A Research Group at Boston University Medical Center

Boston University School of Medicine

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The Project RED Toolkit

AHRQ Releases Toolkit to Reduce Hospital Readmissions

Every year millions of patients are readmitted to hospitals, and many of those stays could have been prevented. The Re-Engineered Discharge (RED) Toolkit, funded by the Agency for Healthcare Research and Quality, can help hospitals reduce readmission rates by replicating the discharge process that resulted in 30 percent fewer hospital readmissions and emergency room visits. Developed by the Boston University Medical Center, the newly expanded toolkit provides guidance to implement the RED for all patients, including those with limited English proficiency and from diverse cultural backgrounds. By helping hospitals plan and monitor the implementation of the RED process, the toolkit ensures a smooth and effective transition from hospital to home. **Download the toolkit**. To order copies of the instructional manual, contact the AHRQ Publications Clearinghouse at **AHRQPubs@ahrq.hhs.gov** or call (800) 358-9295.

These tools were developed to facilitate the Re-Engineered Hospital Discharge intervention.

Tools

The RED toolkit provides complete implementation guidance and is adapted to address language barriers, cross cultural issues and disparities in health care communication and trust. The toolkit includes five tools that provide step-by-step instructions to provide a springboard for hospitals to proactively address avoidable readmissions. Below is a brief description of each tool.

1. **An Overview of the RED Toolkit.** This document explains why hospitals would want to Re-Engineer their discharge processes, provides evidence of the RED's impact, and introduces each of the tools in the toolkit.

   An Overview of the RED Toolkit (PDF 958 KB)

2. **The Re-Engineered Discharge: How to Begin Implementation at Your Hospital.** This document outlines the steps you need to take to begin implementation at your hospital. It will help you consider all aspects of implementation, from planning your implementation team to identifying potential barriers. For example, it reviews the advantages and disadvantages of integrating the discharge education functions into the duties of the staff nurse responsible for patient discharge versus a strategy of hiring dedicated discharge educators to perform these functions.

   How to Begin the ReEngineered Discharge (RED) Implementation at Your Hospital (PDF 1.0 MB)

3. **How to Deliver the Re-Engineered Discharge.** This document describes various tasks the Discharge Educators undertake to implement the RED components, from reconciling medication lists to reviewing the After Hospital Care Plan (AHCP) with the patient. The manual includes instruction about how to create the AHCP, the booklet for patients with instructions about how to take care of themselves after leaving the hospital. The AHCP includes a medication schedule, a schedule of follow-up appointments, information about the patient's condition(s), and guidance on diet and exercise. This document describes the various methods that can be used to create the AHCP, either manually or using automated software. The AHCP can be generated in English, Spanish, and Simplified Chinese, using the automated software. For all other languages, a hospital can choose to manually create the AHCP in the patient's preferred language or to print the AHCP in English, with space where a translation can be entered.

   How to Deliver the ReEngineered Discharge at Your Hospital (PDF 1.14 MB)

4. **How to Deliver the RED to Diverse Populations.** A culturally competent approach ensures the effective delivery of the RED to all eligible patients and improves the quality of health care service. This tool assists Discharge Educators in delivering the RED to patients from diverse backgrounds, including diverse language, culture, race, ethnicity, education, and literacy, and social circumstance. It includes some proactive communication and relational strategies such as AskMe3.

   How to Deliver the ReEngineered Discharge to Diverse Populations (PDF 1.02 MB)

5. **How to Conduct a Post-Discharge Follow-up Telephone Call.** The post-discharge reinforcement phone call is scheduled within 72 hours of a patient's hospital discharge. The objectives are to review appointments, medicines, medical issues, and what to do if a non-emergent problem arises. This document provides a script for the telephone call, as well as scenarios of actual calls and a role play exercise that can be used in training callers.

   How to Conduct a Post-discharge Follow-up Phone Call (PDF 1.07 MB)

6. **How to Benchmark Your Hospital Discharge Improvement Process.** This document will help you begin to examine your hospital's current rate of readmissions and implement a program to monitor your hospital's progress. It reviews the reasons for measuring transitional care, suggests outcome and process measures, and reviews the availability of data to create benchmarks.

   How To Monitor RED Implementation and Outcomes (PDF 1.06 MB)

7. **Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge.** This tool is intended to highlight the roles and needs of family caregivers in the hospital so that they are partners in improving transitions and reducing readmissions. Along with Tool 4, which addresses the special circumstances of delivering RED to diverse populations, this tool broadens the RED perspective to include the skills, potential, and care -related needs of family caregivers.

   Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge (PDF 439 KB)

After Hospital Care Plan (AHCP)

One of the principles of RED and of the NQF Safe Practice is that all patients should leave the hospital with a discharge plan. We call our discharge plan the "After Hospital Care Plan" because in the course of our work we realized that some patients are confused by the word "discharge." The AHCP is a spiral-bound, color booklet that is designed to clearly present the information needed by patients to prepare them for the days between discharge and the first visit with their ambulatory care physician. We worked with consultants from the Rhode Island School of Design to help us with the graphic design. The personalized AHCP lists medications and upcoming appointments and tests; provides a color-coded calendar of upcoming appointments; and is designed to help the patient prepare for his/her upcoming appointment (patient activation).

After Hospital Care Plan (AHCP) Template - English (.doc)

After Hospital Care Plan (AHCP) Template - Spanish (.doc)

Assistance

For more information about Project RED, please visit AHRQ's Frequently Asked Questions website:

RED FAQ's

If you have questions or comments, or need assistance with the Toolkit, please contact:

Jessica Martin, MA, MPH
Project Manager, Project RED
Department of Family Medicine, Boston Medical Center

Email:**mailto:Jessica.martin@bmc.org**

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