

Post Discharge Phone Script: Adult

Hello, (Name), my Name is (X) I work closely with your provider (name). (Provider Name) wanted me to reach out to you after your recent hospital admission.

Q: Have you received phone calls from anywhere else?

If Yes: I apologize for the multiple calls, there are a lot of people who care about how you are doing! Because (provider name) is your PCP and (office name) is your Patient Centered Medical Home, we really want to make sure you have everything you need and assess if there are ways we can help. When you are discharged from the hospital there is a 1 in 5 chance you could be readmitted. We all at (practice name) and your (provider name) really want to make sure that doesn't happen to you and make sure you know we are a resource to call if you have any question or concerns that arise. Is it ok if I ask you some questions?

If No: (provider name) is your PCP and (office name) is your Patient Centered Medical Home, we really want to make sure you have everything you need and assess if there are ways we can help. When you are discharged from the hospital there is a 1 in 5 chance you could be readmitted. We all at (practice name) and your (provider name) really want to make sure that doesn't happen to you and make sure you know we are a resource to call if you have any question or concerns that arise. Is it ok if I ask you some questions?

Q: Did you know that you can call us for same day appointments? *Provider Information and encourage patient to write down.*

Q: Did you know that you can call us after hours? *Provide Information and encourage patient to write down.*

Now for the questions on your hospital stay:

Q: How are you doing?

Q: How are you feeling?

Q: Tell me about your hospital experience?

Q: Was that tough on you?

Q: Is this type of care something you'd like to avoid in the future?

Q: Is there something we can do to help treat you at home?

Q: Can you tell me in your own words why you ended up admitted to the hospital so I can make sure you understand?

Q: Now that you are out of the hospital what matters most to you?

Q: What can I help you with?

Q: What can I convey to your providers?

Q: Q: Did you receive any new diagnosis that you are aware of?

The next question I ask may seem unnecessary, but it is something we here at (Office Name) like to ask all patients regardless of age as it is important to consider at all ages and normalizing these types of conversations is important. *Depending on the patient's age, also ask if they have Advanced Care Planning paperwork on file (Advanced Directive, Living will, Health Care Proxy) **If yes**, do they need a copy to review in case they want to make any changes? **If No**, are*

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*they interested in filling out and do they need help. If the office utilizes ACP videos, you can offer to send them a video. If Skilled Nursing facility, palliative Care or hospice is on the table- there are some nice videos around these. Please contact NPO if you would like more information. Encourage patients to watch videos with family and or friends. **Bill S0257 for this section.***

Q: Who will make decisions for you in the event that you cannot make them for yourself?

Let's go over your medications. I want to make sure you understand any changes so that you don't end up with any problems. (Provider name) will also review these medications. **Bill 1111F**, See "Medication Reconciliation, Transitional Care Management Tips," Handout

Q: Do you know what a red flag symptom is? (*Definition: A red flag symptom is something abnormal about your body or mind, that may indicate something is significantly wrong. 'Red flag' means potentially serious (and potentially treatable). See your doctor soon (even today) if you think you have one.*)

Q: Do you know what your Red Flag symptoms are? (*Diagnosis dependent and OR Medication, see some examples below; should also be in discharge instructions. Be prepared to go over these before calling the patient- can use office's patient education as well*)

Some Diagnosis:

Heart Failure: Sudden weight gain 2-3 pounds in one day or five pounds in one week, swelling in hands, feet abdomen or legs, cough or chest congestion, Shortness of breath, trouble breathing when lying flat, increased fatigue or sudden decrease in ability to perform ADLS, loss of appetite or nausea, mental confusion.

Pneumonia: Fever, Fast Heart rate, Fast Breathing, Chills, Confusion, Low Blood pressure (dizziness, dizziness upon standing), Stomach issues (Nausea, diarrhea, loss of appetite, pain, vomiting), chest pain when breathing

Diabetes with or without complications: feeling extremely hungry or thirsty, feeling similar to drunkenness, clammy skin, profuse sweating, confusion, feeling weak or faint, bleeding or swollen gums, sores on feet, frequent urination, blurred vision.

Some Medications: See "Post Discharge. Counseling Points for Diuretics, ACE-Inhibitors, ARBS, Calcium Channel Blockers, and Beta Blockers," handout.

Q: If you experience any of these red flag symptoms, who are you going to call?

Q: Who will you ask for when you call?

Q: What is the phone number?

Q: If we can offer you an alternative form of caring for you so you don't have to go into the hospital, what can we do for you?

Q: We schedule you a follow-up appointment in (x) days. See, "Medication Reconciliation, Transitional Care Management Tips," Handout and "Timely Follow-up ACO Reach Measure Tips," Handout for appropriate times on TCM and Timely Follow-up, timeframes. Otherwise schedule patient when deemed appropriate at least within 30 days of discharge."

Q: Tell me how you are going to get there. Is there anything I can do to help with that?

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Q: Did you receive the proper equipment you were supposed to receive post-discharge?

I am a MA or Care Manager in the practice...

If MA: We have a great Care Manager program in our office. Our Care Managers work with patients for all different reasons including resource help, disease management and helping patients to learn to cope with and handle their diseases, and they can function as accountability partners if you have any goals you're trying to achieve. Another thing they can help with is touching base with patients after hospital discharges. Would it be ok with you if I have our Care Manager (Name or Possible names) reach out to you and the both of you can go from there?

If Care Manager: I am a Care Manager in the office. Care Managers work with patients for all different reasons including resource help, disease management and helping patients to learn to cope with and handle their diseases, and we can also function as accountability partners if you have any goals you're trying to achieve. Another thing we can help with is touching base with patients after hospital discharges to make sure you continue to do ok and that you don't have any questions. Would it be ok with you if I called you once a week for 4 weeks just to see how you are doing? *Set-up phone calls or virtual visits if the patient agrees.*

I really appreciate you taking the time to talk with me today. Please remember you can call our office at any time if you have any questions or concerns, we want you to call us! Also, please remember our after-hours service.

Q: Do you have the number and instructions written down?

Q: I would like to send you a summary of what we discussed today. How should I send that? (portal, mails etc.)

- *Make sure to include Red Flags to look out for, Instructions on calling office for questions and concerns, Instructions for after hours, Follow Visit information with PCP, Care Manager, Specialists if applicable including location and contact information, Resource help (home care, ACP info/videos etc.) if applicable including location and contact information and any other pertinent information.*
 - *If this is done in the portal and person has taken Team Based Care training, **Track portal time for Care Coordination Codes 99487, 99489** to bill at end of month. * Provider portal time also counts! <https://micmt-cares.org/99487-99489-care-coordination>*

We look forward to seeing you at your scheduled Visits (Date) and the Care Manager will be contacting you (when). *If they agreed to visit and Care Manager*

Q: Is there anything else I can help you with today?

*If you person making the phone call has taken Team Based Care training, **Bill PDCM Phone Code 98966-98968** depending on length of phone call unless. *Phone codes for BCBSM and PH hospital follow-up patients, Not CMS Medicare or in other words TCM patients and Timely Follow-up patients. * <https://micmt-cares.org/98966-98967-98968-telephonic>*

*For ED follow-up, the Care Manager may also bill a **G9007** if updating the provider face-to-face regarding this encounter.*