Editorial

Another Option in Reducing Hospital Readmissions From Skilled Nursing Facilities: Project RED (ReEngineered Discharge)

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There has never been a better time for long term care practitioners to get involved with reducing unnecessary hospitalizations and readmissions. Hospitals have gotten the message, and they are now financially responsible for some readmissions and will go out of their way to help nursing homes avoid unnecessary readmissions with better discharge summaries and more comprehensive plans for continuing care. The Centers for Medicare and Medicaid Services demonstration project to reduce avoidable hospitalizations among nursing facility residents is now going on at 7 locations across the country, and these different projects have taken on a variety of approaches to reducing hospitalizations among nursing facility residents.

The Affordable Care Act directs the Secretary of Health and Human Services to provide technical assistance and promulgate regulations for each nursing home to implement a quality assurance and performance improvement activity. The centerpiece of this regulation may be to improve management of acute changes and conditions and reduce unnecessary hospital transfers. Surveyors are being taught to look for process changes, payers are looking at admission rates, and facilities are trying to find their way into Accountable Care Organizations to remain relevant, secure resources, and limit transitions in care. Part of the new vernacular includes those conditions that are “ambulatory sensitive,” which makes them more amenable to treatment before a hospitalization is contemplated.

Dr Berkowitz and his contributors1 have given us yet another opportunity and tool set to reduce rehospitalizations among skilled facility residents. Project RED (ReEngineered Discharge) has as its centerpiece the hospital discharge planning process. The objectives of this trial were to implement Project RED in a skilled nursing facility to increase patient preparedness for care transitions and lower rehospitalization rates in the 30 days after discharge from a skilled nursing facility. The findings are significant and the project attributes have a good chance of success in the nursing home environment. There are many opportunities to achieve the same goals, and the authors have taken advantage of modifying a hospital-based process to the nursing home. Medical directors will need to be mindful of their role in implementing any new process that has a quality component, affects patient transitions, and requires a rethinking of roles and responsibilities.

This clinical trial1 included new elements more specific to long term care, including advance directives, visiting nurse information, and modified diets. Although not as extensive as the more familiar INTERACT program,2–5 these processes of care have an evidence base and have positive outcomes as well. With Project RED, we have yet another opportunity to reengineer nursing home discharges with different tools and a different perspective to enact change. The Jewish Home has many hospitals that are involved with their transfers and they took advantage of Project RED to meet their needs. Problem solving like this gets all of us to learn from others to enhance the patient experience in long term care.

References