Boost 8P patient risk assessment tool

project BOOST — Better Outcomes by Optimizing Safe Transitions

The 8P Screening Tool
Identifying Your Patient's Risk for Adverse Events After Discharge

The 8Ps (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problems with medications (polypharmacy – i.e. ≥10 routine meds – or high risk medication including: insulin, anticoagulants, oral hypoglycemic agents, dual antiplatelet therapy, digoxin, or narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or history of depression diagnosis) ☐	☐ Assessment of need for psychiatric care if not in place ☐ Communication with primary care provider, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Physical limitations (deconditioning, frailty, malnutrition or other physical limitations that impair their ability to participate in their care) ☐	☐ Engage family/caregivers to ensure ability to assist with post-discharge care assistance ☐ Assessment of home services to address limitations and care needs ☐ Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place.	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all discharge planning and general and risk specific interventions ☐ Post-hospital care plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with appropriate medical provider within 7 days after hospitalization ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers ☐ Engage a transition coach	
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with medical provider within 7 days of hospital discharge ☐ Engage a transition coach	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness? "No" to 1st or "Yes" to 2nd = positive screen) ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address concerning symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/caregiver role of palliative care services and the benefits and services available to the patient	

Source: Flagstaff Medical Center, Flagstaff, AZ, USA; Society of Hospital Medicine (SHM) Project Boost, available at: http://www.hospitalmedicine.org/Web/Quality___Innovation/Mentored_Implementation/Project_BOOST/Project_BOOST.aspx.