Supplementary Data 1

Search Team: ("Noncommunicable Disease" OR "Noninfectious Diseases" OR "Noninfectious Disease" OR "Non-infectious Diseases" OR "Non-infectious Disease" OR "Non infectious Diseases" OR "Non-communicable Diseases" OR "Disease, Non-communicable" OR "Non-communicable Disease" OR "Non communicable Diseases" OR "Non-communicable Chronic Diseases" OR "Chronic Disease, Non-communicable" OR "Non-communicable Chronic Disease" OR "Non communicable Chronic Diseases" OR "Chronic Diseases" OR "Disease, Chronic" OR "Chronic Illness" OR "Chronic Illnesses" OR "Illness, Chronic" OR "Chronically Ill" OR "Chronic Condition" OR "Chronic Conditions" OR "Condition, Chronic") **AND** ("Stroke" OR "Cerebrovascular Accident" OR "Cerebrovascular Accidents" OR "Brain Ischemia" OR "Ischemic Stroke" OR "Hemorrhagic Stroke" OR "Transient Ischemic Attack" OR "TIA" OR "Acute Stroke" OR "Poststroke" OR "Post-stroke") **AND** ("Heart Disease" OR "Heart Diseases" OR "Cardiac Disease" OR "Cardiac Diseases" OR "Cardiovascular Disease" OR "Cardiovascular Diseases" OR "Coronary Artery Disease" OR "Coronary Disease" OR "Ischemic Heart Disease" OR "Myocardial Infarction" OR "Congestive Heart Failure" OR "Heart Failure" OR "Cardiac Conditions") **AND** ("Discharge Planning" OR "Patient Discharge" OR "Discharge, Patient" OR "Discharges, Patient" OR "Patient Discharges" OR "Discharge Plannings" OR "Planning, Discharge" OR "Plannings, Discharge")

Supplementary Data 2. Summary Table

Reference, year, country, setting	Target population (Disease), Sample size (Total, Intervention and control), Age (Mean and SD), Sex	Study Aim, Study Design, Provider Involved, Intervention Delivery Platform	Intervention Detail		Main finding(s) of Included Studies	Implications for further research
			Intervention group/ (Duration, Frequency)	Control group		
(Rahpeima et al., 2022) 2022 Iran Cardiology ward	- Adult patients with coronary artery disease (CAD) undergoing percutaneous coronary intervention (PCI), specifically coronary artery angioplasty. - 70 patients: Intervention group (n=35), Control group (n=35) **- Age (Mean± SD):** 60.58 ± 11.10 **- Sex (%):** Male 53(75.7%) Female: 17 (24.3%)	- To determine the effect of interdisciplinary discharge planning on treatment adherence and readmission in patients undergoing coronary artery angioplasty - A Quasi-experimental study - The interdisciplinary team members are a cardiologist, a pharmacologist, a nutritionist, a nurse, and a social worker - Face-to-face sessions (40–50 minutes each) in the clinic and CCU, plus 10-minute telephone calls based on patient needs	**<u>Interdisciplinary discharge planning</u>** **In the intervention group:** A month long discharge planning program was performed based on an interdisciplinary approach. Medical health care team **Face-to-Face Sessions**: Three meetings are scheduled for one week, one month, and three months post-discharge. **Interdisciplinary Rounds**: During patient admission, the medical team discusses the patient's file, sets healthcare priorities, and develops a care plan. **Educational Materials**: Patients receive a booklet with relevant information (regular medication, proper nutrition, risk factors for heart disease and a healthy lifestyle, regular physical activity, smoking cessation, avoidance of alcohol, and drugs, and the method of protection of an angioplasty site) **Phone Follow-Ups**: A cardiac care nurse makes a phone call at two, six and ten weeks post-discharge to address questions, support self-care, and ensure medication adherence. Each call lasts about 10 minutes. **Family Involvement**: Family Members may attend sessions if needed.	The usual discharge planning in the hospital, including pre-discharge training as well as an educational booklet, was used. Treatment adherence before, immediately, and one month after the intervention, as well as readmission three months after the intervention, was examined in both groups.	**Treatment Adherence:** At one month after discharge, patients in the intervention group demonstrated significantly higher treatment adherence scores compared to the control group. The adherence scores improved from baseline values to 46.14 in the intervention group versus 21.51 in the control group immediately after discharge, and 43.12 versus 23.28 at one-month post-discharge (both $p < 0.001$). **Hospital Readmission:** At three months post-discharge, no readmissions were reported in the intervention group, while the control group had a readmission rate of 11.4%.	Future research should explore the long-term effects of interdisciplinary discharge planning beyond the initial three-month period, particularly focusing on sustained treatment adherence and readmission prevention. Studies with larger, more diverse populations across multiple healthcare settings are needed to confirm the generalizability of these findings. Additionally, future investigations should examine which components of interdisciplinary discharge planning—such as education, follow-up, or care coordination—are most effective in improving outcomes. Incorporating digital health tools into interdisciplinary approaches may also enhance continuity of care, and evaluating their integration could be a valuable direction for further study.

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			Duration: 12 weeks (3 months) post-discharge follow-up period **Frequency:** - 3 face-to-face sessions (at 1 week, 1 month, and 3 months after discharge) - 3 telephone follow-up calls (in the 2nd, 6th, and 10th weeks after discharge)			
(Bikmoradi et al., 2023) 2023 Iran Farshchian Educational Hospital, Hamadan University of Medical Sciences	- Adults diagnosed with coronary artery disease (CAD) undergoing coronary artery bypass graft (CABG) surgery. - 80: intervention (n=40) and control (n=40) groups **- Age (Mean± SD):** intervention group was 52.78±6.20, control group, the mean age was 55.75±8.34 **- Sex (%):** 83.75% male overall	- To examine the effect of telenursing via SMS reminders on depression, stress, and anxiety levels in patients discharged after coronary artery bypass graft (CABG) surgery. - A randomized clinical trial (RCT) - Telenursing conducted by a nurse researcher - SMS text messaging and telephone support	• Standard discharge education and booklet at hospital discharge for all patients. • **Intervention group** additionally received individualized treatment plans and SMS reminders covering medication adherence, diet, physical activity, wound care, and cardiac rehabilitation appointments. • SMS messages were sent **three times a week for six weeks** after discharge. • Patients could contact the nurse for questions via text or phone. **Duration:** 6 weeks post-discharge **Frequency:** 3 SMS text message reminders per week	The control group received routine care only (no follow-up communication).	**Before intervention:** No significant differences between groups in depression, anxiety, or stress scores ($p > 0.05$). **After intervention:** • Depression scores significantly lower in the intervention group (7.85 vs 10.56; $p = 0.04$). • Anxiety scores significantly lower (10.45 vs 16.5; $p = 0.002$). • Stress score significantly lower (10.5 vs 17.9; $p < 0.001$). • Telenursing significantly improved psychological outcomes compared to routine care alone.	Future research should investigate the long-term effectiveness of telenursing interventions on psychological outcomes and overall recovery in patients following coronary artery bypass graft surgery. Studies with larger, more diverse populations across different healthcare settings are needed to validate these findings and assess generalizability. Additionally, research comparing different modes of digital health delivery, such as mobile applications, video consultations, or interactive platforms, could identify the most effective strategies for improving post-discharge mental health. Further studies should also examine the impact of telenursing on clinical outcomes such as hospital readmissions, medication adherence, and quality of life.
(Carvajal Carrascal et al., 2023) 2023 Columbia	- Patients with NCDs (diabetes mellitus, hypertension, cardiac insufficiency, ischemic cardiac disease, and COPD) and caregivers	- To assess the effect of an anticipated and structured discharge care plan (PC-AH-US) on the caregiving load among patients with non-transmissible chronic diseases (NTCD) and their family caregivers.	**Intervention (PC-AH-US):** **- Proactive and structured approach**: Begins with an evaluation of care needs upon hospital admission. - **Tailored education**: Provides educational materials specific to the patient's condition before discharge.	**<u>Usual Care:</u>** **- Standard discharge protocols**: Follows routine hospital discharge procedures. **- Administrative and care instructions**: Includes administrative tasks, care	• The intervention group showed significantly greater improvements in caregiving competencies across all domains compared to the control group ($p<0.001$ for all dimensions). • Dimensions improved included awareness, recognition of uniqueness, capacity for care tasks	Future research should examine the long-term effects of structured discharge planning interventions like the PC-AH-US model on clinical outcomes such as hospital readmissions, patient morbidity, and caregiver health. Studies involving different chronic disease subgroups

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In the hospital and at home	- 585 patient–family caregiver pairs (N = 1,170 individuals; Intervention group = 403 pairs; Control group = 182 pairs - **Age (Mean± SD):** Patients (67.9±13.6), Caregivers (48.4± 14.2) - **Sex (%):** Patient (Male (54.6%), Female (45.4%)), Caregivers (Male (46.5%), Female (51.9%))	- A Quasi-experimental study - Nurse and research team - In-person	- **Patient and caregiver focus**: Ensures both the patient and caregivers are informed and prepared for ongoing care. **Duration:** During hospitalization (care needs assessment upon admission) and just before hospital discharge (delivery of the personalized care plan) **Frequency:** One structured intervention session during hospitalization, before discharge (single session per patient-caregiver pair)	guidelines, and medication instructions. **- Directed to patient and caregiver**: Involves both the patient and the family caregiver, but no tailored educational component of the intervention.	• (instrumentation), well-being, anticipation of risks, and support network utilization. • The intervention significantly reduced perceived caregiving load but did not significantly impact hospital readmissions or mortality rates.	and diverse healthcare settings would help validate and generalize these findings. Additionally, future work should explore integrating digital tools into structured discharge processes to enhance patient and caregiver engagement. Research is also needed to assess cost-effectiveness and institutional burden reduction over time, as initial results showed significant improvement in caregiving competencies but no significant impact on readmissions or mortality rates.
(Pellet et al., 2024) 2024 Switzerland In the hospital (medical unit)	- Multimorbid inpatients; - N = 138: Intervention group (n = 70), Control group (n = 68) - **Age (Mean± SD):** Control (75.7 ± 10.6), Intervention (73.5 ± 9.8) - **Sex (%):** Control (Male (59%), Female (41%)), Intervention (Male (50%), Female (50%))	- To evaluate the effectiveness of a structured personalized discharge teaching intervention on patient activation, readiness for hospital discharge, discharge care experience, and hospital readmission. - Quasi-experimental, 2-group sequential pre/post-intervention design - Clinical nurses - Face-to-face bedside teaching sessions during hospitalization	- Tailored discharge teaching based on patient activation level using tools like ICAN and PAM-13; PODS used to summarize information; 6 content domains personalized per patient needs **Duration**: Admission to 7 - 10 days post-discharge. **Frequency**: During hospitalization; Teaching began at admission, multiple sessions with no fixed number; follow-up via phone, 7 – 10 days post-discharge	- Usual nursing discharge preparation: care coordination, general info on medications and appointments, and less on discharge teaching content.	- Significant improvement in patient activation score at 7 – 10 days post-discharge ($p = 0.05$). - Discharge care experiences were significantly higher among the intervention group compared to the usual care group ($t(127) = -2.79$, $p = .01$) with an effect size of 0.34. - No significant difference in other outcomes.	- Further refinement of teaching components by a nurse and promote activation levels of the participants could be a key of success of the intervention. - Promote the level of activation by questioning and discussing, not just from the teaching content. - May need to take the workload and changes in nursing staff into consideration as it may limit the effectiveness of the intervention.
(Lemos et al., 2020) 2020 Brazil	- Adults with Heart Failure or Diabetes Mellitus - N = 28: Heart failure (HF) (n = 14), Diabetes mellitus (DM) (n = 14)	- To evaluate the effect of discharge planning based on NANDA-I, Nursing Interventions Classification (NIC), and Nursing Outcomes	- Nursing interventions based on NIC: Teaching about disease process, prescribed medications, and diet. The intervention was individualized based on the pathology, following the guidelines. After the intervention session, before hospital discharge,	- Not applicable	- Significant improvement in knowledge scores: HF management increased from 2.05 to 2.54 ($p = .002$); DM management from 2.61 to 3.21 ($p = .000$)	- The study suggests developing discharge planning for long-term care and hospital prevention. - Need for randomized controlled trials

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An emergency and Inpatient units of a public university hospital	- **Age (Mean± SD):** Overall: 55.1 ± 15.5; HF group: 63.1 ± 10.6; DM group: 47.1 ± 15.8 - **Sex (%):** Overall (Male (53.6%), Female (46.3%)), HF group (Male (35.7%), Female (64.3%)), DM group (Male (71.4%), Female (28.6%)	Classification (NOC) taxonomies on patients with HF or DM - Quasi-experimental quantitative study - Nurses - In-person face-to-face sessions during hospitalization	the participants were evaluated with NOC Knowledge outcomes. - **Duration**: Sessions lasted 20 – 40 minutes **Frequency**: Three sessions during hospitalization			
(Kazemi Majd et al., 2021) 2021 Iran Tertiary referral heart hospitals	- Patients with Heart Failure (HF) - N = 120: Intervention group (n = 60), Control group (n = 60) - **Age (Median [IQR])**: Intervention (66.5 [56–75.7]), Control (72 [63–80.2]) - **Sex (%)**: Intervention group: (Male (40%)), Female (60%); Control group: (Male (45%)), Female (55%)	- To assess the effect of patient-centered and physician-prescribed information on hospital readmission and death among heart failure patients - Randomized controlled trial - Cardiologists and clinical librarians - Written evidence-based information tailored to the patient's needs	- Personalized, evidence-based information prescriptions prepared by clinical librarians and approved by physicians, covering HF management and tailored to literacy levels - **Duration:** Follow-up at 3, 6, and 12 months - **Frequency**: Single provision during hospitalization	- Received routine oral information from a nurse or physician	- The 12-month readmission and mortality rates were lower in the intervention group [RR = 0.67, 95% CI: 0.46–0.97], indicating a significant improvement in survival (p = .005). - Over the 12-month follow-up period, the intervention group had a lower readmission rate compared to the control group [RR = 0.61, 95% CI: 0.40–0.93]. - The intervention group had a significantly lower mortality rate at 6 months, and a lower, though not statistically significant, mortality rate at 12 months compared to the control group [6-month mortality: RR = 0.60, 95% CI: 0.15–2.40, p = .46; 12-month mortality: RR = 0.47, 95% CI: 0.20–1.06, p = .05].	- Suggest having clinical librarians as a part of the clinical team for an evidence-based patient information delivery service. - Further trials involving earlier disease stages; explore scalability and multilingual database support; assess interdisciplinary roles in information delivery
(Logeart et al., 2022) 2022 France In the hospital and the clinical research unit	- Acute heart failure - 482 patients: Intervention group (n=237), Control group (n=245) **- Age (Median): 77.0** Intervention group (77.3), Control group (77.6)	- To examine the impact of intensive, early follow-up in patients at high risk of readmission at discharge after acute heart failure treatment. - A randomized controlled trial study.	**Intensive care** In addition to the standard care, patients received planned in-person consultations with a heart failure specialist and a dietitian (i.e., titration of their heart failure medications) at days 7 and 14 after discharge. A further consultation at day 21 was encouraged.	**Standard care** Patients in the control group received standard care; prescribed blood tests (plasma electrolytes, natriuretic peptides, and renal function) follow-up appointment with their general practitioners within the first week after discharge, and visiting their	There were no differences observed between groups for all-cause death or first unplanned hospital readmission during 6-month follow-up (hazard ratio 0.97; 95% CI 0.74-1.26) and for mortality at 6 or 12 months of unplanned heart failure readmission.	Although the intervention (intensive care early post-discharge) did not have superior outcomes compared to the control group (standard care), further studies are still needed to clarify useful translational care services, such as those adapted to specific patient clinical profiles, patient wishes, and available resources.

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center at the University Hospital	**- Sex (%):** Male 352 (73.0%) Female: 130 (27%)	- Heart failure specialist and dietitian. - In-person consultations.	**Duration:** 3 weeks after discharge, follow-up period. **Frequency:** At least 2 in-person consultations (at day 7 and 14 after discharge) and additional consultation at day 21 after discharge.	referring cardiologist within the first month.		
(Deepradit et al., 2023) 2023 Thailand At home and in a community setting	- Patients with stroke and their families - 62 patient–family caregiver pairs (n = 124 individuals; Intervention group = 31 pairs; Control group = 31 pairs) **- Age (Mean± SD):** Intervention group = Patients (67.0±12.4); Caregivers (54.2± 15.2), Control group = Patients (66.2±12.5); Caregivers (52.4± 18.1) **- Sex (%):** Intervention group: Patient (Male 18 (58.1%), Female 13 (41.9%)), Caregivers: 7 (Male (22.6%), Female 24 (77.4%)), Control group: Patient (Male 18 (58.1%), Female 13 (41.9%)), Caregivers: Male (29.0%), Female 22 (71.0%))	- To examine the effectiveness of a family-based program for patients experiencing a stroke and their families. - A cluster randomized controlled trial. - Nurses and research team - In-person and telephone visits	**<u>Family-based program</u>** **Week 1:** Session 1: Assess the stressors and needs of patients. Session 2: Provide information about stress management and emotional support. **Week 2:** Session 3: Provide knowledge and practice based on individual patients' problems. **Week 3:** Session 4: Use empowerment to build hope. **Week 4:** Session 5: Encourage patients to continue the program. **Week 6 and 10:** Session 6: Assess physiological, psychological, sociocultural, developmental, and spiritual stressors and needs and provided advice via telephone visits. **Week 8:** Session 7: Home visit to assess the needs after the intervention and coordinate responsive actions. **Duration:** 10 weeks post-discharge **Frequency:** Patients: 2 sessions at week 1, 1 session at week 2-4, 1 telephone visit at week 6 and 10, 1 home visit at week 8.	**<u>Usual care</u>** The control group received usual care from the Sub-District Health Promoting Hospital, including a home visit at least once a month within the first month after discharge by a community nurse. The home visit includes assessing problems in both patients and their families and providing care as required. After the first home visit, a community nurse would assess and determine whether additional home visits were needed, and home visits would end if the Barthel Index reached or exceeded 15.	**Patients:** Patients in the intervention group reported statistically significant improvements in their functional status and decreased depression compared to the control group ($p<0.05$). Three patients in the intervention group and seven in the control group experienced complications. **Family caregivers:** Family caregivers in the intervention group reported improvements in family function and a decrease in caregivers' burden and stress compared to the control group ($p<0.05$).	The study revealed that patients experienced complications at three months after discharge. This study had 10 weeks of intervention and a follow-up that lasted for 12 weeks (approximately 3 months). Therefore, the future research suggests an extended follow-up period for the post-discharge follow-up program to detect any post-stroke complications, preventing patients from additional burden.
(Neale et al., 2020)	- Patients with mild, moderate, and severe stroke survivors.	- To compare the length of hospital stay, number of days saved, and associated service costs between an	- Early Supported Discharge (ESD) facilitated the earlier transition of eligible patients to home-based rehabilitation, with immediate	- The control group received standard inpatient rehabilitation without access to Early Supported Discharge (ESD), remaining	**Length of stay** - Significant differences in length of stay were found between the treatment and control groups. The treatment group spent	- The findings of this study highlight important organizational implications and support the continued use of Early Supported

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Australia acute stroke unit and inpatient rehabilitation ward, stroke survivors living within the community rehabilitation service	- 44 patients: treatment (n = 28), and control (n = 13) groups. **- Age (Mean± SD):** treatment group was 67.25, control group, the mean age was 65.53 **- Sex (%):** Male 31(75.61%) Female: 14(24.39%) Treatment group, 75% were male, and control groups, 61.54% were male.	Early Supported Discharge (ESD) model of care and standard treatment for patients with mild, moderate, and severe stroke. - A cohort study employing a quasi-experimental design with a convenience control group. - A multidisciplinary team comprising key allied health disciplines, including occupational therapy, physiotherapy, speech pathology, and nursing staff. - In-person	commencement of intensive rehabilitation provided by a multidisciplinary team. Patients were enrolled in the study on the day they were deemed medically safe for discharge home to continue intensive rehabilitation through ESD services. They received ongoing assessment and support, including access to subsidized transportation, personal care, respite, and paid carers as needed. **- Duration**: No fixed time limit; team involvement continued based on patient needs **- Frequency**: They received assessment and intervention up to 5 days per week.	hospitalized until clinically stable and rehabilitation was complete.	significantly fewer days on the acute ward (Mean LOS = 5, SD = 5.54) compared to the control group (Mean LOS = 6.23, SD = 6.30), U = 101.5, p = 0.03. Similarly, the treatment group had a significantly shorter stay on the inpatient rehabilitation ward (Mean LOS = 9, SD = 8.79) than the control group (Mean LOS = 15, SD = 5.79), U = 75.5, p < 0.001. **Cost** **-** The treatment group incurred lower treatment costs compared to the control group; however, this difference was not statistically significant (U = 181.500, p = 0.99).	Discharge (ESD) as a care model. Future research should focus on broader implementation studies to understand how ESD can be effectively scaled. Additionally, there is a need to explore long-term patient outcomes and satisfaction to fully evaluate its benefits. Finally, the applicability of ESD to other patient populations, such as those with heart conditions, warrants further investigation to expand its potential impact.
(Sedia et al., 2019) 2019 Indonesia Two privates hospitals in different places	- Patients who experienced a stroke due to hypertension. - 160 patients: Intervention (n = 33 respondent pre and n = 37 respondent post for intervention), and control (n = 33 respondent pre and n = 33 post respondent for control) groups. Additionally, 24 respondents were observed from hospital admission until discharge to assess patient independence. - No reported data on age (mean and standard deviation) or sex.	- To evaluate the effectiveness of discharge planning for stroke patients with hypertension in improving patient satisfaction and independence, and to identify the contributing factors in discharge planning to be used as baseline data for model development. - A quasi-experimental method was used, with pre- and post-tests conducted for both the control and intervention groups. - Interdisciplinary team — primarily nurses and doctors, possibly including case managers or social workers.	- The intervention group received a structured discharge planning program. This process was delivered by an interdisciplinary healthcare team and aimed to assess patient needs, provide education, and prepare both patients and their families for the transition from hospital to home or another healthcare facility. **- Duration:** The duration of the program began within the first 24 hours of hospital admission and continued throughout the hospitalization period until discharge.	- The control group in this study received standard hospital care without a structured discharge planning program.	**Patient satisfaction** **<u>Pre–Post Control Group</u>** Patient satisfaction in the control group showed no significant differences between pre- and post-test scores across various areas, including room services, food services, hospital admission services, emergency services, the discharge planning process, and doctor and nurse services. Overall, patient satisfaction in the control group also showed no significant difference between pre- and post-test (p = 0.883). **<u>Pre–Post Intervention Group</u>** Patient satisfaction in the intervention group showed significant improvements between pre- and post-test in the following areas: - Room services satisfaction (76.0 vs. 79.9; difference = 3.9; p < 0.001)	Future studies should focus on implementing discharge planning early in hospitalization and forming multidisciplinary teams to improve patient satisfaction and independence. Research is needed to address barriers like incomplete documentation and nurse training gaps. Additionally, long-term effects on patient outcomes and readmission rates should be explored, along with strategies to adapt and scale discharge planning models across diverse settings for better care continuity.

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		- In-person hospital-based delivery, initiated early during admission, focusing on education, discharge readiness, and sustained care coordination.			- Food services satisfaction (75.7 vs. 77.0; difference = 1.3; p = 0.007) - Discharge planning process satisfaction (76.8 vs. 79.9; difference = 3.1; p < 0.001). These results are consistent with both the descriptive data and the findings presented in the results table. - Overall, the intervention group demonstrated a significant increase in patient satisfaction after the intervention (76.8 vs. 78.3; difference = 1.4; p < 0.001). **Comparison of patient satisfaction means between the intervention and control groups.** - The intervention group showed significantly higher room service satisfaction than the control group (mean difference = 4.0, p = 0.019). **Patient independency** A comparison of the mean scores pre and post-intervention among 24 patients revealed that: The average scores for all items assessing patients' independence significantly increased after the intervention, with a p-value of 0.00 (p < 0.05) across all activities. - Sitting to standing: 1.83 ± 0.637 (pre) vs. 2.63 ± 0.824 (post), p < 0.05. - Standing unsupported: 1.79 ± 0.721 vs. 2.79 ± 0.833, p < 0.05. - Sitting with back unsupported, feet supported: 1.88 ± 0.797 vs. 2.75 ± 0.737, p < 0.05. - Standing to sitting: 1.79 ± 0.658 vs. 2.63 ± 0.770, p < 0.05. - Moving: 1.75 ± 0.737 vs. 2.67 ± 0.761, p < 0.05. - Standing unsupported with eyes closed: 1.98 ± 0.751 vs. 2.71 ± 0.751, p < 0.05.	

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					- Standing unsupported with feet together: 1.71 ± 0.624 vs. 2.46 ± 0.779, $p < 0.05$. - Reaching forward with outstretched arm while standing: 1.71 ± 0.751 vs. 2.58 ± 0.776, $p < 0.05$. - Picking up an object from the floor from standing: 1.92 ± 0.830 vs. 2.63 ± 0.824, $p < 0.05$. - Turning to look behind over left and right shoulders while standing: 1.63 ± 0.576 vs. 2.21 ± 0.721, $p < 0.05$. - Turn 360 degrees: 1.38 ± 0.647 vs. 2.25 ± 0.737, $p < 0.05$. - Place alternate foot on step or stool while standing unsupported: 1.58 ± 0.717 vs. 2.25 ± 0.721, $p < 0.05$. - Standing unsupported one foot in front: 1.75 ± 0.794 vs. 2.75 ± 0.737, $p < 0.05$. - Standing on one foot: 1.63 ± 0.875 vs. 2.71 ± 0.859, $p < 0.05$.	
(Su & Yu, 2021) 2021 China Four cardiology units in Tongji Hospital, Wuhan, China	Adult patients hospitalized for coronary heart disease 146 patients: Intervention group (n=73) Control group (n=73) **Age (Mean±SD):** **Intervention:** 55.53 ± 7.30, **Control:** 56.03 ± 7.02 **Sex (%):** Male 122 (83.6%) Female: 24 (16.4%)	- To investigate the effects of a nurse-led eHealth cardiac rehabilitation (NeCR) programmed on lifestyle behaviors in adults with CHD - To examine the effects of NeCR on self-efficacy; anxiety, depression and stress; health-related quality of life; physiological risk parameters; and unplanned utilization of health services - Single-blinded randomized controlled trial design - Registered nurse with experience in cardiovascular nursing	**<u>Preparatory nurse-led goal-setting phase</u>** Nurses conducted an individual assessment of CHD disease management; provided a brief counselling session to increase awareness of self-care deficit; assessed the exercise capacity of the patient with a 6-minute walking test; and uploaded goals and action plans to the patient's account on the NeCR e-platform. The nurse conducted group-based orientation to NeCR online platform; facilitated peer networking, and set up a nurse-led chatroom on WeChat. **<u>Empowerment-based action phase</u>** (1) NeCR online platform *Goal attainment interface* Patients uploaded daily data on lifestyle behaviors. The traffic light	**<u>Usual care</u>** A 10-minute didactic session on medication usage and lifestyle changes (physical activity, diet, and smoking cessation) delivered by the hospital's staff nurses	**At 6 weeks post-intervention,** Significant improvement in the number of steps/day ($\beta = 2628.48$, $p = 0.022$), the number of minutes/weeks sitting ($\beta = -640.30$, $p = 0.006$) and their health-promoting lifestyle profile ($\beta = 25.17$, $p < 0.001$). **At 12 weeks post-intervention,** Improvements in the number of steps/day ($\beta = 2520.00$, $p = 0.006$), the number of minutes/week sitting ($\beta = -719.73$, $p = 0.004$) and health-promoting lifestyle ($\beta = 16.09$, $p < 0.001$), self-efficacy ($\beta = 0.61$, $p = 0.005$) and health-related quality of life (mean difference= 0.56, p <0 .001). **Hospital readmission** Two participants were hospitalized for chest pain and heaviness.	Long-term follow-up is needed to further determine whether the behavior changes can be translated to improved physiological risk parameters and psychological well-being.

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			Intervention group/ (Duration, Frequency)	Control group		
		- In-person, e-platform (WeChat)	system was used to indicate goal attainment. *Experiential learning platform* The role of each CR component and the associated health benefits were briefly introduced, following which behavioral change action advice was presented. Various learning opportunities were provided. *Health dialogue forum* The nurses-initiated health dialogues based on the news to enable patients to access recent CR news reports, and a managed inquiries platform. (2) WeChat Platform Nurse presented a trend analysis on goal attainment for the peer group; moderated real-time experience sharing on goal attainment, and providing health advice on resolving barriers for behavioral changes. **<u>Usual care</u>** A 10-minute didactic session on medication usage and lifestyle changes (physical activity, diet, and smoking cessation) delivered by the hospital's staff nurses **Duration:** 6 and 12 weeks post-intervention test via face-to-face interviews **Frequency:** Reminders for patients to upload the data were sent weekly.			
(Chen et al., 2019) 2019 China	Adult patients diagnosed with decompensated chronic heart failure (CHF) 767 patients:	To investigate whether SMS would help to improve death or readmission-free survival and self-care behavior in CHF patients	**<u>Patients and caregivers in the SMS group</u>** Research nurses delivered the standardized messages from the text messaging platform (educational SMS and reminder SMS). The	**<u>Standard care and inpatient education module before discharge</u>** (1) understanding HF; (2) HF symptoms, signs of exacerbation, and the right time	**Baseline characteristics** were similar among the three groups. During a 180-day follow-up,	The combination of text messaging and smartphone apps would be the interests of further studies to provide better long-term management for CHF patients. Further studies and practice are

Reference, year, country, setting	Target population (Disease), Sample size (Total, Intervention and control), Age (Mean and SD), Sex	Study Aim, Study Design, Provider Involved, Intervention Delivery Platform	Intervention Detail		Main finding(s) of Included Studies	Implications for further research
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Tertiary referral hospital	Short message service (SMS) group (n = 252) Structured telephone support (STS) group (n = 255) Control group (n = 260) **Age (Mean± SD):** **SMS:** 60 ± 15; **STS:** 62 ± 14; **Control:** 61 ± 15 **Sex (%):** Male 433 (56.5%) Female: 334 (43.5%)	A non-blinded randomized controlled trial Hospital ward nurses Text messaging platform (Educational SMS and Reminder SMS); Structured phone call; Inpatient education before discharge	educational SMSs were condensed messages with knowledge of HF (e.g., symptoms of HF decompensation), while the remainder SMSs were brief messages that prompted patients to do things (e.g., taking medicine or weighing). Patients were informed not to reply to the messages. **Frequency:** All educational messages were sent within the first 10 days after discharge, and then the reminder messages were repeated weekly for 1 month. **Patients in the STS group** The research nurses made one structured phone call within 30 days after discharge. Patients were allowed to call back the nurses during work time for consultation. **Frequency:** One phone call **Standard care and an inpatient education module before discharge** (1) understanding HF; (2) HF symptoms, signs of exacerbation, and the right time to visit a doctor; (3) pharmacologic treatment of HF; (4) lifestyle modification; (5) appointment adherence, and the information a doctor needs to know; and (6) motivating and encouraging **Duration:** 180 days of follow-up by phone call or clinic visit after discharge	to visit a doctor; (3) pharmacologic treatment of HF; (4) lifestyle modification; (5) appointment adherence, and the information a doctor need to know; and (6) motivating and encouraging Patients in control group were not contacted in any form after discharge, until the 180 days follow-up.	76 (9.9%) patients died and 274 (35.7%) patients experienced at least one readmission. **Short-term follow-up of 30 days** There was no difference in mortality and the composite endpoint among the three groups (SMS vs. STS vs. usual care: 2.8% vs. 3.1% vs. 3.8% for mortality, P = 0.786; 12.3% vs. 14.5% vs. 15.4% for the composite endpoint, P = 0.588). **180 days follow-up** The 180-day composite event rate was significantly lower in the SMS and STS groups (50.4% vs. 41.3% and 36.5%, both P < 0.05) than in the usual care group, but no difference was observed between the two phone-based intervention groups (P = 0.268). Better self-care behavior was reported in the SMS and STS groups than in the control group (medication compliance, 78.9% vs. 81.4% vs. 69.5%, P = 0.011; water restriction, 70.8% vs. 74.5% vs. 61.5%, P = 0.013). Quality-of-life score was similar among the three groups at 180 days (P = 0.526).	warranted to explore more interactive and tailored interventions for CHF patient management.

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(Daliri et al., 2022) 2022 Netherlands Departments of cardiology and cardiothoracic surgery in six hospitals	- Patients with cardiovascular disease who were ≥ 70 years old and had a high risk of functional loss assessed by DSMS score or had unplanned hospital admission in the previous 6 months. - 198 patients (from 306 CCB), stratified block randomization to intervention (n=99) or control (n=99) (1:1) - Age (Mean ± SD) **Intervention:** 82.0 ± 6.2, **Control:** 82.3 ± 6.5 **Sex (%):** 51.5% were men.	- To evaluate the effect of the CCB on adherence to all high-risk medications associated with preventable medication-related admissions and assess the types and rates of medication-related problems (MRPs) in the intervention group. - A single-blind, multicenter, randomized study (secondary analysis) - Nurses (research, ward, and community), pharmacist (outpatient and community) - In person	**Hospital discharge** - Community nurses (CNs) visited patients and collected discharge medication information. **Home visit** - During the first visit, CNs conducted medication reconciliation and used an "Adapted red flag" tool to identify medication-related problems (MRPs). - CNs sent their observations to the pharmacist, who reviewed and sent back recommendations. **Follow up** - CNs monitored medication use and health status in follow-up visits. - Pharmacists were consulted again if an issue arose. **Duration:** through 6 weeks post-discharge **Frequency:** CN home visits were conducted on days 2, 1,3,6 weeks	- Routine care was received in the hospital and post-discharge care. The MR (medication reconciliation) of one of the participating hospitals was performed at admission and discharge, whereas the other five hospitals performed MR at admission and occasionally at discharge. Post-discharge, patients collect medication at the OPD pharmacy in the hospital, the community pharmacy, or their (adjusted) MDD system. These MDD systems are delivered to patients' homes every 7 to 14 days	- The finding showed that the CCB intervention did not lead to a significant improvement in adherence when compared to the standard care provided to control patients. The extra support and collaboration provided did not change how often patients took their medications correctly after leaving the hospital. - The proportion of days covered (PDC) showed a decreased in the intervention group from 92.3% to 85.2%, while the control group showed a decreased from 88.5% to 84.1%. But it is not different when compared between groups (statistically). - 77% of patients experience one or more medication-related problems (MRPS). These issues included side effects such as toxicity and adverse drug reactions. These could encounter negative effects or complications due to their treatment after discharge. - For the MDD system, the study found that those not using an MDD system showed a slightly better response from the intervention compared to those who did use it.	Future research is recommended to develop and validate more precise methods for calculating adherence, particularly addressing issues like intervention medication discontinuation. Additionally, new metrics should ideally account for the reliability of medication management in a fragile population, where changes in prescription and dosing regimens are common. Increasing sample size and longer follow-up periods might be explored in further research to assess the effect of the intervention.
(Estrada et al., 2024) 2024 Colombia three health institutions (metropolitan area of Bucaramanga, Santander)	Dyads made up of 1) patients: adults with cardiovascular chronic conditions (hypertension and/or DM), 2) Caregivers: **Sample size**: 80 dyads (40 in the intervention and control group) **Age (Mean ± SD), Sex** **Patient** Intervention: 68 ± 14, 52.5% were female	- This study aimed to test whether the Hospital Discharge Transition Plan could improve 1) care competence (get better at handling the care tasks) 2) adherence to the treatment - A controlled and randomized clinical trial - The researcher teams (researcher nurses and other trained healthcare personnel)	**"CUIDEMOS education intervention"** : structured education program was designed to support hospital discharge transition. This intervention included the following key components: - Topics including information about hospital discharge, healthy diet guidance, physical exercise routines and recommendations, care related to cardiovascular and modifiable risk	General care and indications at their hospital admission, as established by each institution, include prevention of falls, accidents at home, and adherence to treatment. Research teams gave the information in an educational booklet. At 1 month, a phone follow-up process was conducted to apply the care competence instrument.	**Main finding** - After they received the intervention, both patients and caregivers showed an increase in care competence. The intervention led to higher scores in all dimensions that collectively portray an increase in the overall ability to manage home care. The study also found that patients demonstrated an improvement in treatment adherence. A key finding is an improvement in care competence and treatment adherence within the group, but there is no significant difference between groups. In conclusion, there was no clear evidence that the more intensive	Further studies should explore enhancing the intervention's design to better differentiate its effects from those of basic education, as the current study did not show significant differences between the groups. Increasing number of sample size and promoting follow-up consistency could be future research. Investigating the impact of diverse education strategies may promote effective intervention. Future research should consider quality of life measures, readmission rates, caregiver burden,

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	Control: 71 ± 10, 52.4 % were female **Caregiver** Intervention: 49 ± 15, 77.5% were female Control: 46 ± 11, 85 % were female	- the face-to-face sessions and follow-up communications	factors, strategies to improve treatment adherence, and roles of patients and caregivers in reducing complications and enhancing QoL. - Booklet and sessions were validated by experts, patients, and caregivers. **Duration:** An initial in-person delivery of the educational content at hospital discharge, followed by three weekly telephone sessions. **Frequency:** session I (medication adherence) provided at once before discharge, and sessions II – IV, including education topics, are a telephone call once per week (3 weeks). This program is designed to be completed within approximately one month.		intervention produced significantly better results than the regular discharge information package.	or cost-effectiveness analysis to provide a more comprehensive assessment of benefit.
(Jepma et al., 2021) 2021 Netherlands Hospital	Cardiac patients ≥ 70 years old admitted to departments of cardiology or cardiothoracic surgery and admitted ≥48 hrs. Must be high risk of functional loss according to the screening instrument for frail older people of the Dutch Safety Management System (DSMS) Also included patients with unplanned hospital admission in the prior 6 months - 306 patients: intervention group (n-153), control group (n=153) - Age (mean ± SD)	To determine the effect of impact of combining case management, disease management, and home-based cardiac rehabilitation on hospital readmission and mortality Parallel single-blind multicenter randomized trial Involved healthcare professionals received post-Bachelor-level training in case management, disease management, and CR. Informal caregivers were involved in the intervention if present. planned home visits	Clinical Phase: Discussion and prioritization of health issues identified by CGA. An integrated care plan was made based on the patient's goals. Discharge Phase: Planning starts when the discharge date is set. The cardiac research nurse contacts CN and PT to arrange the post-clinical phase. CN visit participant and cardiac research nurse to hand over the integrated care plan, medical condition, and treatments. Discharge letter sent to all post-discharge CCB healthcare professionals. Post-Discharge Phase: Planned visits within 3 days, and 1,3, and 6 weeks after discharge, and an	Patients received a comprehensive geriatric assessment (CGA) at baseline by a cardiac research nurse. The control group received usual care, including consultation by other disciplines during hospitalization, outpatient visits to a cardiologist and cardiac nurse specialist, and center-based CR if indicated. A family physician provides standard care.	Primary outcome: The 6-month composite outcome of first all-cause readmission or mortality was 54.2% in the intervention group and 47.7% in the control group. Secondary outcome: At 3 and 12 months after randomization, statistically nonsignificant differences were found in the composite outcome. No statistically significant differences were found on readmission (3, 6, and 12 months) and mortality (3 and 6 months). At 12 months, 38.6% of participants in the intervention group and 26.8% in the control group had died.	Although the integrated discharge planning intervention combining case management, disease management, and home-based cardiac rehabilitation was well-structured, it did not significantly reduce readmission or mortality rates among older cardiac patients. Future research should explore the differential effects of such interventions across specific cardiac subpopulations and frailty levels. Studies with longer follow-up periods may help detect delayed benefits. Additionally, process evaluations assessing patient engagement, intervention fidelity, and caregiver involvement could provide insights into factors

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			Intervention group/ (Duration, Frequency)	Control group		
	Intervention: 82.5 ± 6.1, Control: 82.3 ± 6.5 - Sex (%) Male 156 (51%) Female 150 (49%)		additional home visit within 12 weeks if necessary. During the visit, the integrated care plan, health status, medication, and potential drug-related problems are reviewed. PT provided one to two home-based CR sessions per week with a maximum of 9 sessions in the first 6 weeks.			influencing effectiveness. Cost-effectiveness analyses are also warranted to inform healthcare policy regarding comprehensive post-discharge care in geriatric cardiology settings.
(Piette et al., 2021) 2021 USA Community	Patients are eligible if they have a chronic illness associated with the risk of rehospitalization. - 283 patients Intervention group (n=143), Control group (n=140) - Age (mean ± SD) Intervention group: 60.9 ± 13.1, Control group: 60.5 ± 12.8 - Sex (%) Male 131 (46.3%) Female 152 (53.7%)	To determine the effect of post-hospitalization support for older adults with common chronic conditions. Parallel-group randomized trial Involved healthcare professionals include a nurse practitioner, an outpatient clinician, and a CarePartner. Up to 3 daily assessment phone calls during the first 2 weeks post-discharge, 3 times weekly in the following 2 weeks, and once a week for the remaining 9 weeks. At least one 10 to 15-minute conversation between the patient and the CP.	CarePartner Program Intervention (Interactive Voice Response – IVR) IVR Calls: Up to 3 calls a day for the first 2 weeks, 3 calls a week the following 2 weeks, and one call a week the remaining 9 weeks. Calls included messages to reinforce the importance of medication adherence and managing indicators of worsening health using common language. CarePartner Communication: After each IVR call, CPs receive feedback about the patient's status. CP initiated 10 to 15-minute conversations with patients weekly to review post-discharge appointments, self-management goals, and recent automated assessment reports, and to address goals of effective transitions.	All study participants received usual pre- and post-discharge care, and all CPs received written information about how to successfully support patients' transition from hospital to home. CPs were offered self-care information specific to their patient-partner's diagnosis.	Post-Discharge Acute Events: Control patients had a significantly higher risk of rehospitalization within 90 days post-discharge compared to intervention patients, at 32.2% compared to 20.8%. Overall, 49.2% of control patients experienced an ED visit or rehospitalization within 90 days post-discharge compared to 34.4% of intervention patients.	The findings highlight the potential of interactive voice response (IVR) and CarePartner engagement to reduce post-discharge rehospitalizations and emergency visits. Future research should examine scalability across diverse healthcare settings and patient populations, including those with limited technological literacy or social support. Comparative effectiveness studies are needed to evaluate IVR-based interventions against other digital and nurse-led models. Moreover, mixed-methods research exploring patient and caregiver experiences could inform how to optimize communication content and frequency. Cost-effectiveness and long-term impact on self-management and quality of life should also be assessed to guide implementation strategies.

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