



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

DRAFT

Contract HHS290200600012i

New tool (deliverable 2.4)

April 15, 2011

Prepared for
Cindy Brach
Agency for Healthcare Research & Quality (AHRQ)
Rockville, MD



A note to users: We would greatly appreciate any feedback that you might have on how to improve this toolkit. This information should be directed to Project RED on our Boston University website, www.bu.edu/fammed/projectred/, and leave your comments or questions in the “contact us” section.

OMB Control Number 0935-0173
Expiration Date 12/31/12

Table of Contents

1. How Do You Get Started at Your Hospital?	3
2. Twelve Steps to Implement the ReEngineered Discharge	3
Step 1: Make a Clear and Decisive Statement and Get “Buy-In”	3
Step 2: Identify the RED Implementation Leadership at Your Hospital	3
Step 3: Identify an Implementation Team	4
Step 4: Analyze Your Discharge Process and Your Rehospitalization Rates	4
Step 5: Determine Your Goals. What is Your Target Rehospitalization Rate?	5
Step 6: Identify Which Patients Should Be Targeted to Receive the RED	6
Step 7: Decide Who Will Provide Discharge Education at Your Hospital	6
Step 8: Decide Who Will Conduct Follow-Up Telephone Calls	7
Step 9: Determine How to Train Discharge Educators and Follow-Up Callers	9
Step 10: Decide How to Generate the “After Hospital Care Plan”	9
Step 11: Adapt RED for the Diverse Patient Population at Your Hospital	10
Step 12: Choose How You Will Measure the Progress of the RED Implementation	10
References	11
Appendix A: Example of an Agenda for Physician Trainers at 2-day On-site RED Training	12
Appendix B: Example of Possible Training Agenda for Intensive 2-day Visit to Hospital Wishing to Implement RED	16

1. How Do You Get Started at Your Hospital?

While you might be motivated to improve your discharge process, with a specific goal of reducing readmissions, you may not know where to begin. For this reason, Boston University Medical Center (BUMC) has been contracted by AHRQ to prepare a set of tools to assist hospitals to implement the Project RED intervention. This is the first tool in this series. It provides a step-by-step approach to how to begin implementation at your hospital.

2. Twelve Steps to Implement the Re-Engineered Discharge

Step 1: Make a Clear and Decisive Statement and Get “Buy-In” at High Levels

The first step in successful implementation is that the senior management of the hospital makes a clear and decisive statement about the importance of the hospital providing a comprehensive and safe hospital discharge. This should be communicated to the board of directors, senior leadership, medical and nursing and other clinical staff and patients. This could be in the form of an overview in a presentation format or a meeting discussion.

Like any new initiative that requires a change in hospital culture, it is also important that there is clear “buy-in” by the physician and nursing staffs. Identifying a motivated member of the medical or nursing staff who can advocate to their respective professional groups is often helpful. For successful implementation, it is critical that key constituencies within the hospital clearly understand the clinical, patient safety, and business case for reducing readmission. This could be carried out through a grand rounds presentation, in-service training (live or by webinar or by bringing in an expert speaker or consultant). Some hospitals have found that a public relations campaign designed for your setting creates a positive climate for implementation.

We created a PowerPoint slide show that reviews important information describing some of the studies showing the patient safety issues at the time of hospital discharge, the implications and the policy issues. These slides might be helpful to show at staff meetings, grand rounds or other venues in order to build the case for why your hospital needs to address this issue. A library of slides are available on the Project RED website [<http://www.bu.edu/fammed/projectred/>].

Step 2: Identify the RED Implementation Leadership at Your Hospital

Ultimately, safe discharge requires the shared effort of everyone in the hospital. Both administrative and clinical staff must be dedicated to facilitating system change and conscientious care. Because discharge is “everyone’s issue” this manual is written for both groups.

Hospitals with a motivated “Executive Sponsor” who serves as a readmission reduction champion are more likely to succeed. The executive sponsor can consider whether and how to motivate and/or incentivize other departments to consider ways of supporting this overall mission and effort.

Four months prior to the start of implementation at your hospital, the “executive sponsor” should identify a key individual in your organization to be the *Project Leader*. This could be a nurse, physician, administrator or other member of the hospital team. Ideally, this *Project Leader* should be well-respected within the institution and have the authority to move a new project forward. He or she must understand the importance of the project, be enthusiastic about its success, have clear buy-in on the argument that the project is important to the hospital’s success, and have the skills to carry it out.

Step 3: Identify an Implementation Team

With the assistance of the senior management, the *Project Leader* should identify an implementation team that includes participants from key constituencies from within the hospital clinical and administrative structure. We recommend that this implementation team have representatives from groups such as:

- Nursing and physician leadership
- Case management
- Hospital administration
- Hospital information technology
- Hospital pharmacy or PharmD leadership
- Patients, patient family members and possibly additional community members
- Patient safety officer
- Patient educators
- Health plan representative
- Discharge planning
- Social work
- Chaplain
- Member of the Interpreter Services, if the hospital has such a program; if not, a medical interpreter representative of those providing interpretation at the hospital, and who is familiar with related challenges

The implementation team will need to meet regularly under the direction of the *Project Leader*. The executive sponsor should communicate to the team the high priority of this activity and be sure that the team has the time and resources needed to do its work. This group will be responsible for operationalizing the RED processes within the hospital (as described in these tools) and creating the targets and tools for reporting the results of the implementation. This team should report regularly to the senior management team of the hospital the results of the implementation process and the results toward achieving the hospital goals.

Step 4: Analyze Your Discharge Process and Your Rehospitalization Rates

Before embarking on a time-consuming initiative, it is important to assess the need for it at your hospital and to create clear goals and objectives. Some questions that are important to think about up-front are the following:

- Why is this project important to you and your hospital?

- What is the current readmission rate? By specialty? By unit? By diagnosis?
- What is the readmission rate by race, ethnicity, for those with limited English proficiency substance abuse or mental health issues?
- Have you benchmarked your hospital versus peers and local and regional competitors?
- What is your current discharge process? Can it be improved?
- What “business case” factors apply? What is your expected return on investment?
- What is the target patient population (service, unit) for implementation?
- What is the timeline for “roll-out”?
- How do you determine success? What data do you need?
- Who could you partner with (e.g., insurance companies, health plans)?

Turn to the tool, “How to Benchmark Your Hospital’s Discharge Improvement Process” for some advice on how to examine readmission rates and for ways in which you can determine success.

Step 5: Determine Your Goals. What is Your Target Rehospitalization Rate?

There is wide variation among hospitals in readmission rates. The Hospital Compare website data show that there is a very wide range of readmission rates for hospitals for the diagnoses of pneumonia, CHF and heart attack. Also the study by Jencks showed that the all-cause readmission rate for Medicare patients (i.e., those over 65) is about 20 percent, but there is also great regional variation.

Extrapolating the results of the RED study to your hospital depends on how closely the population you intend to impact compares to the population studied in the RED study. The original RED study was done on the adult medical service at Boston Medical Center. BMC is a safety net hospital serving a diverse patient population, with a low rate of patients over 65. The all-cause 30 day rehospitalizations rate for this study population was consistently 20 percent in the years leading up to the study (despite the relatively young age of the population studied).

The results of implementing RED at your hospital (and therefore the goals you set for your hospital) very much depend on your baseline readmission rate for the population with whom you plan to intervene. For example, if your 30-day readmission rate is 20 percent or greater, then it is reasonable to expect that a comprehensive discharge process like RED will lead to a reduction in the readmission rate of 20-25 percent. However, it will be much more difficult to lower a 30-day readmission rate that is already low, say 15% or less.

To reduce a readmission rate that is already low, it is necessary to introduce interventions that target high risk patients with much more robust and expensive interventions that generally require post-discharge human resource interventions such as those described by Eric Coleman¹ and Mary Naylor.²

¹ Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med.* 2006;166: 1822-8. [PMID: 17000937]

² Naylor MD, Broton D, Campbell R, Jacobsen BS, Mezey MD, Pauley MV, Schwartz JS. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. *JAMA.* 1999;281:613-620.

In recent years several authors have published a variety of methods to help identify those patients who are at risk of readmission. More about this topic can be found in the “[How to Monitor RED Implementation and Outcomes](#)” tool.

Step 6: Identify Which Patients Should Be Targeted to Receive the RED

You may choose to deliver RED to all patients since RED results in cost saving when delivered to undifferentiated adult medical patients and increases patient and family satisfaction. However, based upon the analysis of your hospital’s needs and the goals you have set, you might want to identify selected patients who will receive the RED. Some of the decisions to be made include:

- Do you want to phase in the implementation so that you learn as you go and can correct the process as you learn or do you want to set an implementation date and do a full hospital rollout? The resources available, your decision style, and the urgency of lowering the readmission rate will all factor into this decision.
- You might want to begin implementation with those conditions currently targeted by CMS (e.g., heart attack, pneumonia, heart failure).
- Do you want to target certain diagnoses where the 30-day rehospitalization rates are higher than the national average or higher than your peer hospitals in your community.
- If your hospital has the capability to identify readmission rates by the site of care (floor or unit) or services within the hospital (e.g., surgery, dialysis, post-CABG) – it make sense to first target those sites that have the highest rates.
- It is also possible to target your resources to identify those individuals with a high probability of readmission. The RED research team has developed a risk scoring system that predicts the probability of an individual patient being rehospitalized using variables readily available at hospital admission. More about this topic can be found in “[How To Benchmark Your Hospital Discharge Improvement Process](#)” found in this toolkit.

Step 7: Decide Who Will Provide Patient Discharge Preparation at Your Hospital

One person will serve to provide patient discharge preparation using the RED processes for each patient before leaving the hospital. In the research studies at Boston Medical Center this person was called a “[Discharge Advocate](#)” or “[DA](#)”. We believe that these duties could be performed by a variety of medical professions. Hospitals might decide to carry out the RED tasks in a variety of ways, such as:

- The staff nurse caring for the patient being discharged
- New clinical personnel whose job it is to prepare your hospitalized patients for discharge
- Case managers from the health plans or insurers who hospitalize patients at your hospital
- The resident house staff if you are in a teaching hospital (this could add to efficiencies because the house staff know the discharge plan, medications etc and could produce the RED discharge material (e.g., After Hospital Care Plan) themselves.) A more practical option might include that the house staff reliably enter selected data into the software that produces the AHCP; the

nurse can then add other data and then can teach the information contained in the AHCP before discharge.

Several factors enter into the decision about who should play this role. There are pros and cons for each of these choices. Some of the considerations are:

- Clinical skills are important for some aspects of the discharge such as medication teaching. If the discharge advocate does not have clinical skills then this component could be done by the hospital clinical staff in the hospital.
- There are certain advantages of having the staff nurse who has cared for the patient in the days preceding discharge to be responsible for the RED discharge because this nurse knows the patient and often can more efficiently organize the discharge plan for the patient; however, nurses are of course busy with routine patient care duties and some consideration needs to be made to revising some of these responsibilities. As many nurses now work a 3 days week, the discharge plan should begin on the day of admission and systems set up to insure that the hand off is smooth if the primary nurse is not working the day of discharge.
- If you choose to use staff members who are not already working on the hospital ward, an important consideration is how to integrate these individuals into clinical routines. For example, if a case manager from the health plan is responsible for the RED discharge, then there needs to be clear delineation of responsibilities for the discharge paperwork required by the hospital.

It is also possible to split roles. For example, social workers could perform some of the DA tasks regarding identifying concerns and fears and identifying barriers to motivation or understanding. Social workers could also gather data regarding relevant psychosocial and cultural contexts and engage social supports. However, medically trained personnel are needed for recognition and medical advice regarding side-effects or other symptoms. This option requires an opportunity for good communication among care providers.

No matter which strategy you choose, staff must be provided with adequate time to carry out these new activities.

Ultimately, which method you choose will depend on how many patients you target, how amenable the nursing and physician staffs are to providing a new service, the details of the business case between your hospitals and insurers and the return on investment (or cost) that you anticipate from implementing RED.

Step 8: Decide Who Will Conduct Post-discharge Reinforcement Telephone Calls

An important component of the RED discharge is that patients are contacted by phone beginning at approximately 48 hours after discharge. The purpose of these phone calls is to reinforce the discharge plan and to identify and solve post-discharge problems. There is evidence from the RED research that this post-discharge telephone call is an important part of the interventions. It is important for hospitals to include this call if they want achieve the results found the RED trial. The details of how to do this

telephone call are in the tool “*How to Conduct a Post-discharge Reinforcement Phone Call*” in this tool kit.

As part of the RED research at BUMC, a clinical pharmacist (PharmD) conducted these calls. Thus, it is important to note that the evidence base for the RED process is based on a PharmD conducting this call. However, depending upon the availability of the staff, those who could complete this task, include:

- PharmD as done in the original RED trial
- Nurses hired for this purpose
- Nurses who have discharged the patient from the hospital unit
- Nurses, PharmD or others from the insurer
- Nursing staff from the receiving primary care office

Several factors enter into the decision about who should make the telephone call. Of course hospitals have to weigh the cost of each option versus the anticipated benefit. More research needs to be done to determine the right options for both who does the call and what the content of this call is. There are pros and cons for each of these choices. Some of the considerations are:

- PharmD is appropriate as many of the problems identified at the telephone call relate to issues of obtaining medications, adherence to medications and adverse events related to medication. We believe that this telephone call is an important contributor to the effectiveness of RED rehospitalization. Hospitals must consider the added cost of having pharmacist provide this service.
- Nursing staff hired for this purpose might be effective, and would be able to effectively assist with other discharge needs (e.g., changing appointments, pending tests, durable equipment). It would be necessary to have a physician or pharmacist available if the nurse is faced with questions he or she cannot answer.
- The staff nurse who has discharged the patient from the hospital unit could potentially make a call to the patients they discharged 1-2 days previously. The advantage is that this option does not add to the human resources needed to carry out RED and that the nurses will be more efficient in this process in that they know the patient and his or her discharge plan. This option presents a challenge in that it is difficult to modify a staff nurse’s duties to allow for this new duty. At some hospitals this might be possible.
- Clinicians from the health plan or insurer has the advantage that in some cases these duties could be taken on by staff already in place at the plan and could be cost saving. One implementing site is using PharmDs already employed by the plan to implement these calls.
- Primary care clinician or staff from the primary care office could implement the telephone call to the recently discharged patient followed by a weekly meeting of clinicians at the primary care site. This has been used as several sites resulting in fewer rehospitalizations. Of course this requires that the hospitals and the primary care providers receive the discharge summary and the discharge plan. Finally, some organizations have begun to incentivize the primary care physicians to provide timely post-discharge appointments and to reinforce the discharge plan by telephone.

The staff that you choose to provide the post-discharge telephone call will depend on how many patients you target, how amenable the nursing and physician staffs are to providing this service, and the details of the business case between your hospital and the health plan and insurers.

Step 9: Train Discharge Educators and Post-discharge Reinforcement Telephone Educators

There are several options for how best to provide training to the service educators:

- The discharge educators and their supervisors could read the manual and review its contents in a group session.
- This could be accomplished either as a series of in-service sessions or using the “train-the-trainer” technique where a set of key nurses (perhaps 1-2 from each unit or perhaps a “master trainer”) could be trained at another hospital already using RED and who would then be responsible for training the other nurses at your hospital. Appendix 3 contains an example agenda for a 2-day on-site training, including the project overview and experiential role-playing..

Step 10: Decide How to Generate the “After Hospital Care Plan”

The “After Hospital Care Plan” (AHCP), an essential component of RED, is a booklet that clearly presents information patients will need once they leave the hospital. It was designed for patients with the assistance of design and health literacy consultants. The AHCP is described in detail in the RED tool, *Training Manual for the Discharge Educator at Your Hospital*. The discharge educator uses the RED “Discharge Preparation Workbook”, a pen and paper tool that allows the capture of key patient data. The AHCP is then created in one of several ways:

- **Use a word processing program to manually create the AHCP.** This involves using a template created in Microsoft Word software. This method is rather simple to begin. It requires little training and the use of a simple word processing program in which many clinicians possess a basic understanding. This method allows the most flexibility in creating an AHCP tailored specifically to each patient. Free text can be added and unique patient directions can be entered. However, this method is time and labor intensive; all information and formatting of various combinations of medications and appointments must be done by hand. Manual data entry creates an opportunity to introduce errors. It is recommended that the AHCP is thoroughly reviewed twice for correctness before being given to the patient.
- **Using a software program (the “workstation”) to automatically create the AHCP.** This program has been created by the RED team. It uses drop down menus to enter key discharge information and then automatically creates the AHCP. It now creates the AHCP in English, Spanish and Chinese (Cantonese). The advantage of the software program is that it reduces transcription errors because it allows little to no “free text.” It automatically formats any combination of patient information, thereby saving time and reducing staff frustration. The disadvantage is that there is a cost associated to purchase software from a private company. Also ongoing IT support is necessary to ensure the program is working smoothly and to support the staff if problems are encountered. The software eliminates the ability to add free text to the plan and there is additional start up and training time for those clinicians using the software.
- **Connecting the “workstation” to the hospital information technology environment so that as much information as possible is automatically populated into the software that**

All options require a computer, color printer, and binding apparatus. Option 1 also requires Microsoft Office software and options 2 and 3 require the “workstation” software. For hospitals interested in options 2 and 3, the following link provides further information: <http://www.engineeredcare.com/>

Step 11: Provide RED for Diverse Populations

Providing discharge education to patients with limited English proficiency, limited health literacy, and/or non-Western health beliefs and practices presents unique challenges and is covered more extensively in this toolkit. One of the RED tools, entitled “*Providing RED for Diverse Populations*” provides guidance on working effectively with culturally and linguistically diverse patients. Your hospital, however, will need to adapt RED to meet the needs of the populations that you serve. The RED tools attempt to integrate this information into each tool.

The After Hospital Care Plan has been translated into Spanish and Cantonese. Using the workstation software and inputting the patient’s information in English, the AHCP can be automatically created and printed in these languages. Other languages are under development.

Since literacy rates vary among all patients, remember that written translations will still need interpreters. Even in the absence of language barriers, health disparities linger among racial and ethnic groups in the US regarding measures of healthcare and outcomes. It is possible that including measures, such as the improved interpersonal communication and relational skills presented in the RESPECT model (see the tool [How to Deliver the ReEngineered Discharge to Diverse Populations](#)), may positively impact the readmission rates of populations otherwise at increased risk for poor outcomes.

Step 12: Choose How You Will Measure the Progress of the RED Implementation

It is important to monitor the impact RED implementation has at your hospital, which includes both process and outcomes (how well you are delivering the RED components to your patients) as well as patient outcomes (hospital readmission and patient satisfaction). Data needed to track the implementation are discussed in the RED tool, “[How to Monitor RED Implementation and Outcomes.](#)”

References

- Jack BW, Chetty VK, Anthony D, Greenwald, JL, Burniske G, Johnson AE, Forsythe SR, O'Donnell JK, Paasche-Orlow MK, Manasseh C, Martin S, Culpepper L. The Re-Engineered Discharge: A RCT of a Comprehensive Hospital Discharge Program. *Annals of Internal Medicine* 2009;150:178-187. PMID: PMC2738592.
- Greenwald, JL, Denham C, Jack BW. The Hospital Discharge: A Care Transition with a High Potential for Errors. *The Journal of Patient Safety* 2007;3:97-106.
- Jack B, et al. Developing the Tools to Administer a Comprehensive Hospital Discharge Program: The ReEngineered Discharge (RED) Program. In, Henriksen K, Battles JB, Keyes MA, Grady ML, editors. *Advances in patient safety: New directions and alternative approaches*. Vol. 3. Performance and Tools. AHRQ Publication No. 08-0034-3. Rockville, MD: Agency for Healthcare Research and Quality; August 2008.
- Clancy, Carolyn M. Reengineering Hospital Discharge: A Protocol to Improve Patient Safety, Reduce Costs, and Boost Patient Satisfaction *American Journal of Medical Quality*. 2009; 24: 344.
- Mitchell S, Jack B Et al. Post-Discharge Hospital Utilization Among Adult Medical Inpatients with Depressive Symptoms. *Journal of Hospital Medicine* (JHM-09-0181):2009 – in press
- Greenwald J, Jack B. Preventing the preventable: reducing rehospitalizations through coordinated, patient-centered discharge processes. *Professional Case Management*: 2009;14 (3):135-140 PMID: PMC2720804
- Bickmore T, Pfeifer L, Jack B. Taking the Time to Care: Empowering Low Health Literacy Hospital Patients with Virtual Nurse Agents. 2009 *Computers in Medicine* 978-1-60558-246.
- Bickmore T, Mitchell S, Pfifer L, Paasche-Orlow M, Forsythe S, Jack B. Response to a Relational Agent by Hospital Patients with Depressive Symptoms. *Interacting with Computers*. In Press. NIHMS #169315
- Anthony D, Chetty VK, Kartha A, McKenna K, Rizzo DePaoli M, Jack B. Re-engineering the hospital discharge: an example of a multifaceted process evaluation. In: Henriksen K, Battles JB, Marks ES, Lewin DI, editors. *Advances in patients safety: from research to implementation*. Vol. 2, *Concepts and methodology*. AHRQ Publication No. 05-0021-2. Rockville, MD: Agency for Healthcare Research and Quality; Feb 2005.
- Kartha A, Anthony D, Manasseh CS, Greenwald JL, Chetty VK, Burgess JF, Culpepper L, Jack BW. Depression is a risk factor for rehospitalization in medical inpatients. Depression is a risk factor for rehospitalization in medical inpatients. *Primary Care Companion Journal of Clinical Psychiatry*. 2007;9(4):256-262.
- Strunin L, Stone M, Jack B. Understanding rehospitalization risk: can the hospital discharge be modified to impact recurrent hospitalization. *Journal of Hospital Medicine*. 2007; 2(5): 297-304. PMID: 17935257
- NQF Safe Practices: <http://www.qualityforum.org/docs/safe-practicees/txSafePracticesforWeb05-10-06.pdf>.
- Mostow C, Crosson J, Gordon S et al. Treating and Precepting with RESPECT: A relational model addressing race, culture and ethnicity in medical training. *Journal of General Internal Medicine* 25 (Suppl 2): S146-54, May 2010.

APPENDIX A

Example of an Agenda for Physician Trainers at 2-day On-Site RED Training

Day 1

9:30a-11:00a

Project RED Overview for Senior Managers

Goal: To review clinical and policy issues and to gain consensus on the need for action

Audience: Senior Hospital Leadership

Methods: Lecture (ppt slides) with demonstration and discussion

Objectives:

- Introduce the patient safety and public policy issue related to hospital discharge
- Introduce the BU/BMC AHRQ-funded RED implementation grant
- Review the scientific evidence base for Project RED research
- Demonstrate the health IT tools available to implement the RED
- Describe factors related to the “business case” for hospitals
- Discuss the important role of the senior leaders in supporting this implementation

Materials:

- Handout of slides
- Examples of the “After Hospital Care Plan”
- Demonstration of the RED “workstation” software

11:00a-12:00p

Delineation of [hospital name’s] Strategic Needs

Goal: To understand [hospital name’s] reasons for implementing the RED, to achieve mutual understanding of what constitutes success and to get broad support for implementation

Audience: Senior hospital leadership

Methods: Discussion

Objectives:

- Why is this project important to [hospital name]?
- What is the current readmission rate? By specialty?
- What is the ideal readmission rate?
- Do we know much about the current discharge process?
- What “business case” factors apply at [hospital name]?

- What is the target patient population (service, unit) for implementation?
- Who should we train? Staff Nurses? Selected nurses (train-the-trainer?) Nurse Case Managers? Physicians? A new cadre of worker (“discharge advocate”)?
- What is the timeline for “roll-out”?
- How do we determine success?
- What data do we need?
- What are the grants supported and real costs of this program to the hospital?

Materials:

- Engineered Care “Hospital Fact Sheet”
- Demonstrate “Hospital Compare”
- Synopsis of various “business-case” options and scenarios

1:00p-2:00p

Concurrent Meeting A: Creating a Process Map of [Hospital Name] Discharge Process

Goal: To understand the current process of patient discharge at [hospital] and to identify key opportunities for implementation

Attendees: Those familiar with the current discharge process at hospital and the implementation team

Methods: Interactive discussion and flip chart

Objectives:

- Review the advantages of process mapping
- Sketch out the key components of discharge process at [hospital]
- What are the barriers to implementing RED at [hospital]?
- Identify current roles and responsibilities of clinical staff
- Understand the current benchmarking and data availability
- Determine who will be responsible for the discharge at [hospital]
- Discuss how to be train “sharp end” providers

Materials:

- Example of Boston Medical Center’s process map

1:00p-2:00p

Concurrent Meeting B: Information Technology and Integration of RED

Goal: To discuss the Project RED IT requirements, [hospital] IT systems and respective integration roles.

Audience: [Hospital name] Information Technology Group and Engineered Care representative

Methods: Lecture (slides) with demonstration and discussion

Objectives:

- Review the RED “workstation” and server specs
- Present [hospital’s] IT platform and structure
- Discuss integration of workstation to [hospital] IT systems / EMR
- Understand the [hospital] IT support needed for implementation
- Understand support needed to adapt and integrate RED
- Discuss [hospital] capacity to support adaptation

Materials:

- RED server and workstation
- Demonstration of RED workstation
- Materials describing hardware needs and costs

2:30p-3:30p**Planning for Training and Implementation**

Goal: To review the RED implementation toolkits under development and to formulate the next steps for training and implementation

Audience: [Hospital name’s] implementation team

Methods: Discussion and demonstration RED Implementation Tools

Objectives:

- Understand the Discharge Advocate Role
- Review the implementation tools under development
- Set a date and agenda for the implementation training session

Materials:

- Deployment Plan and Implementation Team document
- RED Toolkit

Day 2

9:00am-12:00pm

Strategic Planning Session

Goal: To discuss plan for implementation

Audience: Senior Hospital Leadership and Hospital Implementation Team (include Social Service, Chaplain, Director of Interpreter Services etc.)

Methods: Discussion

Objectives:

- Develop implementation plan
- Identify key steps to begin
- Discuss facilitators and barriers
- Discuss process maps

Materials:

- Agenda
- Timeline

1:00p-2:30p

Grand Rounds Presentation

Goal: To review clinical and policy issues and to gain consensus on the need for action

Audience: Physician and Nurse Leadership

Methods: Lecture (slides) with demonstration and discussion

Objectives:

- Introduce the patient safety and public policy issue related to hospital discharge
- Introduce the BU/BMC AHRQ-funded RED implementation grant
- Review the scientific evidence base for Project RED research
- Demonstrate the health IT tools available to implement the RED
- Discuss the important role of the physicians in supporting this implementation

Materials:

- Handout of slides
- Examples of After Hospital Care Plan

Appendix B

Example of Possible Training Agenda for Intensive 2-day Visit to Hospital Wishing to Implement RED

Discharge Advocate Agenda

Goal: To discuss and to teach the ReEngineered Discharge (RED) program in order to reduce all-cause 30 day readmissions at [hospital name]

Audience: Senior Hospital Leadership

Methods: Lecture (ppt slides) with demonstration and discussion

Objectives:

- Introduce the patient safety and public policy issue related to hospital discharge
- Introduce the BU/BMC AHRQ-funded RED implementation grant
- Review the scientific evidence base for Project RED research
- Teach the material contained in the DA training manual
- Teach how to do the 2-3 day phone call
- Describe the barriers to implementation

Materials:

- Handout of slides
- Examples of the “After Hospital Care Plan”
- Copies of the Tool on How to Provide the RED
- Demonstration of the RED “workstation” software

Day 1

9:00 – 9:30a	Greetings, coffee
9:30 – 9:45a	Welcome, Objectives, Pre-survey
9:45- 10:45	Problem with discharge, Background and elements of the RED RED RCT, Introduction to AHCP
10:45 – 11:00	Break
11:00a – 12:30p	Overview of Training Manual and Resource Book
12:30 – 1:30p	Lunch
1:30 – 3:00p	Role play RED and critique
3:00 – 3:15p	Break
3:30 – 3:45p	Discussion, barriers to integrating with the hospital, Health IT
3:45 – 4:45p	Learning to use the workstation
4:45 – 5:00	Final questions, closing

Day 2

9:00 – 9:15a	Greetings, coffee
9:15 – 9:30a	Follow-up questions from yesterday

9:30 – 10:45a	Practice entering cases into workstation
10:45 – 11:00a	Break
11:00a – 12:30p	Role play RED and critique
12:30 – 1:30p	Lunch
1:30 – 3:00p	Post-dc pharmacist intervention, review of data
3:00 – 3:15p	Break
3:15 – 4:30p	Role play post discharge phone call
4:30 – 5:00p	Wrap-up, final questions, post survey

DRAFT