

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) <input type="checkbox"/>	<input type="checkbox"/> Medication specific education using Teach Back provided to patient and caregiver <input type="checkbox"/> Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) <input type="checkbox"/> Specific strategies for managing adverse drug events reviewed with patient/caregiver <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) <input type="checkbox"/>	<input type="checkbox"/> Assessment of need for psychiatric aftercare if not in place <input type="checkbox"/> Communication with aftercare providers, highlighting this issue if new <input type="checkbox"/> Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) <input type="checkbox"/>	<input type="checkbox"/> Review of national discharge guidelines, where available <input type="checkbox"/> Disease specific education using Teach Back with patient/caregiver <input type="checkbox"/> Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms <input type="checkbox"/> Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polypharmacy (≥5 more routine meds) <input type="checkbox"/>	<input type="checkbox"/> Elimination of unnecessary medications <input type="checkbox"/> Simplification of medication scheduling to improve adherence <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) <input type="checkbox"/>	<input type="checkbox"/> Committed caregiver involved in planning/administration of all general and risk specific interventions <input type="checkbox"/> Aftercare plan education using Teach Back provided to patient and caregiver <input type="checkbox"/> Link to community resources for additional patient/caregiver support <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (absence of caregiver to assist with discharge and home care) <input type="checkbox"/>	<input type="checkbox"/> Follow-up phone call at 72 hours to assess condition, adherence and complications <input type="checkbox"/> Follow-up appointment with aftercare medical provider within 7 days <input type="checkbox"/> Involvement of home care providers of services with clear communications of discharge plan to those providers	
Prior hospitalization (non-elective; in last 6 months) <input type="checkbox"/>	<input type="checkbox"/> Review reasons for re-hospitalization in context of prior hospitalization <input type="checkbox"/> Follow-up phone call at 72 hours to assess condition, adherence and complications <input type="checkbox"/> 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: <input type="checkbox"/>	<input type="checkbox"/> Assess need for palliative care services <input type="checkbox"/> Identify goals of care and therapeutic options <input type="checkbox"/> Communicate prognosis with patient/family/caregiver <input type="checkbox"/> Assess and address bothersome symptoms <input type="checkbox"/> Identify services or benefits available to patients based on advanced disease status <input type="checkbox"/> Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

