."

That's been widely interpreted as an across-the-board lifting of HIPAA requirements, but Benji Sawyer, president and CEO of Sawyer Solutions, an IT firm specializing in HIPAA compliance, said it may be more complex.

"It is important to be aware of what isn't being said," Sawyer said. "While they are not going to enforce compliance for this one thing, for now, the OCR did not say they are going to stop enforcing data breach reporting."

And Kelly Grahovac, general manager for the van Halem Group, said it's important that home medical equipment and other providers keep HIPAA rules in mind even if standards are more relaxed.

"Explain to the patient that these aren't the typical circumstances and get approval for the visit. Ask the patient to make sure there's no one around that shouldn't hear the information," she said. "The doctor consultation will probably be private, but the patient visit won't be. Make sure that it will be similar to an office visit. The physician will probably be documenting, so include a statement that there was approval [for the video visit]. That will be helpful should the OCR want to enforce later."

Grahovac added that since many delivery services have suspended getting signatures for packages during the pandemic, providers need to ensure that all of their documentation is related to COVID-19.

"Create a narrative," Grahovac said. "Hopefully this will not be an audit scenario."

The OCR recommends that providers use video conferencing applications that will sign a HIPAA-compliant business associate agreement (BAA) in order to avoid any possible conflict.

"If your patients get used to communicating with you in a non-BAA way, then when the crisis is over you will have to retrain them, which is not always the easiest thing," said Sawyer. "Starting out with a solution that will work permanently is just a better idea from a business point of view."

For small providers, the relaxed regulations provide a chance to meet patients where they are, regardless of technical ability or internet speed. But with the Office of Civil Rights continuing enforcement of HIPAA and the HITECH Act, it's important for providers to remember that data breaches happen—and are on the rise. HC

Kristin Easterling is managing editor of HomeCare magazine.

Connecting to the Country

Why virtual care is critical for rural patients

By Lee Horner

Life may be better on the farm, as the saying goes, but it may not be healthier. Rural Americans' health is generally seen as worse than that of their urban counterparts. Almost a fifth of rural adults characterize their health status as fair or poor, compared to 15.6% of urban residents, according to the Rural Health Information Hub. The Centers for Disease Control and Prevention reports that rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease and stroke than those in urban areas. Strengthening rural patients' access to care is critical to improving adherence and outcomes for those with chronic conditions.

In rural communities, home health agencies (HHAs) can be a lifeline as they serve a unique role in providing compassionate care for patients, especially those diagnosed with chronic conditions. However, a study by the Rural Health Reform Policy Research Center found that HHAs encounter several obstacles that hinder their ability to care for rural patients. Nearly half of the agencies in the study indicated that, although licensed by Medicare to serve their entire county, they could only support part of it due to resource, staff and capacity constraints. Some agencies are unable to fully staff for all therapy services, thus limiting their ability to accept referrals. Care providers must also endure snow, storms, floods and poor road conditions throughout a wide geographic area; administrators must factor in additional travel time (and cost) when scheduling their staff's at-home visits.

All of these factors can lead to frequently cancelled or rescheduled appointments as well as a higher-than-average staff turnover. As a result, an agency's ability to recruit and retain quality employees can be negatively impacted, along with the agency's capacity to meet the needs of referral sources. Most importantly, rural patients can suffer from gaps in the continuum of care, leading to weaker outcomes and an increased risk of rehospitalization.

Rural patients can suffer from gaps in the continuum of care, leading to weaker outcomes.

Optimizing Patient Outcomes

To optimize rural patient satisfaction and outcomes, home health agencies are providing virtual care with a HIPAA-compliant communication platform. Instead of spending most of the day en route to a handful of patients, staff can use video to connect with rural patients more often. Administrators can program a cadence of condition-specific emails and text messages to remind rural patients about their medication, upcoming appointments and diet/exercise requirements.

Patients can use their smartphones, tablets or computers to receive messages and participate in the video-based virtual visits; bidirectional communication functionality also enables the patient to proactively reach out to a nurse for a video call on-demand.

Virtual care can also expand an agency's reach into more specialized care. With a shortage of wound care specialists nationwide, many home health agencies do not have a wound care specialist readily available or on staff to see rural patients. Virtual care technology helps patients and staff connect with a wound care nurse who can provide timely care and guidance in wound management. Travel expenses are minimized and productivity is maximized when one wound care specialist can virtually deliver guidance across a rural community. With virtual care, agencies can help their patients receive more immediate care from wound care specialists and continue to heal at home, avoiding unnecessary rehospitalizations.

In addition to providing wound care virtually, an agency can expand the reach and impact of its hospice program. Using HIPAA-compliant video, email, text and secure messaging, a hospice nurse can conveniently and compassionately provide timely instructions regarding pain management to family caregivers. During the virtual visit, the hospice nurse can incorporate additional care team members to provide the patient and family with medical, emotional and spiritual support. Virtual care technology helps an agency facilitate timely interventions during a very challenging time for families and their loved ones.

Benefits for Stakeholders

All stakeholders can benefit from virtual care. Patients with chronic conditions value the ability to access care from the comfort of their home. Distant family members appreciate being able to be involved in their loved ones' care. Staff appreciate the flexibility to care for their at-risk patients from any place, without needing to endure a long drive—especially at night or on the weekend. Administrators appreciate the related decrease in travel expenses and liabilities as well as the ability to better optimize staff productivity, and agencies can achieve greater staff satisfaction, retention and engagement. In short, everyone involved recognizes how virtual care can positively impact outcomes for rural patients.

Rural Americans have gaps in access to care and quality of care. Virtual care technology can help patients access the care they need while enabling agencies to better care for the rural communities they support. HC

Lee Horner is the CEO of Synzi. He is responsible for corporate strategy and development with an emphasis on revenue growth, product direction and customer satisfaction. Prior to launching Synzi, Horner was president of Stratus Video Telehealth and successfully launched several innovative telehealth solutions into the marketplace. He has also served as president of CareCloud software and senior vice president of Sage Healthcare. To learn more, visit synzi.com.

Beyond Basic Telehealth

5 questions with Forcura's CEO

By Hannah Wolfson

A key part of making telehealth work for home health agencies will be thorough integration with the electronic medical record (EMR). HomeCare talked with Craig Mandeville, the CEO and founder of Forcura, which is focused on EMR enhancement and other digital health tools. Its products include a web-based workflow application focused on handling discharge referrals; tools for getting physician signatures; and a mobile care platform with secure messaging, documentation, wound measurement and live video recording. Mandeville, who founded the company in 2012, is on the board of the National Association of Home Care & Hospice.

HOMECARE: How is COVID-19 affecting your business?

MANDEVILLE: It's been very busy but very seamless. We have a lot of prospective customers who were in the pipeline—we've brought on the majority of them in the last two weeks. We also have a few tech features, such as one that allows for live video conferencing in the home, and that's been huge.

HOMECARE: What do you think everything that's going on right now will mean for home health care?

MANDEVILLE: I think health care at home is now front and center, and it's hit everyone square in the nose with a global pandemic, where elective surgeries have been brought to a halt and they're scouring for beds in the hospital. People need to be at home, it's the safest and most efficient place for care. Not only are we seeing a massive influx of interest and business uptick, but I predict because of this, technology innovation and adoption is not just a "want" anymore to drive a little bit of efficiency. This is absolutely a 100% need. And we're in a really good spot to help our industry; that's our passion.

HOMECARE: Do you come from a technology background or a health care background?

MANDEVILLE: I've always been in tech, I went to the University of Texas, I'm from Austin. I'm an entrepreneur and this is the second successful tech company that I started. My wife ran discharge planning here in Jacksonville, discharging from the Mayo Clinic to post-acute settings. That's where the idea is from. These patients were flying in from all over the world to get the best care, and their information wasn't being sent out consistently or quickly. I thought, "How can we get this information to the right hands in real time so clinicians can make good decisions?"

HOMECARE: There's obviously a lot changing in the regulatory and legislative scene. What are you looking out for in particular?

MANDEVILLE: I think we're looking for a more clear definition of what we do if we can't send someone into the home and we don't have remote telemonitoring set up. We really need a telephone call to be paid for as a visit. CMS is worried about fraud, and that makes sense … but if we put some big restrictions on it, I'm hoping for the best.

HOMECARE: Are we at a watershed moment right now when it comes to the future of homecare?

MANDEVILLE: My hope is that this is our moment to shine. Home health is here and we're here to stay in a big big way. And with this overpopulation of hospital beds and how the country is dealing with this today, I think it's going to be a big wakeup call for how we think about what to do if and when this happens again and how we can mobilize the home for testing. There needs to be a robust debriefing on how the globe responded to this and really writing up a good strategic plan for the next time that this happens. To keep this contagion down you need isolation and what better place to isolate yourself than in your home? HC

Hannah Wolfson is editor of HomeCare.

Steady as She Goes

Providers are leveraging existing automation to conquer chaos

By Trish Nettleship

When business is anything but usual–as is the case today–it's important for providers to get the most out of the products they have invested in and let their business management systems do the heavy lifting. By optimizing current products and platforms and automating functions across a business, home medical equipment (HME) providers can take the burden off of staff and continue to satisfy patients while providing a consistent revenue stream.

Providers updating and adapting their business continuity plans around COVID-19 will want to consider several solutions for greater efficiencies and workflow visibility, such as electronic prescriptions, expansions to resupply, mobile delivery and revenue cycle management.

Strengthening Referrals With Electronic Prescribing

Referral challenges top the list of considerations for today's business continuity planning. With closing sleep labs and appointment cancellations and no-shows, the ability to conduct new setups is strained. Technologies like e-prescribe and interoperability tools like GoScripts are enabling providers to communicate with doctors on the front line and keep resupply programs moving uninterrupted.

According to John Skoro, president of XMED Oxygen & Medical Equipment, recent electronic prescribing or e-prescribe technology has filled a void for the acute care industry by eliminating errors and applying the right billing parameters to maximize billing capability and ensure proper reimbursement.

With closing sleep labs and appointment cancellations and no-shows, the ability to conduct new setups is strained.

"Electronic prescribing streamlines the complexity into something that's very simple," Skoro said. "In five minutes, I get an order that's simple, versus five days of wasted time when the order isn't done correctly. We can take the risk out of not getting paid because they didn't get the order right. Instead of a person handling 20 orders a day, they can now do 50 orders a day that are much more accurate, and I have a lot of confidence in what I'm going to bill."

"As we all struggle with reduced margins, we need automation so we're not wasting energy and staff and ink and printing and faxing time," Skoro continued. "With electronic prescribing, my staff members are much more high-powered people working on more complicated problems rather than these mundane tasks."

Resupply Automation for Worry-Free Revenue

While many providers are seeing their revenue drop in sleep and other areas of business, a solid resupply program

Many are addressing the increased demand for home delivery due to COVID-19 with a mobile workflow solution.

offers a less labor-intensive solution to provide needed supplies to patients while supporting social distancing requirements. With an automated resupply program plus fulfillment, providers can safely and efficiently handle all orders and drop ship them to patients for worry-free revenue.

Matthew Ford, chief operating officer of respiratory care specialist Sail Healthcare, said his group has seen tremendous growth with today's resupply technology, moving billing per order from double digits to triple digits and adding hundreds of patients, all with only two staff members.

"In the past, we would be fielding lots of phone calls, making lots of outbound calls and then consequently missing people so we'd have a lot of inbound calls coming in," Ford said. "We wouldn't be able to service the volume of patients that we're now servicing without our resupply technology to revamp our workflow."

"The technology has completely streamlined the process with a template that ensures that when the three-month cycle comes around, we've got all the items correctly listed and patients have an easy way of logging in and ordering those items," explained Ford. "We've had very positive response from our patients who like the fact that they can order at their convenience."

"Patients order online themselves and then we just handle exceptions. It's very straightforward because of the efficiency of this technology in integrating document management with our (prior authorization requests), (certificates of medical necessity) and warehouse logging," he said.

Efficient Home Delivery With Mobile Technology

Adjusting to patients no longer picking up orders and supplies, as well as lean warehouse staff, requires rethinking deliveries to maximize efficiency. Many are addressing the increased demand for home delivery due to COVID-19 with a mobile workflow solution that automates routing, streamlines paperwork and manages electronic signatures.

Indiana-based Deaconess Home Medical Equipment faced a familiar scenario of still relying on paper-based delivery processes that leave companies disorganized and frustrated because of wasted time and money. All of that changed when the business implemented a mobile delivery solution that has created an operations overhaul, according to HME Business Manager Mindy Carlton.

"We've streamlined our overall HME process and that has allowed us to work quickly and more efficiently," Carlton said.

Since rolling out the mobile logistics technology, the company has eliminated paperwork pile-ups and claim delays, decreasing days sales outstanding by eight days, improving customer service and inventory control, and reducing missing tickets to zero.

Patients now only have to sign once for all required paperwork and the technicians are less likely to forget a form as all paperwork is pre-loaded into the software system. The company integrated the advance beneficiary notice form add-on to ensure it is completed when necessary, reducing the need for a patient revisit.

"Our ultimate goal was to improve efficiencies in our workflow and save the time of both our staff and patients," explained Carlton. "Tickets are no longer misplaced and the amount of serial number errors have been significantly reduced."

Support Staffing With Revenue Cycle Management

The HME business is already tough—with increasingly compressed margins and the ever-looming chance of audit takebacks—but today's business disruptors are making it more important than ever that HMEs get the support they need. Revenue cycle management services are one way providers are doing more with less.

David Hosemann, president and CEO of Hometown Medical, has used the services to help minimize disruptions to his business with scalable staffing, healthy revenues and predictable cash flow. He experienced fast results, including heightening business continuity and team morale, as well as increasing cash flow and profits.

"A lot of folks don't think they can afford revenue cycle management services, but the truth is they can't afford not to have it," he said. "If you are stuck, that's your sign you need it."

Hosemann reported that using the services has given Hometown Medical more reliable follow-up on accounts receivable and faster patient payments, allowing them to focus on patients, referral sources and the communities they serve.

While it's difficult to predict next steps during COVID-19, a solid business continuity plan with automation is a sure way to steady operations. HME providers who know how to make the most out of their current product and platform investments are going to experience greater gains. And that means using solutions such as electronic prescription, resupply, mobile delivery and revenue cycle management, which allow providers to not only work faster and easier, but also to maintain profits as well as employee and patient satisfaction. HC

Nettleship is vice president of marketing at Brightree, where she is responsible for marketing strategies and plans for new Brightree offerings and driving demand generation and market development for Brightree's current portfolio of cloud-based post-acute care solutions.

When Crisis Looms

How manufacturers & others are answering the call for oxygen support in the coronavirus pandemic

By Kristin Easterling

Since the coronavirus pandemic began, public health officials have been ringing the alarm: the United States does not have enough ventilators to support the predicted crush of patients.

In truth, the bells have been ringing for a long time. All told, there are an estimated 200,000 ventilators available nationwide—about 62,000 full-featured vents in hospitals, according to a 2009 American hospital survey; an additional 99,000 older models, including the Strategic National Stockpile; and others held separately by states.

But even a moderate non-COVID-19 pandemic could result in as many as 865,000 U.S. residents being hospitalized, according to a 2005 report from the Department of Health and Human Services (HHS). The same figures estimated as many as 9.9 million could require hospitalization during a severe outbreak.

The American Hospital Association projected in a March 13 webinar that as many as 960,000 people hospitalized with COVID-19 would need ventilator support in a worst-case scenario. As of press time, the country appeared to have flattened the curve on the virus, but ventilators are still in short supply.

As a remedy, President Trump invoked the Defense Production Act (see sidebar) to order General Motors to produce additional ventilators for the national stockpile. Since then, the president has signed additional orders for personal protective equipment, including respirators and gloves.

The Industry Responds

General Motors partnered with Ventec Life Solutions to ramp up production of the Bothell, Washington-based company's VOCSN multi-function ventilator.

On March 27, the two companies announced their partnership to manufacture at GM's plant in Kokomo, Indiana and at Ventec's existing facility.

The fast ramp-up wasn't easy. In an April 2 interview with National Public Radio, Ventec CEO Chris Kiple said that the VOCSN includes about 700 components sourced from about 80 suppliers around the world.

In the same interview, the CEO of a casting company in GM's supply chain said it would normally take 12 weeks to increase production on the piston the company was producing for the VOSCN ventilator, but GM demanded the part as quickly as possible.

"They literally woke up their entire supply chain team on Saturday morning at 6 a.m. to source 700 parts," Kiple said–adding that the response has been as unprecedented as the virus itself.

"Health care professionals on the front lines deserve the best tools to treat patients and precision critical care ventilators like VOCSN are what is necessary to save lives," he said in a news release.

Others in the respiratory game have also upped manufacturing in response to the pandemic. Many respiratory suppliers are global companies with factories around the world, which means grappling with varied stay-in-place orders and government shutdowns that may look very different from those in the U.S.

CAIRE, a provider of liquid and portable oxygen, has eight facilities around the globe. Following a mandatory shutdown in early January, CAIRE implemented safety procedures at its China plant that it could then roll out around the world as the pandemic spread.

"Our initial and ongoing focus is on protecting employees while keeping production going. Any employee who can is working from home," said CAIRE CEO Earl Lawson. He said that the company is taking workers' temperatures as they enter the building and employees are sanitizing their hands frequently throughout the day

COMPETITIVE BIDDING

When CMS announced Round 2021 of the competitive bidding program, a new category was added that caused controversy in the home medical equipment community—noninvasive ventilators (NIV). These machines provide ventilation with a mask rather than a tracheostomy tube and are crucial to keeping many patients at home.

On April 9, CMS announced that no contracts for NIVs would be awarded and the devices were being removed from the program due to the novel coronavirus outbreak.

The move was hailed by industry advocates. Support came from a broad range of groups, including the American Association for Homecare (AAHomecare), the National Association for Homecare & Hospice, the American Lung Association and the U.S. COPD Coalition. A House sign-on letter on the topic garnered at least 180 signatures, and its Senate counterpart had at least 38. Late in 2019, Congress passed the Safeguarding Medicare Access to Respiratory Therapy Act (SMART Act) to delay inclusions of ventilators in competitive bidding for five years, and creating an expert panel to help develop Medicare coverage policies for at-home ventilators.

ALTERNATIVES FOR TREATMENT

There are other options to relieve the demand for more ventilators. Auburn University in Alabama is working to repurpose CPAP machines into functional ventilators. The project, called RE-INVENT, was developed in just two days with $700 worth of components by engineering professors Tom Burch and Michael Zabala and sophomore Hayden Burch.

The emergency ventilator system is composed of a common CPAP machine, the RE-INVENT valve assembly and the standard tubing and tracheal tube used in current ventilators to deliver air to the patient. RE-INVENT can provide a range of inspiration-to-expiration ratios between 1:3 and 3:1 on increments of 0.1. It can also provide a range of 10 to 30 breaths per minute.

While Auburn University is scaling CPAP machines up, the devices can also be used on their own for respiratory support, along with bilevel noninvasive ventilation (NIV).

"CPAP can serve as an alternative for lower-severity respiratory patients whose primary need is for oxygenation, particularly in a time of great need when ventilators are in such high demand," said Philips' Diacopoulos. "For COVID patients with oxygenation problems, CPAP is generally provided with supplemental oxygen."

"Bilevels can deliver noninvasive ventilation to treat the respiratory insufficiency many COVID-19 patients have," said ResMed's Nunez.

When using bilevels to deliver NIV, good mask fit, isolation, and PPE for care providers can help keep aerosolization risk low, Nunez added.

and wearing gloves. CAIRE has spaced people out on production lines, staggered shift times and breaks and taken half of the tables out of the cafeteria to ensure social distancing. The company is also quarantining parts entering the facilities, Lawson said, adding to supply chain challenges.

Beyond ventilators, CAIRE is also seeing increased demand for its high-flow devices, portable oxygen concentrators and liquid storage systems, Lawson said.

"We are seeing the majority of demand for oxygen concentrators coming from patients in some respiratory distress, and hospitals are using the concentrators to be able to get patients back home," Lawson said. "This frees up beds for patients that require ventilators."

Ventilator Giants Step Forward

Philips and ResMed are two of the largest ventilator manufacturers in the country. Each has committed to increased production during the coronavirus crisis.

Philips has increased production of hospital ventilators and plans to double production by May and quadruple it by the third quarter of 2020. To do this, Philips is hiring additional manufacturing employees, adding shifts and relocating some current employees.

"In just a few short weeks, we have ramped up hospital ventilator production, collaborated with the U.S. government, supported clinical webinars, further enabled remote monitoring capabilities and made significant strides to care for the health and wellbeing of our employees worldwide," said Eli Diacopoulos, business leader for respiratory care at Philips.

ResMed is aiming to double or triple production on ventilators, bilevel devices and ventilator masks for hospitals, said ResMed Chief Medical Officer Carlos M. Nunez. This will result in tens of thousands more ventilators from the company than usual in 2020, he said.

Why We Need Vents

COVID-19 patients have stunningly low blood oxygen levels, reports STAT, but may lack other signs that they should be sedated, intubated and placed on invasive mechanical ventilation.

The conventional wisdom is that as blood oxygen drops below 93%, a patient should be placed on a noninvasive device such a bilevel ventilator or a continuous positive airway pressure (CPAP) device. If these fail to raise oxygen saturation, the patient is placed on a mechanical ventilator. COVID-19 patients often have blood oxygen levels in the 70s and 80s, and reports from China suggest that early intervention with mechanical ventilators could prevent organ failure.

Yet survival rates for those intubated are low. Researchers in Wuhan, China reported that 30 of 37 critically ill COVID-19 patients placed on mechanical ventilators died within a month. In another report from hard-hit Italy, 90% of 1,300 patients were intubated; one-quarter died in intensive care, reported STAT.

Researchers also reported that in COVID-19 patients with acute respiratory distress syndrome, the air sacs of the lungs filled with a gummy yellow fluid.

"That limits oxygen transfer from the lungs to the blood even when a machine pumps in oxygen," geriatric and palliative care physician Muriel Gillick of Harvard Medical School said in an interview with STAT.

"The patients in front of me are unlike any I've ever seen," critical care physician Cameron Kyle-Sidell told Medscape in an interview about patients he saw in a hard-hit Brooklyn

WHAT THE GOVERNMENT ORDERED

The Department of Health and Human Services has ordered at least 137,431 new ventilators for delivery by the end of 2020 under the Defense Production Act.

As of mid-April, here's what they have ordered:

- General Electric's $64.1 million contract is for 2,410 ventilators produced by June 29, with 112 by May 4 and 736 by June 1.
- Hamilton's $552 million contract is for 14,115 ventilators produced by July 3, with 850 by May 8 and 4,404 by May 22.
- Hill-Rom's $20.1 million contract is for 3,400 ventilators produced by July 13, with 400 by June 1.
- Medtronic's $9.1 million contract is for 1,056 ventilators to be produced by June 22, with 200 by May 4 and 678 by June 1.
- ResMed's $31.98 million contract is for 2,550 ventilators produced by July 13, with 400 by May 4 and 1,150 by June 1.
- Vyaire's contract $407.9 million contract is for 22,000 ventilators produced by June 29, with 1,200 ventilators by May 4 and 9,100 by June 1.
- Zoll's $350.1 million contract is for 18,900 ventilators produced by July 3, with 1,010 by May 4 and 4,410 by June 1.

hospital. "They looked a lot more like they had altitude sickness than pneumonia."

There have been efforts to use CPAP and other noninvasive devices to mediate the a shortage of ventilators, but those pose a risk to health care workers by pushing aerosolized virus particles into the air—meaning that even though a patient may benefit from treatment, anyone who enters the room is at risk.

To be sure, ventilators are needed to fight the current crisis. But this virus defies conventional wisdom and doctors and researchers are struggling to support the sickest patients while ensuring more people are sent home safely.

"We are grateful to the patriotic Americans at companies working around the clock and retooling factories to increase ventilator production," HHS head Alex Azar said in a news release. "The thousands of ventilators delivered to the Strategic National Stockpile starting this month, continuing through the spring and summer, will mean we have more capacity to respond to the pandemic as it evolves." HC

Kristin Easterling is managing editor of HomeCare magazine.

Is Your Ventilator Supply Patient-Ready?

Tips on being prepared for an emergency

By Hannah Wolfson

Ventilators have been in the spotlight during the COVID-19 public health crisis, with most attention focused on manufacturing new ones for hospital use.

But what about those vents that are already sitting on shelves but aren't ready to be deployed? Jim Worrell, chief commercial officer for Quality Biomedical, says the coronavirus pandemic has brought the problem of preventative maintenance out of the shadows.

"What has happened is that the states and the cities go to access their ventilators and they've never been used," Worrell said. "They all have a backup battery if they're ambulatory, and they also have filters that dry out. They suddenly realize that they haven't been (through preventative maintenance). That's why we have thousands going through our process."

Quality Biomedical services respiratory and other home medical equipment (HME), with a specialization in ambulatory ventilators such as the LTV-1200, Philips Trilogy, ResMed Astro and Breas Vivo. They work closely with HME dealers and manufacturers as well as with hospitals and other health providers.

With seven branches around the country and the ability to quickly turn around equipment, the company has found itself providing an essential service during the pandemic—providing maintenance for states, cities and emergency management agencies that find their stockpiles of ventilators need preventative maintenance (PM) before being deployed. Quality

Recent events have shown the critical need for patient-ready ventilators to be deployed at a moment's notice.

FOUR TIPS FROM QUALITY BIOMEDICAL FOR MAKING SURE YOUR VENTILATORS ARE READY TO DEPLOY IN AN EMERGENCY:

1. **Know what you have.** A complete and accurate list of all your respiratory assets needs to be online and available to anyone in your organization who may need it.

2. **Know where it is.** Some states have distributed their respiratory assets around the state via emergency medical service companies, hospitals or governmental offices. While the "distributed" strategy allows for rapid deployment in various areas, it also presents issues around "what is where, and what condition is it in?"

3. **Keep it ready.** Your ventilators do no good if they are not properly maintained. When medical equipment sits idle, batteries die and filters and o-rings dry out. Make sure it is properly maintained according to manufacturer recommendation and all service records are up-to-date.

4. **Make it easy to retrieve and deploy.** Will you have immediate access to your ventilators, even in an unexpected emergency like a tornado or an earthquake? Can you get to it if roads are blocked or power is down? All of these are questions to answer.

Biomedical recently received 100 ventilators from the Florida Department of Health and an additional 42 from Sacramento County, California. Worrell estimates the company is processing about 200 ventilators each day.

In fact, the work has come in so fast that the company is racing to increase staffing,

"We're hiring technicians as fast as we can," Worrell said. "We've gone from one to three shifts at four of our locations; we're adding overtime and weekends."

That brings its own challenges, as a factory-certified technician has to be available for each model of ventilator. Educating staff accordingly and ensuring they are distributed across shifts has been a focus, Worrell said.

Worrell said non-ventilator demand has also increased during the coronavirus outbreak. Overall, he said, they expect to handle around 10,000 pieces of equipment this month, compared to about 6,000 in a typical month. Some of that is because, with COVID-19-related supply chain issues slowing down production and shipment of new devices like oxygen concentrators, HME providers and others need additional work done on those remaining in service longer.

"The demand for oxygen concentrators right now is through the roof and all of the manufacturers are significantly backordered right now," Worrell said. "We're getting requests like crazy to service the concentrators; the demand for concentrator service and repair has never been higher."

Worrell said the pandemic has brought awareness to the company's Total Equipment Control, or TEC, program—in which it stores, services and ships out ventilators and other equipment for providers. It is expanding it to municipalities, states and other government entities. Under the program, the company keeps batteries charged, does regular software updates and fulfills manufacturer requirements.

"Recent events have shown the critical need for patient-ready ventilators to be deployed at a moment's notice," the company's website reads.

It has also allowed staff and administrators to feel they're doing something important to help the health care system as a whole.

"We set the tone from the beginning that we need to play an important part, albeit a small part, in the country's response," Worrell said. "We need to pull out all the stops to help the country and help our customers help their patients." HC

Hannah Wolfson is editor of HomeCare magazine.

Don't Fall Asleep on Polysomnography Documentation

Make sure you know the legal requirements for sleep testing

By Markus P. Cicka

During the past six years, the Department of Health and Human Services Office of the Inspector General (OIG) has made at least five reports regarding improper or questionable billing for sleep studies or polysomnography (PSG). In a recent report regarding polysomnography billing, the OIG found, among other items, that some providers' documentation was incomplete and some attending technicians or technologists lacked the required credentials or training certifications.

What Is Polysomnography?

Part B of the Medicare program includes supplementary medical insurance for PSG services and associated medical supplies.

Medicare coverage for polysomnography services includes a diagnostic sleep study and, depending on a beneficiary's diagnosis, may also include a positive airway pressure (PAP) titration study. Providers conduct a diagnostic sleep study to diagnose medical conditions that can affect sleep, most commonly obstructive sleep apnea (OSA), and to evaluate how effectively PAP devices manage the beneficiary's condition. If the study indicates that a patient has a sleep disorder, then the provider may conduct a PAP titration study.

Providers normally perform PSG services at sleep disorder clinics, which may be either affiliated with hospitals or be freestanding facilities, such as independent diagnostic facilities or provider-owned laboratories.

If a PSG shows that a beneficiary has sleep apnea, a provider may prescribe a PAP device for treatment.

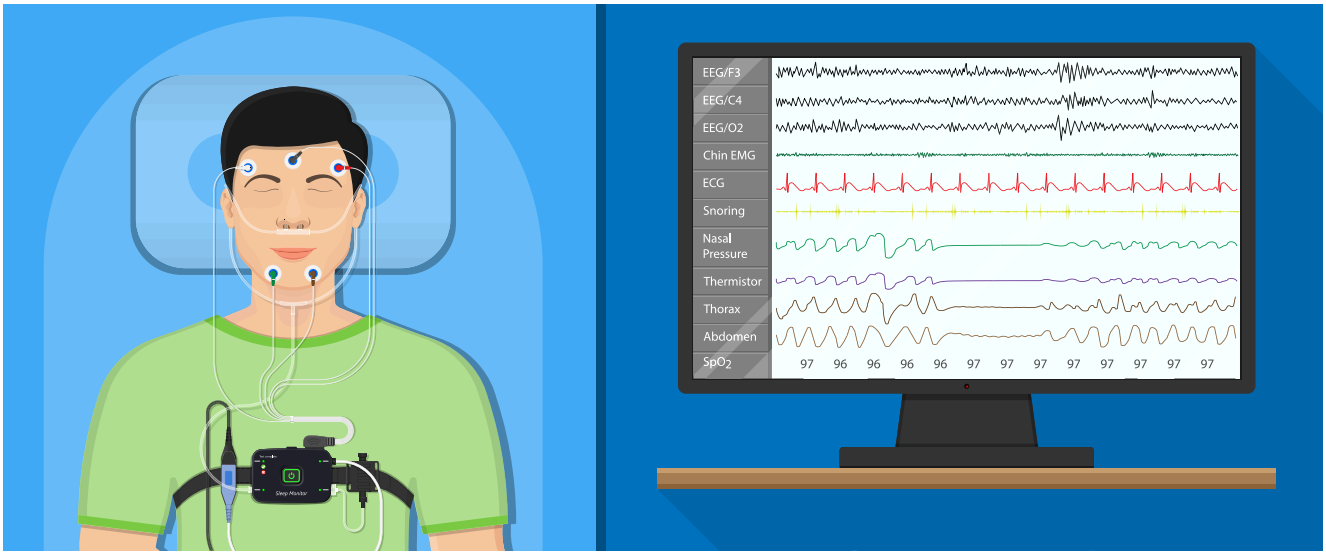
For the test, a beneficiary sleeps overnight while connected to sensors that measure and record sleep parameters such as brain wave activity, eye movement and air flow. If PSG shows that a beneficiary has sleep apnea, a provider may prescribe a PAP device for treatment. Providers fit and titrate PAP devices (i.e., set them to the appropriate pressure for the user), after which beneficiaries may receive a PAP device for home use. Providers also may prescribe a different type of treatment device, called an oral appliance, instead.

Providers can perform diagnostic and titration services in two visits or together in a single visit, known as a split-night service. Providers can perform a split-night service when a diagnosis of sleep apnea can be made within the first few hours of the polysomnography service and the provider is able to fit and titrate the PAP device in the same night. If the provider cannot make a diagnosis early in the sleep test, the beneficiary may need to return later for an additional PSG service to fit and titrate the PAP device.

How Medicare Pays

Medicare pays for sleep tests under the Medicare Physician Fee Schedule when performed in freestanding facilities and under the Outpatient Prospective Payment System when performed in a hospital outpatient department. Providers must use standardized codes, called Current Procedural Terminology codes, to identify the service.

All PSG services consist of two components: the administration of the test, which is the technical component, and the provider's interpretation of the test, which is the professional component. Providers



use modifier code -TC or -26, respectively, to indicate whether the billing is for the technical or professional component. If a provider does not include a modifier code on the claim, it indicates that the provider is billing for a "global service." A provider that bills for a global service receives payment for both the technical and professional components.

Medicare covers all reasonable and necessary diagnostic tests given for sleep disorders only if the patient has symptoms such as:

- Narcolepsy, a syndrome characterized by abnormal sleep tendencies, such as excessive daytime sleepiness or disturbed nocturnal sleep
- OSA, a potentially lethal condition in which the patient stops breathing during sleep
- Impotence, as shown by diagnostic nocturnal penile tumescence testing, which may be covered under limited circumstances, to see whether erectile impotence is organic or psychogenic
- Parasomnias, a group of conditions that represent undesirable or unpleasant occurrences during sleep

From the OIG

In a recent report regarding PSG billing, the OIG found two major issues:

1.Some Providers' Medical Record Documentation Was Incomplete

Medicare will cover all reasonable and necessary diagnostic testing for sleep disorders only if the patient has symptoms such as those listed above and all of the following criteria are met:

- the clinic is either affiliated with a hospital or is under the direction and control of physicians;
- patients are referred to the sleep disorder clinic by their attending physician and the clinic maintains a record of the attending physician's orders; and
- medical evidence confirms the need for diagnostic testing, such as physician examinations and laboratory tests.

Furthermore, most local coverage determinations (LCDs) published by Medicare Administrative Contractors for sleep testing specify that providers must maintain a record of the attending physician's order and the medical record documentation supporting the medical necessity of services performed. This documentation includes, but is not limited to, a face-to-face evaluation by the treating physician that documents relevant medical history and symptoms, a physical examination and the results of pertinent diagnostic tests or procedures.

In its recent report, the OIG found that certain providers' documentation was incomplete because it did not contain the face-to-face clinical evaluation, the physician's order or the technician's report.

2. Some Attending Technicians or Technologists Lacked the Required Credentials or Training Certifications

Some LCDs state that sleep technicians or technologists who attend PSG services must have appropriate training certifications, such as Registered Polysomnography Technologist or Registered Electroencephalographic Technologist.

The OIG found that some providers billed for a polysomnography service but the attending technologists' credentials or training certifications had expired or the provider did not properly document the credentials or certification.

If you have any questions about billing for polysomnography services, you should consult with your health care attorney. HC

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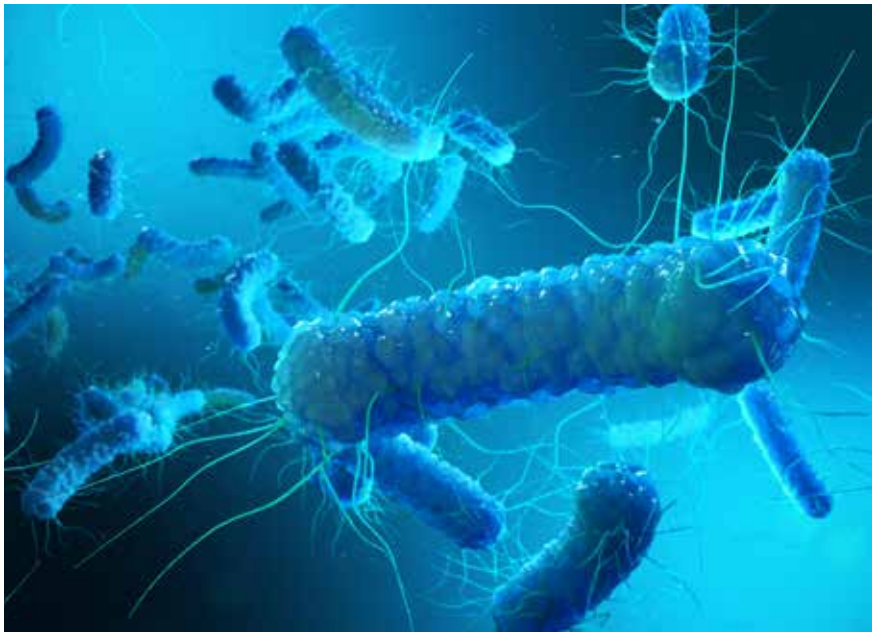
Stepping Up Sepsis Care

Homecare plays key role in identifying & preventing deadly infection

By Sara McMannus & Marijke Vroomen Durning

Home health care providers are in a unique position to work with patients who are either at risk of developing sepsis or recovering after having sepsis or septic shock.

According to the 2016 estimates from the Centers for Disease Control and Prevention (CDC), each year 1.7 million people in the United States develop sepsis and 270,000 die from the condition. These numbers can be lowered with effective infection prevention, through careful monitoring of patients who are at risk for sepsis and by taking appropriate action when sepsis is recognized. The majority of sepsis cases begin outside of the hospital; as many as 87% start in the community. Sepsis is a medical emergency and when sepsis is quickly recognized and treated, lives can be saved.



Understanding Sepsis

Sepsis is a condition characterized by life-threatening organ dysfunction due to a dysregulated host response to infection. Said another way, the body's immune system goes into overdrive in an inflammatory response to the infection and turns upon itself. This overreaction can lead to tissue damage, organ failure and death. Any type of infection can lead to sepsis: bacterial, viral, parasitic or fungal. The most common site for infections that may lead to sepsis are the lungs (pneumonia), urinary tract, skin and intestines. Bacterial infections have traditionally been the most common cause of sepsis. This may change, however, with the high incidence of the novel coronavirus that causes the disease COVID-19, which can lead to sepsis and septic shock. Because this is a new virus, no one has any immunity and there are no available vaccines—so the entire population is susceptible.

Sepsis is a condition characterized by life-threatening organ dysfunction due to a dysregulated host response to infection.

This new infection will increase the number of virally-caused sepsis cases. And the escalation will come on top of the current high number of influenza cases that may be forgotten during the COVID-19 pandemic. The CDC estimates there were 45 million influenza illnesses, 810,000 hospitalizations, and 61,000 deaths in the U.S. between 2017-2018. In most cases, patients are able to fight off the virus on their own with traditional supportive care. But patients with a weakened immune system may develop a secondary bacterial infection, such as pneumonia. In the article "A 15-Year-Old Cheerleader Died From Septic Shock After Having the Flu," infectious

disease physician Amesh A. Adalja said, "When we see people die from influenza, many have sepsis and septic shock. It is a common pathway for death from the flu."

Identifying Sepsis

Anyone can develop sepsis. Those at highest risk are children younger than a year, adults 65 years old and older, people with chronic medical conditions and/or weakened immune systems, and those taking medications that cause immune suppression. Many patients who receive homecare for various health conditions, including post-operative care, may have chronic diseases that put them at risk for infection and sepsis.

Sepsis screening tools are very helpful in the home health care setting. The Home Care Association of New York State (HCA-NYS) created a screening and intervention tool with their contributors and partners. Home health care providers can request use of the tool at sepsistool@hcanys.org. Orientation and training on the tool and on sepsis are prerequisites to using it. HCA-NYS has also created a dedicated website, stopsepsisathomeny.org.

Once sepsis is identified, taking appropriate action is key to decreasing morbidity and mortality. The risk of dying from sepsis increases by as much as 8% for every hour treatment is delayed, according to a 2006 study. If you suspect a patient has sepsis, call 911 or get them to a hospital immediately. It is important for you to convey to first responders and physicians that you suspect sepsis.

Post-Sepsis Homecare

Sepsis survivors often require home health care after hospitalization. Up to half of survivors experience post-sepsis syndrome, which leaves them with long-term physical and/or psychological effects, as reported in the Journal of the American Medical Association. Common sequelae post-sepsis may include:

- difficulty sleeping
- nightmares
- hallucinations
- panic attacks
- disabling muscle or joint pain
- difficulty concentrating
- decreased cognitive functioning
- loss of self-esteem and/or depression.

Sepsis survivors are also at risk for hospital readmission. A study from the Healthcare Cost and Utilization Project found that approximately 19% of people hospitalized with sepsis are readmitted within 30 days of discharge.

Home health care has always been a key component for optimal patient care throughout illness and recovery. During the current COVID-19 emergency, the potential to impact care has increased to meet the current unprecedented health care needs. Many patients receiving homecare have chronic and other medical conditions that put them at risk for infection, including the novel coronavirus that causes COVID-19 and sepsis. In addition, many patients with COVID-19 are being cared for at home, either without being hospitalized or following hospitalization for a severe case. At the time of this writing, approximately 80% of people with COVID-19 will have a mild course and recover without hospitalization. According to estimates, the remaining 20% of patients with COVID-19 may develop sepsis and be admitted to the hospital, with 2% to 3% needing intensive care. For patients with severe illness, home health care will be needed. These patients will have the typical sepsis survivor issues. In addition, they will have experienced isolation, fear and other yet-to-be-understood consequences of the current health care crisis.

Infection prevention is sepsis prevention. Vaccination and good hygiene help prevent infection. When infection does occur, it is important to seek medical help before sepsis sets in. It is estimated that as many as 80% of sepsis deaths could be prevented with rapid diagnosis and treatment. Home health providers play a vital role in monitoring patients and identifying sepsis in the field—and in preventing, recognizing and treating sepsis. HC

IDENTIFYING SEPSIS: IT'S ABOUT T.I.M.E.

The Sepsis Alliance has developed the mnemonic "T.I.M.E" to help caregivers and patients spot and respond to symptoms of sepsis.

T is for **temperature**, which may be higher or lower than normal. (Note that older adults may not mount a significant fever due to the aging process advancing to immunosenescence.)

I is for **infection**, suspected or known.

M is for **mental decline** as there can be confusion, sleepiness, difficulty to rouse or even a fall.

E is for **extremely ill**, with people having severe pain, discomfort and shortness of breath. They may say " I feel like I might die."

Sara McMannus is a clinical advisor for the Sepsis Alliance. She started her career as a staff nurse in critical care. She developed programs and educational tools Clinical Program Manager for GE Healthcare.

Marijke Vroomen Durning, RN, is the director of content at the Sepsis Alliance. Following several years working clinically as a floor nurse, teacher and supervisor, she now writes and edits health and medical information for the public and healthcare professionals. Follow her on Twitter @MarijkeD.

Mind Your CDI

How to establish a Clinical Documentation Improvement program & why you should

By Sharon M. Litwin

For years, home health agencies (HHAs) have been conducting many of the components of a Clinical Documentation Improvement (CDI) program—but they may not have heard it labelled as such. Of course, documentation review, with its goal of improvement, has always been a priority for agencies. Pieces of the program are usually distributed among many roles in the agency office, typically including clinical managers, quality assurance and performance improvement (QAPI) coordinators, coders and/or the billing department.

CDI is a formal program or initiative across health care with certifications in various settings, including acute care hospitals. Documentation is key to compliance and reimbursement across the health care continuum.

Never could this be more true in home health, as increased audits by the Centers for Medicare & Medicaid Services' Medicare Administrative Contractors and third-party contractors have led to a high number of denials that can threaten the viability of agencies. CDI focuses on key areas of Medicare eligibility and compliance, including the face-to-face and skilled need categories—areas that can impact denials.

In addition, increased numbers of condition-level deficiencies and immediate jeopardy resulting from regulatory surveys—which can lead to sanctions—have been occurring in home health. Some problematic conditions of participation (CoPs) are patient rights, QAPI, infection control, care planning, coordination of care and quality of care and aide services.

CDI & QAPI

QAPI focuses on improving patient outcomes. Using data from the Certification and Survey Provider Enhanced Reports OASIS outcomes, Home Health Compare and the Consumer Assessment of Healthcare Providers and Systems will allow an HHA to develop a plan to improve patient outcomes that will include compliant documentation.

Therefore, QAPI and CDI can work well together. A goal of QAPI and CDI is to have continued survey readiness so that no matter when a surveyor comes to visit your agency, your documentation can withstand scrutiny.

While a formal QAPI program is often based on the quarterly review of a percentage of records, CDI can implement real-time processes and audits to prevent problems from occurring in documentation. Also, CDI focuses on preventing denials. Together, QAPI and CDI can help keep HHAs compliant.

CDI & PDGM

The Patient Driven Groupings Model (PDGM) relies heavily on clinical characteristics

Ensuring that the plan of care, comprehensive OASIS assessments and visit documentation support the primary diagnosis is essential; processes to ensure timely, accurate and complete documentation are key components of CDI.

to place home health periods of care into payment categories. Therapy visit thresholds for reimbursement have been eliminated, emphasizing therapy as part of the interdisciplinary team. Documentation showing that outcomes are improved, especially with fewer visits than before, will be key.

Under PDGM, the patient's primary diagnosis is a key driver for reimbursement. There are many common home health diagnoses that can no longer be used as a primary diagnosis. In addition, there can now be up to 24 comorbidities or secondary diagnoses that will factor into reimbursement, and OASIS items (such as activities of daily living, instrumental activities of daily living and hospitalization risk) lead to a functional impairment level of low, medium or high. Ensuring that the plan of care, comprehensive OASIS assessments and visit documentation support the primary diagnosis is essential; processes to ensure timely, accurate and complete documentation are key components of CDI.

Justifying Need

There is more scrutiny of the need for improved documentation to support the need for services. Upon referral to home helath, determining whether the face-to-face encounter (FTF) meets Medicare qualifiers is crucial.

Therefore, CDI must start at the referral. The referral information must include details identifying the patient's needs. If the referral has an unacceptable primary diagnosis, a query to the physician must be made, because an acceptable PDGM primary diagnosis must be on the referral and the FTF in order to qualify for a Medicare home health admission.

If Medicare eligibility remains questionable at the point of referral, an initial assessment should be completed prior to the comprehensive assessment in order to ascertain whether a patient is eligible for home health care. This is a process that the CDI staffer should be involved with, as it is often a weak area and can lead to denials.

Decrease Deficiencies & Denials

The CDI program will ensure that the clinical record review includes such areas as:

- There is an order for every visit performed.
- Each visit note stands alone to show a skilled service provided; they must also tell the patient's story.
- Visit notes include the assessment, skill provided, patient or caregiver response, plan for next visit and need for skilled services and complexity.
- Coordination of care between the interdisciplinary team is well documented throughout the patient's home health clinical record.
- The physician is notified of all patient changes. This is critical, as lack of physician notification is a key reason for negative outcomes and condition-level deficiencies or immediate jeopardy.
- Medical necessity is clearly documented by skilled nursing and therapy.
- Homebound status is documented and supported in the clinical assessment.

The CDI will ensure that the focus of the documentation states:

- Why are you providing the services?
- What interventions and teaching are you doing?
- Why is home health necessary?

The CDI will also ensure that the documentation states why you're providing the services, what interventions you are doing and why home health is necessary. It should also focus on common denial reasons, such as:

- Skilled services not reasonable and necessary
- Repetitive and unclear notes that do not show a skilled service provided
- Therapy assessments that indicate the patient is independent when describing levels of assistance
- Documentation does not support homebound status
- Goals not objective, measurable

Since reviews are frequent, they can be done quickly.

or reasonable for patient
- Progress toward goals not documented

CDI Strategies

It is important to review data and perform analysis on clinical performance with quality metrics. A key CDI methodology that I have found to be very successful is concurrent ongoing clinical record review. A team of qualified reviewers, including trained field clinicians, reviews records from referral through final claim at least once a week so reviews are near enough to real time to catch and correct issues.

Since reviews are frequent, they can be done quickly. The goal is to identify whether corrections from previous review timepoints were completed and to review all new documentation since the last review and note deficiencies. One audit tool per patient is used throughout the entire admission process, and there can be several reviewers.

While QAPI will review a percentage of records quarterly, CDI will review much more frequently on active patients in order to prevent denials and deficiencies.

It is then possible to identify non-compliant documentation according to team, clinician and agency. Education can be tailored to a few clinicians rather than delivered to the entire group.

And using field clinicians on the review team means peer review—an effective method of engaging staff in the CDI process.

Building a CDI Program

Creating a CDI task force or committee is helpful. It is important to include all departments such as leadership, billing, coding, QAPI and office staff. The project leader is the identified CDI professional.

The task force can develop priorities and goals for the agency, such as:
- Decrease denials: Be specific; list the reason for denial, the percentage and the areas of focus (referral, FTF, skilled need, etc.)
- Avoid condition-level deficiencies: Explain in which CoPs you will do this and how
- Identify areas of risk within the agency for documentation inaccuracy, reimbursement and non-compliance with CoPs by reviewing past deficiencies and denials and areas found during clinical record reviews
- Manage inefficient agency processes that lead to non-compliance, such as signed physician orders

An effective CDI program will typically indicate the need for education for home health staff. Home health documentation is not easy, and staff are held to productivity standards and caring for their patients, so don't get frustrated when frequent education is required to have compliant documentation.

In Conclusion

In this era of home health—with the Patient Driven Groupings Model, value-based purchasing, audits and more—robust documentation is required. Many denials stem from improper documentation by agency clinicians who thought they were following coverage guidelines. And many more deficiencies are being seen on surveys under the new CoPs.

If you don't have a Clinical Documentation Improvement Program, consider implementing the key elements. A CDI program can help an agency remain viable for the future. HC

Sharon M. Litwin is founder and senior managing partner of 5 Star Consultants, a national consulting and coding firm specializing in homecare and hospice services. Litwin was an ACHC and CHAP surveyor, performing Medicare-deemed surveys for 10 years. Today, she assists homecare and hospice agencies in providing quality, meeting regulations, ICD-10 coding, OASIS, increasing outcomes and Star Ratings and having continued survey readiness. She is a regular speaker to education companies, state and national associations and publications. Visit 5starconsultants.net.

Don't Leave Them Home Alone

Give employees the tools & training to avoid workplace violence

By Louis Kirby

One of the greatest limits on growth in the home health and hospice sector is the labor shortages that make it difficult to recruit and retain qualified nurses and home health workers. Registered nurses are retiring faster than new ones can be trained, according to the consulting firm Baker Tilly, and one of the primary causes of homecare nurse and aide burnout is workplace violence. Beyond the benefits of implementing a workforce safety plan, equipping your staff with the training and tools to mitigate safety risks has a direct impact on your ability to attract and keep employees.

Safety Is Important

Developing a robust safety program for your mobile workforce has been proven to reduce health care worker stress and turnover. A 2015 study published in BMC Public Health found that the threat of workplace violence was one of home health workers' top concerns, ranking above transportation issues or environmental hazards. In addition, clearly communicating a commitment to workforce safety in your hiring materials allows your organization to distinguish itself as a caring and supportive place to work.

Because violent incidents are routinely underreported, many employers are unaware of the frequency and degree of the violence their employees face and the impact it has on employee retention. Only one-fifth of violent incidents "are ever reported in part due to embarrassment, organizational culture, tolerance or excusing the behavior of 'ill' clients," according to an article in the Online Journal of Issues in Nursing. Nurses have cited fear of retribution from supervisors, the complexity of the legal system and disapproval from administrators as barriers to reporting workplace violence.

Alarming Statistics

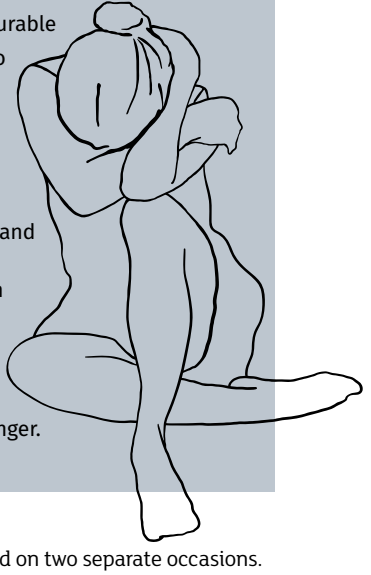
But the violence is real. A review of health care worker safety in the New England Journal of Medicine found that 61% of homecare workers face violence each year, including verbal abuse and threats, sexual harassment, sexual abuse, rape, assault, shoving or displays of weapons. The home health industry carries unique risks and hazards compared to other health-related fields. Home health workers provide care in an uncontrolled environment without the protections offered in traditional health care facilities. Risk factors include drugs and alcohol, access to weapons, client dementia or mental illness and solo work without backup such as an onsite co-worker or panic button. Home health workers also face risks from the surrounding community, which can include robbery, travel after dark, car theft and vandalism, and violence from others involved the patient's care.

Sending home health workers into the community has real consequences for both providers and organizations. The Occupational Safety and Health Administration (OSHA) fined Epic Healthcare $98,000 because it "failed to protect" two providers who were sexually assaulted in the same household on two separate occasions.

"Epic Health Services failed to protect its employees from life-threatening hazards of workplace violence and failed to provide an effective workplace violence prevention program," OSHA's regional administrator said in a news release, adding that the company had received numerous reports of assaults on employees. Companies have

CONSIDER ADDING ALERTING TECHNOLOGY TO HELP KEEP YOUR STAFF SAFE FROM VIOLENCE. BEFORE YOU CHOOSE, IT'S BEST TO HAVE OPTIONS THAT INCLUDE:

- Worn on the body so the alarm is always within reach
- Accurate GPS location that does not rely on 911
- Rapid dispatch of police and ambulance
- Immediately notifies the organization of an incident (OSHA compliance)
- Advance warning of known threats including registered sex offenders
- Discrete, durable and easy to trigger an alarm without needing a phone at hand
- Companion services when the provider feels in danger.



a responsibility to systematically address workplace violence prevention for their workers' safety—and to mitigate the costs to the organization of a failure to do so.

This violence increases worker job dissatisfaction, which leads to staff members leaving the profession or employer. A 2009 study of home health care nurses found that 63% reported one or more violent incidents. Importantly, this study also looked at the intent to leave nursing or their employer and found that the violence inversely correlated with job satisfaction, the chief predictor of turnover.

Turnover is only one of the significant costs to an organization from workplace violence, but these costs—including damage done to the victim, loss of productivity and morale, and public relations impacts—are not fully recognized by management or by accounting.

A violent incident can lead to:

- The temporary or permanent absence of skilled employees
- Psychological damage
- Property damage, theft and sabotage
- Productivity impediments
- Diversion of management resources
- Increased security costs
- Increased workers' compensation costs
- Increased personnel costs

Some of these costs are manifested in employee turnover. Available research clearly establishes that unaddressed workplace violence and aggression against mobile health care workers leads to stress, depression, anxiety, sleep problems, post-traumatic stress disorder, worsened physical health and burnout. Burnout and stress can also adversely influence the quality of care, increasing the risk for medical or care administration errors. Violence and the threat of violence may even lead employees to leave the employer or the industry altogether.

What Can Be Done?

The implementation of credible safety programs and tools geared to the specific needs of mobile homecare and hospice workers represents a significant and largely untapped opportunity to increase the safety of the home health workforce and enhance employee retention outcomes.

The California Division of Occupational Safety and Health (Cal/OSHA) health care regulations that went into effect in 2017 are the most comprehensive in the nation and serve as a model. Those regulations instruct organizations to develop and implement a written violence prevention plan. The elements of the plan include:

1. Procedures for the active involvement of employees in developing, implementing and reviewing the plan
2. Procedures for obtaining the assistance of law enforcement during all work shifts
3. Procedures for accepting reports of workplace violence from employees and preventing retaliation against an employee who makes a report
4. Procedures for communicating with employees about workplace violence matters, including:
   a. How employees can report a violent incident, threat or other workplace violence concern
   b. How employees can communicate workplace violence concerns without fear of reprisal
   c. How employee concerns will be investigated and how employees will be informed of the results and any corrective actions to be taken
5. Procedures for training employees on workplace violence
6. Assessment procedures to identify environmental risk factors for workplace violence
7. Procedures to identify patient-specific risk factors, such as patient's mental status, medications, history of violence, disruptive or threatening behavior
8. Procedures for post-incident response and investigation
9. Guidance to review and update the plan at least annually

Tools You Can Use

Reliance on safety training alone is likely to have limited effectiveness. OSHA's "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" recommends the use of specific tools to address home health worker concerns, including panic buttons, personal alarm devices and GPS devices. This can be illustrated by an experience shared by one of our hospice clients. At 1 a.m., the agitated and possibly inebriated husband of a patient aggressively approached a female hospice worker while brandishing a knife. She discretely pressed the SOS button on her AlertGPS device; police arrived minutes later and diffused the situation. In this case—and most likely the case of the Epic Healthcare workers who were sexually assaulted—pulling out a cellphone would actually have aggravated the situation rather than helped.

Cal/OSHA's guidelines specify the careful appraisal of an organization's requirement for and deployment of safety tools to ensure employees are not relying on a technology that fails to protect them. Alerting technology is especially critical when providers are working in patient's homes at all hours of the day and night and do not have the luxury of assistance from inside a facility building.

Home health organizations should consider the additional benefits of any alerting solution they choose. They can offer advantages in terms of regulatory compliance, increased employee safety and long-term cost reduction.

Conclusion

Many in the home health industry do not believe there is a real danger to their mobile providers. This represents both a risk and an opportunity. Addressing the threats to home health providers in tangible ways through a well-designed safety plan that also incorporates robust alerting technology can pay significant dividends. HC

Louis Kirby, MD is a principal of AlertGPS, a provider of connected enterprise safety technology that offers companies the quickest way to locate, communicate and get help to their mobile workforce. Kirby is a board-certified neurologist and consultant to the pharmaceutical industry on diseases affecting the central nervous system.

OXYGEN & VENTILATORS

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 providers of oxygen and ventilatorsHere and on homecaremag.com/buyers-guide, you can find the essentials to help your business thrive. HC

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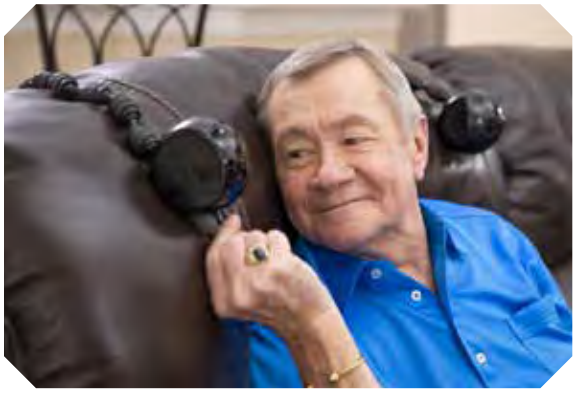
NEW ON THE MARKET

Hand-picked by the editors of HomeCare & 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



2

3

4

1 Zoey CPAP Cleaner

SUNSET HEALTHCARE SOLUTIONS

Zoey is the easy-to-use and easy-to-love new CPAP cleaning option. Zoey features patient-friendly premium packaging and a sleek aesthetic. Its interface of colored lights is silent and simple to operate. Patients start cleaning or set delay mode with a single button, and Zoey uses soft lights to show what's happening. Zoey is smaller by volume than other CPAP cleaners and operates quietly, to fit in the home. Contact a Sunset representative for demo units, free rack cards and posters. Visit sunsethcs.com.

Check 200 on index.

2 ChairSpeaker

KARE, LLC

ChairSpeaker is the newest breakthrough in TV listening technology. This device allows a user to place the TV sound near each ear without the isolation, discomfort or health concerns generally associated with headphones or in-the-ear devices. For those who have previously purchased a soundbar with the expectation of hearing the TV better, only to realize that more volume doesn't necessarily mean clearer sound, ChairSpeaker delivers improved sound clarity through its Voice Enhancing Technology. Setup is a snap with a plug and play design, making it easy to begin enjoying watching TV like never before. Visit chairspeaker.com.

Check 201 on index.

3 RH-Pro9 Medium-Capacity Sterilizer

CPAC Environmental Solutions

CPAC's RapidHeat family of waterless tabletop sterilizers has been expanded with the introduction of the RH-Pro9 Medium-Capacity tabletop sterilizer. With a smaller tabletop footprint, the RH-Pro9 produces the same high-level sterilization that is expected with its FDA cleared "High-Velocity Hot Air" technology. The Pro9 also provides a complete 12-Log Kill cycle from start to finish in 12 minutes for unwrapped instruments and less than 20 minutes for wrapped instruments. Visit cpac.com.

Check 202 on index.

4 Mobility Combo Pack

EASY TO USE PRODUCTS

Users of rollators, walkers and wheelchairs increasingly want convenient access and storage for their personal items. Hang your items, secure your phone and hold your beverage anywhere you go. Visit easytouseproducts.com.

Check 203 on index.

STAIR LIFTS

1

1 Elan Stair Lift

BRUNO

Bruno's Elan SRE-3050, an indoor straight stair lift, now features modern colors and an advanced ergonomic design in addition to renowned durability and ease of use. The Bruno Elan's comfort seat quietly glides on an ultra-narrow vertical rail that installs closer to the wall than any stair lift on the market, maximizing open space on steps. Bruno's Elan SRE-3050 straight offers a 300-pound lift capacity, an offset swivel seat that rotates up to ninety degrees and extends away from the staircase, and safety obstruction sensors. Visit bruno.com

Check 204 on index.

2

2 1100 Straight Stairlift

HANDICARE

The Handicare 1100 Straight Stairlift features next-generation technology with an ultra-streamlined design that takes up less space on a staircase. The traditional gear rack has been eliminated and Handicare has introduced a friction drive system to power the stairlift. This allows the 1100 to achieve a quieter, smoother ride and a more robust design that's easier to maintain. Designed to be a stylish complement to everything else in the home.
Visit handicare.com.

Check 205 on index.

3

3 Pinnacle SL600

HARMAR

The Pinnacle SL600 has earned its name and reputation for standing above the rest. What makes the Pinnacle different? It's what you don't see—the patented helical worm gear and reinforced nylon polymer gear rack. This drive system helps eliminate maintenance and delivers your clients a smooth, stable ride you both can rely on.
Visit harmar.com.

Check 206 on index.

4

4 Pilot Aviator

MERITS

The Pilot Aviator is a stylish and compact straight stairlift designed with safety in mind and with easy, no-fuss installation. The Aviator now comes with a folding hinge track option. The track fully unfolds to allow the stairlift to travel to the lower landing for a safe point to enter and exit the lift. When not in use, the track neatly folds up to leave the walkway clear. The hinge system is also versatile. It can be supplied with one standard track section for shorter staircases or two standard track sections to cover staircases up to 20 feet. This means less waste and more cost savings.
Visit meritsusa.com.

Check 207 on index.

HME BILLING SOFTWARE

1 Billing Platform

CURASEV

Curasev is a cloud-based platform for HME providers to streamline their business and better serve patients. Curasev provides the tools to manage your workflow. Simplify intake processes by consolidating and reviewing incoming referrals electronically while securely storing and verifying patient documents. Integrated inventory management monitors inventory levels, fulfilling sales orders more quickly. Deliver products with improved driver efficiency with real-time route tracking and driver notification system. Submit scrubbed claims and get paid faster by lowering the average days of sales outstanding and increasing accounts receivable collections with revenue cycle management tools and dashboards. Visit curasev.com.

Check 208 on index.

2 SystemOne

QS/1

SystemOne is a comprehensive approach to HME that's still budget friendly. Use it to manage every aspect of your business, from accounts receivable to point-of-sale, shipping, rentals, sales and more. Select only the functionality you need, then add to it as your business grows. With SystemOne, you can avoid duplicate data entry, bill and post payments electronically, batch re-create both sale and rental transactions, capture patient signatures electronically, transfer Medicare Part B claims from QS/1 pharmacy programs for billing, and print hospice, consignment, and patient statements. Visit qs1.com/systemone.

Check 209 on index.

3 TeamDME! XL

TEAMDME

TeamDME! XL combines all the tools you need to manage your HME front and back office. Offering customizable workflow templates, e-eligibility, e-purchasing, e-dropships, electronic health record and mobile delivery apps, you can process all your work with just a few clicks. Make informed financial decisions based on accurate, real-time data because all of your backend office functions are included, giving you a 360-degree view of your company's financial health. Visit teamdme.com.

Check 210 on index.

4 Enterprise Software

ATLAS

Move into the 21st century with technology to process orders with operational efficiencies that improve delivery times of products in compliance with payers' rules resulting in fewer human errors and faster payments. Work with a seamless, fully integrated cloud billing system and get real-time dynamic reporting at your fingertips. ATLAS is changing the way HME providers are doing business. Visit atlas-vue.com.

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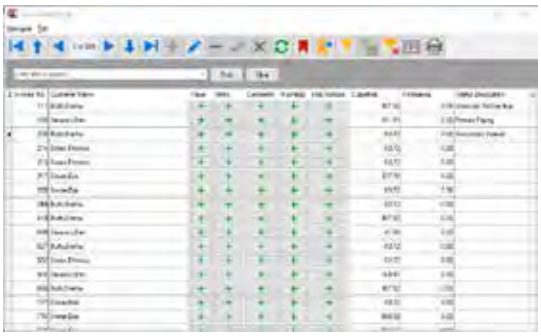
4 Ad Hoc Report Builder in HDMS

UNIVERSAL SOFTWARE SOLUTIONS

In strong accounts receivable management, data is queen. But what good is all of that rich, problem solving power if you don't know how to get to it or use it? With Ad Hoc Report Builder in HDMS, Universal Software delivers the data you need in a workable format that won't require a database specialist. Sick of waiting on custom queries by data analysts in order to tackle your ambitious collection goals? This tool delivers an accessible approach to report building, on demand, whenever you need it. Visit universalss.com.

Check 212 on index.



5 TIMS Software

COMPUTERS UNLIMITED

TIMS Software is an innovative solution developed for HME businesses. TIMS Software provides a customized solution to fit your business and provides the peace of mind that comes with knowing that the right people are working the right claims at the right time. Now, providers can use TIMS Mobile Delivery to offer safe curbside pickup, alert drivers when infectious diseases are present and easily adjust receipt and signature functions to minimize points of contact. Visit cu.net.

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6 Billing Software

NIKOHEALTH

Simplify the way your team works. Whether your business needs to streamline order intake, improve scheduling and delivery processes, manage documentation flow, require end-to-end inventory control, or reduce costs and increase revenue with simple and intuitive billing and claims processing, NikoHealth has you covered. Visit nikohealth.com.

Check 214 on index.

7 Business Management Software

BRIGHTREE

When it comes to the post-acute market, Brightree offers a cloud-based platform that improves business performance and delivers better health outcomes. Brightree provides an industry-leading solution, advanced analytics, revenue cycle management and collections services. Services include the Patient Hub by Brightree app and the Brightree Business Management Software. Visit brightree.com.

Check 215 on index.

8 Raintree HL-7 Compliant SaaS EMR/Billing Software

ARGOSY GROUP

Argosy Group is driven by a passion to improve the standards and quality of businesses. The Raintree HL-7 Compliant SaaS EMR/Billing software is used by HME, physician and physical therapy practices. The system is customized to your environment and workflow driven. No billing staff? No problem! Argosy's billing staff are available to fill in the gaps. Visit argosygroup.org.

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9 COLLECTPlus

ALLEGIANCE GROUP

Allegiance Group offers comprehensive and effective patient pay, patient billing and debt collection strategies for the health care industry, with more than 15 years of experience in the HME, durable medical equipment and pharmacy industries. COLLECTPlus drives cash recovery and staff efficiency by providing billing and collection workflows customized to meet specific business needs. The automated workflow integrates with your billing software and offers a patient payment portal, domestic call center and dashboard. The portal provides patients the ability to create payment plans and view payment history. The dashboard creates at-a-glance transparency to manage critical reporting. Visit allegiance-group.com.

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1. What is your job title? *(Check only one)*

- ◯ 15 Owner, CEO, CFO, COO, Pres, VP, GM, Dir
- ◯ 21 Manager, Supervisor, Controller, Accountant, Purchasing Agent
- ◯ 22 RT, Nurse, Doctor, OT, PT, Pharmacist, ATP, SMS, Rehab Specialist, Other Licensed Medical Professionals
- ◯ 19 Sales/Marketing Rep, Mgr, Dir
- ◯ 20 Other *(Please Specify)* _____

2. What is your primary type of business? *(Check only one)*

- ◯ 01 Home Medical Equipment Provider
- ◯ 13 Hospital with HME
- ◯ 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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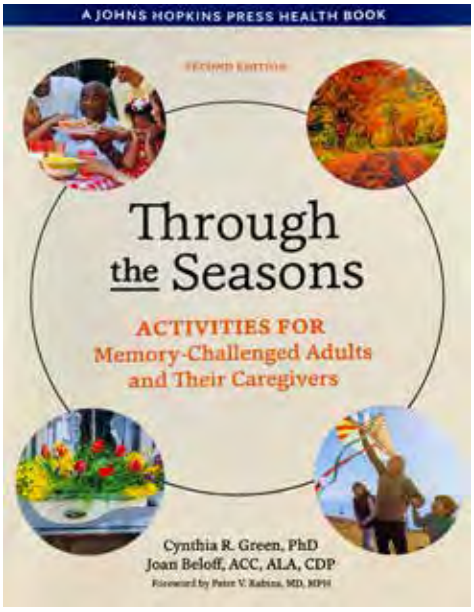
BOOK REVIEW

Coming Together Throughout the Year

Book helps caregivers bond with memory-challenged adults

By Kristin Easterling



For a person in memory care, keeping the mind engaged is vital for physical and mental well-being. Moreover, activities that engage the whole person and acknowledge their dignity are important to ensuring that they participate and find joy in the activity set before them. A new second edition of the book "Through the Seasons: Activities for Memory-Challenged Adults and their Caregivers" lays out 32 experiences for caregivers and memory-challenged adults to try together throughout the year.

The book, from Johns Hopkins Press, was written by Cynthia R. Green, Ph.D., and Joan Beloff, ACC, ALA, CDP. In an interview with HomeCare, Green said the updated edition adds activities that are more culturally appropriate and have updated science behind them.

"When we were first inspired to write the book in 2008, a lot of concepts we saw were very elementary and drew from available resources for children," Green said. "We felt they weren't really dignified and didn't draw on the interests of the person. Person-first engagement was a new concept."

The book emphasizes cognitive stimulation for older adults with memory difficulties, citing research from the Lancet.

"For cognitive stimulation, we promote a lot of ways to meet someone where they are, whether someone can engage verbally, or if they can craft, or if they enjoy cooking," said Green, who is an assistant clinical professor of psychiatry and the founding director of the Memory Enhancement Program at the Mount Sinai School of Medicine. "It's about providing dignity. It's about continuing to support and communicate with the person you care for."

Each of the 32 experiences in the book includes a photograph to illustrate the experience, an introductory prompt, a "Let's talk about" prompt, a "Let's try" task and a "Let's make" activity.

"Let's talk about" encourages patients and caregivers to share cherished memories by talking about Halloween costumes and favorite candies in the fall, or ice cream and family picnics in the summer.

"We had people tell us about these activities that they've done. We also look for activities that have a lot of legs," Green said. "For example, for the holidays, there's a lot of holidays in winter and a lot of cultural traditions."

One activity under "Let's make" is Hungry Ghost Money, a version of the papercrafts that become burnt offerings in Chinese ancestral worship. In that tradition, the craft honors the ancestors and ensures good luck for the future. Projects like that can be approached simply or developed in multiple stages, Green said.

"If someone has the skill and initiative, they can learn more about the tradition, or they can just use it as a craft," she said. "We look for something robust that can be used across the census by a lot of people."

Engaging all of the senses throughout the year is important, she said, because as cognitive challenges progress, they may affect one aspect of sensory engagement before another. A person may struggle to grasp complex language or follow multi-step directions, but be able to connect in other ways, such as enjoying art or taking a walk.

"It's just another way to engage people and making sure there's a door that works for everybody," Green said.

For caregivers who face difficulty leaving the house, planned activities such as a baseball game or a trip to a local garden can help relieve anxiety around travel and disrupted routines, said Green. Spring and summer have several suggestions for taking time out, while fall includes a nature walk to look at changing leaves.

The program, she said, is designed to build common ground and help people find joy in a challenging and changing situation.

"This is an opportunity to be together while recognizing the interests, strengths and challenges every one of us brings to the table," Green said. HC

Kristin Easterling is managing editor of HomeCare magazine.

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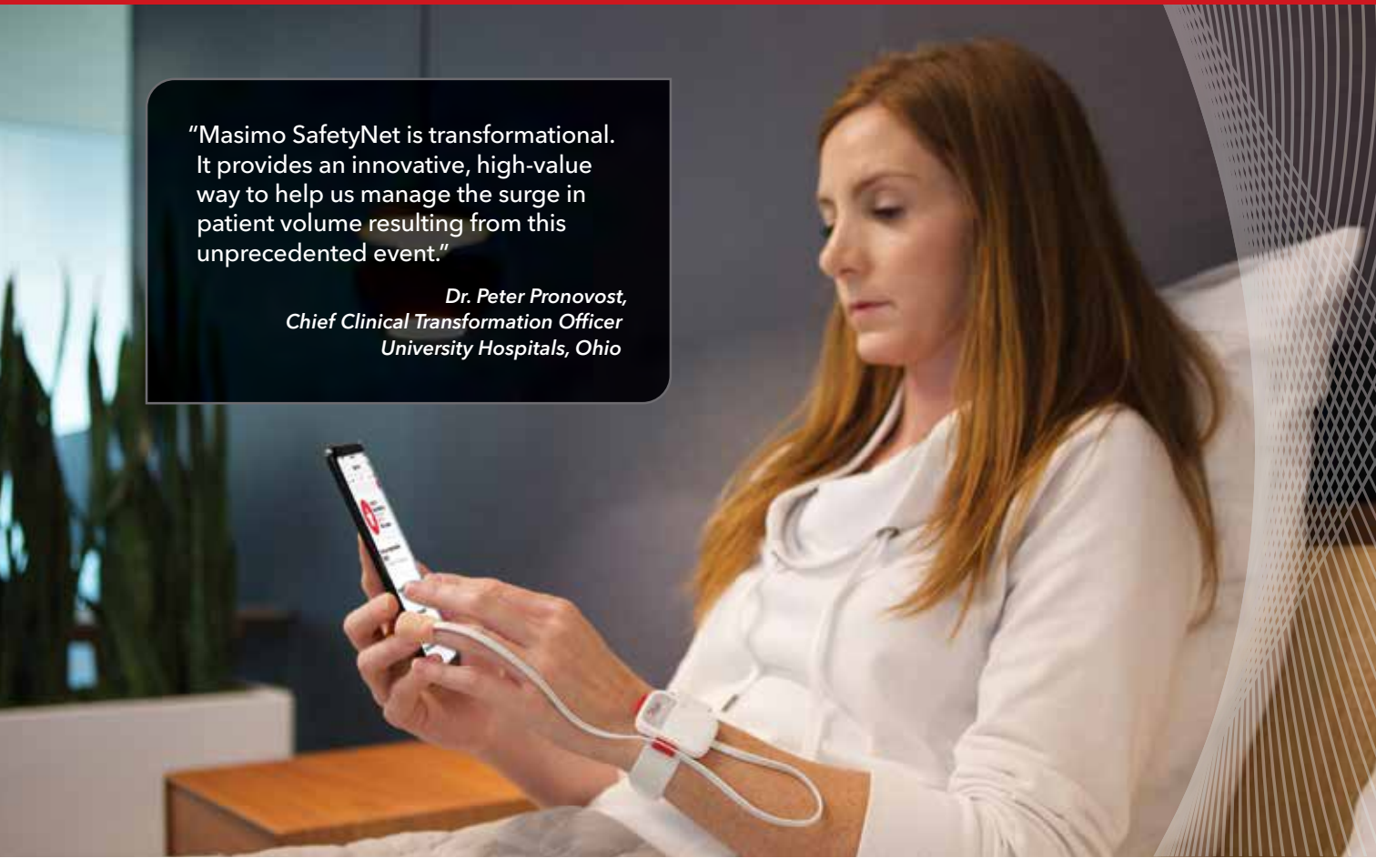

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