Author's response to reviews

Title: Integrated post-discharge transition care in a hospitalist system: disease-specific care and referral

Authors:

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Version: 2 Date: 30 April 2011

Author's response to reviews: see over
April 30, 2011

Dear Mick Aulakh:

Thank you very much for reviewing our original manuscript entitled, "Integrated post-discharge transition care in a hospitalist system: disease-specific care and referral" (MS No. 1678569673526672) that we submitted for possible publication. We appreciate the editors’ and reviewers’ comments and have revised the manuscript accordingly.

Below please find our point-by-point responses to the reviewers’ comments. Attached also is our revised manuscript.

We truly appreciate the time and effort you have given our paper. We look forward to hearing from you soon.

Sincerely yours,

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Reviewer 1

Reviewer's report
Title: Integrated post-discharge transition care in a hospitalist system: disease-specific care and referral
Version: 1 Date: 27 March 2011
Reviewer: Michelle Mourad

Reviewer's report:
Major Compulsory Revisions:
1. The writing style is very vague. The sentence structure is simple, and I often found that three sentences could be condensed into one sentence with more information and more impact. As a result though the article was long, it was lacking in interesting details about how your intervention was employed, which elements were impactful in reducing readmissions.
   Answer: Thank you for your comments. We revised the manuscript and made it more succinct. In addition, we summarized the important factors that reduced re-admissions and mortality. This revised manuscript was reviewed and proofread by a native English editor to polish it before this submission.

2. 30 day readmissions and mortality are presented as a composite outcome. Was this intended from the outset or was this because these were not significant when reported separately. This is essential for understanding your interventions.
   Answer: From the outset, we considered 30-day re-admissions and mortality as our primary outcomes and recorded them within 30 days after discharge. The reason was that both are negative outcomes after discharge. In addition, regarding the general medical patients, the re-admission rate only has a decreasing trend, but was not significant in some telephone follow-up for the general medical patients (Braun et al, Eur J Intern Med. 2009; 20(2):221-5). Therefore, we chose both indicators for our primary outcome.

Minor Essential Revisions:
1. TITLE: The title is misleading and suggests that your intervention is only a follow up phone call program, when your article suggestions that the care plan and referral upon call to follow up care were also part of your program. Please pick a title that more accurately reflects the scope of your intervention.
   Answer: Thank you for your comments. We revised our title as “Integrated post-discharge transition care in a hospitalist system: disease-specific
care and referral”.

2. ABSTRACT: Overall the abstract is awkwardly worded and takes away from the results that you present. Much of the information is located in the wrong heading and is too generically worded. Why are there no % and p values in your results? Consider using as many specifics and statistics as you can. For examples, please see the specific comments below in the Discretionary Reviews section.

Answer: Thank you for your comments. We revised the abstract as suggested.

3. INTRODUCTION: I applaud the authors for their short succinct introduction. The introduction could be strengthened through a better review of the literature and a discussion of other notable programs for care transitions (see references). Consider specifically what your study adds to the literature on other models of care transitions (Project RED, Colman’s model of transitions coaches, etc.). I also finished the introduction not being entirely sure what in fact the PDTC intervention was! In reading the methods I was impressed with the comprehensiveness and more detail should be provided in the introduction. (e.g. “Given the success of care transitions in decreasing adverse events after discharge and improving readmission rates, we aimed to see if a comprehensive PDTC program consisting of a disease specific care plan on leaving the hospital, a daily patient hotline, schedule follow up calls by nurses and a hospitalist-run clinic could affect readmission rates and post-discharge mortality.”)

Answer: Thank you for your comments. First, we did a comprehensive review and cited the Colman’s experience as our reference in our revised introduction. Second, we revised the last paragraph of the introduction as suggested.

4. METHODS: I commend the authors for their robust intervention. Creating and implementing a disease specific treatment plan based on specific indicators is challenging, and the choice if indicators is sound and an excellent model for teaching patients about their disease, and for creating a plan for anticipatory management after discharge. You also describe a robust plan to assess the success of your discharge teaching and also provided patients with way to contact the inpatient team should they see change in indicators in between the calls.

Answer: We appreciate your commendation and would like to share this
post-discharge care model to general practitioners and the journal’s reader worldwide in order to help improving post-discharge outcome.

5. RESULTS: As this is a particularly robust intervention, it will generate a lot of results. I feel that the reported results leave the readers with a lot of questions about the study methodology and adherence to its aims. Additionally, keeping all of the % and p values in the table makes reading exhausting as one is constantly searching for the right table. Please eliminate tables where possible (I would suggest eliminating table 3 and 4 and instead stating those results in the text). Table 4 in particular contains important results that could be VERY easily stated in the text giving substance to the general phrases currently used.

**Answer:** We merged Tables 3 and 2 and removed Table 4. We re-stated the contents of the removed table in the Results section of our revised manuscript.

6. DISCUSSION: On the whole the discussion is too long. A recommended format for the discussion is to succinctly restate your findings, to state whether or not you believe your findings and why, and comment on elements that you expected to see, but didn’t (e.g. ED visit reduction). The third paragraph should place your work in the context of existing literature, and the fourth paragraph should provide limitations to your work. The fifth paragraph can talk about new directions and the importance of your work in furthering the literature – yours is well done and serves that purpose nicely. Many of these elements are done quite nicely (e.g. the discussion on the growth of hospitalist systems in Asia, but without post-discharge guidelines). It’s almost there, but needs a little careful editing.

**Answer:** Thank you. We revised the discussion and made it more concise according to your suggestion. Thank you.

**Discretionary Revisions:**

**Abstract:**

1. Avoid generic statements that add little to the meaning for your readers. “Post discharge care is a challenge” instead say how it is a challenge for who? Why? How does this affect patients? “Care discontinuity is a concern” another generic statement. Consider this: “The period following discharge is a vulnerable time for patients with a high rate of adverse events that may lead to unnecessary readmissions especially in older populations. Close follow up after discharge may be a way to prevent adverse events and decrease
readmission rates…” Speak specifically.

**Answer:** Thank you. We revised the abstract accordingly.

2. It is not clear from the abstract what “post discharge transition care” is it a patient specific post-discharge care plan? is it a phone call? A clinic visit? I would try to define this term before using and help us understand what methods to improve care transitions were employed in this study.

**Answer:** Thank you. We explained the PDTC in the Methods part of the abstract.

3. You mention the location and how the intervention was performed in your Design. Consider putting this in another section, as design is generally a short section that doesn’t include setting and methods.

**Answer:** Thank you for your reminder. We combined the description of the study methodology into the methods part of the abstract.

4. The subject heading does not tell me anything about the patient population that was assessed. The subjects should tell me: Patients called were those hospitalized from December 2009 to May 2010 in a hospitalist ward in XXYY Hospital, a referral center in Taiwan.

**Answer:** Thank you for your correction. We combined the description of the design, subjects, and measurements into the Methods part of the abstract.

5. Please clarify the statement, “In the post-discharge course patients having worsening indicators (what are these?) were at high risk for readmissions.” Was this seen in the observation and intervention groups? Please make this sentence more specific and provide statistical evidence.

**Answer:** Thank you for your comments. Indicators were made for disease-specific discharge plans that were monitored by regular telephone follow-up. We have revised the “worsening indicators” as “worsening disease-specific indicators in telephone monitoring”.

**Introduction**

1. Your first paragraph points to the problem of care transitions with a hospitalist model, however your model of PDTC does not actually fix the link between the hospitalists and the primary providers, unless the primary care physicians receive a transcript of the call or the clinic note. Your intervention is actually trying to bridge the continuity for patients once they return home to
reduce readmissions and deaths. Thus your overall argument for your program would be strengthened if you frame it in terms of how this continuity can reduce adverse events.

**Answer:** Thank you. We addressed how this continuity can reduce adverse events in the first paragraph of the Introduction section.

2. In paragraph 2, is this the same as the “referral center” being studied? if so, please clarify. It is unclear if this is data from the same institution.

**Answer:** Yes, this is the same institution as in this study. We changed the term from “in a referral center…” to “in a particular referral center of this study…” based on a manuscript that has been accepted by J Hosp Med. If more detail is needed, we will cite the reference anew.

3. Again, avoid generic statements that may be obvious to the reader such as “It is an emergent health problem…”

**Answer:** Thank you for your comments. We revised the text and added the reasons for implementing PDTC.

4. Improvements in post-discharge care have actually been extensively studied (refs) and have been shown to decrease readmissions and reduce adverse events, to say that it has been rarely studied is incorrect.

**Answer:** Thank you for your correction. We revised the text and indicated that this kind of integrated PDTC has not been well studied in the hospitalist system.

5. If it is true that this has been rarely studied, why does it follow that it should be incorporated to improve continuity of care. Instead I might say that “As improvements in care transitions have been shown to decrease adverse events after discharge, visits to the ED and readmissions, we created a post discharge program to improve care post discharge are evaluated its performance.”

**Answer:** Thank you. We revised the sentences as suggested and by your comment 3 of your minor essential revisions.

**Methods:**

1. Please define “communication deficits” I am not familiar with that term.

**Answer:** Thank you. We changed the term “Communication deficits” to “no ability to speak mandarin or Taiwanese language”.

reduce readmissions and deaths. Thus your overall argument for your program would be strengthened if you frame it in terms of how this continuity can reduce adverse events.

**Answer:** Thank you. We addressed how this continuity can reduce adverse events in the first paragraph of the Introduction section.

2. In paragraph 2, is this the same as the “referral center” being studied? if so, please clarify. It is unclear if this is data from the same institution.

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**Answer:** Thank you. We revised the sentences as suggested and by your comment 3 of your minor essential revisions.

**Methods:**

1. Please define “communication deficits” I am not familiar with that term.

**Answer:** Thank you. We changed the term “Communication deficits” to “no ability to speak mandarin or Taiwanese language”.
2. Again please define PDTC in more detail as early as possible in the paper. It is unclear initially that this is a discharge care plan consisting of scheduled follow up calls, a hotline and a hospitalist-run clinic, and this detracts from the strength of your paper. This should be clarified in the introduction (see above). 
**Answer:** Thank you. We have defined the PDTC in the last paragraph of the Introduction and elaborated it in the 4th and 5th paragraphs of the Methods section.

3. Refrain from using: and so on. Consider “and other disease specific elements of discharge teaching.”
**Answer:** Thank you. We corrected it as suggested.

4. What was done for patients who were illiterate or had cognitive deficits and thus were unable to understand their care plan? Where any patients excluded on this basis?
**Answer:** Thank you. All patients who were eligible and included in the final enrolment were cared for by caregivers if they had cognitive deficits or Barthel score <35. If the patients were illiterate, a family representative living with the patient was taught the PDTC. Fortunately, there was no patient excluded for such reason. We added this description in the Methods section.

Results:
1. Please explain why 313 of 737 patients were enrolled. This is a low enrollment rate and needs explanation.
**Answer:** Thank you for your suggestion. Although 737 patients had been admitted to the hospitalist ward, only 551 were discharged alive to home care (Figure 1 in the revised manuscript). With the goal of following-up specific diseases, there were 139 patients who did not match such criteria. In the remaining 412 patients, 95 declined to join the study and 4 were defined as “not requiring PDTC”. We have added this description in the first paragraph of the Results section.

2. Please explain your exclusion criteria in your methods. I’m not sure what “disagreement” or “no match for Dx” mean. Do you mean that patients refused to be in the study? Were patients excluded because they did not fall into one or your diagnoses? This belongs in your methods.
**Answer:** Thank you for your suggestion. We detailed our exclusion criteria in
the Methods section. In Figure 1, “disagreement” meant that the patient refused to join the study and “no match for Dx” meant that the patients’ diagnoses did not match our included diseases. We apologize for this vagueness and changed the term “disagreement” to “patients refused” and “No match for Dx” to “Diagnosis, not matched”.

3. Figure 1 is probably unnecessary, if exclusion criteria are clarified. but I will leave this to the editor’s discretion.

   Answer: Thank you for your comments. We maintained Figure 1 for clearer patient enrolment.

4. Does table two describe excluded/refused patients? Or does it describe observation and intervention patients. Please clarify.

   Answer: We apologize for misleading you. The table describes the observation and intervention groups. We have changed the term accordingly. Thank you.

5. Please provide individual P values for the difference in caregiver between the two groups.

   Answer: Due to the above suggestions, we removed Tables 3 and 4. We changed the data of caregivers into Table 2 and added the individual P values in the revised manuscript. Thank you.

6. What percentage of calls were made 843 calls does not help the reader understand how effective the calls were at reaching their target. What percentage of patients received all of their calls?

   Answer: Among 219 patients receiving PDTC, 134 received all of the calls while 32 were re-admitted or died. The remaining 53 patients were lost to follow-up before the end of the 30-day follow-up. We added this description in the third paragraph of the Results section. Thank you.

7. What about the other questions in the calls? How many patients were adhering to their treatment plan?

   Answer: Among 843 calls, 18 patients had worsening disease-specific indicators. Another four cases had wrong tube or wound care that required further education. All of them were corrected by the next follow up. All patients, except two, stated good drug compliance by telephone. In hotline call-in counseling, 29 calls reported new or worsening symptoms. In the other 76
counseling, all asked for minor medical help like health education, skill confirmation, and drug/diet consultation. We described these statement in the 4th and 5th paragraphs of the Results section. However, it is our limitation that expressions via telephone might be misunderstood. We added this point in the limitations part of the Discussion section.

8. Please pay attention to tense, the incorrect tense is often used (e.g with worsening indicators had been found, this should read “were found”

**Answer:** Thank you for the corrections. Before submitting this revised manuscript, it was reviewed and proofread by a native English editor.

9. Of the six re-admitted patients how many were the ED patients and how many were the clinic patients?

**Answer:** Thank you. Five of six patients were referred to the ED from our telephone contact and the remaining one was a clinic patient. We added this description in the 3rd paragraph of the Results section.

10. 0.03 is statistically significant. The word borderline is not needed.

**Answer:** We deleted the word “borderline”. Thank you.

11. Paragraph 4: It is unclear that more scheduled visits in those not receiving PDTC is an important results. Aren’t scheduled follow up visits a good thing?

**Answer:** Thank you. We agree that scheduled follow-up visits are not a good thing. We therefore showed the advantages of PDTC that could decrease the need for scheduled follow-up. However, the visit hospitalist clinic can be a factor for reducing re-admission because it may bridge the care transition if necessary. On the other hand, The frequency of visits to a PCP after discharge is not associated with reduction of re-admission (p=0.890). We described the data in the sixth paragraph of the Results section.

12. Do not say there “seemed to be” more ED visits. Either there were or their weren’t. Perhaps say there was a trend towards more ED visits in the observation group, but this difference was not statistically significant.

**Answer:** We revised the sentence accordingly. Thank you.

13. Please clarify the last sentence of paragraph 4. The wording is unclear. I think you mean to say. The overall ward readmission rate did not differ from that of the observation group during the study period (17% vs. 17.2% p =
0.913).

**Answer:** Thank you. We revised the sentence as “In contrast, the re-admission rate of the overall patients in the general medical wards of the study hospital were similar between the observation and intervention periods (17% vs. 17.2% p=0.913)”.

14. What is the difference in percentage of readmission and death for the observation and intervention group. This should be stated in the manuscript, we should not have to hunt for this in a table.

**Answer:** Thank you. The percentage of re-admission is 21 and 31 in the observation and intervention groups, respectively (p=0.075). The unexpected death is 3 and 1, respectively (p=0.048). We added this description in the second to the last paragraph of the Results section.

15. Why are readmission and death not separated? Were they not significant independently?

**Answer:** Both re-admission and death are negative events after discharge. Both events have higher trends in the observation group, but the statistical significance is borderline as regards re-admission, which may be due to the small study number. Thus, we combined the two negative events as primary outcome.

16. There are an abundance of tables in this article. For ease of reading it is the recommendation of this reviewer that some of the results be put in the text. Consider providing the n,% differences in unplanned visits, ED visits, and readmission and unexpected death in the article text instead of a table for ease of reading. Figure 2. Is nice, but also likely unnecessary. Again will leave this to the editor’s discretion.

**Answer:** Thank you for your comments. We merged Table 3 into Table 2 and removed Table 4 in the revised manuscript. We described the data of Table 4 into the text. In addition, we kept Figure 2 for a better understanding the primary outcomes.

Discussion:

1. First paragraph of your discussion should succinctly summarise your findings. Do not start with literature, instead start with. “In this study we demonstrate that a multi-paceted PDTC program consisting of a disease specific care plan, follow up phone calls and referral to hospitalist-run
outpatient follow up decreased readmissions and 30 day mortality"

Answer: Thank you. We revised the first paragraph of the Discussion accordingly.

2. First sentence is awkwardly worded. Patient’s don’t necessarily worry about readmissions, hospitalists do. Consider changing the phrasing to “especially in elderly patient populations and those…” But would probably suggest removing this sentence all together as the discussion needs no introduction (above)

Answer: Thank you. We removed these sentences in the first paragraph.

3. Limitation: Were those patients who refused or did not have a match for their diagnosis different than the overall population? What was their readmission rate? This may have been a more vulnerable population

Answer: The 30-day re-admission rate is around 19% and 16% ($p=0.318$, Chi square test) in the enrolled patients and excluded patients discharged alive. Although we have no details regarding sub-groups that refused or did not match the enrolled diagnosis, we believed the excluded patients would not be more vulnerable than those enrolled. We added this point in the limitations of the Discussion section.

4. Limitation: Hard to tell where the strength of the intervention is, which piece of the PDTC.

Answer: We added this point in the limitations of the Discussion section.

5. Your references cited as examples of post discharge transitional care are not from top journals, nor do they represent the sentinel work on this front. Consider doing a more comprehensive literature sure to back up your claims.

Answer: Thank you. We have revised the references and added the other important citations as recommended.

6. The ease of your intervention is definitely appreciated and good to cite as a strength of your work.

Answer: Thank you. We showed this advantage in the second paragraph of the Discussion section.

7. Do not restate your findings in paragraph two. The purpose of your second paragraph should be to discuss whether you think your findings are accurate and how they add to the existing literature.
**Answer:** Thank you. We removed the repeated sentences in the second paragraph.
Reviewer 2

Reviewer's report
Title: Integrated post-discharge transition care in a hospitalist system: disease-specific care and referral
Version: 1 Date: 29 March 2011
Reviewer: Jeff Greenwald

Reviewer's report:
Major compulsory:
Design:
# Using a non-randomized controlled study invites significant criticism and comment about the potential for design flaw and too much bias to make credible conclusions about post-discharge telephone intervention on mortality and readmission rates. We would therefore recommend that you consider reframing this study as a Quality Improvement Initiative with the intent on sharing your experience with a post-discharge hospitalist-run intervention to a broader audience.
Answer: Thank you for your suggestion. We revised our methodology as a Quality improvement Initiative study (2nd paragraph of the Methods section and the Abstract).

Methodology:
# If this were to be a randomized controlled trial the study population would need to be more clearly defined, randomization would need to be blinded and methods for randomization would need to be clearly defined.
Answer: Thank you for your suggestion but our study is not a randomized study.

# Study participants in both the intervention and observation/control groups should be enrolled simultaneously and consecutively in a blinded fashion.
Answer: Thank you for your suggestion. Our study is not a randomized study and we revised our aim for quality improvement initiative.

# Exclusion criteria should also include those patients previously enrolled, elective admissions, deaths during hospitalization, discharge to another institution, patients who are residents of long-term care facilities, and patients who, upon admission, have an anticipated life expectancy of < 30 days or are discharged to home with hospice care.
Answer: Thank you for your suggestion. We revised our exclusion criteria.

# Description of study closeout and how patients who could not be reached post-discharge were accounted for is required.
Answer: Patients were followed-up for 30 days after discharge by telephone, or until death, re-admission, or loss of follow-up. We defined loss of follow-up if we could not contact with the patient/caregiver for two consecutive times. We added these descriptions in the Methods section.

# Definition of PCP may be too strict.
Answer: Thank you for your suggestion. However, we followed the rule used by Sharma et al. (JAMA. 2009 Apr 22;301(16):1671-80).

# You should explain why the intervention and observation groups were divided into particular disease-based sub-groups.
Answer: We performed this PDTC based on a disease-specific care plan. We excluded acute illnesses with low risk for recurrence and diseases without specific indicators to follow-up. Nonetheless, the disease items covered most of the diseases that required admission to our hospitalist ward. We added these descriptions in the Method section.

# The particular telephone service intervention needs to be described in a significantly more detailed fashion -- ie, what was the exact nature of the call, what information was collected and exchanged (symptoms, medications and how they were reconciled, needs assessment, patient education about disease process, etc.), how was it standardized, and who specifically performed the intervention.
Answer: Thank you for your comments. We cared for the indicators of change, drug compliance, and adherence. If medication is required, we arranged a clinic for them because telemedicine in Taiwan is illegal. The content of telephone contact included education before discharge by our study nurses. The post-discharge telephone contacts were also performed by our study nurses based on a standard case report form made by our team before patient discharge.

# Explain how and why you chose to report disease/symptom progression (ie, what specifically defined a worsening of symptoms) based on indicators from a general internal medicine textbook; and whether these indicators have been
linked, in an evidence-based manner, to increased risk of hospitalization or mortality.

**Answer:** Thank you for your comments. The progression of the indicators was listed in Table S1 of the online supplement. The indicators chosen from the book of internal medicine are all well known and easily used via telephone line. Although the link from these indicators to hospitalization or mortality is not significantly proven yet, we chose the point to red flag sign for reporting. Of course, if any red flag sign or other caution sign was noted, the study nurses reported these and discuss them with the hospitalist for further action. We described this in the Methods section.

# Explain how you accounted for patients who may have been enrolled with a diagnosis or disease process that does not clearly fall into your subgroups.

**Answer:** All patients admitted to our hospitalist ward were eligible for the study but were not enrolled if their diseases did not fulfill our inclusion criteria. In other words, the patients without a inclusion diagnosis was not enrolled.

### Results

# The manner in which results were reported is very confusing.

**Answer:** We have revised the Results section thoroughly. In the first paragraph, we described the patient enrollment and grouping. In the 2nd paragraph, we described and compared the clinical characteristics on admission and upon discharge between the observation and intervention groups. We started to mention the post-discharge course in the 3rd paragraph, where we also described the results of telephone contacts. The 4th paragraph showed the results of hotline counseling. In the 5th paragraph, we showed the results of outcome assessment. In the last paragraph, we did multivariate analysis for outcome prediction. Based on suggestions by Reviewer 1, we removed Tables 3 and 4 and described the data in the text. Thank you.

# Effects of the primary intervention (post-discharge telephone service) on each primary outcome (unplanned mortality and unplanned readmission) should be reported separately and for both groups (intervention and observation). Presently there is only separate data reported on readmission.

**Answer:** Thank you for your comments. Within 30 days after discharge, the observation group had significantly higher rates of re-admission and death than the intervention group (25% vs. 15%, \(p=0.021\), Fig. 2). Further analysis revealed that the observation group had borderline a higher re-admission rate.
(22% vs. 14%, \(p=0.075\)) and a significantly higher death rate (3% vs. 1%, \(p=0.048\)). We added these to the Results section.

# Despite 70% of patients having “PCP’s” there is no reported data of the rate of post-discharge follow up in the PCP clinic, and no comparison this with the frequency of hospitalist-run post-discharge visits. Thus, secondary outcomes such as unplanned visits to the hospitalist run clinic are less meaningful.

**Answer:** Thank you for your comments. There were more scheduled appointments at our hospitalist-run clinic, either regular (27% vs. 14%, \(p=0.008\)) or unplanned visits (9% vs. 2%, \(p=0.005\)) but less with the primary care physician (72% vs. 83%, \(p=0.038\)) in observation group than in the intervention group. Visits with the hospitalist-run clinic were associated with less re-admission (\(p=0.088\)) than no visits, whereas those with PCP clinic were not significant (\(p=0.890\)). We added the visit rate with the PCP clinics in the Results section.

# Only when the above 2 comments have been reconciled, can results on the combined effect of post-discharge telephone service AND hospitalist-run post-discharge service be better understood.

**Answer:** Thank you for your comments. We added the data according to the above two comments.

# Results do not explain and account for how many calls each patient received (e.g. if each of the 219 intervention patients received 5 calls over 30 days as the methods suggested, this calculates to 1095 calls presumably made. However, the results/discussion account for only 843 calls and do not account for the remaining 252 calls that should have been placed).

**Answer:** Thank you for your comments. Among the 219 patients receiving PDTC, 134 received all of the calls. There were 32 re-admissions or mortalities within 30 days after discharge, while the remaining 53 patients were lost to follow-up before the end of 30 day follow-up. We added these details in the 4th paragraph of the Results section.

# The additional tables describing disease associated by telephone-call follow-up, clinical characteristics and laboratory data of the patients at initial admission and at discharge according to PDTC, are confusing/distracting, and do not necessarily add to the reader’s ability to draw appropriate conclusions about the effect of telephone-service intervention on post-discharge mortality
and readmission rates. Better defining the study population and methodology may eliminate the need to report much of this.

**Answer:** Thank you for your comments. We re-defined the study groups as observation and intervention groups. We also merged Table 3 into Table 2 and removed Table 4 in the revised manuscript.

**o Discussion**

# The discussion section can be strengthened only after the results section is clarified.

**Answer:** Thank you for your suggestion. We have revised and clarified the results section accordingly and look forward your valuable comments.
Editorial Requests

- Please include an Authors' contributions section before the Acknowledgements and Reference list.

Answer: We added the Authors' contribution section accordingly.

- Please include a 'Competing interests' section between the Conclusions and Authors' contributions. If there are none to declare, please write 'The authors declare that they have no competing interests'.

Answer: We added the 'Competing interests' section accordingly.

- Please could you structure your abstract according to the guidelines provided at the link below:

Answer: We revised our abstract accordingly and structured it into four parts (background, methods, results, and conclusions) with length less than 350 words.

- Please also highlight (with 'tracked changes'/coloured/underlines/highlighted text) all changes made when revising the manuscript to make it easier for the Editors to give you a prompt decision on your manuscript.

Answer: We submitted one clean edition and one highlight modified edition of the revised manuscript. Thank you.