From the Office of Health Informatics

Acute Care Management Readmission Prevention for Acute Care Managers

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This solution identifies patients at high risk for readmission. One component of this project is the implementation of 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.

Care Managers at the Hospital

The following process pertains to Care Managers at the hospital.

- From Discharge Planning Worklist the Care Manager will see patient's risk score ranging from 20-80. This can be found in the patient's Length of stay column.
  - Low Readmission Risk Scores range from 20-39.
  - Medium Readmission Scores range from 40-59.
  - High Readmission Scores range from 60-80.
  - Click the link directly after the Risk Score to open the patient's Readmission Risk Summary Page.

Readmission Risk Summary Page

- **Overview Tab**
  - This tab on the Readmission Risk Summary Page provides an overview of the Patient's Care Team, Inpatient Encounter information, Diagnoses, and a Problem List.
- **Readmission Risk tab.**
  - The tab will list the patients risk factors, and the patients 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 or 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.

➢ **Support Services Tab**

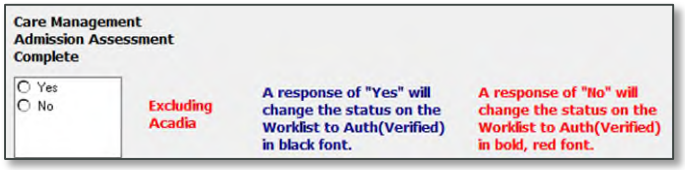
- Service Consults – Care Management, Social Work, Pharmacy, Physical, and Occupational Therapy.
- Interdisciplinary Team Members – This section will not be populating at this time.
- Barriers to the patient's discharge – Documented by Care Management only.

➢ **Documentation Tab**

- Care Managers will start their Discharge Planning Initial Assessment PowerForm from this tab.

Status	Type	Title	Date/Time
Auth (Verified)	Assessment Documents	Discharge Planning Initial Assessment	04/02/2020 09:58
Auth (Verified)	Education Documents	Surgery for Appendicitis	--

- Care Managers will also be able to view any education documentation that has been provided to the patient by nursing.
- When the PowerForm is complete, clicking **YES** indicates the form is completed. This form will be view only if accessed from the Readmission Risk Summary.



NOTE: **If the assessment is not done the NO button can be selected and the form can be completed at a later time from the Readmission Risk Summary Page.**

➢ **Transition Readiness tab**

- Care Managers see the **Discharge Order** status and can access their **Discharge Planning Ongoing Assessment** Power Form.

Status	Type	Title	Date/Time
Ordered	Discharge Order	Discharge (DX)	09/26/2019 15:04
Auth (Verified)	Transition Readiness	Discharge Planning Ongoing Assessment	03/24/2020 09:26

- After completing the Discharge Planning Ongoing Assessment clicking YES indicates the form is completed and will be view only if accessed from the Readmission Risk Summary Transition Readiness Tab. The Care Manager should **NOT** click yes until the patient is discharged.

NOTE: **Clicking the NO button allows the form to be updated daily from the Readmission Risk Summary page.**

NOTE: **The medication reconciliation section is just an FYI to view the status of the admission and discharge medication reconciliation.**

- Next is the **Follow Up** tab. This tab will not show any past visits, and future visits due to organizational security for Acadia.
    - The appointment component will populate through appointments made in Patient Education or the Follow Up tool.
    - The final hyperlink is to the follow up phone call form. This call will be made after the patient's discharge by the Resource Center.

Readmission Risk Score

- The patients Readmission Risk Score will also be located on the Risk Indicators component in the UM Summary, Clinical Review, Discharge Planning, and Readmission MPage.
    - Clicking **readmission** will trigger a pop-up displaying the score and the factors contributing to the score.
    - Clicking **BOOST** will identify the BOOST P's.