Effectiveness of discharge planning and transitional care interventions in reducing hospital readmissions for the elderly

HTA Report

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A tool to support decision-making from the HSCTIAU

The connection we share

Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal

Québec

EXECUTIVE SUMMARY

In the context of meeting ministerial targets set for length of stay of patients on stretcher, the Health and Social Care Technology and Interventions Assessment Unit, of the Centre intégré universitaire en santé et services sociaux de l'Ouest de l'île de Montréal, set out to answer the decisional question elaborated on June 1st 2016 :

Which interventions should be implemented in order to prevent the emergency department visits and hospital admissions/readmissions of the vulnerable older adults?

The results presented here involve multiple directorates including the Nursing Directorate, Professional Services Directorate, Multidisciplinary Services Directorate and the Support for Elderly Autonomy Program Directorate.

The present report aims to support the Centre intégré universitaire en santé et services sociaux de l'Ouest de l'île de Montréal in its decision-making process to implement organisational changes that will improve discharge planning and transitional care for the elderly population.

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DISCLOSURE OF CONFLICT OF INTEREST

None to declare.

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ABBREVIATIONS

CI	Confidence interval
CLSC	Local Community Service Centres
CISSS	Centre intégré de santé et de services sociaux
CIUSSS	Centre intégré universitaire de santé et de services sociaux
CSSS	Centre de santé et services sociaux
ED	Emergency department
EPOC	Effective Practice and Organisation of Care
GP	General practitioner
HTA	Health technology assessment
INESSS	Institut national d'excellence en santé et services sociaux
ODIM	Ouest de l'Île-de-Montréal
OR	Odds ratio
PICOTS	Population, intervention, control, outcome, time frame and study design
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
RCT	Randomized clinical trial
SAD	Home Support Services (of the Support for Elderly Autonomy Program Directorate)
RD	Risk difference
SR	Systematic review
ROBIS	Risk of bias tool for systematic reviews
RR	Relative risk
UETMIS-SS	Health and Social Care Technology and Interventions Assessment Unit

GLOSSARY

Before/After study	"A research design where a group of subjects is observed before and after an intervention or exposure to a given factor" (1)
Discharge planning	"An individualized plan of discharge to facilitate the transfer of a patient from hospital to a post-discharge setting" (2)
Meta-analysis	"Statistical combination of results from multiple studies to obtain a single estimate of effect of a particular intervention or variable. The meta-analysis appropriately weights each included study according to its precision and, when RCTs are included, it maintains the randomisation of the individual included studies" (1)
Non randomized controlled trial	"A clinical trial in which the subjects are divided between an experimental group and a control group using a method that does not involve randomisation—on the basis of the investigators' practical constraints, for example—or other methods, such as alternate assignment of treatments" (1)
Prospective study	"A study to evaluate the effects of exposure to a given intervention or factor, in which the subjects are divided into groups that are exposed or not exposed to the intervention or factor of interest before the outcomes have occurred" (1)
Randomized controlled trial	"A study comparing at least two interventions, in which the eligible participants are allocated randomly to the intervention group, or groups, and the control group. The control may be a standard practice, a placebo, other active intervention, or no intervention. Participants may be individuals or groups" (1)
Risk difference	"The value of the difference between the probability that an event will occur in the group exposed to a given factor and the probability that this event will occur in the group not exposed to this factor (1)
Risk ratio	The ratio (quotient) of the risk that an event will occur among the subjects exposed to a given factor and the risk that this event will occur among the subjects not exposed to this factor" (1)
Statistical significance	"In hypothesis testing, a conclusion drawn when the null hypothesis is rejected, i.e. when the p-value is below the pre-determined alpha level" (1)
Systematic review	"A synthesis that collates all empirical evidence fitting pre-specified eligibility criteria in order to answer a specific research question. Systematic reviews are conducted according to a pre-specified protocol. The methods used are selected with a view to minimizing bias, thus providing more reliable findings from which conclusions can be drawn and decisions made" (1)
Transitional care	"Interventions to improve transition from one care provider to another, for example adolescents moving from child to adult health services" (2)

1. INTRODUCTION

1.1. Context

In 2016, the Ministry of Health and Social Services set a target concerning the reduction of the length of stay of patients on a stretcher, in the emergency departments (EDs), to 12 hours (3). The Health and Social Care Technology and Intervention Assessment Unit (UETMIS-SS), of the Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal (CIUSSS-ODIM), was then approached in order to support the decision-making process relating to the implementation and operation of this priority.

The contribution of the UETMIS-SS to this project was to evaluate the interventions aiming to improve the fluidity of patient trajectories in the acute care services. An assessment of interventions, programs and models aiming at improving service use – more specifically hospital admissions, readmissions and emergency department visits – was undertaken.

Disproportionate health care utilisation by the elderly has been reported in both Canada (4) and the United States (5). In Quebec, the annual rate of hospitalisation between 2006-2009 for patients aged 65-74 was 1 496 per 10 000, and increased to 2 688 per 10 000 for patients aged 75 and over (6). In comparison, the rate of hospital admission for younger adults aged between 25-44 is 583 per 10 000 (6). Moreover, while the elderly population (65 year and over) made up only 14% of the total population in Quebec in 2009, they accounted for more than 58% of all hospitalisation days (7).

Taking this into consideration and given the extent of this project, it was settled that this health social care technology and intervention assessment (HSCTIA) would target the elderly population, frequent users of health care services, along with the interventions aimed at reducing the use of acute hospital services.

The objective of this particular report is to evaluate the effectiveness of one subset of interventions identified: those focused on discharge planning and transitional care to reduce hospital readmissions of the elderly. Other interventions will be evaluated in upcoming reports.

1.2. Discharge planning and transitional care

According to the effective practice and organisation of care (EPOC) (2), the *discharge planning* is defined as an "individualized plan of discharge to facilitate the transfer of a patient from hospital to a post discharge setting". Furthermore, they define *transitional care* as "interventions to improve transition from one care provider to another".

Depending on the source of the definition, several components can be involved in the discharge planning and the transition of care. These can include communication and education to ensure that the patient and his care giver can properly manage his medical problems (8), and support and coordination services, which span across the hospital community interface, that integrate multiple service providers (9).

Quebec ministerial agencies also defined discharge planning and transitional care as involving the evaluation of the patient's autonomy and the services needed after discharge, with the patient's involvement ,to allow for an informed and sound decision and ensure the continuity of services (10). They considered the

following as the key activities of the process: 1- Identification of the services and follow-up needed; 2- provision of enough information to the patients and their caregivers as well as; 3- communication with the healthcare provider from the health and social services network (10).

2. OBJECTIVE

During the planning phase of the HTA, the following decisional question was retained and validated by the steering committee on June 1st 2016:

Which intervention should be implemented in order to prevent the emergency department visits and hospital admission/readmission of the vulnerable older adults?

Considering the multitude of references identified in a preliminary literature search, it was agreed upon with the steering committee to carry out an umbrella review in order to answer the decisional question (11-13). Thus, in order to obtain a global overview of the evidence, a meta-narrative synthesis of systematic reviews (SRs) analysing the effectiveness of the interventions focusing on reducing the use of hospital services among vulnerable older adults was conducted. The objective of this report is to evaluate the effectiveness of one subset of interventions identified: those focused on discharge planning and transitional care interventions to reduce hospital readmissions of the elderly.

This evidence-based report will enable the CIUSSS-ODIM decision makers to identify the most effective and suitable interventions to implement. Eventually, this report may help the provincial decision makers to improve the discharge planning and the transition of care processes in the province of Quebec.

3. METHODS

3.1. Umbrella review

For the purpose of this HTA, an umbrella review of SRs was conducted following a protocol that was specified in advance, documented, and guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement (14).

3.1.1. Data sources and search strategies

The database search strategies and strings – composed of keywords and subject headings – were developed and tested by a professional information specialist (NC) in collaboration with a researcher (MH). The search strategies were developed for the global HTA project, which was broader than this particular report (as specified in section 1.1). For the *systematic review* concept, a search filter was developed, based on those produced by certain HTA Agencies (15, 16) and by the U.S. National Library of Medicine for PubMed (17).

The searches were carried out on April 20th and April 24th 2017 within the following databases: Medline (Ovid platform), CINAHL (Ebsco platform), the Cochrane Database of Systematic Reviews (Cochrane library, Wiley platform), the Database of Abstracts of Reviews of Effects (Cochrane library, Wiley platform), and the Health Technology Assessment Database (Cochrane library, Wiley platform). The results were limited by publication date (January 2011 to April 2017) and by languages (English or French). All the references were entered into an EndNote library, and the Bramer method (18) was used with caution for the deduplication process. The detailed search strings are presented in Appendix 1. The Applied Social Sciences Index and Abstracts database (Proquest platform) was also searched, but the results could not be included due to technical problems. With the same search strings, the Proquest platform did not reproduce the same results. This instability led us to remove this database from our sources.

Other online sources were searched in order to identify SRs in the grey literature and other SRs (sources listed in Appendix 2). Various keywords or categories relevant to the research question – such as *admission, systematic review, medical services,* or *emergency* – were searched in these sources. The International prospective register of systematic reviews (PROSPERO) was also searched at the beginning of May 2017. The authors of relevant SR protocols published from 2014 to 2016 were contacted. It was assumed that protocols prior to 2014 would have been published and retrieved as articles in the database searches, and that protocols from 2017 would not be as yet completed projects. Pearl growing was also added as a search method. Once the studies were selected for the present umbrella review, the reference lists of the articles were examined for supplementary studies. Furthermore, Google Scholar was used to search for all articles citing the selected studies thanks to the *Cited by* function. Finally, one additional record was added following a serendipitous finding while browsing for another document.

As per the present HTA's protocol, specifying the inclusion of peer-reviewed studies, an attempt was made to verify this characteristic. Once the studies were selected, the policies of the journals in which they were published were examined to verify if they include a peer-review process. All sources had review processes, with the majority performing a systematic single- or double-blind peer-review. In 4 journals, the review process may also sometimes be carried out solely by editors (19-22). Since 2 of these journals (20, 21) operate an open peer-

review process, we could verify that the studies included in the present project from these journals were peer-reviewed. The Cochrane Collaboration states that it is developing an overarching policy, and that specific Cochrane groups implement peer review processes (23). Although efforts were made to verify that all the included studies were peer-reviewed, substantial information is lacking to determine this characteristic with certainty. For example, a present-day policy might have been different when a study was published in the past.

3.1.2. Study selection

3.1.2.1. Selection criteria

This review included all SRs meeting our PICOTS (population, intervention, control, outcome, time frame and setting) and our minimum inclusion criteria (Table 1).

For the purpose of this umbrella review, SRs targeting elder adults aged 65 years and over and investigating any intervention aimed at reducing the emergency department visits, hospital admissions or readmissions were included. Interventions implemented in primary care settings, in the community or during the hospital-home or community care interface were considered. This did not include medical, pharmacological, or surgical interventions, or primary prevention for the elderly. Publication dates were limited to reviews published between 2011 and 2017, since all the primary studies from the last 30 years should be represented in the retrieved SRs (11). Due to limited resources, only articles in French or English were included. As the objective of this report focused on the Canadian context, it was concluded that all relevant articles would be included within English and French articles.

Table 1. Inclusion and exclusion criteria

	Inclusion Criteria	Exclusion Criteria
Patient	65 years and older *primary studies criteria ≥ 65 years OR mean age of participants in primary studies ≥ 65 OR the majority of studies with a mean age ≥ 65	Elderly with a specific disease
Intervention	Interventions aimed at reducing ED use or hospitalisation	Other types of interventions such as: - Primary prevention for the elderly - Medical, pharmacological or surgical intervention
Outcome	Data on hospital admissions, hospital readmissions or emergency visits in at least 50% of the primary studies OR 10 primary studies	Any other outcomes
Time of publishing	Published between 2011 and 2017 published	Systematic reviews published before 2011
Setting	Primary care setting, community or during hospital community interface	Limited to hospital setting not related with hospital community interface
Languages:	English or French	Any other language
Study design	Minimum inclusion criteria for systematic reviews: - Literature search conducted in at least 3 databases - A clear list of inclusion and exclusion criteria for study selection - Quality assessment of included studies was performed and documented - At least two reviewers performed the study selection, quality assessment, and data extraction	- Any reviews not respecting the minimum inclusion criteria - Economic studies and reports on the subject - Descriptive studies, no control - Primary studies

3.1.2.2. Selection criteria

All titles were uploaded into an Endnote database and duplicates were removed. Two reviewers (MH and MW) independently screened titles and abstracts, according to the inclusion/exclusion criteria. Any title identified by a reviewer was kept for full text reading. The full articles of the selected titles were retrieved and read by a combination of two reviewers (MH, MW and AL). The reasons for exclusion were documented and validated by a second reviewer. Discrepancies were resolved by consensus between reviewers or by consulting a third reviewer (SB).

3.1.3. Data extraction

Following the selection process, data was extracted in a predefined table agreed upon by two reviewers (MW and MH). Two reviewers (MW and MOT) each extracted the data from half of the included SRs. Validation of the extracted data was performed by the second reviewer (MW or MOT). In case of disagreement, a third reviewer (SB) was consulted.

Data extracted were based on: 1- description of the SRs (year, country, objective, and grading or quality analysis tools used in the SR), 2- primary studies description (year, country, setting, population group and size, intervention and its EPOC classification (2), comparator, outcomes measured, and results), as well as, 3- if the authors reported economical, organizational, or ethical issues in the review.

3.1.4. Assessment of risk of bias

The risk of bias tool for systematic reviews (ROBIS) (24) was used to evaluate the quality of the included SRs. The tool evaluates the potential risk of bias over three phases: 1- assessment of the relevance of the SR, 2- assessment of the review process, and 3- evaluation of the risk of bias. The first phase evaluates the relevance and eligibility of the SR for the research question. Phase two evaluates the risk in four domains: study eligibility criteria, identification and selection of studies, data collection and study appraisal, and synthesis and findings. The third phase summarises the risk assessed in phase 2 and assesses the overall risk of bias in the conclusion of the review findings and whether the risk of bias identified in the four previous domains was addressed or not. Taking the results of the individual domains, an overall assessment of the risk of bias is generated.

A combination of two reviewers independently (MW, MH, MOT, or AL) reviewed the risk of bias using the ROBIS access database available online (25). Any discrepancies between two reviewers were discussed to reach a consensus, otherwise a third reviewer was consulted.

3.1.5. Data analysis

The SRs were subdivided into types of interventions as defined by the EPOC taxonomy (26). For the purpose of this specific report, an analytical framework for discharge planning and transitional care was developed to describe the different components of the interventions and health care professionals involved. Based on this analytical framework, SRs were divided into three categories depending on the intensity of the follow-up provided post-discharge from the hospital as well as the health care professional involved. These 3 categories included: 1- discharge planning and transitional care without follow-up, 2- discharge planning and transitional care with follow-up performed by one or several health care providers, and 3- discharge planning and transitional care with a follow-up performed by a health care provider involved in the discharge planning. As

there was a great deal of heterogeneity between the included primary studies, the results were summarized in a narrative synthesis. In order to eliminate overlap of primary studies across narrative SRs, the results of unique primary studies were reported. Primary studies were considered positive if an intervention was reported to reduce readmission rate in at least 1 time point. Meta-analyses, however, were kept as stand-alone analyses as they could not be fragmented.

The level of evidence was graded while taking into consideration the quality and the risk of bias of the included systematic reviews (ROBIS) in addition to the strength of the outcomes of interest. The grading system proposed by the National Autism Center, under the National Standards Project (27), and retained by the Institut national d'excellence en santé et en services sociaux (INESSS) for the elaboration of guidelines in social services (28), was used for this report (Table 2).

Table 2. Classification system of the effectiveness of the interventions

Established: there is sufficient scientific evidence to conclude that the intervention produces favorable outcomes on the individuals. **Emerging:** few studies of high quality indicate that an intervention has favorable effects on the people involved, but further studies are needed to confirm their theoretical effectiveness. **Non established**: absence of high quality studies to determine if the intervention has favorable effects, no effect or even harmful to those involved. **Ineffective/harmful**: there is enough scientific evidence indicating that an intervention has no effect or has harmful effect on those involved.

*unofficial translation from the grading system by INESSS for the elaboration the elaboration of guidelines in social services (28)

3.2. Contextual and experiential data collection

The steering committee was formed in an advisory capacity in order to help in the understanding of the organizational and clinical context, and to share their opinion in the progression of the project. This committee included experts and stakeholders from different directorates and fields of research.

Furthermore, organized interviews and presentations were held with health care professionals occupying different roles within and outside the CIUSSS, such as directors, coordinators, nurses, and social workers. The objective of these interviews was to collect data from the Lakeshore General hospital, CIUSSS-ODIM as well as other Centres intégrés de santé et de services sociaux (CISSSs) and CIUSSSs in Quebec in order to:

1. Gain an understanding of the patients' pathway from admission to his return home in relation to the ministerial orientations.
2. Identify the different activities and the continuity of care provided after the discharge from the hospital.
3. Identify the role of each professional in this pathway.

4. Discuss the restrictions and what could facilitate the implementations of the different types of interventions found in the scientific literature.
5. Collect suggestions and opinions about the results identified by the systematic review.

These professionals were selected based on their expertise, profession, location, and availability for an interview. The interview process was conducted in French and followed an interview canvas which was modified depending on the interviewee. An example interview canvas is available in Appendix 3.

Moreover, in order to understand the situation in the Lakeshore General Hospital, data were collected regarding the emergency room visits from the info-centre of the CIUSSS-ODIM. Finally, The UETMIS-SS team attended and was involved in the emergency project committee held in the Lakeshore General Hospital.

3.3. Development of recommendations

In order to elaborate final recommendations, a committee was formed to review the evidence presented in this report. Members of the steering committee were invited along with members of the different directorates involved in discharge planning and transitional care. The latter included the Nursing directorate, Professional Services Directorate, Multidisciplinary Services Directorate, and Support for Elderly Autonomy Program Directorate. A list of all invited members is found in Appendix 4.

A meeting was held on November 2nd 2017, which was followed by a series of communications and exchanges. The results of the literature review were presented along with 7 preliminary recommendations supported by the contextual and experiential data. A semi-structured group discussion based on predefined questions was conducted in order to assess the committee's appreciation for the results. The committee was asked to assess the expected advantages and the potential risks of implementing the recommendations. Moreover, the feasibility of implementing the recommendations, their relevance, and any potential ethical issues were evaluated. The recommendations were modified accordingly.

The committee was also surveyed for recommendations for potential independent reviewers whom had not participated in any capacity in the elaboration of this report.

3.4. Scientific validation

The scientific validity of this report was assured two-fold:

1. The steering committee, including the scientific advisors, which accompanied the project from its inception, validated the methodology outlined in the protocol. It should be noted that members of the steering committee hold expertise in both the subject matter of this report and methodology relevant to conduct HTA.

2. Independent experts who had not participated in the project were sought out for both input and scientific validation.

4. RESULTS

4.1. Umbrella review

4.1.1. Search results

The literature search strategies yielded 6172 citations with an addition 314 records found in grey literature, Prospero and by serendipitous findings. Following selection based on titles and abstracts, 405 articles were read. Of these, 27 articles of 24 SRs were selected for analysis based on the eligibility criteria. Appendix 5 illustrates a flow diagram adapted from PRISMA guidelines (14) indicating the selection process. The reasons for exclusion are listed in Appendix 6.

The data presented in these SRs can be subdivided into several types of interventions as defined by the EPOC taxonomy(2). The interventions in the 26 SRs included discharge planning and transitional care (n = 9), prescribing (n = 5), outreach services (n = 4), comprehensive geriatric assessment (n = 2), teams (n = 2), care pathways (n = 1), case management (n = 1), role expansion and task shifting (n = 1), self-management (n = 1), site of delivery (n = 1), telemedicine (n = 1), and others (n = 3).

In this report, only the 9 SRs on discharge planning and transitional care, among which 5 included meta-analyses, are reviewed and discussed. The reviewing of the rest of the SRs will follow in other reports and will be analysed according to organizational priorities.

4.1.2. Studies characteristics

Nine SRs evaluated the effectiveness of discharge planning and transitional care from the hospital (n = 8) or a nursing facility (n = 1) to the community in reducing hospital readmissions for the elderly. In these SRs, 133 unique primary research articles were analyzed. The number of included participants in the individual studies ranged from 32 to 2353, with a total of 50513 participants. Study designs varied between randomized controlled clinical trials (RCTs) (n = 115), non-randomized clinical trials (n = 10), before-and-after studies (n = 7), and a prospective controlled cohort study (n = 1). Countries also varied from the United States of America (n = 50), Australia (n = 19), United Kingdom (n = 15), Sweden (n = 7), Spain (n = 6), Denmark (n = 6), Canada (n = 5), China (n = 5), Belgium (n = 3), Italy (n = 3), Germany (n = 3), New Zealand (n = 2), Austria (n = 1), France (n = 1), Ireland (n = 1), Netherlands (n = 1), Norway (n = 1), Singapore (n = 1), Slovenia (n = 1), Switzerland (n = 1), and a large trial in multiple European countries (n = 1).

4.1.3. Quality assessment

The quality assessment of the included SRs is illustrated in Figure 1. Overall, of the 9 SRs evaluating discharge planning and transitional care, 4 SRs (44%) (29-32) were assessed to present a high risk of bias, while 4 others (44%) were evaluated to have a low risk of bias (33-36). The risk of bias was evaluated to be uncertain for the 9th SR (37). The quality assessments of the individual SRs are presented in Appendix 7.

The main sources of bias, as evaluated by the ROBIS (24) , were the *identification and selection* domain as well as the *synthesis and findings* domain. In the *identification and selection* domain, 3 SRs were rated at high risk of bias and 3 SRs were rated as unclear: the range of databases and time period appeared inadequate and were unexplained. For the *synthesis and findings* domain, 3 SRs were rated as high risk of bias and 2 were rated

as unclear. The reasons for these ratings included: the lack of reporting of statistical significance (29, 32), inconsistencies in extraction/omission of results (32), inclusion of wrong data set in meta-analysis (30), and wrong interpretation of results based on statistical analysis (30).

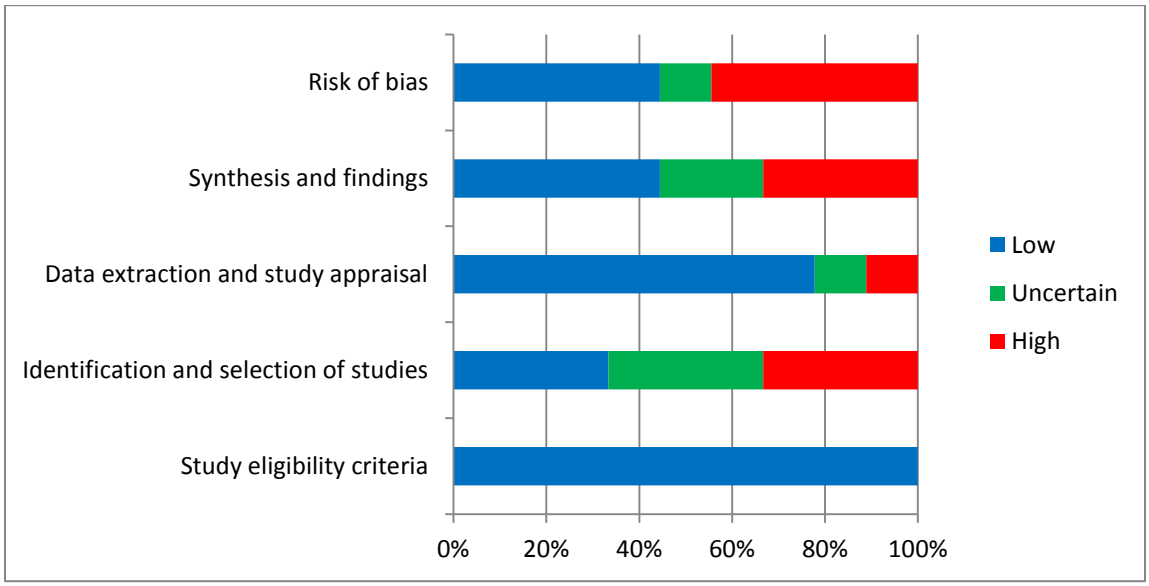

Figure 1. Risk of bias

4.1.4. Synthesis of results

The mode of interventions varied greatly across the SRs in terms of number and complexities of activities performed, as well as the health care professionals involved. Thus, in order to address this variability, 8 SRs on discharge planning from the hospital and their sub-analyses were separated into 3 categories based on the type of follow-up preformed after discharge: 1- discharge planning and transition to the community with no follow-up; 2- discharge planning, transition, and follow-up performed by an unspecified health care professional; and 3- discharge planning, transition, and follow-up performed by the same health care professional (Figure 2). The 9th SR evaluated discharge planning from skilled nursing facilities and its results were reported separately in order to minimize heterogeneity across primary studies.

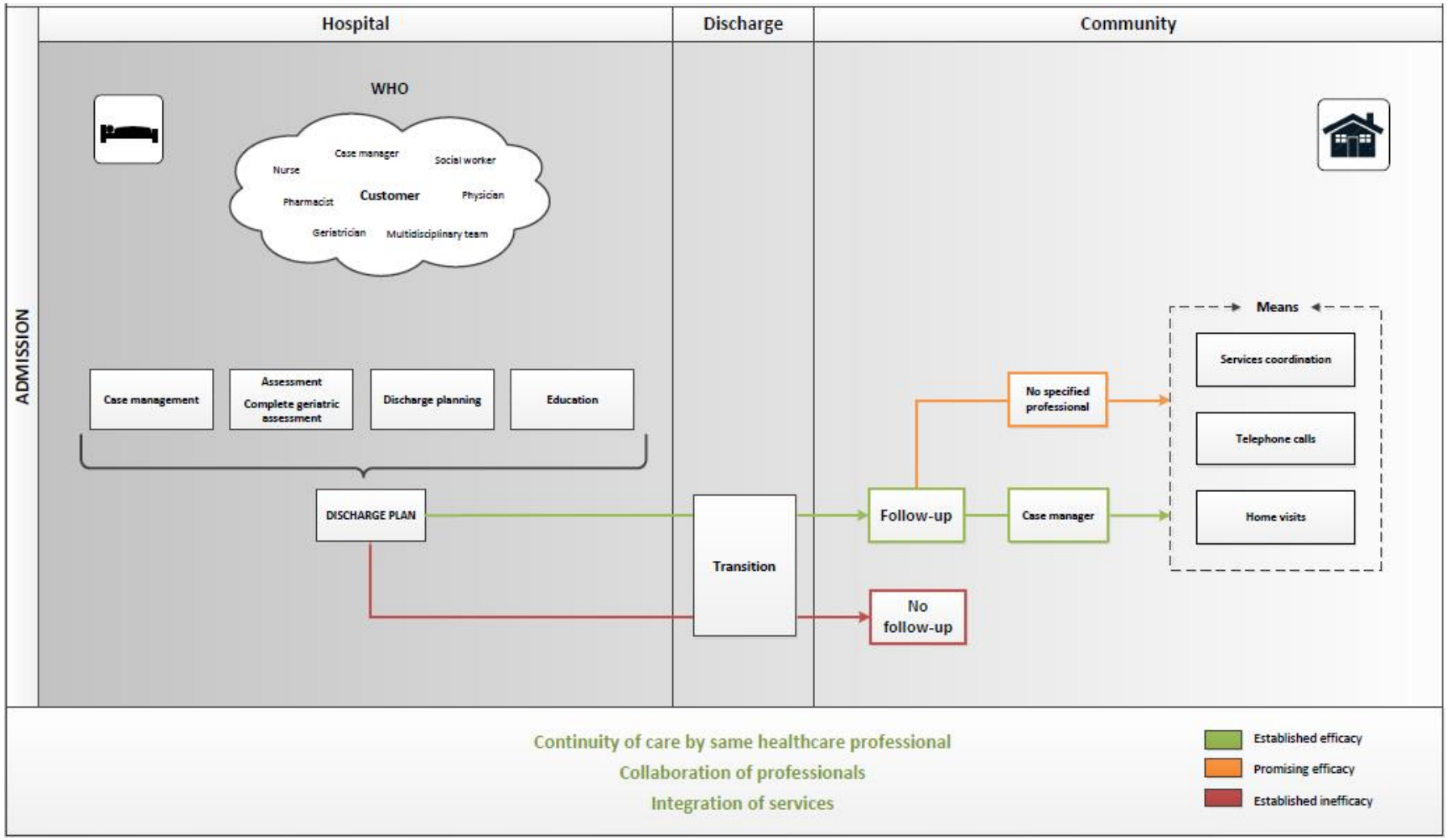

Figure 2. Analytical framework for discharge planning and transition care illustrating the key players and interventions

4.1.4.1. Effect of interventions with discharge planning hospital and transition with referral to the community without follow-up

Overall

In the 3 SRs included in this category (29, 32, 35), only 1 out of the 8 primary studies reported a statistically significant reduction in readmission rate, 2 reported an increase while the other 5 studies showed statistically non significant differences between the intervention and the control groups. Based on this, the level of evidence for the effectiveness of interventions not including a follow-up component was rated as ineffective.

In this HTA, *transition to community* was defined as interventions focusing on developing an individualized discharge plan by an in-hospital caregiver, and patient care was transferred to the community health care services after hospital discharge. Three SRs evaluated the evidence of interventions on transitioning to the community and the data are presented in Table 3.

The SR published by Lowthian *et al.* (35) investigated effective care transition models from the ED to the community. Up to December 2013, 7 out of 9 included studies with interventions focused on community-based referrals reported results on readmission following discharge. Out of these 7 studies, 4 were presented in narrative form, with only one study reporting significant decreases in readmission (38). Moreover, one comparative controlled cohort reported a 13.9% increase in patients with at least 1 unplanned readmission one year following discharge (39). It should be noted that of these 4 studies, 1 included an undefined type of follow-up (40). As the remaining 3 studies were included in a meta-analysis, and a follow-up after discharge was conducted in all 3, they will be discussed in the next section.

Guerin *et al*. (29) conducted an SR on the methods of community caregivers' involvement in an older patient's discharge back to the community. In this narrative review of 12 papers, from 1980 to 2012, the interventions were categorized into 4 types: 1- *Virtual Interface*, 2- *In-reach Interface*, 3- *Out-reach Interface*, and 4- *Independent Interface*. The In-reach Interface included data on transitional care while the other 3 categories (Virtual, Out-reach, and Independent) will be discussed in later sections

The In-reach model was defined as assessment, discharge planning, and transition of patients from the hospital back to the community by community services based in acute care units (29). Within the 12 studies found in their search, 2 studies (1 before-and-after trial and 1 RCT) fell within this model. Assessment and discharge plans were performed by an early discharge and rehabilitation service team in one study (41), and by a community nurse in the other (42). Of note, the early discharge team also provided ongoing care following discharge. Both studies did not measure any significant differences in readmission rates between the intervention group and usual care.

Table 3. Summary of systematic reviews targeting discharge planning and transitional care to the community

Author (sub-analysis)	Number of primary studies	Study designs of primary studies	Population	Intervention	Control	Synthesis	Results*	Risk of Bias of review
Allen 2014 (GP and primary care nurse) (32)	2	2 RCTs	N= 1760, Chronic Illness, 60 years +, Avg 66	GP or primary care nurse involved in the discharge planning patient. In one study, the GP visited the patient in the hospital and had access to all the medical records. In the second study, the primary care nurse conducted the discharge assessment, provided education, and telephoned the patient following discharge.	Usual care	Narrative	↑ 1/2 study ↔1/2 study	High
Guerin 2013 (In-reach) (29)	2	1 RCTs, 1 Before/After	N = 2509, Chronic health condition, 65 years +	Studies engaged the community services in the discharge process by having them situated in the acute care sector to undertake assessment and develop a discharge plan.	Usual care	Narrative	↔ 2/2 studies	High
Lowthian 2015 (Not included in meta-analysis) (35)	4	2 RCTs, 1 Before/After, 1 Prospective cohort	N = 4386, Condition not specified, 65 years +	All primary studies evaluated a discharge planning intervention from the ED, but the interventions subcomponents varied across the studies, including referrals, geriatric assessment, and screening strategies to identify the individuals at higher risk for adverse events. Follow-up varied from 14 days to 18 months.	Usual care	Narrative	↓ 1/4 study ↑ 1/4 study ↔ 2/4 studies	Low

*↓ significant reduction in readmissions, ↑significant increase in readmissions, ↔ non-significant results

The third SR investigated transitional care interventions in comparison with traditional discharge protocols (32). From 1990 to May 2013, 12 RCTs were included in their narrative analysis, of which 11 had data on hospital admissions, and were divided into 5 categories based on the intervention and care provider : 1- discharge protocol & advanced practice nurse; 2- general practitioner (GP) and primary care nurse models; 3- self-management and transition coaching; 4- discharge case management; and 5- inpatient geriatric evaluation, co-management and transitional care. From these categories, only the GP and primary care nurse model focused on transitional care to the community without follow-up. Thus, the other categories will be discussed in later sections.

Two out of the 3 studies included in this model reviewed data on hospital admissions where the primary care nurse and GP were involved in the discharge planning. Pre-discharge visits by the GP could also take place. However, in 1 study, only 52% of patients had a visit from the GP in the intervention group, suggesting potential issues with the implementation of the intervention (43). The authors reported no significant difference in rate of readmissions. In the second study, veterans in the intervention group, which also included a phone call to remind of follow-up appointments, had a significantly higher rate of readmissions compared to the control group. The authors suggested that transitional care may be helping in early detection of health issues (32, 44).

4.1.4.2. Effect of interventions with discharge planning from hospital and follow-up performed by an unspecified health care professional

Overall

In the two meta-analyses included in this analysis, one (76 studies) reported a significant reduction in hospital readmissions (30) while the second (3 studies) reported no effect (35). There were also 3 SRs (29, 31, 37) with narrative analyses including 36 unique primary studies. Of these, 11 reported a significant reduction in readmissions in the intervention groups, 2 studies showed an increase in readmissions and the other 23 reported no significant differences between the two groups. While the results appear to converge towards a positive effect of follow-up interventions, the largest narrative (31) study and the largest meta-analysis (30) were rated to have a high risk of bias. For this reason, the level evidence for the effectiveness of follow-up interventions was graded as emerging.

Five SRs analyzed studies exploring discharge planning and follow-up. The latter was an added component to the intervention carried out with either the patient, the caregiver or the health care providers within the community post-discharge (Table 4). It was not specified who would perform the follow-up and whether this professional was involved in the discharge planning. The objective of this follow-up was to improve support in the community and to ensure proper execution of the discharge plan.

Table 4. Summary of systematic reviews including a discharge plan implemented by an unspecified health care professional

Author (sub-analysis)	Number of primary studies	Study designs of primary studies	Population	Intervention	Control	Synthesis	Results[#*]	Risk of Bias of review
Guerin 2013 (Virtual) (29)	5	4 RCTs, 1 NRCT	N = 2064, Chronic health condition, 65 yr.+	The hospital and the community service staff remained in their respective environments and communicated across the interface through phone or written communication (Fax, paper copy referrals). The hospital staff was responsible for developing the discharge plan and the community services were responsible for its implementation.	Usual care	Narrative	↓ 1/5 study ↔ 4/5 studies	High
Huntley 2013 (Not included in meta-analysis) (37)	3	3 RCTs	N = 1052, Condition not specified, 65 yr.+	Case management initiated at discharge.	Usual care	Narrative	↔ 3/3 studies	Unclear
Le Berre 2017 (30)	76	76 RCTs	N = 18828, At least one chronic disease, 65 yr.+	All of the interventions comprised all of the following elements: (1) coordination and continuity of care; (2) pre-arranged structured post-discharge follow-up (e.g., home visits, phone calls); (3) at least one follow-up starting within 30 days post-discharge.	Usual care	Meta-analysis	1 month RD -0.03 [-0.05, -0.00] 3 months RD -0.08 [-0.14, -0.03] 6 months RD -0.05 [-0.09,-0.00] 12 months RD -0.11 [-0.21, -0.01] 18 months RD -0.11 [-0.21, -0.01] Sub-analysis included in Appendix 7	High
Linertovà 2011 (Discharge planning) (31)	17	13 RCTs, 4 NRCTs	N=8628, Condition not specified,	Not well defined by authors. All studies included a geriatric assessment. Studies also included a ranged of interventions. Authors'	Usual care	Narrative	↓ 3/17 studies ↑ 1/17 study ↔ 13/17 studies	High

			but excluded studies focused on one illness, 75 yr.+	state 11 of the 17 studies included some kind of follow-up and 10 studies included a care plan elaborated by a care team.				
Linertovà 2011 (Home visits) (31)	15	13 RCTs, 2 NRCTs	N = 7701, Condition not specified, but excluded studies focused on one illness, 75 yr.+	All studies included a geriatric assessment and some kind of home care following discharge. Studies could also include home rehabilitation, care plan implementation after discharge, care services coordination and patient education.	Usual care	Narrative	↓ 7/15 studies ↑ 1/15 study ↔ 7/15 studies.	High
Lowthian 2015 (35)	3	2 RCTs, 1 Before/After	N = 3133, Condition not specified, 65 yr.+	All primary studies evaluated a discharge planning intervention from the ED, but the interventions subcomponents varied across the studies, including referrals, geriatric assessment, and screening strategies to identify the individuals at higher risk for adverse event. Follow-up varied from 14 days to 18 months.	Usual care	Meta-analysis	OR 0.90 [0.70, 1.16]	Low

[#] Narrative analysis of all systematic reviews included 36 unique studies, 11 of which were reported to have a reduction in the incidence of readmission, while another 2 studies were reported to have an increase in the incidence of readmission.

*↓ significant reduction in readmissions, ↑significant increase in readmissions, ↔ non-significant results

Le Berre *et al.* investigated the effect of transitional care and follow-up intervention post-discharge (30). Seventy-six RCTs investigating transitional care with follow-up and reporting all-cause readmissions were identified from the literature search, which ranged from 1995 to 2015. Meta-analyses calculating risk differences (RDs) found significant decreases at 1 month (11 studies, 95 % CI -0.05, -0.00), 3 months (18 studies, RD -0.08, 95 % CI -0.14, -0.03), 6 months (35 studies, RD -0.05, 95 % CI -0.09, -0.00), 12 months (18 studies, RD -0.11, 95 % CI -0.17, -0.05), and at 18 months (5 studies, RD -0.11, 95 % CI -0.21, -0.01). Aside from the 1 month analysis, the heterogeneity of the analyses were evaluated to be either substantial (i^2: 50-90) or considerable (i^2: 75-100). Moreover, following sensitivity analysis and after the proration, results were similar although the significance at 18 months was lost.

Sub-group analyses by Le Berre *et al*. identified several components of the interventions which may positively affect the outcome, including having an education component to the intervention (significant reduction in RDs at 3, 12, and 18 months), home visits (3, 6, and 12 months), follow up initiated within 1 week of discharge (3 and 12 months), medication reconciliation (3 and 12 months), and nurse-led interventions (6 and 12 months) (30). There was also a reduction in RDs for 24-hour phone availability at 12 and 18 months, as well as the involvement of a pharmacist at 12 months. The low number of studies included (4, 3 and 1 studies respectively) in the analyses for these components should, however, be taken into consideration (for more details, see Appendix 8). No significant effect at any time point was measured for phone follow-up and telemonitoring (30). It should be noted that the SR by Le Berre *et al.* was evaluated to have a high risk of bias, which was due to: the inconsistencies with the results found in one primary study (45) and with the data included in the meta-analysis, the interpretation of the results with regards to the statistical significance of their analyses, and the inclusion of a non-RCT in the analysis (46). These inconsistencies may have affected the synthesis and the findings of the meta-analysis and should be taken into consideration.

A second meta-analysis was conducted on 2 RCTs following discharge from the ED (35). The authors reported a non-significant difference in hospital admissions 1 month following ED discharge (OR 0.89, 95% CI 0.65-1.21), and a similar result was observed in a secondary meta-analysis including both RCTs and a before-and-after trial (OR 0.9, 95% 0.7-1.16) (40, 47, 48). The authors highlight the lack of high quality data needed in order to make definitive conclusions on the efficacy of the interventions (35).

Three SRs conducted narrative analyses of the literature. In the first review, Linertovà *et al.* (31) investigated the effectiveness of geriatric assessment during discharge planning in 32 studies. The authors separated the primary studies based on whether a home follow-up was performed or not after the discharge planning. The authors reported that only 3 out of 17 studies without a home visit had significant reductions in readmissions, 1 study had an increase in readmissions, while the other 13 reported non significant differences between the 2 groups. It should be pointed out that, although the authors report in their results section that 11 studies had conducted a follow-up, only 9 studies were actually referenced. One of those studies found a significant reduction in readmissions at 1 but not 2 months following discharge (49), while another found a significant increase (50). The authors note that the increase in readmissions was only observed when the intervention was compared to an external control group (31).

Linertovà *et al.* (31) also identified 15 separate studies which implemented at least one home visit in the discharge plan. In addition to the home visits, other components could be added, such as: a post-discharge care plan, home rehabilitation, cooperation with patient's GP, phone calls, coordination of post-discharge care services, or patient education (31). Seven of these 15 studies reported a reduction in the readmission rate, 1 RCT observed an increase in readmission rate, while the other 7 studies reported non-significant differences between the intervention and the control groups.

In Guerin *et al.*'s Virtual model (29), 5 studies investigated interventions in which the hospital staff was responsible for undertaking discharge assessment, developing the discharge plan, and referring to a variety of community services using phone or written communication. The community services were also responsible for implementing the discharge plan. It should be noted that, the hospital staff performed a post-discharge follow-up in only 3 out of the 5 studies. The results of this model were mixed, as 1 out of the 5 studies showed a significant decrease in hospital readmissions, while the others didn't report any significant differences in readmission rate.

Huntley *et al.* (37) also reported on the effectiveness of case management initiated either during the hospital stay or on discharge. The 3 studies which implemented case management on discharge were included in a narrative analysis, which did not show a significant reduction of readmissions.

4.1.4.3. Effect of interventions with discharge planning from hospital and follow-up performed by the same health care professional

Overall

Five SRs, 2 narratives (29, 32) and 3 meta-analyses (34, 36, 37), were included in this category. The two narrative SRs included 15 unique primary studies. A reduction, an increase, and no significant difference were reported in 9, 1, and 5 of these primary studies respectively. There were 2 meta-analyses (34, 36) – with a low risk of bias — reporting a reduction in readmissions, with a third meta-analysis (37) — with an unclear risk of bias — showing a non-significant decrease in readmission. Taking these results together, the level of evidence for the effectiveness of follow-ups performed by the same health care professional involved in the discharge planning is established to be effective.

Five SRs reviewed studies exploring discharge planning and follow-up performed by the same health care professional (Table 5). The objective of this follow-up was to improve patient support in the community and to ensure proper execution of the discharge plan. The main elements of an organized follow-up identified in these SRs were phone calls, the plan or services coordination in the community, and home visits. From admission, the health care professional was involved in the evaluation of the patient, the planning of the discharge from the hospital, the transition of the patient from the hospital back home by organizing community services, and the follow-up to ensure proper implementation of the plan.

Table 5. Summary of systematic reviews including a discharge plan implemented by a professional involved in the planning

Author (sub-analysis)	Number of primary studies	Study designs of primary studies	Population	Intervention	Control	Synthesis	Results[#&]	ROB of review
Allen 2014 (Advanced practice nurse) (32)	4	4 RCTs	N = 841, Chronic illness, 70 yr.+	Advanced practice nurse was responsible for the patient's assessment, discharge planning in collaboration with other health care providers, patient education, and ensuring continuity of care.	Usual care	Narrative	↓ 4/5 studies ↔ 1/5 study	High
Allen 2014 (Case management) (32)	1	1 RCT	N = 598, Chronic illness, avg 76 yr.	Short term case management and provision of post-acute care services (in-home) nursing, allied health, community support	Usual care	Narrative	↔ 1/1	High
Allen 2014 (Coaching) (32)	1	1 RCT	N = 747, Chronic illness, avg 76 yr.	Care Transitions Intervention as defined in Coleman *et al.* 2004 (51)	Usual care	Narrative	↓ 1/1 study	High
Allen 2014 (Geriatric assessment) (32)	2	2 RCTs	N = 858, Chronic illness, 75 yr.+,	In the first study, geriatric evaluation and management team supported the inpatient discharge planning and follow-up at home, while in the second, the geriatrician delivered inpatient intervention, medication review, education, communication, and screening for main risks and frail elderly depression.	Usual care	Narrative	↓ 2/2 studies	High
Bryant-Lukosius 2015 (36)	4	4 RCTs	N = 759, Condition not specified, 75 yr.+	All studies were led by an advanced practice nurse. Studies included discharge planning, care coordination, and patient education. Other frequent intervention components were medication review, referral to other providers, and self-care teaching.	Usual care	Meta-analysis	1-2 weeks RR 0.38 [0.19, 0.77] 6-8 weeks RR 0.63 [0.41, 0.95] 12-24 weeks RR 0.59 [0.47, 0.95]	Low
Gonçalves-Bradley 2016	15	15 RCTs	N = 4743*, Medical	Defined discharge planning as the development of an individualised	Usual care	Meta-analysis	Within 3 months RR 0.87 [0.79,	Low

(Meta-analysis) (34)			condition, 18 yr.+, avg 68 yr.	discharge plan prior to the patient leaving the hospital. Divided the process according to steps identified by Marks (52): • pre-admission assessment • case finding on admission • inpatient assessment, preparation of an individualized discharge plan • implementation of the discharge plan • monitoring Studies were excluded if they did not include an assessment or implementation phase			0.97]	
Gonçalves-Bradley 2016 (Not included in meta-analysis) (34)	3	3 RCTs	N = 2599, Medical and surgical condition, 18 yr.+, avg 67 yr.		Usual care	Narrative	↓ 1/3 study ↑ 1/3 study ↔ 1/3 study	Low
Guerin 2013 (independent Interface) (29)	2	1 RCT, 1 Before/ After	N = 895, Chronic health condition 65 yr.+	Health care professionals working across the hospital-community interface facilitated the discharge plan of adults from the hospital to the community and provided home visits once the person returned to the community	Usual care	Narrative	↓ 1/2 study ↔ 1/2 study	High
Guerin 2013 (Out-reach) (29)	2	1 NRCT 1 Before/ After	N = 646 Chronic health condition 65 yr.+	Interventions where hospital staff crossed the hospital community interface into the community to implement certain aspects of the discharge plan. The hospital staff liaised with community services. Responsibilities included assessing the patient, developing the discharge plan and implementing aspects of the plan	Usual care	Narrative	↓ 1/2 study ↔ 1/2 study	High
Huntley 2013 (Meta-analysis) (37)	3	3 RCTs	N = 1647, Condition not specified, 65+	Case management initiated in hospital or at discharge. Visits were included in the intervention	Usual care	Meta-analysis	Relative rate 0.71 [0.49, 1.03]	Unclear

*Number included in the meta-analysis

[#] Narrative analysis of all systematic reviews included 15 unique studies, 9 of which were reported to have a reduction in the incidence of readmission, while another study was reported to have an increase in the incidence of readmission

[&] ↓ significant reduction in readmissions, ↑significant increase in readmissions, ↔ non-significant results

In the first SR, Gonçalves -Bradley *et al.* (34) evaluated RCTs with individualized discharge planning from the hospital. A search of the literature published up to 2015 found 30 trials, of which 18 focused on the readmissions rate. While the inclusion criteria were not restricted to a geriatric population, the average age of the patients included in this analysis was over 65. Between individual RCTs, there was a wide range of health care providers responsible for the implementation of the intervention, including: discharge coordinator, geriatrician, nurse, and pharmacist. The meta-analysis of 15 studies found a significant reduction in readmission rate among the intervention group at a 3-month follow-up compared to standard care (RR 0.87, 95% CI 0.79-0.97). While the SR focused on individualized discharge plans, 13 of the studies had the same health care professional providing continuity of care which could include phone calls, home visits, and coordination of services. In the 3 additional studies not included in the meta-analysis, 1 study showed a significant reduction at a 4-week follow-up, while the other 2 showed no significant differences at a 6- and a 12-month follow-up.

Similar results were obtained in a second meta-analysis published by Bryant-Lukosius *et al.* (36) on the efficacy of clinical nurse specialist-led transitional care. In their literature search ranging from 1980 to 2013, they found 4 articles in which the efficacy of post-discharge care interventions on readmission rate for elderly patients was investigated. In these studies, assessment and coordination of services were performed by a master's degree-trained nurse, who maintained communication with the patient following discharge to evaluate the implementation of the plan and ensure a continuity of care. A meta-analysis of 3 studies found a reduction in readmission rate at 12 and 24 weeks (RR 0.59, 95 % CI 0.47-0.75) (53-55). Similar results were obtained in 2 other meta-analyses at earlier time points (Table 5). Huntley *et al.* (37) also performed a meta-analysis on the effectiveness of case management initiated either in hospital or on discharge, pooling 3 studies included in 2 meta-analyses previously reported (30, 35). While the relative rate of readmissions was decreased, similar to the results observed by Gonçalves-Bradley *et al.* (34) and Bryant-Lukosius *et al.* (36), the results did not reach significance (Relative rate 0.71, 95% CI 0.49-1.03). It should be noted that in the study by Nikolaus *et al.* (56) (29.9% weight of the meta-analysis), the clinicians in both the control group and the intervention group received extra training and performed complete geriatric assessment. The authors of the systematic review argue that this may have affected the final outcome of the study towards null results (37). The results above are in agreement with a narrative sub-analysis on advanced practiced nurse-led interventions published in a third SR (32). Along with the 3 studies included in the meta-analysis by Bryant-Lukosius *et al.* (36), Allen *et al.* (32) reported readmission rates in 2 other studies (57, 58). Out of 5 studies in which readmission rates following discharge planning led by advanced practice nurses were evaluated, the authors found a reduction in re-hospitalization rates in 4 studies, and no difference in re-hospitalization rate at 6 months in the 5th RCT (58). It should be noted that, although mentioned otherwise in the SR by Allen *et al.* (32), the reduction of readmission rate reported by Naylor *et al.* (57) was statistically *non-significant*. However, the latter also reported a statistically significant reduction in the total number of readmissions (57).

Allen *et al.* (32) also described three other models based on the health care professional providing the care. The first model involved self-management and transitional coaching. While the main objective of this model was to empower the patient to manage his own medical record and follow-up, the transitional coach provided pre-discharge patient education, post-discharge follow-up, and home visits. In this model, the intervention group had significantly lower rates of readmissions at 30, 90 and 180 days after discharge. In the second model, the involvement of a case manager was investigated by Lim *et al.* (59) in comparison to usual

hospital discharge plan and follow-up. No significant difference was reported in this study between the intervention and the usual care group. Finally, the last model described two RCTs (60, 61) in which geriatricians were responsible for the assessment and the transitional care. In Hansen *et al.* (61), the geriatric assessment and management team supported the discharge planning and carried out the follow-up by providing home visits up to 16 weeks post-discharge, coordination with the primary care team, and re-evaluation of the plan if needed. In this RCT, the readmission rate at 6 months was significantly reduced in the intervention group. Similarly, the intervention by Legrain *et al.* (60), which included education for self-management of the disease, communication with the GP and follow-up by a geriatrician, resulted in a significant decrease in the readmission rate at 3 months in the intervention group. However, no significant difference was observed at 6 months.

Finally, Guerin *et al.* (29), as discussed above, conducted a SR investigating the methods of community involvement in an older patient's discharge from the hospital to the community. Two out of the 4 models included a follow-up by a professional involved in the assessment and the discharge planning: *Out-reach* Interface and the Independent Interface models.

In the *Out-reach* model**,** the home visits were provided by the same nurse or social worker (hospital-based) who evaluated the patient and undertook the discharge planning, the transition of the patient, and the coordination of services in the community (29). The visits were carried out within the first 72 hours post-discharge and the main purposes of these visits were to re-evaluate the discharge plan and medications, confirm the community services arranged prior to discharge had commenced, identify other needs of the patients and family, as well as generate referrals to meet those needs. Watkins *et al.* (62) reported a decreased readmission rate, although no statistics were reported, while Siu *et al.* (63) reported no significant difference.

In the two studies included in Guerin's *Independent interface model***,** independent nurses working across the hospital-community interface liaised between the community and the hospital staff (29). The nurses assessed the patients, facilitated the communication between the hospital and the community health care providers, coordinated the needed services and provided home visits within the first 48 hours for Naylor *et al.* (54) and 3 weeks for Ornstein *et al* (64). One study reported significant decrease in readmission (54) while the other didn't report any significant difference between the intervention and the control group (64).

4.1.4.4. Effect of interventions of transitional care from skilled nursing facilities to home

In one SR identified, the evidence for efficacy of transitional care from skilled nursing facilities on clinical outcomes was evaluated (33).Toles *et al*. (33) identified 6 eligible studies from January 1st 2000 to September 2015 based on their inclusion criteria. In the included studies, different combinations of pre, post, and bridging interventions were tested. At 30 days post-discharge, a reduction in re-hospitalization rates was reported in 2 studies (65, 66), while no significant changes were reported in 3 studies (67-69). Finally, at 60 days post-discharge no significant difference of transitional care was found in one study (70). The authors state that there was considerable heterogeneity and that the risk of bias was high across the 6 studies reviewed. They suggest that there is promising but limited evidence for efficacy of transitional care from skilled nursing facilities. They

identified a need for further studies and suggest that there is not enough evidence currently available to make recommendations on the use of transitional care from skilled nursing facilities

4.2. Contextual and experimental data

4.2.1. Liaison nurse at the Lakeshore General Hospital

The liaison nurse (*infirmière de liaison*) works as the link between the hospital and the community. Once the patient arrives at Lakeshore General Hospital, the liaison nurse works with the hospital team in order to identify the services needed after discharge and contacts either:

1- The Hospital-based case navigator *(l'intervenant réseau) :* If the case is complex and the patient is not yet receiving services from the Local Community Service Centres (CLSC)
2- The CLSC-based case navigator *(l'intervenant pivot):* if the case is complex and the patient is already receiving services from the CLSC.

In all cases, the liaison nurse's request for community services is done through an inter-establishments services request (DSIE : *Demande de services interétablissements*) at a single-window access point (*guichet d'accès pour personnes en perte d'autonomie)*. This is typically done 24- 48h prior to discharge. Once the request has been accepted, the Hospital- or the CLSC-based case navigators can put in place the services that the patient requires. Prior to discharge, the liaison nurse can be involved in patient education depending on the services which have been requested. Once the patient is discharged, the liaison nurse typically does not follow up with the patient, unless complications are anticipated prior to discharge, in which case changes to the DSIE can be requested.

4.2.2. Home support services

In Quebec, home support services (*soutien à domicile*) target people losing their autonomy with physical or mental impairment to empower them to reach their abilities while staying at home. The objective of these services is inspired by the homecare support policy: "*Chez soi le premier choix*" (71).

A variety of health care professionals offer such services, such as: nursing care, respiratory therapy, basic and specialised rehabilitation services, psychological care, nutrition services, and others. It was highlighted that there is a difficulty in retaining medical staff, rendering home medical services inconsistent within the network. This has the potential to lead to readmissions if relatively small medical home interventions are not treated in a timely fashion.

Other types of services are provided as well, like food delivery, cleaning services, support for caregivers, and technical support.

At the Lakeshore General Hospital, the hospitalized elderly patients are evaluated using the PRISMA 7 tool, which is used to identify older adults with moderate to severe disabilities. When a complex case is identified, and the patient is already receiving services from the CLSC, his CLSC-based case navigator is contacted and he/she is encouraged to attend the discharge planning .This is not always possible as the case navigator may

not always be available due to circumstances such as being on the road with other cases or on vacation. This has been raised as an issue for potential breakdown in communication between the hospital and the community.

If a patient with complex needs is not receiving services from the CLSC, he is referred to the hospital-based case navigator, a nurse clinician working for the home support services (*Soutien à domicile*, SAD). The hospital-based case navigator is in charge of coordinating the community services prior to discharge, and following up with the patient after discharge. This follow-up can last a few months until the patient is assigned to a CLSC-based case navigator, who will assume the responsibility henceforward. During the interviews, it was suggested that while complex cases are well followed, non-complex cases of patients not receiving services from the CLSC may suffer from complications as they are less likely to receive intensive follow-ups post-discharge.

4.2.3. Case manager

Patients with the most complex needs, which make up approximately 3% of the health care users, require more intense care coordination due to the higher risk of disruption of services in this population. This is in large part due to changes in the patients' physical, psychological or cognitive health as well as of their psychosocial environment.

Recently, the *Direction des orientations des services aux aînés* of the Ministry of Health and Social Services established a role of a case manager to coordinate the services for this at-risk population (72). They describe the role of the case manager as: "an expert health care provider who attends to customers living with recurrent disruption of services or at high risk of long periods of disruption"[1] (72).

The tasks of the case manager related to transitional care described in the ministerial orientation document include:

- Taking note of the relevant patient information in order to plan the discharge for a return home
- Updating the evaluation of the patient's needs (if necessary)
- Organising the services for the return home
- Insuring the services and the necessary assistance are in place if the patient is relocating, making sure to see to the patient as well as their care givers' choices.

According to the experiential data collected from the CIUSSS-ODIM during the summer of 2017, although this role exists, it is not implemented yet in its full capacity.

4.2.4. Contextual data in other CIUSSSs

Contextual data was also collected in other CIUSSSs in order to get an understanding of what had been and/or is being done elsewhere in the city of Montreal. Two pilot projects focusing on discharge planning have been evaluated in recent years.

The first project was based in Charles-Le Moyne Hospital, in the Centre de santé et services sociaux (CSSS) Champlain—Charles- Le Moyne, now in the CISSS de la Montérégie-Centre. In this project, 3 nursing advisors (*conseillères en soins infirmiers*) from the Nursing Directorate were reassigned from their usual activities in order

[1] Unofficial transaltaion from the preamble.

to manage the duration of hospital stay and discharge planning alongside the department heads. In order to follow the patient from admission to discharge, they developed computer-based tools which were facilitated diagnostics, the discharge planning, and tracing whether the patient was already receiving services from the CLSC.

The goals of the project were:

- to ensure that every department head was aware of the patients found within their units and ensure the next steps in patient care were known
- encourage early discharge if the health care services could be provided outside the hospital
- To ensure that the SAD is made aware of every new patient and that a first visit would be performed within 72 hours of discharge.

Previously, DSIE were only filed 48 hours prior to patient discharge. However, in this project, if the patient was already receiving services from the SAD, his/her CLSC-based case navigator could be contacted as soon as possible to attend interdisciplinary team meetings to plan the patient's discharge. Once the patient was discharged, the discharge plan would be faxed to the patient's family physician. No follow-up, however, was performed by the nursing advisor. The project appeared to be successful at reducing emergency department admissions, while having no effect on hospital readmissions. Only anecdotal results, however, were available for this project.

The second project is currently taking place in the CIUSSS de l'Est-de-l'Île-de-Montréal. The Maillage Project, which began Phase 3 in the fall 2017, aims to alleviate the emergency departments by identifying complex and frequent health care service users, as defined by having had 5 hospital visits in the past 6 months. In Phase 1, which took place from 2012-2015, a dedicated professional in each of the CSSS, normally a nurse, was responsible for taking charge of complex cases and coordinating services. Phase 2, which took place from 2015-2016, expanded on Phase 1, increasing the number of professionals available to 6, based out of the CLSC of Olivier-Guimond, in order to have a more systemic effect within the CIUSSS. A dedicated mental health professional was also introduced as a large proportion of the complex clientele had mental health problems. A database was generated in order to instantly identify complex users in a standardised and systematic manner. Over a 14-month period, 500 complex users were identified and appropriate services were coordinated in order to ensure appropriate medical care. The nurse from the Maillage team, working with the hospital staff in charge of the case, implemented the home services required by the patient once discharged. An intense follow-up was put in place, which included patient education and accompaniment to his/her appointments. A 44% decrease in emergency department visits and a 32% reduction in hospital admissions were observed over that time period at Maisonneuve-Rosemont Hospital. This was accompanied with a 107% increase in the use of the CLSC services, which were mainly nursing services and home visits. Building on the success of Phase 2, Phase 3 is currently investigating the efficacy of the Maillage team implemented within the ED for an early discharge, and was launched at the end of 2017.

4.2.5. Patient-Oriented Discharge Summary

During the elaboration of the recommendations, members brought the Patient-Oriented Discharge Summary (PODS) discharge tool to the committee's attention. This tool designed with the help of patients and

caregivers, was proposed by Open Lab with the support of the Toronto Central Local Health Integration Network. It focuses on 5 key areas of the patient's discharge including: medication instruction, potential changes in health status and what to do, lifestyles changes, upcoming appointments and where to go for information. In a multisite pilot study across 8 Toronto-based hospitals, a 9.3% to 19.4% improvement in patient experience for the five areas was observed following the PODS implementation.

5. DISCUSSION

The overall objective of this umbrella review was to investigate the effectiveness of discharge planning and transitional care interventions in reducing the readmission rate for the elderly. In this analysis, the SRs and their sub-analyses were categorized into 3 types of interventions based on follow-up performed after the patient's discharge: 1) discharge planning and transitional care without follow-up, 2) discharge planning and transitional care with follow-up performed by one or several health care providers, and 3) discharge planning and transitional care with a follow-up performed by a health care professional involved in the discharge planning (Figure 2).

The main findings of this report show that, while transitional care without patient follow-up after hospital discharge was ineffective in reducing readmissions, promising results were observed if a follow-up was included in the intervention. Moreover, interventions where the same health care professional assisted in the discharge planning and ensured a better continuity of care in the community, through follow-ups and home visits, were proven efficient. These effects, however, were reasonably small. For example, in the largest meta-analysis among those with low risk of bias included in this report, the relative risk reduction was 13% (34).

In the sub-analyses identified in one of the meta-analysis (30), 5 key components of transitional care were found to possibly increase the efficacy of the intervention, including : 1) starting the follow-up within one week upon discharge from the hospital, 2) involvement of a nurse, 3) patient education, 4) including home visits in the follow-up, and 5) medication evaluation. These results are in line with results reported in other SRs included in this report. Similar to results reported by Le Berre *et al.*(30), a meta-analysis on the effectiveness of advanced practice nurse-led interventions, which included a patient education component, found a significant reduction in readmissions (36). Similarly, most of the studies included in the meta-analysis by Gonçalves-Bradley *et al.* (34) included an educational component, while other narrative analyses suggested the efficacy of both home visits and patient education (31, 32, 34).

It should be noted that it is not possible from this analysis to determine the incremental efficacy of each component as they are found in combinations in a large proportion of the primary studies. It has been suggested, however, that greater efficacy is observed when the interventions are comprehensive, including a greater number of activities with the integration of multiple services in order to develop a personalised discharge plan, while providing patient education and ensuring continuity of care after discharge (34, 73).

The results in this report are in line with other umbrella reviews published in recent years on differing types of populations and interventions. Common themes in successful interventions emerging from these

umbrella reviews included multifactorial and bridging interventions, which spanned across the hospital-community interface (74, 75).

Multiple guidelines and reports have elaborated recommendations for successful transitional care. While these reports did not focus on the elderly population, similar conclusions as the ones reported in this review were reached. As part of a series of reports to reduce avoidable hospitalizations, Health Quality Ontario concluded that there is moderate quality evidence for the efficacy of discharge planning, and low quality evidence that a post-discharge continuity of care and patient support is effective at reducing readmissions (8). Similarly, the Registered Nurses' Association of Ontario elaborated a vast range of recommendations ranging from proper assessment of, collaboration between patient and health care professional to develop an individualised discharge plan suited to the patient's needs, ensuring the proper implementation of the plan and the continuity of care (76). Along the same line, the guideline *Transition between inpatient hospital settings and community or care home setting for adults with social care* recommends, among others: elaborating a discharge plan from the time of admission, ensuring clear communication between team and patient, having a case coordinator as central point of communication, ensuring continuity of care for at-risk patients, and implementing a follow up within 72 hours for patients at-risk of readmission (77). Several reports (78, 79) have identified numerous transitional care programs with varying degrees of efficacy, including the Transitional Care Model (53-55, 57), the Care Transitions Intervention (80), and the Re-Engineered Discharge program. This analysis, however, was not designed to compare the efficacy of these varying programs.

Ministerial orientations in Quebec highlight that a return home from hospital should be considered the first option for the patient, and recognize that the transition home is a critical moment in the process (71). Key components of transitional care have been identified, including: identification of at-risk patients, an evaluation and discharge plan initiated at admission and adapted for the patient's needs, the inclusion of a case coordinator, the involvement and education of the patient, rapid support and follow-up once the patient is discharged and medication reconciliation (71). These components are implemented in different capacities by different players across the province, as seen in the experiential data collected in this analysis. Among surveyed clinicians across the province, however, there is an agreement that, ideally a professional from SAD, should be involved in the discharge planning (81).

In this report, the effectiveness of the interventions was based on the reduction of readmission rates. The included SRs, however, reported other parameters such as ED visits, mortality, quality of life scores, institutionalisations as well as patient and health care staff satisfaction. It is possible that different results would have been observed with the use of some of these parameters.

Several limitations to this review need to be considered when interpreting these results. First, more than half (56%) of the SRs included in this analysis were considered to be at high or unclear risk of bias, with issues arising in the selection (31, 32), reporting (29, 30, 32), and synthesis process (30). While some of these factors were taken into consideration and pointed out in the result section, it is possible that not all issues were identified, as primary articles were not investigated in a systematic fashion. For example, a meta-analysis (30) analysed in this report had inconsistencies between the data included and one of the original article (45). While removal of this data would unlikely change the outcome of the meta-analysis due to the study's small weight

(8.5% at 6 months and 3.8% at 12 months), it was not confirmed whether other inconsistencies were introduced in the meta-analysis. Therefore, this reduces the strength of the evidence.

Other limitations of this report are related to the use of the umbrella review design. This umbrella review includes 133 primary studies cited 171 times in 9 SRs. The study by Naylor *et al.* in 1999 (54), is found in 6 of the 9 SRs, including 3 meta-analysis in this report (30, 36, 37). Another study by Lim *et al*. (59) is found in 5 SRs including one meta-analysis. A study could be cited multiple times across our three types of interventions of this umbrella review. When possible, this overlap was addressed in the results section. However, it was not possible to separate overlapping studies when they were included in meta-analyses classified in two different categories.

Furthermore, while the SRs were categorized within 3 types of interventions, not all the primary studies fit within this classification. For example, in the 8 primary studies from sub-analyses in the 3 SRs that were classified in the "no follow up" category, 3 of those studies (41, 44, 82) included some kind of follow. In order not to break the sub-analysis, the 8 primary papers were classified together. Similarly, only 12 of the 15 studies in the meta-analysis by Gonçalves-Bradley *et al.* (34) included a follow-up by a health care professional involved in the discharge plan, and as the meta-analysis could not be broken up, it was classified as such. This should be taken into consideration, as this overlap may alter the interpretation of the results. Moreover, the interventions of the primary studies were poorly described. For example, the intervention for the control group was often referred to as "usual care". This lack of details made it difficult to appropriately classify the studies.

In the few instances where the interventions for the control group were described, the activities included at baseline varied greatly between studies. The usual care sometimes included follow-ups (83), and in other studies, health care professionals in the control groups received similar training to the ones in the study group (56). These differences in interventions included in the control groups could explain the significant reduction in readmission rates observed in some trials compared to others where no effects were observed.

Heterogeneity was a big factor across the studies surveyed. The interventions included in the SRs varied greatly in terms of the diversity of the health care professionals involved, types and components of interventions, follow-up intervals, and types of patients included. The primary studies within the narrative reviews were classified based on only one of these factors, making it difficult to identify which components of the interventions demonstrated efficacy. In meta-analyses, heterogeneity was ranked as substantial or considerable in 2 reviews (30, 37). While it was sometimes addressed by performing sensitivity analysis (30) and using random-effect models, it was a considerable limitation of these reviews.

Finally, there are limitations on the generalizability of the data. Little data was available for the Canadian population. Only 5 of the 133 clinical trials included in the SRs were conducted in Canada. However, Australia (19 studies), the UK (15 studies) and New Zealand (2 studies) have similar health care system, and combined with the studies from Canada make up 32% of all included studies.

6. RECOMMENDATIONS

In the light of the scientific results combined with the contextual and experiential data gathered, the UTEMIS-SS recommends the following to the CIUSSS-ODIM :

1- To integrate discharge planning focused on the continuity of service and care in the community, following hospital discharge, in order to maintain the support offered to the users and their caregivers.

2- To start the discharge planning upon the users' arrival to the hospital.
   a. That the users and their caregivers' education, focused on their discharge plan (information) and their medical status (self-management), be included during the discharge planning and the follow-up, in order to maintain their health and wellbeing.
   b. That this education be offered by a trained health care provider using simple and clear educational tools.
   c. That the users and caregivers' understanding of the discharge plan be validated by the health care provider (What did you understand?)
   d. That the discharge planning and the follow-up include medication reconciliation.

3- To document the discharge plan in order to facilitate the users' education, its transmission to the treating physician(s) as well as its implementation after discharge.
   a. That the discharge plan document should be brief, understandable and accessible to the users and their health care providers. This patient-centered document will enhance the users and their caregivers' education, and facilitate information transfer —from the hospital to the CLSC, the treating physician(s) and the community pharmacist— as well as the implementation of the plan after the hospital discharge.

4- To deploy *discharge planning with follow-up* for the elderly users and their caregivers, including the following:
   a. That this follow-up be implemented by a health care professional who had a major role in the discharge planning.

5- To consider starting the follow-up within 7 days of the users' discharge from the hospital.

6- To consider optimising the use of communication tools in order to improve the transmission of information between the hospital, the CLSC, the treating physician(s), and the community pharmacist.

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Appendix 1: Search Strategy

A1.1 Medline strategy

Database	**MEDLINE** Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present
Interface	Ovid
Date searched	20th of April 2017
Syntax : Fields and operators	
ti	*Title* field
ab	*Abstract* field
/	Subject heading from the *Medical Subject headings* excluding its narrower terms in the hierarchy (not exploded)
Exp …/	Subject heading from the *Medical Subject headings* including its narrower terms in the hierarchy
Boolean operators	AND, OR, NOT
Adj(n)	Defined adjacency, within *n* words from each other, in either direction
Adj	Adjacency
*	Truncation
"…"	Literal string
Limits or filters	
Year of publication	2011-Current (April 2017)
Languages	English, French
Strategy (hits)	
1 exp Aged/ (2742505) 2 (elder* or geriatric* or aging or ageing or older or senior* or frailty).ti,ab. (698357) 3 1 or 2 (3095447) 4 exp Hospitalization/ (197610) 5 exp Emergency Service, Hospital/ (62184) 6 (readmission* or admission* or hospitali* or rehospitali* or emergency or ED).ti,ab. (551513) 7 4 or 5 or 6 (665264) 8 exp Community Health Services/ (278647) 9 exp Mental Health Services/ (87997) 10 (community-based or (community adj based)).ti,ab. (48128) 11 (community adj3 services).ti,ab. (9573) 12 (community-dwelling or (community adj dwelling)).ti,ab. (17253) 13 (community adj care).ti,ab. (3932) 14 exp Home Care Services/ (44698) 15 homecare.ti,ab. (891) 16 (Home adj2 care).ti,ab. (22821)	

17 (home adj2 support).ti,ab. (1219)
18 (home adj2 visit*).ti,ab. (8193)
19 Home-based.ti,ab. (7659)
20 Homebound.ti,ab. (844)
21 Assisted Living Facilities/ (1147)
22 Homes for the Aged/ (12640)
23 Nursing Homes/ (31835)
24 ltc.ti,ab. (3073)
25 long-term care.ti,ab. (17398)
26 ((home or homes) adj2 (aged or elderly or senior or old or nursing)).ti,ab. (30111)
27 (facilit* adj2 (nursing or care or geriatric or elderly)).ti,ab. (24873)
28 (assisted adj living).ti,ab. (1762)
29 exp Primary Health Care/ (131530)
30 exp Ambulatory Care/ (49778)
31 exp "Continuity of Patient Care"/ (209593)
32 (primary adj healthcare).ti,ab. (3797)
33 (primary adj care).ti,ab. (92814)
34 (primary adj health).ti,ab. (20556)
35 (family adj physician*).ti,ab. (13114)
36 (general adj practi*).ti,ab. (72418)
37 (family adj practi*).ti,ab. (9455)
38 Outpatient*.ti,ab. (140231)
39 Ambulatory.ti,ab. (69787)
40 (integrated adj care).ti,ab. (2818)
41 exp Health Services for the Aged/ (16720)
42 exp Patient Care/ (837606)
43 exp Delivery of Health Care/ (947094)
44 exp Telemedicine/ (21506)
45 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 (2128956)
46 Meta-Analysis/ (79154)
47 Technology Assessment, Biomedical/ (9037)
48 "Synthesis of reviews".ti,ab. (39)
49 "overview* of reviews".ti,ab. (130)
50 review* of reviews.ti,ab. (649)
51 (umbrella adj review*).ti,ab. (90)
52 technology assessment*.ti,ab. (5140)
53 HTA.ti,ab. (2201)
54 HTAs.ti,ab. (225)
55 (meta adj analy*).ti,ab. (112611)
56 metaanaly*.ti,ab. (1783)
57 meta-analysis.pt. (79154)
58 meta-synthes*.ti,ab. (556)
59 (systematic adj3 (review* or overview*)).ti,ab. (108365)
60 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 (209008)
61 Comment/ (689017)

62 Editorial/ (436801)
63 Letter/ (968318)
64 61 or 62 or 63 (1577598)
65 60 not 64 (201761)
66 Homebound Persons/ (561)
67 Skilled Nursing Facilities/ (3924)
68 7 or 45 or 66 or 67 (2498407)
69 3 and 65 and 68 (6366)
70 limit 69 to yr="2011 -Current" (3799)
71 limit 70 to (english or french) (3672)

A1.2 CINAHL strategy

Database	**CINAHL Complete**
Interface	Ebsco
Date searched	24th of April 2017
Syntax : Fields and operators	
TI	*Title* field
AB	*Abstract* field
(MH "…")	CINAHL subject heading excluding its narrower terms in the hierarchy (not exploded)
(MH "…"+)	CINAHL subject heading including its narrower terms in the hierarchy
Boolean operators	AND, OR, NOT
Nn	Defined adjacency, within *n* words from each other, in either direction
*	Optional and unlimited truncation
"…"	Literal string
Limits or filters	
Year of publication	2011-Current (April 2017)
Languages	English, French
Strategy	

Set	Search	Hits
S80	Limiters for S79 - Language: English, French	2,090
S79	Limiters for S78 - Published Date: 20110101-20170431	2,202
S78	S71 AND S76 AND S77	3,466
S77	S75 NOT S32	100,221
S76	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S70	1,232,378
S75	S27 OR S28 OR S29 OR S30 OR S31 OR S65 OR S66 OR S67 OR S68 OR S69 OR S72 OR S73 OR S74	103,147
S74	TI "review" of reviews" OR AB "review" of reviews"	2,458
S73	TI "overview* of review*" OR AB "overview* of review*"	73
S72	TI "synthesis of review*" OR AB "synthesis of review*"	132

S71	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S33 OR S34	693,796
S70	(MH "Skilled Nursing Facilities")	2,740
S69	TI (systematic N3 (review* OR overview*)) OR AB (systematic N3 (review* OR overview*))	55,822
S68	TI (HTA OR HTAs) OR AB (HTA OR HTAs)	699
S67	TI "technology assessment*" OR AB "technology assessment*"	1,880
S66	TI "umbrella review*" OR AB "umbrella review*"	61
S65	(MH "Systematic Review")	41,234
S64	(MH "Telemedicine+")	8,373
S63	(MH "Health Care Delivery+")	245,300
S62	(MH "Patient Care+")	568,640
S61	(MH "Health Services for the Aged")	5,568
S60	TI "integrated care" OR AB "integrated care"	1,962
S59	TI "family Practi*" OR AB "family Practi*"	2,212
S58	TI "general practi*" OR AB "general practi*"	20,626
S57	TI "family Physician*" OR AB "family Physician*"	4,062
S56	TI "primary health" OR AB "primary health"	8,133
S55	TI "primary care" OR AB "primary care"	45,960
S54	(MH "Continuity of Patient Care+")	14,408
S53	(MH "Ambulatory Care")	9,367
S52	(MH "Primary Health Care")	46,213
S51	AB facilit* N2 (AB nursing OR AB care OR AB geriatric OR AB elderly)	11,183
S50	TI facilit* N2 (TI nursing OR TI care OR TI geriatric OR TI elderly)	4,679
S49	((AB home OR AB homes) N2 (AB aged OR AB elderly OR AB senior OR AB old OR AB nursing)	11,789
S48	(TI home OR TI homes) N2 (TI aged OR TI elderly OR TI senior OR TI old OR TI nursing)	13,038

S47	TI "long-term care" OR AB "long-term care"	11,704
S46	(MH "Nursing Homes")	20,055
S45	(MH "Homebound Patients")	579
S44	(MH "Assisted Living")	2,441
S43	TI home N2 visit* OR AB home N2 visit*	4,540
S42	TI home N2 support OR AB home N2 support	1,128
S41	(MH "Home Health Care+")	37,803
S40	TI home N2 car* OR AB home N2 car*	21,757
S39	TI community N3 TI services OR AB community N3 AB services	8,159
S38	(MH "Mental Health Services+")	60,373
S37	(MH "Community Health Services+")	333,519
S36	(MH "Emergency Service+")	40,262
S35	(MH "Hospitalization+")	72,910
S34	TI frailty OR AB frailty	3,124
S33	TI senior* OR AB senior*	15,131
S32	PT comment OR PT editorial OR PT letter	452,008
S31	TI meta-synthes* OR AB meta-synthes*	389
S30	PT meta-analysis OR PT "meta analysis"	13,923
S29	TI metaanaly* OR AB metaanaly*	625
S28	TI "meta analy*" OR AB "meta analy*"	36,958
S27	(MH "Meta Analysis")	27,776
S26	TI ambulatory OR AB ambulatory	15,918
S25	TI outpatient* OR AB outpatient*	36,610
S24	TI "primary healthcare" OR AB "primary healthcare"	1,765
S23	TI "assisted living" OR AB "assisted AB living"	1,170
S22	TI ltc OR AB ltc	2,072

S21	TI homebound OR homebound	865
S20	TI home-based OR AB home-based	4,089
S19	TI homecare OR AB homecare	648
S18	TI "community care" OR AB "community care"	2,491
S17	TI community-dwelling OR AB community-dwelling OR TI "community dwelling" OR AB "community dwelling"	9,135
S16	AB community-based OR AB "community based"	16,063
S15	TI community-based OR TI "community based"	7,758
S14	AB ed	13,528
S13	TI ed	8,003
S12	TI emergency OR AB emergency	75,381
S11	AB Rehospitali*	1,299
S10	TI rehospitali*	445
S9	TI hospitali* OR AB hospitali*	50,735
S8	TI admission* OR AB admission*	44,412
S7	TI readmission* OR AB readmission*	7,144
S6	(MH "Aged+")	607,305
S5	TI older OR AB older	117,913
S4	TI ageing OR AB ageing	25,612
S3	TI aging OR AB aging	33,223
S2	TI geriatric* OR AB geriatric*	16,282
S1	TI elder* OR AB elder*	70,757

A1.3 Cochrane library strategy

Databases	**Cochrane Database of Systematic Reviews (CDSR), Database of Abstracts of Reviews of Effects (Dare) et Health Technology Assessment Database (HTAd)**
Interface	Cochrane Library - Wiley
Date searched	20th of April 2017
Syntax : Fields and operators	
ti	*Title* field
ab	*Abstract* field
MeSH descriptor : […] this term only	Subject heading from the *Medical Subject headings* excluding its narrower terms in the hierarchy (not exploded)
MeSH descriptor : […]explode all trees	Subject heading from the *Medical Subject headings* including its narrower terms in the hierarchy
Boolean operators	AND, OR
NEAR/n	Defined adjacency, within *n* words from each other, in either direction
*	Optional and unlimited truncation
"…"	Literal string
Limits or filters	
Year of publication	2011-2017 (April 2017)
Strategy	

Set Search

#1 MeSH descriptor: [Hospitalization] explode all trees
#2 MeSH descriptor: [Emergency Service, Hospital] explode all trees
#3 MeSH descriptor: [Community Health Services] explode all trees
#4 MeSH descriptor: [Mental Health Services] explode all trees
#5 community-based or "community based":ti,ab
#6 (community near/3 services):ti,ab
#7 (community-dwelling or "community dwelling"):ti,ab
#8 "community care":ti,ab
#9 MeSH descriptor: [Home Care Services] explode all trees
#10 Homecare:ti,ab
#11 Home near/2 care:ti,ab
#12 (home near/2 support):ti,ab
#13 (home near/2 visit*):ti,ab
#14 Home-based:ti,ab
#15 MeSH descriptor: [Assisted Living Facilities] this term only
#16 MeSH descriptor: [Homes for the Aged] this term only
#17 MeSH descriptor: [Nursing Homes] this term only
#18 Ltc:ti,ab
#19 "long-term care":ti,ab
#20 ((home or homes) near/2 (aged or elderly or senior or old or nursing)):ti,ab
#21 (facilit* near/2 (nursing or care or geriatric or elderly)):ti,ab

#22 "assisted living":ti,ab
#23 MeSH descriptor: [Homebound Persons] this term only
#24 MeSH descriptor: [Skilled Nursing Facilities] this term only
#25 MeSH descriptor: [Primary Health Care] explode all trees
#26 MeSH descriptor: [Ambulatory Care] explode all trees
#27 MeSH descriptor: [Continuity of Patient Care] explode all trees
#28 "primary healthcare":ti,ab
#29 "primary care":ti,ab
#30 "primary health":ti,ab
#31 "family physician*":ti,ab
#32 "general practi*":ti,ab
#33 "family practi*":ti,ab
#34 outpatient*:ti,ab
#35 ambulatory:ti,ab
#36 "integrated care":ti,ab
#37 MeSH descriptor: [Health Services for the Aged] explode all trees
#38 MeSH descriptor: [Patient Care] explode all trees
#39 MeSH descriptor: [Delivery of Health Care] explode all trees
#40 MeSH descriptor: [Telemedicine] explode all trees
#41 MeSH descriptor: [Aged] explode all trees
#42 elder*:ti,ab
#43 geriatric*:ti,ab
#44 aging:ti,ab
#45 ageing:ti,ab
#46 older:ti,ab
#47 senior*:ti,ab
#48 frailty:ti,ab
#49 homebound:ti,ab
#50 readmission*:ti,ab
#51 admission*:ti,ab
#52 hospitali*:ti,ab
#53 rehospitali*:ti,ab
#54 emergency:ti,ab
#55 ED:ti,ab
#56 (or #1-#40, #49-#55)
#57 (or #41-#48)
#58 #56 and #57 Publication Year from 2011 to 2017, in Cochrane Reviews (Reviews and Protocols), Other Reviews and Technology Assessments

Hits

CDSR = 253
Dare = 125
HTAd = 32

Appendix 2 : Other sources searched

- Agency for Healthcare Research and Quality (AHRQ) - U.S. Department of Health and Human Services (including the National Guideline Clearinghouse)
- Alberta College of Family Physicians
- Alberta Health and wellness
- American College of Emergency Physicians (ACEP)
- American Geriatrics Society (Geriatrics care online)
- Canadian Association of Emergency Physicians (CAEP)
- Canadian Medical Association - CPG Infobase
- Canadian Agency for Drugs and Technologies in Health (CADTH/ACMTS)
- Canadian Institute for Health Information
- Centre for Reviews and dissemination (CRD), including the Canadian interface
- Danish health Authority (guidelines)
- Germain, Institut universitaire de gériatrie de Montréal
- Google Scholar and Google
- Grey Literature Report (The New York Academy of Medicine)
- Haute Autorité en Santé (HAS)
- Health Improvement Scotland
- Health Quality Council of Alberta
- Health Quality Ontario
- HTAi custom search engine
- International Network of Agencies for Health Technology Assessment (INAHTA), through the CRD database
- Institut national d'excellence en santé et services sociaux (INESSS)
- Institute of Health Economics
- King's Fund
- Manitoba Centre for Health Policy
- National Institute for Health and Care Excellence (NICE)
- Newfoundland and Labrador Centre for Applied Health
- Norwegian Knowledge Centre for the Health Services
- Programs for assessment of technology in health
- Prospero
- Publications numériques du Québec, Bibliothèque et Archives nationales du Québec
- Réseau sur le vieillissement et les changements démographiques (RVCD, Ministère de la santé et des services sociaux)
- Swedish Agency For Health Technology Assessment And Assessment Of Social Services
- Social Care Institute for Excellence (SCIE)
- UBC's Centre for Health Services and Policy Research (CHSPR)
- Health Technology Assessment units in Quebec: CHUS, CHUQ, CUSM/MUHC and CHUM

Appendix 3 : Interview canvas

Canevas d'entrevue : (Données contextuelles)

Consigne : Nous avons préparé une série de questions sur lesquelles nous aimerions discuter avec vous afin de mieux connaître votre contexte d'intervention et de discuter des données scientifiques de notre revue de revues systématiques portant sur la planification des congés. (*Demandez si vous pouvez enregistrer ou prendre des notes*)

1- Pouvez-vous élaborer sur votre projet: le contexte :
   i. Quel était votre mandat?
   ii. Sous quelle direction était-il? SAPA?
   iii. Qui étaient les professionnels impliqués?
   iv. Quel était le rôle de ce professionnel?
   v. Qui était votre clientèle?
2- Quand est-ce que votre équipe était impliquée dans le dossier du patient?
3- Quel était le cheminement du patient dès l'admission jusqu'au retour à domicile, en passant par son plan de congé?
4- Comment était effectuée la planification du congé d'un patient à l'hôpital?
   1. Évaluation
   2. Planification
   3. Éducation du patient
   4. Transition
   5. Suivi
5- Quand est-ce que le plan de congé était élaboré (0-48 après l'admission, avant le congé…)?
6- Qui est impliqué dans cette planification?
7- Est-ce qu'il-y avait un transfert de cas au SAPA (c.-à-d. intervenant pivot)?
   i. Pouvez-vous élaborer un peu plus?
      1. Quand?
      2. Comment?
      3. Est-ce que l'intervenant était impliqué dans la planification du congé?
8- Est-ce qu'il y avait un processus défini de transition entre l'hôpital et la maison?
9- Est-ce qu'il y avait un suivi du patient après le congé?
   1. Est-ce que vous étiez responsable du suivi après le congé? Sinon, qui?
   2. Auprès de qui (patient, SAD, services communautaires)?
   3. Quelle fréquence?
   4. Pour combien de temps?
   5. Comment (les moyens)?
10- Quelle est la relation entre vous, l'hôpital, SAPA, les services communautaires et le patient?

11- Quels étaient les résultats?

1. Est-ce qu'il serait possible de nous les faire parvenir?
2. Avez-vous présenter les résultats?

12- Pourquoi est-ce le programme a été arrêté?

13- De nos connaissances, le projet repart à la fin de l'année 2017, avez-vous apporté des modifications?

14- Quelles ont été les difficultés liées à l'implantation du projet dans votre milieu ?

- Est-ce qu'il y a eu des éléments qui ont facilité la tâche?

15- Quels sont les points forts et points de faibles de la structure actuelle?

<u>Données expérientielles</u>

Nous allons vous présenter les résultats de notre revue de revues systématiques, pour connaitre votre opinion sur la faisabilité et la pertinence de l'organisation des services de planification des congés et du suivi dans la communauté. Nous avons 2 modèles prometteurs relevés dans la littérature. Le premier pour lequel les données sont les plus prometteuses est un suivi fait par un intervenant basé à l'hôpital qui est impliqué dans la planification du congé et assure un suivi avec le patient après le congé pour assurer l'implantation du plan de congé. Le deuxième modèle à un bris dans le continuum de soins, ou l'intervenant après le congé n'est pas déterminé.

- Selon votre expérience avec votre projet, ces modèles pourraient-ils favoriser le maintien à domicile des personnes âgées vulnérables ?
- Comment ceci est-il différent de votre projet?
- Voyez-vous des avantages de l'implantation de ce modèle?
- Voyez-vous des désavantages de l'implantation de ce modèle?
- Selon votre expérience, un de ces modèles est-il applicable dans notre CIUSSS?
- Quels sont les facilitateurs à son implantation dans notre CIUSSS?
- Quelles sont les contraintes à son implantation ?
- Quel intervenant devrait prendre le leadership dans la planification du congé et du suivi communautaire? Quel devrait être sa direction d'appartenance (SAPA ou autre, c.-à-d. : services communautaires ou de l'hôpital)?

Pouvez-vous nous référer à un autre expert avec lequel nous aurions intérêt de le rencontrer ?

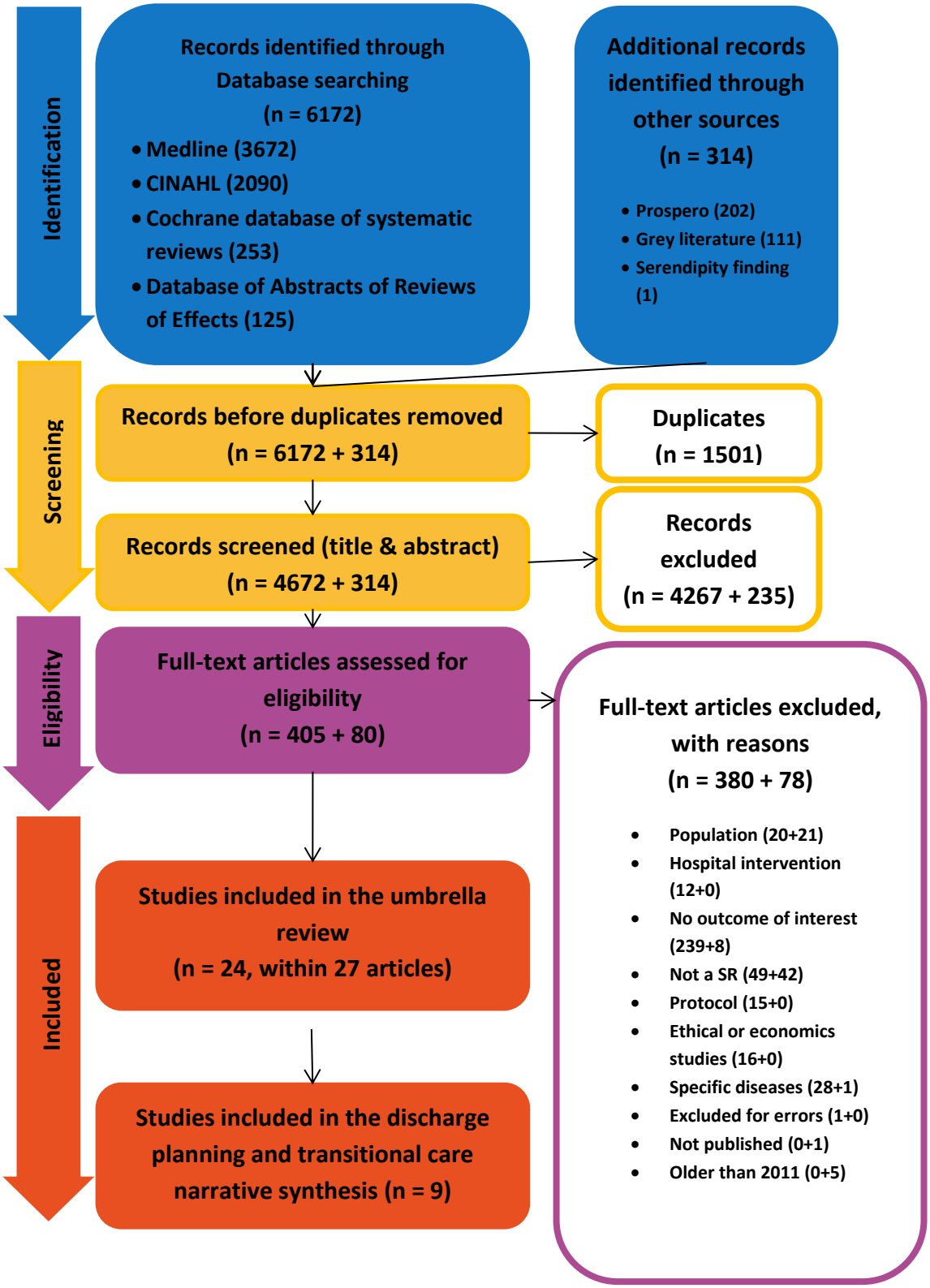
Appendix 4 : Invited members for recommendations elaboration

Sylvie Beauchamp	Chief	UETMISS-SS Academic Affairs, Teaching and Research Directorate, CIUSSS-ODIM
Nadine Bergeron	Assistant to the Director	Support for Elderly Autonomy Program Directorate, CIUSSS-ODIM
Marie-Pierre Bourbonnais	Executive Counsellor	Service thérapeutiques et réadaptation physique* Multidisciplinary Services Directorate, CIUSSS-ODIM
Venise Calluzzo	Assistant to the Director	Approches collaboratives et interdisciplinarité* Multidisciplinary Services Directorate, CIUSSS-ODIM
Steve Castonguay	Planning, Programming and Research Officer	Support for Elderly Autonomy Program Directorate, CIUSSS-ODIM
Stéphanie Côté,	Ethics counsellor	Access, Quality, Performance and Project Office Directorate, CIUSS-ODIM
Geneviève Côté-Leblanc	Chief	Knowldege Transfer and Innovation Academic Affairs, Teaching and Research Directorate, CIUSSS-ODIM
Bernard Cyr	Associate Director	Professional Services Directorate, CIUSSS-ODIM
Manon De Raad	Project Coordinator	St. Mary's Research Center
David Handfield	Project Leader	Bureau de projets organisationnels* Access, Quality, Performance and Project Office Directorate, CIUSS-ODIM
Lydia Ingenito	Associate Director	Local Services, Continuum and Adapted Approach Support for Elderly Autonomy Program Directorate, CIUSSS-ODIM
Rick Mah (Scientific Adivsor).	Chief	Department of Emergency Medicine St. Mary's Hospital Center
Marie-Eve Manseau-Young	Planning, Programming and Research Officer	Knowldege Transfer and Innovation Academic Affairs, Teaching and Research Directorate, CIUSSS-ODIM
Julie Mayrand	Planning, Programming and Research Officer	UETMISS-SS Academic Affairs, Teaching and Research Directorate, CIUSSS-ODIM
Jane McCusker (Scientific Advisor)	Researcher	St. Mary's Research Center
Kristen Oliver	Planning, Programming and Research Officer	Academic Affairs, Teaching and Research Directorate, CIUSSS-ODIM
Jean-François Renaud	Coordinator	Local Services – Home Support Support for Elderly Autonomy Program Directorate, CIUSSS-ODIM
Beverley-Tracey John	Associate Director	Access to Alternative Services to Hospitalization Nursing Directorate, CIUSSS-ODIM
Marc-Olivier Trépanier	Planning, Programming and Research Officer	UETMISS-SS Academic Affairs, Teaching and Research Directorate, CIUSSS-ODIM
Maggy Wassef	Planning, Programming and Research Officer	UETMISS-SS Academic Affairs, Teaching and Research Directorate, CIUSSS-ODIM

CIUSSS-ODIM, Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal; UETMIS-SS, Health and Social Care Technology and Interventions Assessment Unit.

*no English Translation found

Appendix 5 : PRISMA flowchart



Appendix 6 : Reasons for exclusion

A6.1 Records identified through databases

Record number	Reference	Reason for exclusion
1	Abshire, M., Xu, J., Baptiste, D., Almansa, J. R., Xu, J., Cummings, A., . . . Dennison Himmelfarb, C. (2015). Nutritional Interventions in Heart Failure: A Systematic Review of the Literature. Journal of cardiac failure, 21(12), 989-999. doi:10.1016/j.cardfail.2015.10.004	No outcome of interest
2	Ades, P. A., Keteyian, S. J., Balady, G. J., Houston-Miller, N., Kitzman, D. W., Mancini, D. M., & Rich, M. W. (2013). Cardiac rehabilitation exercise and self-care for chronic heart failure. JACC. Heart failure, 1(6), 540-547. doi:10.1016/j.jchf.2013.09.002	Not a systematic review
3	Alberti, T. L., & Nannini, A. (2013). Patient comprehension of discharge instructions from the emergency department: A literature review. Journal of the American Association of Nurse Practitioners, 25(4), 186-194. doi:10.1111/j.1745-7599.2012.00767.x	No outcome of interest
4	Alcide, A., & Potocky, M. (2015). Adult Hospice Social Work Intervention Outcomes in the United States. Journal of Social Work in End-of-Life & Palliative Care, 11(3/4), 367-385. doi:10.1080/15524256.2015.1107806	No outcome of interest
5	Alldred, D. P., Raynor, D. K., Hughes, C., Barber, N., Chen, T. F., & Spoor, P. (2013). Interventions to optimise prescribing for older people in care homes. The Cochrane database of systematic reviews(2).	No outcome of interest
6	Allen, J., Hutchinson, A. M., Brown, R., & Livingston, P. M. (2017). User Experience and Care Integration in Transitional Care for Older People From Hospital to Home. Qualitative health research, 27(1), 24-36. doi:10.1177/1049732316658267	No outcome of interest
7	Allen, J., Ottmann, G., & Roberts, G. (2013). Multi-professional communication for older people in transitional care: a review of the literature. International journal of older people nursing, 8(4), 253-269. doi:10.1111/j.1748-3743.2012.00314.x	No outcome of interest
8	American Geriatrics Society Workgroup on Vitamin, D. S. f. O. A. (2014). Recommendations abstracted from the American Geriatrics Society Consensus Statement on vitamin D for Prevention of Falls and Their Consequences. Journal of the American Geriatrics Society, 62(1), 147-152. doi:10.1111/jgs.12631	No outcome of interest
9	Anderson, L., Thompson, D. R., Oldridge, N., Zwisler, A.-D., Rees, K., Martin, N., & Taylor, R. S. (2016). Exercise-based cardiac rehabilitation for coronary heart disease. Cochrane Database of Systematic Reviews(1). doi:10.1002/14651858.CD001800.pub3	Population
10	Anuruang, S., Hickman, L. D., Jackson, D., Dharmendra, T., Balen, J., & Davidson, P. M. (2014). Community-based interventions to promote management for older people: an integrative review. Journal of clinical nursing, 23(15/16), 2110-2120. doi:10.1111/jocn.12445	No outcome of interest
11	Arendts, G., Quine, S., & Howard, K. (2013). Decision to transfer to an emergency department from residential aged care: A systematic review of qualitative research. Geriatrics & Gerontology International, 13(4), 825-833. doi:10.1111/ggi.12053	No outcome of interest
12	Ausserhofer, D., Deschodt, M., De Geest, S., van Achterberg, T., Meyer, G., Verbeek, H., . . . Engberg, S. (2016). "There's No Place Like Home": A Scoping Review on the Impact of Homelike Residential Care Models on Resident-, Family-, and Staff-Related Outcomes. Journal of the American Medical Directors Association, 17(8), 685-693. doi:10.1016/j.jamda.2016.03.009	Not a systematic review
13	Australian Safety Efficacy Register of New Interventional Procedures Surgical. (2013). Systematic review on needs for medical devices for older people. Health Technology Assessment Database, (4). Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clhta/articles/HTA-32015000975/frame.html	Hospital intervention
14	Avenell, A., Smith, T. O., Curtain, J. P., Mak, J. C., & Myint, P. K. (2016). Nutritional supplementation for hip fracture aftercare in older people. The Cochrane database of systematic reviews, 11. doi:10.1002/14651858.CD001880.pub6.	No outcome of interest
15	Aydin, D., Klit, J., Jacobsen, S., Troelsen, A., & Husted, H. (2015). No major effects of preoperative education in patients undergoing hip or knee replacement--a systematic review. Danish medical journal, 62(7).	No outcome of interest
16	Bagnall, N. M., Malietzis, G., Kennedy, R. H., Athanasiou, T., Faiz, O., & Darzi, A. (2014). A systematic review of enhanced recovery care after colorectal surgery in elderly patients. Colorectal Disease, 16(12), 947-956. doi:10.1111/codi.12718	Hospital intervention
17	Bainbridge, D., Seow, H., & Sussman, J. (2016). Common Components of Efficacious In-Home End-of-Life Care Programs: A Review of Systematic Reviews. Journal of the American Geriatrics Society, 64(3), 632-639. doi:10.1111/jgs.14025	Population
18	Bandayrel, K., & Wong, S. (2011). Systematic literature review of randomized control trials assessing the effectiveness of nutrition interventions in community-dwelling older adults. Journal of nutrition education and behavior, 43(4), 251-262. doi:10.1016/j.jneb.2010.01.004	No outcome of interest
19	Barnason, S., Zimmerman, L., & Young, L. (2012). An integrative review of interventions promoting self-care of patients with heart failure. Journal of clinical nursing, 21(3/4), 448-475. doi:10.1111/j.1365-2702.2011.03907.x	No outcome of interest
20	Beauchet, O., Dubost, V., Revel Delhom, C., Berrut, G., Belmin, J., French Society of, G., & Gerontology. (2011). How to manage recurrent falls in clinical practice: guidelines of the French Society of Geriatrics and Gerontology. The journal of nutrition, health & aging, 15(1), 79-84.	No outcome of interest
21	Beck, A. M., Dent, E., & Baldwin, C. (2016). Nutritional intervention as part of functional rehabilitation in older people with	No outcome of

	reduced functional ability: a systematic review and meta-analysis of randomised controlled studies. Journal of Human Nutrition and Dietetics, 29(6), 733-745. doi:10.1111/jhn.12382	interest
22	Beck, A. M., Holst, M., & Rasmussen, H. H. (2013). Oral nutritional support of older (65 years+) medical and surgical patients after discharge from hospital: systematic review and meta-analysis of randomized controlled trials. Clinical rehabilitation, 27(1), 19-27. doi:10.1177/0269215512445396	Not a systematic review
23	Bélanger, L., Bourbonnais, A., Bernier, R., & Benoit, M. (2017). Communication between nurses and family caregivers of hospitalised older persons: a literature review. Journal of clinical nursing, 26(5/6), 609-619. doi:10.1111/jocn.13516	No outcome of interest
24	Bench, S., Day, T., & Griffiths, P. (2013). Effectiveness of Critical Care Discharge Information in Supporting Early Recovery From Critical Illness. Critical Care Nurse, 33(3), 41-52. doi:10.4037/ccn2013134	No outcome of interest
25	Benetos, A., Rossignol, P., Cherubini, A., Joly, L., Grodzicki, T., Rajkumar, C., . . . Petrovic, M. (2015). Polypharmacy in the Aging Patient: Management of Hypertension in Octogenarians. Jama, 314(2), 170-180. doi:10.1001/jama.2015.7517	No outcome of interest
26	Berglund, H., Blomberg, S., Duner, A., & Kjellgren, K. (2015). Organizing integrated care for older persons: strategies in Sweden during the past decade. Journal of health organization and management, 29(1), 128-151. doi:10.1108/JHOM-04-2013-0082	Not a systematic review
27	Berthelsen, C. B., & Kristensson, J. (2015). The content, dissemination and effects of case management interventions for informal caregivers of older adults: a systematic review. International journal of nursing studies, 52(5), 988-1002. doi:10.1016/j.ijnurstu.2015.01.006	No outcome of interest
28	Beuscart, J.-B., Pont, L. G., Thevelin, S., Boland, B., Dalleur, O., Rutjes, A. W. S., . . . Spinewine, A. (2016). A systematic review of the outcomes reported in trials of medication review in older patients: the need for a core outcome set. British journal of clinical pharmacology, 83(5), 942-952. doi:10.1111/bcp.13197	No outcome of interest
29	Bhattacharya, D., Aldus, C. F., Barton, G., Bond, C. M., Boonyaprapa, S., Charles, I. S., . . . Wright, D. J. (2016). The feasibility of determining the effectiveness and cost-effectiveness of medication organisation devices compared with usual care for older people in a community setting: systematic review, stakeholder focus groups and feasibility randomised controlled trial. Health Technology Assessment, 20(50), 1-250. doi:10.3310/hta20500	No outcome of interest
30	Boisvert, S., Proulx-Belhumeur, A., Doré, M., Gonçalves, N., Francoeur, J., & Gallani, M. C. (2015). An integrative literature review on nursing interventions aimed at increasing self-care among heart failure patients. Revista Latino-Americana de Enfermagem (RLAE), 23(4), 753-768. doi:10.1590/0104-1169.0370.2612	Specific disease
31	Boland, L., Legare, F., Perez, M. M. B., Menear, M., Garvelink, M. M., McIsaac, D. I., . . . Stacey, D. (2017). Impact of home care versus alternative locations of care on elder health outcomes: an overview of systematic reviews. BMC geriatrics, 17(20). doi:10.1186/s12877-016-0395-y	No outcome of interest
32	Boland, M. R. S., Tsiachristas, A., Kruis, A. L., Chavannes, N. H., & Rutten-van Molken, M. P. M. H. (2013). The health economic impact of disease management programs for COPD: a systematic literature review and meta-analysis. BMC pulmonary medicine, 13(40). doi:10.1186/1471-2466-13-40	Economic study
33	Boniface, G., Mason, M., Macintyre, J., Synan, C., & Riley, J. (2013). The effectiveness of local authority social services' occupational therapy for older people in Great Britain: a critical literature review. British Journal of Occupational Therapy, 76(12), 538-547. doi:10.4276/030802213X13861576675240	No outcome of interest
34	Bookey-Bassett, S., Markle-Reid, M., McKey, C. A., & Akhtar-Danesh, N. (2017). Understanding interprofessional collaboration in the context of chronic disease management for older adults living in communities: a concept analysis. Journal of advanced nursing, 73(1), 71-84. doi:10.1111/jan.13162	No outcome of interest
35	Bradford, N. K. (2016). Enhanced Rehabilitation and Care Models for Adults With Dementia Following Hip Fracture Surgery. Orthopaedic Nursing, 35(3), 187-188. doi:10.1097/NOR.0000000000000248	No outcome of interest
36	Braet, A., Weltens, C., & Sermeus, W. (2016). Effectiveness of discharge interventions from hospital to home on hospital readmissions: a systematic review. JBI database of systematic reviews and implementation reports, 14(2), 106-173. doi:10.11124/jbisrir-2016-2381	Population
37	Brown, C. J., & Flood, K. L. (2013). Mobility limitation in the older patient: a clinical review. Jama, 310(11), 1168-1177. doi:10.1001/jama.2013.276566	No outcome of interest
38	Brown, L., Forster, A., Young, J., Crocker, T., Benham, A., & Langhorne, P. (2015). Medical day hospital care for older people versus alternative forms of care. Cochrane Database of Systematic Reviews(6). doi:10.1002/14651858.CD001730.pub3	No outcome of interest
39	Brusco, N. K., Taylor, N. F., Watts, J. J., & Shields, N. (2014). Economic evaluation of adult rehabilitation: a systematic review and meta-analysis of randomized controlled trials in a variety of settings. Archives of physical medicine and rehabilitation, 95(1), 94-116.e114. doi:0.1016/j.apmr.2013.03.017	Economic study
40	Bunn, D., Jimoh, F., Wilsher, S. H., & Hooper, L. (2015). Increasing fluid intake and reducing dehydration risk in older people living in long-term care: a systematic review. Journal of the American Medical Directors Association, 16(2), 101-113. doi:10.1016/j.jamda.2014.10.016	No outcome of interest
41	Burton, E., Cavalheri, V., Adams, R., Browne, C. O., Bovery-Spencer, P., Fenton, A. M., . . . Hill, K. D. (2015). Effectiveness of exercise programs to reduce falls in older people with dementia living in the community: a systematic review and meta-analysis. Clinical interventions in aging, 10, 421-434. doi:10.2147/CIA.S71691	No outcome of interest
42	Burton, E., Lewin, G., & Boldy, D. (2015). A Systematic Review of Physical Activity Programs for Older People Receiving Home Care Services. Journal of aging and physical activity, 23(3), 460-470. doi:10.1123/japa.2014-0086	No outcome of interest
43	CADTH. (2012). Campus of care models for adults with disabilities and seniors: a review of clinical benefits and harms and cost-effectiveness. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clhta/articles/HTA-32012000659/frame.html	Not a systematic review
44	Cajita, M. I., Gleason, K. T., & Han, H.-R. (2016). A Systematic Review of mHealth-Based Heart Failure Interventions. Journal of Cardiovascular Nursing, 31(3), E10-22. doi:10.1097/JCN.0000000000000305	No outcome of interest

45	Cameli, D., Francis, M., Francois, V. E., Medder, N. R., Von Eden, L., & Truglio-Londrigan, M. (2012). A systematic review of medication reconciliation strategies to reduce medication errors in community dwelling older adults. JBI library of systematic reviews, 10(42 Suppl), 1-18. doi:10.11124/jbisrir-2012-247	No outcome of interest
46	Cameron, I. D., Gillespie, L. D., Robertson, M. C., Murray, G. R., Hill, K. D., Cumming, R. G., & Kerse, N. (2012). Interventions for preventing falls in older people in care facilities and hospitals. Cochrane Database of Systematic Reviews(12). doi:10.1002/14651858.CD005465.pub3	No outcome of interest
47	Campbell, A. D., Godfryd, A., Buys, D. R., & Locher, J. L. (2015). Does Participation in Home-Delivered Meals Programs Improve Outcomes for Older Adults? Results of a Systematic Review. Journal of nutrition in gerontology and geriatrics, 34(2), 124-167. doi:10.1080/21551197.2015.1038463	No outcome of interest
48	Candy, B., Holman, A., Leurent, B., Davis, S., & Jones, L. (2011). Hospice care delivered at home, in nursing homes and in dedicated hospice facilities: A systematic review of quantitative and qualitative evidence. International journal of nursing studies, 48(1), 121-133. doi:10.1016/j.ijnurstu.2010.08.003	No outcome of interest
49	Cardona-Morrell, M., Kim, J., Turner, R. M., Anstey, M., Mitchell, I. A., & Hillman, K. (2016). Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem. International Journal for Quality in Health Care, 28(4), 456-469. doi:10.1093/intqhc/mzw060	Hospital intervention
50	Carpenter, C. R., Shelton, E., Fowler, S., Suffoletto, B., Platts-Mills, T. F., Rothman, R. E., & Hogan, T. M. (2015). Risk factors and screening instruments to predict adverse outcomes for undifferentiated older emergency department patients: a systematic review and meta-analysis. Academic Emergency Medicine, 22(1), 1-21. doi:10.1111/acem.12569	No outcome of interest
51	Carpenter, J. G. (2017). Hospital Palliative Care Teams and Post-Acute Care in Nursing Facilities. Research in Gerontological Nursing, 10(1), 25-34. doi:10.3928/19404921-20161209-02	Not a systematic review
52	Casimir, Y. E., Williams, M. M., Liang, M. Y., Pitakmongkolkul, S., & Slyer, J. T. (2014). The effectiveness of patient-centered self-care education for adults with heart failure on knowledge, self-care behaviors, quality of life, and readmissions: a systematic review. JBI Database of Systematic Reviews & Implementation Reports, 12(2), 188-262. doi:10.11124/jbisrir-2014-1438	Specific disease
53	Cawood, A. L., Elia, M., & Stratton, R. J. (2012). Systematic review and meta-analysis of the effects of high protein oral nutritional supplements. Ageing research reviews, 11(2), 278-296. doi:10.1016/j.arr.2011.12.008	No outcome of interest
54	Chase, C. A., Mann, K., Wasek, S., & Arbesman, M. (2012). Systematic Review of the Effect of Home Modification and Fall Prevention Programs on Falls and the Performance of Community-Dwelling Older Adults. The American Journal of Occupational Therapy, 66(3), 284-291. doi:10.5014/ajot.2012.005017	No outcome of interest
55	Chase, J.-A. D., Phillips, L. J., & Brown, M. (2017). Physical Activity Intervention Effects on Physical Function Among Community-Dwelling Older Adults: A Systematic Review and Meta-Analysis. Journal of aging and physical activity, 25(1), 149-170. doi:10.1123/japa.2016-0040	No outcome of interest
56	Chatterjee, S., Sardar, P., Lichstein, E., Mukherjee, D., & Aikat, S. (2013). Pharmacologic Rate versus Rhythm-Control Strategies in Atrial Fibrillation: An Updated Comprehensive Review and Meta-Analysis. Pacing & Clinical Electrophysiology, 36(1), 122-133. doi:10.1111/j.1540-8159.2012.03513.x	No outcome of interest
57	Chen, Y. M., & Li, Y. (2013). Safety and efficacy of exercise training in elderly heart failure patients: a systematic review and meta-analysis. International journal of clinical practice, 67(11), 1192-1198. doi:0.1111/ijcp.12210	Specific disease
58	Chenoweth, L., Kable, A., & Pond, D. (2015). Research in hospital discharge procedures addresses gaps in care continuity in the community, but leaves gaping holes for people with dementia: A review of the literature. Australasian Journal on Ageing, 34(1), 9-14. doi:10.1111/ajag.12205	Not a systematic review
59	Cherofsky, N., Onua, E., Sawo, D., Slavin, E., & Levin, R. (2011). Telehealth in adult patients with congestive heart failure in long term home health care: a systematic review. JBI library of systematic reviews, 9(30), 1271-1296.	Specific disease
60	Chesham, R. A., & Shanmugam, S. (2017). Does preoperative physiotherapy improve postoperative, patient-based outcomes in older adults who have undergone total knee arthroplasty? A systematic review. Physiotherapy Theory & Practice, 33(1), 9-30. doi:10.1080/09593985.2016.1230660	No outcome of interest
61	Chhabra, P. T., Rattinger, G. B., Dutcher, S. K., Hare, M. E., Parsons, K. L., & Zuckerman, I. H. (2012). Medication reconciliation during the transition to and from long-term care settings: a systematic review. Research in Social & Administrative Pharmacy, 8(1), 60-75. doi:10.1016/j.sapharm.2010.12.002	No outcome of interest
62	Chi, N.-C., & Demiris, G. (2015). A systematic review of telehealth tools and interventions to support family caregivers. Journal of telemedicine and telecare, 21(1), 37-44. doi:10.1177/1357633X14562734	No outcome of interest
63	Chinthammit, C., Armstrong, E. P., & Warholak, T. L. (2012). A Cost-Effectiveness Evaluation of Hospital Discharge Counseling by Pharmacists. Journal of pharmacy practice, 25(2), 201-208. doi:10.1177/0897190011418512	Economic study
64	Choi, J. (2011). Literature review: using pictographs in discharge instructions for older adults with low-literacy skills. Journal of clinical nursing, 20(21/22), 2984-2996. doi:10.1111/j.1365-2702.2011.03814.x	No outcome of interest
65	Choi, M., & Hector, M. (2012). Effectiveness of intervention programs in preventing falls: a systematic review of recent 10 years and meta-analysis. Journal of the American Medical Directors Association, 13(2), 188.e113-121. doi:10.1016/j.jamda.2011.04.022	No outcome of interest
66	Christensen, M., & Lundh, A. (2013). Medication review in hospitalised patients to reduce morbidity and mortality. Cochrane Database of Systematic Reviews(2). doi:10.1002/14651858.CD008986.pub3	Hospital intervention
67	Christensen, M., & Lundh, A. (2016). Medication review in hospitalised patients to reduce morbidity and mortality. Cochrane Database of Systematic Reviews(2). doi:10.1002/14651858.CD008986.pub3	Hospital intervention
68	Chuna, Y. J., & Patterson, P. E. (2012). A suggestion for future research on interface design of an Internet-based telemedicine system for the elderly. Work, 41 Suppl 1, 353-356. doi:10.3233/WOR-2012-0181-353	Not a systematic

		review
69	Chung, J., Demiris, G., & Thompson, H. J. (2012). Mobility limitation in community-dwelling older adults: a systematic review. Communicating Nursing Research, 45, 426-426.	Not a systematic review
70	Chung, J., Demiris, G., & Thompson, H. J. (2016). Ethical Considerations Regarding the Use of Smart Home Technologies for Older Adults. Annual Review of Nursing Research, 34(1), 155-181. doi:10.1891/0739-6686.34.155	Ethical study
71	Chunhu, S. (2014). Interventions for Preventing Falls in Older People in Care Facilities and Hospitals. Orthopaedic Nursing, 33(1), 48-49. doi:10.1097/NOR.0000000000000023	Not a systematic review
72	Chunmei, Z., Xiangjuan, L., Xiaomeng, W., Qi, W., Yun, Z., Zhiming, G., . . . Ge, Z. (2015). Efficacy of Enhanced External Counterpulsation in Patients With Chronic Refractory Angina on Canadian Cardiovascular Society (CCS) Angina Class: An Updated Meta-Analysis. Medicine, 94(47), 1-8. doi:10.1097/MD.0000000000002002	No outcome of interest
73	Church, J., Goodall, S., Norman, R., & Haas, M. (2011). An economic evaluation of community and residential aged care falls prevention strategies in NSW. New South Wales public health bulletin, 22(3-4), 60-68. doi:10.1071/NB10051	Economic study
74	Clark, A. M., Wiens, K. S., Banner, D., Kryworuchko, J., Thirsk, L., McLean, L., & Currie, K. (2016). A systematic review of the main mechanisms of heart failure disease management interventions. Heart, 102(9), 707-711. doi:10.1136/ heartjnl-2015-308551	Not a systematic review
75	Clark, S., Parker, R., Prosser, B., & Davey, R. (2013). Aged care nurse practitioners in Australia: evidence for the development of their role. Australian Health Review, 37(5), 594-601. doi:10.1071/AH13052	No outcome of interest
76	Clarke, M., Shah, A., & Sharma, U. (2011). Systematic review of studies on telemonitoring of patients with congestive heart failure: a meta-analysis. Journal of telemedicine and telecare, 17(1), 7-14. doi:10.1258/jtt.2010.100113	Specific disease
77	Clarkson, P., Giebel, C. M., Larbey, M., Roe, B., Challis, D., Hughes, J., . . . Members of the HoSt, D. P. M. G. (2016). A protocol for a systematic review of effective home support to people with dementia and their carers: components and impacts. Journal of advanced nursing, 72(1), 186-196. doi:10.1111/jan.12737	Protocol
78	Classen, S., Monahan, M., Auten, B., & Yarney, A. (2014). Evidence-Based Review of Interventions for Medically At-Risk Older Drivers. American Journal of Occupational Therapy, 68(4), e107-108. doi:10.5014/ajot.2014.010975	No outcome of interest
79	Clegg, A. P., Barber, S. E., Young, J. B., Forster, A., & Iliffe, S. J. (2012). Do home-based exercise interventions improve outcomes for frail older people? Findings from a systematic review. Reviews in clinical gerontology, 22(1), 68-78. doi:10.1017/S0959259811000165	No outcome of interest
80	Clegg, A., Siddiqi, N., Heaven, A., Young, J., & Holt, R. (2014). Interventions for preventing delirium in older people in institutional long-term care. Cochrane Database of Systematic Reviews(1). doi:10.1002/14651858.CD009537.pub2	No outcome of interest
81	Clyne, B., Bradley, M., Hughes, C., Fahey, T., & Lapane, K. (2012). Electronic prescribing and other forms of technology to reduce inappropriate medication use and polypharmacy in older people: a review of current evidence (Provisional abstract). Clinics in Geriatric Medicine, 28(2), 301-322. doi:10.1016/j.cger.2012.01.009	Not a systematic review
82	Clyne, B., Fitzgerald, C., Quinlan, A., Hardy, C., Galvin, R., Fahey, T., & Smith, S. M. (2016). Interventions to Address Potentially Inappropriate Prescribing in Community-Dwelling Older Adults: A Systematic Review of Randomized Controlled Trials. Journal of the American Geriatrics Society, 64(6), 1210-1222. doi:10.1111/jgs.14133	No outcome of interest
83	Cochrane, A., Furlong, M., McGilloway, S., Molloy, D. W., Stevenson, M., & Donnelly, M. (2016). Time-limited home-care reablement services for maintaining and improving the functional independence of older adults. The Cochrane database of systematic reviews, 10. doi:10.1002/14651858.CD010825.pub2.	No outcome of interest
84	Coffey, A., Mulcahy, H., Savage, E., Fitzgerald, S., Bradley, C., Benefield, L., & Leahy-Warren, P. (2017). Transitional care interventions: Relevance for nursing in the community. Public Health Nursing. doi:10.1111/phn.12324	No outcome of interest
85	Coles, E., Themessl-Huber, M., & Freeman, R. (2012). Investigating community-based health and health promotion for homeless people: a mixed methods review. Health Education Research, 27(4), 624-644. doi:10.1093/her/cys065	Population
86	Combes, M., & Price, K. (2014). Hip protectors: are they beneficial in protecting older people from fall-related injuries? Journal of clinical nursing, 23(1/2), 13-23. doi:10.1111/jocn.12193	No outcome of interest
87	Commodore-Mensah, Y., & Dennison Himmelfarb, C. R. (2012). Patient education strategies for hospitalized cardiovascular patients: a systematic review. Journal of Cardiovascular Nursing, 27(2), 154-174. doi:10.1097/JCN.0b013e318239f60f	Population
88	Conroy, S. P., Stevens, T., Parker, S. G., & Gladman, J. R. F. (2011). A systematic review of comprehensive geriatric assessment to improve outcomes for frail older people being rapidly discharged from acute hospital: 'interface geriatrics'. Age and ageing, 40(4), 436-443. doi:10.1093/ageing/afr06	No outcome of interest
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358	Vedel, I., & Khanassov, V. (2015). Transitional Care for Patients With Congestive Heart Failure: A Systematic Review and Meta-Analysis. Annals of family medicine, 13(6), 562-571. doi:10.1370/afm.1844	Specific disease
359	Vedel, I., Akhlaghpour, S., Vaghefi, I., Bergman, H., & Lapointe, L. (2013). Health information technologies in geriatrics and gerontology: a mixed systematic review. Journal of the American Medical Informatics Association : JAMIA, 20(6), 1109-1119. doi:10.1136/ amiajnl-2013-001705	No outcome of interest
360	Vlaeyen, E., Coussement, J., Leysens, G., Van der Elst, E., Delbaere, K., Cambier, D., . . . Milisen, K. (2015). Characteristics and effectiveness of fall prevention programs in nursing homes: a systematic review and meta-analysis of randomized controlled trials. Journal of the American Geriatrics Society, 63(2), 211-221. doi:10.1111/jgs.13254	No outcome of interest
361	Wakefield, B. J., Boren, S. A., Groves, P. S., & Conn, V. S. (2013). Heart Failure Care Management Programs: A Review of Study Interventions and Meta-Analysis of Outcomes. Journal of Cardiovascular Nursing, 28(1), 8-19. doi:10.1097/JCN.0b013e318239f9e1	Specific disease
362	Wales, K., Clemson, L., Lannin, N. A., & Cameron, I. D. (2012). Functional assessments used by occupational therapists with older adults at risk of activity and participation limitations: a systematic review and evaluation of measurement properties. Systematic reviews, 1. doi:10.1186/2046-4053-1-45	Protocol
363	Wallace, E., Hinchey, T., Dimitrov, B. D., Bennett, K., Fahey, T., & Smith, S. M. (2013). A systematic review of the probability of repeated admission score in community-dwelling adults. Journal of the American Geriatrics Society, 61(3), 357-364. doi:10.1111/jgs.12150	No outcome of interest
364	Wallis, M. (2011). Further research is required to provide evidence of the effectiveness and feasibility of the nurse-led, case management approach to the care of older adults with chronic comorbid conditions. Evidence Based Nursing, 14(4), 109-110. doi:10.1136/ebn.2011.100119	Not a systematic review
365	Walsh, B. (2013). Unplanned admissions and readmissions in older people: a review of recent evidence on identifying and managing high-risk individuals. Reviews in clinical gerontology, 23(2), 228-237. doi:10.1017/S0959259814000082	Not a systematic review
366	Walsh, K. A., O'Riordan, D., Kearney, P. M., Timmons, S., & Byrne, S. (2016). Improving the appropriateness of prescribing in older patients: a systematic review and meta-analysis of pharmacists' interventions in secondary care. Age and ageing, 45(2), 201-209. doi:10.1093/ageing/afv190	No outcome of interest
367	Warner, G., Killian, L., Doble, S., McKenzie, J. E., Versnel, J., & Packer, T. (2012). Community-based self-management programs for improving participation in life activities in older adults with chronic conditions. Cochrane Database of Systematic Reviews(9). doi:10.1002/14651858.CD010097	No outcome of interest
368	Warner, G., Packer, T., Villeneuve, M., Audulv, A., & Versnel, J. (2015). A systematic review of the effectiveness of stroke self-management programs for improving function and participation outcomes: self-management programs for stroke survivors. Disability & Rehabilitation, 37(23), 2141-2163. doi:10.3109/09638288.2014.996674	No outcome of interest
369	Welsh, S. M., Sherriff, A., & Flodgren, G. (2015). The champion for improved delivery of care to older people in long-term care settings: effects on professional practice, quality of care and resident outcomes. Cochrane Database of Systematic Reviews(11). doi:10.1002/14651858.CD011956	Protocol
370	Winter, H., Watt, K., & Peel, N. M. (2013). Falls prevention interventions for community-dwelling older persons with cognitive impairment: a systematic review. International psychogeriatrics, 25(2), 215-227. doi:10.1017/S1041610212001573	No outcome of interest
371	Wion, R. K., & Loeb, S. J. (2016). End-of-Life Care Behind Bars: A Systematic Review. The American journal of nursing, 116(3), 24-37. doi:10.1097/01.NAJ.0000481277.99686.82.	Population
372	Wysocki, A., Butler, M., Kane, R., Kane, R., Shippee, T., & Sainfort, F. (2012). Long-term care for older adults: A review of home and community-based services versus institutional care. Comparative Effectiveness Review No. 81. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2007-10064-I.). Retrieved from Rockville, MD:	No outcome of interest

	http://onlinelibrary.wiley.com/o/cochrane/clhta/articles/HTA-32013000235/frame.html	
373	You, E. C., Dunt, D., Doyle, C., & Hsueh, A. (2012). Effects of case management in community aged care on client and carer outcomes: a systematic review of randomized trials and comparative observational studies. BMC health services research, 12. doi:10.1186/1472-6963-12-395	No outcome of interest
374	You, E., Dunt, D. R., & Doyle, C. (2013). Case Managed Community Aged Care: What Is the Evidence for Effects on Service Use and Costs? Journal of Aging & Health, 25(7), 1204-1242. doi:10.1177/0898264313499931	No outcome of interest
375	Young, C., Hall, A. M., Gonçalves-Bradley, D. C., Quinn, T. J., Hooft, L., van, M. B. C., & Stott, D. J. (2017). Home or foster home care versus institutional long-term care for functionally dependent older people. Cochrane Database of Systematic Reviews(4). doi:10.1002/14651858.CD009844.pub2	No outcome of interest
376	Young, C., van, d. G. E. M., Quinn, T. J., Hooft, L., Legg, L. A., van, M. B. C., & Stott, D. J. (2012). At-home versus institutional long-term-care for chronic functionally dependent older people. Cochrane Database of Systematic Reviews(6). doi:10.1002/14651858.CD009844	Protocol
377	Young, K., Bunn, F., Trivedi, D., & Dickinson, A. (2011). Nutritional education for community dwelling older people: a systematic review of randomised controlled trials. International journal of nursing studies, 48(6), 751-780. doi:10.1016/j.ijnurstu.2011.03.007	No outcome of interest
378	Zhuang, C.-L., Ye, X.-Z., Zhang, X.-D., Chen, B.-C., & Yu, Z. (2013). Enhanced recovery after surgery programs versus traditional care for colorectal surgery: a meta-analysis of randomized controlled trials. Diseases of the colon and rectum, 56(5), 667-678. doi:10.1097/DCR.0b013e3182812842	Hospital intervention
379	Zimmerman, S., Anderson, W. L., Brode, S., Jonas, D., Lux, L., Beeber, A. S., . . . Sloane, P. D. (2013). Systematic review: Effective characteristics of nursing homes and other residential long-term care settings for people with dementia. Journal of the American Geriatrics Society, 61(8), 1399-1409. doi:10.1111/jgs.12372	No outcome of interest
380	Zwijsen, S. A., Niemeijer, A. R., & Hertogh, C. M. P. M. (2011). Ethics of using assistive technology in the care for community-dwelling elderly people: an overview of the literature. Aging & mental health, 15(4), 419-427. doi:10.1080/13607863.2010.543662	Ethical study

A6.2 Records identified through grey literature

Record number	Reference	Reason for exclusion
1	Althaus, F., Paroz, S., Hugli, O., Ghali, W. A., Daeppen, J. B., Peytremann-Bridevaux, I., & Bodenmann, P. (2011). Effectiveness of interventions targeting frequent users of emergency departments: a systematic review. Annals of Emergency Medicine, 58(1), 41-52.e42. doi:10.1016/j.annemergmed.2011.03.007	Population
2	ACEP Transitions of Care Task Force. (2012). Transitions of Care Task Force Report. Retrieved from https://www.acep.org/administration/personnel--team-management/transitions-of-care-resources/#sm.000141soidilselwzha2ayp34fvad	Not a systematic review
3	American College of Emergency Physicians. (2015). Transitions of Care Resources : Rapid Integration of Care Toolkit. Retrieved from https://www.acep.org/transitionsofcare/#sm.000141soidilselwzha2ayp34fvad	Not a systematic review
4	American College of Emergency Physicians. (2017). Emergency Medicine Crowding and Boarding. Retrieved from https://www.acep.org/Clinical---Practice-Management/Emergency-Medicine-Crowding-and-Boarding/	Not a systematic review
5	American College of Emergency Physicians, The American Geriatrics Society, Emergency Nurses Association, & the Society for Academic Emergency Medicine. (2013). Geriatric Emergency Department Guidelines. Retrieved from https://www.acep.org/geriEDguidelines/	Not a systematic review
6	Axon, R. N., & Williams, M. V. (2017). [Eliminating Hospital Readmissions: "No Hospital Left Behind"].	Not a systematic review
7	Bångsbo, A., Dunér, A., Dahlin-Ivanoff, S., & Lidén, E. (2017). Collaboration in discharge planning in relation to an implicit framework. Applied Nursing Research, 36, 57-62. doi:10.1016/j.apnr.2017.05.010	Not a systematic review
8	Benbassat, J., & Taragin, M. I. (2013). The effect of clinical interventions on hospital readmissions: a meta-review of published meta-analyses. Israel Journal of Health Policy Research, 2(1). doi:10.1186/2045-4015-2-1	Not a systematic review
9	Boult, C., Boult, L. B., Pacala, J. T., Snyder, C., & Leff, B. (2009). Successful Models of Comprehensive Care for Older Adults with Chronic Conditions: Evidence for the Institute of Medicine's “Retooling for an Aging America” Report. Journal of the American Geriatrics Society, 57(12), 2328-2337. doi:10.1111/j.1532-5415.2009.02571.x	Older than 2011
10	Boutwell, A., Griffin, F., Hwu, S., & Shannon, D. (2009). Effective interventions to reduce rehospitalizations: A compendium of 15 promising interventions. Retrieved from Cambridge, MA: http://www.ihi.org/resources/Pages/Changes/EffectiveInterventionstoReduceRehospitalizationsCompendium15PromisingInterventions.aspx	Not a systematic review
11	Briggs, M. C. E., & McElhaney, J. E. (2014). Health workfoce educational needs for seniors care: Interprofessional education and collaborative practice. Retrieved from http://staging.cou.on.ca/wp-content/uploads/2014/08/Health-Workforce-Educational-Needs-for-Seniors-Care-Interprofessional-Education-and-Collaborative-Practice.pdf	Not a systematic review
12	Canadian Agency for Drugs and Technologies in Health. (2011). Patient Care Pathways: Clinical Effectiveness and Guidelines. Retrieved from https://www.cadth.ca/patient-care-pathways-clinical-effectiveness-and-guidelines	Population
13	Canadian Agency for Drugs and Technologies in Health. (2014). Interventions for Non-Elderly Patients who are High Users of Ambulatory and Emergency Medical Services: Clinical and Cost-Effectiveness. Retrieved from https://www.cadth.ca/interventions-non-elderly-patients-who-are-high-users-ambulatory-and-emergency-medical-services	Population
14	Carpenter, C. R., & Platts-Mills, T. F. (2013). Evolving prehospital, emergency department, and “inpatient” management models for geriatric emergencies. Clinics in Geriatric Medicine, 29(1), 31-47. doi:10.1016/j.cger.2012.09.003	Not a systematic review
15	Carrier, E., Yee, T., & Holzwart, R. A. (2011). Coordination Between Emergency and Primary Care Physicians. Retrieved from Washington, DC: http://nihcr.org/analysis/improving-care-delivery/prevention-improving-health/ed-coordination/	Not a systematic review
16	Centers for Medicare & Medicaid Services. (2017, 05/11/2017 2:12 PM). Program of All-Inclusive Care for the Elderly (PACE). Retrieved from https://www.cms.gov/medicare/health-plans/pace/overview.html	Not a systematic review
17	Centre for Reviews and Dissemination. (2013). Advance care planning. Retrieved from https://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=32014001370&UserID=11570	Not a systematic review
18	Centre for Reviews and Dissemination. (2014). Inpatient rehabilitation services for the frail elderly. Retrieved from https://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=32014001365&UserID=11570	No outcome of interest
19	Centre for Reviews and Dissemination. (2014). Primary care 'in-reach' in hospital settings. Retrieved from https://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=32014001371&UserID=11570	Population
20	Chalkley, M., McCormick, B., Anderson, R., Aragon, M. J., Nessa, N., Nicodemo, C., . . . Wittenberg, R. (2017). Elective hospital admissions: secondary data analysis and modelling with an emphasis on policies to moderate growth. Health Services and Delivery Research, 5(7).	Not a systematic review
21	Couturier, B., Carrat, F., & Hejblum, G. (2016). A systematic review on the effect of the organisation of hospital discharge on patient health outcomes. BMJ Open, 6(12). doi:10.1136/bmjopen-2016-012287	Not a systematic review
22	Craven, E., & Conroy, S. (2015). Hospital readmissions in frail older people. Reviews in Clinical Gerontology, 25(2), 107-116. doi:10.1017/S0959259815000064	No outcome of interest

23	Damiani, M., & Dixon, J. (2002). Managing the Pressure: Emergency hospital admissions in London 1997-2001. Retrieved from https://www.kingsfund.org.uk/publications/managing-pressure	Not a systematic review
24	Davies, S. L., Goodman, C., Bunn, F., Victor, C., Dickinson, A., Iliffe, S., . . . Froggatt, K. (2011). A systematic review of integrated working between care homes and health care services. BMC Health Services Research, 11(320). doi:10.1186/1472-6963-11-320	No outcome of interest
25	Delisle, D. R. (2017). Care transitions programs: A review of hospital-based programs targeted to reduce readmissions. Professional Case Management, 18(6), 273-283. doi:10.1097/NCM.0b013e31829d9cf3	Not a systematic review
26	Ghosh, A., Shchmitz, R., & Brown, R. (2015). Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006-2011. Retrieved from https://aspe.hhs.gov/pdf-report/effect-pace-costs-nursing-home-admissions-and-mortality-2006-2011	Not a systematic review
27	Goodwin, N., Ross, S., & Curry, N. (2011). Case management: What it is and how it can best be implemented. Retrieved from https://www.kingsfund.org.uk/publications/case-management	Not a systematic review
28	Guo, B., & Harstall, C. (2006). Strategies to reduce emergency department overcrowding (1-894927-34-6). Retrieved from Edmonton, AB: http://www.ihe.ca/advanced-search/strategies-to-reduce-emergency-department-overcrowding	Population
29	Halter, M., Chatters, R., Koniotou, M., & Evans, B. (2015). A systematic review of literature on the care of older people who fall and use out-of-hospital emergency services. Emergency Medicine Journal, 32(5), e3. doi:10.1136/emermed-2015-204880.7	Not published
30	Hazarika, R., & Purdy, S. (2015). Integrated care: demonstrating value and valuing patients. Future Hospital Journal, 2(2), 132-136. doi:10.7861/futurehosp.2-2-132	Not a systematic review
31	Hesselink, G., Schoonhoven, L., Barach, P., Spijker, A., Gademan, P., Kalkman, C., . . . Wollersheim, H. (2017). Improving Patient Handovers From Hospital to Primary Care: A Systematic Review. Annals of Internal Medicine, 157(6), 417-428. doi:10.7326/0003-4819-157-6-201209180-00006	Population
32	Humphries, R., Thorlby, R., Holder, H., Hall, P., & Charles, A. (2016). Social care for older people: Home truths. Retrieved from https://www.kingsfund.org.uk/publications/social-care-older-people	Not a systematic review
33	Imison, C., Poteliakhoff, E., & Thompson, J. (2012). Older people and emergency bed use: Exploring variation. Retrieved from https://www.kingsfund.org.uk/publications/older-people-and-emergency-bed-use	Not a systematic review
34	Institut canadien d'information sur la santé. (2014). Sources des visites potentiellement évitables aux services d'urgence. Retrieved from Ottawa, ON: https://secure.cihi.ca/estore/productFamily.htm?locale=fr&pf=PFC2708	Not a systematic review
35	Institute of Medicine. (2008). Retooling for an aging america: Building the health care workforce. Washington, D.C.: The National Academies Press.	Older than 2011
36	Jodoin, Y. (2008). Approche gériatrique transhospitalière. Retrieved from Montréal, QC: https://cap.banq.qc.ca/notice?id=p::usmarcdef_0003675934	Older than 2011
37	Jokanovic, N., Tan, E. C. K., Sudhakaran, S., Kirkpatrick, C., M., Dooley, M. J., Ryan-Atwood, T. E., & Bell, J. S. (2017). Pharmacist-led medication review in community settings: An overview of systematic reviews. Research in Social and Administrative Pharmacy, 13(4), 661-685. doi:10.1016/j.sapharm.2016.08.005	Population
38	Kansagara, D., Chiovaro, J. C., Kagen, D., Jencks, S., Rhyne, K., O'Neil, M., . . . Englander, H. (2015). Transitions of care from hospital to home: An overview of systematic reviews and recommendations for improving transitional care in the veterans health administration (VA-ESP Project #05-225). Retrieved from Washington, DC: https://www.hsrd.research.va.gov/publications/esp/h2h.cfm	Population
39	Kansagara, D., Chiovaro, J. C., Kagen, D., Jencks, S., Rhyne, K., O'Neil, M., . . . Englander, H. (2017). So many options, where do we start? An overview of the care transitions literature. Journal of Hospital Medicine, 11(3), 221-230. doi:10.1002/jhm.2502	Population
40	Katz, E. B., Carrier, E. R., Umscheid, C. A., & Pines, J. M. (2012). Comparative effectiveness of care coordination interventions in the emergency department: a systematic review. Annals of Emergency Medicine, 60(1), 12-23.e11. doi:10.1016/j.annemergmed.2012.02.025	Population
41	Khangura, J. K., Flodgren, G., Perera, R., Rowe, B. H., & Shepperd, S. (2012). Primary care professionals providing non-urgent care in hospital emergency departments. The Cochrane database of systematic reviews, 11(CD002097). doi:10.1002/14651858.CD002097.pub3	Population
42	Kripalani, S., Theobald, C. N., Anctil, B., & Vasilevskis, E. E. (2014). Reducing Hospital Readmission Rates: Current Strategies and Future Directions. Annual Reviews of Medicine, 65, 471-485. doi:10.1146/annurev-med-022613-090415	Not a systematic review
43	Kumar, G. S., & Klein, R. (2013). Effectiveness of case management strategies in reducing emergency department visits in frequent user patient populations: a systematic review. Journal of Emergency Medicine, 44(3), 717-729. doi:10.1016/j.jemermed.2012.08.035	Population
44	Lawrie, M., & Battye, F. (2012). Older people's experience of emergency hospital readmission. Retrieved from London, UK: http://www.scie-socialcareonline.org.uk/older-peoples-experience-of-emergency-hospital-readmission-research-report/r/a11G00000017zULIAY	Not a systematic review
45	Lehnbom, E. C., Stewart, M. J., Manias, E., & Westbrook, J. I. (2014). Impact of Medication Reconciliation and Review on Clinical Outcomes. Annals of Pharmacotherapy, 48(10), 1298-1312. doi:10.1177_1060028014543485	Population
46	Lim, F., Foust, J., & Cleave, J. V. (2012). Transitional care. In M. Boltz, E. Capezuti, T. Fulmer, & D. Zwicker (Eds.), Evidence-Based Geriatric Nursing Protocols for Best Practice (4th ed.). New York, NY: Springer Publishing Company.	No outcome of interest
47	Lowthian, J. (2017). How do we optimise care transition of frail older people? Age and Ageing, 46(1), 2-4.	Not a systematic

	doi:10.1093/ageing/afw171	review
48	MacAdam, M. (2008). Frameworks of integrated care for the elderly: A systematic review. Retrieved from http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=viewlink&link_id=7284&Itemid=109&lang=en	Older than 2011
49	Martin, C. M., Vogel, C., Hederman, L., Smith, K., Zarabzadeh, A., Grady, D., & Su, J. (2017). Avoidable hospitalizations in older adults. In J. Sturmberg & C. Martin (Eds.), Handbook of Systems and Complexity in Health (pp. 445-465). New York, NY: Springer.	Not a systematic review
50	McCusker, J., Roberge, D., Aarnaert, A., Brown, B., Brunet, J., Ciampi, A., . . . Verdon, J. (2008). Le congé sécuritaire des aînés du département d'urgence vers la communauté. Retrieved from Montreal, QC: http://pnq.banq.qc.ca/sdx/pnq/document.xsp?app=ca.BAnQ.sdx.pgq&db=notice&id=b6b9a41ca39fe165c1f886faef8372db9e7e3aeb&n=21&col=*&dbrv3=&order=descendant&dbrv2=%C3%A2g%C3%A9es&dbrv1=urgence*+OU+hospitali*&dbrd2=&dbrd1=&type=*&dbrn=5&dbrf3=xtgw_auteur&dbrf2=xtgw_sujet&dbrf1=xtgw_sujet&sortfield=sdxscore&&p=2&chpp=20&dbrqp=search_notice&qid=sdx_q2	Not a systematic review
51	McHugh, M., VanDyke, K., McClelland, M., & Moss, D. (2011). Improving patient flow and reducing emergency department crowding: A guide for hospitals. (Prepare by the Health Research & Education Trust, an affiliate of the American Hospital Association, under contract 290-200-600022, Task Order No. 6) (AHRQ Publication No. 11(12)-0094). Retrieved from Rockville, MD: https://www.ahrq.gov/research/findings/final-reports/ptflow/index.html	Not a systematic review
52	Morath, B., Mayer, T., Send, A. F. J., Hoppe-Tichy, T., Haefeli, W. E., & Seidling, H. M. (2017). Risk factors of adverse health outcomes after hospital discharge modifiable by clinical pharmacist interventions - a review with a systematic approach. British Journal of Clinical Pharmacology, 83(10), 2163-2178. doi:10.1111/bcp.13318	Population
53	National Institute for Health and Care Excellence. (2015). Home care: delivering personal care and practical support to older people living in their own homes (NG21). Retrieved from https://www.nice.org.uk/guidance/ng21	No outcome of interest
54	National Institute for Health and Care Excellence. (2016). Transition between inpatient hospital settings and community or care home settings for adults with social care needs (QS136). Retrieved from https://www.nice.org.uk/guidance/qs136	Population
55	National Institute for Health and Care Excellence. (2016). Transition between inpatient mental health settings and community or care home settings (NG53). Retrieved from https://www.nice.org.uk/guidance/ng53	Population
56	Nuckols, T. K., Keeler, E., Morton, S., Anderson, L., Doyle, B. J., Pevnick, J., . . . Shekelle, P. (2017). Economic evaluation of quality improvement interventions designed to prevent hospital readmission: A systematic review and meta-analysis. JAMA Internal Medicine, 177(7), 975-985. doi:10.1001/jamainternmed.2017.1136	Population
57	Pinkney, J., Rance, S., Benger, J., Brant, H., Joel-Edgar, S., Swancutt, D., . . . Byng, R. (2016). How can frontline expertise and new models of care best contribute to safely reducing avoidable acute admissions? A mixed-methods study of four acute hospitals. Health Services and Delivery Research, 4(3). doi:10.3310/hsdr04030	Not a systematic review
58	Poteliakhoff, E., & Thompson, J. (2011). Emergency bed use: what the numbers tell us. Retrieved from https://www.kingsfund.org.uk/publications/data-briefing-emergency-bed-use	Not a systematic review
59	Purdy, S. (2010). Avoiding hospital admissions: What does the research evidence say? Retrieved from https://www.kingsfund.org.uk/publications/avoiding-hospital-admissions	Not a systematic review
60	Registered Nurses' Association of Ontario. (2014). Care transitions. Retrieved from Toronto, ON: https://rnao.ca/bpg/guidelines/care-transitions	Population
61	Rennke, S., Nguyen, O. K., Shoeb, M. H., Magan, Y., Wachter, R. M., & Ranji, S. R. (2017). Hospital-initiated transitional care interventions as a patient safety strategy: A systematic review. Annals of Internal Medicine, 158(5 Part 2), 433-440. doi:10.7326/0003-4819-158-5-201303051-00011	Population
62	Riverin, B. D., Li, P., Naimi, A. I., & Strumpf, E. (2017). Team-based versus traditional primary care models and short-term outcomes after hospital discharge. Canadian Medical Association Journal, 189(16), E585-E593. doi:10.1503/cmaj.160427	Not a systematic review
63	Roberts, E. (2000). Improving services for older people: What are the issues for PCGs. Retrieved from https://www.kingsfund.org.uk/publications/improving-services-older-people	Not a systematic review
64	Roper, K. L., Ballard, J., Rankin, W., & Cardarelli, R. (2015). Systematic Review of Ambulatory Transitional Care Management (TCM) Visits on Hospital 30-Day Readmission Rates. American Journal of Medical Quality, 32(1), 19-26. doi:https://doi.org/10.1177/1062860615615426	Population
65	Rowe, B. H., Bond, K., M.B., O., Blitz, S., Friesen, C., Schull, M., . . . Sinclair, D. (2006). Emergency department overcrowding in Canada: what are the issues and what can be done? (Technology overview no 21). Retrieved from Ottawa: https://www.cadth.ca/emergency-department-overcrowding-canada-what-are-issues-and-what-can-be-done-1	Older than 2011
66	Ruiz, S., Snyder, L. P., Rotondo, C., Cross-Barnet, C., Murphy Colligan, E., & Giuriceo, K. (2017). Innovative Home Visit Models Associated With Reductions In Costs, Hospitalizations, And Emergency Department Use. Health Affairs, 36(3), 425-432. doi:10.1377/hlthaff.2016.1305	Not a systematic review
67	Service de l'évaluation des technologies et des modes d'intervention en santé (ETMIS). (2014). Indicateurs de suivi des interventions visant à favoriser l'autonomie et la mobilité des personnes âgées hospitalisées - Prepared by Simon Deblois and Luigi Lepanto. Retrieved from Montreal, QC: https://www.chumontreal.qc.ca/	No outcome of interest
68	Shang, M. (2012). Recension des écrits portant sur la planification du congé de personnes âgées à partir de l'urgence. Retrieved from Longueuil, QC: http://extranet.santemonteregie.qc.ca/depot/document/3772/Recension%20planif%20du%20cong%C3%A9%20%20VF%202012%2007%2003.pdf	Not a systematic review

69	Snooks, H. A., Anthony, R., Chatters, R., Dale, J., Fothergill, R., Gaze, S., . . . Russell, I. T. (2010). Support and Assessment for Fall Emergency Referrals (SAFER) 2: a cluster randomised trial and systematic review of clinical effectiveness and cost-effectiveness of new protocols for emergency ambulance paramedics to assess older people following a fall with referral to community-based care when appropriate. Health Technology Assessment, 21(13).	Specific disease
70	Social Care Institute for Excellence. (2005). Involving individual older patients and their carers in the discharge process from acute to community care: implications for intermediate care. Retrieved from http://www.scie.org.uk/publications/briefings/briefing12/	Not a systematic review
71	Social Care Institute for Excellence. (2013). Evidence review on partnership working between GPs, care home residents and care homes. Retrieved from London, UK: www.scie.org.uk	No outcome of interest
72	Social Care Institute for Excellence. (2014). Commissioning home care for older people. Retrieved from London, UK: www.scie.org.uk	Not a systematic review
73	Somme, D., Trouve, H., Passadori, Y., Corvez, A., Jeandel, C., Aline Bloch, M., . . . De Stampa, M. (2013). Prise de position de la Société Française de Gériatrie et Gérontologie sur le concept d'intégration: Résumé. La Revue de gériatrie, 38(5), 323-330.	Not a systematic review
74	Tian, Y., Dixon, A., & Gao, H. (2012). Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions. Retrieved from https://www.kingsfund.org.uk/publications/data-briefing-emergency-hospital-admissions-ambulatory-care-sensitive-conditions	Not a systematic review
75	Unité d'évaluation des technologies et des modes d'intervention en santé du CHU de Québec – Université Laval (UETMISCHU de Québec – Université Laval. (2015). Évaluation d'un mode d'organisation des services dans les unités d'urgence selon le concept de zone d'évaluation rapide - Assessment report prepared by Martin Bussières, Sylvain Bussières, Martin Coulombe and Marc Rhainds (03-15). Retrieved from Québec, QC: https://www.chudequebec.ca/professionnels-de-la-sante/evaluation/publications.aspx	No outcome of interest
76	Van den Heede, K., & Van de Voorde, C. (2016). Interventions to reduce emergency department utilisation: A review of reviews. Health Policy, 120(12), 1337–1349. doi:10.1016/j.healthpol.2016.10.002	Population
77	Wilson, A., Baker, R., Bankart, J., Banerjee, J., Bhamra, R., Conroy, S., . . . Waring, J. (2015). Establishing and implementing best practice to reduce unplanned admissions in those aged 85 years and over through system change [Establishing System Change for Admissions of People 85+ (ESCAPE 85+)]: a mixed-methods case study approach. Health Services and Delivery Research, 3(37).	Not a systematic review
78	Wilson, M. G., & Waddell, K. (2016). Evidence brief: strengthening care for frail older adults in canada. Retrieved from Hamilton, ON: https://macsphere.mcmaster.ca/handle/11375/21195	Not a systematic review

Appendix 7 : Quality assessment

Author	Domain 1: Study eligibility criteria	Domain 2: Identification and selection of studies	Domain 3: Data extraction and study appraisal	Domain 4: Synthesis and findings	Risk of bias	Reason for high or unclear risk of bias rating
Allen (2014)	Low	High	Low	High	High	Inconsistent extraction of data within included articles. Non-significant results were discussed as significant
Bryant-Lukosius (2015)	Low	Low	Low	Low	Low	N/A
Gonçalves-Bradley (2016)	Low	Low	Low	Low	Low	N/A
Guerin (2013)	Low	Unclear	High	Unclear	High	Selection and data collection only performed by one evaluator
Huntley (2013)	Low	Unclear	Low	Unclear	Unclear	Inconsistent use of dichotomous and count data for RR calculation. Unclear how relative rate was calculated
Le Berre (2017)	Low	Unclear	Unclear	High	High	Inclusion of wrong data set within meta-analysis. Interpretation of non-significant as significant results
Linertovà (2011)	Low	High	Low	High	High	No clear explanation why search was only performed up to 2007. Heterogeneity and robustness of data was not discussed
Lowthian (2015)	Low	Low	Low	Low	Low	N/A
Toles (2016)	Low	High	Low	Low	Low	N/A

Quality assessment of individual systematic review by ROBIS. Table includes the risk of bias of the systematic review as assessed by the 4 domains of the ROBIS as well as the overall risk of bias. Risk of bias was rated as either low, unclear, or high. Justification was provided if a study was assessed to have a high or unclear risk of bias

Appendix 8 : Supplementary results from Le Berre et al. 2017

Intervention	3 months	6 months	12 months	18 months
Education	-0.08 [-0.14,-0.03] (18/18)	-0.04 [-0.09,0.01] (31/35)	-0.11 [-0.17,-0.05] (18/18)	-0.11 [-0.21,-0.01] (5/5)
Phone availability 24/7	N/A	-0.06 [-0.19,0.07] (4/35)	-0.24 [-0.42,-0.07] (4/18)	-0.27 [-0.42,-0.12] (1/5)
Nurse involvement	-0.05 [-0.11,0.00} (14/18)	-0.06 [-0.11,-0.01] (28/35)	-0.11 [-0.17,-0.05] (17/18)	-0.06 [-0.14,0.02] (4/5)
Pharmacist involvement	-0.23 [-0.53,0.05] (4/18)	-0.03 [-0.12,0.06] (7/35)	-0.15 [-0.25,-0.05] (3/18)	-0.07 [-0.20,0.06] (2/5)
Medication reconciliation	-0.10 [-0.19,-0.01] (8/18)	-0.01 [-0.05,0.04] (19/35)	-0.09 [-0.18,-0.01] (11/18)	-0.09 [-0.24,0.07] (3/5)
Home visits	-0.09 [-0.16,-0.02] (11/18)	-0.06 [-0.16,-0.01] (19/35)	-0.09 [-0.14,-0.04] (10/18)	-0.07 [-0.20,0.06] (2/5)
Phone calls	-0.07 [-0.14,0.00] (5/18)	-0.08 [-0.19,0.03] (8/35)	-0.12[-0.31,0.06] (3/18)	N/A
Telemonitoring	0.09 [-0.15,0.33] (2/18)	0.01 [-0.05,0.07] (6/35)	-0.37 [-0.77,0.33] (2/18)	N/A
Initial contact within 1 week of discharge	-0.09 [-0.16,-0.01] (13/18)	-0.05 [-0.11,0.00] (25/35)	-0.13 [-0.22,-0.05] (11/18)	-0.16 [-0.34,0.02] (1/5)

Table adapted from supplementary results from Le Berre et al. (30). Data represent results from meta-analyses for studies including specific interventions at the different follow-up intervals. Results in red illustrate significant results as determined by the meta-analyses. Number in brackets indicate the number of studies included in the meta-analysis out of the number of studies within that follow-up interval