Public Comments Summary
Potentially Avoidable Hospital Readmissions Report and Recommendations

Thank you for the many valuable and constructive comments made by over 45 respondents during our public comment period. We made a number of changes to the report and recommendations as a result of the comments. The Report was approved by the provider, purchaser, health plan, and quality organizations that comprise the Bree Collaborative in July 2014.

To Problem Statement

- Added "Reducing potentially avoidable hospital readmissions will require multiple strategies on the part of all community stakeholders. This report represents a first step toward reducing readmissions."
- Added background on the Bree Collaborative.
- Added clear acknowledgement of socioeconomic factors influencing readmission (Hu et all., 2014; Lindenauer et all., 2013; Arbaje et all, 2013; Foraker et all., 2008; Kangovi et all., 2013).
- Added reference to INTERACT quality improvement program and impact of community care facilities (Ouslander et all., 2011; Ouslander et all., 2010).

To Recommendation I: Collaborative Model

- Clarified that this is a first step and that additional tools and techniques (e.g., better integration of behavioral health, home health) may also greatly impact readmissions but are out of the scope of this project.
- Clarified that individual members of a collaborative may be different from site to site and may include many different stakeholders (e.g., hospitals, SNFs, patients, home health, etc..).
- Clarified what the minimum criteria are for a designation of a "Collaborative" and that Bree is not prescribing complete adherence to the IHI's structured model.

To Recommendation II: Washington Tools and Techniques

- Clarify the consensus work based on best available evidence behind the WSHA Care Transitions Toolkit (the Toolkit).
- Recommend that hospitals adopt the Toolkit in its entirety.
- Acknowledge that some variation may be appropriate based on clinically compelling reasons.

To Recommendation III: Proposed Measurement

- Changed time for both metrics to within three business days of discharge
- Added that these align with the Medicaid Quality Incentive Program to reduce reporting burden
- Added that the discharge information summary is consistent with the hospital medical staff by-laws or another form of documentation, not "as consistent with the Joint Commission requirements"
- Added exclusions:
    - Patient discharged to SNF, LTC, assisted living, or prison.
    - Patient refuses phone call.
    - Patient has no phone or no alternative contact number.
- After initial roll out of six months, sites would be expected to represent numerator/denominator results for both measures publically on the WSHA web site.
- Added inclusion: If the discharging physician and follow-up care provider are the same, discharge information being provided to the follow-up care provider is still required.

Bree Readmissions Public Comment

SurveyMonkey

1. What sector do you represent? (Choose the option that is the best fit.)

	Response Percent	Response Count
Primary Care	10.6%	5
Hospital/Clinic	31.9%	15
Government/Public Purchasers	4.3%	2
Employers	0.0%	0
Health Plans	0.0%	0
Consumers/Patients	8.5%	4
Self	8.5%	4
Other (please specify)	**36.2%**	**17**
	answered question	**47**
	skipped question	**0**

2. Do you agree with the problem statement (page 2)?

	Response Percent	Response Count
Yes	**87.2%**	**41**
No	6.4%	3
Neutral/No Opinion	6.4%	3
	answered question	**47**
	skipped question	**0**

3. Do you have any changes, additions, or comments about the problem statement?

	Response Count
	38
answered question	38
skipped question	9

4. Do you have any changes, additions, or comments about the discussions of interventions (page 6)?

	Response Count
	47
answered question	47
skipped question	0

5. Do you have any changes, additions, or comments to the summary of state-wide readmission efforts in Washington (page 7)?

	Response Count
	47
answered question	47
skipped question	0

6. Do you agree with Recomendation I: "Support for the collaborative model as used in Washington State" (page 11)?

	Response Percent	Response Count
Yes	**68.1%**	**32**
Somewhat	17.0%	8
Neutral	10.6%	5
No	4.3%	2
answered question		**47**
skipped question		**0**

7. Do you have any changes, additions, or comments to Recommendation I: Collaborative Model (page 11)?

	Response Count
	31
answered question	**31**
skipped question	**16**

8. Do you agree with Recommendation II: Endorsement of Tools and Techniques Used in Washington State (page 12)?

	Response Percent	Response Count
Yes	**72.3%**	**34**
Somewhat	19.1%	9
Neutral	8.5%	4
No	0.0%	0
	answered question	**47**
	skipped question	**0**

9. Do you have any changes, additions, or comments to Recommendation II: Endorsement of Tools and Techniques Used in Washington State (page 12)?

	Response Count
	28
answered question	**28**
skipped question	**19**

10. Do you agree with Recommendation III: Recommended Measurement (page 13)?

	Response Percent	Response Count
Yes	**61.7%**	**29**
Somewhat	25.5%	12
Neutral	6.4%	3
No	6.4%	3
	answered question	**47**
	skipped question	**0**

11. Do you have any changes, additions, or comments to Recommendation III: Recommended Measurement (page 13)?

	Response Count
	33
answered question	33
skipped question	14

12. Please provide any general comments here:

	Response Count
	23
answered question	23
skipped question	24

13. Name:

	Response Count
	29
answered question	29
skipped question	18

14. Email address:

	Response Count
	29
answered question	29
skipped question	18

15. Organization:

	Response Count
	27
answered question	27
skipped question	20

Page 2, Q1. What sector do you represent? (Choose the option that is the best fit.)		
1	Health system	Jun 20, 2014 3:50 PM
2	Physician professional association	Jun 20, 2014 3:44 PM
3	Washington State Pharmacy Assocation	Jun 20, 2014 3:27 PM
4	Health System	Jun 18, 2014 10:21 AM
5	Home Health	Jun 17, 2014 2:23 PM
6	LTC	Jun 17, 2014 10:40 AM
7	Post acute, skilled nursing, assisted living	Jun 17, 2014 9:53 AM
8	Skilled Nursing	Jun 16, 2014 12:18 PM
9	in home care	Jun 16, 2014 8:31 AM
10	Home Health Occupational therapist	Jun 13, 2014 5:53 PM
11	Home Health	Jun 11, 2014 10:44 PM
12	Behavioral Health	Jun 11, 2014 5:38 PM
13	Government Regulator	Jun 11, 2014 5:07 PM
14	Retail pharmacy	Jun 11, 2014 7:41 AM
15	community mental health	Jun 10, 2014 8:57 PM
16	outpatient mental health and chemical dependency counseling	Jun 10, 2014 7:34 PM
17	Consulting	Jun 10, 2014 9:10 AM

Page 2, Q3. Do you have any changes, additions, or comments about the problem statement?		
1	• We would appreciate seeing a broader acknowledgment of the factors that impact readmissions. Socioeconomic influences must be well represented in the discussions around preventing readmissions. Social services, housing, primary care providers etc. must be involved to a larger degree moving forward in this pursuit. Risk adjustment around readmissions related to socio-demographic issues should also be considered.	Jun 21, 2014 11:48 AM
2	The report should more broadly acknowledge in the Problem Statement the relevant socioeconomic and sociodemographic factors that influence readmission rates and which are less directly controllable by providers in managing clinically complex patients.	Jun 20, 2014 3:44 PM
3	In general we agree with the statement, but thought that the statement emphasized a lack community resources rather than a lack of coordination and communication with community providers. The problem statement ought to mention access to medications and lack of understanding of how to use medications as a cause for readmissions.	Jun 20, 2014 3:27 PM
4	Yes. WSHA and our members would appreciate a broader acknowledgment in the problem statement of other factors (e.g., socioeconomic and sociodemographic) which influence readmissions. Focusing on health care, specifically transitions of care is a logical first step toward reducing readmissions, however, the Bree should acknowledge the complexity of this issue and the future need to engage diverse stakeholders (e.g., public health, social services and housing), all of whom have accountability in reducing readmissions. A recent report by the by the National Quality Forum provides a nice overview of the impact of socioeconomic and sociodemographic on health and how such factors should be accounted for in quality measurement.	Jun 20, 2014 2:22 PM
5	lack of information transfer, especially across-settings to the primary care provider, poor communication between provider and patient, and lack of patient and family activation These issues are CRITICAL! If a doctor does not face to face with the patient and caregiver during a hospital stay, there is no opportunity for patients to become engaged with any authority in the diagnosis and self-management.	Jun 20, 2014 1:13 PM
6	Some readmissions are due to social determinants of health, over which hospitals and communities have very little control. Included in these social determinants are: socioeconomic status, behavioral health, substance abuse, and cultural norms. Current focus at the national level is to include social determinants of health in risk-adjusting for readmission rates.	Jun 20, 2014 11:51 AM
7	no, agree	Jun 20, 2014 8:17 AM
8	The hospital-acquired condition (HAC) is a significant factor that contributes to the problems of readmissions. However, we do not see this important factor is addressed in the problem statements. Studies have shown that readmission is greater for patients who experienced adverse events at hospitals than similar patients who have no such adverse events. For instant, Ashton et al. (2007) found that patients who were readmitted were 55% more likely to have experienced complications due to substandard care. Therefore, besides all the excellent approaches to improve discharge planning, care transition, and quality of community-based care, we recommend that identifying and documenting all	Jun 19, 2014 9:24 PM

Page 2, Q3. Do you have any changes, additions, or comments about the problem statement?		
	HACs be included in the recommendation to reduce readmissions.	
9	• We would appreciate seeing a broader acknowledgment of the factors that impact readmissions. Socioeconomic influences must be well represented in the discussions around preventing readmissions. Social services, housing, primary care providers etc. must be involved to a larger degree moving forward in this pursuit. Risk adjustment around readmissions related to socio-demographic issues should also be considered.	Jun 19, 2014 3:30 PM
10	The ability to identify and reach patients at highest risk and in the most need for coordinated care services seems to be a large barrier/problem	Jun 19, 2014 12:05 PM
11	In addition to a lack of community based care options in some areas, poorly coordinated community based care is also a problem even in settings where services may appear adequate.	Jun 19, 2014 11:10 AM
12	•Need a broader recognition of more factors that impact readmissions. Socioeconomic influences are often overlooked or underestimated regarding preventing readmissions. Social services, housing, primary care providers should be factored in to this discussion and measurement. Risk adjustment around readmissions related to socio-demographic issues should be considered.	Jun 19, 2014 8:17 AM
13	did feel like some disconnect when speaking about communities and then about systems or individ health care entitities	Jun 18, 2014 4:14 PM
14	The problem statement should include the phrase "a lack of patient follow-up" in its content.	Jun 18, 2014 1:39 PM
15	We would appreciate seeing a broader acknowledgment of the factors that impact readmissions. Socioeconomic influences must be well represented in the discussions around preventing readmissions. The report does later recommend a community collaborative and that's a positive thing – social services, housing, primary care providers etc. must be involved to a larger degree moving forward in this pursuit. Risk adjustment around readmissions related to socio-demographic issues needs to be considered.	Jun 18, 2014 10:21 AM
16	Little mention of home health	Jun 17, 2014 2:23 PM
17	NO	Jun 17, 2014 10:40 AM
18	No	Jun 16, 2014 12:47 PM
19	None	Jun 16, 2014 12:18 PM
20	Trend to discharge patients, especially medicaid only and older adults, too early - not waiting long enough to see if conditions develop to a perceivable level, or not listening to patients' complaints (deemed 'normal'), or thinking erroneously that post-hospitalization setting can effectively manage anything that comes up. Clearly the idea is "out of hospital, out of responsibility" However, clearly this is a "penny wise, pound foolish" approach. 24 extra hours can save tremendously vs readmission	Jun 16, 2014 8:31 AM
21	None.	Jun 14, 2014 1:46 PM

Page 2, Q3. Do you have any changes, additions, or comments about the problem statement?		
22	Medicare requirements for equipment needs requires face to face with patients and the PCP, instead of other providers, such as home health professionals alerting the MD as to the needs of patients and Vendors being able to take a prescription from the MD and fill an order. Many times a patient goes into the MD office for their Face to Face and they don't think about asking the MD to justify in their note that the patient needs these items and to request a prescription. This is an additional problem.	Jun 13, 2014 5:53 PM
23	no	Jun 13, 2014 11:19 AM
24	Re-admissions need to be clearly identified in relating to the initial cause of the first admission. It is very common to see a patient admitted again (within 30 days) but not related to the first diagnosis. One needs to be careful in not just lumping all 30 admissions as a re-admission issue when it may not be.	Jun 12, 2014 12:02 PM
25	Yes. As a Patient/Patient Advocate there appears to be no reliable process/tools to gather and analyze inputs from the Consumer side. Did they get information at discharge, how, who, why, what? Was there a reliable process at intake of readmission to determine main causes. Where does the patient information get compiled and analyzed. It appears this is a major gap in data collection and analysis. A new process or greatly improved methodology may be needed.	Jun 12, 2014 7:21 AM
26	Poor transitions are also very often driven by the business goals of the facility making the transition. Thus favoritism and business relationships receive priority versus patient quality of care	Jun 11, 2014 10:44 PM
27	I would add concerns re: the disconnect between physical and mental health care as an additional driver of unplanned readmissions.	Jun 11, 2014 5:38 PM
28	No	Jun 11, 2014 5:07 PM
29	no	Jun 11, 2014 1:55 PM
30	No	Jun 11, 2014 7:41 AM
31	I. Support for the collaborative model as used in Washington State. II. Support for the tools and techniques to reduce readmissions in Washington State, especially the Washington State Hospital Association's Care Transitions Toolkit, the work done by Qualis Health, and the work done by the Washington Health Alliance. III. Measurement of the percent of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is: a. Patient discharge information summary sent to the primary care provider (PCP) or aftercare provider within two days of discharge. b. A documented follow-up phone call within two days of discharge. Thank you.	Jun 10, 2014 10:00 PM
32	No, it sounds about right.	Jun 10, 2014 8:57 PM
33	Yes. Primary care physicians can provide weekly group counseling for patients recently discharged from the hospital. These can be facilitated by a social worker that can also bill Medicare. Focus of group is self-care, linkage to needed resources, building strong family and other support systems that are	Jun 10, 2014 7:34 PM

Page 2, Q3. Do you have any changes, additions, or comments about the problem statement?		
	NOT hospital/high cost supports. This type of may need to be built into the current Medicare/Medicaid payment system but over time will most likely improve quality of life for patients and prevent the high costs of hospitalization.	
34	NO	Jun 10, 2014 3:54 PM
35	While I understand your point, there isn't a single encapsulating "problem statement" in there. Suggest you start the paragraph with a summary statement then follow with the rest as supportive statements. (The problem statement in Appendix A is more clear.)	Jun 10, 2014 2:43 PM
36	The problem statement is largey defined with Medicare data and ignores both Medicaid and Employed populations. I would draw your attention to HCUP brief 154 showing C-section having the highest number of readmissions yet the paper excludes moms and infants. I the first 30 days of life, infants have two very preventable disorders that have best practices (RSV and jaundice). http://www.hcup-us.ahrq.gov/reports/statbriefs/sb154.jsp Table 1. All-cause 30-day readmissions ranked by the most frequent procedures* performed during the index stay, U.S. hospitals, 2010 Rank All-listed procedure for index hospital stay** Number of index stays 30-day all-cause readmissions Number of readmissions Percent readmitted 1 Cesarean section 1,209,422 24,281 2.0	Jun 10, 2014 9:10 AM
37	no	May 31, 2014 1:43 PM
38	no specifics	May 31, 2014 10:07 AM

Page 2, Q4. Do you have any changes, additions, or comments about the discussions of interventions (page 6)?		
1	No	Jun 21, 2014 11:48 AM
2	NO	Jun 20, 2014 4:23 PM
3	No.	Jun 20, 2014 3:50 PM
4	No	Jun 20, 2014 3:44 PM
5	Table lacks pre-intervention data to show to impact of the intervention. We appreciate the review of projects already done in the state!	Jun 20, 2014 3:27 PM
6	No.	Jun 20, 2014 2:22 PM
7	My concern is that much of the follow-up with the patient is reliant upon self-reporting. Confusion, being overwhelmed and exhausted, denial, lack of awarenesa and knowledge of body systems/symptoms and much more can keep a patient from acknowledging a need before they end up being readmitted. Intensive patient education is needed during the hospital stay, not just at discharge.	Jun 20, 2014 1:13 PM
8	Improved recognition of these issues and financial support for programs that address social determinants of health may be the only way to decrease readmissions in some patient populations.	Jun 20, 2014 11:51 AM
9	no, agree	Jun 20, 2014 8:17 AM
10	All proposed approaches in the care transition toolkit are valid and good steps. But, again, what is missing is a required procedure to identify and document all HACs in medical records and in discharge summary. These records should be available to all care providers involving care transition and to patients and families. The records will help identify and track the primary causes for readmissions.	Jun 19, 2014 9:24 PM
11	No	Jun 19, 2014 3:30 PM
12	n/a	Jun 19, 2014 12:05 PM
13	No	Jun 19, 2014 11:10 AM
14	no	Jun 19, 2014 8:17 AM
15	Can some baseline data be provided for Table 3? i found it confusing to read and not sure how to quantify actual improvements	Jun 18, 2014 4:14 PM
16	No	Jun 18, 2014 1:39 PM
17	No.	Jun 18, 2014 10:21 AM
18	Add home health	Jun 17, 2014 2:23 PM
19	NO	Jun 17, 2014 10:40 AM
20	Involvement of post acute efforts such as INTERACT tools are critical to positive outcomes.	Jun 17, 2014 9:53 AM

Page 2, Q4. Do you have any changes, additions, or comments about the discussions of interventions (page 6)?		
21	No	Jun 16, 2014 12:47 PM
22	None	Jun 16, 2014 12:18 PM
23	Re-evaluate criteria for readmission risk assessment. Patient Management by Interdiscplinary team very good. Adequately address pain management: include active hands on arrangements for post-hospitalization. Train personnel who have more directly/actively interaction with patient active listening skills. Patient cooperation and compliance possibly would be better if needs and concerns and wants are heard and addressed. Patient ombudsman meets with all at risk for readmission patients to discern other concerns that patients may feel inhibited to not share with medical staff. Those concerns may be pertinent to at risk readmission	Jun 16, 2014 8:31 AM
24	no	Jun 15, 2014 9:52 AM
25	I saw no mention of community/residential care facilities, clinical and non-clinical outpatient staffing shortages, or other community-related components before/after in-hospital care, etc.	Jun 14, 2014 1:46 PM
26	Yes, Patients need equipment in place prior to returning home, this should include hospital bed, O2, commodes, wheelchairs, tub transfer benches, hoyer lifts. If equipment was in place, pt's would be safe, have an easier recovery, and be able to psychologically heal if they are able to use the bathroom and take a shower safely. This should be done at the hospital level, as once these people are home, some will not allow Home Health in and financially do not want to pay for these needed safety, and well being items.	Jun 13, 2014 5:53 PM
27	no	Jun 13, 2014 11:19 AM
28	None	Jun 12, 2014 12:02 PM
29	Prioritize these in order of likely impact. If they are all the same benefit, say so. Without selecting the key drivers of success there will be less likelihood that either patients or medical staff will know what future improvements are needed.	Jun 12, 2014 7:21 AM
30	No	Jun 11, 2014 10:44 PM
31	Attention to behavioral health needs should be factored into interventions.	Jun 11, 2014 5:38 PM
32	No	Jun 11, 2014 5:07 PM
33	no	Jun 11, 2014 1:55 PM
34	Shoukld include coordination with AAA, regarding in home care client's.	Jun 11, 2014 9:14 AM
35	As a retail pharmacist I often see lack of coordination of the hospital with outpatient services. Patients are pushed out the door before learning that their outpatient rx insurance does not cover the therapies assumed to continue. High cost antibiotics and anti coagulation therapies are the most common. The discharge planner or primary care physician needs to communicate directly with insuraNce BEFORE discharge. Access to pain medication is also a problem	Jun 11, 2014 7:41 AM
36	no	Jun 10, 2014 10:00 PM

Page 2, Q4. Do you have any changes, additions, or comments about the discussions of interventions (page 6)?		
37	Co-occuring disorders are critical to understand and serve.	Jun 10, 2014 8:57 PM
38	Stronger community supports to reinforce self-care through medication and other-adherence must be implemented. Sponsored by medical home, i.e. primary care physician. Use person-centered planning for health care, much like what is used in the mental health system now.	Jun 10, 2014 7:34 PM
39	Yes. More can be done. Referrals to appropriate complementary providers are not mentioned.	Jun 10, 2014 7:03 PM
40	Yes-cannot always determine PCP. Large healthcare systems are better equipped to manage this follow up process. Not all hospitals have staff to accommodate these follow up calls, visits, and clerical aspects of care (like faxing to PCP)	Jun 10, 2014 3:54 PM
41	What about alternate language instructions? If the pt. is not capable of understanding verbal or written English, or is in compromised state, it would need to be given to that person's representative (family member, etc.) Sometimes such things are not only poorly understood to begin with, but suffer in translation from one lay person to another. Providing language-of-origin information may help.	Jun 10, 2014 2:43 PM
42	I believe Operation RED with a randomized trial trumps a WA group in what are best practices. While step 4 of RED allows a targeted step approach there are no clear plans to extend pilots beyond those programs where Medicare is holding hospitals accountable for the 2% http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool2.html#Step4 Step 4: Identify Which Patients Should Receive the RED Even if your goal is to deliver the RED to all patients discharged from your hospital, it might make sense to roll out the implementation in phases. Based on the analysis of your hospital's needs and the goals you have set, you might want to identify selected subsets of patients who will receive the RED. Possible target populations include: • Patients with conditions initially targeted by the Centers for Medicare & Medicaid Services (i.e., heart attack, pneumonia, and heart failure) for reduced funding if the hospital has excess readmissions. • Patients with diagnoses with 30-day rehospitalization rates higher than the national average or higher than peer hospitals in your community. • Sites of care (floor or unit) or services within the hospital (e.g., surgery, dialysis, post-CABG) that have the highest readmission rates. Our experience is that most hospitals begin with a targeted implementation focusing on a single diagnosis (usually heart failure), learning as they go and correcting the process as they learn. Some hospitals chose to start small and enroll only heart failure patients from a single unit of the hospital. Other hospitals chose to start with a full hospital implementation and, in at least one case, the RED was implemented simultaneously across an entire hospital system. Each implementation strategy can be effective if there is sufficient institutional motivation for success. The resources available, your decision style, and the urgency of lowering the readmission rate will all factor into this decision	Jun 10, 2014 9:10 AM
43	Once it is put in an "EPIC in basket" all is well. You should just have EPIC send an e-mial or text telling the patient to not come back to the hospital for at least a month.	Jun 1, 2014 11:25 AM
44	no	Jun 1, 2014 7:28 AM

Page 2, Q4. Do you have any changes, additions, or comments about the discussions of interventions (page 6)?		
45	no	May 31, 2014 1:43 PM
46	no specific but we need to have more transparency of data to be shared this will need to include payers as well for data	May 31, 2014 10:07 AM
47	None	May 30, 2014 3:45 PM

Page 2, Q5. Do you have any changes, additions, or comments to the summary of state-wide readmission efforts in Washington (page 7)?		
1	No	Jun 21, 2014 11:48 AM
2	No	Jun 20, 2014 4:23 PM
3	No.	Jun 20, 2014 3:50 PM
4	No	Jun 20, 2014 3:44 PM
5	A brief review of the projects was helpful. It is difficult to keep them all straight.	Jun 20, 2014 3:27 PM
6	No.	Jun 20, 2014 2:22 PM
7	This will only work through coolaboration of all stakeholders and across multiple efforts. I could not clearly tell the level of involvement of patients in any of these efforts or if it is all being done by administrators and practitioners.	Jun 20, 2014 1:13 PM
8	Implement community-based programs that address social determinants of health that can lead to hospital readmission.	Jun 20, 2014 11:51 AM
9	no, agree	Jun 20, 2014 8:17 AM
10	No.	Jun 19, 2014 9:24 PM
11	No	Jun 19, 2014 3:30 PM
12	n/a	Jun 19, 2014 12:05 PM
13	No	Jun 19, 2014 11:10 AM
14	no	Jun 19, 2014 8:17 AM
15	excellent set of resources and synopsis, anything to connect this to the state exchange work	Jun 18, 2014 4:14 PM
16	No	Jun 18, 2014 1:39 PM
17	No.	Jun 18, 2014 10:21 AM
18	Add home health	Jun 17, 2014 2:23 PM
19	NO	Jun 17, 2014 10:40 AM
20	There should be increased involvement with post acute providers. There is a high level of involvement with hospitals, clinics, payors, but no active involvement on the collaborative by SNF or AL providers. WHCA and Leading Age are more than willing to support efforts are we are involved with other efforts throughout the state.	Jun 17, 2014 9:53 AM
21	No	Jun 16, 2014 12:47 PM
22	Should mention the importance of utilizing the Interact Program to help reduce rehospitalizations as well.	Jun 16, 2014 12:18 PM

Page 2, Q5. Do you have any changes, additions, or comments to the summary of state-wide readmission efforts in Washington (page 7)?		
23	no	Jun 16, 2014 8:31 AM
24	no	Jun 15, 2014 9:52 AM
25	There is NO mention anywhere in this document of mental health or chemical dependency (or co-morbitity with those two conditions) as they affect admission/re-admission rates.	Jun 14, 2014 1:46 PM
26	Medicaid needs to make the process of appropriate equipment needs for safety and wellbeing in the home to be expedited more quickly. Most bathroom equipment takes greater than 3 weeks for patients to receive needed items.	Jun 13, 2014 5:53 PM
27	no	Jun 13, 2014 11:19 AM
28	None	Jun 12, 2014 12:02 PM
29	No.	Jun 12, 2014 7:21 AM
30	We have been part of the Qualis health initiatives and have seen a great deal of positive conversation but very little actual change.	Jun 11, 2014 10:44 PM
31	No.	Jun 11, 2014 5:38 PM
32	No	Jun 11, 2014 5:07 PM
33	no	Jun 11, 2014 1:55 PM
34	NO	Jun 11, 2014 9:14 AM
35	No	Jun 11, 2014 7:41 AM
36	no	Jun 10, 2014 10:00 PM
37	In theory it looks good, in practice...it will be hard to implement.	Jun 10, 2014 8:57 PM
38	Please see comments.	Jun 10, 2014 7:34 PM
39	Many more patients with financial means in Washington find they can avoid hospital stays by seeking out complementary health care providers.	Jun 10, 2014 7:03 PM
40	No	Jun 10, 2014 3:54 PM
41	No	Jun 10, 2014 2:43 PM
42	I would Operation RED (an AHRQ best practice and proven tool for all popualtions sets the bar). Why would a provider, given a randomized trial on how to treat a patient, deviate from that care. To do less is to invite less.	Jun 10, 2014 9:10 AM
43	STAAR is the best acronym, but Medicaid Medical Director's Learning Network is the best idea. Is that like an AA meeting?	Jun 1, 2014 11:25 AM
44	no	Jun 1, 2014 7:28 AM

Page 2, Q5. Do you have any changes, additions, or comments to the summary of state-wide readmission efforts in Washington (page 7)?		
45	no	May 31, 2014 1:43 PM
46	no specific comments as yet	May 31, 2014 10:07 AM
47	None	May 30, 2014 3:45 PM

Page 2, Q7. Do you have any changes, additions, or comments to Recommendation I: Collaborative Model (page 11)?		
1	No	Jun 21, 2014 11:48 AM
2	The document could be more explicit as to how the progress and outcomes of the Collaborative Model as a community-wide solution will be assessed over time.	Jun 20, 2014 3:44 PM
3	We found the recommendation too prescriptive. The idea of forming a collaborative is something we completely support. However, details about how often to meet and for how long is beyond the scope of this recommendation. The actionable request of recommendation I was not clear. We would like to see more detail about how it will be implemented and incentivised or required.	Jun 20, 2014 3:27 PM
4	Yes. • Please add a foot note to page 11 – *WSHA will recognize collaboratives for a period of one year after which WSHA will reevaluate its role. • The draft charter, appendix E lists organizations that "may" be involved in a collaborative. Are there any organizations that "must" be a part of a collaborative? I.e., is there a minimum threshold?	Jun 20, 2014 2:22 PM
5	This is a yes, but answer. As a patient, I must ask how intentional these intitiatives are in seeking out the patient voice. Without it, these work groups are shooting darts at a moving target, and at best lending a provider/payer perspective on what the patient needs. Why not ask the patients and actually listen to the responses?	Jun 20, 2014 1:13 PM
6	See comments above.	Jun 20, 2014 11:51 AM
7	no, agree	Jun 20, 2014 8:17 AM
8	Most of the state-wide efforts to reduce readmissions so far have been largely focused on improving communications among care transition teams and with patients and families, discharge summaries and readmission risk assessment, making follow-up appointment and phone calls, etc. However, there should also be collaborative and conscientious efforts for hospitals and community-care institutions to identify, document, and track all HACs. Since patients are at the center of the effort to reduce readmission and they have the first-hand observations of care transitions and follow-up care after discharge, patients and family members should be included as a critical stakeholder in this state-wide efforts. One way to get patients and family members involved is to include them on readmission reduction boards or committees at both institution/hospital level and at the state level, invite them to workshops or stakeholder meetings, and get their perspectives and feedbacks.	Jun 19, 2014 9:24 PM
9	no	Jun 19, 2014 3:30 PM
10	These are very detailed recommendations. Is this level of detail appropriate and/or needed?	Jun 19, 2014 11:10 AM
11	no	Jun 19, 2014 8:17 AM
12	consider adding clarification that this about frame work big pciture, as other recommendations are really more about how to start to operationalize.	Jun 18, 2014 4:14 PM

Page 2, Q7. Do you have any changes, additions, or comments to Recommendation I: Collaborative Model (page 11)?		
13	No	Jun 18, 2014 1:39 PM
14	No.	Jun 18, 2014 10:21 AM
15	NO	Jun 17, 2014 10:40 AM
16	No	Jun 16, 2014 12:47 PM
17	No mention of collaboration across specialties, or of integration-related mandates on their affect on the admission/re-admission problem.	Jun 14, 2014 1:46 PM
18	Include Home Health Staff and PCP and their staff as stakeholders in regards to the implementation. You need the people who are sending the patient's back to the hospital involved to report their insight.	Jun 13, 2014 5:53 PM
19	no	Jun 13, 2014 11:19 AM
20	Involve patients and advocates in the Learning Process to assess levels of understanding and gain insights from patient perspectives.	Jun 12, 2014 7:21 AM
21	I think if you are truly going to drive success you simply have to talk about the business. The formation of an ACO is one way. Where the collaboraters are financially motivated. The Fransican ACO in Pierce county might be used an an example.	Jun 11, 2014 10:44 PM
22	No	Jun 11, 2014 5:07 PM
23	no	Jun 11, 2014 1:55 PM
24	Should include coordination with case managment AAA, regarding in home care client's.	Jun 11, 2014 9:14 AM
25	Implement additional trainings	Jun 10, 2014 8:57 PM
26	no	Jun 10, 2014 7:34 PM
27	Stop trying to make cookie cutters out of very unique populations/healthcare systems and communities.	Jun 10, 2014 3:54 PM
28	Larger systems may have their own model/approach; while smaller entities may not have time/personnel/funding to engage w/ a larger group.	Jun 10, 2014 2:43 PM
29	Start with what is known and proven and build from there. Require changen to proven to be proven themselves. DO not dilute the science.	Jun 10, 2014 9:10 AM
30	Collaboration generally means a lot of hot air.	Jun 1, 2014 11:25 AM
31	no	May 31, 2014 1:43 PM

Page 2, Q9. Do you have any changes, additions, or comments to Recommendation II: Endorsement of Tools and Techniques Used in Washington State (page 12)?		
1	No	Jun 21, 2014 11:48 AM
2	No	Jun 20, 2014 3:44 PM
3	Consider addition of the Washington Patient Safety Coalition "mymedicationlist.org" for patient oriented medication list information.	Jun 20, 2014 3:27 PM
4	No.	Jun 20, 2014 2:22 PM
5	Another "yes,but' answer - a tool kit is only as good as the source delivering it. If the tool kit results in patients being handed another stack of papers to read, we have not gained anything. If, however, it engages providers with patients in face to face conversation, then the impact will be valid.	Jun 20, 2014 1:13 PM
6	no, agree	Jun 20, 2014 8:17 AM
7	I have looked only the WSHA's toolkit. Overall it is good. But, it lacks of plans to track and document hospital-acquired conditions, a critical factor for readmission. A study by Chassin et al. (2011) shows that one in three patients experienced adverse events during hospital stays. This study and others (e.g., 2010 OIG report; Landrigan et al., 2010; John James; 2013) show the urgent need to better document and track HACs. So we would recommend that all form of readmission assessment include HACs as a significant risk factor. In addition, all discharge summaries should include the course of treatment for HAC(s), if identified, and patient's recovery status from the HACs at the discharge. Also, we think just feedback from primary care provider to hospital (Tool 12) is not adequate. Studies have shown that patients and families are capable of identify quality of care issues and gaps between a care transition. Therefore, patients' feedbacks such as HCAHPS (Hospital Consumer Assessment of Healthcare) or any other type of written feedbacks should be included in the toolkit as additional information for follow-ups after discharge.	Jun 19, 2014 9:24 PM
8	no	Jun 19, 2014 3:30 PM
9	The emphasis should be on coordination of the work of these organizations to avoid duplication of efforts.	Jun 19, 2014 11:10 AM
10	no	Jun 19, 2014 8:17 AM
11	excellent to capitalize and provide ready to use	Jun 18, 2014 4:14 PM
12	No	Jun 18, 2014 1:39 PM
13	No.	Jun 18, 2014 10:21 AM
14	Don't forget there are home health partners out there across WA state who know how to decrease readmissions	Jun 17, 2014 2:23 PM
15	NO	Jun 17, 2014 10:40 AM
16	No mention of pre-hospitalization or 'diversionary' resources to off-set hospitalization such as crisis/triage centers. No mention of community health workers, certified peer counselors, or other para-professional roles in reducing	Jun 14, 2014 1:46 PM

Page 2, Q9. Do you have any changes, additions, or comments to Recommendation II: Endorsement of Tools and Techniques Used in Washington State (page 12)?		
	costs and rates.	
17	no	Jun 13, 2014 11:19 AM
18	There is no specific assessment of viability for Washington State Hospital Association methods and processes. Lack of transparency, data collection accuracy concerns, failure to disclose serious shortfalls and similar problems have been surfaced by Patient Advocacy groups without suitable followthrough or sufficient response. Accountability by Washington State Hospital Association for data transparency is not clearly spelled out (e.g. required reporting) and is likely to confuse or create measurement errors on a significant magnitude. Tools and techniques are needed to address this disparity along with the other excellent processes listed on page 12.	Jun 12, 2014 7:21 AM
19	no	Jun 11, 2014 10:44 PM
20	No	Jun 11, 2014 5:07 PM
21	no	Jun 11, 2014 1:55 PM
22	IMR	Jun 10, 2014 8:57 PM
23	no	Jun 10, 2014 7:34 PM
24	na	Jun 10, 2014 3:54 PM
25	No	Jun 10, 2014 2:43 PM
26	The paper needs to address more than Medicare data and Medicare issues. I would recommend that maternity and the 1st year of life be included to bring focus to the employer issues. I also think that like ED over use, attention to outliers (very high rehospitalization rate > 5 per year) need to be addressed. 30 day while a good start ignores the repeated hospitalizations the drive costs up and likely have deminshing value.	Jun 10, 2014 9:10 AM
27	"Choosing wisely" made me laugh.	Jun 1, 2014 11:25 AM
28	no	May 31, 2014 1:43 PM

Page 2, Q11. Do you have any changes, additions, or comments to Recommendation III: Recommended Measurement (page 13)?		
1	• The description of the metric should be modified to read: Patient discharge information summary sent and/or made available electronically with notification to the PCP or aftercare provider within two days or discharge. The comment should reflect that the metric must reflect our increasingly paperless environment, with multiple modes of preferred communication established between hospitals and community providers. • An exclusion should be added to the metric to exclude cases where the PCP is the discharging provider. • Additionally, in some rural areas the discharging provider is also a patient's primary care provider. In this case, does the discharge information need to be sent? How would a hospital report on the first measure when the discharging provider is the same as the patient's primary care provider? • For the follow-up phone call: The description of the metric should be modified to read: A documented phone call within 24 to 72 hours following discharge, based on risk stratification. Also, additional considerations for timeframe of discharge phone call should include patients seen by home care within 48 hours of discharge and patients discharged to a skilled nursing facility.	Jun 21, 2014 11:48 AM
2	We support the proposal to extend the timeframe to three business days post discharge for the measures for both the communication of discharge information, and completion of discharge phone calls We believe we would be able to support the Discharge Phone Call measure, and have systems in place to do this within a year. We believe that we will be unable to effectively operationalize the Discharge Information Summary measure right now due to the following: a. Inability to accurately identify PCP and contact numbers, especially if patient does not currently have a PCP, or is from out of state. We have been working on this for many years with minimal success, and do not think we will be able to do this well until we migrate to a new EHR, which we are doing over the next three years. b. Shortage of supply of PCP's in community, especially those taking new patients, which makes it extremely difficult to ensure availability of an LIP for follow up care, in turn making it impossible to inform a specific provider of the discharge information. We believe that the focus on the Discharge Information measure, and the resources required to collect it, will actually limit and/or delay our ability to provide the intended services. We recommend a three-year delay in incorporating the full discharge measure into public reporting or the Medicaid Incentive Program to allow for: a. development of community resources and partnerships to ensure availability of care, and b. the development/adoption of technology to support this type of communication and reporting, specifically: i. a focused community effort to ensure the availability of providers to provide follow up care in the community needs to precede holding hospitals accountable for communicating with them. ii. the pilot program used Epic inbasket to inform PCP of admissions, and then subsequently used feedback to correct the identification of the PCP. Without Epic, or similar functionality in the EHR, the ability to do this is extremely limited. Our time would be better spent on improving our processes through focused development of functionality in our Epic rollout, rather than identifying multiple transitional solutions in our currently limited and fragmented IT environment. We would support exemptions for certain types of hospitals such as those with very low readmission rates or few admissions.	Jun 20, 2014 3:50 PM
3	No	Jun 20, 2014 3:44 PM
4	These two interventions in isolation have not been proven to reduce	Jun 20, 2014 3:27 PM

Page 2, Q11. Do you have any changes, additions, or comments to Recommendation III: Recommended Measurement (page 13)?		
	readmissions. The two day turnaround for a call is a best practice, but leaves little wiggle room for providers to accommodate. A better measure may be if a call was done, then at	
5	Yes. • It would be helpful to note that the measures recommended by the Bree are a part of the Medicaid Quality Incentive Program and were selected in an effort to promote alignment and reduce reporting burden. • The time requirement (i.e., “two days of discharge) for the first measure received a great deal of discussion/debate. It would be helpful to provide a technical foot note citing the literature around the time requirement for this measure. • Please add a foot note to page 13 – *Collaboratives will submit data to WSHA on an annual basis from the start of their collaborative. Data will be presented on WSHA's public website. WSHA will receive and post data for a period of one year after which WSHA will reevaluate its role. • The current measures reflect a hospital’s role in reducing unplanned readmissions via improved care transitions. Will other stakeholders be asked to take concrete actions to reduce unplanned readmissions? Are measures needed which assess the primary care provider or after care provider’s role in reducing readmissions? • In some rural areas the discharging provider is also a patient’s primary care provider. In this case, does the discharge information need to be sent? How would a hospital report on the first measure when the discharging provider is the same as the patient’s primary care provider? An exclusion should be added to the first measure to exclude cases where the PCP is the discharging provider. • The proposed measures are process in nature and should sunset or be evaluated at predetermined intervals to assess their value and impact in reducing readmissions.	Jun 20, 2014 2:22 PM
6	The effort has to begin somewhere, but I question how much time will be given to educating the patient to the point of understanding. The recommendation relies heavily on an educated patient group. Truth is, mot patients do not understand their diagnosis, prognosis or treatment. Patients with dementia will never understand, and when their caregivers are in a self-chosen denial that has opted for a less than sufficient at home care plan, then readmission is inevitable. I have even heard caregivers state that they are going this direction on purpose, so that when readmitting, the doctor will make the decision about going to a SNF and let the care giver off the hook. Sad situation for everybody!	Jun 20, 2014 1:13 PM
7	1. Change the timing for post discharge phone call to 3 days. Rationale: The nationally recognized Studer Group, consultants for Patient Satisfaction and Quality recommends 3 days post discharge to complete this call. 2. Change timing for discharge information e.g. discharge summary to 5 business days. Rationale: would harmonize with the Behavioral Health guidelines HBIPS-7a. Preliminary summaries have not been reviewed for errors. Errors in dictation/transcription for medications or other critical treatments could result in harm to patients. For the Discharge Summary metric, the definition for the denominator does not exclude short stay inpatients. Currently, our hospital policy is that a discharge summary is only required for patients that stay >48 hours (unless the patient died or was transferred). This is also consistent with Joint Commission Standards for patient record documentation, so we would expect the same policy at most hospitals statewide. We would recommend that the criteria be amended to only include patients with LOS >2 days. (We don’t require discharge summaries on Observation patients, and they are often in-house for 2 days.)	Jun 20, 2014 11:51 AM

Page 2, Q11. Do you have any changes, additions, or comments to Recommendation III: Recommended Measurement (page 13)?		
8	no, agree	Jun 20, 2014 8:17 AM
9	a). Since diabetes, pulmonary embolism without mcc, and renal failure are shown to have the highest readmission rates among the state Medicare conditions (Table 1), we do not understand why these conditions are excluded from the Recommended Measurement (see Inclusion). We believe the efforts to reduce readmission should be focused on both financial incentives with CMS and the maximum patient protection. So, we would like to see that diabetes, pulmonary embolism without mcc, and renal failure are included in the recommended measurement. b). The discharge summary should include information on whether a HAC occurred during the hospital stay and what was the course of actions for treating the HAC(s). This discharge summary should be shared among all care transition teams and with patients and families. d). Besides a list of all diagnosis in the discharge summary, patients should also be provided with a copy of all lab results (e.g., all blood work, X-ray, CT-scan, MRI, procedure summaries, etc.) and a copy of HCAHPS survey form. e). In addition to what is currently included in the readmission assessment tools (Tool 1.1-1.5 in WSHA “Reducing Readmission: Care Transitions Toolkit”), HACs should be documented and evaluated as a risk factor in readmission assessment. Such assessments should be provided to patients or their family members, so that they will have a better understanding of the course of their care at the hospital and risks to be readmitted. The better informed, the better motivated the consumers will be.	Jun 19, 2014 9:24 PM
10	• The description of the metric should be modified to read: Patient discharge information summary sent and/or made available electronically with notification to the PCP or aftercare provider within two days or discharge. The comment should reflect that the metric must reflect our increasingly paperless environment, with multiple modes of preferred communication established between hospitals and community providers. • An exclusion should be added to the metric to exclude cases where the PCP is the discharging provider. • Additionally, in some rural areas the discharging provider is also a patient’s primary care provider. In this case, does the discharge information need to be sent? How would a hospital report on the first measure when the discharging provider is the same as the patient’s primary care provider? • For the follow-up phone call: The description of the metric should be modified to read: A documented phone call within 24 to 72 hours following discharge, based on risk stratification. Also, additional considerations for timeframe of discharge phone call should include patients seen by home care within 48 hours of discharge and patients discharged to a skilled nursing facility.	Jun 19, 2014 3:30 PM
11	Potentially Use of Teach Back as a patient-centric measure to help improve education efforts	Jun 19, 2014 12:05 PM
12	Although they are freqently included in "tool kits", I am not aware of convincing evidence demonstrating that these interventions are effective in reducing unplanned hospital readmissions with reproducible results. High quality studies are still needed in order to determine which interventions are effective and cost effective. How were these two measurement items selected from the longer list included in the WSHA tool kit and the other programs that were referenced?	Jun 19, 2014 11:10 AM
13	• Patient discharge information summary sent and/or made available	Jun 19, 2014 8:17 AM

Page 2, Q11. Do you have any changes, additions, or comments to Recommendation III: Recommended Measurement (page 13)?		
	electronically with notification to the PCP or aftercare provider within two days or discharge. Please stay in alignment with the federal Meaningful Use measures, particularly as relates to an ever-evolving paperless environment, •An exclusion should be added to the metric to exclude cases where the PCP is the discharging provider. •How would a hospital report on the first measure when the discharging provider is the patient's primary care provider? •For the follow-up phone call: Additional considerations for timeframe of discharge phone call should include patients seen by home care within 48 hours of discharge and patients trasnfered to SNF or other care facility.	
14	Why is diabetes not on the list? it is the number one readmission reason. Might be good to just call out why it is not on the list. The list is already pretty long in terms of different conditions. Maybe scope to even fewer? Suggest providing more stanradards around the who and how data to collect --> don't be prescriptive but for example, what are the elements of a good post-d/c call; examples of "who" should call	Jun 18, 2014 4:14 PM
15	No	Jun 18, 2014 1:39 PM
16	The description of the metric should be modified to read: Patient discharge information summary sent and/or made available electronically with notification to the PCP or aftercare provider within two days or discharge. The comment should reflect that the metric must reflect our increasingly paperless environment, with multiple modes of preferred communication established between hospitals and community providers. An exclusion should be added to the metric to exclude cases where the PCP is the discharging provider. Additionally, in some rural areas the discharging provider is also a patient's primary care provider. In this case, does the discharge information need to be sent? How would a hospital report on the first measure when the discharging provider is the same as the patient's primary care provider? For the follow-up phone call: The description of the metric should be modified to read: A documented phone call within 24 to 72 hours following discharge, based on risk stratification. Additional considerations for timeframe of discharge phone call should include patients seen by home care within 48 hours of discharge and patients discharged to a skilled nursing facility.	Jun 18, 2014 10:21 AM
17	NO	Jun 17, 2014 10:40 AM
18	Include any diagnostic tests done Not just pending test results Standardized format across all hospitals for discharge summary. Each hospital only needs to create report that pulls from electronic records.	Jun 16, 2014 8:31 AM
19	Follow up by Pharmacy should be included, also medications for at least 1 week should be given at hospital discharge.	Jun 13, 2014 5:53 PM
20	no	Jun 13, 2014 11:19 AM
21	Yes. More data of a structured nature should be collected during phone call followups. It is not clear what information is to be gathered during this process. This part of the report seems ambiguous and incomplete; and unlikely to bear fruit with useful learnings for the medical providers.	Jun 12, 2014 7:21 AM

Page 2, Q11. Do you have any changes, additions, or comments to Recommendation III: Recommended Measurement (page 13)?		
22	no	Jun 11, 2014 10:44 PM
23	No	Jun 11, 2014 5:07 PM
24	no	Jun 11, 2014 1:55 PM
25	Not sure the tool will accurately reflect everything we need to fix the problem.	Jun 10, 2014 8:57 PM
26	no	Jun 10, 2014 7:34 PM
27	As above	Jun 10, 2014 3:54 PM
28	Who pays?	Jun 10, 2014 2:43 PM
29	The June 3rd Annuals of Internal Medicine addresses both phone and home visits and could added to keep up with the most current science	Jun 10, 2014 9:10 AM
30	The patient should read the discharge summary back to the nurse, because it is the only time they will actually look at it before handing it to another provider as either a folded, crumpled mess or a neat, perfect untouched paper in a folder, exactly as it was given to them.	Jun 1, 2014 11:25 AM
31	no	Jun 1, 2014 7:28 AM
32	no	May 31, 2014 1:43 PM
33	we need to make sure that measurements are based on quality outcomes that are meaningful results- 1. lower readmission rates- because people are getting into primary care and management of their chronic disease 2. need to have specific targets for behavioral health issues- which can also contribute to both er visits and readmission and currently is not specifically addressed in this draft	May 31, 2014 10:07 AM

Page 2, Q12. Please provide any general comments here:		
1	The draft proposed represents commendable work with the goal of preventing hospital readmissions. However critical stakeholders remain absent from the process, without whom Nurses comprise the largest group of health care workers in the state and in the country. Consumers select nurses as most trusted professionals compared to every other discipline. Nurses are the drivers of discharge planning and patient education. Why are no nurses on the committee charged to plan changes that will reduce the rate of hospital readmissions? In Washington state 5700 NPs provide primary care and specialty services in every county and see a higher percentage of Medicaid and Medicare patients than other disciplines. Only one RN participated in one of the workgroups and no ARNPs are represented in the collaborative. Nursing voices need to be heard in the planning phase to better inform committee members and to assure transparency. Successful implementation of the plan requires that nurses are aware of the process development. Ensure that we can do well what we are already assigned to do. Safe staffing levels are the first need – as this directly impacts the ability to perform discharge planning. Barriers to care by NPs must be removed, including restrictions on hospital privileging, that prohibit PCPs from reviewing their patients inhouse progress to prespare for their discharge.	Jun 20, 2014 4:23 PM
2	The document could be more explicit in acknowledging the providers' perspective in needing to comply with requirements of many competing quality improvement efforts and that such demands impose administrative burden and costs on the provider community.	Jun 20, 2014 3:44 PM
3	Discussion of the PAR Workgroup and Accountable Payment Models Workgroup didn't seem to fit in this document. The review of these two workgroups is too detailed. We also are not clear where the surgical bundles and warranty model fit into readmissions. These are Bree Collaborative works, but may better fit into an appendix. A clear discussion of why HCA is involved, or how HCA will use this document and interventions would strengthen the recommendations.	Jun 20, 2014 3:27 PM
4	• Given the volume of quality improvement efforts underway across the state the Bree should consider a phased approach to the recommendations, allowing hospitals time to form collaboratives, ramp up new systems and test system changes. Thank you for the opportunity to participate.	Jun 20, 2014 2:22 PM
5	This is a multi-facted problem. The report does an excellent job of pulling together the current efforts and resources, but it feels like a voice is missing - the patient voice. At least half the burden for preventable readmission rates rests with the patient. Just doing something different to or with the patient will not be enough. The patient voice is critical to making the greatest headway in reducing these rates. My experience with hospital stays for mysef and family members is that the admission process regarding finances, etc is given far more time and importance than the discharge. Until every corner of the hospital stay is tuned around the patient, these valiant efforts are likely to bring only modest change. Preventable readmissions are a symptom of a much larger issue, and that makes this effort seem like a band-aid approach that will likely keep energies spinning around unacceptable rates. If the goal of adverse events is zero, why is it acceptable to accept a precentage of a reduction? This just tells me the efforts are perhaps aimed at the wrong target - cost and reimbursement, rather than the best for the patient. It is a tricky slope to navigate, and I respectfully remind everyone that the patient, not the provider or payer, should be the central focus,	Jun 20, 2014 1:13 PM

Page 2, Q12. Please provide any general comments here:		
	people - not statistics and dollar signs, not ease for medical staff.	
6	For three years, UW Medicine has been working on reducing readmissions with King County/Pierce County community transitions efforts coordinated by Aging & Disability Services (ADS). Qualis has been a very visible and active partner in these formal efforts. We also have our own internal Process Improvement Teams to address readmission issues across our system. Increasing amounts of time are being consumed by duplicative initiatives/meetings/reporting, which is placing a considerable burden on hospital resources and staff. We would request that we very carefully tease out the unique value in pursuing overlapping initiatives, especially as we anticipate further emphasis on this matter by Medicaid in the upcoming year.	Jun 20, 2014 11:51 AM
7	We appreciate the opportunity to provide comments on Bree recommendations to reduce readmission in Washington State. Improving discharge planning, care transition, and quality of community-based care are all great efforts and will benefit patients' safety. But, we are concerned that the plan lacks emphasis on identifying, documenting and tracking HACs, which have been shown to contribute significantly to the readmission. In 2008, my Dad was discharged with several significant hospital-acquired conditions due to an adverse drug event and the resulting complications, such as acute respiratory failure, acute heart failure, acute kidney injury, and open bedsores. However, the latter three were not documented in my Dad's hospital records; we were never informed about acute kidney injury and he was never treated for this hospital-acquired life-threading condition. Without identifying and documenting these HACs, hospitals will not be able to determine which factors are the primary reasons for readmission. A focused effort will enable the state to achieve its ultimate goal --- to improve patient safety and to reduce medical harm. Therefore, we highly recommend that Bree Collaborative include HAC identification and documentation as one of its high priorities in the collaborative efforts to reduce readmission. This information should be included in the discharge summary and readmission assessment. The copies should be shared with the entire care transition team and with patients and their families. Patients' feedbacks such as the HCAHPS should also be included in the discharge files that will be shared among all care team members. In addition, we would recommend that patient/family representatives be included as one of the major stakeholders in the state-wide collaborative efforts to reduce readmission.	Jun 19, 2014 9:24 PM
8	I am unclear why the information on the THR/TKR bundle and warranty are included in this report. This information seems unrelated to the identified readmission populations of focus.	Jun 19, 2014 11:10 AM
9	I agree with the recommendations.	Jun 18, 2014 1:39 PM
10	Tools to facilitate "hand-off" between acute care hospitals and SNFs are very helpful.	Jun 17, 2014 10:40 AM
11	I'm not clear on the purpose of the Bree collaborative, when there are already several groups within WSHA and Qualis addressing readmissions. The Bree group does not appear to have interdisicplinary membership, which seems important to any oversight of the readmissions initiative.	Jun 16, 2014 12:47 PM
12	Hopefully there will be a renewal of BREE collaborative work committee as the	Jun 16, 2014 8:31 AM

Page 2, Q12. Please provide any general comments here:		
	efforts have been positive.	
13	I believe your workgroup will benefit from having internet technology representatives present. All the problems you are describing of PAR can be reduced by unifying a collective post admission software. Wouldn't par be reduced by a post admission follow up call centers this would mean the medical industry would need to invest some of the 17.4 billion pre year end quarterly taking a preventative stance to PAR.	Jun 15, 2014 9:52 AM
14	Thorough education at the hospital level including written and verbal with teach back as I being recommended and follow through by Home Care and Physicians is needed. Please be judicious in the cost of this process/program.	Jun 13, 2014 5:53 PM
15	Instead of 2 days to provide the discharge summary, restate it to say 2 business days after discharge	Jun 12, 2014 12:02 PM
16	This would be the time to engage a number of patient advocate groups along with Qualis Health experts in a common work session to gain additional insights on viability of processes and tools to gather patient-centered data. Although this information may already be available it is not readily apparent in this report.	Jun 12, 2014 7:21 AM
17	In addition to comprehensive, timely discharge summary to provider, some format of the same information should be provided to patient/advocate who can absorb and use as reference material following discharge.	Jun 11, 2014 5:07 PM
18	A complementary health care practitioner, I have helped elderly diabetes patients with annually recurring community acquired pneumonias avoid repeated admissions to hospitals. Indeed, once they begin a relationship with me they do not develop pneumonia again. If doctors in hospitals could refer patients to continue care with acupuncture clinics, they could improve many situations exponentially. At this point in time, it's a small percentage of patients who find their way to acupuncturists even though insurance is mandated to cover acupuncture visits.	Jun 10, 2014 7:03 PM
19	Who will provide clerical support for faxing of information to PCP. Optum and others offer solutions, but this causes undue financial burden on some health care entities. Not all services are created equal when you dole out requirements.	Jun 10, 2014 3:54 PM
20	Need to label the axes in Fig. 4 (Appendix D)	Jun 10, 2014 2:43 PM
21	I think this needs more work to be fair to employers and Medicaid. As to Medicaid there is no mentionn of mental health readmissions. A recent 19 state review of Medicaid readmission shows 1) respiratory (asthma), 2) perinatal and 3) behavioral health as top drivers. Given the huge number of WA popuation enrolled in Medicaid I think these facts need to be in the report. Dan Lessler MD has the data.	Jun 10, 2014 9:10 AM
22	I am surprised the physicians on your collaboration have not yet told you that this is a symptom you are treating. You have acknowledge the problem, but don't address it. When someone has no stake in the cost of a service delivered to them they will make use of it to an excess. These are most likely to also be your most at risk, least self-sufficient patients.	Jun 1, 2014 11:25 AM

Page 2, Q12. Please provide any general comments here:		
23	as a family doctor who no longer does admissions it is difficult coordinating care when a patient is discharged but the most important part of keeping a person from being readmitted is the hospital follow up because when they follow up I can keep a stable patient stable but another important key is they need to be stable at discharge and not be prematurely discharged so that a hospital or hospitalist's numbers "look" good	May 31, 2014 1:43 PM

Page 3, Q13. Name:		
1	Michael Myint	Jun 21, 2014 11:49 AM
2	Nancy Lawton, MN, ARNP, FNP	Jun 20, 2014 4:24 PM
3	Jenny Ulum	Jun 20, 2014 3:50 PM
4	Bob Perna	Jun 20, 2014 3:45 PM
5	Jenny Arnold, PharmD, BCPS	Jun 20, 2014 3:28 PM
6	Ian Corbridge	Jun 20, 2014 2:22 PM
7	Jeanne Lowe, PhD, RN Manager, Pay-For-Performance	Jun 20, 2014 11:51 AM
8	Lori Murray	Jun 20, 2014 8:18 AM
9	Yanling Yu and Rex Johnson	Jun 19, 2014 9:25 PM
10	Russell A Shear	Jun 19, 2014 3:31 PM
11	Angela Stewart	Jun 19, 2014 11:12 AM
12	Julie McDonald	Jun 19, 2014 8:18 AM
13	Megan McIntyre	Jun 18, 2014 4:15 PM
14	Eileen Sullivan	Jun 18, 2014 10:22 AM
15	Donna Goodwin	Jun 17, 2014 2:23 PM
16	Lisa Evans	Jun 17, 2014 9:53 AM
17	Carol Charles	Jun 16, 2014 12:47 PM
18	Randi Saeter	Jun 16, 2014 12:19 PM
19	Travis Turner	Jun 15, 2014 9:53 AM
20	Dr. David Kincheloe	Jun 14, 2014 1:47 PM
21	Joan Fargo	Jun 13, 2014 5:53 PM
22	sami haddad	Jun 13, 2014 11:20 AM
23	Vernon Dwight Schrag	Jun 12, 2014 7:22 AM
24	Jeff Weil, PT: Division Vice President	Jun 11, 2014 10:45 PM
25	Patricia Dawson	Jun 11, 2014 9:16 AM
26	Carol A. Grabowski, MA, NCC, LMHC, CDP	Jun 10, 2014 7:36 PM
27	Miranda	Jun 10, 2014 7:04 PM

Page 3, Q13. Name:		
28	Jeff Thompson	Jun 10, 2014 9:11 AM
29	carrie horwitch	May 31, 2014 10:07 AM

Page 3, Q14. Email address:		
1	michael.myint@swedish.org	Jun 21, 2014 11:49 AM
2	nelawton1@gmail.com	Jun 20, 2014 4:24 PM
3	julum@peacehealth.org	Jun 20, 2014 3:50 PM
4	rjp@wsma.org	Jun 20, 2014 3:45 PM
5	jenny@wsparx.org	Jun 20, 2014 3:28 PM
6	ianc@wsha.org	Jun 20, 2014 2:22 PM
7	jlowe@uw.edu	Jun 20, 2014 11:51 AM
8	lorimurray@YVMH.org	Jun 20, 2014 8:18 AM
9	yy8@uw.edu rex1@uw.edu	Jun 19, 2014 9:25 PM
10	Russell.Shear@providence.org	Jun 19, 2014 3:31 PM
11	stewas@wsu.edu	Jun 19, 2014 11:12 AM
12	julie.mcdonald@providence.org	Jun 19, 2014 8:18 AM
13	megan.mcintyre@vmmc.org	Jun 18, 2014 4:15 PM
14	eileen.sullivan@providence.org	Jun 18, 2014 10:22 AM
15	goodwndr@aol.com	Jun 17, 2014 2:23 PM
16	lisa.evans@hcr-manorcare.com	Jun 17, 2014 9:53 AM
17	carolc6@uw.edu	Jun 16, 2014 12:47 PM
18	rsaeter@nikkeiconcerns.org	Jun 16, 2014 12:19 PM
19	trenrut@gamil.com	Jun 15, 2014 9:53 AM
20	dkincheloe@gmail.com	Jun 14, 2014 1:47 PM
21	joan.fargo@providence.org	Jun 13, 2014 5:53 PM
22	samihaddad@Hotmail.com	Jun 13, 2014 11:20 AM
23	dwights30@comcast.net	Jun 12, 2014 7:22 AM
24	jeffrey.weil@lhcgroup.com	Jun 11, 2014 10:45 PM
25	Patricia.Dawson@ Seattle.gov	Jun 11, 2014 9:16 AM
26	Carol_Grabowski@comcast.net	Jun 10, 2014 7:36 PM
27	MirandOM1@gmail.com	Jun 10, 2014 7:04 PM

Page 3, Q14. Email address:		
28	jeff.thompson@mercer.com	Jun 10, 2014 9:11 AM
29	carrieho@Comcast.net	May 31, 2014 10:07 AM

Page 3, Q15. Organization:		
1	Swedish Medical Center	Jun 21, 2014 11:49 AM
2	President, ARNPs United of Washington State www.AUWS.org Washington State Representative, AANP	Jun 20, 2014 4:24 PM
3	PeaceHealth	Jun 20, 2014 3:50 PM
4	Washington State Medical Association	Jun 20, 2014 3:45 PM
5	Washington State Pharmacy Association	Jun 20, 2014 3:28 PM
6	WSHA	Jun 20, 2014 2:22 PM
7	UW Medicine	Jun 20, 2014 11:51 AM
8	Yakima Valley Memorial Hospital	Jun 20, 2014 8:18 AM
9	Washington Advocates for Patient Safety	Jun 19, 2014 9:25 PM
10	Providence Sacred Heart Medical Center & Children's Hospital; Providence Holy Family Hospital	Jun 19, 2014 3:31 PM
11	College of Pharmacy, WSU	Jun 19, 2014 11:12 AM
12	Providence Regional Medical Center Everett	Jun 19, 2014 8:18 AM
13	virginia mason medical center	Jun 18, 2014 4:15 PM
14	Providence Health & Services	Jun 18, 2014 10:22 AM
15	Washington Health Care Association	Jun 17, 2014 9:53 AM
16	University of WAshington Medical Center	Jun 16, 2014 12:47 PM
17	Seattle Keiro Rehabilitation and Care Center	Jun 16, 2014 12:19 PM
18	WWU/PeaceHealth/NSMHA	Jun 14, 2014 1:47 PM
19	Providence Home Care	Jun 13, 2014 5:53 PM
20	Washington Advocates for Patient Safety (Seattle WA)	Jun 12, 2014 7:22 AM
21	LHC Group	Jun 11, 2014 10:45 PM
22	City Seattle Aging and Disabilities.	Jun 11, 2014 9:16 AM
23	AMTA	Jun 10, 2014 10:00 PM
24	non-profit, outpatient mental health and substance abuse treatment agency in Spokane, WA	Jun 10, 2014 7:36 PM
25	High Point Health PLLC	Jun 10, 2014 7:04 PM
26	Mercer	Jun 10, 2014 9:11 AM

Page 3, Q15. Organization:		
27	ACP	May 31, 2014 10:07 AM