Review of “How Effective are Programs that Manage Transitions From Hospital to Home? A Case Study of the Australian Transition Care Program”.

This paper is a brief review of programs aimed at managing transition from hospital to home and then focuses on a case study of the Australian Transition Care Program. Overall, the review portion of the paper lacked clarity, mostly in terms of the models chosen under the rubric chosen. The case study of the Australian Transition Care Program was well argued and would be of interest to readers of the journal.

Specific comments:

Background section:
The background section was confusing. This was due mainly to a lack of clarity around the definition of the clinical programs captured by the authors under the rubric of programs that manage transitions from hospital to home. There were multiple types of models that were proffered and coherence was lacking. There was first a discussion of the GRACE Program as a transitional care program. While a component of the GRACE model is dedicated to transitions, GRACE is far more comprehensive than just transitions. GRACE is a home-based care management by a nurse practitioner and social worker who collaborated with the primary care physician and a geriatrics interdisciplinary team that provides a range of services, not just transition services, to older adults with multiple chronic conditions. The discussion on page 3 discusses systematic reviews of discharge planning, very different from a GRACE model, and then it leads to a discussion of early discharge hospital at home models. Again, it is often difficult to draw clear lines between these different types of programs; however, with the lack of clearly defined terms, the background discussion felt muddled.

Page 4, first paragraph – the authors note that economic incentives often drive decisions to evolve older people in certain settings. This is true to a certain extent. I also believe that there are those who would argue that the incentives also to provide higher quality care and less intensive care settings in order to meet the needs and priorities of older adults with multiple chronic conditions.

Page 4, Line 7 – Authors note issues related to staffing. It may also relate to culture of various care venues.
Discussion

Page 6, Paragraph 2 – The authors note that a majority of operational places are community based. Could the authors inform us what the minority are.

Page 6, Paragraph 2, Sentence 1 – A definition of eligibility for the age care assessment team is provided. It is still unclear to me what services the patients actually receive. I was confused as to whether this is simply all home rehabilitation service.

Page 7, Table 1, Evaluation Findings – I don’t quite understand the second sentence where people discharge to home or to residential care to get the program.

Page 8, top of table – Can the authors provide a quantitative estimate for the item.

Page 8, last row of table – These feel more like system problems and not just transitional care program systems.

Page 9 – Again, the definition issue arises and it feels a bit fuzzy.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.