Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

Improving Nursing Home Discharges and Reducing Readmissions
Project RED: Re-Engineered Discharge

Preparing Your Patients: 12 Key Elements

1. Medication reconciliation
2. Reconcile discharge plan
3. Follow-up appointments
4. Outstanding tests
5. Post-discharge services
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone Reinforcement
12. Language-appropriate

+ Connection with Community Services and Supports

Sample: 22 Nursing Homes in Southeast MA

- Sample of Residents Impacted 5,649
- Intervention started in April 2017
- Expanded to include 12 additional nursing homes in November 2018
- Process Measures self-reported monthly

Project Goals

- Improve communications and align strategies between care settings (focus on SNFs, hospitals, ASAPs, home health, and other community providers)
- Better prepare patients for discharge home using After Care Plan, community supports, follow-up calls

Targeted Intervention, Delivers Results

MA has one of the highest readmission rates for those patients discharged home or with home health in the nation. Patients typically do not receive adequate support to be successful at home.

Project RED targets these gaps and increases real-time engagement with these services for an effective care plan to keep patients home.

This intervention has the potential to impact readmission rates at 30-60-90 days after both hospital and SNF discharge.

A True Collaborative Effort

Reducing readmissions is a shared responsibility. Project RED engages and aligns all care settings and the patient/caregiver to keep the patient at home.

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