



Post Discharge Follow-Up Call Script

Tips for Using This Tool:

- The tool is one element of a transitional care services program and provides a framework for standardized follow-up discharge calls to patients identified as high risk for rehospitalization. The tool can be used for discharges from multiple levels of care, including hospital to home, skilled nursing facility (SNF) to home, or hospital to hospice.
- The tool can be modified for specific high-risk conditions or align with your facility's post-discharge follow-up protocol.
- The tool can be modified to include your institution's logo.
- It is recommended that this tool (or a summary of information and readmission risks identified during post-discharge calls) be shared with primary care physicians and other providers involved in the patient's post-discharge care as part of care transitions communication.
- Establish a process to review unanticipated call findings or trends with Quality and/or Case Management leadership for ongoing process improvement. Trends could be by topic (food insecurity, medication orders, equipment) by discharging unit or provider.
- In communities where ED alert systems are in place for multi-visit patients, consider a process to include information gleaned from follow-up calls.

Pre-Call Checklist


Patient Name: _____ Date of birth: _____ Phone Number: _____

Individual that the patient has asked to be called on their behalf:

Name: _____ Phone Number: _____

Language Interpreter needed? No Yes: _____ (language)

Review the following to gather pertinent background information:

- Discharge summary
- Case management or social services notes (pay particular attention to readmission risk assessments, health literacy and references to other social determinants of health)
- Patient discharge instructions
- Zone tools : circle zone tools given to patient on discharge: (i.e., CHF, Diabetes, COPD, COVID, Sepsis, UTI, Anticoagulation, other)
- Current vaccination status: Flu Pneumococcal Shingles
 COVID #1_____#2_____Booster_____
- Referral to Home Health made: Yes _____ (Name of Agency)
 No (declined or did not meet criteria) – circle one
- Current or newly added high-risk medications:

High-Risk Medication	Medication Name	Dose/Frequency	Upcoming Lab Tests and Due Dates	Notes
Antibiotic				
Anticoagulants				
Antipsychotics				
Diabetic Medications				
Opioids				
Other (patient-specific)				

New Prescriptions				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Outreach


To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), verify you are speaking with the patient or care partner/designated individual. If the patient or designated individual is not available, leave your name, where you are from, and a contact number. Do not disclose any personal health information (PHI) or details of the hospital or SNF stay in the message. The patient's date of birth can be used as an identifier.



Once you identified that you are speaking with the patient or designated individual, begin with a greeting such as "Hello _____. I am (your name), a (type of clinician) from (name of the facility). Since you have been discharged from (facility name), you may have questions that I can help answer for you. Do you have a few minutes to speak to me now, or would you like to schedule a more convenient time for me to call back? Do you have a family member, care partner and/or community case manager you would like to join you on the call?"



Attempt #1 date/time	Attempt #2 date/time	Attempt #3 date/time

Call

"There was a lot of information given to you at discharge, and I would like to take some time to discuss any questions you have."

Open-Ended Questions (allow time for pauses)	Response/Notes
In your own words, can you describe what your main health concern was during your hospitalization (stay)?	
What do you recall learning about this health issue?	
What symptoms will you watch for if this health issue becomes worse?	
Refer to and re-educate utilizing the zone tool and ask the patient: What color zone  best describes how you feel today?	
What are you most worried about today?	

Readmission Risk Categories	Notes/Follow-Up Guidance
Medications	
What medications and supplements are you currently taking?	Compare to discharge instructions
<p>Have you called in and picked up the new prescription(s) given to you at discharge?</p> <ul style="list-style-type: none"> • Are you taking all of the new prescriptions given to you? • What is your plan for getting refills? 	
<p>Do you have medication(s) you were taking before hospitalization that you have been instructed to continue taking?</p> <ul style="list-style-type: none"> • Do you have a supply of these medications, or do you need refills? 	
<p><i>Interviewer Guidance: If the patient is unable to answer questions about medications or does not have a plan for obtaining refills</i></p>	<ul style="list-style-type: none"> • Contact the patient's pharmacy to determine delivery options, medication reconciliation assistance or patient education. • Ask the patient for permission to involve care partner or family in coming up with a plan to obtain medications • Contact the home care provider to engage in care planning and medication reconciliation.
Equipment, Services and Personal Care	
<p>Has the home care provider seen you since you returned from the hospital (or SNF)?</p> <ul style="list-style-type: none"> • Is the home care provider using your zone tool  with you during each visit, or do you tell them which color zone  you are in? 	Consider follow-up with the home care provider if the zone tool is not being used during each visit or call.
<p>Has a physical, occupational and/or speech therapist been to your home?</p> <ul style="list-style-type: none"> • Have they made any suggestions about furniture, rugs, etc.? • Have you been able to do what they suggest? 	Consider contacting the home health care social worker or community agency if the patient needs assistance with implementing recommendations.
Are you able to do personal care and bathing without assistance?	
<p>How are you getting food?</p> <ul style="list-style-type: none"> • Who is preparing your meals? • What did you eat yesterday? 	
<p>Have you received all of the equipment and supplies ordered for you?</p> <p><input type="checkbox"/> medical equipment</p> <p><input type="checkbox"/> oxygen / nebulizer treatment/CPAP</p> <p><input type="checkbox"/> IV or feeding tubing/supplies</p> <p><input type="checkbox"/> wound or incisional care supplies (dressings, tape, packing)</p> <p><input type="checkbox"/> ostomy supplies</p> <p><input type="checkbox"/> other: _____</p>	
<p>Has your primary care provider been contacted to schedule a follow-up appointment?</p> <ul style="list-style-type: none"> • When is your appointment? 	

<p>Has your specialty provider been contacted to schedule a follow-up appointment?</p> <ul style="list-style-type: none"> • When is your appointment? 	
<p>Has an appointment for any outpatient blood-work or imaging been scheduled?</p> <ul style="list-style-type: none"> • When is your appointment? 	
<p>How will you be getting to your physician or testing appointments?</p>	<p>If there is no plan, schedule transportation or ask to contact family to ask for assistance with coming up with a transportation plan.</p>
<p><i>Interviewer Guidance: If the patient has questions regarding meals, follow-up appointments, discharge instructions or pending/ordered blood draws or imaging/ results</i></p>	<ul style="list-style-type: none"> • Refer to discharge summary • Contact outpatient facility/hospital to confirm or schedule lab/imaging appointments • Assist patient with appointment scheduling • Request dietary consult • Discuss with the home health provider. If the patient is not receiving home health, offer to connect with a community food provider such as Meals on Wheels
<p>Diagnosis Specific Questions: When applicable, ask the following and reference the appropriate zone tool </p>	
<p>How do you perform daily weighs?</p> <ul style="list-style-type: none"> • Have you noticed a weight gain of more than 3lbs? 	<p><input type="checkbox"/> own scale <input type="checkbox"/> RN weighs</p>
<p>Do you take your blood pressure?</p>	
<p>What was your last blood pressure reading?</p>	
<p>What was your last pulse oximetry reading?</p>	
<p>Who does your finger stick?</p>	
<p>What were the last 24-hour finger stick results?</p>	
<p>Have your dialysis appointments been scheduled?</p> <ul style="list-style-type: none"> • How will you be getting to these appointments? 	
<p>Do you use a home INR finger stick test? When was your last test, and what was the reading?</p>	
<p><i>Interviewer Guidance: Review zone based on current patient reporting </i></p> <p><i>If the patient has not received a zone tool, consider providing one. Your provider may have one. A library of zone tools is also available in English or Spanish on the Alliant Health Solutions website.</i></p>	<ul style="list-style-type: none"> • If there is an emergency (Red Zone), call 911 for the patient • Urgent (Yellow Zone), refer the patient to an urgent care center or call their physician to set up an appointment. • All clear! (Green Zone) <p>Alliant Health Solutions zone tools: https://quality.allianthealth.org/?s=zone</p>

Conclusion of Call:

- ✓ Ask the patient if there is anyone from the hospital (or SNF) they would like to give a gold star to?
- ✓ Obtain permission to share notes with Primary Care Physician and other providers
- ✓ Provide contact information for the patient to call with any questions.
- ✓ Recommend the patient keep a notebook of home test results and bring it and their zone tool to their physician appointments.

Interviewer Name: _____

Interviewer Signature: _____

Date and duration of call: _____

References for additional information and best practice examples related to the importance of follow-up calls in improving care transitions and the components of transitional care management programs.

CMS Transitional Care Management: Transitional_Care_Management_Services_MLN908628.pdf	The Care Transitions Program: https://caretransitions.org/
AHRQ Designing and Delivering Whole-Person Transitional Care: Aspire Guide	Project Red (Re-Engineered Discharge): http://www.bu.edu/fammed/projectred/index.html