

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Reasons for Readmission in a High-Risk Population
AUTHORS	Long, Theodore; Genao, Inginia; Horwitz, Leora

VERSION 1 - REVIEW

REVIEWER	Hinami, Keiki Northwestern University, Medicine
REVIEW RETURNED	05-Jun-2013

The reviewer completed the checklist but made no further comments.

REVIEWER	Englander, Honora Oregon Health and Science University, Medicine
REVIEW RETURNED	02-Jul-2013

THE STUDY	<p>Authors explore a very important topic in this manuscript, and I agree with and applaud their assumption that not all transitional care improvements will apply to diverse populations. I also think that their conclusions about the importance in investing in primary care infrastructure and the way that underserved adults relate to primary care are important. I hope that my suggestions strengthen the quality of their manuscript.</p> <p>Methods: In the limitations you state that you reach saturation however this will be important to include in the methods. Also, how did you manage data if not with software? Fuller description of qualitative methods is warranted. Also, were interviews performed Monday through Friday or did they include weekend admissions?</p> <p>Survey: survey did not explicitly ask patients about the quality of the patient education that they received or their understanding of how to self-manage illness or when to contact providers. This may be a major issue with urban underserved populations with high prevalence of low health literacy, and wonder if this emerged at all as a theme. In addition, authors did not address issues of timely post-discharge follow up. Similarly, I am interested to know if this emerged.</p> <p>References: Would review and update references about phone triage, and about patient and provider perceptions of hospital-to-home transitions. For example, Colemans early qualitative work might be useful to include. - Coleman EA. Falling through the cracks: challenges and opportunities for improving transitional care for persons with</p>
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	<p>continuous complex care needs. J Am Geriatr Soc. 2003;51(4):549–555.</p> <p>I would also recommend adding references around under-served transitions:</p> <ul style="list-style-type: none"> - Davis MM, Devoe M, Kansagara D, Nicolaidis C, Englander H. “Did I Do as Best as the System Would Let Me?” Healthcare Professional Views on Hospital to Home Care Transitions. Journal of General Internal Medicine. 27(12):1649-56, 2012 Dec - Raven MC, Billings JC, Goldfrank LR, Manheimer ED, Gourevitch MN. Medicaid patients at high risk for frequent hospital admission: real-time identification and remediable risks. J Urban Health. 2009;86 (2):230–241. - Englander H, Kansagara D. Planning and designing the Care Transitions Innovation (C-Trailn) for uninsured and Medicaid patients. J Hosp Med. 2012. doi:10.1002/jhm.1926.
<p>RESULTS AND CONCLUSIONS</p>	<p>Patient demographics: The manuscript would be greatly improved by a demographics table that describes the participants. For example: % with a telephone, % with marginal housing, % uninsured/ publicly insured, income, education).</p> <p>Themes: authors provide a list of topics that surfaced during their interviews, however it is unclear to me how they come together as themes. For example, if the results support it, I might recommend changing a theme such as ‘self-triage’ to ‘self-triage led to potentially avoidable ED use.’ Similarly, what is thematic about ‘Discharge planning’ or ‘patient characteristics?’ Also, it is unclear to me how the themes fit together – referencing a theoretical framework may be helpful to make this more useful.</p> <p>Similarly, I am concerned that authors do not fully support their conclusions. For example, they note that participants report fragmented relationships with primary care providers, but it is unclear if this contributes to readmission risk. It is unclear if their interviews suggest this as a cause for readmission, or if this was a complaint noted by frequently readmitted patients (but perhaps not causative).</p> <p>The notion that self-triage contributes to frequent ED use is interesting and important and the quotes here support their findings more directly.</p> <p>In the examples that they note in reference to self-triage, pain management is an issue. Did authors identify issues around opioid seeking?</p> <p>Discussion: Authors’ conclusions feel far reaching (in particular around telephone access). If their findings support their conclusions, it will be important to show this in the results. Otherwise, I would recommend being more speculative (for example, they say that telephone access is critical, however 2 of the 3 studies they cite for this were published in the early 1990s before the age of internet. Their study didn’t explicitly explore the best modes of communication between patients and providers – I might suggest this as a future direction.</p> <p>Similarly, I think that their findings about provider continuity, while hypothesis generating, are not as conclusive as authors state. The manuscript would be improved to more thoroughly describe the results and shorten the discussion and recommendations for</p>

	<p>systems change (unless there were direct recommendations from their study, but the survey guide doesn't look like this was the main focus).</p> <p>I think that the author's suggestion to invest in primary care infrastructure is important, and often overlooked in transitional care improvements, however without adequate description of their sample, it is hard to know in what populations this applies.</p> <p>Minor comments: The author frequently writes in the passive voice. For example: p 5, line 56: 'the instrument was then revised...'</p> <p>Grammar could also be tightened up: for example, p10: 'we explored how patients were interacting' – instead change to 'we explored how patients interacted'; 'we found that patients were delaying care' could be improved to 'we found patients delayed care...'</p>
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VERSION 1 – AUTHOR RESPONSE

Comments of Reviewer Keiki Hinami, MD MS:

1. p4, lines 22-24: The final sentence makes clear the authors' primary assumption that readmission is a problem related to inadequacies of outpatient care. A conceptual model or an explanation for this assumption would be appropriate.

Response: We agree that we do not want to judge the relative importance of outpatient care with respect to all the factors contributing to readmissions. Because our study is focused on the patient experience outside of the hospital, we have changed this sentence to reflect our exploration of this issue.

New text: It has been unclear what happens to patients once they are discharged from the hospital, and whether their health care outside of the hospital could be improved in order to prevent hospital readmissions.

2. p5, lines 10-12: It seems as if the PCC is staffed by housestaff on a rotating basis. If so, this needs to be made explicit in the methods section.

Response: We agree and have added a description about the staffing of the PCC.

New Text: The PCC is staffed by internal medicine residents who are typically present for one half day per week as well as part and full time attending providers. Residents are assigned to the PCC for their entire three years of training.

3. p5, line 32: A rationale for the inclusion criteria needs some explanation. Four or more admissions in 6 months is clear enough but why a diagnosis of heart failure? Diagnosis of heart failure by what criteria?

Response: Thank you for this clarification. We in fact only included patients with four or more admissions in the past six months. We separated these patients out of the general list of high-risk patients, which also included heart failure patients. We have clarified this approach and reworded the sentence.

New Text: From the daily list, we identified patients who had four or more admissions in the past six months and who had an established primary care provider in the PCC as well as at least two

completed clinic notes from the prior 12 months.

4. p5: Were patients approached for this study in the hospital during their readmission stay? This is not clear.

Response: Yes, all interviews were conducted during the readmission stays for the patients. We added a sentence to clarify this.

New Text: All interviews were conducted inpatient during the patients' readmission stays.

5. p5, lines 54-56: It is not clear how the interview script was piloted.

Response: Thank you. The pilot interviews were conducted to revise the list of questions, and feedback was solicited from the patients. We then extensively reviewed the transcription from the first interview to ensure appropriateness of questions and interviewing strategies. We have reworded this area to clarify the piloting of the interview script.

New Text: We then conducted pilot interviews and solicited feedback about the interview questions from patients. The instrument was revised based on this feedback. We also extensively reviewed the first complete interview transcription, and further revised the instrument based on this feedback as well.

6. Appendix 1: The interview script reads like survey questions with about half the questions prompting an affirmative/negative or numerical response. What systematic prompting techniques were used? How long did an average interview take?

Response: Each interview took an average of 15 to 20 minutes. For questions asking for an affirmative/negative or numerical response, we used a strategy of planned prompts and probes to extend the narrative. We have clarified this strategy and the length of the interviews by adding one sentence to the end of the Design section and one sentence in the results section.

New Text (for Design section): For questions asking for an affirmative/negative or numerical response, we used a strategy of planned prompts and probes to extend the narrative.

New Text (for Results section): On average, the interviews were 15 to 20 minutes long.

7. The authors focus on the absence of a primary care relationship as a "recurrent theme" that contributed to readmissions. While this may be a relevant theme, it seems that with so many questions asking about PCPs (nearly a third), it would have been impossible for PCPs not to have emerged as a theme.

Response: We agree that there was significant attention paid to the relationship between patients and their primary providers, making it highly likely that this would emerge as a central theme. However, as the intent of our study was to evaluate post-discharge care, we felt it was necessary to comprehensively elicit opinions about primary care providers during the interviews. Also, the specific finding that the primary provider relationship was fragmented was not an inevitable conclusion, but rather a recurrent theme that arose from the interview responses.

8. Just on face value, the 11 main themes distilled from the data seem incomplete. Pervasive health factors such as social isolation, loneliness, poor self-efficacy, physical and mental disabilities, financial problems not related to medications, poor nutrition, care-taker responsibilities, and neighborhood crime may not have been able to be elicited by the script without significant prompting.

If they were, they may be absent from the authors' main themes.

Response: Thank you for making a note of these important themes. We certainly agree that these pervasive health factors are quite relevant to our population of patients. We did explore social isolation, loneliness, and care-taker responsibilities under our theme of Heavy Reliance on Informal Support Systems. In this category, we were surprised to find that the patients had a great deal of support from family members and friends in their communities. In different ways, the patients demonstrated resilient attitudes, and notably described that they did not feel lonely despite spending a great deal of time in the hospital. In terms of care-taker responsibilities, the patients had worked these issues out within their informal support systems. Physical disabilities were a common issue, with patients describing the various hospital beds and other resources they had access to at home. We included this under Formal Services. We also explored neighborhood crime, and all patients reported feeling safe at home. We included this topic under Informal Support Systems. We have added the following addition under the heading of Heavy Reliance on Informal Support Systems.

New Text: Patients demonstrated resilient attitudes based on the high degree of support they received from friends and family members, and notably described that they did not feel lonely or socially isolated despite spending a great deal of time in the hospital. Patients also reported feeling safe at home.

9. This reviewer would like to have seen the raw patient responses to the second interview question. If administered to enough patients, this is where I would expect to see the clearest articulation of the problem.

Response: We agree that the patient perspective about whether anything could have been done to have prevented the readmission is crucial to our project. Interestingly, this question often required follow up with a prompt or an additional question. The patients often replied "I don't think so" or "not really."

10. p10, line 12: The sentence may better be rephrased, "...patients from our sample did not have difficulty accessing medications,...." so as to not imply that access is not a problem, universally. Patients at YNHH may have unique resources to help them with access not available to all the urban poor.

Response: We agree that this sentence should reflect the finding from our patient sample. We reworded this sentence to make this change.

New Text: Contrary to our expectations, patients from our sample did not have difficulty accessing medications, home care, or transportation.

11. p10, lines 24-32: "We found that patients were delaying care and then making the decision to go to the ED without attempting to contact their primary providers. This delay of care likely resulted in a worsening of their health status which consequently precipitated another hospital admission." This is the narrative that most physicians believe but I don't think the majority of at-risk patients fit this story. The authors' generalization of this simple narrative to patients, in general, is disappointing. The qualitative methodology's potential can be fully leveraged by generating new hypotheses, not just reinforcing stereotypes.

Response: We wholeheartedly agree that the underlying purpose of this qualitative research should be to generate hypotheses, and not to reinforce stereotypes. In our sample of high-risk patients though, delaying care was indeed a prevalent finding that we are hopeful can be ameliorated through intervention focused on the underlying reason that is causing this to happen. In our evaluation of the

results, we sought to generate hypotheses about both the etiology of readmissions as well as areas for intervention. In our Discussion we sought to propose several targeted areas for intervention that were tailored to the themes we found. We hope that the new hypotheses for interventions that we generated will help to improve care for these high-risk patients once they have left the hospital.

12. p11-12: "...many patients in our study had stopped calling their primary care provider because of their perceptions of the primary care clinic as incapable of hand[ling] acute medical concerns...We would suggest educating patients about the scope of their primary care clinics as urgent care centers..." This statement put the authors at risk of sounding unreasonably paternalistic if I read this to mean that patients should be "educated" into believing that their perceptions about the limitations of clinics are wrong.

Response: Thank you for asking for clarification about this intervention strategy. We agree that the first step toward changing patient perceptions is to rectify the underlying problem that has caused these perceptions to exist. We have changed this section to reflect that change must first happen to access to care as well as repairing primary care relationships before education can take place about the improvements that have been made for patients.

New Text: Once access to providers has been improved and the lack of primary care relationship has been repaired, we would suggest educating patients about the scope of their primary care clinics as urgent care centers, as well as the role of their primary providers in their care when they have a change in their health status.

Comments of Reviewer Honora Englander, MD, FACP:

1. In the limitations you state that you reach saturation however this will be important to include in the methods. Also, how did you manage data if not with software? Fuller description of qualitative methods is warranted.

Response: We appreciate the recommendation to include more details about the qualitative analysis, which was completed without qualitative software. We coded the transcriptions on Microsoft Word documents. We have added this description, and we also introduced the concept of theoretical saturation into the Methods.

New Text: The transcriptions were saved as Microsoft Word documents, with codes being tracked as Comments within these documents.

New Text: It was decided ahead of time that transcriptions would be coded until theoretical saturation was reached and no new codes were being introduced in the interviews.

2. Also, were interviews performed Monday through Friday or did they include weekend admissions?

Response: The interviews were performed on weekdays and weekends. We appreciate this clarification, and have added a sentence to this effect.

New Text: Interviews were completed on both weekdays and weekends.

3. Survey: survey did not explicitly ask patients about the quality of the patient education that they received or their understanding of how to self-manage illness or when to contact providers. This may be a major issue with urban underserved populations with high prevalence of low health literacy, and wonder if this emerged at all as a theme. In addition, authors did not address issues of timely post-discharge follow up. Similarly, I am interested to know if this emerged.

Response: We agree that these issues are important and particularly relevant to the underserved patients in our study. The theme of patients' understanding about when to contact their providers definitely emerged as a major issue. We included this under the Self Triage theme. Patients were describing that they were making the decision to go to the ED when they had a change in their health status without first reaching out to their primary provider. In terms of evaluating patients' understanding of their illness, we did have a Health Literacy theme, but the codes describing this among patients in our sample were not consistent enough to have health literacy listed as a major theme. Several patients had low health literacy, and several demonstrated adequate literacy about their illnesses. With respect to post-discharge follow up, we included these codes under the theme of Discharge Planning. We found that the patients generally reported adequacy of timely discharge follow up.

4. Would review and update references about phone triage, and about patient and provider perceptions of hospital-to-home transitions. For example, Colemans early qualitative work might be useful to include.

Response: We agree and appreciate this suggestion. We have added all of the recommended references.

5. Patient demographics: The manuscript would be greatly improved by a demographics table that describes the participants. For example: % with a telephone, % with marginal housing, % uninsured/ publicly insured, income, education.

Response: We appreciate the recommendation to add further description of our cohort through including a demographics table. However, in our study we only sought to obtain self-reported information from the patients that were interviewed. Generally speaking, we did complete a chart abstraction as part of a quality improvement activity for the approximately 36 PCC patients meeting our enrollment criteria the year prior to our study. This showed that these patients are poor and mostly publically insured, which reflects the underserved population that receives care from the PCC. As part of a future intervention, it would be useful to know the percentage of patients with a telephone or marginal housing.

6. Themes: authors provide a list of topics that surfaced during their interviews, however it is unclear to me how they come together as themes. For example, if the results support it, I might recommend changing a theme such as 'self-triage' to 'self-triage led to potentially avoidable ED use.' Similarly, what is thematic about 'Discharge planning' or 'patient characteristics?' Also, it is unclear to me how the themes fit together – referencing a theoretical framework may be helpful to make this more useful.

Response: Thank you for the feedback that our selection of themes could have more clarity in our Results section. We agree and have made several changes to make this section more clear. In terms of how the five main themes that we discuss were selected, we added a description that these themes represented both consistent codes and either risks for readmission or discussion of current interventions. The other themes represented codes that came from self-reported descriptions, but were either not consistent or not relevant to readmissions. We added a sentence to help clarify this, with a brief example. Finally, we added further description to several of the themes based on this Reviewer's suggestion.

New Text: We identified 11 themes (Table 1), and describe five relating to risk of readmission: fragmented primary care relationships contributing to avoidance of ambulatory care, self triage leading to potentially avoidable ED use, adequacy of formal services, heavy reliance on informal support systems, inadequate access to care.

New Text: The codes contributing to these five themes were consistent throughout the interviews and pertained to either reasons for readmission or current interventions targeted at decreasing readmissions. The other themes represented self-reported descriptions, such as substance abuse for the theme of patient characteristics.

New Text (subheading): Fragmented Primary Care Relationships Contributing to Avoidance of Ambulatory Care

New Text (subheading): Self Triage Leading to Potentially Avoidable ED Use

New Text (subheading): Adequacy of Formal Services

New Text (subheading): Heavy Reliance on Informal Support Systems

New Text (subheading): Inadequate Access to Care

7. Similarly, I am concerned that authors do not fully support their conclusions. For example, they note that participants report fragmented relationships with primary care providers, but it is unclear if this contributes to readmission risk. It is unclear if their interviews suggest this as a cause for readmission, or if this was a complaint noted by frequently readmitted patients (but perhaps not causative).

Response: We appreciate this Reviewer's feedback about our Results section on a lack of primary care relationship. We have added a quotation that suggests the fragmented relationship with the primary provider may lead to readmission.

New Text: Another patient described improving the relationship with her primary provider, stating "It [would] make me feel better knowing that somebody cares [...] They could give advice on the phone telling me what I should do. And I could do that to prevent going to the hospital because I'm in the hospital a lot."

8. The notion that self-triage contributes to frequent ED use is interesting and important and the quotes here support their findings more directly.

Response: Thank you.

9. In the examples that they note in reference to self-triage, pain management is an issue. Did authors identify issues around opioid seeking?

Response: We did make specific inquiries into pain management as an issue. We did not identify opioid seeking as an issue, but this would be an interesting avenue for future research.

10. Authors' conclusions feel far reaching (in particular around telephone access). If their findings support their conclusions, it will be important to show this in the results. Otherwise, I would recommend being more speculative (for example, they say that telephone access is critical, however 2 of the 3 studies they cite for this were published in the early 1990s before the age of internet. Their study didn't explicitly explore the best modes of communication between patients and providers – I might suggest this as a future direction.

Response: We agree that exploring the best modes of communication between patient and provider will be an increasingly important future direction. Especially with our poor and underserved population, this will be an important area for future research. We have added a sentence in reference to this.

New Text: Future research regarding the best modes of communication with providers will be an important area of inquiry moving forward.

11. Similarly, I think that their findings about provider continuity, while hypothesis generating, are not as conclusive as authors state. The manuscript would be improved to more thoroughly describe the results and shorten the discussion and recommendations for systems change (unless there were direct recommendations from their study, but the survey guide doesn't look like this was the main focus).

Response: We appreciate this comment, and have made several additions to the Results that provide further detail. In particular, we provided an additional quotation about improving the provider relationship to decrease hospital admissions. We included this quotation based on this Reviewer's recommendation above. We also added further detail to the Results section in terms of the main themes as well as the informal support systems subheading. We have also made several changes to the Discussion in order to make it more concise. We will include a few of the New Text changes below here, and please see the original document for all changes. Please note that these additions were previously mentioned as New Text changes based on the Reviewer comments above.

New Text (in Results): The codes contributing to these five themes were consistent throughout the interviews and pertained to either reasons for readmission or current interventions targeted at decreasing readmissions. The other themes represented self-reported descriptions, such as substance abuse for the theme of patient characteristics.

New Text (in Results under the Fragmented Primary Care Relationship Contributing to Avoidance of Ambulatory Care subheading): Another patient described improving the relationship with her primary provider, stating "It [would] make me feel better knowing that somebody cares [...] They could give advice on the phone telling me what I should do. And I could do that to prevent going to the hospital because I'm in the hospital a lot."

12. I think that the author's suggestion to invest in primary care infrastructure is important, and often overlooked in transitional care improvements, however without adequate description of their sample, it is hard to know in what populations this applies.

Response: Thank you for asking for this clarification. The PCC is a hospital-based clinic that serves low-income residents of New Haven. We have added further description of the PCC based on Reviewer comments above, stating that the PCC is staffed by internal medicine residents. While we only collected self-reported data from patients for this study, we do know from a recent chart abstraction that the high-risk PCC patients are indeed poor and mostly publically insured. We believe that our result pertains to populations of patients that are underserved but have access to hospital-based resources and outpatient ambulatory care, and that have the highest risk for readmission.

VERSION 2 - REVIEW

REVIEWER	Englander, Honora Oregon Health and Science University, Medicine
REVIEW RETURNED	19-Jul-2013

THE STUDY	My concerns about the small sample size and inadequate description of the patients' interviewed remain. I think that - to be of publishable quality - the paper needs a demographic table that describes simple demographics (age, race, gender, comorbidities, insurance), at a minimum
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	<p>Authors still do not link their work to any theoretical framework (both reviewers have pointed to this gap). A very nice example of a paper that does this in the recent literature comes from Health Affairs: Understanding Why Patients of Low Socioeconomic Status Prefer Hospitals Over Ambulatory Care.</p>
<p>RESULTS AND CONCLUSIONS</p>	<p>Conclusions are still too far reaching and are not adequately described in light of the data/ findings from the study.</p> <p>For example, researchers state 'This delay in care likely resulted in a worsening of their health status which consequently precipitated another hospitalization.' Their results do not show support for this association, even if it is a hypothesis.</p> <p>They also describe that their high risk patients likely had 'more interaction with the health system than other patients with fewer hospital admissions and therefore more opportunity to be linked in with formal services such as VNA and arranged transportation.' They didn't evaluate other patient groups (who may have had more clinic utilization but not hospital utilization) so this, again, feels far reaching.</p> <p>Similarly, the comments about the 'critical' nature of telephone access could be restated to better reflect findings of the study and make fewer broad conclusions.</p>

VERSION 2 – AUTHOR RESPONSE

Comments of Reviewer Honora Englander, MD, FACP:

1. My concerns about the small sample size and inadequate description of the patients' interviewed remain. I think that - to be of publishable quality - the paper needs a demographic table that describes simple demographics (age, race, gender, comorbidities, insurance), at a minimum

Response: We agree that including demographic information for the population of patients that we sought to describe through our qualitative evaluation would be helpful. We have thus included both simple demographic information as well as more detailed descriptions of ED visits and utilization for the entire cohort of 36 patients that met our enrollment criteria. As we describe in our Results, 21 of these 36 were approached for the study, and 17 interviews were completed. We appreciate this reviewer's comment about including this information, and believe that this helps to clarify the population that we were looking at in our study. Please do note, though, that this demographic information is for the entire cohort of 36 patients meeting our enrollment criteria. Due to our IRB exemption, we did not retain descriptive or identifying data for the patients we interviewed. However, we believe that the new demographic information we are including will help our readers to understand the population that we were focusing on for our qualitative evaluation.

New Text: Thirty-six patients met inclusion criteria at the onset of the study. Of the 36 patients, 21 eligible patients were approached, and four declined. We completed 17 interviews (11 women, 6 men). On average, the interviews were 15 to 20 minutes long. For the overall cohort of 36 patients meeting inclusion criteria, patient characteristics are provided in Table 1. When patients presented to the ED, 67% of the time they were admitted to the hospital (see Table 2 for hospital admission and ED diagnoses). Patients also had multiple visits to the PCC and the ED (Table 3). Sixteen of the 17 patients we interviewed screened negative for unhealthy alcohol use per the NIAAA tool and 47% had a positive screen for depression per the PHQ-2.

Table 1: Patient Characteristics for Cohort Meeting Inclusion Criteria (N=36)
Age Number (%)

19 to 39 10 (28)
 40 to 64 18 (50)
 65 or above 8 (22)
 Race/Ethnicity
 Hispanic 8 (22)
 Black 16 (44)
 White 11 (31)
 Other 1 (3)
 Insurance Status
 Medicaid only 15 (42)
 Medicare only 1 (3)
 Medicaid and Medicare 16 (44)
 Self-pay 1 (3)
 Other 3 (8)

Table 2: Most Common Diagnoses for ED Visits and Hospital Admissions in 2011

ED Visit Diagnosis	Hospital Admission Diagnosis
Abdominal pain (16%)	Abdominal pain (12%)
Chest pain (9%)	Nausea/Vomiting, Abdominal pain (9%)
Nausea/Vomiting, Abdominal pain (9%)	COPD exacerbation (8%)
COPD exacerbation (5%)	Shortness of breath (6%)
GI bleed (4%)	Congestive heart failure (6%)
Other (43%)	Other (59%)

Table 3: PCC and ED Utilization

Primary Care and ED Characteristics N=36
 Medications, mean 12.0
 Polypharmacy (>6 medications), n (%) 30 (83)
 Number of patient diagnoses (comorbidity), mean 7.1
 ED visits in 2011, mean 6.6
 Number of follow-up appointments made with PCC 66
 Number of follow-up appointments kept 29
 Number of patients using behavioral health, n (%) 5 (14)
 Average number of PCC visits in the last 12 months 4.3

2. Authors still do not link their work to any theoretical framework (both reviewers have pointed to this gap). A very nice example of a paper that does this in the recent literature comes from Health Affairs: Understanding Why Patients of Low Socioeconomic Status Prefer Hospitals Over Ambulatory Care.

Response: We appreciate the importance of clarifying the theoretical framework for our qualitative study. For our study, we focused on understanding the patient experience after leaving the hospital through the lens of social support and health system support. We have added a sentence below with a description of the conceptual framework that we used, and we have included a citation from Cohen and Wills for this framework. Also, in reference to Kangovi's recent paper in Health Affairs, we added two sentences in the discussion about how our results related to the social norm they described of high-risk patients preferring the hospital.

New Text (Methods): Given that most interventions are focused on supporting the patient in the post-discharge period, we focused our study on understanding the patient experience of several key support domains: social/emotional support (from friends, family, and clinicians), instrumental health system support (medications, transportation, access to outpatient care), and informational support (knowledge and self-efficacy).

New Text (Discussion): Another recent study by Kangovi et al (2013) described a social norm of high-risk patients preferring the hospital for care when they have a change in their health status. They similarly conclude that targeted interventions should address the needs of high-risk patients in the ambulatory setting.

3. Conclusions are still too far reaching and are not adequately described in light of the data/ findings from the study.

For example, researchers state 'This delay in care likely resulted in a worsening of their health status which consequently precipitated another hospitalization.' Their results do not show support for this association, even if it is a hypothesis.

Response: We agree that our results from this qualitative study should be employed for the generation of hypotheses. We have made several changes in the Discussion section to reflect this. In terms of the above quote related to delaying care, we do have a paragraph in the Self Triage Leading to Potentially Avoidable ED Use section in the Results that looks at delaying action after a change in health status. We included a quote here where a patient describes delaying care after starting to get sick, which resulted in the patient being brought to the ED via ambulance. We agree, though, that the above sentence as it stands should be written as a hypothesis, so we have made this change.

New Text: Delays in care may have increased risk for readmission.

New Text: The high-risk underserved patients that we enrolled may have had more interaction with the hospital system than other patients with fewer hospital admissions, and therefore may have had more opportunity to be linked in with formal services such as medication assistance, visiting nurse services, and transportation arranged through the hospital. However, future studies will be needed to determine if there is indeed a direct association between increased interaction with the hospital system and increased formal services compared to other patient populations.

4. They also describe that their high risk patients likely had 'more interaction with the health system than other patients with fewer hospital admissions and therefore more opportunity to be linked in with formal services such as VNA and arranged transportation.' They didn't evaluate other patient groups (who may have had more clinic utilization but not hospital utilization) so this, again, feels far reaching.

Response: We agree and have changed this sentence (see above for change). As stated above, we have made several changes to the Discussion to support the hypothesis-generating nature of our qualitative evaluation. For this sentence in particular, we added the qualification that future research would be needed to determine if there was a direct association between increased hospital interaction and increased formal services. We appreciate this reviewer's suggestion for this.

5. Similarly, the comments about the 'critical' nature of telephone access could be restated to better reflect findings of the study and make fewer broad conclusions.

Response: We agree and have changed this sentence.

New Text: First, improving telephone access to primary care offices is important, as many primary care patients prefer this method of communication, and it is linked to improved patient outcomes.