

## *Comparative Effectiveness Research Review Disposition of Comments Report*

**Research Review Title:** *Transition of Care for Acute Stroke and Myocardial Infarction Patients From Hospitalization to Rehabilitation, Recovery, and Secondary Prevention*

Draft review available for public comment from April 25, 2011 to May 23, 2011.

**Research Review Citation:** Olson DM, Prvu Bettger J, Alexander KP, Kendrick AS, Irvine JR, Wing L, Coeytaux RR, Dolor RJ, Duncan PW, Graffagnino C. Transition of Care for Acute Stroke and Myocardial Infarction Patients: From Hospitalization to Rehabilitation, Recovery, and Secondary Prevention. Evidence Report No. 202. (Prepared by the Duke Evidence-based Practice Center under Contract No. 290-2007-10066-I.) AHRQ Publication No. 11(12)-E011 Rockville, MD. Agency for Healthcare Research and Quality. October 2011. Available at: [www.effectivehealthcare.ahrq.gov/reports/final.cfm](http://www.effectivehealthcare.ahrq.gov/reports/final.cfm).

### **Comments to Research Review**

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Comments on draft reviews and the authors' responses to the comments are posted for public viewing on the EHC Program Web site approximately 3 months after the final research review is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator, if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #5	Abstract	Important in abstract/ ES to state that given studies could include more than one intervention and state how parse out effect of different interventions	We have added this statement to the Executive Summary and the Discussion section as well as the Abstract:  "Some studies included more than one intervention, which made it difficult to determine the effect of individual components on clinical outcomes."
Peer Reviewer #5	Abstract	In abstract, 2 of the positive findings are highlighted. Other positive findings were shown in the later tables, how were these 2 selected?	Due to the word limit, we were unable to list all the positive results in the Abstract; however, the two findings with the strongest level of evidence are included in the Abstract.
Peer Reviewer #1	Executive Summary	On page 9 of the Executive Summary, under KQ2 paragraph (lines 15-16, and lines 19-20) in reference to early supported discharge, the words "for stroke patients" seems to be missing. This is confusing because the other intervention types were specific to MI.	We have inserted the missing phrase in the KQ 2 paragraph.
Peer Reviewer #4	Executive Summary	The executive summary was well done.	Thank you.
Peer Reviewer #5	Executive Summary	The statement in ES-1 line 23, 24 that care transition "requires interdisciplinary programs" is a belief, not a fact	We have revised this statement in ES-1.
Peer Reviewer #5	Executive Summary	Typo on ES-1, line 42	We have corrected this.
Peer Reviewer #5	Executive Summary	Page ES-13, not clear how giving a manual is "ongoing" education	We reported the types of educational materials implemented by the study authors using their description. We acknowledge your comment.
Peer Reviewer #5	Executive Summary	ES-14, line 22 seems extreme to say that translating studies from other countries is "inappropriate." Please consider less absolute statement (esp since it appears you used them) that translation was "more challenging" or "more limited"	We have revised the wording as you suggested to state "more challenging" in the Limitations section of the Executive Summary and the main report.

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Peer Reviewer #5	Executive Summary	ES-15 is it also possible that failure to show strong outcomes related to lag time between intervention and measured outcomes? How far out do we anticipate seeing benefit from a limited acute care transition that lasts less than a month?	While lag time between the intervention and the outcome measurement may have resulted in a failure to detect an immediate effect of the intervention, the more important issue is whether the outcomes have a long-term effect on clinical outcomes, beyond the end of the intervention period. We cannot definitively state how far we anticipate seeing an intervention benefit since we are reporting only the outcomes at time points reported by the study authors.
Public Reviewer #1	Executive Summary	Too brief, it is also mixing apples and oranges in the continuum of health care for MI and Stroke. This demonstrates a lack of appreciation to the continuum of care, LTAC, Inpatient rehabilitation, subacute and outpatient care.	We concur that MI and stroke, which are both acute cardiovascular disorders, have varied needs, pathologies, and continua of care. We appreciate the interest in highlighting these differences. The task order for this project directed the team to assess both MI and stroke populations. Throughout this report, we have listed the findings from stroke and MI studies separately.
Peer Reviewer #1	Introduction	The authors effectively frame the study and the objectives.	Thank you.
Peer Reviewer #2	Introduction	The purpose and scope of this project are well defined.	Thank you.
Peer Reviewer #4	Introduction	Introduction well explained.	Thank you.
Peer Reviewer #5	Introduction	Page 1, paragraph 2 mixes data and statements about MI and stroke with much broader category of cardiovascular disease. Please revise to focus on your two conditions of interest.	We have revised this statement in the second paragraph.
Public Reviewer #1	Introduction	Stroke and MI have very different functional deficits, prediction of disability outcomes and general clinical needs. These must be separated.	We concur that MI and stroke, which are both acute cardiovascular disorders, have varied needs, pathologies, and continua of care. We appreciate the interest in highlighting these differences. The task order for this project directed the team to assess both MI and stroke populations. Throughout this report, we have listed the findings from stroke and MI studies separately.

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Peer Reviewer #1	Methods	The search strategy terms seem appropriate for the key questions. The authors defined the inclusion/exclusion criteria, as well as the methods for settling disagreements for inclusion. The authors were only able to provide descriptive definitions of the outcome measures, and due to heterogeneity, statistical methods could not be applied. The only issue in this section is why the year 2000 was chosen for the literature review? Was this based on an arbitrary cut point, or was there truly no evidence of interventions done prior to this year?	The Technical Expert Panel approved a literature start date of 2000 because it provided the most current publications and emphasized the current paradigms of care. We have added this footnote to the Inclusion/Exclusion criteria table in both the Executive Summary and Methods in the main report:  "The TEP approved a literature start date of 2000 because this date provided the most current publications and emphasized the current paradigms of care."
Peer Reviewer #2	Methods	Search strategies and terms are clear and seem appropriate. Their grading methods and screening strategies are well outlined.	Thank you.
Peer Reviewer #4	Methods	The criteria presented and the search strategies were very clearly stated and appear logical.	Thank you.
Peer Reviewer #5	Methods	Please provide end date for review articles.	We have added the beginning and ending search dates to the Executive Summary and the main report as follows: January 1, 2000, to April 21, 2011
Peer Reviewer #5	Methods	Might be helpful to provide a rationale for selecting start date 2000	The Technical Expert Panel approved a literature search start date of 2000 because it provided the most current publications and emphasized the current paradigms of care.
Peer Reviewer #5	Methods	Did literature provide information about whether discharge location matters for effect of intervention? (home vs. SNF vs. IRF)	Table 5/5b reports the discharge location for each article. We did not find an article assessing whether discharge location mattered for the intervention effect.
Peer Reviewer #5	Methods	The method for determining study quality is defined. Were studies excluded based on assessed quality? (If yes, how many?)	We did not exclude studies based on study quality.

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Peer Reviewer #5	Methods	page 5, analytic framework—"multiple referrals" label is not self-explanatory	<p>"Multiple referrals" in the figure refers to primary care and other health care providers (we had limited space in the text box of the figure and therefore chose this term).</p> <p>We have added a footnote to the analytical framework (in the Executive Summary and main report) as follows: "Multiple referrals indicates referrals to primary care and other health care providers."</p>
Peer Reviewer #5	Methods	<p>page 7, interventions row of table – specialty referrals are in bullet 2 and bullet 6;</p> <p>For bullet 7, difficult to understand how referral to PCP would differ from usual care. Is this meant to identify intentional communication or transfer of info to PCP?</p>	<p>Bullet 2 refers to followup care (e.g., home health, social services, rehabilitation), and bullet 6 refers to specialty care providers (e.g. cardiologist, neurologist). We have added these examples in this table (in both Executive Summary and Methods) for clarity.</p> <p>Bullet 7 refers to intentional communication with the primary care provider as part of the transition of care intervention. This is in contrast to the definition listed in the Comparator row of that table; i.e., "a simple recommendation for followup with primary care and other health care providers."</p>
Peer Reviewer #5	Methods	page 7, timing row of table, how many were excluded because < 3 months? This seems important to know given relatively high rate of readmit in 30 -60 days and expectation that better discharge transition would be most likely to have benefit proximate to the intervention.	Our original intent was to limit the literature to articles that reported outcomes at 3 months or longer. Given the limited number of articles identified, <i>none</i> of the studies were excluded due to data less than 3 months (see Table 5/5b). We have replaced "3 months or longer" with "any time period (up to 1 year)"
Public Reviewer #1	Methods	The program is clearly acute care focused. But without the continuum represented this is not relevant to best practices.	Thank you. We acknowledge the CDC/AHRQ focus on acute care—and more specifically transitional care—following these two acute events, rather than the continuum of care following the acute period.

Source: <http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=821>

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Peer Reviewer #1	Results	<p>The results section is excellent. The authors provide tables and text descriptions for the key questions that are easy to follow and comprehensive. However, I do have a few minor comments:</p> <ol style="list-style-type: none"> <li>1. For tables 3 and 4, there should be a column added for the study location (i.e. country). This is useful when assessing the interventions, even though this is included in later tables. Having this early in the report would make it more user-friendly.</li> <li>2. On page 42, lines 13 and 14, I think the authors used "TIA" instead of "stroke" in this sentence.</li> </ol>	<ol style="list-style-type: none"> <li>1. We have inserted study location in Tables 3 and 4.</li> <li>2. We have corrected this sentence on page 42.</li> </ol>
Peer Reviewer #2	Results	No recommendations for this section.	Thank you.
Peer Reviewer #4	Results	Results section provided sufficient information and the tables were very helpful in summarizing.	Thank you.
Peer Reviewer #5	Results	Does the # of elements in the intervention matter? E.g., does education coupled with provider follow-up lead to better results than either alone?	We were unable to quantitatively analyze whether the number of elements in the intervention was associated with outcomes because of the heterogeneity in reporting the dose and intensity for each element. Several studies involved complex interventions with care elements customized to the patients' needs and therefore may not have always employed all available elements. We refer the reviewer to Table 7, which lists the range of intervention approaches used in each study.
Peer Reviewer #5	Results	Consider mentioning positive trend toward benefit (as you do on ES-15) but were underpowered or outcomes diluted, in abstract. This seems an important point to emphasize.	Word limits prevented us from adding this sentence in the Abstract; however, it is mentioned in the Summary and Discussion section.
Peer Reviewer #5	Results	Is it possible to give breakdown of # for the 688 articles that were excluded (see flow diagram ES-8) and page 12. Although it is shown by study in appendix E, flow chart would be much more informative if counts were provided.	We have added a breakdown in the literature flowcharts of the number of articles excluded for each reason.

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Peer Reviewer #5	Results	Table 3 is nice, but was really first clue, after reading abstract, exec summary, and methods, of the breadth of the hospital based category. In addition to concerns about the obscurity of the taxonomy I raise above, perhaps hospital based “preparation” could be more clearly described earlier on. Need to make clear that many of the services continue into the community after discharge. Some of the studies in this group were, indeed, more preparatory. However, others were more focused on providing services after discharge, even though may have been planned prior to discharge or involved hospital outreach. These were more bridging the transition. Other words that come to mind are hospital supported, hospital organized, hospital initiated and extending into the community.	We have replaced the term “hospital-based preparation” with “hospital-initiated support” in the description of the intervention types in Tables 3 and 4 as well as throughout the report.
Peer Reviewer #5	Results	Also, education includes both traditional education and counseling which I would not view as being adequately captured by an education label	The interventions were categorized by the primary element or component of the delivery. While an intervention may include more than education or provision of information, the category of education reflects the main element of the intervention.
Peer Reviewer #5	Results	Likewise, the abstract and exec summary “specialty” follow up fails to capture “guideline-based practice, disease management programs” in bullet on page 27.	The word limit prevented us from adding these items to the Abstract. The Executive summary table (ES-2) summarizes the bulleted findings.
Peer Reviewer #5	Results	Table 3 component of Sulch intervention would benefit from a bit more description.	We have added the following sentence to clarify: “Specified recommendations for medicine, nursing, physiotherapy, occupational therapy, speech and nutrition for 5 weeks following discharge” in Table 3.
Peer Reviewer #5	Results	For Table 3, is it possible, to aid the reader to move some of the data from appendix d to here? For example, country of study would be extremely informative when looking at components. It was frustrating and time consuming to have to flip across tables to see that when trying to envision (however crudely) “comparison”	We have added country of study to Tables 3, 4, and 5.
Peer Reviewer #5	Results	It is not clear why the Boter study was classified as community based rather than patient/family education. The description provided seemed to match other education studies more than other community based studies.	We agree that education is one element featured in the Boter 2004 study; however, we applied the same rule to each study to classify type— the primary component of the intervention. The Boter study described an intervention involving several elements that were dependent on the involvement of a community-based nurse doing followup and a general practitioner involved on a referral basis. Both were community based rather than hospital based.

Source: <http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=821>

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Peer Reviewer #5	Results	In Joubert, were intermediate outcomes (risk factor management) measured/reported?	The Joubert studies did report intermediate outcomes (risk factor management of blood pressure, cholesterol), but these were not included in Table 5/5b since these were not outcomes outlined in Table ES-1 or Table 1.
Peer Reviewer #5	Results	Page 26, taxonomy: does transition type include hospital to other setting as mentioned on page 7?	We have added a footnote to the taxonomy. The transition of hospital to other setting would, for this report, be included with acute hospital to home since all interventions that started in the acute hospital ended when the patient was home in the community. The transition between settings was not the primary focus of any of the studies included.
Peer Reviewer #5	Results	Table 5 might be easier to read if divided into stroke and MI subheaders	We have split Table 5 into stroke (5) and MI (5b) sorted by intervention type.
Peer Reviewer #5	Results	KQ 4, page 53, the bullet re: use of ED decreased by “education” seems worth noting in abstract and Exec summary	Table ES-2 of the Executive Summary has noted this under the KQ 4 findings. Word limits prevented us from adding this to the Abstract.
Public Reviewer #1	Results	Really only a summary of descriptive study. There really is little that one could do a meta-analyses on.	Thank you.
Peer Reviewer #1	Summary and Discussion	The discussion, conclusions and future research sections are very clearly written. There were two important findings from the study that were not discussed. First, the fact that medication compliance was completely missing as an outcome for stroke studies should be emphasized, although this was mentioned as an example of a future strategy. In addition, the lack of studies that include a diverse population of race-ethnic minorities is very important because this population frequently has worse outcomes, poor access to care, and under- or uninsured. Therefore, even though this population is also more difficult to study because of challenges in recruitment and agreement to participate, inclusion of these patients in future studies is critical.	Thank you for your feedback. We have added text in the Limitations section to address medication management and racial and gender effects on transition of care services.



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Peer Reviewer #2	Summary and Discussion	<p>The conclusions are interesting in that they report insufficient evidence in most areas studied and state that an optimal method for implementation in the US has not been evaluated.</p> <p>In light of their conclusions, it would be nice to see a tighter connection of the differences in trajectories of transition for MI and stroke and what implications this could have in terms of whether these two populations have unique challenges in transitions compared with a general medical population, and whether future research on transitions of care should be population/disease specific or whether there is or is not sufficient overlap in transitions with the general medical population. I realize that this review was not focused on this, but in terms of future research, the point of whether MI and stroke patients require unique transition interventions and transition research quite separate from general transitions may be an important consideration.</p>	We have added a paragraph to the Future Research section that addresses whether transitions of care should be disease specific or have overlap with transitions of care in the general population.
Peer Reviewer #4	Summary and Discussion	The discussion/conclusion clearly provided the state of the transition of care for acute MI and stroke in the U.S. in clear terms.	Thank you.
Public Reviewer #2	Summary and Discussion	I think that this paper raises a very important question as to the inefficient and inconsistent methods we currently have in place in the continuum of care.	Thank you.
Public Reviewer #1	Summary and Discussion	Agree that much more research is necessary. But the politics of the American Heart Association to lump together MI, ischemic stroke and hemorrhagic stroke into one document would be like comparing colon cancer to alzheimer's disease. While there are similarities it really is apples and oranges.	We concur that MI and stroke, which are both acute cardiovascular disorders, have varied needs, pathologies, and continua of care. We appreciate the interest in highlighting these differences. The task order for this project directed the team to assess both MI and stroke populations. Throughout this report, we have listed the findings from stroke and MI studies separately.

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Public Reviewer #2	Future Research	I would like to see a group of hospitals/ healthcare systems join together to pilot a system where a patient is followed by a particular team of experts from admission through the continuum until ultimate discharge from the system. A realistic length may be 1 year to see a well coordinated injury to resumption of life course. I would like to see our traditional system compared to this coordinated approach and see if in fact there is a case for a single "case management group ( case manager, RN, PT,OT,ST, social services)" to coordinate case/oversee the course and assist with obstacles to care as they occur.	Thank you—this is an excellent idea.  We feel that the report addresses the reviewer's idea in text that appears in the Implications for Future Research section of the Executive Summary, and in the main report Future Research section, as follows:  "In other circumstances, it may not be possible to study subcomponents of an intervention; instead, a systems approach to care would need to be evaluated. Multidisciplinary discharge-planning teams (composed of doctors; nurses; social workers; and physical, occupational, and speech therapists) are an example of the latter. In that case, the entire team program could be tested against "standard," single-provider discharge planning."
Public Reviewer #1	Future Research	Separate out: 1. Ischemic stroke 2. Hemorrhagic stroke 3. MI Then look at the continuum of care and flow of the patients through the system and measure one year outcomes in a Quality Improvement Model utilizing best practices applications. This means the use of PRAEDO and control charts. It is not amenable to randomized trials.	We have added sentences to separate outcomes from ischemic from hemorrhagic stroke in future stroke trials (many articles in this report included a mixed stroke population). We also added text about other study designs to the list of future research interventions.
Peer Reviewer #1	General	Quality of the report: Good	Thank you.
Peer Reviewer #1	General	This is a very comprehensive and useful summary of the literature on transitions of care for stroke and MI. For researchers and practitioners, this review provides a clear picture of where the field is currently, and some preliminary steps that need to occur before the research can move forward. It is interesting that the methodology recommended by the authors is focused on defining usual care and appropriate outcomes, rather than rigorous design of randomized trials. This makes sense because the ideal intervention is one that shows clinical effectiveness and can be easily implemented into clinical practice.	Thank you.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #1	General—clarity and usability	The report is overall very clear and easy to use, particularly the tables as they pertain to the key questions. The conclusions mostly inform policy as it pertains to future research, and the definitions of methodology and outcomes, and the populations of interest (as stated in the comments under discussion/conclusion), in these future studies. Best practices are clearly not known in this area, as made clear in this report.	Thank you.
Peer Reviewer #2	General	Quality of the report: Superior	Thank you.
Peer Reviewer #2	General	The target population is well defined, the key questions are well stated in the abstract, executive summary and the full report, and easily understood.  Researchers should be commended for including representatives from health insurers and other clinical research experts on the Technical Advisory Panel.	Thank you.
Peer Reviewer #2	General—clarity and usability	This report should be useful to those both with and without a high level of knowledge on this subject.	Thank you.
Peer Reviewer #4	General	Quality of the Report: Good	Thank you.
Peer Reviewer #4	General	The report will be very informative and will provide guidance for future efforts.	Thank you.
Peer Reviewer #4	General—clarity and usability	Report is nicely structured and lent itself to easy reading.	Thank you.

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Peer Reviewer #5	General	<p>The review was thorough, well documented and useful</p> <p>The taxonomy was unclear and did not add to the organization of the report or to understanding of the literature. Indeed, it impeded reading the report. This lack of clarity was magnified in reading the abstract and the executive summary, but also applied in the text. Questions about how the categories differed, whether they overlapped, etc significantly slowed reading those sections. In addition, the wide variation in elements of the studies within a grouping meant the grouping obscured understanding the literature. Although the categories eventually became somewhat clearer in the body of the report, many readers will start with (or limit reading to) the abstract/ executive summary.</p> <p>In addition, because of the heterogeneity of elements within a particular taxonomic category, the taxonomy did not seem useful and at times was confusing. For example, the reader might want to know if hospital only, hospital and community elements, or community elements only.</p>	<p>Our Technical Expert Panel suggested that we define the taxonomy of the transition of care interventions, which is the rationale for Key Question 1. We agree that the heterogeneity of elements in these categories, and the individual articles within the category, does not lend itself to a comparison of outcomes by category. We developed the taxonomy after much consideration of the heterogeneity and believe that the taxonomy is appropriate.</p>
Public Reviewer #3	General	<p>From attachment:</p> <p>The AHRQ white paper provides background information and conceptualization of the issues surrounding the hospital to home transitions of care for these two populations. There is recognition of the need for interdisciplinary programs, and for important utilization and outcome measures such as the number of rehospitalizations and emergency department visits as well as functional and quality of life measures. We applaud this recognition of the need to study hospital to home transitions for these two populations and the acknowledgement of both the importance of interdisciplinary care and the measures that are important to patients and their families.</p>	Noted.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer #3	General	<p>From attachment:</p> <p>However, as the document authors do point out, these are two very different populations with different care trajectories. Most MI patients do not require institutionalization in another setting after hospitalization most moderate to severe stroke patients are not initially treated at home, but rather in another institutional setting, such as inpatient rehabilitation or a skilled nursing facility, often after discharge in home health and/or outpatient programs. The transition from hospital to the first level of care has quite different meanings and importance for these two populations. Although the first post-acute care transition is important in both populations, so are the other transitions across an often prolonged period of post-acute care for patients with moderate to severe stroke.</p>	Noted.
Public Reviewer #3	General	<p>From attachment:</p> <p>Also, a significant difference in the stroke populations in different countries is the length of stay in acute care. Therefore, severity of impairment or disability at discharge is actually more important than severity on hospital admission when researching the question of transition to the next level of care for hospitalized stroke populations. Varying amounts of education and additional interventions likely occur, based on length of stay in the acute hospital and the time available for these care processes.</p>	Noted.
Public Reviewer #3	General	<p>From attachment:</p> <p>Health literacy, cultural and linguistic issues in health care delivery, are important to any discussion of discharge planning and educational interventions, as well as other components of care delivery at transitions. There is no mention in the document of these patient/family characteristics, or any critique of the research literature in regard to these issues. There is also no clear indication of consideration for socioeconomic and other factors in the analysis. There is no evaluation of the difference between the standard American Health delivery and the practices in other countries where integrated models of care are more common.</p>	Table 6 outlines the types of caregivers involved in the transition of care process. Most articles do not report socioeconomic status of the patient population, but we agree that this could influence outcomes. Our report describes the body of literature available. We did not conduct a formal quantitative analysis given the heterogeneity of interventions, outcomes, and measurement time points. We acknowledge that health care differences between the U.S. and other countries will limit the generalizability of these findings.

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Public Reviewer #3	General	<p>From attachment:</p> <p>The issue of post acute care to home transition is very critical and there is a significant failure in many instances with this as evidenced by the high rates of re-institutionalization and recurrence in both populations. Although the course of post stroke and post MI patients differ, rehabilitation is an important part of the transition of care.</p>	Noted.
Public Reviewer #3	General	<p>From attachment:</p> <p>It is interesting that rehabilitation is primarily mentioned in regards to institutional and outpatient care without differentiation. Outpatient cardiac rehab should be done for ALL patients post MI, but is usually only provided for about 30% of patients.</p>	Noted.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer #3	General	<p>From attachment:</p> <p>Literature shows benefit for outpatient cardiac rehabilitation in decreased re-hospitalization. The study does not include any of these studies which would prove valuable. Of value would also be to include differences in post acute care settings for cardiac and stroke patients as well as the educational components of rehabilitation programs in the form of secondary prevention.</p>	<p>Cardiac rehabilitation was not included because it is a treatment rather than a systematic transitional service. A systematic intervention to enroll patients and ensure participation in cardiac rehabilitation would have been more consistent with the project inclusion criteria, but cardiac rehabilitation in general is not. In addition, our review did not include routine stroke rehabilitation since that is also an independent service and not a transitional care program. Both cardiac and stroke rehabilitation are proven to be beneficial for several outcomes but would also likely have the same pitfalls as other services for gaps in continuity and care coordination. We did not identify any transitional care interventions that were developed to support patients transitioning from hospital to rehabilitation (either cardiac or stroke) or from rehabilitation to home.</p> <p>We have thus inserted the following explanation in the Methods section of the ES and main report:</p> <p>“Interventions solely comprised of cardiac rehabilitation or stroke rehabilitation were excluded since both are services that can be prescribed independently from a transition of care program. These articles were excluded at the full-text screening stage in the category of ‘not a system-level transitional intervention.’ We did not identify any transition of care interventions that were developed to support patients transitioning from hospital to rehabilitation (either cardiac or stroke) or from rehabilitation to home.”</p>

Commentator & Affiliation	Section	Comment	Response
Public Reviewer #3	General	<p>From attachment:</p> <p>Decisions regarding determination of reinstitutionalization for both conditions is highly dependent on the patients age, cognitive level, comorbidities, and pre and post MI or CVA functional levels. Adding to the complexity in determining best course of post acute care for patients who have had MI's or CVA's is considering those patients who have experienced both concurrently. Furthermore, one should consider the risk for ischemic CVA conversion to hemorrhagic CVA, and risk of an acute MI occurring following CVA during inpatient rehabilitation in this population with similar risk factors.</p>	We acknowledge that demographic factors and multiple comorbidities may influence clinical care decisions and outcomes.
Public Reviewer #3	General	<p>From attachment:</p> <p>In short, due to CMS guidelines, part of the hospital continuum of care is taken out of the system. This is particularly true with these patients who are expected to go from a very comprehensive medical program in acute care straight to an outpatient setting or skilled nursing facility when they may have considerable medical issues. This often results in increased bounce backs. . Inpatient rehabilitation is now part of the hospital continuum and has considerable medical capabilities if integrated into the disease specific team and continuum of care. The same could be stated for LTAC, skilled nursing facilities and outpatient settings. This would improve outcomes and decrease bounce backs.</p>	Noted.
Public Reviewer #4	General	<p>From attachment:</p> <p>The American College of Cardiology (ACC) is pleased to submit comments on the draft report on the above topic. The College is a 40,000-member nonprofit medical society composed of physicians, nurses, nurse practitioners, physician assistants, pharmacists and practice managers, and bestows credentials upon cardiovascular specialists who meet its stringent qualifications. The ACC is a leader in the formulation of health policy, standards and guidelines, and is a staunch supporter of cardiovascular research. The College provides professional education and operates national registries for the measurement and improvement of quality care.</p>	Noted.



Commentator & Affiliation	Section	Comment	Response
Public Reviewer #4	General	<p>From attachment:</p> <p>The ACC is very concerned about the significant cost to patients and Medicare for readmitted patients. Two years ago, we started an initiative with the Institute for Healthcare Improvement to address this in a program called Hospital to Home (H2H). This program serves as a mechanism for bringing interested individuals together as a learning community and has enabled the sharing of best practices among participants since that inception. While we know it has done a great deal to improve knowledge, it has not yet identified a best practice that is appropriate for all communities. Instead, the participants have identified practices that work in individual practices and institutions, based on the circumstances of each.</p>	We acknowledge the H2H program and applaud its efforts.
Public Reviewer #4	General	<p>From attachment:</p> <p>The draft research review indicates preliminary support for the concept that care transitions can reduce rehospitalizations and improve postdischarge care quality. However, the authors discovered insufficient evidence to support the efficacy of any of the identified transmission of care categories. This is similar to what we have learned so far from H2H.</p>	Thank you.
Public Reviewer #4	General	<p>From attachment:</p> <p>The ACC appreciates the work of the report authors and agrees that additional, well-structured research performed in the United States is necessary before concluding that a specific approach is effective and worthy of widespread adoption. The ACC supports the importance of investigator consensus on unified taxonomy and conceptual framework for future research, and looks forward to the opportunity to work with the AHRQ on future projects through our established community dedicated to improving care transitions.</p>	Thank you.

Commentator & Affiliation	Section	Comment	Response
Public Reviewer #5	General	<p>From attachment:</p> <p>On behalf of the American Physical Therapy Association, I would like to thank the Agency for Health Care Research and Quality (AHRQ) for the opportunity to comment on the draft review entitled "Transition of Care for Acute Stroke and Myocardial Infarction Patients From Hospitalization to Rehabilitation, Recovery, and Secondary Prevention." APTA is a professional association representing over 78,000 physical therapists, physical therapist assistants, and students of physical therapy. APTA's goal is to foster advancements in physical therapy practice, research, and education. The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public.</p>	Thank you.
Public Reviewer #5	General	<p>From attachment:</p> <p>Role of Physical Therapists in the Transition of Care for Acute Stroke and Myocardial Infarction Patients Physical therapists are an essential member of the health care team assisting in discharge planning and transitions in care for both acute stroke and myocardial infarction patients. Physical therapists, in conjunction with other members of the hospital health care team, assist in discharge planning, including the determination of the most appropriate setting for a patient taking into account their medical status, functional status, prognosis and other factors, such as their home environment and family support. The need for a coordinated effort across the continuum of care is imperative to good outcomes for patients. In addition, the need for optimal access to healthcare, including physical therapist services in the post-acute phase of care is critical, especially for individuals at high risk for re-admission. Information from the physical therapist's discharge summary should always be communicated to the post-acute care providers</p>	We agree and encourage physical therapists' involvement in transition of care interventions when appropriate.

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Public Reviewer #5	General	<p>From attachment:</p> <p>Physical therapists provide evaluation and treatment in a variety of practice settings in which patients receive care following acute strokes and myocardial infarctions, including hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, rehabilitation agencies, private practices, and comprehensive outpatient rehabilitation facilities. Physical therapists evaluate and treat patients' post acute stroke and myocardial infarction in order to increase recovery of function and promote appropriate physical activity to avoid subsequent impairments, activity limitations, and/or participation restrictions. Physical therapists are critical to ensuring patients attain an optimal level of mobility and safety in their environment. Physical therapists are uniquely qualified to provide functional training and educate the patient and caregivers on important factors such as prevention of further injury, illness and/or decline in functional status and the resulting effects of immobility. In addition, physical therapists are able to recognize subtle changes in a person's status that may require further evaluation or referral to other healthcare providers before the problems are exacerbated and require readmission.</p>	Thank you for your comments.
Public Reviewer #5	General	<p>From attachment:</p> <p>Transitions of care, as discussed in the review, require coordinated management across multiple providers and settings. The initial period of discharge or transition planning from the acute care setting is important as the provision of the appropriate level of services can lead to successful transitions and the avoidance of readmissions. We acknowledge that education and risk factor modification are also important in both patient populations; however, beyond these similarities, post acute care interventions for these two patient populations differ significantly and the intensity of services required for rehabilitation are related to the severity of disability.</p>	Thank you.

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Public Reviewer #5	General	<p>From attachment:</p> <p>Following a myocardial infarction, patients may participate in a formal cardiac rehabilitation program or receive other rehabilitative services. Patients who have suffered a stroke often have impairments in motor and sensory systems, motor planning, communication and respiratory systems. The importance of rehabilitation services for these patients is essential for their recovery and return to function, and these patients often may receive services at an inpatient rehabilitation facility immediately following their acute stroke. Although some studies demonstrating the efficacy of rehabilitation were included in this report, others were not. We recognize that not all of these studies are randomized controlled trials (RCT's), however, in the absence of such rigorous research, the value of these interventions should not automatically be assumed inconsequential, but rather simply understudied. APTA emphasizes that any identified shortage in randomized controlled trials (RCTs) or perceived lack in quality evidence comparing the effectiveness of interventions, such as rehabilitation services, that prevent readmissions represents an opportunity upon which AHRQ should pursue further investigations. APTA stands willing to assist in this effort.</p>	Thank you.
Public Reviewer #5	General	<p>From attachment:</p> <p>APTA would like to ensure that the future research needs in demonstrating the efficacy of transition of care programs reflect the impact of rehabilitation on the functional recovery and long term outcomes of individuals, including the avoidance of preventable secondary events such as readmissions. We applaud AHRQ for recognizing the need for standardization of the transition in care process, including the need for uniform terminology. APTA believes that patient care will be improved in our health care delivery system by appreciating the impact of all interventions during an episode of care across the continuum. We recognize that in our current environment obtaining data from disparate electronic health records remains a challenge not just to researchers, but also to practicing clinicians. We strongly encourage AHRQ to investigate the impact of comprehensive multi-setting, multi-provider transitions in care programs for these two high risk patient populations, as well as others, in order to fill the existing research knowledge gaps.</p>	Thank you.

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Public Reviewer #5	General	<p>From attachment:</p> <p>As AHRQ looks further into the areas of care transitions, APTA offers its support and collaboration and welcomes the opportunity to serve as a resource or as a partner with the Agency to develop a strategy to advance the quality and effectiveness of transitions of care.</p>	Thank you.
Public Reviewer #5	General	<p>From attachment:</p> <p>In conclusion, APTA would like to thank AHRQ for the opportunity to comment on the draft review concerning the future research needs for the transition of care for acute stroke and myocardial infarction patients. We look forward to working with AHRQ in the future to ensure that this process is comprehensive and reflects best practices.</p>	Thank you.