Northern Light Health

From the Office of Clinical Informatics

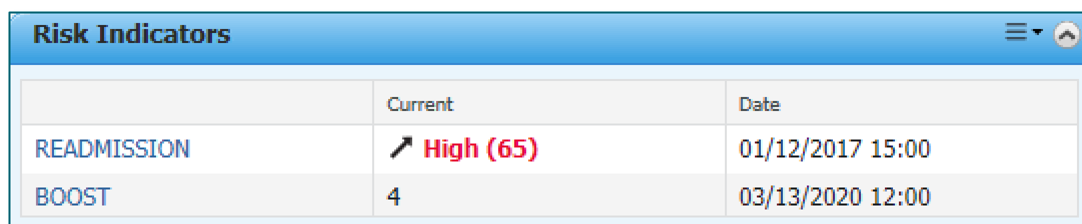
Readmission Prevention Project
Resource Center Care Manager

May 1, 2020

On June 15, 2020 the Readmission Prevention Project will go live. 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.

Resource Center Care Manager

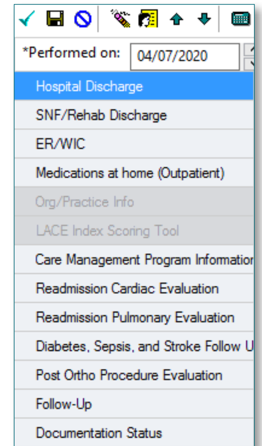
STEP 1: Open the patient's chart and navigate to the **Care Manager View** and review the **Risk Indicators Component** to see the patients **Readmission Risk Score**.



- The **Risk Indicators Component** is located 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.
- The **BOOST P** Categories are:
  - **Polypharmacy**-A patient taking 15 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.

<u>STEP 2</u>: Navigate to the **AdHoc** folder

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



<u>STEP 3</u>: The Care Manager will complete the desired/relevant sections.

- Note there are seven new sections:
  - Care Management Program Information
  - Readmission Cardiac Evaluation
  - Readmission Pulmonary Evaluation
  - Diabetes, Sepsis and Stroke Follow up
  - Post Ortho Procedure Evaluation
  - Follow-up
  - Documentation Status

<u>STEP 4</u>: The Care Manager will complete the appropriate sections based on the pts discharge diagnosis.

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

<u>STEP 5</u>: The last section is the **Documentation Status**. If all the documentation is complete the **YES** button is selected.

- If you are unable to reach the patient select the **NO** button.

Documentation Status
Follow-Up Documentation Complete
Yes
No
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.
Additional Readmission Follow-Up Phone Call Date,Time
Best Contact Phone Number

<u>NOTE</u>: **This form can be accessed later from the Readmission Risk Summary Page to complete documentation.**

- You can also select an additional phone call date and time if needed and document a number for contact.

<u>STEP 6</u>: Sign the form by clicking the sign Icon in the upper left-hand corner.

For questions regarding process and/or policies, please contact your unit's Clinical Educator or Clinical Informaticist. For any other questions please contact the Customer Support Center at: 207-973-7728 or 1-888-827-7728.