Northern Light Health

From the Office of Clinical Informatics

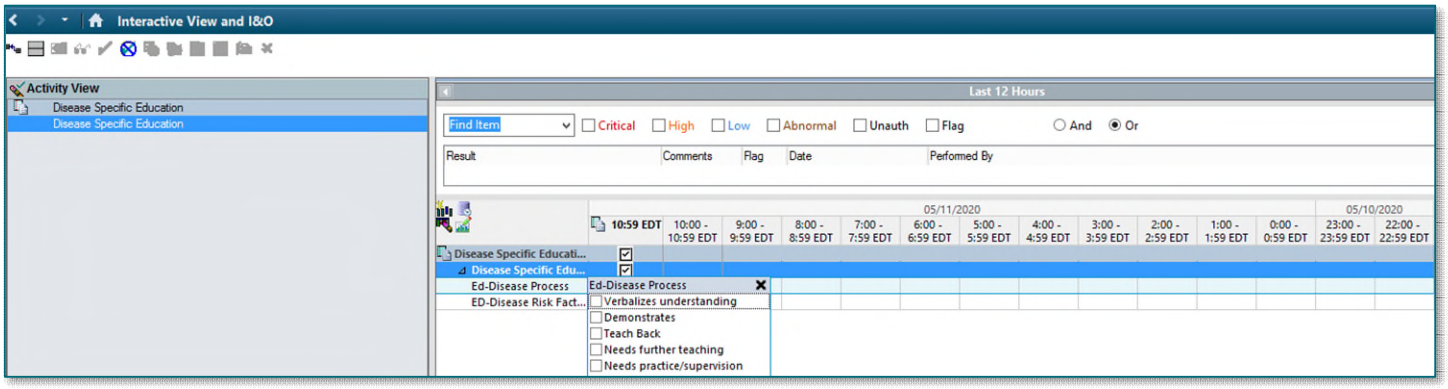
Readmission Prevention Project
Inpatient Nursing

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.

New Care Compass Tasks

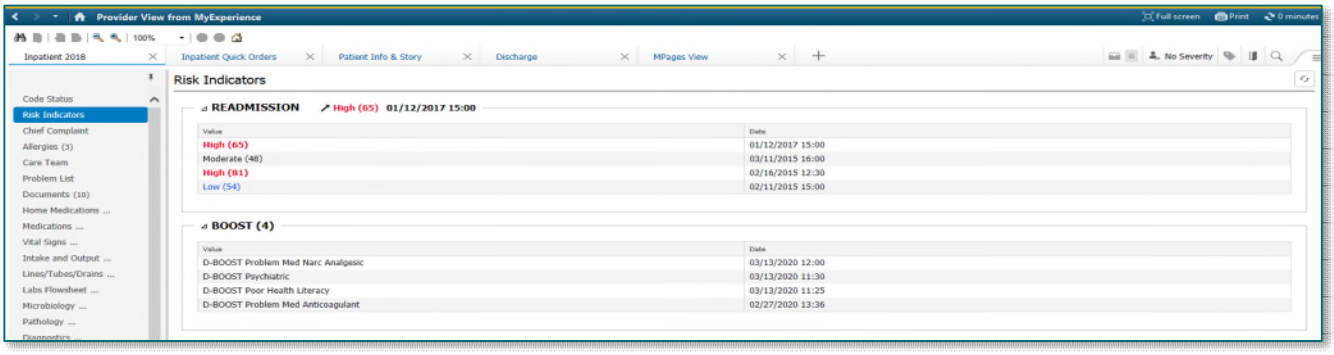
- When a discharge order is placed, Inpatient Nurses will get two new tasks on Care Compass.
  - **Provide Patient with Disease Specific Education**
  - **Educate Patient on Medication Adherence topics/problems**
    - Highlight the individual task, and click **Document**.
    - **Activity View** will open for that specific Task(s).
    - Once the documentation is signed in Activity View, the task will complete and fall off Care



Compass.

Risk Indicators Component

- **Nursing** will see a **Risk Indicator component in their Mpages view in which the Readmission Risk Score displays.**
  - Clicking the black carat next to **Readmission** will display the patient's readmission score trend.
    - Click the score to see the contributing risk factors.
- Clicking the carat next to BOOST will display the patients **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.
- **BOOST** provides organizations with the ability to identify those patients who are at risk for readmission, to mitigate these risks by employing appropriate and timely interventions, to support patients and their caregivers as they transition from the hospital to home, and to more effectively communicate with the post-discharge team.

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.