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How oxygen providers are learning to transform in a market in flux

BY JOSEPH DUFFY

In an industry unsettled by cuts, caps and competitive bidding, portable oxygen, with its lower service costs and higher level of patient independence, is the North Star from which many providers are guiding their oxygen business. But it's not without its challenges, as providers try to figure out how to adapt to a model some call a radical transformation of the industry.

"The portable oxygen market is at the beginning phase of a radical transformation," says Scott Wilkinson, Executive Vice-President, Sales & Marketing, Inogen. "It's clear that the new non-delivery modalities, whether we look at home transfill products or portable oxygen concentrators, offer lower total service costs and a higher level of patient freedom and independence. It simply doesn't make sense to continue to deliver portable oxygen when technology solutions are commercially available."

The value proposition of Portable Oxygen Concentrators (POCs) has been that a POC is a self-generating oxygen system, explains Chris LaPorte, product marketing, portable oxygen concentrators, Invacare. A POC takes room air and through an electro-chemical process strips away the nitrogen that you get from room air to deliver concentrated oxygen to someone who needs supplemental oxygen. There is nothing that ever has to be refilled, radically slashing costly delivery overhead. The therapeutic benefits might be massive, but so is the positive impact to the bottom line.

"Before it used to be done exclusively by filling tanks with concentrated oxygen," he says. "Now the technology exists where the separation of nitrogen from room air can take

place in a device that doesn't have to store it. It makes it as it goes along. Where as all those tanks had to be delivered from a provider to a patient before, now essentially you have one delivery with a few maintenance calls.

"It's not even remotely close to the same sort of operational costs associated with what you have today," LaPorte continues. "And that doesn't mean that patient care is any less — it just mean you can focus your efforts from sending drivers out with nothing but oxygen tank redeliveries and refills on a net day-to-day basis to caring for patients, looking in on them when they need it, making sure the preventative maintenance is being done, and checking that they are following their oxygen prescription regularly."

Sam Jarczynski, President, Rx Stat Inc., is a provider who has embraced POCs in his oxygen business since they were first available. For him, it's been a viable business model. He says that many providers have been shortsighted in not incorporating POCs in their business.

"The POC market is growing as more providers start to adapt to the technology of non-delivery," Jarczynski says. "The biggest challenges to overcome are the national companies



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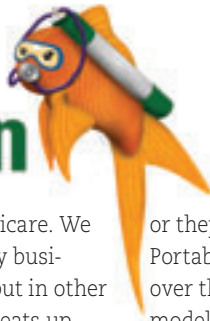
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telling physicians that POCs are not covered by Medicare. We hear this time and time again. I see the non-delivery business model continuing to expand, not just in POCs but in other models as well. As competition in the POC market heats up, prices are continuing to drop. As the POC prices drop, providers will start to compare POCs to cheaper systems, such as the Invacare Homefills and Respironics UltraFill."



"Providers are struggling to convert their businesses from a 'labor intensive' delivery model to a 'capital asset' non-delivery model.."

- Scott Wilkinson, Inogen

Oxygen Challenges

Although highly touted by providers and manufactures, POCs, along with the oxygen industry in general, are certainly not without challenges. From competitive bidding to reimbursement cuts to preparing a business for a new model, many providers are struggling on how to best cope with so many factors.

"Providers are struggling to convert their businesses from a 'labor intensive' delivery model to a 'capital asset' non-delivery model," says Wilkinson. "The transformation requires an investment in the future — a difficult proposition when credit markets are tight and the future is uncertain. Competitive bidding makes this transformation more essential — it's virtually impossible for providers to absorb 30 percent or more reimbursement cuts without radical business change, but at the same time the uncertainty surrounding competitive bidding makes investment in the future difficult for many providers to swallow, particularly smaller providers."

Ultimately, says Wilkinson, whether through competitive bidding or other means, oxygen reimbursement will be reduced and will drive business model change to non-delivery products. Once providers know they are in the game for the long term, they will make the necessary investment in the future

"We see patients being more involved in their healthcare today and wanting to move forward with their lives ... For providers, this is an opportunity for retail sales of POCs."

- Jay Vreeland, Philips Respironics, Home Healthcare Solutions

or they simply won't be able to compete with those that do. Portable oxygen concentrator demand will continue to grow over the next three to five years, as the industry adopts a new model. Manufacturing costs and prices for POCs will continue to come down as volume increases.

The POC has matured and taken hold as a primary as well as secondary source of oxygen used in treating the needs of patients who seek freedom and flexibility over older technologies, says Ron F. Richard, CEO and President, SeQual Technologies. He says the focus in the future of homecare related to POC systems will be targeting an FiO2 that maintains adequate saturation levels for patients that are highly ambulatory and need consistent levels of oxygen to avoid hypoxic events.

"Recidivism and 'bounce back patients' suffering from COPD will require discharge planners in the medical centers to work closely with homecare providers to reduce the percentage of patients being readmitted 30 days post admission or the medical centers will assume the expenses related to those readmissions," says Richard. "Educating patients on the various elements of their disease using the best technologies to improve outcomes and reduce bounce back will take a priority in the next few years.

"Many medical centers are endorsing and utilizing portable oxygen systems to encourage patients to ambulate and resume normal daily activities in order to alleviate problems often associated with COPD, such as depression, hypertension and shortness of breath during exertion, sleep, altitude or at rest," he continues. "This is coupled with their pulmonary rehab programs and working in cooperation with their respiratory care teams in order to give the patient a better overview of treatment options and the importance of remaining adherent with using their oxygen therapy. POC devices are a natural fit in the evolution in the care of COPD and their adoption should continue to increase over the next two to three years."

For manufacturers, POC challenges are often technical.

LaPorte says that the No. 1 challenge for all manufacturers is the reliability of the products. POCs are basically a computer that is making oxygen and patients' active lifestyles can put the device at risk of rough handling. LaPorte points out that because the POC is over someone's shoulder it is being set down and being pulled through all sorts of elements. In that regard the reliability issue is probably the toughest one that all manufacturers have to deal with on a day-to-day basis as they try to make devices that are robust.

"We are already light years ahead of where we were when these devices were first introduced in 2003 and 2004," says LaPorte. "You are already seeing devices that have had the bugs worked out of the software and kinks worked out of the internal workings, so they are already becoming a popular

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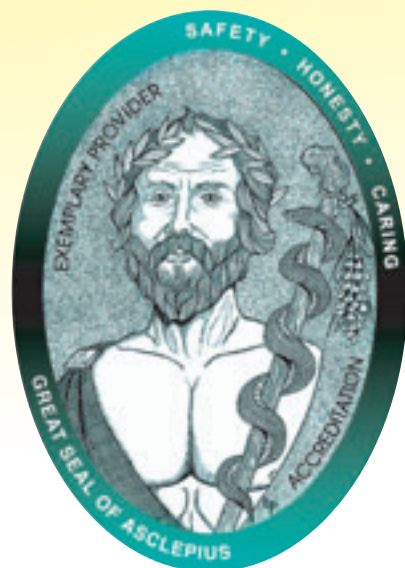
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alternative. You've also seen the cost of these devices come down significantly. And that's made them more accessible and popular for people."

Although POCs have been around for about eight years, Wilkinson feels that widespread adoption of POCs is just getting started, so the jury is still out whether they have been successful yet.

"Providers have experimented with POCs over the last three years, most using them as part of their travel support and retail strategy," says Wilkinson. "But experimentation in these areas has helped providers understand and confirm patient demand for this product category, and understand the difference between a good POC and a bad one. We are just beginning to see providers use POCs as their everyday asset for daily portable use."

Richard says he has seen the greatest success in transitioning to non-delivery models using POC technology in vertically integrated healthcare models or in geographies that challenge the economics of the providers. As providers become more familiar with POC devices they begin to develop both clinical and business cases that incorporate a number of key metrics that enable them to set the patient up on the best solution from the start, thus reducing costs and seeing positive improvements in patients care, as well as their profit margins, he says.

At the end of the day, says Jarczynski, providers are most worried about competitive bidding.

"If competitive bidding goes forward, it will put many providers out of business," he says. "It is a bad program that will eventually fail but in the meantime patients and providers will suffer. Oxygen reform is unfortunately on the back burner until competitive bidding is resolved. My opinion is that the entire oxygen payment methodology needs to be reworked. CMS pays too much for stationary equipment but not enough for portable equipment. The portable component is where the provider incurs cost. I do not anticipate any oxygen reform other than reimbursement cuts as a result of the failure of competitive bidding."

Competitive bidding creates a situation where providers

don't know if they will be in the game in the future and such uncertainty makes it difficult to invest in new technologies and business changes today that would drive down their own service costs, says Wilkinson. Once providers know they are in the game, they can make the necessary investments to transform their business.

The Rental Cap

Another challenge is the 36-month cap, which Jarczynski calls one of the worst policies that CMS has ever implemented.

"We get calls all the time from patients who have moved to Florida from another state and their providers cannot service them," says Jarczynski. "We also see patients who are getting zero service from their current providers once they get 24 months or more into their rental cap. The patients want to change providers but cannot find anyone to take them on. The 36-month cap hurts good providers in that they have to service these patients without any reimbursement from CMS. As the patient gets further into the cap period, their disease is progressing so equipment need and service need requirements actually go up. The patients are suffering and the providers are suffering."

Richard points out that the 36-month cap has been in effect now for over 12 months and providers are making adjustments in order to meet the demands of these changes.

"The statistics continue to indicate that a greater and greater number of patients will live beyond the 36-month cap and use oxygen," he says. "Obviously POC devices will meet the demands of the patients that are traveling more with oxygen and reduce delivery costs to almost zero during the 36-month cap and beyond. As patients demand more from their providers due to lifestyles associated with the 'baby boomer' generation, the ability to use oxygen in various settings will increase the need to provide LTOT options that not only maintains the standard of care but also aligns with the economics in the competitive bidding environment."

According to Wilkinson, providers by and large have weathered the storm brought on by the 36-month cap.

"At its core, it's a fancy way to reduce reimbursement, just like competitive bidding," he says. "The repeal of the ownership transfer provision, which was originally part of the 36-month cap, has made this program a lot easier to swallow. The 9.5 percent reimbursement cut that went into effect in January 2009 has had more of a negative impact on providers than the 36-month cap. This cut reduced the reimbursement for every single patient on day one. The cap only affects the minority of patients who are still on service after 36 months."

"Unfortunately, the 36-month cap has had a negative impact on patients. Existing patients are routinely denied access to new technologies that could improve their daily quality of life because the cap makes it financially difficult to impossible for a provider to make such an investment for their current patients."



"The provider is forced to lower their service levels in order to make money in declining reimbursement environment. The patient is the one who suffers in the long run."

- Sam Jarczynski, Rx Stat Inc.

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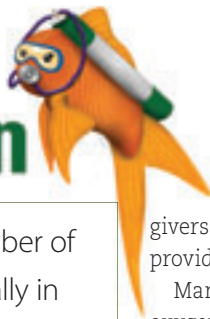
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"If you look at the number of oxygen patients annually in the U.S. in terms of net growth there are probably 2 percent

to 3 percent on average people per year ... The question is how do you profitably service that segment?"

– Chris LaPorte, Invacare

We are contacted daily by patients who would like the freedom of a POC but they are nearing the 36-month cap end-point. Providers simply can't afford the investment when they won't be reimbursed for it after the cap."

Listening to patients

Many of the interviewees for this article commented about the savviness of patients and their ability to research their oxygen concerns. Today's patients are more active into their later stages of life, and independence becomes very important. POCs offer patients the ability to do things other oxygen methods cannot.

"The portable oxygen market continues to grow as patients look for more options and greater portability in their oxygen therapy," says Jay Vreeland, director of marketing for North America, Philips Respironics, Home Healthcare Solutions. "The current population of oxygen patients is being diagnosed earlier, is more active, and does not want oxygen therapy to limit their life. As a result, this market should continue to grow as more patients are being diagnosed earlier with conditions such as COPD, now the third leading cause of death in the United States.

"We see patients being more involved in their healthcare today and wanting to move forward with their lives. In particular, we see a lot of family members seeking out treatment options for their parents. Many times, patients and family care-



"POC devices are a natural fit in the evolution in the care of COPD and their adoption should continue to increase over the next

two to three years."

– Ron F. Richard, SeQual Technologies

givers choose POCs once they have evaluated the options. For providers, this is an opportunity for retail sales of POCs."

Many providers have their fingers crossed for some sort of oxygen reform that helps tip the scales of profitability.

LaPorte says that in regards to POCs, you are seeing a level of interest and inquiry from the patient side you probably haven't seen in other types of oxygen devices in recent memory.

"POCs in particular really lend themselves more to that type of retail sale where the patient is much more involved in researching the purchasing a lot more than what we've seen in the past," he says. "In a way it's exciting there is a product in the options category where patients seem to be driving a lot of the behavior in the market both from a technology standpoint as well as a quality and reliability standpoint. It's something definitely unique for this space and something we haven't seen before."

Jarczynski says he sees patients doing more research on oxygen equipment and demanding something other than the old-fashioned cylinder delivery model.

Portable O2 Outlook

For POCs, the future is optimistic. POCs are arguably the leading new product category in the portable oxygen market. And things will only get better as the technology is refined and cost reductions make POCs a mainstream, everyday device.

"At the core, oxygen therapy is still a growing market, says Wilkinson. "Net patient growth has averaged 8 percent to 10 percent consistently over the past decade. So from a patient demographics standpoint, we have a market with strong, consistent unit growth. On the reimbursement side, we have seen cuts that have offset unit growth so ultimately, while we have a unit growth market we don't necessarily have a dollar growth market.

"Certainly the level of cuts we saw in Round 1 Competitive Bidding offset three plus years of unit growth if implemented across the country," he continues. "Some providers have started being more selective regarding payors they will accept. They shy away from Medicare patients and try to forge relationships with other payors that provide better reimbursement opportunities, sacrificing unit growth in favor of higher reimbursement. Others have re-tooled their business to a newer, lower cost service model, and they take on patients that others don't want. We are certainly seeing cases where providers deemphasize Medicare patients, sacrificing share in favor of better profitability.

"But at the end of the day, any successful business has to improve efficiency, reduce costs and improve productivity," Wilkinson concludes. "Our industry is no different than any others and the laws of business apply — you simply have to do more with less."

According to LaPorte, from Invacare's perspective the

companies that they do business with that are successful today are the companies that recognize business was changing several years ago and got on board.

“Most of the providers who are successful today transitioned to a nondelivery modality for their oxygen business several years ago,” says LaPorte. “A lot of providers are shocked by the bids they saw in the nine competitive bid areas. They really wondered how certain providers were able to bid what they did. When you look at a lot of providers in those areas, those who moved to change their businesses away from delivering tanks several years ago and invested in all this technology that has now depreciated after three years, those are the people who are successful today. They are continuing to grow their business because their operational costs for doing so are just so much less than someone who supports the old way and that entire infrastructure that goes with having to do that.”

LaPorte says the providers that will continue to grow and survive are those who recognize having to move to a nondelivery modality.

“If you look at the number of oxygen patients annually in the US in terms of net growth there are probably 2 percent to 3 percent on average people per year who are becoming regular oxygen patients,” says LaPorte. “The market demand is there. The question is how do you profitably service that segment? The companies that are successful in doing that have embraced the newer modalities and abandoned the older ones. The tough part for a lot of providers is figuring how to get there because they have so much invested in the old infrastructure they’ve built up over the years. When you go to providers and say, look it’s tough to do this profitably anymore, the question they always have is: How much is it going to cost me to transition away from this and into newer technologies? And that scares a lot of people to not doing anything until it is too late.”

Those unable to weather the cuts and caps might turn down a different road.

“Post competitive bidding we will most likely see a decrease in the number of providers offering LTOT to patients due to decreases in reimbursement,” says Richard. “It has been documented and a well known fact that over 30 percent of the bids awarded to providers in the MSA areas are either bankrupt or insolvent and couple that with manufacturers now taking on the role of a home care provider will have a negative impact in the LTOT markets. Providers will shift from LTOT to other market segments that offer better margins and less stress to their businesses.”

As we turn the page on another year, perhaps the oxygen market can best be summarized by the first line to Dickens’s “A Tale of Two Cities”: It was the best of times, it was the worst of times. The best being the rise of technology in the form of POCs as an effective, low-cost approach that gives oxygen patients more freedom than ever before. The worst being the cuts and

caps forced on an industry faced with the need to change in order to survive.

“One of the problems I see today is that providers are simply fighting change and trying to preserve the status quo,” says Wilkinson. “We really need to come together as an industry, manufacturers and providers alike, and drive change that works for patients, payors, and us. Providers are holding out for clarity regarding the future. I do think we will see some kind of trade or compromise regarding reimbursement in exchange for repeal of the 36-month cap, at least I hope so. If we could repeal the cap, patient access to new technologies would no longer be limited, and providers could better plan for the future. It would also eliminate a lot of administrative burden regarding cap management, and would better match cash inflows to actual service costs.” □

Joseph Duffy is a freelance writer and marketing consultant, and a regular contributor to HME Business and Respiratory & Sleep Management. He can be reached via e-mail at jduffy@hmemediagroup.com or jduffy@prooferati.com.

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RT Vital Signs

By Joseph Duffy

Our latest survey takes the pulse of respiratory therapists

Therapists seem to be coping with the 36-month cap on oxygen reimbursement, but as competitive bidding is set to rear its ugly head, respondents worry about the fate of their industry.

Last year's exclusive survey on respiratory therapists gave these embattled professionals a forum to tell it like it is in an industry that focuses on providing strong clinical care for more patients even while cuts and caps plague their companies. This year, with reimbursement issues and competitive bidding leading a charge of concern, *Respiratory & Sleep Management* once again takes the temperature of dedicated professionals facing arguably some of the industry's toughest challenges to date.

WHO RESPONDED

Some quick facts about the breadth of respondents for this survey: Respondents work in the main regions of the United States. The East makes up about 31.4 percent of respondents, followed by the Midwest (30.8 percent), the South (25 percent) and West (12.8 percent).

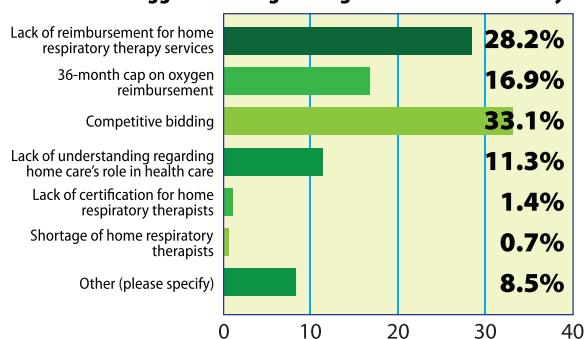
Of these survey takers:

- 31.5 percent devote 10 percent to 25 percent of their time to oxygen therapy, where 3.1 percent devote none
- 25.2 percent devote 26 percent to 50 percent of their time to sleep therapy, where 5.5 percent devote less than 10 percent
- 41.4 percent devote less than 10 percent of their time to asthma therapy, where less than 1 percent devotes more than 90 percent
- 46.1 percent devote none of their time to ventilation therapy, where less than 1 percent devotes 50 percent to 75 percent

YOUR BIGGEST CHALLENGES

Topping the chart as the single biggest challenge you feel faces the home care industry is competitive bidding (33.1 percent). Interesting to point out: Last year's survey revealed your biggest challenges as lack of reimbursement for home respiratory therapy services (28 percent) and the 36-month cap on oxygen reimbursement (24 percent). For 2011, lack of reimbursement stayed a strong concern at 28.2 percent while the

What is the SINGLE biggest challenge facing the home care industry?



36-month cap on oxygen reimbursement as the single biggest concern fell to 16.9 percent.

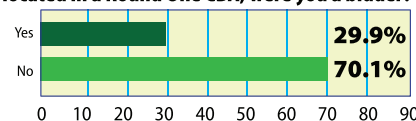
For one respondent, the biggest concerns are “the short sightedness of the people in the industry and focusing on the immediate problems and not becoming a part of the broader solution, which is the complete integration of healthcare delivery to the patient starting in the primary care setting, and working with the hospitals and post acute care facilities and agencies to provide to the patient a seamless delivery of services and care with out regard to turf battles and special interests.”

Another survey taker puts all the blame on competitive bidding: “Competitive bidding has stopped us from being able to compete in homecare. We cannot make money or be reimbursed for all our Medicare patients.”

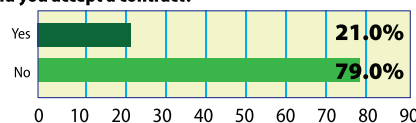
BIDDING ON THE FUTURE

Although the competitive bidding program was created allegedly to reduce fraud and costs regarding DMEPOS reimbursements, it has caused a titanic wave of concern to wash over the home care industry, as highlighted in this year's survey. Many experts say it has put the home oxygen industry in serious jeopardy.

If located in a Round One CBA, were you a bidder?



If you were a Round One bidder, were you offered and did you accept a contract?

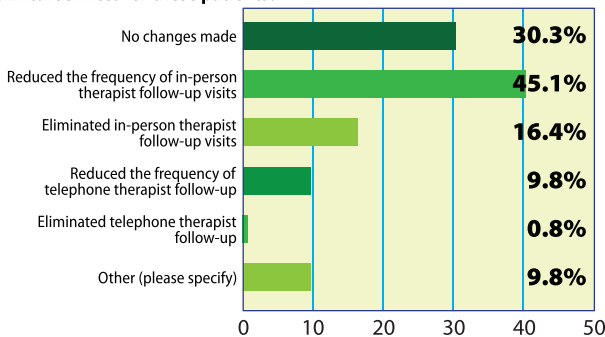


Survey takers were asked if located in a Round One CBA, were they a bidder? Of our respondents, 29.9 percent answered yes and 70.1 percent said no. And of those who were Round One bidders, 21 percent said they were offered and accepted a contract, where 79 percent said they were not.

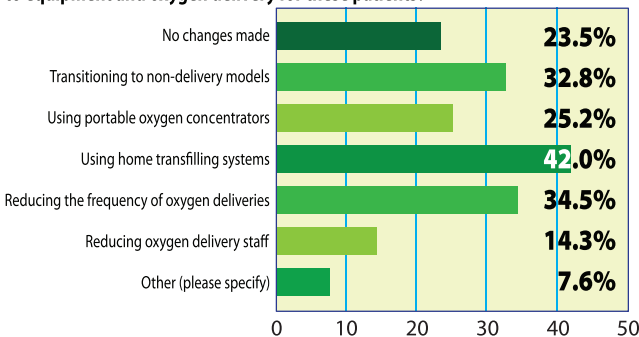
AS THE CAP TIGHTENS

According to a comparison of last year's and this year's surveys, the 36-month cap on oxygen reimbursement dropped as a concern, but not without causing changes to the practice of about 70 percent of respondents. Leading the list of repercussions from the 36-month cap was reducing the frequency of in-person therapist follow-up visits (45.1 percent), similar to last year's survey result of 46 percent.

How has the reimbursement cap changed your company's approach to clinical services for these patients?



How has the reimbursement cap changed your company's approach to equipment and oxygen delivery for these patients?



"Patients remain on a therapist visit schedule until capped, then go on a maintenance schedule, unless the RT deems visits remain necessary for certain patients," explains a respondent. Another respondent has dealt with the cap by eliminating extra products they would give to patients to help with their oxygen therapy. And in a drastic measure, one respondent said, "I left the home care arena and jumped ship to the physician's side of care."

When asked how the reimbursement cap changed your company's approach to equipment and oxygen delivery for these patients, 42 percent of respondents said they are using home transfilling systems. Last year, 50 percent of respondents said they reduced the frequency of oxygen deliveries, where in 2011, only 34.5 percent said they reduced the frequency of oxygen deliveries.

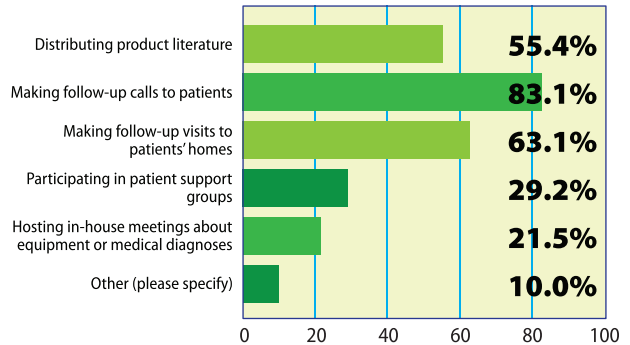
IT'S ALL ABOUT THE PATIENT

Regardless of the hurdles and roadblocks peppering the industry, the biggest industry concern is patient care and a big

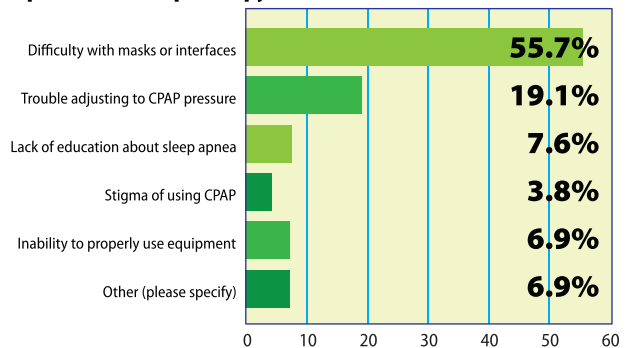
part of that is figuring how to create better patient compliance.

By an overwhelming margin, the primary barrier to patient compliance for sleep therapy is difficulty with masks or interfaces (55.7 percent). This was also the biggest barrier named in last year's survey (61 percent). Coming in second is trouble adjusting to CPAP pressure (19.1 percent).

What methods do you employ to address or improve patient compliance?



In your experience, what is the PRIMARY barrier to patient compliance for sleep therapy?



"Pressure issues are big," said a survey taker, "but so is working against the clock. Medicare's time requirements are sometimes a barrier, not allowing patients with other medical conditions that prevent them from tolerating PAP therapy quickly."

The stigma of using CPAP grew from 1 percent last year to 3.8 percent this year, and may be related to what one respondent observed:

"They [sleep problem patients] do not really feel that their sleep problems are really that bad and that sleep therapy will help."

A few respondents addressed the problem of patient laziness or a lack of motivation to comply with their treatments. Another said the No. 1 barrier is a lack of proper patient education, which leads us to our next question: What methods do you employ to address or improve patient compliance?

Like last year, making follow-up calls to patients ranked No. 1 at 83.1 percent as the top method used for patient compliance. Second was making follow-up visits to patients' homes (63.1 percent) and then distributing product literature (55.4 percent), up from 44 percent last year. □

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saving Jim

How a bilevel rescue transformed a difficult patient's compliance

By Joseph Duffy

What happens when you're faced with a sleep patient that just won't comply? Sometimes, you have to completely rethink your treatment. That's exactly what happened with Tracy Kinlaw. Kinlaw is a Respiratory Therapist from Advocate Home Health Services, who also helps as a CPAP liaison at the Arlington Heights Sleep Laboratory. She recently worked with a patient named "Jim," who had severe trouble staying awake during the day and staying alert at his job.

Jim is a 41-year-old male with Downs Syndrome, and Obsessive Compulsive Disorder. He saw a sleep physician because his family recognized his symptoms of daytime fatigue, diminishing job performance, and weight gain. They were familiar with these signs and symptoms because five years prior, Jim was diagnosed with sleep apnea.

The sleep technicians tried to work with him, but, unfortunately, due to his Downs Syndrome and OCD, he was unable to tolerate Cpap. As a result, the doctor ordered Jim to have a tonsillectomy. The surgery worked to help his sleep apnea for a few years. Now, five years later, his daytime tiredness was back in full force, and the family was very concerned and wanted help.

A Second Look

Jim came into the Sleep Center to be re-evaluated. The physician recommended that he have a polysomnograph. A PSG is an overnight sleep study that records a patient's sleep patterns, breathing, heart activity, oxygen levels and limb movements during sleep.

The tests and expert opinion concluded that Jim's sleep apnea returned and he was considered severe, with an AHI (apnea-hypopnea index) of 98. Jim was having shallow breathing or stopped breathing 98 times per hour. At this point the sleep technicians worked with Jim to get him comfortable with the CPAP mask and machine so he would be able to tolerate the CPAP titration study.

During this study Jim would sleep with the CPAP mask and machine and technicians would titrate the levels of pressure to find Jim's ultimate pressure to keep his airway open and maintain safe oxygen levels. Jim did much better this time and the CPAP titration study was successful. An urgent order was sent to Advocate Home Health Services to set up Jim on a ResMed Auto CPAP set at 16-20cwp.

A New Solution

Jim had many difficulties becoming compliant with the CPAP therapy. He lives in a group home and has limited

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help with working with the CPAP. After 60 days on CPAP therapy he was at 5 percent compliance, which meant he wasn't wearing his machine and wasn't feeling the relief he should be feeling.

It was decided to change his therapy and do a bi-level rescue. Jim was put on ResMed's VPAP (variable positive airway pressure) AUTO, which delivers two levels of pressure and tends to be more comfortable for the patient. His settings on the VPAP auto were 20/10cwp with a pressure support of four. This type of therapy is meant for difficult patients that have a hard time tolerating higher pressures on CPAP.

After 60 days on his new bi-level machine, Jim's compliance skyrocketed to 73percent compliance.

Jim was feeling all the benefits of his VPAP machine. He felt more awake and alert, and his concentration improved at work and at home. Even his weight improved. After treatment Jim started to feel the benefit of more energy, which led him to weight loss. Before treating his sleep apnea with VPAP his BMI was 42.6 and after 60 days on treatment his BMI had dropped to 39.4.

Jim's story is an example of a true team effort. The sleep laboratory was very involved and worked together with Advocate Home Health to get this patient compliant, with the best quality of life. The patient and family came in for many doctor visits and respiratory therapists from Advocate Home Health went to the group home and worked with family members on many occasions for education on sleep apnea, education of the machine, mask fittings and positive reinforcement.

When Kinlaw first met the patient he was sleepy, tired, and didn't speak. On their last meeting she claims he was alert, smiling and happy to talk to her. Jim referred to his treatment as "a pain in the butt," but added that he knows it helps him at work to be awake and help other people. □

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