SUPPORTING STATEMENT

Part A

The Re-engineered Visit for Primary Care (AHRQ REV)

April 20, 2017

Agency for 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,[i] 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 promotes health care quality improvement by conducting and supporting:

1. Research that develops and presents scientific evidence on all aspects of health care;

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.

AHRQ conducts and supports research and evaluations, and supports demonstration projects, on (A) the delivery of health care in inner-city areas, and in rural areas; and (B) health care for priority populations, which 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.

This research has the following goals:

1. Analyze current processes in the primary care visit associated with hospital discharge; and

2. Identify components of the re-engineered visit.

To achieve the goals of this project the following data collections – as outlined in the table below - will be implemented:

Form	Audience (for each of the nine primary care sites)	Survey/interview topics
Primary Care Site Organizational Characteristics Survey (Attachment G)	1 primary care site administrator (e.g., medical director)	• Organizational characteristics (e.g., patient-centered medical home status, participation in an accountable care organization) • Number of different staff role types • Patient record management • Care coordination with hospitals
Primary Care Site Patient Characteristics Survey (Attachment H)	1 primary care site IT analyst	• Patient demographics • Patient hospitalizations, readmissions, and referrals to the hospital • Timing of primary care follow-up visits
Work Flow Mapping Preliminary Interview Guide (Attachment I)	8 primary care site staff (e.g., nurses, medical assistants, front desk staff)	• Transitional care roles and workflow • Consistency of steps in the workflow • Barriers and challenges experienced in delivering transitional care
Work Flow Mapping Group Interview Guide (Attachment J)	10 primary care site staff (e.g., nurses, medical assistants, front desk staff)	• Clarification of the transitional care activities that occur during a patient's hospitalization, post-discharge and before the primary care visit, during the primary care visit, and after the primary care visit • Consistency of transitional care activities in terms of how they are delivered and to which patients
Work Flow Mapping Follow-Up Interview Guide (Attachment K)	8 primary care site staff (e.g., nurses, medical assistants, front desk staff)	• Confirmation of transitional care roles and workflow • Impact and frequency of barriers and challenges in delivering transitional care • Suggestions for how to remove or reduce barriers and challenges in delivering transitional care
Patient Interview Guide (Attachment L)	10 primary care site patients after discharge	• Reason for hospitalization • Concerns and challenges post-discharge • Care received post-discharge • Nature of post follow-up phone call or visit • Issues or recommendations to inform better transitional care
Community Agency Interview Guide (Attachment M)	5 community agency staff members (e.g., manager, social worker)	• Overview of community agency services and clients • Client post-discharge needs and relevant services delivered by the agency • Number of joint clients with the primary care practice • Communication and collaboration with the primary care practice

This project, The Re-engineered Visit for Primary Care (AHRQ REV), directly addresses the agency's goal to conduct research to enhance the quality of health care and focuses

on a current major policy issue of national significance, as avoidable readmissions are a major indicator of poor quality and patient safety. Research from AHRQ's Healthcare Cost and Utilization Project (HCUP) indicates that in 2011 there were approximately 3.3 million adult hospital readmissions in the United States.[ii] Adults covered by Medicare have the highest readmission rate (17.2 per 100 admissions), followed by adults covered by Medicaid (14.6 per 100 admissions) and privately insured adults (8.7 per 100 admissions).[iii] High rates of readmissions are a major patient safety problem and are associated with a range of adverse events such as prescribing errors and misdiagnoses of conditions in the hospital and ambulatory care settings.[iv] Collectively these readmissions are associated with $41.3 billion in annual hospital costs, many of which could potentially be avoided.[v] The post-hospital discharge is a handoff ripe with hazards, potentially leading to an array of adverse events including the development of new or worsening symptoms, unplanned readmissions, and increased costs.[vi]

In recent years, payer and provider efforts to reduce readmissions have proliferated. Many of these national programs have been informed or guided by evidence-based research, toolkits and guides, such as AHRQ's RED (Re-Engineered Discharge),[vii] STAAR (STate Action on Avoidable Readmission),[viii] AHRQ's Project BOOST (Better Outcomes by Optimizing Safe Transitions),[ix] *the Hospital Guide to Reducing Medicaid Readmissions[x],* and Eric Coleman's Care Transitions Intervention.[xi] These efforts have largely focused on enhancing practices occurring within the hospital setting, including the discharge process transitions among providers and between settings of care. While many of these efforts have recognized the critical role of primary care in managing care transitions, they have not had an explicit focus on enhancing primary care with the aim of reducing avoidable readmissions.

Evidence-based guidance for the primary care setting to reduce readmissions and improve patient safety are comparatively lacking. This gap in the literature is becoming more pronounced as primary care is increasingly serving as the key integrator across the health system as part of payment and delivery system reforms. This research project aims to address the important and unfulfilled need to improve patient safety and reduce avoidable readmissions within the primary care context.

AHRQ's goals in supporting this 30-month project are to build on the knowledge base from the inpatient settings, add to the expanding evidence base on preventing readmissions by focusing on the primary care setting, and provide insight on the components and themes that should be part of a re-engineered visit (REV) in primary care. This project will ultimately inform an effective intervention that can be tested in a diverse set of primary care clinics. *Attachment A: Project Summary for AHRQ's Re-engineered Visit for Primary Care (AHRQ REV)* offers an overview of this project's purpose, setting, methods, and key activities.

To meet AHRQ's goals and objectives, the agency awarded a task order to John Snow, Inc. (JSI) to conduct qualitative research using quality improvement techniques to investigate the primary care-based transitional care workflow from the primary care staff, patient, and community agency perspective. The data collection instruments and methods

included in this package were informed by project consultants and a technical expert panel (see *Attachment B: Contract Staff, Consultant, and Technical Expert Panel Lists*; see also Section 8.b.). From June - August 2016, the data collection instruments and methods were tested in a pilot at Cambridge Health Alliance (Massachusetts) and Altamed (California), which was greatly informative as to the feasibility of the methods, including time burden, and the value of the data collected (see *Attachment C: Pilot Methods and Results*).

The pilot demonstration serves as a foundation for an analysis of primary care processes, patient interviews, and community agency interviews. *Attachment D: Summary of Common Data Collection Instruments* offers an overview of the instruments and information the number of type of research participants targeted, time burden, and instrument content. *Attachment E: Fielding, Data Collection, and Analysis Methods* explains how the data will be collected and analyzed in this research.

Method of Collection

The JSI project team will conduct an Analysis of Primary Care Processes in partnership with three organizations: Cambridge Health Alliance, Altamed, and Kaiser Permanente (see *Attachment F: Primary Care Site Overview*). A principal investigator (PI) at each organization will select three primary care sites each to participate in this research: two primary care sites affiliated with their organization and one non-affiliated site in their service area for a total of nine different primary care sites. The organizations' PI will oversee all of the research activities in their organizations and in nonaffiliated sites in their area. Contractor staff will train the organization PIs to collect the information for the following tasks to ensure consistency.

To analyze current processes in the primary care visit associated with hospital discharge, the data collection has separated into seven smaller data collection activities to minimize research participant burden while still allowing for the collection of necessary data. Each of these tasks will be conducted at nine primary care sites:

1. Primary care site organizational characteristics survey: The purpose of this background information on the primary care site's organizational characteristics is to offer context for the work flow mapping. It will help make the work flow mapping process more efficient and reduce burden by only requesting information that is already known by each site contact. One person per primary care site will be engaged for this task. The survey questions are included in *Attachment G: Primary Care Site Organizational Characteristics Survey*.

2. Primary care site patient characteristics survey: The purpose of this background information on the primary care site's patients is to offer context for the work flow mapping. It will help make the work flow mapping process more efficient and reduce burden by only requesting information that is already known in the primary care practices' billing or clinical information systems. One person per primary care site will be engaged for this task. The

survey questions are included in *Attachment H: Primary Care Site Patient Characteristics Survey.*

3. Work flow mapping preliminary interviews: The purpose of this flow mapping "pre-work" is to engage individual primary care staff members to think about the work flow map in order to set a foundation for the actual work flow mapping process. It is anticipated that eight individuals per primary care site will participate, for a total of 72 participants. The interview questions are included in *Attachment I: Work Flow Mapping Preliminary Interview Guide.*

4. Work flow mapping : This collection will take place in a group meeting that brings together staff from various role-types to collaborate in identifying their workflow processes involved in planning for and executing post-hospital follow up services for their patients. Based on feasibility these may be smaller or larger group meetings, but the total burden on each role type participant is the same. The end goal of this meeting is to have enough information to develop an initial process flow map on paper. It is anticipated that 10 individuals per primary care site will participate, for a total of 90 participants. The interview questions are included in *Attachment J: Work Flow Mapping Group Interview Guide.*

5. Work flow mapping follow-up interviews: Once the initial process flow map is on paper, each role type will be asked to review to correct, add, or confirm detail to the document. Once the flow map has been edited and ratified by the primary care site staff, each role type will be asked specific questions regarding failure modes identified in the process flow for the failure mode effects analysis. It is anticipated that eight individuals per primary care site will participate, for a total of 72 participants. The interview questions are included in *Attachment K: Work Flow Mapping Follow-Up Interview Guide.*

6. Patient Interviews: As a complement to the work flow mapping, there will also be a process flow map from the patient's perspective. The purpose of the patient interviews is to capture patient perspectives on potential breakdowns in making the transition from the hospital to care in the primary care settings and to get in their own words, information about the initial hospitalization and barriers to accessing follow-up care. One of the widely acknowledged limitations of the existing evidence based toolkits is that they are not designed with input from patients. This has occurred despite the fact that clinical experience suggests that providers often fail to identify patient needs and concerns. Research has shown that there are cultural, social, and behavioral factors that may contribute to readmissions and assessing the patient's perspective can help to better understand the barriers to receiving appropriate follow-up care.[xii,xiii] Patient and family interviews are increasingly common practices in efforts to improve care transitions and reduce readmissions, endorsed by CMS, the Institute for Healthcare Improvement, Kaiser Permanente, and others. The patient interview will collect unique

information on the barriers to effective care transitions in the post-discharge period care, information which cannot be collected in other ways. Ten post-discharge patients per primary care site will be interviewed for a total of 90 patients. The patient interview guide is included in *Attachment L: Patient Interview Guide.*

7. Community agency interviews: As a complement to the patient interviews, the community agency interviews will reflect the perspective of community agencies affiliated with the primary care sites to assist patients. Five community agency representatives per primary care site will be interviewed, for a total of 45 participants. The community agency interview guide is included in *Attachment M: Community Agency Interview Guide.*

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

2. Purpose and Use of Information

The purpose of this data collection is to understand the key components that should be included in the REV in primary care. The project team will examine the diverse settings, staff, and transitional care activities across a variety of primary care practices to identify key transitional care processes that impact patient outcomes, the challenges to implementing those processes, and ways to improve those processes. The project team will distill the themes/principles that should be a part of the REV and develop an outline and summary of the REV components, with a comparison/contrast of the components across sites and discussion of the generalizability of these components to different settings. The information identified from this research will add to the expanding evidence base on preventing readmissions by focusing on the primary care setting, and provide insight on the components and themes that should be part of a REV that will ultimately inform an effective intervention that can be tested in a diverse set of primary care clinics.

3. Use of Improved Information Technology

Notes from work flow mapping and patient interviews will be taken by using password protected laptops. There will be no IT burden on the part of these research respondents. For the primary care site background information, the data collection forms (Attachments G and H) will be emailed to the nine respondents who will use Microsoft Word or excel to access the form. Since this is standard office equipment and software, there will be no IT burden on the part of these respondents. Because this is a one-time limited project, investments in improved technology to decrease burden would not be necessary, nor would they be cost effective.

4. Efforts to Identify Duplication

As described above in Section 1, the information collected for this project through the key informant interviews and data collection tasks associated with the analysis of primary care processes and workflow will be unique. No similar information on the components a REV in primary care is available. During the spring of 2016, JSI and its partners conducted an extensive literature review on programs and strategies for primary care organizations to reduce avoidable readmissions. However, there is very little research in the published literature on primary care strategies for reducing readmissions. The sizeable literature focusing on readmissions from a hospital perspective is only of limited usefulness for primary care organizations. This research thus does not duplicate existing efforts.

5. Involvement of Small Entities

Providers in small primary care practices may be asked to help recruit participants for the survey or interviews. The researchers will make every effort to ensure that the recruitment burden on participating small practices is minimal and that interviews are scheduled at the convenience of the respondents.

The information being requested from the participants has been held to the absolute minimum required for the intended use.

6. Consequences if Information Collected Less Frequently

This is a one-time 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), a notice was published in the Federal Register on February 13th, 2017 on page 10487 for 60 days (see *Attachment N: 60 Day Federal Register Notice*).

8.b. Outside Consultations

AHRQ's contractor consulted individuals outside the agency about the research and data collection activities for this project. These individuals include the AHRQ personnel who oversee the contract: Deborah Perfetto, PharmD and Eileen Hogan, MPA. The contractor, JSI, and the five project consultants and subcontractors are partners in this effort and have worked jointly on the design of the project and have met biweekly since the start of the project to discuss the data collection activities and protocols for the workflow mapping

processes, patient interviews, and community agency interviews; the availability of the data at the nine primary care sites; frequency and modality of data collection; and data to be collected. In addition, AHRQ's contractor also consults a 10 member technical expert panel to inform the research approach, questions, and analysis. The panel is scheduled to meet several times during this project, but members have agreed to also be available for individual consultation. *Attachment B* includes project consultant biographies and lists the technical expert panel members and their professional affiliations. There are no unresolved issues stemming from these consultations.

9. Payments/Gifts to Respondents

There will be no payment for individual participants in any of the data collection activities.

10. Assurance of Confidentiality

Individuals and organizations will be assured of the confidentiality of their replies under Section 944(c) of the Public Health Service Act 42 U.S.C. 299c-3(c). That law requires that information collected in AHRQ-supported research that identifies individuals or establishments be used only for the purpose for which it was supplied.

Key informant interview respondents, workflow process participants and patient participants will be given this assurance during recruitment and again immediately before their participation. They will further receive assurance that the information being gathered is for research purposes only, and will not affect the care that they are receiving in either primary care or hospital settings. Key informant interview respondents and workflow process participants will also be asked for their permission to have the conversation audio-recorded solely for the purpose of filling in any gaps in the research notes (patient interviews will not be recorded). JSI will capture the names of key informants for the key informant interviews, and of the individuals participating in the work flow mapping processes. However, JSI will not report in any dissemination materials identifying information about health providers or others respondents.

JSI will not collect social security numbers, home contact information, and similar information that can directly identify the respondents for all data collection activities, nor collect names for the patient interviews. The only Personal Health Information (PHI) that may be collected from the patients will be reason for hospitalization and individuals cannot be identified by this information alone. Should a patient accidentally disclose any other confidential information that can identify an individual, it will not be used or reported in any dissemination materials.

In order to safeguard data, the contractor will keep information from all the collection instruments, outlined in this OMB statement, in study-specific folders and locked file cabinets that only project staff may access. The contractor uses secure web servers using the latest SSL technology, state-of-the-art firewalls, mandatory scanning of all incoming e-mail, intrusion detection and monitoring systems to ensure that their network is safe and secure. The contractor's technology staff perform system backups nightly. Access to data

centers is strictly controlled and logged. All devices (servers, workstations, routers, switches, etc.) at JSI require a valid user ID and password before they can be used. During visits to the primary care organizations for the process flow mapping, investigators will at all times keep notebooks and laptop computers on their persons or in locked locations.

11. Questions of a Sensitive Nature

Because this is a patient safety project, it is possible that primary care site or community agency staff may offer information that current transitional care practices are inadequately delivered (see Attachments I, J, and K for interview guides with the primary care staff; see also Attachment M: Community Agency Interview). Such information would qualify as sensitive information per the Department of Health and Human Services list of sensitive topics (i.e. "critical appraisals of other individuals with whom respondents have close relationships, e.g., family, pupil-teacher, employee-supervisor"). However, investigating the transitional workflow at these primary care sites represents the core objective of this project, so that the context of transitional care work in primary care practices can be understood, and the key challenges in the delivery of transitional care from the primary care perspective can be clearly addressed.

There is also the potential that questions for the patient interviews may elicit sensitive information. The contractor will be asking patients about the reason for their recent hospitalization, their concerns and challenges post-discharge, care received post-discharge, and issues or recommendations to inform better transitional care (see Attachment L). It is possible that the questions will elicit answers around mental, substance, or other medical problems potentially embarrassing to respondents. However, the patient concerns and care received with regard to these issues are critical to understanding the gaps and delivery of high-quality transitional care.

To help ensure that an appropriate protocol is in place to minimize potential harm from these questions, all of the data collection instruments will be submitted to each participating organization's IRB for approval before any data collection takes place. The contractor will obtain verbal consent from participants before the interviews, which will include language indicating that all information will be confidential, that their participation is voluntary, and they can refuse to answer questions and stop participation at any time. Any sensitive information obtained will be handled carefully, and not shared or attributed to individuals in an identifiable way in any written or oral communications.

12. Estimates of Annualized Burden Hours and Costs

Exhibit 1 shows the estimated burden hours to the respondents for providing all of the data needed to meet the project's objectives. The hours estimated per responses are based on the pilot project results (see *Attachment C*).

For the primary care site organizational characteristics survey and patient characteristics survey, one person per each of the nine primary care sites will participate. Both surveys are anticipated to take 1.5 hours to complete.

For the workflow mapping preliminary interviews, we estimate that eight primary care staff per primary care site will participate, with each individual spending 0.5 hours in these interviews. For the workflow mapping group interview, we estimate that 10 primary care staff per primary care site will participate, with each individual spending 1.5 hours in these interviews. Finally, we estimate that eight primary care staff per primary care site will participate in the workflow mapping follow-up interviews, with each individual spending 0.5 hours in this data collection activity.

There will be 10 patients interviewed in association with each primary care site. These patient interviews are expected to take 0.5 hours per individual research participant.

Lastly, there will be five community agency staff members interviewed in association with each primary care site. These interviews are expected to take 1 hour per individual research participant.

Exhibit 2 shows the estimated cost burden for the respondents' time to participate in the project. The total annualized cost burden is estimated at $11,500.30.

Exhibit 1: Estimated Annualized Burden Hours

Form Name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Primary care site organizational characteristics survey; Attachment G	9	1	1.5	13.5
Primary care site patient characteristics survey; Attachment H	9	1	1.5	13.5
Workflow mapping preliminary interview; Attachment I	72	1	0.5	36
Workflow mapping group interview, Attachment J	90	1	1.5	135
Workflow mapping follow-up interview; Attachment K	72	1	0.5	36
Patient interview; Attachment L	90	1	0.5	45
Community agency interview, Attachment M	45	1	1	45
Total	**387**	**n/a**	**n/a**	**324 hours**

Exhibit 2: Estimated Annualized Cost Burden

Form Name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Primary care site organizational characteristics survey; Attachment G	9	13.5	$ 40.41[a]	$ 545.54
Primary care site patient characteristics survey; Attachment H	9	13.5	$ 40.41[a]	$ 545.54
Workflow mapping preliminary interview; Attachment I	72	36	$ 40.41[a]	$1,454.76
Workflow mapping group interview; Attachment J	90	135	$ 40.41[a]	$5,455.35
Workflow mapping follow-up interview; Attachment K	72	36	$ 40.41[a]	$1,454.76
Patient interview; Attachment L	90	45	$ 23.23[b]	$1,045.35
Community agency interview; Attachment M	45	45	$ 22.20[c]	$ 999.00
Total	**387**	**n/a**	**n/a**	**$11,500.30**

* For hourly average wage rates, mean hourly wages from the Bureau of Labor Statistics (BLS) May 2015 national occupational employment wage estimates were used. http://www.bls.gov/oes/current/oes_nat.htm#00-0000

[a] Participants will include a mix of providers and front desk staff; therefore a blended rate for these tasks are used including Nurse ($33.55), Medical Assistant ($15.01[1]), Front Desk Staff ($13.38[2]), Program Director ($32.56), Pharmacist ($56.96), Physician ($91.60), Behavioral health provider ($22.03).

[b] Based upon the mean wages for consumers (all occupations).

[c] Based upon the mean wages for Social Workers.

13. Estimates of Annualized Respondent Capital and Maintenance Costs

There are no direct costs to respondents other than their time to participate in the project.

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1 http://www.bls.gov/oes/current/oes319092.htm
2 http://www.bls.gov/oes/current/oes434171.htm

14. Estimates of Annualized Cost to the Government

Exhibit 3 shows the total and annualized cost for the data collection activities. The total cost to the government of the data collection activities is $76,462 over a 22-month period; hence, the annualized cost is $42,064. These costs will be incurred from July 2016 through May 2018.

Exhibit 3. Estimated Total and Annualized Contractor Cost

Cost Component	Total Cost	Annualized Cost
Project Development	$15,160	$8,269
Data Collection Activities	$16,417	$8,954
Data Processing and Analysis	$8,638	$4,711
Publication of Results	$6,320	$3,447
Project Management	$3,565	$1,944
Overhead	$26,362	$14,379
Total	$76,462	$42,064

Exhibit 4 shows the annual cost to AHRQ of overseeing this data collection.

Exhibit 4: Annual Cost to AHRQ for Contract Oversight

Tasks/Personnel	Staff Count	Annual Salary	% of Time	Cost
Management and Research Support: GS-14, Step 5 average	2	$123,406	.075	$955.54
Grand Total				$1,851

Annual salaries based on 2016 OPM Pay Schedule for Washington/DC area: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2016/DCB.pdf

Note that these oversight costs are included in "Overhead" in Exhibit 4.

15. Changes in Hour Burden

This is a new collection of information.

16. Time Schedule, Publication and Analysis Plans

The timeline for data collection, analysis, and publication is shown in Exhibit 5 below.

Exhibit 5: Timeline for data collection, analysis and publication

Task/Activity	Timeline
Conduct Work Flow Mapping and Patient Interviews	June 2017- September 2017
Analysis of Work Flow and Patient Interviews	October 2017 – December 2017
Report annual findings and recommendations, including dissemination	January 2018 – May 2018

16.a. Publication and Use of Findings

AHRQ plans to submit at least one manuscript describing project findings to a peer-reviewed journal.

16.b. Analysis Plans

Having collected data from the primary care site forms, workflow mapping activities, patient interviews, and community agency interviews across nine primary care sites, the research team will distill the themes and/or principles that should be part of the REV model. The workflow mapping activities will result in a set of tables and workflow maps that summarize the roles and responsibilities of primary care staff, and display how their activities relate over time and differ by patient groups. The key challenges and potential solutions will also inform the REV. The patient and community agency interviews will highlight gaps in current workflow processes. A comparison/contrast of the workflows will be conducted across the nine sites, and across the primary care staff, patient, and community agency perspectives. This data analysis, also informed by the project's environmental scan and key informants, will allow the research team to develop a robust set of REV components for primary care that could reduce readmissions.

17. Exemption for Display of Expiration Date

AHRQ does not seek this exemption.

List of Attachments

- Attachment A: Project Summary for AHRQ's Re-engineered Visit for Primary Care (AHRQ REV)

- Attachment B: Contract Staff, Consultant, and Technical Expert Panel Lists
- Attachment C: Pilot Methods and Results
- Attachment D: Summary of Data Collection Instruments
- Attachment E: Fielding, Data Collection, and Analysis Methods
- Attachment F: Primary Care Site Overview
- Attachment G: Primary Care Site Organizational Characteristics Survey
- Attachment H: Primary Care Site Patient Characteristics Survey
- Attachment I: Work Flow Mapping Preliminary Interview Guide
- Attachment J: Work Flow Mapping Group Interview Guide
- Attachment K: Work Flow Mapping Follow-Up Interview Guide
- Attachment L: Patient Interview Guide
- Attachment M: Community Agency Interview Guide
- Attachment N: 60 Day Federal Register Notice
- Attachment O: Public Comment – Carefusion
- Attachment P: Response to Public Comment - Carefusion

[i] See http://www.ahrq.gov/hrqa99.pdf

[ii] Hines AL, et al. Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011. HCUP Statistical Brief #172. April 2014. AHRQ.

[iii] Ibid.

[iv] Tsilimingras D & Bates DW. "Addressing postdischarge adverse events: a neglected area." *Jt Comm J Qual Patient Saf* 34.2 (2008): 85-97.

[v] Hines AL, et al. Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011. HCUP Statistical Brief #172. April 2014. AHRQ.

[vi] Greenwald J., et al. "The hospital discharge: a review of a high risk care transition with highlights of a reengineered discharge process." *J Patient Safety* 3.2 (2007): 97-106.

[vii] Greenwald JL, Jack BW. "Preventing the preventable: reducing rehospitalizations through coordinated, patient-centered discharge processes." Prof Case Manag 14.3 (2009): 135.

[viii] Institute for Healthcare Improvement. (2015). State Action on Avoidable Rehospitalizations: An initiative of The Commonwealth Fund. http://www.ihi.org/engage/Initiatives/completed/STAAR/Pages/default.aspx

[ix] Hansen LO, et al. "Project BOOST: effectiveness of a multihospital effort to reduce rehospitalization." J of Hospital Med 8.8 (2013): 421-427.

[x] Hospital Guide to Reducing Medical Readmissions. August 2014. AHRQ, Rockville, MD: http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

[xi] Coleman E, et al. "The care transitions intervention: results of a randomized controlled trial." *Arch Int Med* 166.17 (2006): 1822-1828.

[xii] Cain, et al. Patient experiences of transitioning from hospital to home: an ethnographic quality improvement project. J Hosp Med. 2012 May-Jun;7(5):382-7.

[xiii] Rising, et al. Return visits to the emergency department: the patient perspective. Ann Emerg Med. 2015 Apr;65(4):377-386.