THE MEDTRADE EAST ISSUE

HomeCare®

OCTOBER 2021

THE LEADING BUSINESS RESOURCE FOR HME & HOME HEALTH PROFESSIONALS

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Can Seniors Afford to Stay Home?

One Arizona nonprofit is trying to make it possible

Plus:

>> 4 big aging in place trends

>> Home as the new hospital

HME
Why M&A is hot right now

IHC
Tricks for safe transfers

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Dear HomeCare Readers,

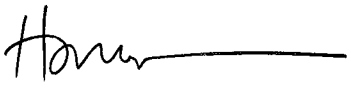
Talk about déjá vu: Didn't I just write about heading to Medtrade a couple of months ago? The condensed post-COVID-19 schedule means we're loading up once more, this time for Atlanta and (we expect) a bigger show. Hope to see many of you there! Stop by and visit us at Booth 524.

Meanwhile, there is a lot changing in the homecare landscape right now. As I write, we're waiting to hear what will happen during budget reconciliation and the so-called "human infrastructure" bill that includes billions in elder care funds. The administration should also be coming out soon with more details on its new vaccine mandates for health care and for other employers; you can read more about that on page 10. And booster shots for older Americans are still pending government approval.

Our cover series this month dives into something we haven't talked about much: how pressures on affordable housing may hamper seniors' ability to age in place. One nonprofit organization in Phoenix is working to overcome those hurdles by building housing and providing homecare, accessibility modifications and more to elders with very low incomes. I hope you'll be inspired by it—I was in writing it.

Also inside, you'll find tons of great info from our experts on everything from properly reporting your provider relief funds to managing your denial data, route planning and safely transferring patients with mobility issues. Plus there's lots more to help you better run your business.

Thanks for reading,



Hannah Wolfson

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

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PHILIPS

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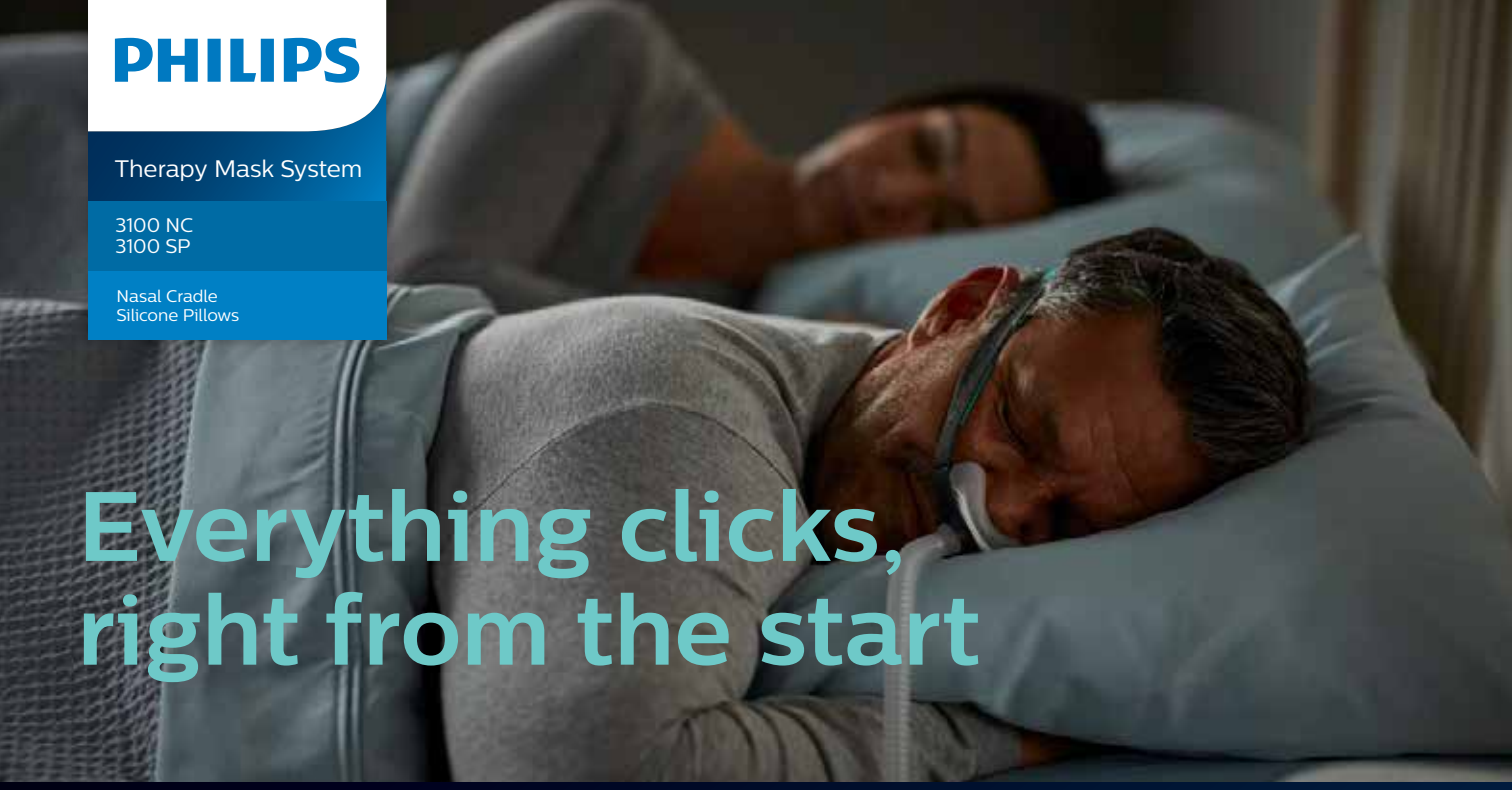
3100 SP

Nasal Cradle
Silicone Pillows



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Easy to use

With integrated magnets in the cushion and frame, 3100 NC and 3100 SP allow effortless assembly of the cushions to the frame.[1]

A comfortable fit

Smaller and lighter than the leading competitive masks in the nasal and pillows category.[5]
Can be adjusted for a personalized fit that can be maintained throughout therapy.

Creating value for you

It is the only tube-in-front mask that provides the ability to switch between an under-the-nose nasal cradle and silicone pillows cushion while keeping the same frame.[2-4]

Learn more

See how Philips Therapy Mask System 3100 NC and 3100 SP will click with your patients.
Visit philips.com/professional/3100-NC-SP.

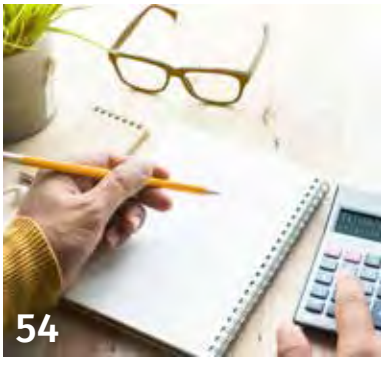
innovation you

Check 134 on index.

References: 1. Data analysis of June 2020 Clinician Ease of Use and First Impression trial – optional blindfold task where n=27. Comparison masks were the ResMed AirFit P10 and the ResMed AirFit N30 2. Analysis after 10 days of use of July 2020 Nasal Patient Preference trial data n=123. Prescribed masks include Wisp, Activa, AirFit N10, AirFit N20, ComfortGel Blue Nasal, EasyLife, Eson, Eson 2, Mirage FX, Pico, TrueBlue. 3. Analysis after 10 days of use of July 2020 Pillows Patient Preference trial data n = 113. Prescribed masks include AirFit P10, Brevida, Nuance/ Nuance Pro, Opus, Pilairo, and Swift/Swift FX/Swift LT. 4. Data analysis of June 2020 Clinician Ease of Use and First Impression trial where n=31. Comparison masks were the ResMed AirFit P10 and the ResMed AirFit N30. 5.Based on engineering analysis of the size and weight of the Philips Therapy Mask System 3100 NC and 3100 SP, AirFit N30 and AirFit P10 masks.

OCTOBER 2021

In this issue



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New DME Partnership Promotes E-Prescribe

Leaders in the durable medical equipment (DME) industry announced the formation of DMEscripts LLC, an independent e-prescribe company dedicated to improving the patient, prescriber and provider experience by eliminating inefficiencies and reducing paperwork. The new venture is being formed by a group of investors that includes the American Association for Homecare (AAHomecare); VGM & Associates, Ltd.; AdaptHealth, LLC; Apria Healthcare Group LLC; Lincare Inc. and Rotech Healthcare Inc.

DMEscripts will combine the thought leadership and resources of its founding members and leverage industry experts in digital health to administer an industry-owned, operated and managed e-prescribe platform. DMEscripts will use proprietary e-prescribe software to operate an open network that any DME supplier may join at no cost to prescribers or patients.

"This is an important step forward for the DME community, as well as for the clinicians and referral sources we work with every day," said Tom Ryan, president and CEO of AAHomecare. "The wide-scale adoption of e-prescribe can provide for considerable efficiency improvements for all DME suppliers, thereby strengthening the industry as a whole."

The founding investors also expect to welcome investment by other industry participants in ownership of a platform that will create a smoother, simpler, more efficient and less costly ordering process for health care prescribers and suppliers—one designed to eliminate unnecessary delays in the processing and delivery of critical home therapy devices and therapies to patients.

dmehub.com

UPCOMING EVENTS

We want to make sure our readers know about upcoming event opportunities. Here is what is coming up in the next few weeks. Did we miss an event? Send information to keasterling@cahabamedia.com.

OCT 6–8 MAMES Fall Excellence in HME Midwest Conference
Welch, MN
mames.com

OCT 18–20 Medtrade East 2021
Atlanta, GA
medtrade.com

OCT 24–27 LeadingAge Annual Meeting and EXPO
Atlanta, GA
leadingage.org

NOV 10–12 Pennsylvania Homecare Association Annual Conference
Farmington, PA
pahomecare.org

Drive DeVilbiss Discontinues CPAP Line

Drive DeVilbiss Healthcare will discontinue its DV5 and DV6 series continuous positive airway pressure (CPAP) devices as of December 2021. Drive DeVilbiss will no longer accept new CPAP orders in order to fill as many open orders as possible.

The decision to discontinue the CPAP line comes amidst material shortages, difficulty securing parts and increased component pricing, the company said. Drive DeVilbiss will continue to focus on other oxygen products in response to the pandemic.

"It has been our duty to provide essential therapeutic oxygen products to the global market. We have taken that responsibility very seriously and have focused our resources to that end," said CEO Derek Lampert. "With the most recent resurgence of COVID-19, we continue to run at maximum capacity. The ability to transition the manufacturing space away from the CPAP lines will allow us to raise our output of these critical medical devices."

Drive DeVilbiss will continue to support warranty commitments on the DV5 and DV6 Series CPAP products and the sale of accessories such as chambers, filters and patient tubing to support continued usage of the devices by users.

drivemedical.com

Collaborative Effort With Hospitals Launches in New York

Homecare and hospital association representatives in New York state are working together to further enhance collaboration through the statewide Hospital-Home Care Collaborative.

The Home Care Association of New York State Education & Research (HANYS), Healthcare Association of New York State (HCA) and Iroquois Healthcare Association (IHA) developed the collaborative in 2020 with support from the Mother Cabrini Health Foundation, which is also funding Phase II of this initiative, which will extend the project through 2022.

As part of this effort, HCA, HANYS and IHA have curated a series of upcoming webinars featuring prototypes of existing hospital and homecare collaboration models developed by providers across New York state. The goal is to provide a blueprint for developing similar models across the state.

Cross-sector collaboration is especially important when emergencies like the COVID-19 pandemic stress hospital capacity. According to one HCA report, 65% of homecare agencies in New York state have seen an increase in referrals to home from hospitals and other settings since the onset of the public health emergency.

hca-nys.org

LHC Group Acquiring 23 HHAs, More

LHC Group, Inc. announced it has entered into an agreement to purchase Brookdale Health Care Services agencies from the recently formed home health, hospice and outpatient therapy venture between HCA Healthcare and Brookdale Senior Living, Inc. The agencies, which are not in areas served by HCA Healthcare, include 23 home health agencies, 11 hospices and 13 therapy

Split Decisions?

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Signature Series

These images show the Hi-Low adjustable base without the mattress. Several mattress choices are available.

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agencies in 22 states. The agencies will continue to operate under their existing brands and locations.

LHC Group expects annualized revenue from this purchase of approximately $146 million and said that it will not materially affect 2021 diluted earnings per share due to the timing of the closing. It is anticipated that the purchase will be finalized in the fourth quarter of 2021, subject to customary closing conditions.

With this latest agreement, the company has now acquired or announced $308 million in merger and acquisition activity to date. The purchase marks LHC Group's initial entry into two new states—Minnesota and New Mexico—and expands its service areas in states where the company already operates.
lhcgroup.com

VGM Fulfillment Opens Pennsylvania Warehouse

VGM Fulfillment, a division of VGM & Associates, announced it has opened a new warehouse in Shiremanstown, Pennsylvania, to expand services to the heavily populated northeastern corridor. The 108,000-square-foot warehouse opened Sept. 7 and will eventually employ approximately 40 people.

VGM Fulfillment already has warehouses in Waterloo, Iowa; Nashville, Tennessee; and Phoenix. Customer service, systems, sales and support services for all locations are offered from the VGM Fulfillment headquarters in Waterloo.
vgmfulfillment.com

Best Life Brands Lands at No. 1

Great Place To Work and Fortune magazine have recognized ComForCare/At Your Side Home Care—a subsidiary of Best Life Brands—as the No. 1 homecare company on the Best Workplaces in Aging Services 2021 list.

The Best Workplaces for Aging Services award is based on an analysis of survey responses from more than 220,000 current employees. In that survey, 90% of ComForCare and At Your Side's employees said that the organization is a great place to work. This number is 31% higher than that of the average company in the United States.

89%

of Americans support public investment in homecare services for older adults, according to a recent LeadingAge survey

"Excellent care is top priority for our family of franchise owners, and that includes their amazing caregivers. They are the heart of everything we do and it's important to us that they feel valued and truly enjoy the vital work they do," said J.J. Sorrenti, CEO of Best Life Brands, the parent company of ComForCare and At Your Side.

ComForCare and At Your Side Home Care also ranked as a Best Workplace for Millennials and was ranked No. 38 on the list of Best Workplaces in New York.
comforcare.com

WellSky Adds Andy Eilert to Leadership Roster

WellSky, a health and community care technology company, announced that Andy Eilert has joined the company as president for emerging markets. In this role, Eilert will focus on enhancing WellSky's provider software and analytics capabilities to optimize care and scale provider performance through new ventures and strategic opportunities in emerging health care markets.

Eilert has more than 25 years of experience in the health care services and technology sectors. Throughout his career, he has championed solutions that coordinate care, reduce costs and improve patient outcomes.

Before joining WellSky, Eilert served as president of post-acute, home and emerging solutions at Evernorth, a division of Cigna; before that, he served as chief growth officer for eviCore Healthcare, which was acquired by Express Scripts and then by Cigna.

Eilert has also served in senior leadership roles for organizations such as Optum, GeoAccess, STERIS and Stryker. His experience ranges from leadership of strategic initiatives and solution innovation to responsibilities that included growth and broad profit and loss reporting. While at Optum, a division of UnitedHealth Group, Eilert held progressively senior positions that included senior vice president roles for payer solutions and growth.

"[Eilert] brings decades of experience and proven success in building solutions and businesses that transform healthcare, and WellSky is fortunate to have him join our leadership team," said WellSky CEO Bill Miller. "Our industry is at an inflection point with the shift to home- and value-based care. [Eilert's] commitment to furthering WellSky's technology and analytics capabilities will allow us to better partner with our clients to improve quality and thrive in the world of value-based care."

Eilert earned a bachelor's degree in business administration from the University of Kansas and an MBA from the University of Missouri at Kansas City. He is active in his local community and serves on boards of not-for-profit organizations in the Kansas City area.
wellsky.com

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Check 132 on index.

Closer Look: CMS Enacts Sweeping Vaccine Mandates

What we know so far

On Sept. 9, the Biden administration announced that staff at Medicare and Medicaid-certified "facilities"—including home health agencies and likely home medical equipment providers—will be required to have the COVID-19 vaccine. Homecare providers should work now to get health care staff vaccinated to make sure they are in compliance when the rule takes effect, the government said.

At the same time, the president also announced a vaccine or testing requirement for companies with more than 100 employees, which will be administered by the Occupational Health and Safety Administration (OSHA). Both mandates will be outlined through a combination of executive orders and rulemaking but those rules and details were not yet available at press time. The Centers for Medicare & Medicaid Services (CMS) was expected to release an Interim Final Rule with a comment in September or October; OSHA is working on an Emergency Temporary Standard and will not have comments.

And that's why confusion reigns. Who will the mandate apply to? How will it be implemented?

"Based on what we think is going to happen, (CMS's mandate) won't apply to private duty providers," Angelo Spinola, shareholder at Polsinelli law firm, said during an informational webinar from the National Association for Home Care & Hospice (NAHC). But, he said, it will likely apply to Medicare home health and hospice providers.

That's good news for Susan Ponder-Stansel, president and CEO of Alivia Care, Inc., a home health agency working in North Florida and South Georgia.

"We were relieved when we heard the mandate was coming because it took it out of our hands," she said on the NAHC webinar. "We were doing everything we could to encourage vaccination."

Ponder-Stansel said her agency experienced operational issues when local health systems demanded proof of vaccination. The agency has 76% of staff vaccinated in Florida and 36% in Georgia, with many caregivers expressing "strong feelings" on the vaccine, she said.

She and other providers said that having other large employers also fall under the federal mandate might alleviate their retention and hiring problems, because employees who leave health care over vaccination won't have as many other places to turn. Now, retail and other jobs will also require proof of vaccination or a negative test.

"When you level the playing field from a jumping off capacity, that was very helpful," said Ken Albert, president of Androscoggin Home Healthcare + Hospice, based in Maine, which has already instituted a state vaccine mandate for health care providers.

Neal Kursban, CEO of Family and Nursing Care in Maryland and the District of Columbia, said that 94% of his company's 1,400 caregivers are vaccinated—and the push will now be on getting shots to the last few. Even if you don't feel strongly about the vaccine, he said, it makes business sense.

"I think it's a no-brainer that clients want vaccinated caregivers ... and as a business person, when they ask for that I want to find a way to get to yes."

Will Vail, another lawyer with Polsinelli, said when it comes to state and local mandates versus the new federal manadate, providers should "figure out which are applicable to you. ... The one that creates the most restriction on employers or protection for employees is the one you should follow. If you do that, you shouldn't see any contradiction." HC

WHEN IT HAPPENED:

- **July 29, 2021**
  The administration mandates that on-site federal employees must attest to vaccination status
- **Aug. 18, 2021**
  Vaccines mandated for staff at 15,000 Medicare- or Medicaid-funded nursing homes
- **Sept. 9, 2021**
  President Biden announces current mandate via CMS and OSHA; federal contractors also mandated to vaccinate

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Check 131 on index.

Investing In America's Aging Infrastructure

The Better Care Better Jobs Act
HR 4131/S 2210

By Kristin Easterling

The COVID-19 pandemic highlighted the urgent need to ensure that all Americans can receive quality, long-term care in the setting that best meets their needs and preferences. Most Americans would prefer to receive services and supports at home. Today, more than 3.5 million older adults and people with disabilities receive Medicaid home- and community-based services (HCBS). Though all states provide coverage for some HCBS services, eligibility and benefit standards vary, leading to significant variations and gaps in coverage. Some states cap the number of individuals who may receive services, leaving almost 820,000 Americans on wait lists.

The Better Care Better Jobs Act seeks to remedy this issue. It would:

- Facilitate statewide planning to develop HCBS infrastructure improvement plans
- Enhance Medicaid funding for HCBS by providing states a permanent increase in federal Medicaid match if they expand access to HCBS and strengthen the HCBS workforce
- Incentivize workforce growth through innovative models that benefit direct care workers and care recipients and help workers organize
- Support quality and accountability by funding programs through the Centers for Medicare & Medicaid Services and conducting oversight and offering technical assistance to program coordinators
- Permanently authorize protection against impoverishment for individuals whose spouses received Medicaid HCBS, as well as permanently authorize the Money Follows the Person program to support individuals transitioning from institutions to home- or community-based settings

STATUS»

The bill was introduced June 26, 2021, and at press time had 126 cosponsors in the House and 39 cosponsors in the Senate. Industry leaders expect it to pass as part of the budget reconciliation bill.

BUILDING THE WORKFORCE

Workforce recruitment and retention are major issues for HCBS providers, and many providers say they cannot compete with other professions due to Medicaid reimbursement rates. To help with these problems, the Better Care Better Jobs Act would:

- Address HCBS payment rates to promote recruitment and retention of direct care workers
- Regularly update payment rates with public input
- Pass rate increases through to direct care workers to increase wages
- Update and develop training opportunities for this workforce as well as for family caregivers

TOTAL INVESTMENT

The National Association for Home Care & Hospice estimates the act will inject roughly $150 billion into HCBS services. This includes $100 million for states to develop their Medicaid HCBS plans.

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Check 113 on index.

Data Management & Its Impact on the Bottom Line

Why you should track denials & more

By Miriam Lieber

MIRIAM LIEBER is president of Lieber Consulting, LLC, and a member of HomeCare's Editorial Advisory Board. Visit lieberconsulting.com.

In the home medical equipment (HME) industry today, data management is used to improve all parts of a provider's business. Data is used to improve marketing campaigns and optimize business operations, thereby increasing revenue, efficiencies and bottom-line profit. Managing data correctly is essential in compliance matters to protect privacy and avoid breaches, a burgeoning issue in all businesses. While data management is a general term, for HME providers the notion of using data for revenue and operations makes it the essence of a healthy and successful company.

Data Management for Internal Control

As stated above, data management allows HME providers to make well-informed business decisions and run day-to-day operations more efficiently, reducing expenses. For example, using data to track and manage denials will not only bring in more bottom-line cash, but data can also be used to train staff about their mistakes. This will improve the order intake process—where errors are typically made—and will ultimately streamline the operational flow to hasten the order-to-cash process. Specifically, if you find that more than 10% to 12% of claims are denied, you should drill down into the data to determine the root cause of those denials. Avert denials by filtering the reason for denial and focusing on staff retooling and retraining. Additionally, use your software to stop people from perpetuating the errors.

Likewise, insurance verification is not always a straightforward one-step process. However, by using data that trends each payer and their eligibility and benefits requirements as well as your contract specifics (e.g., in or out of network, various plan/group types, third-party administrator), you should be able to determine who the correct payer is and reduce wrong payer denials. By tracking each denial by reason and payer as well as by product, amount and date, you will learn about timely filing issues, as well as other preventable payer denial trends. Payers often change rules without informing their contracted parties. For example, the payer might have been allowing supplies for CPAP but now no longer pays without a physician's authorization. By drilling down on the data, you will learn these and a slew of other avoidable reasons that, with quality improvement initiatives, will enhance your profitability. You can also use software that looks for policy changes and reports them back to you.

Despite the fact that front-end insurance verification, accurate order intake and inventory management all impact bottom-line data management, the financial part of the order-to-cash process is key to the success of any HME company. For instance, when setting key performance indicators, how many companies look at waterfall cash reports? This means that you report on the dates of service paid rather than just applying the cash to the invoice and forgetting about it. The waterfall cash report shows you how much of the money that

comes in is for old receivables and how much is attributed to newer balances. What about measuring how frequently a claim is submitted before it is paid? The more times you submit a claim, the more costly it is to the business's bottom line, so the number of resubmissions and touch points matter.

This is all part of data management, and the more you can drill down on your data and determine your wins and opportunities, the more you will see where to focus your attention for process improvement. Watching companies engage in deep data analytics is refreshing and generates a level of bottom-line understanding that creates a successful and more profitable business.

Data Management for External Purposes

Similar to internal operational control, data management can also help you find additional revenue, improve referral relationships and uphold your positive image in the marketplace. By managing your data well, you will be able to spot market trends and cultivate opportunities. This makes you more agile and affords you the chance to hone existing relationships and to build upon your strengths. For example, you can report to your referral sources on your timeliness of delivery, which contributes to a swift and smooth hospital discharge. You can demonstrate your impact on value-based care by reporting on patient satisfaction survey results and/or surveys such as net promoter score. Among the myriad of other data to report on is the number and type of referrals received month over month and year over year. This, along with how well the patients have progressed at home, illustrates how you are saving costly bed days and reducing readmission rates. It can all be accomplished by reporting on data that is used to both manage internal operations and to promote external relationships and business opportunities.

Data Compliance & Breaches

In addition to internal and external controls, data management is used to help in compliance matters and to avoid data breaches, an increasingly common occurrence. From data privacy and protection to regulatory compliance requirements, data management has grown in importance. In fact, according to MedCity News, health care industry data breaches spiked 55% in 2020, with nearly 600 health care data breaches last year. Moreover, the costs per breach increased by 10%. With the expansion of email, texting, telehealth and more, increased scrutiny and audits have ensued and will continue to expand. Expect this area of law and regulation to continue to broaden. From data breaches to illegitimate telehealth doctors and more, protecting your data has never been more important. Vet and scrutinize your software, your contracts and your relationships. Consider hiring an attorney or consultant who is well versed in privacy to ensure you are up to date on the latest requirements.

A well-organized and focused data management strategy can help HME companies improve operational controls and effectiveness. From management reports to data analytics and more, a deep dive into data improves operational efficiencies. Further, data management can also help companies gain a competitive advantage over their competitors, allowing them to make better business decisions for their revenue growth and market share. Organizations with well-managed data can also become more nimble, enabling them to uncover market trends and seize new business opportunities more quickly. Finally, with the onslaught of data breaches and privacy leaks as well as compliance issues, use data to avoid damaging legal issues.

By using data effectively, you will benefit by making better business decisions, demonstrating superior overall performance with improved revenues and reduced expenses—the key to enhanced profitability. HC

How to Stay Competitive in the Move From Fee-for-Service

Answers to 5 pressing questions about Medicare Advantage

By Ashton Harrison & Michael Neuman

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As a new wave of patients reaches Medicare's age of eligibility, it's essential to know what plans they're choosing and how those choices are impacting care patterns in your market. Medicare Advantage enrollment is on the rise, accelerated by value-based care initiatives. Does your post-acute organization have the visibility it needs to adjust to the changing landscape? Below we answer several questions surrounding Medicare Advantage (MA) trends and the changes that post-acute care organizations should be aware of.

1 How do I stay competitive in my market when my organization has historically relied on Medicare fee-for-service (FFS)?

We're seeing an industry-wide shift from Medicare FFS to MA. In fact, MA adoption has surpassed 40% nationwide, and it's projected that 50% or more of Medicare beneficiaries will switch from Medicare FFS to MA by 2030. Some areas of the country have already seen those numbers, and they're continuing to rise. To stay competitive, post-acute care (PAC) organizations need to start digging into key metrics to understand benchmarks and trends. Knowing what the industry standards are, where you need to improve and where you stand against the competition will help you stay competitive in any payment model.

2 Will MA expansion continue into the foreseeable future?

While we don't have a crystal ball, we can make some educated guesses about the future of Medicare Advantage. The Biden administration has made it clear that the expansion of Medicare (and specifically of value-based payment models like MA) is a priority and a goal. Furthermore, as of right now, the burden lies on the federal government to pay for Medicare, which means that the federal government is going to focus on finding ways to contain those costs. As MA has thus far shown to be a successful way to limit costs without sacrificing patient outcomes, it's safe to say that the program will continue to receive government support.

Also, as patients have begun to shift to private markets to receive care, commercial payers are incentivized to keep costs low to protect their revenue. This bodes well for the expansion of MA, as it gives both federal and private payers a strong incentive to keep costs low while improving patient outcomes.

3 How can PAC organizations use MA plans to increase historically low adherence rates?

One of the big advantages of Medicare Advantage is the financial incentive to improve outcomes. Based on Medicare Parts A and B data—as well as on data from commercial payers—we know that patients who do not receive recommended post-acute care are much more likely to be readmitted to the hospital. Higher readmission rates cause more expenditures, which land on those commercial payers. Facing potentially significant financial penalties, payers and

The post-acute care market is highly competitive and you simply cannot compete without visibility into key metrics on your own organization.

hospitals alike are more likely to collaborate with PAC organizations and patients to ensure patients receive the right care, in the right setting, at the right time.

4 What do PAC organizations need to consider for the future under MA?

Medicare Advantage enrollment is growing, and it's projected to continue to grow over the long term. Organizations cannot continue to rely solely on Medicare FFS to stay competitive and must shift their focus to finding appropriate referral partners for their populations by nurturing the right partnerships for collaborative success. If you're connected with the right referral partners and the right MA plans, you'll be more likely to succeed under the new payment model.

Likewise, PAC organizations must account for geographical differences. What do your payer and patient mixes look like in a certain area? What services are you currently offering in that region, and what services do your referral partners need to offer to improve outcomes and control costs? The goal should be to understand what's happening in your market, what's happening with different payer mixes, and how to market your organization to your referral partners to get the right mix of patients to help grow your business.

Understanding your payer mix can help you determine where your organization and your network excel and where you may need improvement. You can then make informed decisions about which referral sources you want to pursue to further improve performance. To do all this, you need to have a road map. The post-acute care market is highly competitive and you simply cannot compete without visibility into key metrics on your own organization and your competition. Raw data can only tell you so much. You need insights and analytics to get your operational and business teams on the same page and to ensure that everyone involved knows the lay of the land, your organization's long-term goals, how your organization stands out and which referral sources to target.

5 MA plans don't reimburse at the same rate as Medicare FFS and other payers. Is that likely to change over time?

At the end of the day, you need to succeed as a business, and Medicare Advantage's lower reimbursement rates can be daunting from that perspective. It's expected that, over time, these rates will be adjusted to keep Medicare Advantage moving forward. Right now, rates under MA are lower than fee-for-service rates because the federal government has set capitated per-beneficiary amounts and commercial payers are restricted to working within those limits to control costs.

However, it's important to remember that the Centers for Medicare & Medicaid Services is always evaluating and reevaluating its terms and costs. They are keenly attuned to those costs, and we can expect to see costs and reimbursement rates adjusted as the program matures. HC

Opportunities vs. Roadblocks

Understanding a slew of new interoperability regulations that affect post-acute care

By Nick Knowlton

NICK KNOWLTON is the vice president of strategic initiatives for ResMed, the parent company of MatrixCare and Brightree. He leads the company's interoperability initiatives, among other areas. Knowlton is also board chairman of the CommonWell Health Alliance and has been involved in the alliance since helping form it in 2013. Visit resmed.com.

The COVID-19 pandemic has amplified the fragmentation of the American health care system and put a spotlight on the significant gaps in digital access across care settings. After being largely left out of national interoperability mandates and incentives, post-acute care (PAC) providers are beginning to adapt their practices to catch up to the health care industry as a whole.

Interoperability has been widely adopted in acute and ambulatory care settings, to great benefit. As post-acute care providers look to embrace interoperability, new regulations offer opportunities rather than roadblocks when it comes to connecting with the broader ecosystem and creating successful, long-lasting referral relationships.

Adopting Interoperability in Post-Acute Care

The Health Information Technology for Economic and Clinical Health Act of 2009 set the groundwork for the Centers for Medicare & Medicaid Services' (CMS) electronic health record (EHR) incentive programs, which subsidized the "meaningful use" of these systems. Unfortunately, the PAC industry did not receive the same financial incentives as hospitals and physician offices. Naturally, this led to slower adoption rates in PAC and national capabilities that skew toward the needs of acute and ambulatory providers compared to their counterparts in PAC.

Despite this, 78% of home health agencies had adopted some form of EHR by 2017, according to a data brief published in 2018 by the Office of the National Coordinator for Health Information Technology (ONC). And those figures are likely much higher today.

The ONC's information-blocking and interoperability rules have allowed many provisions to go into effect this year. Under these provisions, providers cannot block patients and other providers from accessing health data unless they meet one of eight specific exceptions. This has accelerated the rise in nationwide networks and opened a new focus on post-acute care settings, including defining standards across the industry.

78% **percentage of home health agencies that had adopted some form of EHR, according to a data brief published in 2018**

As rules about information blocking and interoperability take hold, post-acute care organizations must do what they can to catch up to their acute and ambulatory counterparts.

Additionally, certain provisions in the ONC's rule related to how application programming interfaces (APIs) allow different applications to communicate and share data with one another. By setting specific and easily replicable standards for APIs implemented by certified health care software developers, post-acute care providers will be more likely to use software that leverages the same data standards; these standards represent new roads for more information to flow to and from PAC settings. This will allow providers to more easily share information electronically and will begin to break down the data silos that have slowed the growth of interoperability in PAC for too long.

Within the PAC industry, tides are beginning to shift. Tremendous investments have been made to connect care across settings and adapt standards to meet the unique needs of post-acute providers, such as passing documentation and medication lists back and forth to meet strict reimbursement requirements.

The Opportunity Offered by Information-Blocking Rules

Rules that solve for information blocking have undoubtedly opened a new era in interoperability, representing a notable shift for PAC providers, who have often struggled to electronically communicate with their referral sources.

The fact of the matter is that the flow and sharing of health care data has long been driven by hospitals. With these new regulations in place, data sharing between necessary parties will be much more streamlined and accessible. However, as rules about information blocking and interoperability take hold, post-acute care organizations must do what they can to catch up to their acute and ambulatory counterparts, even though they have further to travel up the interoperability maturity gradient. With these new regulations, PAC providers have the opportunity to rise to meet the rest of the industry—for the benefit of their patients, clinicians, referral relationships and business overall.

In fact, roughly three-quarters (74%) of acute care providers indicated they would switch to a post-acute care partner that has electronic data-sharing capabilities, such as the ability to accept electronic referrals, according to a recent survey conducted by MatrixCare and the market research firm Porter Research.

With the ONC's recent rules acting as a level of enforcement behind data exchange for treatment, care transitions and other use cases, post-acute care providers now have an opportunity to embrace interoperability and in turn provide better patient care, improve collaboration with their partners and form stronger referral bonds that will support long-term success. This can lead to winning business over competitors, while also allowing home-based care organizations to streamline their operations and reduce administrative burdens for staff.

The Road Ahead

Because the initial focus for interoperability has been on acute and ambulatory care, the health care industry must work together to shift focus toward bridging the gap between care settings. A focus on the patient at the center of everything will be key in meeting the unique needs of the homecare industry and ensuring high-quality patient care.

EHR vendors play a large role in driving interoperability success. Vendors must move their investments in interoperability forward or risk putting their customers at a severe disadvantage. The recent Porter Research survey indicated that both PAC providers and referral sources expect EHR vendors to lead the way—yet 48% of home-based care providers were unsatisfied with their systems' abilities to meet their most important interoperability needs.

The push to interoperability is inevitable, and embracing these changes is truly a necessity for post-acute care providers. There are a variety of environmental factors, including an aging population and the COVID-19 pandemic, making it critical for PAC providers to share data across care settings in as close to real time as possible. Providers leaning toward more digitized practices are taking part in this tremendous opportunity to boost health care efficiencies, enable smoother care transitions, build stronger referral businesses and ensure high-quality patient care at a pivotal moment in the industry. HC

GET MORE INFO

Visit homecaremag.com/tags/interoperability for more.

Building a Safe Home for Seniors, Brick by Brick

Arizona nonprofit has 40+ years of experience in affordable aging in place

By Hannah Wolfson

You've heard all the statistics and anecdotes about the growing number of seniors who'd like to remain in their homes as they age. But for some seniors, just having a place to live is the first hurdle.

While most American seniors own their homes, a growing number rent—a figure that's expected to hit about 23% of seniors in 2035, according to the U.S. Department of Housing and Urban Development. And those who own are carrying more mortgage debt than they used to; the percentage of homeowners over 75 with mortgages has tripled since 1989. At the same time, the maintenance costs and property taxes continue to grow, even without considering the money older residents may have to spend on home modifications, home medical equipment and companion care in order to make their safe to stay in.

That's where the Foundation for Senior Living (FSL) comes in. The Arizona-based nonprofit organization founded more than four decades ago is dedicated to providing affordable housing for seniors, veterans and others—but doesn't stop there. It also ensures that its clients have a safe and healthy place to live, offering home modifications, weatherization, home health services, food support and adult day services and senior engagement options.

FSL's holistic approach to aging in place—plus its broad reach—probably make it unique in the country among nonprofits.

"There's nothing exactly like us out there," said Megan Word, director of development and marketing for FSL.

Where It Began

When the organization was founded in 1974 by the Catholic Diocese of Phoenix, the initial vision was for it to provide housing and social services to seniors and others with disabilities.

"But immediately, we saw that seniors wanted to stay in their own homes," Word said.

Care planning is part of FSL's services. All images provided by FSL.

FSL provides day activities, including gardening, for seniors and people with developmental and physical disabilities.

BY THE NUMBERS

In its most recently reported fiscal year, FSL:

- **Provided weatherization services and accessibility modifications to more than 4,106 homeowners throughout metropolitan Phoenix**
- **Distributed 464,719 supplies from food pantries across the state**
- **Served 61,087 congregate and home-delivered meals**
- **Provided nearly 265,000 miles of reliable transportation**

Working to keep seniors' homes cool in Arizona

Today, it's one of the largest nonprofits in Arizona, with a four-pronged focus: affordable housing, health and wellness, healthful meals and caregiver support. And Word said they are even considering possible expansion to nearby states in the future with a focus on providing additional affordable housing.

Housing for All

FSL operates 26 affordable multi-family apartment buildings with about 1,000 units around Arizona, including crowded Phoenix and isolated rural areas.Most are for seniors or adults with conditions like vision or hearing impairment or developmental disabilities. Renters must meet income criteria based on local median income and household size.

In addition to operating—and in some places constructing—affordable apartments, FSL has also branched into building single-family homes, with 126 currently online. Those homes don't have age restrictions, but some owners are 65 and up. Others are veterans; all purchasers must meet certain income requirements to qualify.

Offering this kind of housing is critical in Arizona, where approximately 18% of the population is 65 or older, said Tom Egan, FSL's president and CEO. There's already a waiting list about 300 deep for FSL's affordable units. Couple that with the fact that Arizona has one of the biggest deficits of affordable housing in the country—and that may get worse with the end of the federal eviction moratorium put in place during the early months of the COVID-19 pandemic.

"We're going to see a dramatic spike in the number of people who need affordable housing and in the homeless population," Egan said, adding that in Maricopa County, which includes Phoenix and is one of the largest counties in the country, there has been a recent increase in adults over the age of 55 who are homeless for the first time.

"They can no longer afford to stay in the place they have lived in," he said.

While Arizona may be a hot spot, there are nationwide predictions that the silver tsunami will bring increased demand for affordable senior housing. In a 2019 study, researchers in New York City found an emerging crisis of elderly homelessness, with the number of shelter residents aged 50 and up nearly tripling in a 13-year period; similar studies have

been done in Boston and Los Angeles. And homeless adults in their 50s tend to have the same mobility issues, fall rates and chronic medical problems of housed seniors who are in their 70s.

LEADING BY EXAMPLE

One of the most unusual programs FSL offers is a model house that shows off home modification options. Created around 2007 or 2008, the equipment in the home, which is based at the organization's corporate office, was donated by local home medical equipment provider MedAssure, Inc.

Half of the house shows what can be done simply and on a budget. The other half presents universal design concepts such as an accessible shower and an overhauled kitchen with lowered countertops.

"This is an opportunity for folks to look, touch and feel" without feeling they're being pushed to buy as they might in a showroom, Word said.

Checking usability in a kitchen

Making Home Safe

But just having a roof over your head isn't enough, especially for seniors on fixed incomes with chronic health conditions. That's why FSL also has a home improvement program that includes accessibility modifications. The organization works with state and other partners, including home medical equipment (HME)

providers and local contractors, to provide grab bars, wheelchair ramps and more for residents. In some cases, it even installs kitchen appliances with larger, easy-to-push buttons on the front to make it easier for seniors or other adults with limitations to their dexterity or eyesight.

FINDING WORKERS

Just like any other home health agency or homecare provider, FSL is struggling to fill positions. It was a problem even before the pandemic. After all, as a nonprofit working with low-reimbursement clients, they can't pay what a health system might; plus, staffers often have to travel long miles or into rough neighborhoods to reach clients.

"We have to look for the bleeding heart, we're looking for the person who literally wants to help this population … With direct care workers it's very difficult; this is hard work," Word said.

Recently, for the first time in a decade working there, the human resources team came to her for help marketing its open positions.

"I'm sure some of your readers would say, 'duh, we've been doing that forever,' but for us as a nonprofit, we have very limited advertising dollars."

So she's not just putting money into advertising but also planning on holding a job fair in their brand-new, unused adult day care center (closed for COVID-19) and also shooting videos of staff working with clients to show how meaningful the work can be.

"We need to find the person who truly wants to make that difference—and we do," she said.

The organization also focuses on weatherizing units for residents to help save them money. While the nationwide average for home cooling costs for the summer is about $150, Arizona residents paid on average more than $475.

"That way, they don't have to choose between electricity or the doctor's appointment or the medication or groceries," Word said.

There's also a new pilot program in cooperation with a local energy company that provides free repairs or replacement for broken air conditioners—critical in the summer desert heat, where an un-cooled apartment can be unhealthy or even deadly.

The key, Word said, is understanding that the way a person lives day-to-day can affect their health care outcomes.

"The home is an environment—we want that environment to be safe and healthy," she said.

Adding Care to the Equation

In case all that wasn't enough, FSL also provides home- and community-based services for its clients.

That includes personal care, respite care, errand-running and housekeeping, all for people who are unable to pay privately for nonmedical care. There are Medicare-approved home health options, including a skilled hourly side that can work with patients who have ventilators or tracheostomies, providing breaks for family caregivers. And there's transportation so seniors can make it safely to doctors' appointments, the pharmacy or drug store.

FSL also performs some transitional hospital-to-home care for uninsured or underinsured individuals, "holding their hand," as Word said, for the first 90 days to ensure that their HME and medications are properly in place. It's Care by Design program is designed help clients with care planning and coordination, ensure there are fewer barriers to care, seek out unmet needs and educate family caregivers on referrals and resources. Their private care management includes family mediation, home safety assessments, care planning and community resource connection, especially for families who may not live locally.

About 80% of FSL's home health patients are Medicaid users; some may be on waiting lists for eligibility with local agencies but can received short-term charity care through FSL to get their needs taken care of immediately.

Activities of Daily Living

In conjunction with its work on aging in place, FSL runs three state-licensed adult day centers; two can serve 99 people a day and the third is smaller (based on pre-pandemic operation numbers). At least one of the ReCreatión centers offer wellness options, an accessible kitchen that can be used by members, and activities for adults with chronic diseases, diabilities or early stage dementia.

Yet another focus area for the organization is nutritious meals. It operates food pantries that are open to anyone in the community, as well as home delivered meals to seniors and other homebound adults in a Phoenix suburb and a rural town.

FSL has also traditionally served lunches and snacks at its senior centers—but that had to change during the COVID-19 pandemic. Instead, they offered meal delivery or a drive-through option, and that led to 43% growth in use of its meals. Also during the pandemic, FSL started a system to deliver supplies from its food pantries.

"We started contactless delivery, about $50 in groceries, including paper goods, and we would leave it on their doorsteps," Word said. "It was for those early months of the pandemic when grocery store shelves were truly bare, and also for our rural communities."

Word said that at the heart of all of the work is the idea that the elder generations are so often forgotten—even though we all hope to be there someday.

"No one was paying attention to seniors; we've not considered seniors in anything," she said. "Yet if we're all lucky, we're going to be there one day and we'll want to have those supports to age as we want to." HC

Hannah Wolfson is editor of HomeCare magazine.

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How to Reach Seniors Looking to Age in Place

4 key trends fueled by COVID-19

By Amy Moneypenny

The pandemic has changed the conversation on senior care options. As hospitals and health care systems were overwhelmed by the rise of the pandemic, deciding how to care for seniors became a hot topic of discussion. Technological innovations emerged quickly, and a higher quality of care and safety became a top priority.

While tough conversations about where a senior will reside so they can receive the best care are sometimes side-stepped by families until they're unavoidable, this renewed focus on staying healthy and safe has created the momentum to think proactively about aging loved ones.

An Aging Population

By 2025, the Census Bureau projects that the number of seniors is expected to surpass the number of children 13 and under for the first time. All of the nation's 74 million baby boomers will be 65 or older by 2030.

When assessing the best ways to provide care for the aging population, it's important to be aware that the landscape is changing quickly. Options like assisted living centers and skilled nursing facilities have adapted to the pandemic by upgrading their technology and infrastructure to accommodate telemedicine and to meet heightened cleaning protocols. Improvements such as extra ventilation, air purification systems and sanitization stations contribute to increased safety and reduced risk for seniors in institutional care.

Yet even as these facilities invest in safety improvements and work to provide

a higher quality of life overall, a recent national survey from Capital Caring Health reported that 90% of Americans aged 50 and older expect to age in place. As the population ages, health care and homecare solutions will need to adapt to meet the growing demand of seniors looking to stay home in their twilight years.

Here are four key trends fueled by the pandemic around aging in place. Understanding them will help you reach this demographic effectively.

1 Seniors value their independence. Seniors often still live where they raised their families. Home serves as a personal oasis, and the suggestion of leaving due to a serious illness or health care complication can create anxiety and stress. Being able to stay at home and function independently means preserving a level of dignity—and avoiding the feeling of becoming a burden on others. Adult children often prefer to keep their loved ones in their homes too, sidestepping the tough conversations, emotional arguments and high costs of finding an alternative living situation.

However, certain risks are much higher for seniors at home:

- One out of every four older adults (65+) will fall each year
- One out of every five falls causes a serious injury
- More than 95% of hip fractures are caused by falling
- Falls are the most common cause of traumatic brain injuries

The amount of risk highlights a growing need for accessible and affordable home upgrades to keep seniors safe. Solutions that help older adults maintain their independence are—and will continue to be—in high demand.

2 Home solutions can make all the difference. The National Institute on Aging reports that 80% of falls occur in the bathroom, making improvements to this space the first line of defense for seniors and their loved ones. Solutions that help seniors and adult children identify high-risk areas—and provide guidance on how to address them affordably—can significantly reduce the chances of an injury while meeting the demand for adaptive home solutions.

For example:

- Converting a conventional tub into a low-threshold or a walk-in tub can drastically reduce fall risk by removing the need to step over the tub.
- Replacing loose throw rugs with flooring options decreases fall risks.

- Installing grab bars in areas where loved ones commonly use furniture or other objects to brace themselves can provide needed support and stability.
- Making solutions like stair lifts increasingly available and affordable can help maintain or return access to the whole home. Often, seniors will be confined to a single level of their home due to their inability to move up and down stairs easily.

3 Home modifications are valued investments.

While significant home modifications can cost anywhere from $10,000 to $100,000, emphasizing that these investments translate into higher home values can help rationalize the initial dollar amount. Offering different patterns, an array of styles and sleek finishes can help families feel like they're shopping for another home appliance rather than dealing with a life change. By steering towards options that don't look institutional, the home solutions industry can continue to position modifications as an investment—especially now, with home values rising—as much as for home safety. As the population keeps aging, the demand for modern modified homes that support independent living will rise, too.

4 Seniors want to be involved & in charge.

When advocating for a safer space, conversations proposing modifications can cause a lot of anxiety. Including seniors early on in conversations and empowering them to shape the outcomes can help sidestep the fear that stems from uncertainty. Education is a crucial step for seniors, caretakers and decision makers. If you include the people affected by these decisions from the start, you'll remove a major barrier to adoption.

When communicating with older adults, it may take a little extra time for the message to resonate. Repetition can be a helpful, too—and leaving time for longer calls with customer service reps can increase close rates. When putting together marketing and sales materials, relying on visuals rather than dense paragraphs of written descriptions helps communicate the value of features and their benefits faster. Lead with messages of kindness and with an awareness of a senior's desire to maintain independence.

If you prioritize the needs of seniors and their families and propose solutions that simplify the path to independence, you'll successfully reach more of this population. HC

Amy Moneypenny is the senior product marketing manager for Leaf Home Safety Solutions, which transforms homes through high-quality accessibility solutions that improve mobility and independence.

Home May Be the New Hospital

Remote patient monitoring can bolster aging in place

By Jorge Rodriguez

Digital health is the wave of the future in health care. We've heard many times that the COVID-19 pandemic brought telehealth greater popularity—but telehealth can't do it all. While providers can "see" patients with a telehealth visit, they can't check and monitor vital signs. The increased use of telehealth during the pandemic exposed some of the limitations of the technology. Vital sign readings such as blood pressure, temperature and oxygen saturation were missing from the conversation.

Remote patient monitoring (RPM) fills this gap, allowing for the collection of vital signs. The use of RPM accelerated rapidly when COVID-19 hit; patients could be monitored at home rather than make trips to the doctor's office or health care facility, thus avoiding potential viral exposure. Yet RPM's real purpose is for chronic care monitoring. RPM can connect patients to their care teams, providing the real-time data needed to control symptom and disease progression—and allowing them to remain in their homes longer.

How RPM Helps

Remote patient monitoring grew immensely during the COVID-19 pandemic as a way for providers to monitor less severe coronavirus patients at home, freeing up hospital beds for more severe patients. Kaiser Permanente Southern California recently released the results of an 11-month study that documents the value of monitoring patients at home. The study showed that of 13,000 COVID-19 patients monitored remotely at home from April 2020 through February 2021, only 10% needed to be admitted to the hospital. By monitoring patients' oxygen saturation levels, providers were able to make treatment plan adjustments when a patient's level ran low, thus avoiding hospitalization. In addition, the study revealed that patients were satisfied with the quality of care they received and would recommend the program to others.

Although it was a study of COVID-19 patients, the Kaiser Permanente study shows the value of RPM as an in-home health care delivery method for chronic care management and for acute care. Chronic and acute care patients often are sent home from the emergency room or hospital when they stabilize. Then, when their condition reaches a new crisis point, they may be readmitted. But if patients are monitored at home, providers can intervene before their condition reaches a crisis level.

Under an RPM program, the physician sets the target parameters for each patient's vital signs, which patients take every day. An ideal RPM program triggers an alert if a patient's vital signs register out of their normal range. These critical alerts serve as proactive intervention to address any

Of the 13,000 COVID-19 patients monitored at home using RPM from April 2020 through February 2021, only 10% needed to be admitted to the hospital.

health issues that arise, in an effort to keep patients out of the emergency room and prevent readmissions. This is better for the patient and helps keep costs down.

A March 2019 article in the American Journal of Accountable Care used Medicare claims to study emergency room dispositions, specifically evaluating inpatient admissions compared with home health referrals. It showed that home health can reduce costs by nearly $7,000 and decrease the chances of readmission by allowing patients to recover in their home with home health care.

Home Health Agencies & RPM

There is a consensus among health care providers on the benefits of real-time updates on a patient's condition and timely feedback on their current status, thereby increasing patient engagement with providers. Home health agencies can incorporate RPM data to manage their patients' care and achieve care plan goals.

Monitoring a patient between visits could alert the provider of a significant change in a patient's health. For example, a congestive heart failure patient could experience weight gain over the course of a few days if their medications have been adjusted. The ability to see the change in real time allows for proactive intervention before the problem gets worse.

RPM can improve the care planning process when it is included in the care plan, along with an explanation of how the technology will help achieve the therapy plan's goals. Remote patient

monitoring is an additional tool and truly a valuable resource for providers in the continuum of care because they have access to daily vitals, much like a hospital setting, and can adjust the care plan based on the patient's progress. Some RPM systems also incorporate the ability to conduct a telehealth visit (with current vitals) if a provider needs to see the patient right away. For home health agencies, RPM is not only effective in the care plan of an individual patient, but can also be useful in determining the scheduling priority of a nurse's visits on a daily basis.

RPM Reimbursement for Home Health Agencies

In 2018, the Centers for Medicare & Medicaid Services (CMS) amended regulations to include the costs of RPM as an allowable administrative cost if RPM is used by a home health agency to augment the care planning process. By allowing the costs associated with RPM to be reported on the cost report, they can better determine the cost and frequency of use by home health agencies and whether it improves patient outcomes.

Despite the benefits of RPM, reimbursement is a challenge right now for home health agencies. The COVID-19 crisis accelerated the learning curve and increased user comfort with telehealth. The pandemic provided CMS the utilization data necessary to make the decision to continue allowing telehealth services after the public health emergency expires. Remote patient monitoring is quickly being implemented across the country and will provide actual clinical data to impact decision-making in Washington and allow for greater use, including by home health agencies. The industry is hoping that CMS sees the value in the service—and in the outcomes—in the very near future.

RPM's Future Is Wide Open

Remote patient monitoring has an important role to play in health care and its future is a blank canvas waiting to be painted. COVID-19 played a role in expanding the potential opportunities and speeding the process to mainstream acceptance. The reimbursement challenges that kept traditional telehealth services from surpassing a 1% market share are in the past. The accumulation and analysis of clinically relevant physiologic data and patient outcomes will validate the importance of RPM in the decision-making hierarchy of patient health care.

Home has already become an extension of the hospital, albeit with the addition of the convenience and comfort many have grown accustomed to in their daily lives. As such, the role of homecare providers has come to the forefront in care delivery. HC

Jorge Rodriguez is vice president at WITHmyDOC, a digital health company that uses a web-based intelligence platform for remote patient monitoring.

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NEW PRODUCT PREVIEW

The Latest & Greatest

Manufacturers bringing best new products to Medtrade East

By Kristin Easterling

Each year, HomeCare sponsors the New Product Pavillion and Providers Choice at Medtrade—and this month's Medtrade East is no exception. Throughout the show, providers should be able to view and vote on their favorite new products between rows 500 and 600. Because not everyone can be at the show in Atlanta, we've chosen a few of our favorites to preview here; note these do not reflect all New Product Pavilion entries and could change.

AirSense 11 CPAP

RESMED

The AirSense 11 includes new features like Personal Therapy Assistant and Care Check-In designed to provide tailored guidance to PAP users, helping ease new users into therapy and comfortable nightly use. Remote software updates are available so users can always access the latest version of these tools. The unit features an easy-to-use touchscreen and simple start/stop button. An integrated heated humidifier can be controlled manually or automatically with the Climate Control feature. The AutoRamp feature delivers a low airflow pressure to help users fall asleep, then steadily increases to the prescribed level. AirSense 11 also gives access to myAir (a patient engagement app) and AirView (a remote monitoring platform for clinicians). Visit resmed.com.

Deluxe DL1 Toilet Lift

DIGNITY LIFTS

The DL1 Deluxe Toilet Lift is an automatic toilet lift that installs easily over a toilet or can be used independently as a commode. The sleek design works with most home décor and comes with adjustable legs to fit toilets 14 inches to 18 inches tall. At just 23 7/8 inches wide and 21 inches deep, the lift will fit in even very small bathrooms. With 14 inches of lift from a seated position, the Deluxe DL1 is designed for people who need toileting assistance but want to maintain their dignity and independence. Dignity Lifts prevent patient falls and caregiver injuries. Battery backup and wall plug included. The Deluxe Lift Model DL1 is sleek, stable and easy to sanitize. It retails for $1,499 and was expected to ship Oct. 12. Visit dignitylifts.com.

Vacu-Aide QSU Quiet Suction Unit

DRIVE DEVILBISS HEALTHCARE

With more than a 50% reduction in sound from previous models, the Vacu-Aide QSU is one of the quietest portable high flow/high suction units on the market. Vacuum adjustment allows for 50–550 mmHg (millimeters of mercury) and a free flow of 27 liters/minute. The unit features a container assembly with integrated bacteria filter and float shutoff to prevent overflow. Comes complete with internal battery, carrying case, six feet of tubing, AC/DC adapters and power cord. The device can be operated while in the carrying case. The unit is approved for use on infants, children and adults. Visit drivemedical.com.

Therapy Mask System 3100

PHILIPS RESPIRONICS

The Philips Therapy Mask System 3100 is designed to encourage sleep therapy acceptance by offering fully adjustable, discreet headgear and effortlessly interchangeable cushions. The masks help reduce setup time as well as the need for high-touch refits. Innovative design effortlessly clicks the cushion into place, making it a tube-in-front CPAP mask that allows for easy swapping between nasal and pillow cushions on the same mask frame. Easily adjustable headgear also offers high-value efficiency in the fitting process. Visit philips.com.

Hot on the heels of Medtrade West, Medtrade East returns to the Georgia World Congress Center in Atlanta from Oct. 18 to 20.

"Excitement is building for Medtrade East, and we are seeing that enthusiasm among major manufacturers who are choosing to exhibit at the show," said York Schwab, associate show director for Medtrade. "Medtrade East is truly the place to get back to business with companies large, medium and small ready and eager to show their wares."

At press time, the show is expected to happen in person, with all the usual fanfare that accompanies the largest trade show for home medical equipment (HME) providers. This includes a new Welcome to Atlanta Preview Night on Monday, Oct. 18, from 4:30 p.m.–6:30 p.m. Attendees and exhibitors will get a first look at the more than 140 exhibitors while enjoying drinks and light snacks. Additional expo hours are: Tuesday, Oct. 19, 9:30 a.m.–5:00 p.m and Wednesday, Oct. 20, 10:30 a.m.–3:00 p.m.

Familiar favorites are planning to return to the show, as well. The American Association for Homecare (AAHomecare) will host the AAHomecare Update on Tuesday, Oct. 19, at 8:00 a.m., and later that evening will hold the Stand Up for Homecare reception. Also returning is the Power Lunch, scheduled for Wednesday, Oct. 20, at 11:45 a.m., where providers can get facetime with industry experts on issues facing their companies. Stand Up for Homecare and the Power Lunch require separate registration.

Conference attendees will be able to attend conference sessions each day of the show, with more than 50 sessions to choose from. The topics range from audits to patient engagement to merger and acquisition activity. There are also four workshops taking place Monday, Oct. 18:

- Take Action! Productivity Planning for 2022, presented by Brightree
- An Introduction to the Certified Durable Medical Equipment Specialist (CDME), presented by the Board of Accreditation & Certification
- Forensic Denials, presented by VGM & Associates
- Team@Work Sales BootCamp, presented by Team@Work

Workshops require a separate registration and may require an additional fee. HC

A Growing Appetite for Post-Acute Care Companies

Today's market trends will shape the future

By Bradley Smith & David Coit, Jr.

It's a great time to be an owner and operator of any company in the health care space. That's especially the case for owners of home medical equipment (HME) companies. During the past few years, there have been many noteworthy developments that have only served to make an already hot HME marketplace even hotter. Buyers are aggressively pursuing acquisitions, with intense competition for HME companies driving up prices. In short: It's a good time to sell your HME company, or to at least begin looking into whether selling sooner rather than later would be in your best interest.

This article will help you gain a better understanding of the HME marketplace and how it got where it is now. We'll start by recapping historic HME mergers and acquisitions (M&A) information, highlight some key macroeconomic and microeconomic trends, and then look at the qualities of companies that buyers are looking for and what they are likely to pay for HME companies.

Historical Performance

The onset of Medicare competitive bidding in 2008 greatly depressed HME valuations. This was due to the uncertainty brought on by competitive bidding and the negative impact on the pricing that came with the bids. These two factors dragged the entire HME vertical down into low valuations and created a plethora of failing small providers. A silver lining of the COVID-19 pandemic is that this enormous weight on HME has largely been lifted.

Key Macroeconomic Factors

What is currently happening is a confluence of events in the broader M&A landscape in the United States. Here are three of the most significant macroeconomic factors to understand.

1 Private equity has money. Lots of it. There is a large amount of liquidity; in fact, there is more than $1 trillion of capital overhang in the market right now. Private equity is looking to spend that money and buy companies, but it won't all be deployed any time soon. It's a monumental task to put that much money into good companies.

With that said, a lot of that money is expected to end up in health care and HME. Why? Private equity has pegged health care as a recession-proof and, more importantly, a pandemic-proof area to invest in. There is an increased concentration of companies looking to deploy capital into HME and other facets of homecare, and, more specifically, into good quality companies and operators.

2 Baby boomers keep working. Many expected the baby boomer generation to transition out of their companies over the last decade or so. Some of that has happened, but most boomers have not yet retired. They are holding onto their businesses for much longer. It's still common to see owners operating their companies full time into their 60s, 70s and even 80s. This will continue to drive a robust M&A market for at least the next decade.

3 Cash is cheap. Interest rates are very low. How low? This will likely be the lowest we see in our

lifetimes. With cash so inexpensive and easy to obtain, this will fuel the M&A market for the next decade. The industry may experience a little bit of a slowdown depending on what happens with capital gains' rates, but that will be short lived. The low cost of accessing cash will further drive M&A.

Key Microeconomic Factors

Now let's look more closely at three of the most substantial microeconomic factors affecting HME.

1 There's a big emphasis on investing in post-acute care practices.

Post-acute care businesses—whether HME, home health or others—are highly desirable. The primary reason is because the Medicare Part A side of the business is so expensive. For whatever reason, it has taken about half a century for federal agencies like the Centers for Medicare & Medicaid Services (CMS) to figure out that it's more expensive to treat patients on the Medicare Part A acute side of the business versus the lower cost to treat them in the home. People have finally realized that there are avenues to deliver great, cost-effective care and treatment in the home. This is motivating people to gravitate toward the market.

The number of new applicants filling out the Medicare 855S form, which is essentially the way to create a new Medicare entity, has hit its highest rate in at least a decade. People are opening *de novo* businesses in the space because of its perceived strength and viability.

2 Medicare competitive bidding seems over.

As noted earlier, Medicare competitive bidding, for the most part, went away with the pandemic. The off-the-shelf orthopedic brace competitive bidding program still exists, but that's only a small segment. The industry is still waiting on a proposed rule from CMS regarding what the next round will look like, whether it is delayed or providers only bid on the bracing category again. Competitive bidding greatly contributed to consolidation of markets and players.

Large players in the market have always used the strategy of buy and build, either to buy up geographic territories or invest in new segments in existing markets. This was the case before competitive bidding. During the years of competitive bidding, which started in 2008 and essentially ended in 2020, mid-size providers also grew through acquisition. Competitive bidding has largely gone away, but these players still have that appetite and business strategy of growth through acquisition. And small providers are also getting into the mix.

So now you still have the bigger players making acquisitions, but they are being joined by regional and even local players. There are smaller HME companies doing $10 million a year in business that are identifying a company in the same or adjacent market doing $2 million in revenue and pursuing an acquisition. Growth

through acquisition is no longer just an avenue for growth for the largest players.

3 Skilled nursing presents additional challenges.

More buyers are interested in HME due to the multitude of challenges currently facing skilled nursing. This includes everything from the risk of future lockdowns due to COVID-19 or other pandemics, the ongoing spread of COVID-19, vaccine mandates and testing requirements that are motivating some staff to pursue other careers, and hardline immigration policies that have shrunk the available pool of workers.

In addition, patients and their caregivers are increasingly opting to receive care in the home, not just for comfort but also because the services there tend to be significantly less expensive than those provided in skilled nursing facilities.

What the Future Looks Like

There may be a slight slowdown in Q1 and Q2 of 2022 as people work to figure out how to navigate potential tax implications and changes from the Biden administration. Once they figure that out, the industry will return to a flurry of activity that should continue into the foreseeable future.

Since the onset of COVID-19, there has been a substantial supply and demand issue for HME businesses. The market fundamentals are off in that there is much more demand than supply. That demand is coming from private equity, the capital markets, and from national, regional and local players. If you have a strong and healthy HME company, it will transact for a lot of money—the highest multiples seen in 20 years. If you have an okay company that's perhaps antiquated and needs help growing, it will still transact for a high amount because the supply is lacking. These trends are not likely to change any time soon.

What Buyers Want: Key Attributes

When HME buyers are researching potential acquisition targets, the most important quality in a prospective HME company is profitable growth. Buyers want to feel confident that they can take what an HME organization owner has created and build on it, ultimately making the new owner more money from the acquisition.

In a risk/reward analysis, HME buyers will be looking to see that a company's strengths far outweigh its weaknesses. When buyers analyze a prospective company, they usually do so with a checklist mentality, looking to see if a company has the attributes that the buyer feels are most important to both the short- and long-term success that will drive up what the owner can earn. In addition to profitable growth, one of the most important

attributes is a strong, capable management team—one that will work with the new owner to sustain the company's current growth and profitability and then help build upon those factors. This is also why buyers look for a tenured, experienced workforce with low employee turnover.

Solid in-network relations with payers and long-term payer contracts help a buyer feel more confident that a company's financial prospects are viable and sustainable. Diversity is a highly sought-after attribute—more specifically, diversity in regards to a company's physician and non-physician referral network and its payer mix. Meanwhile, a large population base with good client demographics is appealing to buyers because such qualities tend to lend themselves to achieving growth.

Finally, buyers will also look closely at other key financial attributes, such as good revenue growth and earnings before interest, taxes, depreciation and amortization (EBITDA) margins typically in the 10% to 20% range.

Determining a Price

When buyers are weighing how much they want to spend to acquire an HME company, they are looking for rewards—that is, upsides—from their potential purchase. These upsides are the ways that the buyer will generate a strong return on investment (ROI), with many buyers looking for short-term wins.

Such upsides come from positive industry market conditions that give a company a competitive edge and/or unique position in a market. These tend to include the following:

- Expanded in-network coverage
- Increasing revenue on a per-client basis with overlapping products and services
- Client treatment demand not affected by economic cycles
- Niche products or services with high usage and reimbursement rates
- Skilled employees (e.g., assistive technology professionals, respiratory therapists, billers)

As a buyer works to value a company, they will typically gravitate towards a trailing EBITDA. EBITDA is the easiest and most direct way to determine an ROI. Buyers tend to go through a risk/reward analysis to come up with a purchase price. The price is usually based on a multiple of normalized or adjusted earnings before EBITDA. A one times (1x) of EBITDA is equal to one year of earnings. This means that a company transacting for 4x EBITDA is four years of forward earnings. Public companies are valued in the same manner—for example, Lincare is trading at 19.90x forward earnings and Amazon at 60.63x. Adjustments to EBITDA include nonrecurring expenses

(e.g., one-time legal fees), discretionary expenses (e.g., charitable contributions), and owner-related personal expenses (e.g., excess owners' salaries and vehicle lease expenses).

Understanding Market Multiples

Now let's look at the market multiples for HME. Market multiples refers to the estimated purchase price relative to EBITDA. The typical range of market multiples for HME providers is 3x to 5x EBITDA. Whether an HME company falls within that range is based on quantitative factors, such as historical and projected financial performance, as well as on the qualitative factors highlighted above. Not surprisingly, larger revenue providers tend to attract more buyers than smaller revenue providers.

Here are estimated market multiples for HME providers by revenue:

- $1 million to $3 million in annual revenue: 2x to 4x EBITDA
- $3 million to $5 million in annual revenue: 3x to 5x EBITDA
- $5 million to $10 million in annual revenue: 4x to 6x EBITDA
- More than $10 million in annual revenue: 5x to 10x EBITDA

While the information provided here should serve as a reasonable shortcut if you are interested in estimating the value of your company, it is important to understand that there are outlier market multiples in transactions in which more optimized buyer/seller synergies can push valuations above the norm—sometimes well above it.

Moreover, don't forget that market multiples, like any financial projection, change over time. Influencing factors include the overall state of the economy, regulatory and reimbursement modifications, and industry trends such as those discussed earlier in the column.

Speak at least annually with an advisor familiar with the HME market and broader health care trends that affect HME who can serve as a guide about these concepts. This will allow you to better understand the market and the options for your HME company. HC

Bradley M. Smith, ATP, CMAA, is a former durable medical equipment company owner, a managing director with the international health care mergers and acquisitions firm VERTESS and a member of HomeCare's Editorial Advisory Board. If you would like to personally discuss this article, the value of your health care company/practice, or how to get the best price when you sell it, you can reach him directly at bsmith@vertess.com or (817) 793-3773.

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New Challenges for Home Vents

Recalls, reimbursement, remote data & referrals all changing the landscape

By Nick Macmillan

Even if you were a great storyteller, you could not have dreamt up the scenario durable medical equipment (DME) suppliers are facing as they grapple with an onslaught of home mechanical ventilation challenges. From the public health emergency to recalls to supply chain constraints, suppliers have proven resourceful and resilient in their response. Let's break down these challenges to explore the impact and response.

The Elephant in the Room

Let's start with "the recall," as it's so often called. On June 14, 2021, Philips Respironics issued a global recall notification for affected ventilation and sleep apnea devices. Philips advised of potential health risks related to the sound abatement foam used in these devices, including all Trilogy 100, Trilogy 200, Garbin Plus, Aeris, LifeVent devices and serial numbers manufactured before April 26, 2021.

At press time, the situation is still fluid. However, there is good news: On Sept. 1, Philips announced it had received approval from the U.S. Food and Drug Administration (FDA) to repair and replace the affected PAP devices. The company anticipates that the process will be completed globally within 12 months. The timeline comes in the wake of calls from providers for better communication from Philips and the FDA. Scott Owsiak, vice president of clinical services at Medical Service Company in Ohio, said that "these delays are impacting care." Suppliers are encouraged to get the latest updates from their local Philips representatives and at usa.philips.com/healthcare; there is a banner at the top of the page to click on.

Meanwhile, other respiratory manufacturers are doing their best to fill the void not only for existing patients, but also for new ventilation clients. The delta variant of COVID-19 is making this task harder. When asked what is the biggest challenge posed by the recall, Tony Mozzone, vice president of respiratory sales for New Jersey-based PromptCare said, "Getting vents for new patients!"

Several ventilator companies have been promoting and launching products, including Ventec Life Systems with its V+Pro standard ventilator with High Flow Therapy and Breas with its EveryWare cloud-based web application, to name just two. One thing's for sure: Suppliers that narrowed their purchasing to select manufacturers in an effort to boost their purchasing power are now much more inclined to diversify their product portfolio.

Reimbursement Changes

To address rigid criteria in local and national coverage determinations, the CHEST Health Policy and Advocacy Committee convened the Optimal Noninvasive Ventilation Medicare Access Promotion Technical Expert Panel. The panel's work addressed the following: thoracic restrictive disease, chronic obstructive pulmonary disease (COPD), hypoventilation, obstructive sleep apnea and central sleep apnea. Regarding ventilation, the aim was to propose national coverage determinations to the Centers for Medicare & Medicaid Services (CMS) for noninvasive ventilation (NIV) and home mechanical ventilation.

While welcomed by numerous industry and clinical constituents, including the American Association for Homecare (AAHomecare) and the Council for Quality Respiratory Care, there remain enough details outstanding to warrant ongoing robust discussions. And the timeline for adoption of these recommendations, if at all, remains to be seen.

"This was a long time coming, as coverage policy and criteria need to change to meet today's technology," Roxanne Venard, owner of Colorado-based Ascent Respiratory Care and vice chair of AAHomecare's Home Medical Equipment and Respiratory Therapy Council said. Venard added that she was especially pleased to see the pulmonary community advocate for coverage of respiratory clinicians in the home.

In the meantime, AAHomecare's Payer Relations Council has been battling an

It remains to be seen how any CMS policy changes trickle down to the commercial payers.

onslaught of commercial and Medicaid program policy changes around NIV coverage. These changes have been mainly focused on capping reimbursement for noninvasive ventilation, either via bi-level devices or home ventilators. Through the council's efforts, a number of proposed policy changes have been blocked, delayed or rescinded (for example, a new law in Louisiana prevents payers from capping payments on home ventilators). Advocates have called this a big win for medical equipment providers and more importantly for the patients they serve.

It remains to be seen how any CMS policy changes trickle down to the commercial payers. And since at least 37 states—with others pending—employ commercial managed care organizations (MCOs) for Medicaid program management, one can be assured of a swift Medicaid response, whatever those new policies entail.

No matter the future, suppliers have universally said that the COVID-19-related regulatory changes from CMS are having a positive impact—and that they hope these changes become permanent.

Technology Adoption & Remote Monitoring

While there has not been a significant uptick in new technology in the home ventilation space, existing technology has provided welcome relief, especially in the COVID-19 era. Specifically, remote access to ventilator data and the ability to connect with patients and caregivers via video call applications have provided the tools necessary to effectively monitor and address patient care issues. So remote ventilator monitoring has become the standard of care, and the day-to-day use of this capability has become essential to adjusting patient follow-up methodology.

Despite these technological advantages, utilization among suppliers spans the spectrum. Some suppliers have fully embraced remote visits; some have created hybrid solutions based on patient choice, disease severity or the patient's experience with ventilation; others have opted to maintain face-to-face visits while safeguarding patients and clinicians through proper precautions.

Most encouraging from these forced changes to care delivery are some of the resulting efficiencies and positive patient outcomes. PromptCare's Mozzone indicated that the company has created "a new algorithm of care," citing data that embraces these technologies "helps them wean patients faster."

Medical Service Company has primarily maintained a comprehensive home visit program, but has used additional data points, including the COPD Assessment Test (CAT) score, to alter care plans that significantly reduce hospital readmissions. Owsiak said that their program, which includes five patient encounters (remote and face-to-face) in the first month, "sets up the patients for success." He said that the results are so compelling that he intends to submit the company's findings to a peer-reviewed body for publication.

An additional benefit to using these new technologies is efficiency. Mozzone says that streamlining care has improved profitability. Given the increased cost of equipment and supplies, supply-chain issues and the overall increased costs of doing business, this is welcome news and an impetus for every supplier to continually evaluate their care paths.

Marketing to Physicians

As the delta variant has again impeded access to referral sources, reaching and messaging to them has proved challenging. Most referral sources have indicated that in-person visits are simply not possible. Remote meeting technology can be a friend to this effort.

In fact, as several of the strategic national stockpile ventilators manufactured by Ventec have been employed by hospitals, a comprehensive remote training program developed by Ventec Director of Clinical Operations Jason Sesmundo and Lead Clinical Specialist Craig Morris for use by the hospital's team of clinical specialists has proven incredibly valuable. The takeaway here is that referral sources and clinicians are open to remote contact, provided it supplies useful information from which they can benefit, such as recall response, ventilator patient data access, follow-up protocols and more.

Life in the Trenches

The interviewees quoted here have all indicated that, for the most part, their respiratory therapists have responded favorably to the required adaptations. Turnover has been minimal, which again points to just how dedicated this sector is. Venard from Ascent uses a lot of reinforcement through fun staff activities and luncheons, while Owsiak from Medical Services Company regularly repeats the mantra "right patient, right time, right therapy."

And though trying at times, it is heartwarming and gratifying to know that we keep company with the best of the best, and that patient care always trumps adversity. HC

Nick Macmillan is director of market access and strategy at Ventec Life Systems and principal consultant at Outside the Box Consulting. Mamillan's experience includes serving as the MED Group's senior director of MED's Networks and strategy, home care business segment manager at Vapotherm, national clinical director for Rotech Healthcare, Inc., and other product development and home medical equipment services management roles. Vist venteclife.com.

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AAHOMECARE
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No Such Thing as a Free Lunch

Make sure you're on top of provider relief reporting & repayment

By Craig Douglas

Since the onset of the COVID-19 pandemic, there have been several funding sources available to home medical equipment (HME) providers. Many of the options can be completely forgiven if used properly, while others will need to be repaid. Some money was sent automatically without providers requesting it, while other relief funds required providers to complete an application process. While these resources have helped many businesses survive the pandemic, there is some additional work associated with most of the programs.

Provider Relief Fund

One of the more commonly used funding sources was the Department of Health and Human Services (HHS) and Health Resources & Services Administration (HRSA) Provider Relief Fund (PRF). The PRF has allocated more than $186 billion to be distributed to various provider types since April 2020 and has been replenished a few times through various pieces of legislation, including the CARES Act and the American Rescue Plan, among others.

Between April and November 2020, there were three phases of the PRF. The funds that providers received through this program did not need to be paid back as long as the funding was used as intended and according to the program's terms and conditions. If you want to avoid being required to return those funds, it is imperative that you know and understand the expectations for how to use and report on the use of those funds. The window for providers to begin submitting their reports opened July 1, and providers must complete their reports by specific deadlines to avoid paying the money back.

TIMING FOR REPORTING

Period 1:
For payments received between April 1, 2020, and June 30, 2020, all funds must have been used by June 30, 2021.

Your final use of funds report must be submitted between July 1, 2021, and Sept. 30, 2021; however, there has been a 60-day extension for certain criteria.

Period 2:
For payments received between July 1, 2020, and Dec. 31, 2020, all funds must have been used by Dec. 31, 2021.

Your final use of funds report must be submitted between Jan. 1, 2022, and March 31, 2022.

Period 3:
For payments received between Jan. 1, 2021, and June 30, 2021, all funds must be used by June 30, 2022.

Your final use of funds report must be submitted between July 1, 2022, and Sept. 30, 2022.

Period 4:
For payments received between July 1, 2021, and Dec. 31, 2021, all funds must be used by Dec. 31, 2022.

Your final use of funds report must be submitted between Jan. 1, 2023, and March 31, 2023.

Providers who received payments totaling more than $10,000 in any of the four payment windows (see details in the box at left) will be required to submit reports. If you received more than $10,000 during multiple payment windows, you will be required to submit multiple reports. Providers are not required to submit reports for periods in which they did not receive at least $10,000.

During the reporting process, providers must be able to prove that all of the funds they received were used on either certain approved expenses or to make up for lost revenues attributable to COVID-19. There are two types of expense types:

1 General & administrative expenses include:

- Mortgage and/or rent
- Insurance
- Personnel
- Fringe benefits
- Lease payments
- Utilities or operations

2 Health care-related expenses include:

- Supplies
- Equipment
- Information technology
- Facilities

In the reporting portal, PRF dollars received by providers will first be offset by those two expense categories. If the expenses incurred do not fully exhaust the funds received, lost revenues will then be considered to offset the remainder of the funds. To calculate lost revenues, providers can utilize one of three methods:

AAHOMECARE.ORG/STANDUP

STAND UP FOR HOMECARE

OCTOBER 19 | 5:30-7:00 PM
VENTANAS, ATLANTA

Funds from Stand Up for Homecare are helping communicate the HME value proposition and raise awareness of the extraordinary contributions by suppliers in protecting patients and reducing stresses on hospitals and clinicians during the COVID-19 pandemic.

Register today to support the campaign.

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HME Business · HME News · HomeCare · mobility management

Check 100 on index.

The window for providers to begin submitting their reports opened July 1.

- They can compare actual 2019 revenue to actual 2020 revenue.
- They can compare budgeted 2020 revenue to actual 2020 revenue. To use this option, providers must prove that a budget was created and adopted by the reporting entity's appropriate corporate officer(s) before March 27, 2020.
- The provider can choose an alternative reasonable methodology. If selecting this method, a provider will submit their alternative methodology for calculating lost revenues, and HRSA will review the proposed methodology using their own discretion and will notify a reporting entity if their proposed methodology is not considered reasonable. The review process will consider whether the proposal demonstrates with a reasonable certainty that claimed lost revenues were caused by the pandemic. If HRSA determines that a reporting entity's proposed alternate methodology is not reasonable, the entity will be asked to resubmit their report within 30 days using one of the other two methods outlined above.

There are two recent developments with the HHS PRF. First, for funds received during Period 1, the deadline remains Sept. 30, 2021. However, HRSA has announced a 60-day grace period for providers who cannot attain compliance by Sept. 30. Those providers will have 60 days to become compliant; if they fail, they will face recoupment of the PRF funds they received.

Second, on Sept. 10, 2021, HHS announced that a fourth phase of funding would be available to providers beginning Sept. 29, 2021. At press time, there were very few details available as to whether the funds would be available to all provider types in all areas. Certain provider types have been excluded from specific phases in the past. For example, in Phase 3 of the PRF, HME providers were excluded from eligibility, even though they were included in Phase 1 and Phase 2. What is known is that in Phase 4,

there will be $25.5 billion dollars available to providers, and that the funding is intended to go to:

- providers who serve rural Medicaid, Children's Health Insurance Program or Medicare patients
- providers who can document revenue loss and expenses associated with the pandemic
- providers who serve vulnerable communities
- providers who operate on thin margins and often serve vulnerable, isolated and/or rural communities

Phase 4 payments will be based on providers' lost revenues and expenditures between July 1, 2020, and March 31, 2021. More details should be available in October, and you can find those as well as all other PRF program details online at hrsa.gov/provider-relief.

Medicare Advance Payments

Much like the HHS PRF, the Centers for Medicare & Medicaid Services' COVID-19 Accelerated or Advance Payment (CAAP) program was created in response to the public health emergency. For this program, however, providers had to apply to receive funds, which are not forgivable and therefore must be paid back. For more information on this program, please visit cms.gov/medicare/covid-19-accelerated-and-advance-payments.

Repayment Timeline:

- Repayment begins one year from the issue date. For the first 11 months, Medicare payments owed to providers will be recouped at a rate of 25%.
- After those 11 months, Medicare payments owed to providers will be recouped at a rate of 50% for the next six months.
- After 17 months, if there are still funds that have not been recouped or repaid, the provider will be notified that the remainder must be repaid within 30 days. If the provider fails to do that, 4% interest will begin to accrue.

Please make sure you are doing everything you can to remain in compliance with the programs outlined above so that you can continue to care for the patients you serve. HC

Craig Douglas currently serves as vice president of payer and member relations for VGM & Associates, where he focuses on helping providers navigate payer relationships, as well as addressing other market forces that impact VGM's broad range of members. Douglas previously served as vice president of provider relations for VGM's Homelink division, where he built and fostered relationships with payers and providers across the country. Douglas has been with VGM since 1999.

Benefits Too Big to Miss

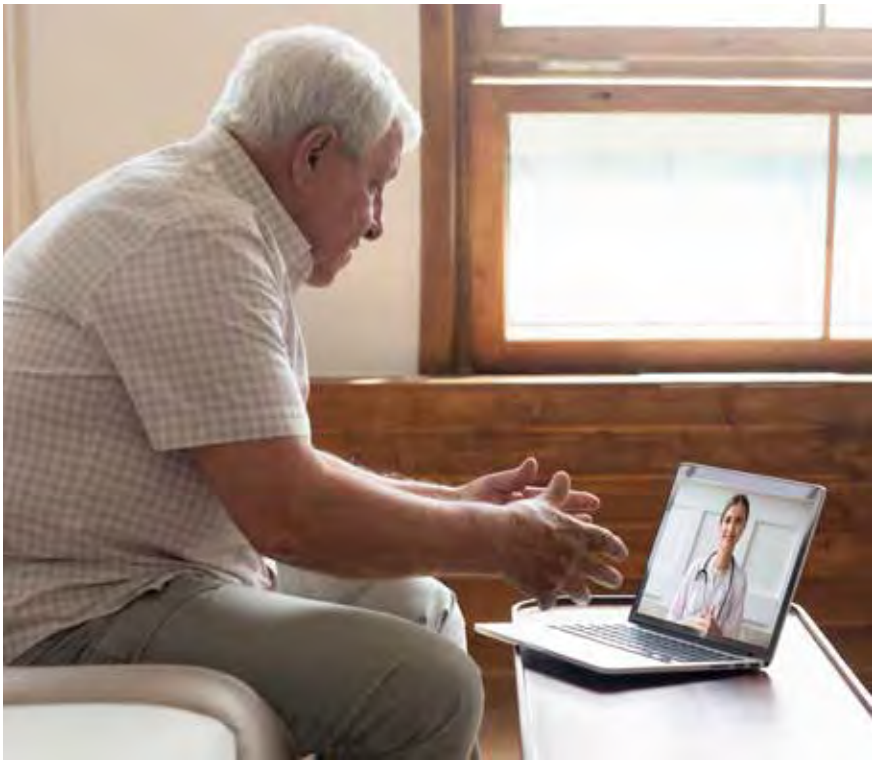
Why you should integrate your telehealth & ERP systems

By Ty Bello

What are the essentials of strong telehealth and enterprise resource planning (ERP) systems for the post-acute care industry? What benefits must providers look for, and how should a telehealth platform and ERP platform be integrated together?

In a June 2021 article in HomeCare, I discussed the benefits of telehealth for the complex rehab industry. But providers from across the post-acute care industry—including home health, hospice, home medical equipment, complex rehab, infusion therapy and occupational, speech and physical therapy—are all investigating opportunities to adopt telehealth.

Consider your own health care consumer journey. It wasn't all that long ago that you made appointments with your physician or other care professionals via a landline phone and received appointment reminders the same way. Today, patients can (and do) interface with medical providers via text, cellphone, email and web-based portals. The advances in this arena have been tremendous over a short period of time. Today, telehealth has the same potential for speedy development and adoption, especially since the COVID-19 public health emergency has increased the creation and execution of technology.



At press time, national association sources have shared that members in both the House and Senate have said that discussions about telehealth policy are taking place and that telehealth remains a priority on the Hill. Legislation is expected soon, but there is nothing definitive yet. The Expanded Telehealth Access Act (HR 2168) is still on the table; this legislation authorizes physical and occupational therapists as practitioners for telehealth beyond the public health emergency.

Features & Benefits of Telehealth

The evolution of telehealth is unfolding before our eyes. The benefits vary slightly among post-acute providers but are generally centered around the patient and those charged with care. A telehealth platform should maximize patient interaction and the impact of care. Features must produce benefits for both provider and patient. Providers can use telehealth for assessments, evaluations, followups, compliance and education.

As you consider a telehealth platform for your organization, review its capacity to provide remote scheduling for appointments. Today, the scheduling of appointments is predominantly handled by providers, but as telehealth expands into home health, physical therapy, speech therapy, ocupationtal therapy and more, the need for patients to be able to self schedule will become a reality. If the platform you are looking at does not offer this option today, ensure that it can expand in the future.

There must also be support for low bandwidth and slow internet. The ability to work from a mobile hot spot or a dial-up connection in rural areas is critical. The platform should demonstrate these capabilities, but the provider must also qualify both the patient's bandwidth and internet connection before any telehealth call to avoid care issues.

The post-acute space should also be able to store some level of patient history. This will be an advantage for those who are seeing a patient multiple times for therapy and treatment management.

Integrate Telehealth With Your ERP

Having the ability to integrate telehealth with an ERP system will produce additional long-term benefits to the provider, patient and payer source. Some of these benefits include reduced health care costs, increased speed of diagnosis and treatment, increased patient compliance, reduced readmissions and increased communication along the continuum of care. The practicality of this sort of ERP and telehealth integration seems like a natural progression. The combination of these workflows will also impact patient satisfaction.

This integration would give clinical staff a patient engagement framework in which information gathered would integrate seamlessly back into the ERP. The ERP workflow would then take hold of this interaction and carry it through the workflow process.

The post-acute care industry does not currently share enough about its process with referral sources. Telehealth is something new that providers can offer in tandem with direct patient care. This is valuable information to share with referrers. As your team of sales professionals engage the referral community, remind them about the second phase of sales: partnering with the referral community for improved outcomes. The fact that homecare providers can offer telehealth is a differentiator for those who have already adopted this patient communication platform.

But providers need to do more than just inform partners that they are providing telehealth. Because some may see it as just the latest buzzword in post-acute care, a referral source may dismiss your efforts. Sales professionals who know the process can speak to how telehealth actually benefits the patient and their family and how the referral source will capture market share. Do not put yourself in the "me-too" box of providers. Educate and train your sales team to truly understand the nuances of integrated telehealth and how it makes a difference in patients' lives.

Select the right telehealth platform to integrate with your ERP. Then, make sure the referral community has a clear understanding of the capabilities and how this will impact the referral process and patients' lives. HC

Ty Bello, RCC, is the president and founder of Team@Work, LLC. He is an author, communicator and registered coach. Contact Bello at ty@teamatworkcoaching.com or visit teamatworkcoaching.com.

Don't Break Your Back

6 tips to help you move your patient without injury

By Jon Winer & Amy Villars

While patient handling and mobility activities such as lifting, transferring and repositioning are fundamental components of health care at home, they are fraught with the risk of injury to both caregivers and patients. Providing care in the home can be physically demanding for both the caregiver and the client. And the home setting presents special challenges for home health care providers who are caring for clients with compromised mobility.

The Risks of Transferring Patients at Home

A care provider may need to perform many types of transfers depending on a patient's medical condition and mobility level. Examples include helping a patient move from a wheelchair to a bed, chair, toilet or car—and back. Other types of transfers involve assisting someone from a bed to a walker or lift, in and out of a chair, and getting in and out of a bathtub or shower. It may also be necessary to reposition a client in their bed or chair.

Home health care workers may not have access to the safe patient handling support available in hospitals and long-term care facilities. For example, many facilities have designated "safety champions" or "lift champions"—peer leaders who can address handling challenges and are available to assist with patient transfers. In the home setting, a care provider must often conduct transfers alone and may resort to using manual force by pulling or tugging the individual, which can be painful for the client and cause injury to the caregiver. Unsafe patient handling techniques can also lead to fall injuries and shear or friction injuries to a client's skin.

Pivoting a patient is easier with a slide sheet. Images provided by Inovi Healthcare.

Reducing the Risk of Injury

Using appropriate patient handling equipment and techniques can prevent injuries in the home setting. There are many devices available to assist with patient transfers. Here are six common transfer situations and the tools that can best help:

1 Edge of the Bed

Moving a patient to the edge of their bed so they can get up can be a difficult task. It is imperative to avoid tugging on the client's arms or allowing them to pull on yours. Using a slide sheet facilitates this process and avoids strain or discomfort. A slide sheet is a slippery tube-like device that reduces friction between the patient and the mattress. The caregiver places the sheet under the patient's hip and heel, and in one smooth movement, pivots the individual to the edge of the bed.

2 Bed to Walker—Higher Mobility

Patients with greater levels of mobility can benefit from a nonpowered sit-to-stand lift. This device allows clients to pull themselves up to a standing position from a bed, chair or toilet. A removable footplate enables the client to walk with the device. They can also hold onto it while lowering themselves into position, and it has a padded seat that can be used if the person becomes tired when walking and needs to

A sit-to-stand lift reduces fall risk.

A bed rail system can help patients self-tranfer into or out of bed.

sit down. A nonpowered sit-to-stand lift increases mobility and reduces fall risk.

3 Bed to Recliner & Back—Medium Mobility

A power sit-to-stand lift system is an option for those who are 30% weight bearing or more and can be very useful for those who need just a little extra help getting to a standing position. You can even use this device with a client who is a single amputee.

To begin the transfer, place the sling around the person's waist and connect the sling straps to the sling hook. Press a button, and with no effort you can help the patient stand. Then you can wheel the person to the chair or toilet and lower them into a seated position. Using a powered sit-to-stand lift alleviates the discomfort that normally occurs when pulling a person up by holding them underneath their arms and tugging them awkwardly.

4 Bed to Wheelchair & Back—Very Limited Mobility

A total mobile lift system safely moves clients with very limited mobility from one surface to another. Simply place a sling underneath the person and attach the sling to the mobile lift. The device lifts the patient up, and the caregiver can roll the device with the individual to the wheelchair, chair or bed and then lower them with a press of a button. This technique provides a comfortable and safe transfer for both the individual and caregiver. With heavier individuals or carpeted floors, the total mobile lift may be too difficult to roll. In this case, another—although much more expensive—option is to mount a lift in the ceiling, through wall mounts or on four posts to facilitate transfers.

5 Toileting & Bathing

Getting on a toilet seat can be easier with a nonpowered lift. This device, which looks like a dolly, is used to wheel the patient into the bathroom. The patient can hold onto the lift to sit down and stand back up. For those with more mobility, grab bars or poles may be enough. For patients with less mobility, raising the seat height or using a powered lift seat can be helpful. Grab bars and poles can also be used for getting into a bath or shower. Alternatively, a shower chair can be used to wheel the client into an accessible shower or use a lift device to help them walk into the shower and sit on a shower seat.

6 Repositioning in a Bed or Chair

The best way to reduce repositioning transfers is to decrease how often a client slides down in their bed or chair. One-way slides, which have friction in one direction, are ideal for preventing patients from sliding down in chairs. For a bed, there are satin sheet systems that work similarly. There are also slide sheets that are slippery in all directions to help.

7 Car Transfers

Getting in and out of a vehicle can be challenging. There are floor lifts that are designed for this purpose, but they are expensive. A pivot pad can also be placed on the seat to help the client spin while swinging their legs into and out of the car.

A total mobile lift safely moves patients with very limited mobility.

Meeting the Needs of Clients With Compromised Mobility

For patients who face daily challenges with movement from one place to another, there are a range of patient-handling products that are appropriate for each phase of the mobility curve. These devices increase the client's ability to manage these activities more independently and greatly diminish the risk of injury to both patients and their caregivers.

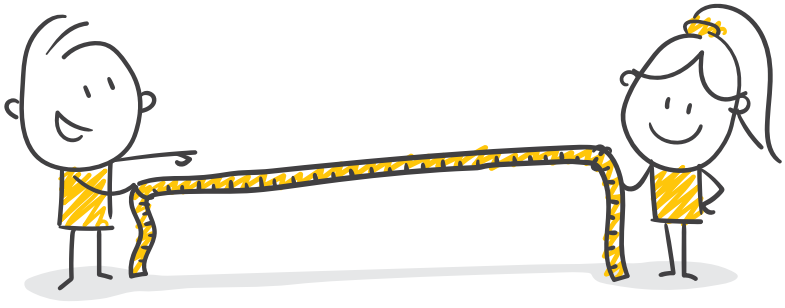
Since the level of mobility can range from simply needing a walker to requiring more assistance—up to and including total assistance—the products recommended should change accordingly. HC

Jon Winer is the president and founder of Inovi Healthcare. Amy Villars is the vice president of clinical services and general manager of Inovi Healthcare's Barrier Free Division. Winer and Villars both have decades of experience working with health care organizations large and small across the country to make care as safe as possible for patients and those providing care. Inovi Healthcare is a safe patient handling company that serves the acute care, long-term care and homecare industries. Visit inovihealth.com.

Don't Take a Wrong Turn

How route planning software can help your agency increase revenue

By Steve Milroy



During the past decade, home health care providers have taken their share of financial hits. Operational costs are continuing to rise and Medicare reimbursement rates are not keeping up with inflation. The aggregate fee-for-service (FFS) Medicare margin for freestanding home health agencies was 15.8% in 2019, according to the Medicare Payment Advisory Commission; however, margins ranged from 3% to 24.5%, with larger agencies clearing higher profits.

These monetary pressures make it even more necessary to find cost-effective ways to reduce operating costs and increase revenue. Route planning software is one of the best ways to accomplish this goal—and it's a must for several reasons.

Homecare nurses, aides and therapists drive 4.8 billion miles per year to reach home-bound patients, according to a National Association for Home Care & Hospice study. Home health care companies must reimburse workers for mileage when they use their own cars to get to patients due to a tax law change in which workers can no longer write off mileage. And fuel costs comprise 60% of home health care companies' annual fleet operating budget.

Given the tremendous amount of driving involved in operating a home health care business, route planning software is an absolute necessity for cost-conscious home health care business owners and managers.

What Is Route Planning Software?

Route planning software is a tool that quickly generates the most efficient routes for home health care workers visiting homebound patients.

Optimizing a route with route planning software is a simple three-step process:

1. Upload or input the addresses of the day's patient visits.
2. Click the "Optimize" button.
3. Once the route has been generated, it can be printed and/or exported to a driver's smartphone or tablet and configured with turn-by-turn navigation.

Improved Operations

Significant benefits occur when home health care companies deploy route planning software, including:

- *Saved time for office staff*—Route planning software generates the most efficient route in a few minutes. When home health care company managers optimize routes manually, it often takes several hours per day.
- *Reduced fuel costs*—Route planning software generates more efficient driving routes, which reduces the number of miles driven. This helps reduce fuel costs, which are the biggest expense of operating a fleet.
- *Reduced labor costs*—More efficient routing means drivers spend less time driving each day. Nurses, aides and therapists can get to their patients faster, which can reduce overtime costs.
- *Reduced carbon emissions*—The homecare industry adds significant carbon emissions into the atmosphere because it's so driving intensive. The use of route planning software is one of the most affordable ways to reduce a home health care company's carbon footprint.
- *Mileage reimbursements that are more accurate*—Route planning software documents the number of miles that will be driven for a given route (i.e., the day's round of patient visits). This

data helps home health care managers ensure that mileage reimbursement claims are accurate when home health care workers are using their own vehicles.

- *Reduced vehicle maintenance costs*—When you cut back on the miles needed to get patients visited, it takes longer between oil changes or new tires.
- *Reduced risk and accidents*—The less time employees are on the road, the lower the odds of getting into an accident. In addition, optimized routes can be exported to a driver's cellphone for turn-by-turn navigation instructions. This reduces distracted driving because homecare professionals can keep their eyes on the road, instead of reading instructions or a map.
- *Increased revenue potential*—More efficient routing helps create opportunities to handle more patient visits per week and increase revenue.

How to Evaluate Routing Software

There are a lot of route planning software options on the market—and the pricing models can be confusing. Here are some tips to make sure you're not spending too much:

1 Look for a flat-fee solution.
The most affordable route planning software pricing model is when you pay one flat fee to use the software. In contrast, many route planning software options charge by the vehicle, so the software will cost more as you expand operations, add more workers and increase the size of your fleet.

2 Seek out simple pricing.
Some route planning software providers have pricing models that are so complicated, it's hard to tell what you'd really be paying per month. Choose a software provider with a simple, straightforward and clear pricing model that you understand.

3 Compare the functionality you get at various price points of the software.
Some companies charge a subscription fee and you get all the functionality of the route planner for that price. Other companies have "starter" offerings with a low monthly price, but you don't get the full software capabilities. Make sure you understand what functionality is available at the various price points.

The demand for home health care services is continuing to grow at a time when financial challenges for the industry continue to increase. As a result, it's imperative that home health care company owners and managers deploy some form of route planning software to mitigate these effects. HC

Steve Milroy is the president of OnTerra Systems, the developers of RouteSavvy—powerful, affordable route planning software. He can be reached at stevem@onterrasystems.com or routesavvy.com.

Is Your Agency Headed for Boom or Bust?

Checking in with 2023 planning initiatives

By Gary Patterson

Is your homecare agency positioned for a boom or destined for a bust? How ready are you to meet the highest priority requirements by the end of the year 2023, as targeted by a survey of your peers at the January 2020 Care Coordination Technology Healthcare Summit? Winners of the race to better value-based patient care will reap true competitive advantages; unfortunately, losing organizations may not survive.

This article expands on the information in "How to Evaluate and Improve Your 2023 Patient Outcomes" from HomeCare's August 2019 issue and the June 2020 follow up, "3 Priorities to Focus on as You Prepare for the Future." Regardless of all the inevitable distractions—including and especially COVID-19—standing still is not an option when you face the hindsight judgments of an ever-growing group of second guessers.

In 2019, a 2023 deadline from your peers would have seemed an eternity away. But these insights offered a rare opportunity for well-positioned, well-led organizations to lap the competition and seize the lead in value-based patient care. You will soon get your 2023 boom-or-bust grade.

Boom or Bust?

If you boom, Your agency gets the improved patient outcomes you wanted when you chose a career in health care. Mandated improvements are methodically and relentlessly driving improved patient care. If you boom, patients will choose your agency for better, less-expensive care. You'll retain medical staff, and you can poach workers from competitors who are falling short. You will be able to negotiate better contracts with non-Medicare payers. These are the outcomes your stakeholders expect.

If you boom, patients will choose your agency for better, less-expensive care. You'll retain medical staff and you can poach workers from competitors who are falling short.

A bust can involve a failure to meet expected scores on patient quality outcomes, plus the related financial incentives and penalties. This could lead to an organization going out of business, being acquired or falling dramatically behind as patients move to better-ranking competitors. At a minimum, your patients will migrate to where they get better-quality care for less money, your best staff will move to where they have better tools to serve health care needs, and you may lose out on entry into payer networks.

Avoiding the Bust

As always on crucial, yet nonurgent issues, people normally fall into three categories: strategic-thinking leaders; leaders driven by the crisis of the moment, with different agendas or underfinanced organizations; and procrastinators. Let's look at how you can easily evaluate where you are, where you want to be and what options you can create for your agency.

This article will focus on three key points that will help agency owners tackle the top areas of concern for the 2023 target:

- The suggested procedures and policies you need to have in place and in practice by year-end 2023;
- Where you stand on those objectives today; and
- How you can you create options now—plus which of the three areas of concern you should primarily focus on to get as close to those 2023 targets as possible.

Top 3 Areas of Concern for 2023

Participants at the 2020 Care Coordination Technology Healthcare Summit suggested three crucial areas where most organizations need to significantly improve:

- Increased "hospital-at-home" and virtual care availability for longer periods
- Improved "build-versus-buy options" to reduce departmental silos and islands of data
- Expanded focus on the social determinants of health (SDOH)

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HOMECARE & HOSPICE
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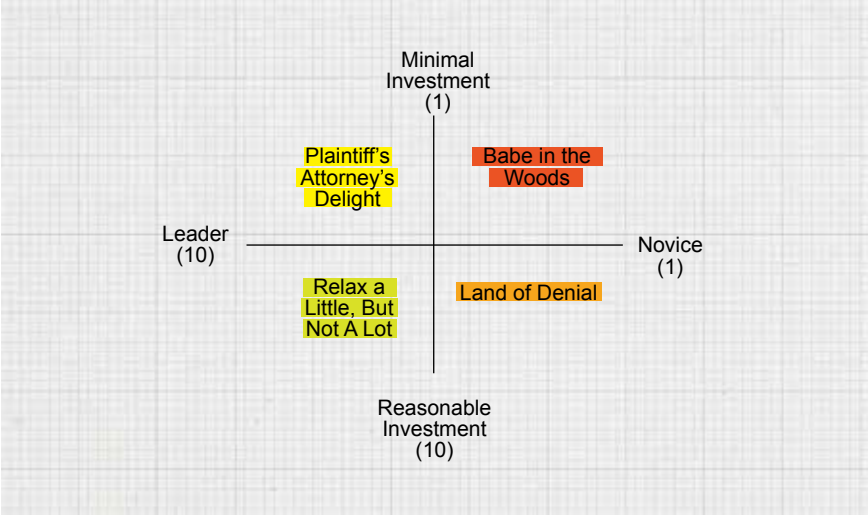
Learn more at **www.nahc.org/membership**

Home Health Awareness Versus Investment



Where You Stand

Using this two-minute exercise, assess where your organization is today in each of the three critical areas, and then where you need to be by 2023. To provide a tool for that evaluation, I updated the Home Health Awareness versus Investment process and four quadrant visual.

1 Mark your answers for each area on the two axes in the graphic.

For "Awareness," rate your organization on the horizontal continuum from Leader to Novice (one to 10, where one means your head is in the sand, and 10 means you are ahead of schedule and building in a margin of error). Then do the same for "Investment," marking your answer on the vertical continuum from reasonable investment to minimal investment.

Draw a line between these two points to spotlight your current position and suggest where to begin your strategic review.

2 Rinse & repeat.

For each of the three areas, repeat the steps above and determine what quadrant status you can reasonably achieve by the end of 2023.

3 Calculate your current status versus your end of 2023 requirements.

Acknowledge this status to top management and your board of directors, and begin moving toward your new targets for value-based delivery.

If you are one of the fortunate few whose knowledge and actions have put you well ahead in addressing risks and opportunities, use these steps to determine your present situation and unearth your next opportunity. If you are not so lucky, consider how you can best move forward. Whatever your position, you now have an estimate of your 2023 ranking—and you have pinpointed the most crucial improvements needed.

Finally, to help you get moving, consider the following next steps based on where your organization ranked on the 1–10 scale described above:

- ***1–2:*** If you haven't even started, you will be ruthlessly second guessed, probably well before 2023. Take some baby steps and regroup.
- ***3–6:*** If you have started but probably won't get there without investing additional resources of people and money, get your sponsor or advocate more deeply involved or get external expert support.
- ***7–10:*** If you are well under way, keep the pedal to the metal. Someone will be the winner in providing better patient support, and they will have the ability to exploit their hard work and leadership to acquire the laggards' best people, patients or even their organizations. Why not be that winner?

Take Your Medicine

Tough news is never easy to give or receive. Nor is cod liver oil easy to take, Vicks VapoRub easy to apply or a healthier diet easy to maintain. But the benefits explain why those products and services sell year after year. Personally, none of those are my favorites. Yet depending on the year, how bad I feel or what my medical experts tell me to do, I take those unpleasant yet appropriate prescriptions.

You still have time to get started on the effective improvements that need to be in place by 2023. Take advantage of your limited time rather than procrastinating. Your actions will benefit your patients as well as your organization (and maybe even save your job or the job of a colleague).

Remember that standing still is not an option: You can dodge the bust by avoiding inertia. Keeping your focus on the three top issues above, make sure your organization will be well positioned to meet the increased demands of 2023—and be rewarded with a boom. HC

Gary W. Patterson is CEO of fiscaldoctor.com. He helps health care leaders make more money by creating opportunities and keep more of their money by reducing risk so they can make better decisions.

NEW ON THE MARKET

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

1

1 Medical Alert System

ALOE CARE

Aloe Care's service delivers a voice-activated, in-home medical alert and communication system for older adults and caregivers. The service improves safety for seniors and makes connection and care collaboration intuitive and easy. Aloe Care includes a patented smart hub for live, two-way, hands-free communication and smart sensors to detect falls, motion, air quality and temperature. Users have 24/7 access to a professional emergency response team and a family app for care collaboration. Visit get.aloecare.com.

Check 200 on index.

2

2 ProCare Optima

APEX MEDICAL

The ProCare Optima is a dynamic pressure redistribution alternating air mattress that comes with a pump that inflates the mattress in less than 15 minutes. The mattress includes an auto-sensing feature that automatically initiates the pressure settings with its one-touch setup. It provides the ideal pressure based on the patient's weight distribution. The mattress is equipped with patient-focused attributes like multi-zone air pressure redistribution, heal relief, micro-air loss, microclimate management and more to improve perfusion in at-risk or damaged soft tissues. Visit apexmedicalcorp.com.

Check 201 on index.

3

3 The Back Bandit Pro

DOCTOR IN THE HOUSE

Many existing back brace products rigidly immobilize the back, but tightening a brace around the waist and abdomen constricts blood flow and circulation, altering one's ability to digest and process food. The Back Bandit Pro brace system offers dynamic step-down bracing that allows the user to gently move in a protected way in order to heal without becoming stiff or causing the rest of the body to abnormally adjust for the rigid brace. As the patient heals, panels can be removed until they are wearing only a simple lumbar support wrap. Visit docinthehouse.com.

Check 202 on index.

4

4 Rosie 2.0

SIMPL TECHNOLOGY

Rosie 2.0 has been called the Alexa or Google Home for seniors. It's a SiMPL Technology solution for memory loss patients and their caregivers. Rosie 2.0 is a talking alarm clock that allows family members and/or caregivers to record reminders in their own voices to remind memory loss patients to take their medication, eat meals, keep important appointments and more. One three-month study found that Rosie helped patients with poor medication compliance improve to 80% compliance. Visit simpltc.com.

Check 203 on index.

EXERCISE & REHAB

1 Protone

AQUA CREEK

The Protone is an affordably priced commercial-quality fitness machine designed to allow people with disabilities to independently gain strength and stay fit and healthy. It allows the user to perform resistance strength training without assistance from others, helping them to become stronger—and stronger means easier and safer transfers, position adjustments, chair movements and daily activities. The sliding and hand crank adjusts with no-grip locking knobs, and the handles allow for easy manipulation and adjustment to accommodate almost any user. Visit aquacreekproducts.com.

Check 204 on index.

2 GAP-FLEX

GAP-FLEX

The GAP-FLEX system provides 50% faster results with 90% less time on device for patients recovering from total knee arthroplasty and other knee injuries. It was recently issued a Medicare code, so patients with any insurance have the chance to recover quickly in the comfort of their own homes. A gentle approach to knee therapy gives patients the chance to avoid costly treatments and extensive physical therapy and to achieve clinical results in the process. Patients can track progress in the mobile app. Visit gap-flex.com.

Check 205 on index.

3 OmniTrainer Active & Passive Exercise Trainer for Arms or Legs

HEALTHCARE INTERNATIONAL

The OmniTrainer is portable and can be used with either a standard chair or a wheelchair. It includes a height-adjustable upper body section, ergonomic U-shaped handles, extra-wide pedals, adjustable cranks and oscillating calf supports to help securely fit users at various ability levels. The workout report function allows users to track their progress, displaying total time, total distance, number of spasms, percent active versus passive training and percent left versus right power at the end of the training session. Visit hcifitness.co.

Check 206 on index.

4

4 KneeWell

KNEEWELL

The KneeWell device is a United States Food and Drug Administration-registered, patented rehab device engineered to assist patients with post-arthroscopic knee surgery contractures. It is classified as a low-load, prolonged stretch device and assigned the capped rental HCPCS code E1811 for reimbursement of up to 13 months of use. The device is easy to use, lightweight and durable, making safe knee therapy at home easy. The device helps patients reduce pain and can be used immediately to assist patients with regaining lost range of motion. It helps them to recover more quickly and regain freedom to walk again by increasing mobility. Visit kneewell.com.

Check 207 on index.

5

5 GOxCy 30

HEALTHPEDAL

The HealthPedal GOxCy 30 is designed for indoor or outdoor use. The user's legs are engaged in a smooth cycling movement at a walking pace through indoor hallways. The cycle is rugged enough to use outdoors on smooth walking tracks. The 2021 HealthPedal GOxCy 30 has no-flat tires and quickly folds for easy storage when not in use. Visit pedalwheelchair.com.

Check 208 on index.

6

6 VibraCool

PAINCARELABS

VibraCool provides hospital-quality, drug free pain relief for muscles, joints and post-surgical pain in an easy-to-wear compression wrap. After surgery, stroke, overuse or injury, the device's patented M-Stim focal muscle vibration technology increases blood flow, lowers inflammation and is more comfortable and effective than electronic stimulation or TENS. Combined with unique freeze-solid ice packs for inflammation, VibraCool provides pain relief on contact. Available in four configurations to target upper/lower extremities, feet, and neck/hip/back. FSA/HSA eligible. Visit paincarelabs.com.

Check 209 on index.

POWER CHAIRS

1 Aviva Storm Rx

INVACARE

The new Invacare AVIVA STORM RX Power Wheelchair with the Ultra Low Maxx Seating and Positioning System was developed with the customer experience in mind and brings new features to enhance the user, provider and clinician experience. The AVIVA STORM RX is targeted for users who travel outdoors but also need maneuverability indoors. It is intuitive to drive and is an easy transition for people who move from a manual wheelchair to a power wheelchair. Visit rehab.invacare.com.

Check 210 on index.

2 Vision Sport

MERITS

The Vision Sport is Merits' flagship product. Powered by MK Battery, the Sport is rated for up to 18 miles per charge to allow your clients to enjoy all facets of life. This customizable power chair is meant to not only meet but to exceed the needs and expectations of your clients. Available options include a power seat lift. Visit meritsusa.com.

Check 211 on index.

3 Jazzy EVO 613 Series Power Chairs

PRIDE MOBILITY PRODUCTS

The new Medicare-reimbursable Jazzy EVO 613 has a narrow base width of only 22 inches. The Jazzy EVO 613Li model is lithium enabled, featuring 25% less charging time and 25% more range. Both chairs in the series feature a depth-adjustable, limited-recline comfort-style memory foam seat that swivels for greater access. Other series highlights include mid-wheel drive, a three-inch ground clearance, maximum speeds up to 5.1 miles per hour, 13-inch mid-wheel drive tires, Pride's patented Active-Trac Suspension and removable matte-finish color shrouds. Visit pridemobility.com.

Check 212 on index.

PERS & HOME MONITORING

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 featuring personal emergency response systems (PERS) and home monitoring providers. Here and on homecaremag.com/buyers-guide, you can find the essentials to help your business thrive. HC

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Freeus
Farr West, UT
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freeus.com

GrandCare System
West Bend, WI
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grandcare.com

GreatCall
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independa.com

LifeStation
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lifestation.com

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(800) 519-2419
logicmark.com

Medical Guardian
Philadelphia, PA
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medicalguardian.com

MobileHelp
Boca Raton, FL
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mobilehelphealthcare.com

ResponseNow Medical Alert Systems
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ADVERTISERS

Advertiser Name	RS#	Page
AAHomecare		45
Assured Comfort	❑ 128	7
Aurora Manufacturing	❑ 101	49
Board of Certification/ Accreditation	❑ 102	27
Brightree	❑ 103	5
Brownmed	❑ 104	25
CAIRE	❑ 108	1
Centratel	❑ 109	49
Centratel	❑ 110	63
Costcare/Integrity United	❑ 114	23
Dignity Lifts	❑ 112	63
Dynarex Corporation	❑ 113	13
KayserBetten	❑ 115	63
Mac's Lift Gate Inc.	❑ 116	53
Masimo	❑ 117	BC
Medtrade		43
MES	❑ 119	38
National Association for Home Care & Hospice		55
National Seating and Mobility	❑ 121	31
Parks Health Products	❑ 122	30
Philadelphia Insurance Companies	❑ 123	IBC
Philips	❑ 134	3
Proactive Medical Products	❑ 125	32
Ruby Slipper LLC	❑ 126	40
Shipp Cleaning Systems	❑ 127	63
Sunset Healthcare Solutions	❑ 129	39
Tactical Back Office	❑ 130	IFC
TeamDME!	❑ 131	11
The Compliance Team	❑ 132	9
TIMS/Computers Unlimited	❑ 111	28
Tranquility	❑ 124	53
Universal Software Solutions Inc	❑ 133	37

PRODUCTS

Company Name	RS#	Page
Aloe Care	❑ 200	57
Aqua Creek	❑ 204	58
Apex Medical	❑ 201	57
Doctor in the House	❑ 202	57
Gap-Flex	❑ 205	58
Healthcare International	❑ 206	58
Healthpedal	❑ 208	59
Invacare	❑ 210	60
Kneewell	❑ 207	59
Merits	❑ 211	60
PainCareLabs	❑ 209	59
Pride Mobility Products	❑ 212	60
SiMPL Technology	❑ 203	57

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- ◯ 19 Sales/Marketing Rep, Mgr, Dir
- ◯ 20 Other *(Please Specify)* _____

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

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- ◯ 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
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MARKETPLACE

Making Some Noise

Homecare user & health care activist explains why HCBS are so vital

By Kristin Easterling

A tracheostomy takes away most people's voice. But not Ady Barkan's.

Barkan, the co-founder of the Be A Hero political action committee, has dedicated his life to advocating for progressive health care legislation and for all Americans to receive the care they need at home.

In 2016, at the age of 32, Barkan received a diagnosis of amyotrophic lateral sclerosis (ALS) and was told he had three to five years to live. About a year later, he confronted former Arizona Sen. Jeff Flake on an airplane about a tax bill that Barkan believed would limit vital health care services. He filmed the encounter—and it went viral.

Be A Hero is named for his plea to Sen. Flake, and he is still working to amplify personal stories, even though he can only speak with an assistive device. Recently, he has been arguing for the inclusion of homecare in the federal infrastructure bill. He is also getting attention for a documentary on his life, called "Not Going Quietly," which is showing in select theaters and will air on PBS in January.

"Without in-home care, I probably would need to be in a nursing home to stay alive. And, to be honest, I don't know if that would be a quality of life that I would be willing to tolerate," Barkan said in an interview with HomeCare. Leaving home would separate him from his wife and two young children.

He and his family are able to pay out of pocket—about $9,000 per month, even with insurance—for his care, which includes a 24-hour team of caregivers. But, the activist said, almost 1 million disabled children, adults and seniors sit on waiting lists for Medicaid's home- and community-based services (HCBS). The federal government currently requires states to fund nursing home care for everyone eligible, but there is a patchwork of requirements for HCBS eligibility and funding.

That waiting list is one reason Barkan and the Be A Hero organization are pushing for Congress to include HCBS measures in its final budget.

"We're seeing such strong support for homecare from Democrats because they realize it's not only critically necessary, but also incredibly popular," Barkan said. According to a poll from Data for Progress, 77% of voters, including 66% of Republicans, support fully funding home- and community-based care.

Barkan expressed his appreciation to Rep. Debbie Dingell and Sen. Bob Casey for championing the Better Care Better Jobs Act (see page 12 for more details). He has also been a long-time advocate of Medicare for All, an expansion of the Medicare program to all Americans championed by Sens. Bernie Sanders and Elizabeth Warren, among others. Under the expanded system, he said, home- and community-based services would be required to be covered and prioritized over institutional care, eliminating the patchwork there is today.

"In the richest nation in the history of the world, we can afford to provide every senior and disabled person with the care they need to live safely and with dignity," Barkan said. "And in the future, I hope this right is guaranteed to all." HC

Kristin Easterling is managing editor of HomeCare magazine.

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Check 123 on index.

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[1]Hasani A et al. *Chron Respir Dis*. 2008;5(2):81-86. [2] Roca O et al. *Respir Care*. 2010;55(4):408-413.

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