

Discharge Phone Calls

Menu of Improvement Ideas

Increase your reach rate

- Do not assume medical record phone number is correct. Confirm best number to reach the patient or caregiver.
- Tell patient you are going to call prior to discharge. Ask what number is best and what time of day is best.. Ask, Is there a certain time of day we should not call?
- Discharge caller texts patient with the phone number prior to discharge and / or puts DC Nurse call number in phone contacts.
- Inquire if there is a family or trusted friend caregiver who should be present for the call and when they will be available.
- Prior to the call, text the patient to ask if this is still a good time.
- Place an appointment card or Sticky note on DC instructions with the call day, time and phone number.

Improve follow up on high-risk patients

- Use the whole person transitional care Aspire tool 9 to identify SDOH's and adjust discharge plans. Have this tool in hand when making the discharge call so that the caller can customize questions based upon relevant information
- Use a readmission risk tool to identify high risk patients for discharge call
- Create a process to escalate a patient barrier or clinical question or concern within a short timeframe (same day)
- Discharge caller has access to the patient's medical record or discharge instructions.

Build patient trust, loyalty and satisfaction

- Ask a patient family partner to review your discharge call script and patient notification process
- Test your discharge call process with a patient family partner
- Establish a system in which a staff person who has a relationship with the patient, is the discharge caller. Meets the patient at discharge at minimum.
- Identify who the patient family caregiver is and when it is best to reach them
- Personalize the questions based upon the patients discharge instructions

Improve Care Transitions

- Collect data from calls regarding the barriers or issues they encountered
 - Medications, follow up provider appointment, transportation, home care, equipment /supply, food, accessibility, etc.
 - Analyze barriers or issues to identify trends
- Share trended data and create action plans in collaboration with community partners and patient family partners

