From the Office of Health Informatics

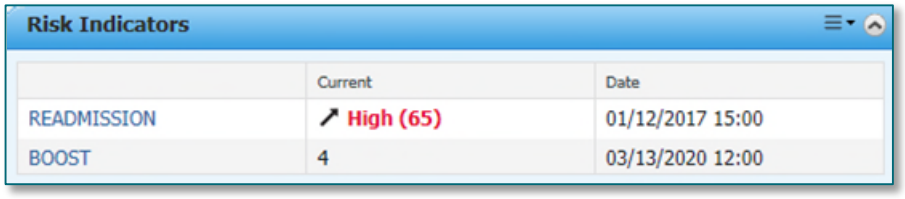
Acute Care Management Readmission Prevention for Resource Center Care Mangers

August 12, 2025

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

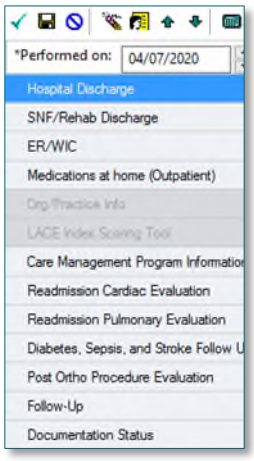
STEP 1: Open the patient's chart, navigate to the **Care Manager View,** and review the **Risk Indicators Component** to see the patients **Readmission Risk Score**.



- The **Risk Indicators Component** is 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 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.

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

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



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

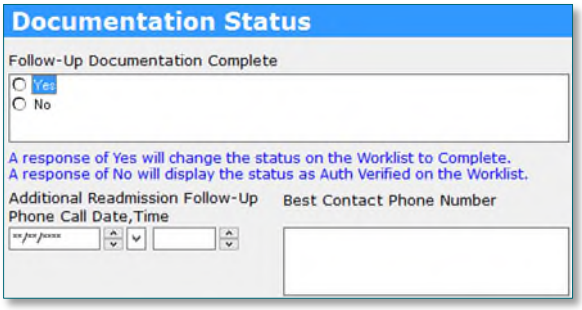
- Note there are seven new sections:
  - Care Management Program Information
  - Readmission Cardiac Evaluation
  - Readmission Pulmonary Evaluation
  - Diabetes, Sepsis, and Stroke Follow Up
  - Post Ortho Procedure Evaluation
  - Follow-Up
  - Documentation Status

STEP 4: The Care Manager will complete the appropriate sections 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**. If all the documentation is complete, select the **YES** button.

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



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

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

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