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.*