### The 8Ps Screening Tool

#### Identifying Your Patient’s Risk for Adverse Events After Discharge

<table>
<thead>
<tr>
<th>The 8Ps</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insuring intervention administered</th>
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</table>
| **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 “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 |