McLAREN FLINT
Flint, Michigan

BOOST EVALUATION FORM

Tool for Addressing Risk: A Geriatric Evaluation for Transitions

Risk Assessment: 8P Screening Tool (Check all that apply.)	**Risk Specific Intervention**	**Signature of individual responsible for insuring intervention administered**
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, 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 ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) ☐	☐ Assessment of need for psychiatric aftercare if not in place ☐ Communication with aftercare providers, 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	
Polypharmacy (≥5 more routine meds) ☐	☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all general and risk specific interventions ☐ Aftercare 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 (absence of caregiver to assist with discharge and home care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers	
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 aftercare medical provider within 7 days	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address bothersome symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

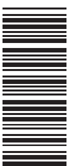
PT.

MR.#/P.M.

DR.

BOOST EVALUATION FORM

17860 Rev. 8/13



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Universal Patient Discharge Checklist

Item	Response	Initials
1. GAP assessment (see below) completed with issues addressed	YES ☐ NO ☐	______
2. Medications reconciled with pre-admission list	YES ☐ NO ☐	______
3. Medication use/side effects reviewed using Teach Back with patient/caregiver(s)	YES ☐ NO ☐	______
4. Teach Back used to confirm patient/caregiver understanding of disease, prognosis and self-care requirements	YES ☐ NO ☐	
5. Action plan for management of symptoms/side effects/complications requiring medical attention established and shared with patient/caregiver using Teach Back	YES ☐ NO ☐	______
6. Discharge plan (including educational materials; medication list with reason for use and highlighted new/changed/discontinued drugs; follow-up plans) taught with written copy provided to patient/caregiver at discharge	YES ☐ NO ☐	______
7. Discharge communication provided to principal care provider(s)	YES ☐ NO ☐	______
8. Documented receipt of discharge information from principal care provider(s)	YES ☐ NO ☐	______
9. Arrangements made for outpatient follow-up with principal care provider(s)	YES ☐ NO ☐	______
For increased risk patients, consider	Not applicable ☐	______
1. Interdisciplinary rounds with patient/caregiver prior to discharge to review aftercare plan	YES ☐ NO ☐	______
2. Direct communication with principal care provider *before* discharge.	YES ☐ NO ☐	______
3. Phone contact with patient/caregiver arranged within 72 hours post-discharge to assess condition, discharge plan comprehension and adherence, and to reinforce follow-up	YES ☐ NO ☐	______
4. Follow-up appointment with principal care provider within 7 days of discharge	YES ☐ NO ☐	______
5. Direct contact information for hospital personnel familiar with patient's course provided to patient/caregiver to address questions/concerns *if unable to reach principal care provider* prior to first follow-up	YES ☐ NO ☐	______

Confirmed by: ______________ Signature ______________ Print Name ____/____/____ Date

PT.

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General Assessment of Preparedness (GAP)

Prior to discharge, evaluate the following areas with the patient/caregiver(s). Communicate concerns identified as appropriate to principal care providers.
A = beginning upon Admission; **P** = Prior to discharge; **D** = at Discharge

Logistical Issues

Item	YES	NO	N/A
1. Functional status assessment completed (P)	☐	☐	☐
2. Access (e.g. keys) to home insured (P)	☐	☐	☐
3. Home prepared for patient's arrival (P) (e.g. medical equipment, safety evaluation, food)	☐	☐	☐
4. Financial resources for care needs assessed (P)	☐	☐	☐
5. Ability to obtain medications confirmed (P)	☐	☐	☐
6. Responsible party for insuring med adherence identified/prepared, if not patient (P)	☐	☐	☐
7. Transportation to initial follow-up arranged (D)	☐	☐	☐
8. Transportation home arranged (D)	☐	☐	☐

Psychosocial Issues

Item	YES	NO	N/A
1. Substance abuse/dependence evaluated (A)	☐	☐	☐
2. Abuse/neglect presence assessed (A)	☐	☐	☐
3. Cognitive status assessed (A)	☐	☐	☐
4. Advanced care planning documented (A)	☐	☐	☐
5. Support circle for patient identified (P)	☐	☐	☐
6. Contact information for home care services obtained and provided to patient (D)	☐	☐	☐

Confirmed by: ______________ Signature ______________ Print Name ___/___/___ Date