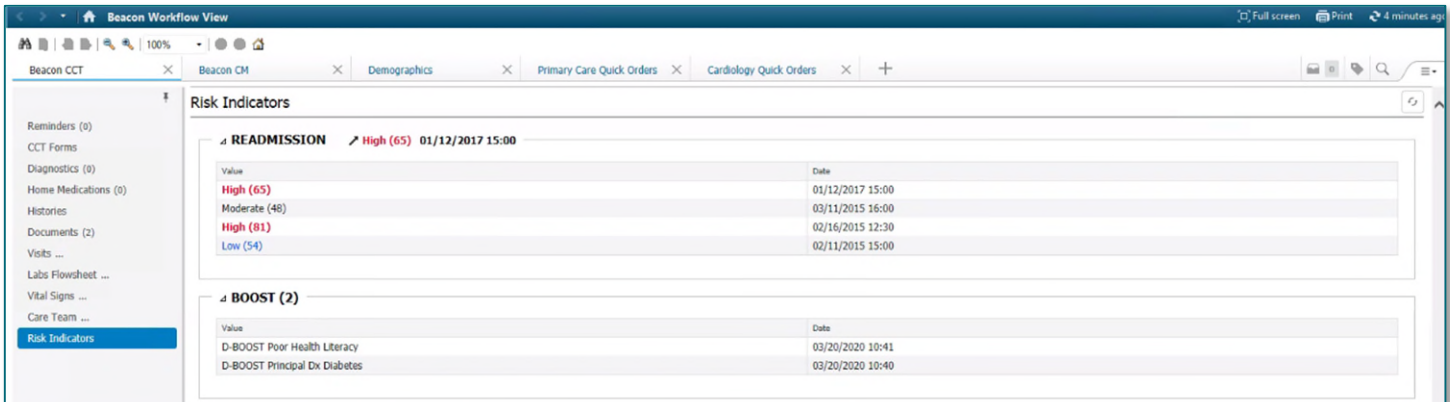


This solution identifies patients at high risk for readmission. One component of this is BOOST (Better Outcomes for Older Adults Through Safe Transitions), a program aimed at reducing unnecessary readmissions and improving the overall quality of care. BOOST allows clinicians to assess potential factors that may negatively impact post-discharge outcomes and implement appropriate interventions to mitigate the identified risks.

AMB Care Manager

STEP 1: Open the patient's chart and navigate to the **AMB CCT** or **AMB CM MPage** and locate the **Risk Indicators Component** to see the patient's **Readmission Risk Score**.



Value	Date
High (65)	01/12/2017 15:00
Moderate (48)	03/11/2015 16:00
High (81)	02/16/2015 12:30
Low (54)	02/11/2015 15:00

Value	Date
D-BOOST Poor Health Literacy	03/20/2020 10:41
D-BOOST Principal Dx Diabetes	03/20/2020 10:40

- Clicking the black carat next to **Readmission** will display the patient's readmission score trend.
 - Click the score to see the contributing factors.
 - Clicking the carat next to **BOOST** will display the patient's BOOST P's.
- The **BOOST P** Categories are:
 - **Polypharmacy** – A patient taking fifteen or more routine medications, or certain medications like anticoagulants, anti-platelets, or antidiabetics.
 - **Psychiatric History** – History of depression, History of Alcohol abuse, Suicidal Ideation.
 - **Principal Diagnosis** – Certain diagnosis (Cancer, Stroke, Diabetes COPD, etc.).
 - **Physical Limitations** – Patient is unable to participate in their own care due to frailty, deconditioning or physical limitations.
 - **Poor Health Literacy** – Patient is unable to understand their care plan or unable to teach back.
 - **Patient Support** – Patient is in a shelter/homeless or patient has a history of falls in last three months.

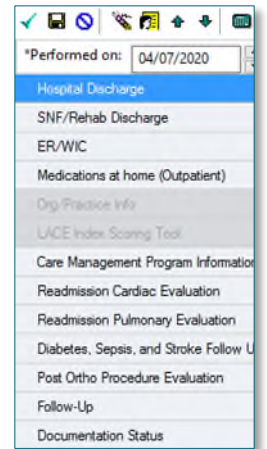
- **Previous Hospitalizations** – Three or more ER visits or a prior observation stay within six months.
- **Palliative Care** – Patient has an active Palliative Care consult.

STEP 2: Navigate to the **AdHoc** folder.

- Select the **CM Care Coordination** Form to begin documentation.

STEP 3: The Ambulatory Care Manager will complete the form as previously done.

- Note there are seven new sections that are not required by the AmbulatoryAM Care Manager.
 - Care Management Program Information
 - Readmission Cardiac Evaluation
 - Readmission Pulmonary Evaluation
 - Diabetes, Sepsis and Stroke Follow Up
 - Post Ortho Procedure Evaluation
 - Follow-Up
 - Documentation Status



STEP 4: The new sections can be completed based on the patient's discharge diagnosis.

- The follow-up section will list any follow up appointments. This is a quick way to see the patient's scheduled follow up appointments.

STEP 5: The last section is the **Documentation Status**. This section is used by the Resource Center.

STEP 6: Sign the form by clicking the **Sign** icon in the upper left-hand corner.

A screenshot of a form titled "Documentation Status". The form has a blue header. Below the header, it says "Follow-Up Documentation Complete" and has two radio buttons: "Yes" (selected) and "No". Below this, there is a blue text box that reads: "A response of Yes will change the status on the Worklist to Complete. A response of No will display the status as Auth Verified on the Worklist." Below the text box, there are two sections: "Additional Readmission Follow-Up" and "Best Contact Phone Number". The "Additional Readmission Follow-Up" section has a label "Phone Call Date, Time" and a date/time picker. The "Best Contact Phone Number" section has a text input field.