SUPPORTING STATEMENT

Part A

Avoiding Readmissions in Hospitals Serving Diverse Patients

Version December 15, 2010

Agency of Healthcare Research and Quality (AHRQ)

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A. Justification

1. Circumstances that make the collection of information necessary

The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see Attachment A), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by conducting and supporting:

1. research that develops and presents scientific evidence regarding all aspects of health care; and

2. the synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

3. initiatives to advance private and public efforts to improve health care quality.

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to (A) the delivery of health care in inner-city areas, and in rural areas (including frontier areas); and (B) health care for priority populations, which shall include (1) low-income groups, (2) minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

An important part of AHRQ's mission is to disseminate information and tools that can support improvement in quality and safety in the U.S. health care community. The transition process from the hospital to the outpatient setting is nonstandardized and frequently inadequate in quality. One in five hospital discharges is complicated by an adverse event (AE) within 30 days, often leading to an emergency department visit and/or rehospitalization. Many readmissions stem from errors that can be directly attributed to the discontinuity and fragmentation of care at discharge. High rates of low health literacy, lack of coordination in the "hand-off" from the hospital to community care, gaps in social supports, and other limitations also contribute to the risk of rehospitalization.

Boston University Medical Center (BUMC), through a grant from AHRQ, previously defined the discharge process and determined what improvements could be made to improve this care transition for patients. This new process was called the "re-engineered discharge" (RED). The RED consists of 11 elements, including educating the patient throughout the hospital stay, making follow-up appointments, and giving the patient a written discharge plan. The RED was tested in a randomized controlled trial in an academic safety net hospital at BUMC with English-speaking, general medical patients being discharged to home or community settings. Results of this trial of 749 patients

showed a reduction in rehospitalizations within 30 days and emergency department visits following hospital discharge. Participants also followed up with primary care providers more often and reported higher patient satisfaction with the discharge process. Project RED researchers created several tools to help hospitals replicate RED. After AHRQ and Project RED researchers fielded many inquiries about how to implement Project RED at hospitals nationwide, AHRQ realized that the Project RED Toolkit did not provide sufficient guidance to potential replicators. Various components of the RED were not documented, and issues regarding implementing the RED at hospitals serving linguistically and culturally diverse patient populations had not been addressed. AHRQ has therefore contracted with the RED researchers to create a revised RED Toolkit that will address these issues.

This proposed information collection supports AHRQ's mission by improving upon the RED Toolkit. This project has the following 2 goals:

1) To pre-test the revised RED Toolkit in ten varied hospital settings, evaluating how the RED Toolkit is implemented in varied hospital settings by: a) documenting the implementation process; b) assessing the fidelity of implementation; and c) identifying the factors that affect redesign fidelity, including intensity of technical assistance (TA).

2) To modify the revised RED Toolkit based on pre-testing and to disseminate it.

BUMC will provide TA at two varying levels. Four selected hospitals will receive "train-the-trainer" TA, which includes:

1) telephone assistance in conducting a baseline needs assessment;
2) master trainer training;
3) access to webinar trainings specifically designed for each user (nurse, IT professional, hospital leadership, and pharmacist);
4) an electronic template to print an After Hospital Care Plan (AHCP) booklet (see Attachment B); and
5) emails regarding updates to the RED website and the opportunity to ask questions about the newly revised and enhanced RED tools and implementation via telephone and email.

Six selected hospitals will receive intensive TA, which includes:

1) telephone baseline needs assessment;
2) on-site training;
3) monthly semi-structured interviews via phone calls with the implementation team to discuss implementation efforts and barriers;
4) adaptation of the revised RED Toolkit to include specific details about the hospital (such as the hospital name on the cover of the AHCP booklet and hospital-specific services provided to patients included in the AHCP booklet) ;

5) an assessment and evaluation site visit by the organizational change evaluator (a member of the implementation team), at baseline and 12 months after the start of implementation efforts to interview select participating hospital staff;
6) IT support to install and support the RED Toolkit software to automatically generate the AHCP booklet; and
5) emails regarding updates to the RED website and the opportunity to ask questions about the newly revised and enhanced RED tools and implementation via telephone and email.

A diverse group of hospitals will be selected to receive each level of TA, based upon hospital size, location, readmission rate and patient population. Implementing the revised RED Toolkit in diverse settings will provide a better understanding of whether and how RED can be best implemented in different hospital settings.

To achieve the projects' goals, the following data collections and training will be implemented for the six hospitals that will receive intensive TA as well as the 4 hospitals receiving train-the-trainer TA, unless otherwise noted:

1) Baseline needs assessment to help each hospital plan and prepare for implementation of the revised RED Toolkit and to evaluate it in varied settings (see Attachment C). This is not a data collection but will impose a time burden on the participating hospitals as they prepare to participate in this project. The purpose of the needs assessment is for the hospital to become familiar with their discharge process and what parts of the process are being done well and what parts of the process need improvement. In order to implement the new RED discharge process, it is important for a hospital to plan how they will do this. This information will be shared during the baseline key contact semi-structured interview.

2) Baseline key contact semi-structured interviews will be administered by telephone, approximately two months prior to implementation, to the key contact at each of the ten study hospitals (see Attachment D). The purpose of the interview is to identify the implementation team, collect some basic information about the hospital, such as the number of beds and if electronic medical records are used, and to establish the baseline readmission rate.

3) Monthly semi-structured interviews with the key contact or other implementation team member will be conducted monthly for 12 months after implementation (see Attachment E). These interviews will be conducted by phone with each of the six hospitals receiving intensive technical assistance (TA) (the two levels of TA are described above). The purpose of these interviews are to allow hospitals to share their experiences with implementing the revised RED Toolkit, their use of specific tools, changes resulting from using the tools and problems encountered implementing the revised RED Toolkit and how they are being addressed.

4) Baseline semi-structured interviews will be conducted prior to the implementation of the revised RED Toolkit with 15 hospital staff from each of the six study hospitals

receiving intensive TA (see Attachment F). The purpose of this interview is to measure the staff's opinion of the current discharge process, their perceived need for a redesigned process, and the perceived barriers and facilitators to redesigning the discharge process.

5) Post implementation semi-structured interviews will be conducted 12 months after the implementation of the revised RED Toolkit with 15 hospital staff from each of the six study hospitals receiving intensive TA (see Attachment G). The purpose of this interview is to measure the staff's opinion of the redesigned discharge process, which tools were used and their opinion of the tools, and the observed barriers and facilitators to redesigning the discharge process.

6) Patient surveys will be administered by telephone to a random sample of patients 30 days after being discharged from one of the six intensive TA study hospitals (see Attachment H). The purpose of this survey is to measure patient outcomes, including satisfaction with the care they received, 30-day hospital and emergency department visits, and physician appointments, to help determine the success of the RED Toolkit implementation in diverse patient populations. The survey will be administered by a hospital staff member to patients during the pre-implementation period and again during the post-implementation period to compare patient outcomes.

7) Hospital reutilization rates, which constitute patient outcomes, will be calculated by administrative staff at all ten study hospitals (see Attachment I). The data will be retrieved from each hospital's technology system and will be limited to: (1) the number of readmissions (all-cause) that occurred within 30-days of the index admission; and (2) the number of emergency room visits that occurred within 30-days of the index admission. These data will be collected both pre- and post-implementation of the revised RED Toolkit and will inform the success of the revised RED Toolkit implementation in diverse patient populations. We will suggest that hospitals present these data in a "run chart" that simply displays this information as a rate for both those who have received the intervention and those who have not. Hospitals receiving intensive TA will transmit to BUMC a list of names of patients who received the RED who visited the ED and/or were readmitted within 30 days of discharge. From the RED workstation, used to generate the AHCP, these hospitals will also transmit data on which components of RED were completed for each patient. See Attachment I. These data will inform the success of the revised RED Toolkit implementation.

8) Master trainer training will be conducted with 3 staff members from each of the 4 hospitals receiving train-the-trainer TA (see Attachment J). These people will be trained to administer the RED Toolkit and be able to use recorded webinar training sessions within their organization. They will be invited to travel to BUMC for a 2-day onsite orientation of the RED intervention. These people will meet with several members of the BUMC implementation team (physician leader, discharge advocate nurse) and will have the opportunity to shadow the nurse discharge advocates in conducting the RED intervention.

9) Intensive training will be conducted with about 28 staff from each of the 6 hospitals receiving intensive TA (see Attachment K). The training will consist of a two-day on-site orientation and training at each hospital conducted by the BUMC implementation team. The BUMC implementation team will consist of a physician researcher, a discharge advocate nurse, an organizational change champion /evaluator and the information technology expert. The BUMC team will spend two days, 8 hours per day, to train the relevant hospital staff to perform the 11 components of the RED discharge. The training will include material for senior hospital management, hospital physicians, nurses, IT staff, and pharmacists.

The project will be framed within a model of organizational change and transformation called the Organizational Transformation Model (OTM), which is based on the evaluation of Robert Wood Johnson Foundation's *Pursuing Perfection* initiative. OTM identifies key elements that drive dramatic system change and informs the implementation process and impact evaluation. Using a mixed-methods design, the evaluation tracks change over time and across the implementation period within each hospital. The evaluation therefore will encompass feedback on specific implementation processes and factors in microsystems where RED is adopted, in the larger organizational context, and interactions between the two.

This research study is being conducted by AHRQ through its contractor, BUMC, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and disseminate information on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299(b) and 299a(a)(1) and (2).

2. Purpose and Use of Information

The implementation of the RED Toolkit will be tracked at each hospital for 12 months. There will be pre-post comparisons, comparing hospitals before implementation and 12 months after implementation. Implementing hospitals will be compared against each other to determine whether the redesigned toolkit and implementation process is applicable across settings or whether modifications are needed to tailor it to specific practice settings. For process outcomes, hospitals receiving intensive TA will receive evaluation team site visits, whereas those hospitals receiving "train the trainer" TA will receive evaluation telephone interviews. This information will be used to: 1) tailor modifications to practice settings in future roll-outs; 2) inform further revisions of the RED tools; 3) guide implementing all hospitals receiving TA with their RED Toolkit implementation efforts.

For patient outcomes, all hospitals will receive detailed instructions about data they must collect and provide to the research team. This information will be used to determine the success of the RED process and the revised RED Toolkit in diverse hospital settings, compare outcomes in varying levels of TA and to better understand what level of TA is needed for successful implementation.

Data from these sources will be used formatively to tailor the RED Toolkit to the practice settings and summatively to assess implementation success in diverse settings, draw lessons learned about implementation strategies and identify areas for modifying the RED Toolkit.

3. Use of Improved Information Technology

The project team acknowledges the importance of using information technology in order to lessen the burden of respondents. For this project, consideration was also given to what would yield the greatest response rate for each data collection at each implementation site. Accordingly, data will be entered and managed at each implementation site through a linked database. This will enable the project team to easily manage and track the progress of each implementation hospital's data collection. This will streamline the sharing and analysis of de-identified data. The RED workstation software that will be provided to intensive TA hospitals can utilize the electronic medical record to produce the RED AHCP booklet. The software also collects the process outcomes for all patients who receive the RED intervention.

4. Efforts to Identify Duplication

To our knowledge, the RED Toolkit hasn't been formally evaluated at hospitals other than BUMC.

No formal efforts to identify duplication have been conducted because program staff, through extensive contacts with organizations and individuals in both the private and public sectors, are confident that there are no similar data available.

5. Involvement of Small Entities

This project does not involve or impact any small entities.

6. Consequences if Information Collected Less Frequently

This is a one-time data collection.

7. Special Circumstances

This request is consistent with the general information collection guidelines of 5 CFR 1320.5(d)(2). No special circumstances apply.

8. Federal Register Notice and Outside Consultations

8.a. Federal Register Notice

As required by 5 CFR 1320.8(d), notice was published in the Federal Register on June 21st, 2010 for 60 days (see Attachment L). One comment was received; see Attachment M for the comment and Attachment N for AHRQ's response.

8.b. Outside Consultations

The following individual has been consulted:

VK Chetty, PhD, Statistician and Health Economist, Boston University Medical Center, Department of Family Medicine. Contact: chettyvk@gmail.com.

9. Payments/Gifts to Respondents

No payments will be made to respondents.

10. Assurance of Confidentiality

Individuals and organizations will be assured of the confidentiality of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). They will be told the purposes for which the information is collected and that, in accordance with this statute, any identifiable information about them will not be used or disclosed for any other purpose.

Information that can directly identify the respondent, such as name and/or social security number will not be collected by the leadership team however, identifiable information will be collected by the implementing hospital. This identifiable information will include: patient medical record number, patient name, and patient age. This information will be handled by the project manager at each implementing hospital and stored by the implementing hospitals. Once de-identified data has been shared with the Project RED leadership team at BUMC, it will be stored in a password secured database that only the project manager will have access to. Data will only be shared within the leadership team for the following reasons: data analysis, organization and review. Matters of human subject's protection will be monitored under the auspices of Boston University's Institutional Review Board (IRB).

11. Questions of a Sensitive Nature

Questions of a sensitive nature will not be asked. All patients will be informed of the topics they will be surveyed about, as included in the informed consent form required for their participation.

12. Estimates of Annualized Burden Hours and Costs

Exhibit 1 shows the estimated annualized burden hours associated with the respondent's time to participate in this research. The baseline needs assessment will be conducted by staff at each of the 10 participating hospitals and takes about 8 hours to complete. Baseline key contact semi-structured interviews will be conducted with the key contact at each hospital and requires 1 hour to complete. Monthly semi-structured interviews with the key contact or other implementation team member will be conducted monthly for 12 months after implementation. These interviews will be conducted by phone with each of the six hospitals receiving intensive TA and will require 1 hour to complete. Both the base-line and post-implementation semi-structured interviews will be conducted with 15 staff members from each of the 6 hospitals receiving intensive TA and will last about one hour. The patient survey will be administered twice, pre and post implementation, to 3,108 patients recently discharged from one of the 6 hospitals receiving intensive TA and requires 10 minutes to complete. The patient survey will be administered by the hospital staff and will require 10 minutes of their time to administer. Hospital reutilization rates will be calculated by all 10 participating hospitals using their IT system. As most hospitals already tabulate this information we estimate that it will take each hospital

about 1 hour to extract the rate of all intervention patients from the entire population of discharges. Master trainer training will be conducted with 3 staff members from each of the 4 hospitals receiving train the trainer TA and will last 16 hours. Intensive training will be conducted with about 28 staff members from each of the 6 hospitals receiving intensive TA and will also last 16 hours. The total annualized burden is estimated to be 5,486 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondent's time to participate in this research. The total annualized cost burden is estimated to be $186,544.

Exhibit 1. Estimated annualized burden hours

Form Name	Number of Respondents	Number of responses per respondent	Hours per response	Total Burden hours
Baseline needs assessment	10	1	8	80
Baseline key contact semi-structured interview	10	1	1	10
Monthly semi-structured interview	6	12	1	72
Base-line semi-structured interview	6	15	1	90
Post implementation semi-structured interview	6	15	1	90
Patient survey	3,108	2	10/60	1,036
Administration of patient survey by hospital staff	6	1,036	10/60	1,036
Hospital reutilization rates	10	12	1	120
Transmission of patient-level data from RED workstation	6	12	1	72
Master trainer training	4	3	16	192
Intensive training	6	28	16	2,688
Total	3,178	na	na	5,486

Exhibit 2. Estimated annualized cost burden

Form Name	Number of Respondents	Total Burden hours	Average Hourly Wage Rate*	Total Cost Burden
Baseline needs assessment	10	80	$41.94 [a]	$3,355
Baseline key contact semi-structured interview	10	10	$51.91 [b]	$519
Monthly semi-structured interviews	6	72	$40.91 [c]	$2,946
Base-line semi-structured interview	6	90	$38.51 [d]	$3,466
Post implementation semi-structured interview	6	90	$38.51 [e]	$3,466
Patient survey	3,108	1,036	$20.32 [f]	$21,052
Administration of patient survey by	6	1,036	$31.31 [h]	$32,437

hospital staff				
Hospital reutilization rates	10	120	$17.32 [g]	$2,078
Transmission of RED workstation data	6	72	$17.32 [g]	$1,247
Master trainer training	4	192	$31.31 [h]	$6,012
Intensive training	6	2,688	$40.91 [i]	$109,966
Total	3,172	5,486	na	$186,544

*Based upon the mean of the average wages, National Compensation Survey: Occupational wages in the United States May 2008, "U.S. Department of Labor, Bureau of Labor Statistics." a) 75% Nurses (29-1111, $31.31/hr), 20% Physicians (29-1069, $79.33/hr) and 5% General and Operations Managers (29-1069, $51.91/hr); b) 100% General and Operations Managers (29-1069, $51.91/hr); c) 80% Nurses and 20% Physicians; d and e) 85% Nurses and 15% Physicians; f) 100% General public (00-0000, $20.32/hr); g) 100% Statistical assistants (43-9111, $17.32/hr); h) 100% Nurses; i) 80% Nurses and 20% Physicians.

13. Estimates of Annualized Respondent Capital and Maintenance Costs

Capital and maintenance costs include the purchase of equipment, computers or computer software or services, or storage facilities for records, as a result of complying with this data collection. There are no direct costs to respondents other than their time to participate in the study.

14. Estimates of Annualized Cost to the Government

Exhibit 3 shows the total and annualized cost over the 18 months of this clearance. The total cost is $449,976.

Exhibit 3. Estimated Total and Annualized Cost

Cost Component	Total Cost	Annual Cost
Project RED Toolkit Development	$97,413	$64,942
Dissemination Planning and Support	$98,080	$65,387
Data Collection Activities	$84,563	$56,375
Data Processing and Analysis	$52,215	$34,810
Publication of Results	$3,184	$2,123
Project Management	$28,892	$19,261
Overhead	$85,629	$57,086
Total	$449,976	$299,984

15. Changes in Hour Burden

This is a new data collection effort.

16. Time Schedule, Publication and Analysis Plans

The overall purpose of the project is to revise the RED Toolkit to increase its applicability by increasing the guidance and attention to cultural and linguistic competency. The revised toolkit will be tested and evaluated in a diverse group of hospitals to determine if the toolkit can facilitate implementation of the RED process and achieve similar results as those seen at BUMC.

Evaluation data will be obtained from six sources:

Baseline key contact semi-structured interview
Monthly semi-structured interviews
Base-line semi-structured interview
Post implementation semi-structured interview
Patient survey
Hospital system data

The project will be framed within a model of organizational change and transformation called the Organizational Transformation Model (OTM), which is based in the evaluation of Robert Wood Johnson Foundation's *Pursuing Perfection* initiative. OTM identifies key elements that drive dramatic system change and informs the implementation process and impact evaluation. Using a mixed-methods design, the evaluation tracks change over time and across the implementation period within each hospital. We will track the implementation of the RED Toolkit at each hospital for 12 months. Specifically, we will track the 30 day all cause readmission rate and the 30 day all cause emergency room visit rate. We will collect each hospital's reutilization rates monthly during the 12 months of implementation and compare the changes to their baseline rates (pre-implementation). We will also collect the numbers of readmissions and ED visits within 30 days of discharge for each patient receiving the RED.

Baseline key contact semi-structured interview. These data will be analyzed qualitatively. Using an explanation-building analytic strategy, we will analyze in depth the dynamics of each site and identify organizational factors across sites. We will analyze our data from the ground up, based on a content analysis, such as is done in grounded theory. Consistent with grounded theory in qualitative analysis, we will use the following process to analyze the qualitative data. All transcripts will be entered as text files into HyperResearch, a qualitative software program, for data analysis. Analytic procedures will follow the general procedures of grounded theory methodology. Data will be analyzed through a process of thematic-content analysis. Transcripts will be marked by code words to identify passages indicating conceptually distinct themes. Passages associated with a given codeword will be extracted, collected from all subjects, and reviewed as a set marked by a codeword.

In conducting our analysis, we will use the data-driven inductive approach which allows themes to emerge from the data using inductive coding. This inductive process of coding involves finding repetitive statements or ideas within the raw data and coding them prior

to interpretation, thereby searching for themes that emerged from the data as being important to addressing the goals of our investigation. This method of coding the data will allow us to organize the information to identify and develop themes to interpret the data.

Consistent with Miles and Huberman's guidelines for comparative case studies (1994), we will work to understand each case before proceeding to cross-site explanations, and then will cycle back and forth between analytic strategies aimed at understanding case dynamics and understanding the effect of key variables. Summaries organized by the OTM factors along with documentation of the implementation process will be the starting point for developing our understanding of each case. The analysis framework will also remain open to capture other system experiences and dynamics that appear to have a strong impact on the project. Based on the summaries, the evaluation team will develop analytic memos that describe the key factors which appear to influence redesign implementation and outcomes within each site. For cross-case analysis, we will code and sort the focus group and implementation team notes into descriptive meta-matrices organized by: 1) the OTM factors and, if appropriate, emerging factors; 2) levels of implementation fidelity; and 3) success in meeting redesign goals. The evaluation team will re-visit the individual case analyses in order to ensure that the cross-site explanations of important components are consistent with the explanations developed within each site.

Monthly semi-structured interviews. This qualitative data will be analyzed as in the baseline key contact semi-structured interview.

Baseline semi-structured interview. This qualitative data will be analyzed as in the baseline key contact semi-structured interview.

Post implementation semi-structured interview. This qualitative data will be analyzed as in the baseline key contact semi-structured interview.

Patient survey. Standard empirical methods will be used to analyze the quantitative data collected from the patient survey. All data will be entered into a Microsoft Excel file and analyzed using R statistical software. After data are collected, we will perform data checking on a 10% sample of the data to check for data quality and missing data. Once the database is completed, we will perform standard statistical analyses, specifically descriptive statistics including frequencies, measures of central tendency, and measures of variability. Data will be stratified by hospital characteristics and patient variables. We will examine change from pre-implementation to post-implementation using bi-variate analyses, such as t-tests and chi-squares as appropriate.

Hospital system data. Standard empirical methods will be used to analyze the quantitative data collected from the hospitals. The change in pre- and post-implementation hospital reutilization rates will be calculated for RED recipients. Pre- and post-implementation hospital reutilization rates will also be calculated for patients who did not receive RED to control for secular trends.

Using the numbers of readmissions and ED visits for each patient receiving RED, data extracted from the RED workstation will be used to analyze whether reutilization was associated with demographic characteristics or with failure to receive certain RED components.

Time Schedule and Publication Plan

Table 2: Timetable for Data Collection, Analysis, and Publication

Activity	Expected Month (s)
Task slate 1=Administrative Tasks	8/2009-3/31/2012
Task slate 2=Revision of RED Toolkit	10/2009-8/2011
Task slate 3=Delivery of Technical Assistance	1/2011-2/2012
Task slate 4=Study Implementation and Evaluation	1/2011-2/2012
Task slate 5=Dissemination	10/2011-2/29/2012
Task slate 6=Submission of final report	1/29/2012

Dissemination Plan

The dissemination of the revised RED toolkit and testing results involves three parts:

1) After the RED tools have been finalized, they will all be made publicly available to download on the BUMC Project RED website and on the AHRQ website.

2) The results of the toolkit testing will be presented at national research and healthcare conferences. Scientific articles will be submitted to peer-reviewed journals.

3) A private partner has been recruited in order to distribute, tailor, and support the software application which can automatically produce the AHCP booklet. This resource will be available to all hospitals for a fee, should they choose to utilize it.

17. Exemption for Display of Expiration Date

AHRQ does not seek this exemption.

List of Attachments:

Attachment A -- Healthcare Research and Quality Act of 1999 (separate)
Attachment B -- Electronic template for the After Hospital Care Plan (example)
Attachment C -- Baseline needs assessment protocol
Attachment D – Baseline key contact semi-structured interview protocol
Attachment E -- Monthly semi-structured interview protocol
Attachment F -- Baseline semi-structured interview protocol
Attachment G -- Post implementation semi-structured interview protocol
Attachment H -- Patient questionnaire
Attachment I -- Hospital system data
Attachment J -- Master trainer training guide
Attachment K -- Intensive training guide
Attachment L -- Federal Register Notice
Attachment M – Public Comment
Attachment N – Response to Public Comment

References

1. Jack BW, Chetty VK, Anthony D, Greenwald JL, Sanchez GM, Johnson AE, et al. A Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. *Annals of Internal Medicine*. 2009;150(3):178-187.
2. Greenwald JL, Denham CR, Jack BW. The Hospital Discharge: A Review of a High Risk Care Transition with Highlights of a Reengineered Discharge Process. *J Patient Saf*. 2007;3:97-106.
3. Jack B, Greenwald J, Forsythe S, O'Donnell J, Johnson A, Schipelliti L, et al. Developing the Tools to Administer a Comprehensive Hospital Discharge Program: The Reengineered Discharge (Red) Program. Rockville, MD: Agency for Healthcare Research and Quality; August 2008. Report No.: AHRQ Publication No. 08-0034-3.