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# Project RED: A Transformational Approach to Post-Discharge Care

A recent study, showing 20% of Medicare patients are readmitted within 30 days and only 50% of those patients had a prior follow-up medical visit, has stimulated an increased focus on reducing hospital readmissions[1]. Furthermore, new government legislation may affect financial performance by eliminating reimbursement for 30-day readmissions starting in federal fiscal year 2013.[2] Riddle Hospital, a 200-bed acute care hospital in the Main Line Health System, is taking steps to reduce hospital readmissions by participating in the Project RED (reengineered discharge) national pilot project with 39 other hospitals. First implemented at Boston University Medical Center, Project RED reduces readmissions by streamlining the patient discharge process through patient education and community follow-up. Evidence shows Project RED reduces readmissions by approximately 30% and generates cost savings of $412 per patient.[3] The Agency for Healthcare Research and Quality (AHRQ) and Joint Commission Resources are providing funding, educational modules, networking, and technical support for the project until December 2012.

Project RED offers numerous benefits to patients and providers. Patients and caregivers experience improved communication and understanding of clinical outcomes, timely services, enhanced discharge preparation, and tools for transitioning to the community. Scheduling follow-up appointments improves patient and physician interaction while increasing primary care utilization.[3]

Riddle Hospital in Delaware County, PA, primarily serves an older population. A multidisciplinary team steers Project RED on a 34-bed medical-surgical unit. Two nurses designated as Discharge Advocates (DA) guide the eleven components of Project RED (Table 1).[4] The components incorporate a comprehensive discharge plan using pictures and cues to support patients of varying health literacy levels. Project RED also includes a scripted pharmacy follow-up phone call to review specific medications and medical issues, assess patient satisfaction, and support the newly discharged patient.[3]

**Eligibility criteria for Project RED include patients:**

1. With a respiratory diagnosis
2. Admitted from home and not discharged to a long-term care facility (excluding assisted living)
3. Able to sign an informed consent and/or demonstrate knowledge of the discharge information, or have a caregiver who can demonstrate knowledge of the discharge information
4. Who have access to a phone

The multidisciplinary team is engaged using a respiratory disease care plan to guide daily interventions and patient teaching. Upon discharge, patients receive the comprehensive discharge plan, including physician and emergency care contact information, a medication calendar, and disease-specific information. The discharge plan also includes information on follow-up appointments and tests, scheduled by case management according to patient availability. The pharmacist contacts the patient within 72 hours of discharge and resolves diagnosis-related medical issues.

**Riddle Hospital's Project RED goals include:**

- 100% of patients are discharged with a discharge plan
- 85% of patients complete the pharmacy follow-up phone call within 72 hours
- 75% of patients see a primary care physician within 30 days after discharge
- 30% reduction in readmissions
- 90$^{th}$ percentile for patient satisfaction in "readiness for discharge."[5]

Project RED offers process improvements through better resource utilization and reduced costs. Patient outcomes also improve due to

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**Table 1: Components of the Re-Engineered Discharge (RED)**

1. Educate the patient about his or her discharge throughout the hospital stay
2. Make appointments for clinician follow-up and post-discharge testing
3. Discuss with patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up results
4. Organize post-discharge services
5. Confirm the medication plan
6. Reconcile the discharge plan
7. Review the appropriate steps for what to do if a problem arises
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
9. Assess the degree of understanding by asking them to explain in their own words the details of the plan
10. Give the patient a written discharge plan at the time of discharge
11. Provide telephone reinforcement of the discharge plan and problem–solving 2-3 days after discharge

stronger partnerships and communication with physicians, thereby facilitating the process for medication reconciliation and post-discharge appointment scheduling prior to discharge.[3] Further investment in post-discharge care may offer significant benefits to healthcare organizations as health policy experts explore opportunities to enhance provider incentives and reimbursement. For example, accountable care organizations (ACOs) will provide a single payment for an episode of care, to be split among the hospital, physician, and other clinicians.[6] Healthcare organizations can ease the transition to future compensation models, such as ACOs, by strengthening the continuum of care through improved post-discharge care as promoted by Project RED. ■

**Shane Flickinger, MHA**
*Administrative Fellow, Main Line Health*

**Shawna G. Kates, LSW, MSW, MBA, CMAC**
*Director of Case Management and Social Work*
*Riddle Hospital*

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