Components of the Re-Engineered Discharge (RED)

1. Educate the patient about his or her diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post-discharge testing and
    - Make appointments with input from the patient regarding the best time and date of the appointment.
    - Coordinate appointments with physicians, testing, and other services.
    - Discuss reason for and importance of physician appointments.
    - Confirm that the patient knows where to go, has a plan about how to get to the appointment; review transportation options and other barriers to keeping these appointments.
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.
4. Organize post-discharge services.
    - Be sure patient understands the importance of such services.
    - Make appointments that the patient can keep.
    - Discuss the details about how to receive each service.
5. Confirm the Medication Plan.
    - Reconcile the discharge medication regimen with those taken before the hospitalization.
    - Explain what medications to take, emphasizing any changes in the regimen.
    - Review each medication's purpose, how to take each medication correctly, and important side effects to watch out for.
    - Be sure patient has a realistic plan about how to get the medications.
6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for what to do if a problem arises.
    - Instruct on a specific plan of how to contact the PCP (or coverage) by providing contact numbers for evenings and weekends.
    - Instruct on what constitutes an emergency and what to do in cases of emergency.
8. Expedite transmission of the Discharge Resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient's care after discharge that includes:
    - Reason for hospitalization with specific principal diagnosis.
    - Significant findings. (When creating this document, the original source documents – e.g. laboratory, radiology, operative reports, and medication administration records – should be in the transcriber's immediate possession and be visible when it is necessary to transcribe information from one document to another.)
    - Procedures performed and care, treatment, and services provided to the patient.
    - The patient's condition at discharge.
    - A comprehensive and reconciled medication list (including allergies).
    - A list of acute medical issues, tests, and studies for which confirmed results are pending at the time of discharge and require follow-up.
    - Information regarding input from consultative services, including rehabilitation therapy.
9. Assess the degree of understanding by asking them to explain in their own words the details of the plan.
    - May require removal of language and literacy barriers by utilizing professional interpreters.
    - May require contacting family members who will share in the care-giving responsibilities.
10. Give the patient a written discharge plan at the time of discharge that contains:
    - Reason for hospitalization.
    - Discharge medications including what medications to take, how to take them, and how to obtain the medication.
    - Instructions on what to do if their condition changes.
    - Coordination and planning for follow-up appointments that the patient can keep.
    - Coordination and planning for follow-up of tests and studies for which confirmed results are not available at the time of discharge.
11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge.

Source: http://www.bu.edu/fammed/projectred/index.html.