



Science of Nursing
and Health Practices



Science infirmière
et pratiques en santé


Article de protocole de recherche | Research protocol article


Understanding Long-Term Professional Home Care Services and Care Transitions Among Older Adults: A Scoping Review Protocol


Comprendre les services professionnels de soins à domicile de longue durée et les transitions de soins chez les personnes âgées de 65 ans et plus : protocole de revue de portée

Isaura Anselmo  <https://orcid.org/0009-0002-8605-7835> Faculty of Medicine and Health Sciences, Université de Sherbrooke, Quebec, Canada


Sarah Emmanuella Brou  <https://orcid.org/0009-0006-2268-5380> School of Nursing, Université de Sherbrooke, Quebec, Canada


Marie-France Dubois  <https://orcid.org/0000-0001-6553-7827> Department of Community Health Sciences, Université de Sherbrooke, Research Center of Aging, Centre intégré universitaire de santé et de services sociaux de l'Estrie - Centre hospitalier universitaire de Sherbrooke (CIUSSS de l'Estrie - CHUS), Quebec, Canada


Hassiba Chebbihi  <https://orcid.org/0000-0003-2609-815X> Faculty of Medicine and Health Sciences, Université de Sherbrooke, Research Center of Aging, CIUSSS de l'Estrie - CHUS, Quebec, Canada

Nathalie Delli-Colli  <https://orcid.org/0000-0003-4649-2664> School of Social Work, Université de Sherbrooke, Research Center of Aging, CIUSSS de l'Estrie - CHUS, Quebec, Canada

Yohann M. Chiu Department of Family Medicine, Université de Sherbrooke, Quebec, Canada

Didier Mailhot-Bisson  <https://orcid.org/0009-0001-2679-6874> School of Nursing, Université de Sherbrooke, Research Center of Aging, CIUSSS de l'Estrie - CHUS, Quebec, Canada

Christine Loignon  <https://orcid.org/0000-0002-9828-3090> Department of Family Medicine, Université de Sherbrooke, Quebec, Canada

Isabelle Dufour  <https://orcid.org/0000-0002-6142-0442> School of Nursing, Université de Sherbrooke, Research Center of Aging, CIUSSS de l'Estrie - CHUS, Quebec, Canada



Correspondance | Correspondence:

Isabelle Dufour

Isabelle.Dufour3@USherbrooke.ca



Keywords

home care services; aged; care transition; professional care; scoping review

Abstract

Introduction: Older adults with complex health needs experience frequent care transitions, which increase the risk of adverse outcomes. Long-term professional home care services (HCS) are expected to help reduce these risks and support aging in place; however, their role within broader care trajectories remains insufficiently documented. **Objective:** To examine the current state of the literature regarding long-term professional HCS and care transitions among older adults experiencing loss of autonomy and to examine how the duration, type of interventions, and intensity of long-term professional HCS are measured and reported, and which care transitions are considered, and avoidable transitions addressed. **Method:** A scoping review on care transitions for individuals aged 65 and older receiving long-term professional HCS, following the methodology outlined by Arksey and O'Malley (2005), later refined by Levac et al. (2010), using data published from January 2015 through October 2025. Quantitative empirical studies, mixed-methods studies, conceptual papers, literature reviews and peer-reviewed editorials will be searched and extracted from the following databases: Ageline, CINAHL Plus (via EBSCO), MEDLINE (via EBSCO), and PsycINFO. PubMed will be searched additionally to identify in-process and non-MEDLINE records. Two independent reviewers will screen and select articles based on predefined criteria. Discrepancies will be resolved through discussion or a third reviewer. Findings will be shared with relevant partners to inform and enrich the interpretation of the results. **Discussion and Research Spin-offs:** This scoping review will inform transitional care practices by synthesizing existing evidence, to identify system-level gaps in long-term professional HCS, and to outline priorities for future research and practice development.

Résumé

Introduction : Les personnes de 65 ans et plus avec des besoins de santé complexes vivent des transitions de soins fréquentes, augmentant les risques de conséquences indésirables. Les soins à domicile de longue durée devraient réduire ces risques et favoriser le maintien à domicile; toutefois, leur rôle dans les transitions de soins demeure peu documenté. **Objectif :** Examiner l'état de la littérature sur les services professionnels de soins à domicile de longue durée et les transitions de soins chez les personnes âgées en perte d'autonomie, en analysant comment la durée, le type et l'intensité des services sont mesurés, ainsi que les transitions considérées, incluant celles potentiellement évitables. **Méthode :** Revue de la portée utilisant la méthodologie proposée par Arksey et O'Malley (2005), améliorée par Levac et al. (2010), basée sur les publications de janvier 2015 à octobre 2025. Les études empiriques quantitatives ou mixtes, les articles conceptuels, les revues de la littérature et les éditoriaux évalués par les pairs seront ciblés des bases de données Ageline, CINAHL Plus (via EBSCO), MEDLINE (via EBSCO) et PsycINFO. Une recherche complémentaire sera effectuée dans PubMed pour repérer les articles ne se retrouvant pas dans MEDLINE. Deux évaluateurs indépendants trieront et sélectionneront les articles selon des critères préétablis. Les divergences seront résolues par discussion ou par un troisième évaluateur. Des partenaires seront consultés pour enrichir l'interprétation des données. **Discussion et retombées anticipées :** Cette revue soulignera les opportunités d'amélioration du système actuel. Elle fournira des données pour optimiser les pratiques de soins transitoires et définir des priorités de recherche.

Mots-clés

soins à domicile; personnes âgées; transitions de soins; soins professionnels; revue de la portée

INTRODUCTION

Over the next decade, the proportion of people aged 65 years and older in Canada is projected to reach 21% of the population (Institut de la statistique du Québec, 2021). Significant transformations in individuals' profiles are anticipated, as with advancing age, a certain proportion will experience health and well-being challenges such as physical comorbidities, cognitive impairments, and loss of autonomy, which can require additional support to facilitate aging in place. Given that remaining safely in the comfort of one's home is a widely shared priority among older adults in many countries, including Canada, home care services (HCS) continue to be the most sought-after option to support aging in place while ensuring adequate care (Archambault, 2019; Bolster-Foucault et al., 2024; Johnson et al., 2018; Kosteniuk et al., 2022; Ministère de la Santé et des Services sociaux [MSSS], 2003, 2023).

HCS encompass various services offered to community-dwelling individuals in multiple settings, including professional care such as nursing care, psychosocial services, rehabilitation, nutrition, and domestic and personal assistance (Commissaire à la santé et au bien-être [CSBE], 2023a; MSSS, 2023). More specifically, the objectives of HCS in Canada, and particularly in Quebec, are diverse, emphasizing prevention, enhancing end-of-life care, supporting older adults living at home, ensuring service adequacy, and integrating various health services to deliver comprehensive care (MSSS, 2023). HCS can be provided on a short-term basis, such as for transitional care programs, post-discharge support, or temporary follow-up visits (CSBE, 2023b). However, long-term home care, provided for at least a few months, often becomes necessary for older adults with a loss of autonomy to address their ongoing needs (CSBE, 2023b). In Quebec, a recent report showed that 91% of HCS interventions were provided on a long-term basis, and that a large majority of these patients received professional care (CSBE, 2023b).

Older adults experiencing loss of autonomy and complex healthcare needs are exposed to various care transitions (CSBE, 2023b; Low et al.,

2011), defined as a transfer of responsibility between healthcare professionals across different settings and sectors (Government of Canada, 2018). Care transitions involve physical transfers, typically requiring overnight or multiple days of care (Kosteniuk et al., 2022). The most frequent care transitions are in and out of hospitals, visits to emergency departments (ED), and placement in long-term care facilities. These transitions place older adults at risk of adverse outcomes, including fragmented care, compromised safety, negative health effects, and a decline in the overall quality of care (Cations et al., 2020; Jencks et al., 2009; Ouslander et al., 2020). Furthermore, about 20% of care transitions are deemed avoidable (Auerbach et al., 2016; van Walraven et al., 2011). Additionally, within a one-year post-discharge period, approximately 20% of older adults transitioning from hospital to home were re-hospitalized within 30 days (Field et al., 2015; Joynt & Jha, 2012).

According to various studies, HCS may reduce care transitions among older adults, including potentially avoidable care transitions, such as unnecessary hospitalizations and ED visits, or premature transfers to long-term care facilities (Di Pollina et al., 2017). HCS have also been shown to improve healthcare outcomes and patient satisfaction, while decreasing hospitalization rates (Contandriopoulos et al., 2022; Eltaybani et al., 2023). However, mixed results are often reported, as various studies showed increased odds of hospital admission among older HCS patients, particularly those with comorbidities and polypharmacy (Contandriopoulos et al.; Glans et al., 2020; Hain et al., 2012;).

While numerous studies have advanced our understanding of how professional HCS influence care transitions among older adults experiencing loss of autonomy, important dimensions remain underexplored. Recently, an umbrella review by Eltaybani et al. (2023) synthesized systematic reviews on the effectiveness of long-term nursing HCS for older adults, highlighting its effectiveness in reducing hospitalization rates.

However, outside of nursing, a lack of clarity is reported regarding the types of professional services provided, their intensity and their definition. This limits our ability to assess how

specific service configurations, beyond nursing, but also including rehabilitation, social support, and physician involvement, may influence or prevent care transitions like hospitalizations, ED visits, and institutionalization. Moreover, most research focuses on short-term interventions, such as transitional care following hospital discharge, and there is no consensus on the definition of long-term HCS. Thus, the role of long-term professional HCS in shaping the broader trajectory of aging individuals remains insufficiently examined despite their growing importance in supporting aging in place (Archambault, 2019; Eltaybani et al., 2023). The absence of standardized outcome measures limits the generalizability of findings and makes it difficult to identify effective, scalable interventions. These limitations underscore the need for a more nuanced and comprehensive understanding of how long-term professional HCS influence care transitions.

OBJECTIVE

The objective of this scoping review is to map and synthesize the recent literature on care transitions among older adults receiving long-term professional home care services, with particular attention to how HCS's characteristics (type, duration, and intensity) are described and examined in relation to care transitions. The review also aims to identify how potentially avoidable care transitions are conceptualized and to summarize how relationships between home care services and care transitions are reported in the literature.

METHOD

This scoping review will follow the methodology outlined by Arksey and O'Malley (2005) and later improved by Levac et al. (2010). The recommendations by Levac et al. aimed to enhance the prior version and allow researchers to describe specific literature characteristics. Additionally, we will follow the Preferred Reporting Items for Systematic Reviews and Meta-analysis extension for Scoping Review (PRISMA-ScR) (Tricco et al., 2018).

STAGE 1: IDENTIFYING THE RESEARCH QUESTION

This scoping review will seek to answer the following primary question: "What does the recent literature report regarding care transitions among older adults receiving long-term professional home care services?" The review will also address the following secondary questions: 1) "How are the characteristics of long-term professional home care services—specifically type, duration, and intensity—described and examined in relation to care transitions?" 2) "Which types of care transitions are examined in the literature, and how are potentially avoidable care transitions conceptualized and reported?" 3) "How are relationships between long-term professional home care services and care transitions described in the literature?"

STAGE 2: IDENTIFYING RELEVANT STUDIES

There is currently no clear consensus on the definition of long-term HCS. In Quebec, long-term professional HCS are defined as services provided in the homes of older adults for a period of 6 months or longer, and dispensed by licensed healthcare professionals (such as nurses, physiotherapists and social workers) in public and private settings (CSBE, 2023b). In line with this definition, long-term HCS will be defined in this protocol as home care services provided for a minimum period of 6 months. This threshold has been established, following conceptual and clinical considerations by the research team, to allow for a clear distinction between long-term care needs and transitional services, typically often lasting over a period of a week to a few months (CSBE, 2023c; Tourigny, 2013).

Also, we will report on all care transitions, the most frequently considered being: 1) ED visits; 2) hospitalizations; 3) long-term care facility transfer. We will also pay particular attention to avoidable care transitions, recently defined as transitions that "(a) are without significant patient-relevant benefits or with a risk of harm outweighing patient-relevant benefits and/or (b) are when a comparable health outcome could be achieved in lower resource settings using the resources available in that place/health care system, and/or (c) violate a patient's/informal caregiver's

preference or an agreed care plan” (Makhmutov et al., 2023, p. 6). Following this definition, we will consider avoidable care transitions occurring for chronic health conditions where timely management, either in primary care or through home care services, could have prevented the deterioration of the individual’s health status (e.g., pneumonia), hospital readmission, and ED visits deemed avoidable (Lin et al., 2017; Organization for Economic Co-operation and Development, 2023).

Our inclusion criteria are as follows: 1) the article is a quantitative empirical study, mixed-methods study, a conceptual paper, a literature review or a peer-reviewed editorial; 2) the study focuses on people aged 65 years and over; 3) long-term professional HCS, provided by at least one professional, is the primary focus of the study; 4) the study reports on care transitions, including unnecessary or avoidable care transitions; 5) the paper was published between January 2015 and October 2025 (to ensure that the most recent information and results presented by the articles will be a direct reflection of the current state of knowledge); 6) the study is published in English or in French (considering that all team members are fluent in both languages, thus ensuring all articles will be well understood, and that most research articles are written in English).

Our exclusion criteria are as follows: 1) the article is a study protocol, a conference abstract, or a non-peer-reviewed publication; 2) articles not focusing on older adults living in the community (e.g., people residing in long-term care facilities); 3) articles using only remote services (e.g., telephone-based care) or focused on telehealth interventions. Telehealth intervention is defined as a clinical process employing telehealth as a major component of their delivery (Maeder & Wilson, 2017); 4) articles that only include care provided by family caregivers or non-health professionals; 5) articles focusing on “hospital-at-home,” because of their focus on recovery from acute events with specific treatment programs (Kanagala et al., 2023); 6) articles focusing on dental health; 7) articles focusing on economic evaluation.

We will use the following scientific databases: Ageline, CINAHL plus with Full Text (EBSCO), MEDLINE with full text (EBSCO), and PsycINFO.

PubMed will be searched additionally to identify in-process and non-MEDLINE records. An experienced librarian helped organize and initiate research strategies based on our eligibility criteria. The research team further improved it to ensure adequacy before starting the project. Controlled vocabulary supplemented with keywords will identify appropriate articles related to HCS and care transitions. An example of a search strategy in MEDLINE with full text (EBSCO) is presented in table 1. We will also examine the reference lists of the selected full-text articles to identify additional sources.

In addition, grey literature sources will be searched to enhance the comprehensiveness of the evidence base. More specifically, keywords designed to capture the most relevant literature will be used in Google Scholar to include all documents published between January 2015 and October 2025. Only the first 200 results will be considered for the article title searches (Haddaway et al., 2015).

STAGE 3: STUDY SELECTION

All articles will be transferred to Covidence, a web-based software platform for systematic reviews (Veritas Health Innovation, 2013). Covidence will be used to deduplicate search results, screen titles, and abstracts, and perform the full-text review. During the initial steps, abstracts and titles screening pilot (10% of the total number) will be conducted by two independent reviewers to estimate the inter-rater reliability. Reviewers will hold at least one meeting to answer questions, clarify any misunderstandings, and ensure consistency in applying the selection criteria. Once a common interpretation of inclusion and exclusion criteria is reached between the two reviewers, they will independently screen the remaining 90% of titles and abstracts. A third party will help manage any conflicts regarding inclusion and exclusion criteria. Similarly, in the second step, two reviewers will independently conduct full-text reviews to evaluate their relevance and eligibility, with the support of a third reviewer as needed. The results of the search will be reported in full in the final review and presented in a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram (Moher, 2009).

Table 1

Example of a Search Strategy in MEDLINE with Full Text (EBSCO)

Boolean search strategy using controlled vocabulary and free-text terms

```
((Elder* OR Geriatric* OR Aging OR Ageing Or Senior* OR "Old person*" OR "Old people" OR "Old age" OR "Old adult*" OR "Old patient*") OR AB (Elder* OR Geriatric* OR Aging OR Ageing Or Senior* OR "Old person*" OR "Old people" OR "Old age" OR "Old adult*" OR "Old patient*")) AND ((In-home OR home OR home-based OR community OR formal OR informal) N2 (care OR healthcare OR health-care OR "health care" OR aid OR assistance)) OR AB ((In-home OR home OR home-based OR community OR formal OR informal) N2 (care OR healthcare OR health-care OR "health care" OR aid OR assistance))) AND ((Emergenc* OR "Hospital readmission" OR Re-hospitali* OR Rehospitali* OR hospital* OR ED OR "Care coordination") OR AB (Emergenc* OR "Hospital readmission" OR Re-hospitali* OR Rehospitali* OR hospital* OR ED OR "Care coordination")) OR ((continuity OR transitions OR transition OR handoff) N2 care OR (Avoidable OR care OR healthcare) N2 transition*)) OR AB ((continuity OR transitions OR transition OR handoff) N2 care OR (Avoidable OR care OR healthcare) N2 transition*))
```

STAGE 4: DATA EXTRACTION

Using Covidence software, a descriptive-charting tool for data extraction will be developed, inspired by the data extraction tool elaborated by the Johanna Briggs Institute (Pollock et al., 2023). The same two independent reviewers will then extract pertinent information from the selected studies identified at stage 3.

The following data will be extracted : 1) study characteristics: authors, year of publication, country, study design, and objectives; 2) population characteristics: age range, sex, gender, health conditions, and eligibility criteria related to HCS; 3) context and characteristics of long-term professional HCS: type of services provided, duration and intensity of services, type of interventions delivered, how these characteristics are defined and measured, and any additional service-related characteristics deemed relevant; 4) information on care transitions: types of transitions, the settings of these transitions, and transition-related outcomes; 5) when available, data related to the conceptualization of care transitions: how transitions are framed (e.g., necessary or potentially avoidable) and any strategies or approaches discussed to address or reduce potentially avoidable transitions; 6) relationships or associations between characteristics of HCS and care transitions; 7) recommendations related to practice, professional training, policy, or future research. Following the recommendations of Levac et al.

(2010), the two reviewers will independently chart the same first few articles (10% of the total number of articles included) using our extraction charting form. The results from this initial exercise will be reviewed by the principal investigator (ID) to determine if the extracted data truly represents the essence of the topic to answer the research question. Once again, any discrepancies will be discussed and resolved by a third reviewer. Once the extraction test is completed, the two reviewers will read and chart each article to ensure inter-reviewer reliability, which the primary investigator will double verify. Constant communication and meetings will be held throughout this process to clarify any confusion and ensure consistent charting methods.

In addition, an Excel spreadsheet containing the following sections will be used to chart the grey literature data: the search date, the website name, the title of the article, the search performed, the keywords used to obtain results, the number of results and studies retained, and the information extracted.

STAGE 5: COLLATING, SUMMARIZING AND REPORTING RESULTS

Based on the extracted data, descriptive tables (see Appendix 1) will be developed to facilitate the clear visualization and interpretation of findings. A narrative synthesis approach, as proposed by Popay et al. (2006), will be used to integrate findings from the included studies. This will involve an in-depth analysis ensuring that all

aspects of the studies are examined, and that the data are presented in such a way that highlights similarities and/or differences. This approach will also enable the identification of both consistent findings and knowledge gaps, thereby informing future avenues of research. The title and abstract screening phase has already begun and is expected to be completed by mid-2026. Full-text screening will follow with completion expected by the end of summer 2026, after which data extraction and analysis will be conducted.

STAGE 6: CONSULTATION

Lastly, to add methodological rigor, consultations with five to eight partners (e.g., health professionals providing health care services, decision makers, patients and their families) will be conducted, in the form of focus groups, to share the major findings. Ethics approval will be obtained from the research ethics board prior to conducting these consultations. Partners will be recruited via the teams' networks, and will include members of the team, researchers from the fields, and healthcare professionals playing a role in HCS, such as nurses. Feedback from these consultations will contribute to data validation and interpretation. The integration of these perspectives will support the interpretation of findings and inform future research. The scoping review, along with the consultation step, is planned to be completed by the end of fall 2026.

DISCUSSION AND RESEARCH SPIN-OFFS

This scoping review aims to examine the state of the recent literature regarding care transitions for older adults receiving long-term professional HCS.

The potential impact of this review is to generate evidence-based strategic knowledge to support health care professionals in home-care settings. This knowledge may guide initiatives to reduce the frequency and duration of care transitions, especially avoidable ones, for older adults receiving home care. Focusing on long-term HCS is critical, given their essential role in enabling aging in place and the limited attention this area

has received in scientific research. Given the importance of various professional services in meeting the complex health needs of older adults receiving home care, especially nurses, this review will notably enable us to assess the level of interprofessional collaboration in providing HCS. Additionally, this review aligns with government priorities to evaluate the performance of HCS, improve their organization, and increase funding to support a growing number of older adults experiencing loss of autonomy in the community.

STRENGTHS AND LIMITS

Regarding strength, this scoping review follows widely recognized and established methodological frameworks, ensuring methodological rigor. It will be conducted by a skilled and multidisciplinary team, while being supported by an experienced librarian specialized in search strategy development. Furthermore, consultations with various stakeholders will enhance and refine the study's conclusions. However, a notable limitation is the restricted search of grey literature to Google Scholar, potentially underrepresenting valuable non-academic articles. The focus on recent literature (2015–2025) may also introduce a temporal bias, as it excludes earlier studies that could provide valuable historical or conceptual insights into long-term home care services and care transitions.

From a nursing practice perspective, the results of this scoping review, through its consultative and descriptive methodological approach, will provide an overview of how long-term professional HCS are currently described in the literature, thereby highlighting areas of convergence and variation across existing practices. By mapping how care transitions and HCS are reported, our work may inform reflections on interprofessional collaboration within HCS settings. From a nursing research perspective, this review will identify conceptual, methodological, and analytical gaps in the existing literature, including how care transitions are defined, measured, and analyzed in relation to home care service characteristics. In addition, the synthesis will highlight opportunities to strengthen and refine analytical approaches for future studies. Overall, this mapping of evidence is intended to

contribute to the ongoing development of nursing roles in HCS and to inform future research aimed at addressing the growing, complex needs of older adults receiving care at home.

Authors' contribution: All authors contributed to developing the review objectives and method. The search strategy was implemented by IA, SEB, DMB, CL and ID. IA, ID, DMB, and SEB participated in the selection of studies and the development of the extraction grid. All authors revised and approved the final version of the manuscript.

Acknowledgments: The authors are grateful to the librarian Florence Nadeau for her support in developing the research strategy.

Funding: The authors received no funding to conduct the project reported in this article nor to draft this article.

Statement of conflict of interest: The authors declare no conflict of interest.

Ethics certificate number: An ethics certificate is not required for a synthesis of existing literature, as it does not involve human participants or primary data collection.

Reçu/Received: 24 Mars/March 2025 **Publié/Published:** 27 Mai/May 2026

REFERENCES

- Archambault, M., Candas, B., Fortino, M., & Raymond, M. H. (2019). *Évaluation du continuum de soins et services aux aînés. Perspectives pour l'évolution de la mesure*. Institut national d'excellence en santé et en services sociaux. https://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/ServicesSociaux/INESSS_Evaluation_continuum_aines.pdf
- Arksey, H., & O'Malley, L. (2005). Scoping Studies: Towards a Methodological Framework. *International Journal of Social Research Methodology*, 8(1), 19–32. <https://doi.org/10.1080/1364557032000119616>
- Auerbach, A. D., Kripalani, S., Vasilevskis, E. E., Sehgal, N., Lindenauer, P. K., Metlay, J. P., Fletcher, G., Ruhnke, G. W., Flanders, S. A., Kim, C., Williams, M. V., Thomas, L., Giang, V., Herzig, S. J., Patel, K., Boscardin, W. J., Robinson, E. J., & Schnipper, J. L. (2016). Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients. *JAMA internal medicine*, 176(4), 484–493. <https://doi.org/10.1001/jamainternmed.2015.7863>
- Bolster-Foucault, C., Vedel, I., Busa, G., Hacker, G., Sourial, N., & Quesnel-Vallée, A. (2024). Social inequity in ageing in place among older adults in Organisation for Economic Cooperation and Development countries: A mixed studies systematic review. *Age and Ageing*, 53(8), afae166. <https://doi.org/10.1093/ageing/afae166>
- Canadian Institutes of Health Research. (2021, June 14). *Transitions in Care: Overview*. Government of Canada. <https://cihr-irsc.gc.ca/e/50972.html>
- Cations, M., Lang, C., Crotty, M., Wesselingh, S., Whitehead, C., & Inacio, M. C. (2020). Factors associated with success in transition care services among older people in Australia. *BMC geriatrics*, 20(1), 496. <https://doi.org/10.1186/s12877-020-01914-z>
- Commissaire à la santé et au bien-être. (2023a, 28 mars). *Bien vieillir chez soi – Tome 1: comprendre l'écosystème*. https://www.csbe.gouv.qc.ca/fileadmin/www/2023/Rapportpreliminaire_SAD/CSBE-Rapport_Preliminaire_SoutienDomicile_V2.pdf
- Commissaire à la santé et au bien-être. (2023b, 20 juin). *Bien vieillir chez soi - Tome 2: chiffrer la performance*. https://www.csbe.gouv.qc.ca/fileadmin/www/2023/Rapportpreliminaire_SAD/CSBE-Tome2_Rapport_Preliminaire_SoutienDomicile.pdf
- Commissaire à la santé et au bien-être. (2023c, 15 novembre). *Horizon 2040 : projection des impacts du soutien à l'autonomie au Québec*. https://www.csbe.gouv.qc.ca/fileadmin/www/2023/Chaire_Jacques_Parizeau/CSBE-rapport_Projection_Soutienadomicile.pdf
- Contandriopoulos, D., Stajduhar, K., Sanders, T., Carrier, A., Bitschy, A., & Funk, L. (2022). A realist review of the home care literature and its blind spots. *Journal of Evaluation in Clinical Practice*, 28(4), 680–689. <https://doi.org/10.1111/jep.13627>
- Di Pollina, L., Guessous, I., Petoud, V., Combescure, C., Buchs, B., Schaller, P., Kossovsky, M., & Gaspoz, J.-M. (2017). Integrated care at home reduces unnecessary hospitalizations of community-dwelling frail older adults: A prospective controlled trial. *BMC Geriatrics*, 17(1), 53. <https://doi.org/10.1186/s12877-017-0449-9>
- Eltaybani, S., Kawase, K., Kato, R., Inagaki, A., Li, C. C., Shinohara, M., Igarashi, A., Sakka, M., Sumikawa, Y., Fukui, C., & Yamamoto-Mitani, N. (2023). Effectiveness of home visit nursing on improving mortality, hospitalization, institutionalization, satisfaction, and quality of life among older people: Umbrella review. *Geriatric nursing (New York, N.Y.)*, 51, 330–345. <https://doi.org/10.1016/j.gerinurse.2023.03.018>
- Field, T. S., Ogarek, J., Garber, L., Reed, G., & Gurwitz, J. H. (2015). Association of early post-discharge follow-up by a primary care physician and 30-day rehospitalization among older adults. *Journal of General Internal Medicine*, 30(5), 565–571. <https://doi.org/10.1007/s11606-014-3106-4>
- Glans, M., Kragh Ekstam, A., Jakobsson, U., Bondesson, Å., & Midlöv, P. (2020). Risk factors for hospital readmission in older adults within 30 days of discharge – a comparative retrospective study. *BMC Geriatrics*, 20(1), 467. <https://doi.org/10.1186/s12877-020-01867-3>
- Haddaway, N. R., Collins, A. M., Coughlin, D., & Kirk, S. (2015). The Role of Google Scholar in Evidence Reviews and Its Applicability to Grey Literature Searching. *PLoS ONE*, 10(9), e0138237. <https://doi.org/10.1371/journal.pone.0138237>
- Hain, D. J., Tappen, R., Diaz, S., & Ouslander, J. G. (2012). Characteristics of older adults rehospitalized within 7 and 30 days of discharge: implications for nursing practice. *Journal of gerontological nursing*, 38(8), 32–44. <https://doi.org/10.3928/00989134-20120703-05>
- Institut de la statistique du Québec. (2021, June 17). *Towards a population of 10 million people in Québec by 2066*. Gouvernement du Québec. <https://statistique.quebec.ca/en/communiquer/towards-a-population-of-10-million-people-in-quebec-by-2066>
- Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *The New England journal of medicine*, 360(14), 1418–1428. <https://doi.org/10.1056/NEJMs0803563>

- Johnson, S., Bacsu, J., Abeykoon, H., McIntosh, T., Jeffery, B., & Novik, N. (2018). No Place Like Home: A Systematic Review of Home Care for Older Adults in Canada. *Canadian journal on aging = La revue canadienne du vieillissement*, 37(4), 400–419. <https://doi.org/10.1017/S0714980818000375>
- Joynt, K. E., & Jha, A. K. (2012). Thirty-day readmissions—Truth and consequences. *The New England Journal of Medicine*, 366(15), 1366–1369. <https://doi.org/10.1056/NEJMp1201598>
- Kanagala, S. G., Gupta, V., Kumawat, S., Anamika, F., McGillen, B., & Jain, R. (2023). Hospital at home: Emergence of a high-value model of care delivery. *The Egyptian Journal of Internal Medicine*, 35(1), 21. <https://doi.org/10.1186/s43162-023-00206-3>
- Kosteniuk, J., Osman, B. A., Osman, M., Quail, J. M., Islam, N., O’Connell, M. E., Kirk, A., Stewart, N. J., & Morgan, D. (2022). Health service use before and after dementia diagnosis: A retrospective matched case-control study. *BMJ open*, 12(11), e067363. <https://doi.org/10.1136/bmjopen-2022-067363>
- Levac, D., Colquhoun, H., & O’Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation science : IS*, 5, 69. <https://doi.org/10.1186/1748-5908-5-69>
- Lin, P. J., Zhong, Y., Fillit, H. M., Cohen, J. T., & Neumann, P. J. (2017). Hospitalizations for ambulatory care sensitive conditions and unplanned readmissions among Medicare beneficiaries with Alzheimer’s disease. *Alzheimer’s & dementia: the journal of the Alzheimer’s Association*, 13(10), 1174–1178. <https://doi.org/10.1016/j.jalz.2017.08.010>
- Low, L.-F., Yap, M., & Brodaty, H. (2011). A systematic review of different models of home and community care services for older persons. *BMC Health Services Research*, 11, 93. <https://doi.org/10.1186/1472-6963-11-93>
- Maeder, A. J., & Wilson, L. S. (2017). Chapter 25 Evaluating Telehealth Interventions. In *Handbook of eHealth Evaluation: An Evidence-based Approach [Internet]*. University of Victoria. <https://www.ncbi.nlm.nih.gov/books/NBK481616/>
- Makhmutov, R., Meyer, G., Ellen, M. E., & Fleischer, S. (2023). Avoidable Care Transitions: A Consensus-Based Definition Using a Delphi Technique. *Innovation in Aging*, 7(8), igad106. <https://doi.org/10.1093/geroni/igad106>
- Ministère de la Santé et des Services sociaux. (2003). *Chez soi, Le premier choix : La politique de soutien à domicile* (Publication no : 02-704-01). Gouvernement du Québec. <https://publications.msss.gouv.qc.ca/msss/fichiers/2002/02-704-01.pdf>
- Ministère de la Santé et des Services sociaux. (2023). *Orientations en soutien à domicile - Actualisation de la Politique de soutien à domicile « Chez soi: Le premier choix »*. Gouvernement du Québec <https://publications.msss.gouv.qc.ca/msss/fichiers/2023/23-704-01W.pdf>
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS medicine*, 6(7), e1000097. <https://doi.org/10.1371/journal.pmed.1000097>
- Organization for Economic Co-operation and Development. (2023, Novembre 7). *Health at a Glance 2023*. https://www.oecd.org/en/publications/health-at-a-glance-2023_7a7afb35-en.html
- Ouslander, J. G., Reyes, B., Diaz, S., & Engstrom, G. (2020). Thirty-Day Hospital Readmissions in a Care Transitions Program for High-Risk Older Adults. *Journal of the American Geriatrics Society*, 68(6), 1307–1312. <https://doi.org/10.1111/jgs.16314>
- Pollock, D., Peters, M. D. J., Khalil, H., McInerney, P., Alexander, L., Tricco, A. C., Evans, C., de Moraes, É. B., Godfrey, C. M., Pieper, D., Saran, A., Stern, C., & Munn, Z. (2023). Recommendations for the extraction, analysis, and presentation of results in scoping reviews. *JBI evidence synthesis*, 21(3), 520–532. <https://doi.org/10.11124/JBIES-22-00123>
- Popay, J., Roberts, H.M., Sowden, A.J., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the Conduct of Narrative Synthesis in Systematic Reviews A Product from the ESRC Methods Programme.
- Tourigny, André. (2013). *Soins à domicile – Une synthèse des connaissances pour répondre à des questions prioritaires aux paliers local et central*. CHU de Québec/Centre d’excellence sur le vieillissement de Québec.
- Tricco, A. C., Lillie, E., Zarin, W., O’Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., Lewin, S., ... Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of internal medicine*, 169(7), 467–473. <https://doi.org/10.7326/M18-0850>
- van Walraven, C., Bennett, C., Jennings, A., Austin, P. C., & Forster, A. J. (2011). Proportion of hospital readmissions deemed avoidable: A systematic review. *CMAJ: Canadian Medical Association Journal = Journal de l’Association Médicale Canadienne*, 183(7), E391–E402. <https://doi.org/10.1503/cmaj.101860>
- Veritas Health Innovation. (2013). *Covidence® Systematic review software* [Computer software]. <https://www.covidence.org>

Appendix 1

Table 1

Descriptive Tables of Extracted Data (Part I)

Study characteristics				
Authors	Year of publication	Country (where data was collected)	Study design	Study objectives

Table 1

Descriptive Tables of Extracted Data (Part II)

Population characteristics				
Age range	Sex/gender	Health conditions	Eligibility criteria related to HCS	

Table 1

Descriptive Tables of Extracted Data (Part III)

Context and characteristics of professional HCS					
Type of services provided	Duration of services	Intensity of services	Type of intervention	Characteristics definition and measurement	Additional service-related characteristics

Table 1

Descriptive Tables of Extracted Data (Part IV)

Information on care transitions				
Care transitions 1				
Type and setting	Conceptualization (potentially avoidable, etc.)	Related outcomes	Relationships with HCS	Recommendations
Care transitions 2				
Type and setting	Conceptualization (potentially avoidable, etc.)	Related outcomes	Relationships with HCS	Recommendations