

Peer Review File

Article information: <https://dx.doi.org/10.21037/apm-23-524>

Thank you for providing detailed comments on the manuscript. We have found them very useful in clarifying the manuscript and believe they have helped improve its quality. Below please find responses to the comments.

Comment	Response
<p>Overall, I think the paper could benefit from more conceptual clarity and clearly stated research question(s). Specifically, who is the population, what exactly are you trying to understand about care transitions, and what exactly is a care transition? Is the purpose of this paper to understand factors associated with transitions in care (e.g., socio-demographics) or do you want to know how people move from HH to hospice care, or is it something else?</p>	<p>Thank you for these comments. Below you will find each addressed individually.</p> <p>To clarify the purpose of the paper, the following now appears in the Objective subsection: “The purpose of this systematic review was to examine literature pertaining to (1) care transitions for PLWD who are enrolled in skilled HH and hospice in the US, and (2) specifically, care transitions between skilled HH and hospice for PLWD.”</p> <p>Care transitions are now defined on p. 3 as movements between healthcare services or locations of care. On p. 4, we elaborate on this by explaining that a care transition for PLWD may involve being discharged from a healthcare service into the care of their informal care partners.</p>
<p>Also, concepts around hospitalization are unclear—do you want to include hospital transitions or not?</p>	<p>Thank you. We have clarified the research questions in the Objective subsection to include (1) all care transitions for PLWD enrolled in skilled HH or hospice and (2) specifically between skilled HH and hospice. Therefore, hospitalization is included if it occurs in an enrollee of skilled HH or hospice.</p>
<p>To me, transitions in care involve moving from one type of health service provider (e.g., home health) to another service provider (e.g., hospice). I’m not convinced that live discharge from hospice and community-based discharges should</p>	<p>Thank you for this comment. We have now clarified the definition of a transition for PLWD. Specifically, the following appears in the Background section, at the top of p. 4:</p>

<p>count as care transitions. A clear definition could change my mind.</p>	<p>“For PLWD, a transition may involve moving from one healthcare service to another, or it may involve being discharged from a healthcare service into the care of their informal care partners. In the present review a care transition for PLWD includes being discharged from or admitted to a health service; or transferred from one health service to another. Discharges from skilled HH to community or from hospice to community are considered care transitions for the purposes of this review because care partners of PLWD must find alternate services to support their caregiving (21).</p>
<p>Finally, what is homecare exactly? Should this expand to anyone receiving care in the community or is it just skilled homecare services? And, are you only interested in community-based hospice care or is inpatient hospice also included in this study?</p>	<p>Thank you for this comment. In the Background section, at the end of p. 4, we have now defined home-based care as a broad, umbrella term under which skilled HH and hospice fall. We have clarified that 98% of all hospice care in the US is home hospice. We have included in the limitations that the literature did not differentiate between home hospice and in-patient hospice.</p>
<p>1. Page 1, lines 35-36 (and elsewhere). I am having difficulty understanding exactly what this literature review aimed to investigate. The statement, “the purpose of this systematic review was to examine literature pertaining to (1) care transitions for PLWD in HH and hospice and (2) care transitions between HH and hospice for PLWD” is unclear.</p>	<p>Thank you. We have clarified the statement to read as follows: “The purpose of the present systematic review was to examine literature pertaining to (1) all care transitions for PLWD who are enrolled in skilled HH and hospice in the US and (2) specifically, care transitions between skilled HH and hospice for PLWD in the US.”</p>
<p>For question (1), I’m trying to understand who the population is-- it PLWD who are receiving either skilled homecare services OR hospice or is it PLWD in the community more generally? Is HH restricted to skilled homecare or is it for anyone receiving support in the home?</p>	<p>Thank you for this comment. In the Objective subsection, we have now clarified the research question and hope that this clarifies the population as well: “The purpose of the present systematic review was to examine literature pertaining to (1) all care transitions for PLWD who are enrolled in skilled HH and hospice in the US and (2) specifically, care transitions between skilled HH and hospice for PLWD in the US.”</p>
<p>Also, what do you mean by a care transition? Do you mean to synthesize the literature around all transitions in care for people who are either</p>	<p>Thank you. Care transition has now been defined on p.3 as movements between health care services or location of care.</p>

<p>receiving HH or Hospice care? It would be very helpful to define care transitions somewhere in the early part of the manuscript.</p>	<p>Further, in the Background section, at the top of p. 4, we have now clarified: “For PLWD, a transition may involve moving from one healthcare service to another, or it may involve being discharged from a healthcare service into the care of their informal care partners. In the present review a care transition for PLWD includes being discharged from or admitted to a health service; or transferred from one health service to another. Discharges from skilled HH to community or from hospice to community are also considered care transitions for the purposes of this review because care partners of PLWD must find alternate services to support their caregiving (21).”</p>
<p>For question 2, I think this is pretty clear—you are looking for literature on care transitions between HH and hospice—is this correct?</p>	<p>Yes.</p>
<p>2. P2 line 62—need to spell out PLWD prior to using the acronym</p>	<p>Thank you. This has been corrected and now appears in the Background section, paragraph 2.</p>
<p>3. P2 Lines 64-66—I'm having trouble following the meaning and relevance of the statement starting with “PLWD have high...” Are you trying to say that their functional status is poorer over a longer period of time when compared to a person without dementia?</p>	<p>Thank you. In the Background section, second paragraph, we have added “Long trajectories of decline as evidenced by high, sustained functional impairment in the last 4 years of life, ...” for clarification.</p>
<p>4. Overall, I find the background section to be unfocused and difficult to follow. Especially the second paragraph where are a lot of ideas packed into a single paragraph. The paragraph starts out describing prognosis, then goes into living situations, then to caregiving burden, and then to HH and hospice services and details about the home health Medicare benefit relationship to early discharge, and then finally to fragmented care systems. I recommend using this section to highlight how PLWD are at great risk for nonbeneficial, potentially avoidable care transitions and how hospice/PC can be an important way to support long term care in the home or something along those lines. I think all of the details about various potential care settings distracts from the main idea.</p>	<p>Thank you for the helpful suggestions. The Background section has been revised for clarity and conciseness.</p> <p>The Background section now includes the following:</p> <p>“Care transitions for all patients increase risks of medical errors, disruptions in continuity of care, avoidable hospital admissions, and preventable adverse events (17-19). Persons living with dementia (PLWD) are at risk for multiple care transitions during their long trajectory of decline.” And, “PLWD have the added risk of cognitive impairment, and their</p>

	<p>care partners manage and negotiate care with multiple providers, manage illness, and cope with psychosocial issues (17-19).”.”</p> <p>“Hospice has been found to benefit PLWD since it is associated with improved symptom management and care partner satisfaction, decreased care partner burden, preventing hospitalization, and discontinuing unnecessary medications (35).”</p>
<p>5. Page 3, 1st paragraph. This paragraph needs more context. The first sentence, starting on line 88, talks about PLWD near EOL, but the next sentence goes on to talk about care transitions in the 6-months following diagnosis...considering it was stated earlier that PLWD can live for 20 years with a diagnosis, I don't follow the point being made here. Is this about EOL care transitions or something else?</p>	<p>Thank you, we have added for context, “during their long trajectory of decline toward death” throughout the Introduction section.</p>
<p>Also, when talking about costs of care, how does this size up to the population? Is it high? Low? Why is dementia different? It would help to have some sort of comparison here for context. Also, I don't understand the relevance of the place of diagnosis in this context. Wouldn't place care is being received more telling?</p>	<p>Thank you for this comment. No comparison to the general population was given. Instead, the cost comparison was made between settings, so we have added this information for context: “suggesting that PLWD cared for in home and outpatient settings are better managed and cost the healthcare system less; and that the earlier PLWD are managed, the longer they can avoid intensive healthcare resource use (20).” (Background section, top of p. 3)</p>
<p>6. Page 3, second paragraph lines 100-102, I don't understand what predictors of inappropriate hospital transitions for PLWD at EOL (e.g., age, depressed mood, etc.) have to do with transitional care models management models. Also, how does Connect-Home ADRD fit into this discussion?</p>	<p>Thank you for this comment. These have been deleted.</p>
<p>7. Pg3, lines 117—while the statement about who gets homecare is true, I think there is an opportunity here to make the case for increasing diversity in homecare.</p>	<p>Thank you for this comment. We have added a sentence to the effect that the growing diversity of the US population may affect the demographics of home-based care in the future (p.4).</p>
<p>8. Pg 3, lines 119—although this may be true, how does it relate to care transitions? Does managing NPS reduce hospitalizations, for example?</p>	<p>Thank you. We have switched the last sentence to introduce this (p.4).</p>

<p>9. Pg 3, lines 122-124 – This was mentioned earlier, so I don’t think it needs to be repeated here.</p>	<p>Thank you. Yes, it was mentioned by way of the Introduction (p.4).</p>
<p>10. This paragraph also talks a lot about hospital transitions in care but I thought the and NP or PA involvement...I’m not sure how this fits into the HH and hospice context. Also, how does goal-concordant care fit in?</p>	<p>Thank you. The content has been clarified to reflect that the involvement of mid-level providers has been associated with improved outcomes (p. 4).</p>
<p>11. Pg 4, lines 150-152. This sentence seems out of place since it is discussing things that were excluded prior to describing the study. Recommend moving it to the discussion section.</p>	<p>Thank you. It has been moved to the discussion section.</p>
<p>12. Pg 4, objective—once again, more clarity is needed on the purpose of the study</p>	<p>Thank you. The objective has now been clarified in the Objective subsection: “The purpose of this systematic review was to examine literature pertaining to (1) care transitions for PLWD who are enrolled in skilled HH and hospice in the US, and (2) specifically, care transitions between skilled HH and hospice for PLWD.</p>
<p>13. Pg. 4, lines 168-169—needs to be more clear</p>	<p>Thank you. It has been clarified in the Methods section as follows: “The question was, ‘What is the literature pertaining to care transitions for PLWD enrolled in skilled HH and hospice and specifically between the two settings?’” (p. 7)</p>
<p>14. Pg4, line 169. It really isn’t possible to conduct a systematic review without a protocol. It seems that you did have a protocol (e.g., inclusion and exclusion criteria) so I presume this refers to not completing a formal protocol that was registered in a database? If not, and there really was no protocol, this is a major methodological flaw in this study.</p>	<p>Thank you. Yes, the protocol is reflected by the methods. We have now clarified the text to show that the protocol was not formally registered (Methods section, p.7).</p>
<p>15. Pg 4, eligibility paragraph—need to clarify what it is you are investigating.</p>	<p>Thank you. We have clarified the inclusion and exclusion criteria in the Eligibility section as follows:</p> <p>“Inclusion criteria included English-language, peer-reviewed articles set in the US and published between 2017 and 2023 that addressed care transitions for PLWD or cognitive impairment related to skilled HH and hospice. The rationale for the timeframe</p>

	<p>was due to our intention to find evidence that might reflect recent US policy changes affecting PLWD in skilled HH and hospice (37, 47-48). Exclusion criteria included articles older than the timeframe, did not fit the topic, and literature reviews, meta-analyses, study protocols, and opinion pieces.</p>
<p>16. Pg 4, eligibility paragraph—I find the rationale to limit to the last 5 years to find recent evidence to be unconvincing. While this review of the literature is indeed important, it seems like the purpose of the review is to understand care transitions in a general way. Most research in this area is at a low level of evidence (e.g., cross-sectional, correlational studies)—so there really is no EBP for HH to hospice care transitions, which is why this statement doesn’t make sense to me.</p>	<p>Thank you for this comment. We have now clarified in the Eligibility section as follows: “The rationale for the timeframe was due to our intention to find evidence that might reflect recent US policy changes affecting PLWD in skilled HH and hospice (37, 47-48).”</p> <p>Therefore, we re-ran the search with the time parameter of 2017-2023, as the 2-tier payment policy took effect in 2016. The changes in the search strategy are reflected in the Methods section, Figure 1 (PRISMA diagram), and Figure 2 (Search Terms)</p>
<p>17. Pg 5, lines 212-215. This is a clearer explanation of the research questions guiding this study, but I’m not sure it is consistent with what was originally stated. Please try to make these consistent.</p>	<p>Thank you. Yes, we have clarified the research question to be consistent throughout the manuscript.</p>
<p>18. P5., Results: What do you mean by "in home health?" Is this limited to studies that only include people receiving the Medicare Home Health Benefit for skilled nursing care? What about PLWD residing in the community who may receive in home supportive care services (e.g., private duty homecare). Are these excluded? How do you know when you read the studies what type of homecare people were receiving—it seems like some were just about community-based care with no clear definition of homecare services.</p>	<p>Thank you. We have added “skilled” to clarify skilled home health and “enrolled in” to clarify setting throughout the manuscript.</p>
<p>19. Results “Care transitions” – just curious if there was anything notable about reference #43 since it is not described in this section.</p>	<p>This Reference (now #54 due to revision) is described in the second paragraph of the Results subsection on Home Health (p. 9).</p>
<p>20. Pg6. Line 227. PLWD are more likely to be institutionalized...compared to whom?</p>	<p>Thank you. In the Results section, Skilled Home Health subsection, this has been revised as follows: “When being discharged from the hospital, PLWD are more likely to</p>

	<p>be institutionalized in a skilled nursing facility than to transfer to skilled HH,” to clarify that the two comparisons are between settings, not populations (p. 9).</p>
<p>21. Pg 6—and generally—so is a discharge to the community a care transition? Is readmission to HH a care transition?</p>	<p>Thank you. The definition of transition is now included in the Introduction section at the top of p. 4 as follows: “For PLWD, a transition may involve moving from one healthcare service to another, or it may involve being discharged from a healthcare service into the care of their informal care partners. In the present review a care transition for PLWD includes being discharged from or admitted to a health service; or transferred from one health service to another. Discharges from skilled HH to community or from hospice to community are also considered care transitions for the purposes of this review because care partners of PLWD must find alternate services to support their caregiving (21).”</p>
<p>22. Pg6. Lines 244-246. I thought the population is people either receiving homecare OR people in hospice. If a study focuses on transitions into hospice, where does this fit? Is a live discharge a care transition?</p>	<p>Thank you. This has now been clarified in the Objective subsection (p. 6) as follows: “The purpose of the present systematic review was to examine literature pertaining to (1) all care transitions for PLWD who are enrolled in skilled HH and hospice in the US and (2) specifically, care transitions between skilled HH and hospice for PLWD in the US.”</p> <p>We have now clarified on p. 4 that a care transition for PLWD can include a live discharge.</p>
<p>23. Pg6. Line 260—please clarify what “this” refers to</p>	<p>Thank you. The wording has been changed in the Results section, Hospice subsection (p. 10) as follows: “For example, among those with long hospice stays, dementia has been found to be the predominant diagnosis; however, PLWD are up to four times more likely to experience live discharge, for which African Americans and Hispanic Americans are at higher risk (38-43).”</p>
<p>24. Pg6, lines 292-297. I think this means that they utilized both services in the past 6 months, it</p>	<p>Thank you. The wording has been changed to “may indicate.”</p>

<p>doesn't mean they transitioned from one setting to the other (i.e., HH -> Hospice – unless this isn't the focus of the study—I'm still unsure). They may have, for example, been hospitalized in between. Although it is rare, I also believe that it is possible for a person to receive both homecare and hospice services simultaneously. For example, wound care related to a car accident, which has nothing to do with the hospice diagnosis, I believe, is eligible to receive skilled homecare services.</p>	
<p>25. Pg 7, 3rd paragraph. Surely there are things other than prognostication that are inhibiting care transitions...how about provider comfort with raising the issue that a care transition is warranted?</p>	<p>We agree. Provider comfort did not appear in our findings; thus, we did not include it. However, we have now listed in the Limitations section the following: “Although the timeframe was intended to reflect recent policy changes, it may have limited the results. For example, no included studies listed provider comfort with end-of-life themes as a potential variable affecting care transitions for PLWD.”</p>
<p>More generally, I suspect you will find that much of what is published in this area are more generally focused on care transitions with the mention of dementia within them, rather than being focused on dementia HH care transitions.</p>	<p>Thank you. This is why we recommend future research focus on dementia or cognitive impairment be included as a specific variable when studying transitions between these two settings.</p>
<p>26. Page 8, like 349, should also cite Sullivan.</p>	<p>Thank you. This has been changed on p. 13. The Sullivan et al. reference is now number 63.</p>
<p>27. PRISMA diagram. Records identified and records excluded boxes don't seem to add up. Please verify—I count 190 articles in records identified (8+166+16) (not 183) and 131 reports excluded (not 124).</p>	<p>Thank you. The PRISMA diagram has been corrected.</p>
<p>Matrix of articles. I am not sure that the following articles are related to HH or hospice care transitions based on the descriptions in the matrix. It is possible that I am still confused about the purpose of the review so please take a look. Burke (2021)—Need more clarity in the body of the manuscript regarding your population—I thought the review was focusing only on HH and hospice transitions—not hospital to community?</p>	<p>Thank you. We have clarified the definition of transition as including a live discharge to community as well as readmission to HH or hospice on p.4. We have kept the following articles that meet the definition: Burke (2021), Kaplan (2019), Knox (2022a), Knox (2022b), Luth (2020), Russell (2017), Władkowski (2023).</p>

<p>Kaplan (2019)—although this article compares HHC use between cognitively and non-cognitively impaired persons, does it include information about the actual care transition?</p> <p>Knox (2022a)—Need to have a clear definition of care transitions—does care transition also include community-based discharge?</p> <p>Knox (2022b)—same—there is a lot about early discharge from hospice. Is this a care transition or something else? To me, a care transition is when a person moves from one health service provider to another—I don’t see how discharge to the community really fits.</p> <p>Luth (2020) – same – this appears to be about live discharge from hospice</p> <p>Russell (2017)—same—is live discharge from hospice a care transition?</p> <p>Wilkins (2019) – Need more detail – it isn’t clear to me that this article meets inclusion criteria.</p> <p>Wladkowski (2023)—Is hospice reenrollment a care transition</p>	
<p>28. The purpose of Sullivan’s (2022) article is to identify QOL and SDH factors associated with hospice use among PLWD in the community. The study - isn’t causal so it can’t really speak to access.</p>	<p>Thank you for catching this. We have moved Sullivan’s reference to the Discussion section.</p>
<p>29. Depending on whether you decide to limit to skilled homecare or if you are more generally interested in community-based care transitions, including hospice, consider the following article: Sullivan SS, de Rosa C, Li CS, Chang YP. Dementia caregiver burdens predict overnight hospitalization and hospice utilization. Palliat Support Care. Oct 20 2022:1-15. doi:10.1017/s1478951522001249</p>	<p>Thank you for this recommendation. The study appears to show predictors of hospice use in PLWD related to caregiver burden and does not fit our inclusion criteria.</p>
<p>Reviewer B</p> <p>The biggest concern I have for the authors is the lack of focus for the review, which highlights research and findings on 1) experience of care transitions for PLWD in HH and Hospice and 2) the care transitions for PLWD BETWEEN HH and Hospice. I found myself going back and forth wondering whether the focus was about live discharge, or if it was about the experience of transitioning from HH care to hospice, which are distinctly different services – and I think you</p>	<p>Thank you. It has been clarified in the Objectives subsection as follows:</p> <p>“The purpose of this systematic review was to examine literature pertaining to (1) care transitions for PLWD who are enrolled in skilled HH and hospice in the US, and (2) specifically, care transitions between skilled HH and hospice for PLWD.”</p>

<p>ought to better clarify the differences between all these care models up front.</p>	<p>We have now clarified on p.4 that a care transition for PLWD can include a live discharge into the care of their care partners.</p>
<p>Along the lines of the introduction, much of the detail in the first several paragraphs could be condensed or succinctly written as to allow more focus on the experience of transitioning from HH to Hospice.</p>	<p>Thank you. The Introduction has been condensed for clarity and conciseness.</p>
<p>Furthermore, better clarity on the population is needed. Are you conducting a review re: the PLWD experience with care transitions, or folks who are cognitively impaired, or both? Authors jump between these various descriptors, and it is confusing.</p>	<p>Thank you. Although this appears in the Methods section, we have now added it to the Introduction section (p. 2) so that the reader may know that cognitive impairment has been used as a measure of dementia and that both terms are used in the review.</p>
<p>There were minor grammatical errors throughout. Utilizing a technical writer or an editor would strengthen the resubmission.</p>	<p>Thank you. A copy editor has reviewed the revised version.</p>
<p>Reviewer C</p> <p>Overall, it is well-written and interesting. Although you could better state the importance of focusing on this specific transition of care among people with dementia. My first main concern is that the article is very USA-focused. I find it hard to believe there is no article from outside the USA exploring this topic. You might need to review your search strategy. But if your aim was to focus on the USA, then you should say that more clearly.</p> <p>Nevertheless, further healthcare context and explanations for your hypothesis might be useful for international readers. Hospice care looks very different in different countries. You do not even say where the included articles are from. This is an international journal and I believe readers from other countries might not necessarily understand some of your hypotheses and discussions without further context. But most of all, your results might not feel useful if you do not contextualise them better.</p>	<p>Thank you. We have added “US” to the Introduction, Objective, and Eligibility sections. Specifically, in the Introduction on p. 5, we have added the following:</p> <p>“...Center for Medicare and Medicaid Services’ 2016 implementation of a 2-tier payment system reducing reimbursement for hospice stays longer than 60 days, which has been associated with reductions in the total number of hospice patients with ADRD (36, 37)”</p> <p>We have added to the Limitations subsection: “Further, the research was limited by the inclusion criteria of studies set in the US, as skilled HH and hospice may look different in other countries, based on policy and practice.”</p> <p>The table now lists country in column 1.</p> <p>We have confirmed with the editor that the journal would still be interested in reviewing the manuscript if the results were US-focused.</p>

<p>My second main concern is that your results section looks more like a discussion, and it includes some hypotheses and conclusions. A more systematic narrative analysis approach might help better frame your results. Find below some specific comments and suggestions by section.</p>	<p>Thank you. Please see below.</p>
<p>Title: The term 'home health' might not be understood in all settings. I suggest 'home care'.</p>	<p>Thank you. We have clarified that we are examining "skilled home health," (p. 2) as defined by US Medicare. The review does not include all home care environments.</p>
<p>Abstract: I miss from the introduction the relevance of understanding transitions between hospice and home care and not other transitions. I recognise there are other systematic review exploring these other transitions, but it would be useful to understand why to focus on this specific one. What is the relevance. For instance, from my point of view, it is much more concerning transitions between community and hospital settings. I'm not saying it is not relevant, just suggesting you explain better the importance. Line 42. It is not very clear what you mean by 'unsuccessful discharge to the community' here as well as 'prognostic assessment tools may not be compatible with'</p>	<p>Thank you for this comment. We have added to the Introduction section (p. 5) that the decision to choose hospice is like no other, and that live discharge from hospice has been described as distressing, and that a transition to HH may disrupt continuity of care and bring risks for poor outcomes.</p> <p>"Unsuccessful discharge to community" is defined on p. 9 as "...readmission to the hospital during skilled HH, unplanned hospitalization after discharge from skilled HH, or mortality (56).</p> <p>The following has been added on p. 12 to clarify the meaning of current prognostic assessments: "Appropriate timing of referral to hospice for PLWD may be affected by the limitations of current prognostic assessment tools based on functional status"</p>
<p>Introduction I think you also need to explain why transitions of care are a bad outcome for people with dementia, beyond the continuity of care issue. People with dementia are particularly susceptible to bad outcomes with transitions. You could add some explanation for that, which will enhance your argument.</p>	<p>Thank you. We have added evidence from Hirschman et al. (2018) about poor outcomes associated with care transitions for PLWD. In the Introduction, on p.3, appears the following:</p> <p>"Care transitions for all patients increase risks of medical errors, disruptions in continuity of care, avoidable hospital admissions, and preventable adverse events; however, PLWD have the added risk of cognitive impairment, while their care partners manage and negotiate care with multiple providers,</p>

	manage illness, and cope with psychosocial issues (17-19).”
You could make the link between prognostication in dementia and transitions to hospice clearer in the introduction. I think I understand your point, mainly in the context of how hospice care funding works in the USA. But hospice involvement looks different in other countries. You could be more explicit about that. In the USA, to get hospice care you need to have a specific length-of-life prognosis and discontinue curative treatment. But this is not the reality in the UK for instance.	Thank you. We have clarified the discussion of prognostication in the introduction. On p.2 in the Background section: “In the US...hospice is defined as comfort-oriented care provided by an interprofessional team to patients with prognoses of 6 months or fewer who choose to discontinue curative treatments (2,3).”
Methods Line 172. Eligibility: did you include non-English articles? You could also clarify what was the criteria for articles including another diagnosis in addition to dementia people, and cognitive impairment without a diagnosis of dementia, or if you only included people with a diagnosis of dementia confirmed by a physician. Also not clear if your inclusion criteria included a specific end-of-life timeframe. What about articles exploring different types of transitions that included hospice to home? A table with the inclusion and exclusion criteria following the PICOT framework is desirable.	Thank you. We have added non-English-language articles to our exclusion criteria. We have clarified in the Search Strategy subsection (p. 7) that cognitive impairment and dementia were both used as search terms and the rationale behind that. We have made a table of inclusion and exclusion criteria.
Line 187. You need to describe what did you do with disagreements between reviewers.	Thank you for this reminder. We have now added what we did with disagreements between reviewers to the Data Extraction subsection: “Author CCC resolved disagreements and checked for accuracy.” (p. 8)
Line 197. Please describe how the quality assessment was done (by one or more authors, independency, what did you do in case of discrepancies)	Thank you. We have now elaborated on the quality assessment: “Two authors (AAA, BBB) appraised studies independently. Discrepancies were resolved through consensus.” (p. 8)
Line 204. Narrative synthesis of systematic review results can also follow specific and more systematic methodologies. Chapter 12: Synthesizing and presenting findings using other methods Cochrane Training. You need to justify why not follow a more systematic approach, or at least describe better how did you approach the synthesis in more detail.	Thank you for this reference. We have found and cited a Cochrane reference specific to synthesis on p. 8: Ryan R. Cochrane Consumers and Communication Review Group. Cochrane Consumers and Communication Review

	<p>Group: data synthesis and analysis. http://cccr.org.cochrane.org. June 2023</p>
<p>Results Your Figure 1 could be improved. For instance, I imagine the first box 'Records screened' refers to the title and abstract screening, and the following ones are about full-text screening? Also, not clear why you excluded meta-analysis.</p>	<p>Thank you. The PRISMA diagram has been revised for clarity.</p>
<p>Before describing articles in the three categories, it would be useful a more general description of all the articles included (year, country, method, etc.). Also, you should include here a summary of the results of the quality appraisal of studies.</p>	<p>Thank you. We have added the following on p.9: "Articles included were set in the US, published between 2017-2023, and were primarily quantitative studies involving descriptive or regression analyses of administrative datasets. One included study was qualitative."</p>
<p>Table 1 should include country</p>	<p>Thank you. Country has been added to the first column of Table 1.</p>
<p>My main concern about your result section is that you are having here a discussion rather than a narrative description of a systematic review. For instance, in line 223 you say 'PLWD may have the choice to rehabilitate at home with HH or at a skilled nursing facility'. Is this a result of an included study? In which context? In the third paragraph, the term 'Overall' for instance is too vague. How many of your included studies reported that people living with dementia were more likely to be readmitted to hospice than those without dementia? In which context? You are giving us here your conclusions from your reading, but we need more information here to be able to judge whether we agree with your conclusions or not. Particularly in this context, as you said there was heterogeneity across studies.</p>	<p>Thank you. We have revised this line in the HH results subsection (p.9) to read as follows: "When being discharged from the hospital, PLWD are more likely to be institutionalized in a skilled nursing facility than to transfer to skilled HH, even though PLWD may benefit more from a supportive home environment, and rates of mortality and readmission to the hospital are the same between the two settings (54)."</p> <p>In the third paragraph, "overall" has been deleted.</p>
<p>Line 254. Which literature? Is this a result of your included articles?</p>	<p>Thank you. This has been deleted.</p>
<p>Discussion Line 311. It is also possible that people with dementia transition from nursing homes or long-term care facilities to hospice. As you said, people with dementia can experience a prolonged period of constant decline and require support years before reaching the last year of life and therefore transition earlier to a nursing home and then, moving to a hospice might be less needed than for</p>	<p>Thank you, we have added: "however, it is possible that the transition may not be direct, involving a third care setting such as a skilled nursing facility or a hospital." (p. 12)</p> <p>We have included in the limitations that hospice may look different in other countries (p. 15).</p>

<p>people without dementia. But most importantly, the fact that you did not find articles investigating transitions between home and hospice does not mean these transitions don't exist.</p> <p>You need to discuss the fact that hospice care looks very different in different countries. In the UK for instance, discharge from hospice care does not necessarily mean a discontinuity of care, as hospices also provide community/ambulatory care.</p>	<p>In the Discussion section (p. 13) we have added the following:</p> <p>“Future research should examine such transitions in non-US countries, as policies and practices may vary.”</p>
<p>Conclusion</p> <p>Line 384. I disagree the findings from this review allow you to conclude that HH or hospice benefit people with dementia. Your review was not about the effectiveness of hospice care, so you cannot conclude this. Also not sure about the prognostic tools conclusion. Is that a conclusion from your research or a hypothesis?</p>	<p>Thank you. While it is correct that our particular findings did not show the benefit of the services nor the effects of prognostication tools, we did cite studies regarding these items in the Introduction and the Discussion. In the conclusion section, they have been repeated as part of a summary of the whole article. We have added citations to support them as follows:</p> <p>“Evidence shows that both HH and hospice benefit PLWD and their care partners (25-27, 35). Our findings illustrate there is a high risk of care transitions for PLWD, especially for those from racial and ethnic minoritized groups; however, we found a gap in the literature specifically regarding transitions between skilled HH and hospice for PLWD. Given PLWD's long trajectory of decline, future research should include dementia or cognitive impairment as a factor in studying care transitions for PLWD enrolled in skilled HH and hospice. In addition, future work should explore assessment approaches specific to PLWD that lead to higher quality of coordination of care to, from, and between skilled HH and hospice. “</p> <p>Our primary finding was a gap in the literature regarding transitions between HH and hospice for PLWD. We have suggested future research to focus on this phenomenon to fill the gap in the literature.</p>