**Appendix 1: Project BOOST Tools to Improve Care Transitions, the BOOST Toolkit**

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| Risk Assessment and Discharge Checklist: *the Tool for Adjusting Risk: a Geriatric Evaluation for Transitions (TARGET)* | The TARGET is a 4-part tool that includes:   * Individualized risk stratification process * Risk-specific intervention plan linked to the risk stratification * Universal set of expectations for all patients being discharged from the hospital to home (the Universal Discharge Checklist) * General Assessment of Preparedness (GAP), a component list of issues important to providers and patients (and their caregivers) surrounding the readiness of patients tor transition out of the hospital. |
| Patient Teachback | Implementation of the frontline “teachback” method by which patients and/or caregivers confirm understanding of discharge instructions by “teaching” hospital staff important content |
| Follow-up Phone Call | Follow up phone calls were recommended to assess patient symptoms and affirm understanding of post-discharge care plan. |
| Discharge Summary Completion | Timely transmission of the hospital discharge summary within 48 hours of discharge was recommended. |
| Individualized Written Discharge Instructions | This tool was designed to create a focused and highly individualized patient plan for care after discharge. The tool included:   * Reason for hospitalization * Important warning signs and symptoms * Discharge medications * Follow up appointments * Pending test results * Physician, hospital, pharmacy contact information   Two templates were developed: The Patient PASS (Preparation to Address Situations after discharge Successfully) Tool and the Discharge Patient Education Tool (DPET) |