**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.
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| 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) |