**Additional file 1. The 12 components of the RED Toolkit**

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| **RED Component** | **Responsibilities** |
| **1. Ascertain need for and obtain language assistance.** | • Find out about preferred languages for oral communication and written materials.• Determine patient and caregivers’ English proficiency• Arrange for language assistance as needed, including translation of written materials. |
| **2. Make appointments for follow-up medical appointments and post discharge tests/labs.** | • Determine primary care and specialty follow-up needs.• Find a primary care provider (if patient does not have one) based on patient preferences: gender, location, specialty, health plan participation, etc.• Determine need for scheduling future tests.• Make appointments with input from the patient regarding the best time and date for the appointments.• Instruct patient in any preparation required for future tests and confirm understanding.• Discuss importance of clinician appointments and labs/tests.• Inquire about traditional healers and assure that traditional healing and conventional medicine are complementary.• Confirm that the patient knows where to go and has a plan about how to get to appointments; review transportation options and address other barriers to keeping appointments (e.g., lack of day care for children). |
| **3. Plan for the follow-up of results from lab tests or studies that are pending at discharge.** | • Identify the lab work and tests with pending results.• Discuss who will be reviewing the results, and when and how the patient will receive this information. |
| **4. Organize post-discharge outpatient services and medical equipment.** | • Collaborate with the case manager to ensure that durable medical equipment is obtained.• Document all contact information for medical equipment companies and at-home services in the AHCP.• Assess social support available at home.• Collaborate with the medical team and case managers to arrange necessary at-home services. |
| **5. Identify the correct medicines and a plan for the patient to obtain and take them.** | • Review all medicine lists with patient, including, when possible, the inpatient medicine list, the outpatient medicine list, the outpatient pharmacy list, and what the patient reports taking.• Ascertain what vitamins, herbal medicines, or other dietary supplements the patient takes.• Explain what medicines to take, emphasizing any changes in the regimen.• Review each medicine’s purpose, how to take each medicine correctly, and important side effects.• Ensure a realistic plan for obtaining medicines is in place.• Assess patient’s concerns about medicine plan. |
| **6. Reconcile the discharge plan with national guidelines.** | • Compare the treatment plan with National Guidelines Clearinghouse recommendations for patient’s diagnosis and alert the medical team of discrepancies. |
| **7. Teach a written discharge plan the patient can understand.** | • Create an AHCP, the easy-to-understand discharge plan sent home with patient.• Review and orient patient to all aspects of AHCP.• Encourage patients to ask. |
| **8. Educate the patient about his or her diagnosis.** | • Research the patient’s medical history and current condition.• Communicate with the inpatient team regarding ongoing plans for discharge.• Meet with the patient, family, and/or other caregivers to provide education and to begin discharge preparation. |
| **9. Assess the degree of the patient’s understanding of the discharge plan.** | • Ask patients to explain in their own words the details of the plan (the teach-back technique).• May require contacting family members and/or other caregivers who will share in the care-giving responsibilities. |
| **10. Review with the patient what to do if a problem arises.** | • Instruct on a specific plan of how to contact the primary care provider (PCP) by providing contact numbers, including evenings and weekends.• Instruct on what constitutes an emergency and what to do in cases of emergency. |
| **11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.** | • Deliver discharge summary and AHCP to clinicians (e.g., PCP, visiting nurses) within 24 hours of discharge. |
| **12. Provide telephone reinforcement of the Discharge Plan.** | • Call the patient within 3 days of discharge to reinforce the discharge plan and help with problem-solving.• Staff DE Help Line. Answer phone calls from patients, family, and/or other caregivers with questions about the AHCP, hospitalization, and follow-up plan in order to help patient transition from hospital care to outpatient care setting. |