BLUEGRASS Oxygen

"Improving Lives One Breath at a Time"

Readmission Reduction Program

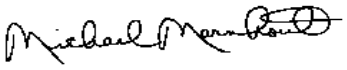
October 2014

Contents

Our Commitment

We at Bluegrass Oxygen are committed to preventing COPD/CHF readmissions, now and in the future for your patients. With the ever changing landscape of healthcare and insurance requirements, we understand that it is imperative that we extend our educational/professional services and include facility discharge follow-up assessments that will address reducing your costly readmission rates. This is accomplished by our use of a dedicated, licensed team of nurses and respiratory therapists. We ask that you give us the opportunity to demonstrate the expertise and quality of care synonymous with our company. We invite you to visit our website to learn more about Kentucky's only nationally recognized award winning respiratory company. Bluegrass Oxygen was honored nationally in 2005 and again in 2012 as our industries "Best Home Oxygen Company". No home medical company in Kentucky, locally owned or national chain, has ever won this prestigious award. We look forward to caring for your patients.

Respectfully,



Mike Marnhout
President/CEO

"We are Kentuckians caring for Kentuckians"

SECTION I: The BGO Readmission Reduction Guide: Overview

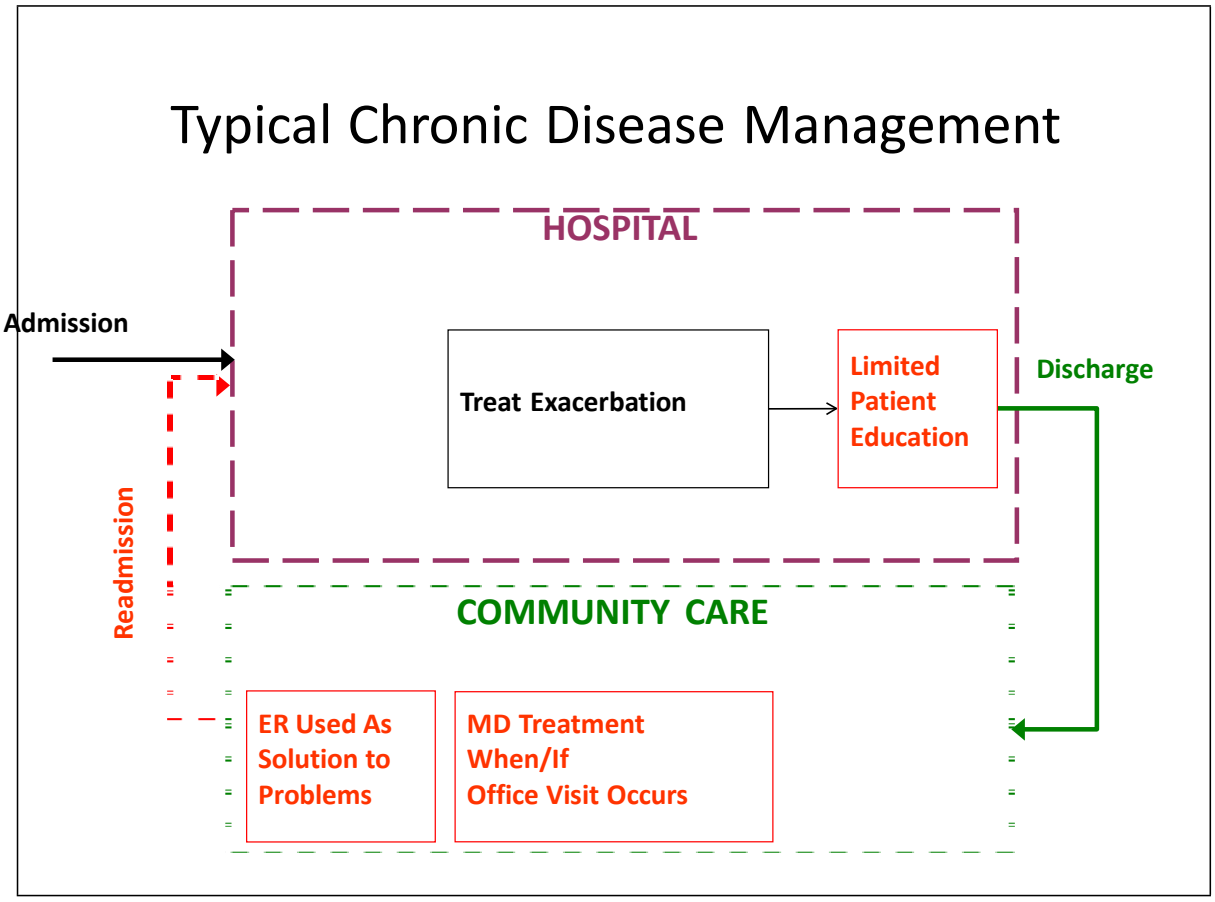
Background

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154). Excess Readmissions are measured by a ratio, by dividing a hospitals number of "predicted" 30-day readmissions for heart attack, heart failure, pneumonia and COPD by the number that would be "expected," based on an average hospital with similar patients. A ratio greater than 1 indicates excess readmissions.

Readmission rates have increased in many hospitals across the United States, including some of the country's most elite academic medical centers, new research shows. About one in six Medicare patients now return to the hospital within 30 days of being discharged for a medical condition. Many of these readmissions may be preventable. Although Medicare readmissions are higher, the problem is not limited to the Medicare population. The estimated annual financial impact of 30-day readmissions for Medicare alone is $17 billion. Medicare penalized a record 2,610 hospitals nationally in its third year of fines totaling 428 million dollars. Reston Hospital Center and Fauquier Hospital in Warrenton, VA were among 39 hospitals in the country to receive the maximum penalty: a 3 percent cut in payments for every Medicare patient admitted from this month through September 2015. Not only are hospitalizations among the most expensive forms of health care, but inpatient stays increase the risk of acquiring healthcare-associated infections. Further, there is evidence that the hospitalization itself can contribute to a further deterioration in patient health status, particularly for older patients. The negative impact on patient quality of life and the huge burden on the healthcare system have made reducing hospital readmissions a central goal of healthcare delivery and payment reform efforts.

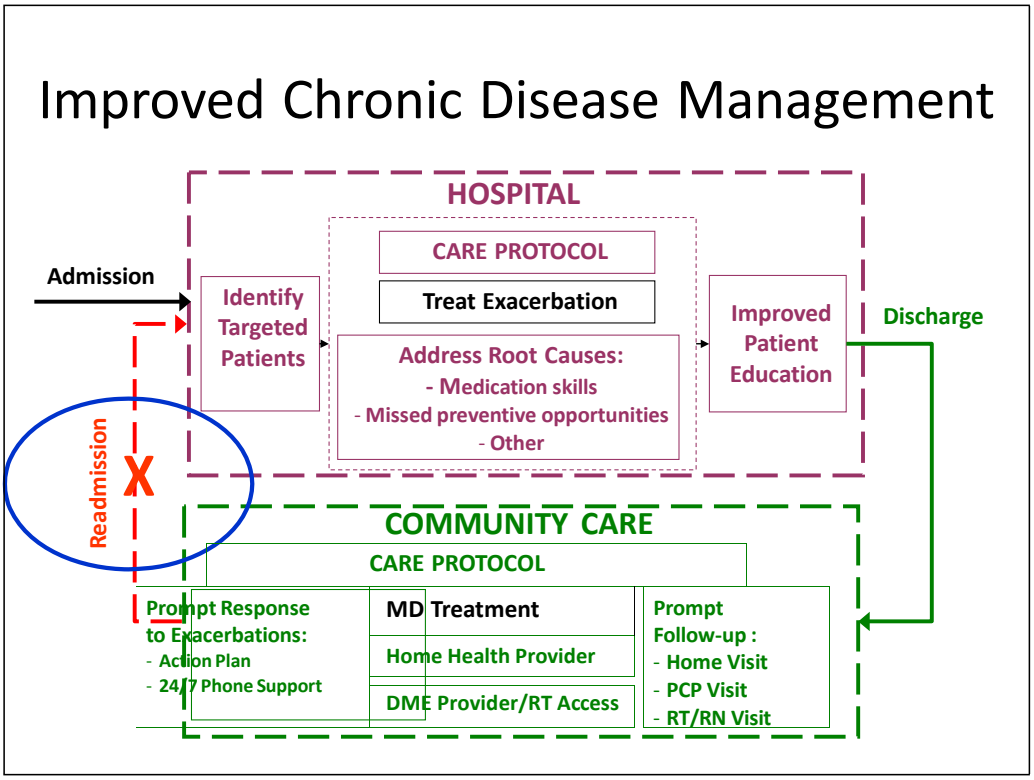
Abundant evidence indicates that improving the processes of care – particularly for patients with chronic diseases – can reduce avoidable hospitalizations. The typical management of a patient's chronic disease, along with the ensuing cycle of admissions and readmissions, is sketched out in **Figure 1**. This figure describes the process for individuals who are admitted to the hospital and treated for a serious exacerbation of a chronic condition. At the hospital, the patient's condition is treated and medications adjusted with the primary goal of getting the patient well enough for discharge. Often rather than addressing the factors that caused the admission in the first place; the patient normally receives limited education during his/her hospital stay about self-care after discharge that could prevent further exacerbations and hospitalizations; the patient is discharged with prescriptions for medications that may differ from the medications they were given during the hospital stay and which may not match the medications they used prior to the hospital admission; there is often no formal hand-off to his/her community care providers or coordination to determine whether or not compliance with the hospital's recommended treatment regimen is even possible; finally, the patient may or may not visit their primary care physician for a post-discharge appointment, and there is typically no follow-up by the hospital itself. When subsequent exacerbations arise, the Emergency Room is the typical solution. "It's very important that patients and health care providers communicate clearly so that all questions are answered and everyone understands what will happen when the patient leaves the hospital," Dr. Risa Lavizzo-Mourey, President and CEO of the Robert Wood Johnson Foundation in Princeton, New Jersey.

Figure 1



Most current readmission reduction initiatives focus on improving the transition of patients from hospital to community. The readmission penalty program compels hospitals to prioritize efforts to improve transitions and reduce readmissions. **The unique aspect of hospital readmissions is that their causes can potentially span multiple providers along the whole continuum of patient care.** A readmission may be due to something which does or does not occur in the hospital, or it may have little to do with factors the hospital can control, such as inadequate care in the community (e.g., DME provider, Home Health, Physical Therapy, etc.) after discharge. With these issues in mind, an improved chronic disease management process is depicted in **Figure 2**. Note that there are multiple opportunities to improve care along the entire continuum.

Figure 2


Improved Chronic Disease Management
HOSPITAL
CARE PROTOCOL
Treat Exacerbation
Admission
Identify Targeted Patients
Address Root Causes:
- Medication skills
- Missed preventive opportunities
- Other
Improved Patient Education
Discharge
Readmission
X
COMMUNITY CARE
CARE PROTOCOL
Prompt Response to Exacerbations:
- Action Plan
- 24/7 Phone Support
MD Treatment
Home Health Provider
DME Provider/RT Access
Prompt Follow-up :
- Home Visit
- PCP Visit
- RT/RN Visit

SECTION II. Critical Elements of Reducing Readmissions

While the Bluegrass Oxygen Clinical Team will focus on problems and solutions that are not only identified in the literature, but also specific to the needs of the partner organization(s), there are two aspects of successful readmission reduction that are critical and should be part of any readmission reduction effort: care management and patient engagement. Both are described herein.

Clinical Care Manager Home Visits

A major finding from research on reducing hospital admission and readmission rates for people with chronic diseases is that it is critical to provide focused patient education and an assessment of the patient in their home setting by a nurse or respiratory therapist in the days following hospital discharge. For example, care management using patient education by nurses or respiratory therapists over the phone has been shown to reduce hospital admissions by 40% and ER visits for exacerbations of COPD by 41%. Because clinical care managers (CCMs) can be so critical to preventing avoidable hospital readmissions, we feel it is imperative that the initial follow-up after discharge be in person in the patient's home rather than over the phone to further enhance patient compliance.

The CCM is a health professional, either a nurse or respiratory therapist, who makes initial contact with patient within 24-48 hours of discharge. The CCM should become an integral member of the primary care team with responsibility for:

- Identifying patients appropriate for visits after discharge;
- Educating patients (and families or caregivers as necessary) after discharge;
- Working with hospital staff, as needed, to understand what the patient will need after discharge;
- Visiting patients at home within 24-48 hours of discharge;
- Encouraging patients to arrange for and keep physician appointments within a week following discharge;
- Coaching the patient to be more healthy by going over their nutrition schedule, exercise program and medications

Patient Engagement

Once a suitable patient for the Readmission Reduction project is identified, it is important to take advantage of the unique opportunity for teaching positive compliance outcomes. Staff involved with care can initiate conversations about the patient's condition using relevant education material.

Patient Education Material

The quality of the education material is very important. The following patient education literature is items that BGO shares with its patients:

- The language used to explain the disease and its treatments are simple;
- There are visual depictions of important instructions;
- There is information included on common treatments and medications;
- There is space for patients to record important information, such as daily weight, blood pressure or prescription dosage and instructions;
- There are instructions on the day-to-day management of the disease;
- The education material includes a *Patient Action Plan* that patients can customize to include information such as physician contact information.

Patient Action Plan

The *Patient Action Plan* is the tool for helping the patient to understand and better manage their condition (See **Appendix A**). It is created by the patient with the assistance of a CCM during the 24-48 hour initial home visit. The plan includes:

- What the patient agrees to do to prevent exacerbations;
- Warning signs of an exacerbation;
- Clear instructions on when to call for help, whom to call and what to expect in response;
- Physician contact information

Post-Discharge Home Visits

Scheduled one to two days post discharge, the home visit provides an opportunity for the CCM to assess the patient's ability to cope in their home environment and to reinforce the instructions that were discussed with the patient while in the hospital. For example, the CCM will reassess patient understanding and use of treatments and equipment, and determine whether any additional care is needed. Together with the patient, the CCM can review the actions the patient has agreed to take to help prevent exacerbations, emphasize the early signs of an exacerbation and reinforce the importance of taking immediate steps as spelled out in the *Patient Action Plan* (see **Appendix A**).

APPENDIX A: COPD Patient Action Plan

COPD PATIENT ACTION PLAN: Page **1** of 3

Patient: _____ Care Manager: _____ Phone #: _____

ACTION PLAN GOAL: The patient/caregiver will use the tools/instructions that the COPD Care Manager has supplied, and to know when to call the physician's office/Care Manager when problems occur.

TRIGGERS THAT MAKE MY BREATHING WORSE:

1. _____

2. _____

3. _____

4. _____

WHAT I AGREE TO DO TO TRY AND AVOID THE ABOVE TRIGGERS:

1. _____

2. _____

3. _____

4. _____

I AM HAVING THESE ISSUES WITH MY RESPIRATORY MEDICATIONS:

1. _____

2. _____

3. _____

I WILL RESOLVE THE ISSUES WITH MY RESPIRATORY MEDICATIONS BY DOING:

1. _____

2. _____

3. _____

PATIENT ACKNOWLEDGEMENT

I, _____, agree to try and avoid the triggers that exacerbate my COPD, and resolve the issues I have with my respiratory medications.

_____ **Signature of Patient** (or Personal Rep*)

_____/_____/_____ **Date**

_____ *Name & Description of Personal Rep's Authority to Act for the Patient *(If Applicable)*

COPD PATIENT ACTION PLAN: Page **2** of 3

RESPIRATORY MEDICATIONS

Long-acting Bronchodilators – are medications used to provide control – not quick relief – of your COPD symptoms by opening the airways to the lungs. These medications are given either once a day or twice a day, every day. These are considered maintenance treatment of COPD to reduce disability, reduce exacerbation and improve quality of life. You may not feel any immediate effect, but if you don't use it every day, you'll be more likely to get an exacerbation.

Medication	Dose/Route/Frequency	Normal Side Effects	Call Physician if:

Short-acting Bronchodilators – are medications that relieve COPD symptoms very quickly by opening the airways to the lungs. They are sometimes referred to as 'rescue' inhalers or 'puffers' and are used regularly up to 4 times a day or just as needed. **FOR REMINDERS ON INHALER USE – REFER TO "HOW TO LIVE WITH COPD" BOOKLET.**

Medication	Dose/Route/Frequency	Normal Side Effects	Call Physician if:

Bronchodilators act as stimulants and have side effects such as **nervousness** and **agitation**. Some patients may experience these symptoms during the inhalation or immediately after the inhalation. Sometimes, these symptoms will resolve on their own within a short period of time, however, if this does not resolve **within 30 minutes** you or your caregiver will need to call the physician's office. The medication may need to be adjusted or possibly changed to a different type of respiratory medication. Your physician may prescribe oral anti-inflammatory such as Prednisone when your symptoms get worse (exacerbation). These are rarely prescribed on a permanent basis. This medication helps to relieve symptoms such as shortness of breath, cough and secretions. These are usually ordered as a taper dose and you must follow the directions by decreasing the dosing as ordered. Sometimes antibiotics may be prescribed for treating respiratory infections, take these as directed.

IF YOU NEED TO CALL THE PHYSICIAN'S OFFICE:

- ☑ Tell the office staff you are a COPD patient and your action plan says you need to call and make an appointment ASAP.
- ☑ Tell the staff member exactly what is the problem.

IF YOU CALL AFTER OFFICE HOURS OR ON THE WEEKEND:

- ☑ Tell the answering service that you are a COPD patient and you were instructed by the Physician's office and your care manager to contact them immediately if you are having any problems.
- ☑ If you do not receive a return call from the Physician within 30 minutes, call again.
- ☑ If you still have not received a return call within 2 hours, call your COPD Care Manager.

COPD PATIENT ACTION PLAN: Page **3** of 3

MANAGING MY COPD AT HOME

GREEN ZONE: ALL CLEAR

- **My respiratory goal of no increased shortness of breath over my baseline is met**
- **My breathing does not interfere with activity, movement or ability to enjoy life**
- **I am comfortable and proficient with administration of my respiratory medications**

GREEN ZONE MEANS:

- **Continue to use your respiratory medications as directed by the physician.**

YELLOW ZONE: CAUTION

- **Any increase in shortness of breath over my baseline of breathing**
- **Any increase in coughing or sputum production over my baseline (what normally happens on a daily basis)**
- **If my sputum changes color from clear white to dark yellow, brown or green**
- **If I develop a fever**

YELLOW ZONE MEANS:

- **Your respiratory status may be changing and you may need to take action.**
- **With any increase in shortness of breath, use your rescue inhaler (if ordered) and try the pursed lip breathing. If ordered, administer a nebulizer treatment.**
- **If symptoms persist and your breathing does not improve within 24 hours, call the physician's office, DO NOT WAIT and think the problem is going to resolve on its own.**

Physician's Phone #: _____

COPD Care Manager's Phone #: _____

RED ZONE: CALL 911 IMMEDIATELY

- **I feel as though I cannot breathe or have chest pain**
- **If my caregiver notices that I am confused and/or drowsy along with severe shortness of breath**

RED ZONE MEANS:

************CALL 911 IMMEDIATELY************

YOU NEED TO BE ASSESSED BY MEDICAL STAFF!

SMOKING CESSATION

IF YOU ARE CURRENTLY SMOKING IT IS EXTREMELY IMPORTANT THAT YOU QUIT. Cigarette smoke is the primary pollutant that can damage your lungs and is the leading cause of COPD. If you stop smoking, the decline in your lung function can be slowed or stopped and further disability may be avoided. There are several products on the market that do not require a prescription from the physician for smoking cessation. There are prescription medications that your physician can order for you. I encourage you to speak with your physician to see which product may be appropriate for you.

TRIGGERS TO AVOID

BE AWARE OF FACTORS THAT CAN MAKE YOUR SYMPTOMS WORSE AND TRY TO AVOID THEM IF THEY AFFECT YOU.

- **INDOOR POLLUTANTS –** cigarette smoke, household cleaning products, strong odors, animal dander/fur, burning fireplace and dust – QUIT SMOKING AND AVOID SECOND-HAND SMOKE, AVOID STRONG ODORS BY STAYING IN WELL VENTILATED AREAS, AVOID SLEEPING WITH YOUR CAT OR DOG IF YOU HAVE ALLERGIES.
- **OUTDOOR POLLUTANTS –** exhaust fumes, gas fumes, smog, pollen and cut grass – AVOID SMOG BY STAYING INDOORS.
- **EMOTIONS –** anger, anxiety and stress – IF YOU ARE STRESSED AND ANXIOUS, TALK TO YOUR FRIENDS AND FAMILY ABOUT YOUR FEELINGS, PRACTICE BREATHING AND RELAXATION TECHNIQUES PROVIDED IN THE COPD BOOKLET.
- **CHANGES IN TEMPERATURE –** extreme heat or cold, wind or humidity – WHEN IT IS COLD, DRESS WARMLY AND COVER YOUR NOSE WITH A SCARF, WHEN IT IS HOT, STAY IN AN AIR-CONDITIONED ENVIRONMENT IF POSSIBLE, DRINK PLENTY OF WATER UNLESS THERE ARE MEDICAL RESTRICTIONS, AVOID STRENUOUS ACTIVITIES AND WEAR LIGHT CLOTHING IN LIGHT COLORS AND A HAT.
- **RESPIRATORY INFECTIONS –** cold, flu, bronchitis or pneumonia – AVOID PEOPLE WHO HAVE A RESPIRATORY INFECTION SUCH AS A COLD OR FLU. WASH YOUR HANDS IF YOU ARE IN CONTACT WITH THEM. YOU AND THE PEOPLE YOU ARE LIVING WITH SHOULD GET A FLU SHOT EVERY FALL. ASK YOUR DOCTOR ABOUT THE PNEUMONIA VACCINE.

APPENDIX B: COPD Home Assessment Tool

COPD HOME ASSESSMENT TOOL: Page **1** of 4

Patient: _____ Date: _____ / _____ / _____ Time In: _____ Out: _____ Miles: _____

Patient Physician: _____ Physician Phone: _____

Medication Allergies: _____ Environmental Allergies: _____

RESPIRATORY ASSESSMENT

1.	Is the size of the chest appropriate for the size and age of the patient?	☐ Yes	☐ No
2.	Is the chest symmetrical?	☐ Yes	☐ No
3.	Can you hear audible noises?	☐ Yes	☐ No
4.	Do you see signs of dyspnea?	☐ Yes	☐ No
5.	Does the chest rise and fall symmetrically?	☐ Yes	☐ No
6.	Are the nail beds normal?	☐ Yes	☐ No
7.	Is there clubbing of the fingers?	☐ Yes	☐ No
8.	Is a cough present?	☐ Yes	☐ No
9.	Is the skin dry?	☐ Yes	☐ No
10.	Does the patient have dyspnea while talking?	☐ Yes	☐ No
11.	Is cyanosis present?	☐ Yes	☐ No
12.	Is nasal flaring present?	☐ Yes	☐ No
13.	Is the patient extremely apprehensive or agitated?	☐ Yes	☐ No

How long have you known you have COPD? _____

Have you ever had Pneumonia? ☐ No ☐ Yes – When? _____

HISTORY OF PATIENT STATUS FOR LAST 14 DAYS

☐ Patient admitted to _____ for _____ on _____ / _____ / _____
Facility Diagnosis Date

☐ Patient discharged to home on _____ / _____ / _____
Date

CO-MORBIDITIES

_____

_____

_____

_____

COPD HOME ASSESSMENT TOOL: Page **2** of 4

Patient: _____ DOB: _____ / _____ / _____ Care Manager: _____

NUTRITION

Diet: _____

Height: _____ Weight: _____ lbs

Appetite: _____

How many meals do you eat a day? _____

Who prepares the meals? _____

Who does the grocery shopping? _____

Supplements: _____

Alcohol Consumption: _____

PAIN

Pain level: _____ (Scale of 0-10)

Pain medication: _____

_____

_____

Pain Location: _____

_____

_____

Do you have any of the following on a daily basis?

Cough?	☐ Yes ☐ No	Sputum?	☐ Yes ☐ No	Wheezing?	☐ Yes ☐ No
Dyspnea?	☐ Yes ☐ No	Nasal Discharge?	☐ Yes ☐ No	Sinus Congestion?	☐ Yes ☐ No

SMOKING

Smoking History: ☐ Non Smoker ☐ Previous Smoker ☐ Smoker – _____ Packs per day ☐ Chewing Tobacco

Does anyone who lives with you smoke? ☐ No ☐ Yes – Do they want to quit? ☐ No ☐ Yes

Have you ever tried to quit smoking? ☐ No ☐ Yes – When? _____

Willingness to Quit: ☐ High ☐ Medium ☐ Low

IMMUNIZATION

Flu:	☐ Unknown	☐ No	☐ Yes – Date: _____ / _____ / _____
Pneumonia:	☐ Unknown	☐ No	☐ Yes – Date: _____ / _____ / _____
TB:	☐ Unknown	☐ No	☐ Yes – Date: _____ / _____ / _____

INDOOR POLLUTANTS

☐ Cigarette Smoke	☐ Household Cleaning Products	☐ Strong Odors	☐ Dust
☐ Burning Fireplace	☐ Dogs	☐ Cats	☐ Other Animals

COPD HOME ASSESSMENT TOOL: Page **3** of 4

Patient: _____ DOB: _____ / _____ / _____ Care Manager: _____

EXERCISE PROGRAM / SLEEP QUESTIONNAIRE

Current Exercise Program? ☐ Yes ☐ No

What is your normal level of activity? _____

Have you been able to resume your normal level of daily activity since your discharge from the hospital? ☐ Yes ☐ No

How many steps can you climb without a feeling of respiratory distress? _____

How far can you walk without a feeling of respiratory distress? _____

How are you sleeping at night? _____ How many hours do you sleep? _____

Do you require sleep during the day? ☐ No ☐ Yes – How many hours do you sleep during the day? _____

Do you feel rested when you wake up? ☐ Yes ☐ No

Do you use any of the following when you sleep (check all that apply)? ☐ O_2 ☐ CPAP ☐ BiPAP ☐ PSV

How many pillows do you use in order to breathe while you sleep? _____

MEDICATIONS

Drug	Dose	Route	Frequency

How do you keep track of your meds? _____ Who helps you? _____

Is patient compliant with medications? ☐ Yes ☐ No

COPD HOME ASSESSMENT TOOL: Page **4** of 4

Patient: _____ DOB: _____ / _____ / _____ Care Manager: _____

TREATMENTS

Inhaler Teaching? ☐ No ☐ Yes – Demonstrated proper technique in use and care? ☐ Yes ☐ No

Nebulizer Teaching? ☐ No ☐ Yes – Demonstrated proper technique in use and care? ☐ Yes ☐ No

O_2 Teaching? ☐ No ☐ Yes – Demonstrated proper use, care and safety? ☐ Yes ☐ No

Medication Regimen Reviewed? ☐ Yes ☐ No

HOME ENVIRONMENT

Structural Barriers: _____

Safety Issues: _____

Heating and Ventilation Issues: _____

Pets: _____ Where do your pets sleep? _____

Personal Hygiene: _____ Who helps you with your bath? _____

Who cleans your house? _____ Who vacuums your house? _____

PSYCHOSOCIAL

Language Barriers: _____ Ability to read? _____

Visual/Hearing Barriers: _____

Abuse/Neglect Issues: _____

Hx of Depression? _____ Recent Loss/Grief Issues: _____

FOLLOW-UP

Next PCP Appt: _____ / _____ / _____ Time: _____ ☐ AM ☐ PM

Next Pulmonologist Appt: _____ / _____ / _____ Time: _____ ☐ AM ☐ PM

Next Pulmonary Rehab Appt: _____ / _____ / _____ Time: _____ ☐ AM ☐ PM

Next Care Manager Visit: _____ / _____ / _____ Time: _____ ☐ AM ☐ PM

Goals:

1. _____

2. _____

3. _____

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CITATIONS

1.) Medicare.gov. August, 2014. “Hospital Readmissions Reduction Program.”

2.) Managed Healthcare Executive. October 09, 2014. “Medicare fines record number of hospitals under the ACA’s Hospital Readmission Reduction Program.”

3.) Pittsburgh Regional Health Initiative. January 21, 2011. “Spreading Quality, Improving Costs; A Manual for Preventing Hospitalizations.”

4.) CMS.gov. August 4, 2014. “Readmissions Reduction Program.”

5.) Medicine.net. Dartmouth Atlas Project, News Release, Sept. 28, 2011. “Hospital Readmission Rates On the Rise in Older Adults: Study.”

6.) Health Affairs Blog. October 10, 2014. “Time to Get Serious About Hospital Readmissions.”

7.) The Washington Post. October 2011. “Medicare Penalizes Washington Area Hospitals For Readmissions.”