



Nurse-Led Digital Navigation for Postdischarge Continuity

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Abstract

The transition from hospital to home is a clinically vulnerable period during which patients must interpret discharge instructions, reconcile medications, recognize changing symptoms, arrange follow-up appointments, and coordinate multiple services with substantially less professional supervision than was available during hospitalization. Nurse-led transitional-care models have demonstrated the importance of continuity across settings, while telephone follow-up research indicates that postdischarge nursing contact can address information and communication needs, although effects on hospital readmission have varied among studies. The present study develops a simulation-based model of nurse-led digital navigation that combines telephone contact, secure messaging, digital reminders, symptom check-ins, medication clarification, follow-up coordination, and nurse-directed escalation. A hypothetical cohort of 500 adults discharged from acute hospital care was divided equally between a digitally supported nurse-navigation pathway and conventional discharge follow-up. Because no original clinical dataset was provided, all numerical outcomes are synthetic and intended for methodological demonstration.

The simulated pathway produced higher rates of successful contact within 48 hours, medication-issue resolution, scheduled follow-up completion, appropriate escalation of concerning symptoms, and overall 30-day continuity. Among digitally navigated participants, 84% were modeled as maintaining continuity through the first 30 days compared with 61% under conventional follow-up. Medication questions or discrepancies accounted for 31% of simulated problems detected through navigation, followed by new or worsening symptoms at 25%. The findings support conceptualizing digital navigation not as an automated substitute for clinical care but as a nurse-mediated continuity infrastructure through which digital tools organize information, identify gaps, and connect patients with appropriate professional services. Future empirical evaluation should examine patient safety, equity, nursing workload, digital accessibility, unresolved medication discrepancies, follow-up completion, and health-service utilization rather than relying on readmission alone.

Keywords: nurse-led care; digital navigation; postdischarge continuity; transitional care; telephone follow-up; care coordination; nursing informatics; medication reconciliation; patient safety; hospital discharge

1. Introduction

Hospital discharge represents a major change in the structure of patient care. During hospitalization, medication administration, clinical observation, diagnostic testing, nursing assessment, and



interprofessional communication occur within an organized institutional environment. Following discharge, much of this coordination must be reconstructed by patients and families while they manage new medicines, altered treatment plans, follow-up appointments, rehabilitation requirements, dietary guidance, symptoms, and uncertainty about when professional review is necessary. Transitional-care research has therefore treated discharge as a process extending across settings rather than as a single administrative event. Naylor and colleagues demonstrated in early randomized studies that advanced-practice-nurse-led discharge planning and postdischarge follow-up could improve selected outcomes in high-risk older adults, establishing an influential foundation for nurse-led transitional care.

Continuity problems often become visible only after the patient reaches home. A person may discover that the medication list differs from medicines already available at home, may be unable to obtain a newly prescribed drug, may misunderstand activity restrictions, or may realize that no specialist appointment has actually been scheduled. Coleman and colleagues' Care Transitions Intervention addressed several of these vulnerabilities through cross-setting communication, active patient involvement, and transition coaching and reported lower rehospitalization at selected follow-up points. Such findings support the principle that postdischarge continuity requires active navigation rather than passive reliance on discharge documents.

Telephone follow-up has consequently become one of the most practical mechanisms for extending contact after hospitalization. Harrison and colleagues reported an association between timely postdischarge telephone follow-up and lower near-term readmission in their study, while later systematic reviews by Bahr and colleagues and Woods and colleagues found heterogeneous evidence across different patient groups, intervention designs, timing, and outcomes. This mixed evidence is important. It suggests that the value of postdischarge contact should not be judged exclusively by whether a single telephone call reduces readmissions. Calls may also clarify information, identify medication problems, detect symptoms, reinforce self-management, and connect patients with appropriate services.

Digital technologies can extend this principle by allowing follow-up to occur through a combination of telephone calls, text or secure messaging, electronic reminders, symptom questionnaires, appointment prompts, and digital information exchange. However, the presence of technology does not itself create continuity. A reminder system that tells a patient to attend an appointment cannot resolve uncertainty when the appointment was never successfully scheduled, and an automated symptom questionnaire cannot safely manage a clinically important deterioration unless there is a clear escalation mechanism. Nurse-led digital navigation therefore differs from simple automated messaging because the nurse interprets patient-reported information within an established scope of practice and coordinates the next appropriate step.

The present study develops a simulation-based framework for Nurse-Led Digital Navigation for Postdischarge Continuity. The model combines structured early contact, medication review, confirmation of follow-up arrangements, symptom screening, discharge-instruction clarification, digital reminders, and nurse-directed escalation. Because no real patient-level dataset was provided, the analytical values are intentionally synthetic and are not presented as observed clinical effects. The purpose is to define a reproducible research model through which future prospective or pragmatic studies can evaluate whether nurse-led digital navigation improves continuity without creating



unnecessary digital burden, inequitable access, excessive nursing workload, or unsafe substitution for direct clinical assessment.

2. Objectives of the Study

2.1 To Strengthen Continuity During the Hospital-to-Home Transition

The primary objective is to examine whether nurse-led digital navigation could improve the proportion of discharged patients who remain connected with the intended care pathway during the first 30 days at home. Continuity is defined broadly to include successful early contact, access to prescribed medications, understanding of discharge instructions, confirmation of follow-up appointments, and appropriate professional response when new problems arise.

This formulation reflects established transitional-care principles. Hirschman and colleagues described the Transitional Care Model as a nurse-led approach intended for high-risk older adults moving across health-care settings and emphasized continuity, patient and caregiver engagement, symptom management, collaboration, and coordinated care. Digital navigation is proposed as a contemporary delivery mechanism for several of these functions, rather than as a separate clinical model disconnected from established nursing practice.

2.2 To Improve Early Detection and Resolution of Postdischarge Problems

A second objective is to determine whether structured digital contact can identify unresolved problems before they progress into preventable care disruption. Medication discrepancies, difficulty obtaining medicines, uncertainty regarding wound or activity instructions, missed follow-up appointments, and worsening symptoms can remain invisible to the discharging hospital unless patients actively seek assistance.

Postdischarge telephone research indicates that nursing calls can respond to information and communication needs, although clinical effects vary across studies. Woods and colleagues' mixed-method systematic review concluded that nurse-led calls can improve satisfaction and have potential benefits for communication and self-management, while emphasizing heterogeneity in the evidence. The proposed navigation model therefore measures problem detection and resolution as explicit outcomes instead of assuming that readmission is the only meaningful endpoint.

2.3 To Develop a Safe and Equitable Digital Navigation Framework

The third objective is to establish clear boundaries around the use of digital communication after discharge. Digital navigation should support access to professional care but should not encourage patients to rely on electronic messaging when urgent physical assessment is required. The nurse navigator must therefore distinguish routine clarification from symptoms requiring same-day review or emergency escalation.

Equity is equally important. Patients may differ in phone ownership, internet access, digital literacy, language, visual or cognitive ability, and confidence using electronic systems. A digitally supported model should consequently retain telephone and other low-complexity communication pathways rather than assuming that every patient can use an application or portal independently. The



proposed intervention treats digital flexibility as a continuity resource, not as an eligibility requirement for receiving follow-up care.

3. Review of Literature

3.1 Nurse-Led Transitional Care and Care Coordination

Naylor and colleagues' randomized research established the importance of nurse-led transitional care for older adults at elevated risk after hospitalization. Their 1999 trial of comprehensive discharge planning and home follow-up found fewer readmissions, longer intervals between discharge and readmission, and lower health-care costs among intervention participants. A subsequent randomized trial among older adults hospitalized with heart failure evaluated an advanced-practice-nurse transitional-care intervention with follow-up extending for one year. Together, these studies positioned nursing continuity as an active clinical process extending beyond institutional discharge.

Coleman and colleagues approached the transition through a complementary model emphasizing patient activation, cross-setting communication, and transition coaching. Their randomized trial reported lower rehospitalization at selected follow-up intervals among intervention participants. The model is relevant to digital navigation because navigation similarly seeks to make the postdischarge pathway visible to patients rather than expecting them to independently reconstruct medication, appointment, and follow-up responsibilities.

Chow and Wong later evaluated nurse-led case management for hospital-discharged older adults with comorbidities and reported favorable effects on several patient outcomes and lower readmission in intervention groups. These studies collectively indicate that nurses can contribute to continuity through assessment, education, self-management support, and coordination. They do not, however, establish that every nurse-led discharge intervention will reduce health-service use.

3.2 Telephone and Digital Follow-Up After Discharge

Postdischarge telephone follow-up represents one of the earliest scalable forms of digitally mediated continuity. Harrison and colleagues reported that patients receiving timely telephone follow-up were less likely to experience 30-day readmission in their observational analysis. Harrison and colleagues later found that completing a postdischarge telephone intervention was associated with lower adjusted odds of readmission, although such observational findings remain susceptible to differences between patients who can and cannot be successfully contacted.

Systematic evidence is more cautious. Bahr and colleagues reviewed 19 postdischarge telephone-call studies and found inconsistent findings, methodological limitations, variation in the professional making the call, and substantial differences in intervention content and patient populations. Woods and colleagues' 2019 mixed-study systematic review similarly found that nurse-led telephone follow-up could improve patient satisfaction and address communication and information needs but did not support treating telephone contact as uniformly effective across every clinical outcome. These findings provide an important rationale for examining *what nurses detect and resolve during follow-up*, rather than evaluating the intervention solely according to readmission.

Nurse-led telephone support has also been tested within disease-specific programs. Awoke and colleagues combined structured heart-failure education with telephone follow-up at 7, 30, and 90 days



and reported improvements in knowledge and several self-care measures, although a statistically significant improvement in 30-day readmission was not demonstrated. Mols and colleagues similarly found that a standardized nurse-led motivational telephone consultation after percutaneous coronary intervention did not improve medication adherence, illustrating that telephone contact is not inherently effective simply because it is nurse delivered.

3.3 Medication Continuity, Follow-Up, and the Remaining Research Gap

Medication discontinuity is a particularly important postdischarge risk because inpatient medication changes must be reconciled with preexisting prescriptions and the medicines actually available in the patient's home. Schnipper and colleagues evaluated a computerized medication-reconciliation tool and redesigned process involving physicians, nurses, and pharmacists, demonstrating the relevance of structured electronic reconciliation processes during transitions. A later systematic review by Mekonnen and colleagues found that pharmacist-led medication-reconciliation programs frequently incorporated patient counseling, telephone follow-up, or home visits as part of comprehensive transition interventions.

Early nursing and physician follow-up may also work most effectively when coordinated rather than implemented as isolated services. Murtaugh and colleagues examined heart-failure patients receiving home health care and found that early intensive nursing combined with early physician follow-up was associated with a reduction in readmission probability, whereas either strategy alone did not demonstrate the same effect. This finding reinforces the idea that postdischarge continuity depends on connections among services rather than on a single professional interaction.

The principal research gap is therefore not whether telephone calls, messaging, medication reconciliation, or appointments are individually valuable. The more important question is whether a nurse-led navigation layer can integrate these elements into one coherent postdischarge pathway. Digital navigation has the potential to organize repeated contact and prioritize nursing attention, but it requires evaluation of safety, resolution of detected problems, digital accessibility, workload, and escalation quality. The present simulation addresses this pathway-level gap.

4. Research Methodology

4.1 Study Design and Simulated Population

The study adopts a simulation-based comparative design involving 500 hypothetical adult patients discharged from acute hospital care to home. Two hundred fifty participants were assigned to a nurse-led digital navigation pathway and 250 to conventional discharge follow-up. The modeled population includes adults with medical, postoperative, and chronic-disease-related discharge needs but excludes patients whose condition would ordinarily require institutional rehabilitation, continuous skilled monitoring, or another level of care incompatible with routine home discharge.

No real participants were enrolled and no electronic health records were analyzed. All numerical values were synthetically generated to demonstrate a research methodology. A future empirical study would require institutional ethics approval, informed consent or an appropriate waiver where permitted, clearly defined inclusion criteria, standardized discharge procedures, and explicit data-security arrangements for digital communication.



A real study should measure baseline age, sex, diagnosis, number of medications, previous hospital utilization, health literacy, digital access, caregiver availability, comorbidity burden, discharge destination, socioeconomic circumstances, and planned follow-up. These variables may influence both continuity and the probability of successfully engaging with digital navigation.

4.2 Nurse-Led Digital Navigation Protocol

The intervention begins before discharge. The nurse navigator confirms the preferred communication method, verifies contact information, reviews the principal discharge plan, and determines whether the patient or caregiver can use telephone, SMS, secure messaging, or a hospital digital platform. The system then schedules an initial nurse contact within approximately 48 hours, with subsequent contact determined by clinical need and unresolved navigation problems rather than by a rigid requirement for identical follow-up frequency.

During contact, the nurse verifies whether prescribed medicines were obtained, whether the patient understands major medication changes, whether planned appointments are confirmed, whether essential home services or equipment are available, and whether new symptoms have developed. Digital questionnaires or reminders may collect basic information, but concerning responses are routed to the nurse rather than managed autonomously. The nurse may provide clarification within scope, contact the responsible clinical service, support scheduling, arrange review, or direct the patient toward urgent care according to predefined escalation procedures.

Table 1: Proposed Nurse-Led Digital Navigation and Questionnaire Framework

Domain / Code	Proposed navigation activity or questionnaire item	Primary purpose	Follow-up response
Medication navigation	Review whether discharge medications were obtained and whether discrepancies or uncertainties exist	Medication continuity	Clarification or referral to prescriber/pharmacy team
Symptom navigation	Structured check for new or worsening symptoms	Early problem recognition	Nurse assessment and escalation according to protocol
Appointment navigation	Verify dates, location, mode, and feasibility of planned follow-up	Continuity of scheduled care	Scheduling assistance or service coordination
Discharge-plan clarification	Review unclear instructions concerning diet, wound care, activity, monitoring, or rehabilitation	Improve comprehension	Nurse explanation or specialty referral
Digital	Confirm preferred contact	Prevent digital	Telephone or alternative



Domain / Code	Proposed navigation activity or questionnaire item	Primary purpose	Follow-up response
accessibility	channel and ability to use it	exclusion	pathway where needed
NDQ-1	“I knew how to contact the nurse navigation service when I had a postdischarge question.”	Accessibility	1–5 Likert scale
NDQ-2	“The digital or telephone follow-up helped me understand what I needed to do after discharge.”	Continuity understanding	1–5 Likert scale
NDQ-3	“I received useful help when I had questions about medicines, appointments, or recovery instructions.”	Navigation usefulness	1–5 Likert scale
NDQ-4	“I understood which symptoms required urgent professional assessment.”	Escalation understanding	1–5 Likert scale
NDQ-5	“I would be willing to use nurse-led digital navigation after a future hospital discharge.”	Acceptability	1–5 Likert scale

Note: The five questionnaire items are proposed research instruments and have not been administered or psychometrically validated. Future use would require expert review, pilot testing, cultural and linguistic adaptation where appropriate, and formal reliability and validity assessment.

4.3 Outcomes and Statistical Strategy

The primary outcome is 30-day postdischarge continuity, operationalized as remaining appropriately connected with the planned care pathway without unresolved critical navigation failures. Component measures include successful contact, medication-problem resolution, completion of scheduled follow-up, appropriate response to symptom escalation, and availability of required postdischarge services.

Secondary outcomes include patient experience, number and type of navigation problems detected, time to resolution, emergency-department use, unplanned readmission, digital engagement, nurse time per patient, unsuccessful contact attempts, and equity of participation across digital-access groups. Readmission is retained as an important secondary outcome but is not treated as a direct proxy for navigation quality because some readmissions are clinically appropriate and prior telephone/discharge-intervention evidence has shown inconsistent effects.



In a real comparative study, categorical outcomes could be analyzed using chi-square tests and multivariable logistic regression. Time to problem resolution could be analyzed using time-to-event methods. Where multiple hospitals or wards participate, multilevel models should account for clustering. Intention-to-treat analysis should be used in randomized designs, and inability to reach a patient should be reported as an implementation outcome rather than silently removed from the analysis.

5. Analysis

5.1 Simulated Continuity and Navigation Outcomes

The synthetic analysis demonstrates higher continuity across each major process indicator in the nurse-led digital pathway. Successful postdischarge contact within 48 hours was modeled at 91% compared with 68% under conventional follow-up. Medication questions or discrepancies were resolved within the planned time frame in 83% of relevant digital-navigation cases compared with 58% in the conventional pathway.

Thirty-day continuity was modeled at 84% in the digitally navigated group and 61% in the comparison group. These values do not represent clinical-effect estimates. They were generated to illustrate how future research can separate overall continuity from individual components such as medication management, appointment coordination, and symptom escalation.

Table 2: Simulated Outcomes of Nurse-Led Digital Navigation

Outcome indicator	Nurse-led digital navigation (n = 250)	Conventional follow-up (n = 250)	Simulated difference
Successful contact within 48 hours	91%	68%	+23 percentage points
Medication issue resolved within defined pathway	83%	58%	+25 points
Planned outpatient follow-up completed	86%	67%	+19 points
Correct escalation after concerning symptom report	89%	70%	+19 points
Discharge instructions reported as clear at first follow-up	88%	69%	+19 points
Overall 30-day continuity maintained	84%	61%	+23 points
Unresolved navigation problem at day 7	11%	26%	–15 points

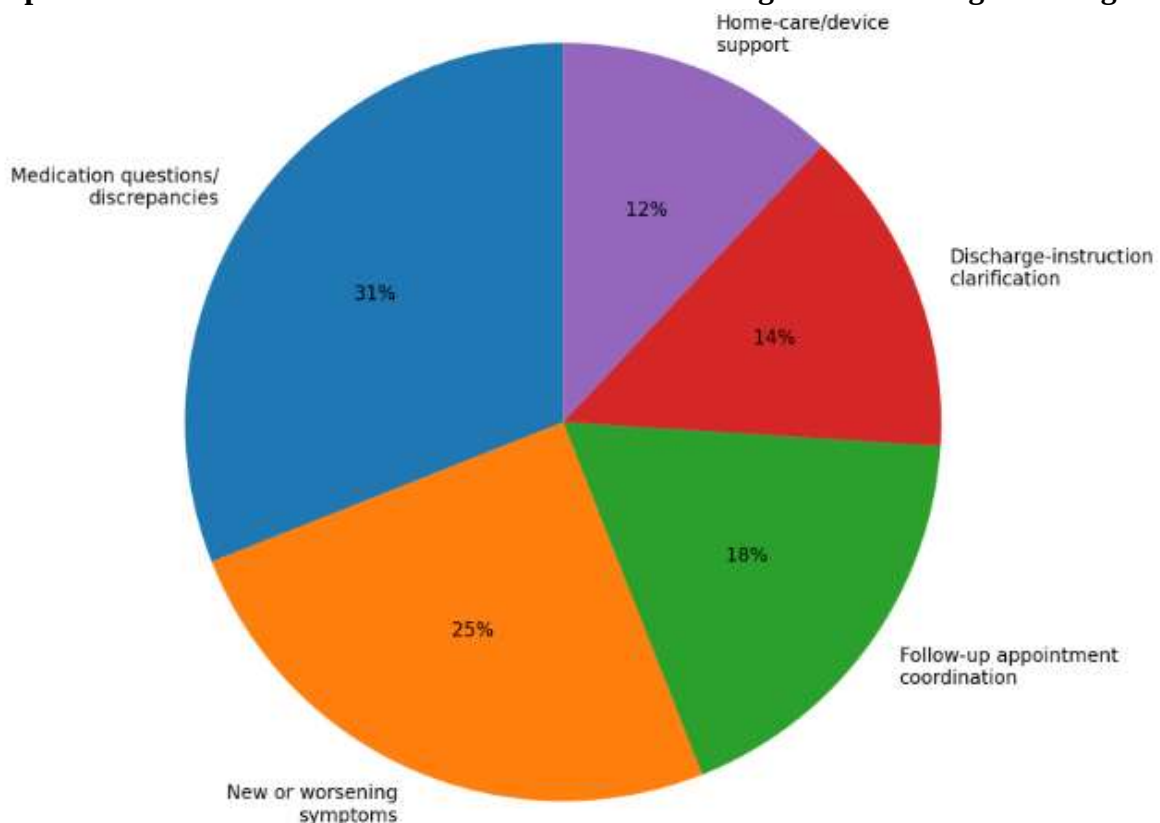
Note: All outcomes are synthetic. They do not represent real patients, hospitals, nurses, or observed treatment effects.

The comparatively modest simulated difference in readmission is intentional. Previous studies have shown that some nurse-led transitional and telephone interventions improve self-management or continuity without necessarily producing a statistically significant reduction in readmission. Awoke and colleagues demonstrated improvements in knowledge and self-care but not a significant 30-day readmission improvement, while Lisby and colleagues found that a comprehensive nurse-led discharge intervention did not significantly reduce readmissions or health-care utilization. The model therefore avoids constructing an unrealistically large readmission effect.

5.2 Types of Problems Detected Through Digital Navigation

The simulated problem log was categorized to illustrate what nurse-led navigation might identify during early postdischarge contact. Medication questions and discrepancies formed the largest category at 31%, followed by new or worsening symptoms at 25%. Appointment coordination accounted for 18%, discharge-instruction clarification for 14%, and home-care or equipment issues for 12%.

Graph 1: Simulated Distribution of Issues Detected During Nurse-Led Digital Navigation



Source: Author-generated synthetic data; percentages do not represent observed patients.

The distribution demonstrates why navigation should not be restricted to symptom monitoring. More than half of simulated problems arise from medication and follow-up coordination when medication and



appointment categories are considered together. These concerns may not constitute emergencies, but unresolved issues can undermine the intended treatment plan and create uncertainty for patients and caregivers.

The 25% of simulated issues involving new or worsening symptoms require a different response. The nurse navigator's role is not to resolve every symptom digitally but to determine the appropriate next step. Digital navigation therefore functions partly as an escalation architecture, ensuring that concerning information reaches an appropriate professional rather than remaining within an automated messaging system.

5.3 Continuity, Accessibility, and Residual Risk

The model retains residual failure even under digital navigation. Nine percent of digitally navigated participants are not contacted successfully within 48 hours, 11% have an unresolved navigation problem at day seven, and 16% do not meet the composite 30-day continuity definition. These modeled gaps recognize that communication technology cannot eliminate every barrier.

Some patients may have incorrect contact information, unstable housing, limited telephone access, low digital confidence, rapidly changing health status, or difficulty attending follow-up because of transportation, caregiving, employment, or financial constraints. Digital navigation can identify several of these barriers but cannot independently correct all of them.

Accordingly, evaluation should include the population that the service fails to reach. Reporting only outcomes among patients who successfully engage with a digital platform could exaggerate effectiveness. A future trial should therefore report unsuccessful contact, technology access, language needs, and reasons for non-engagement as core implementation outcomes.

6. Discussion

6.1 Digital Navigation as Nursing Continuity Infrastructure

The central implication of the proposed model is that digital navigation should be understood as nursing continuity infrastructure, not merely as a collection of messages or reminders. Nursing value arises from interpretation, prioritization, communication, and coordination. The digital system can make information available earlier and organize follow-up, but the nurse determines whether a reported problem can be clarified, requires another professional, or represents a potentially urgent situation.

This position is consistent with established transitional-care evidence. Naylor's Transitional Care Model and Coleman's Care Transitions Intervention both demonstrate that effective transitions require more than information transfer. They emphasize continuity, engagement, coordination, and support across settings. Nurse-led digital navigation extends these principles through contemporary communication channels without changing the underlying requirement for professional accountability.

Digital contact can also create continuity where patients would otherwise remain uncertain until the next scheduled appointment. Woods and colleagues found that nurse-led postdischarge telephone calls can address communication and information needs and improve patient satisfaction, even though outcome effects are heterogeneous. This supports treating patient understanding, problem resolution, and successful connection with follow-up care as meaningful outcomes in their own right.

6.2 Why Readmission Alone Is an Inadequate Measure

Hospital readmission is important because it can indicate postdischarge instability and carries substantial implications for patients and health systems. However, it is an imperfect stand-alone measure of navigation quality. Some readmissions are clinically necessary and should occur promptly when a patient's condition deteriorates. A navigation system that identifies a serious complication and directs the patient back to hospital may be functioning correctly even though a readmission subsequently appears in the dataset.

The empirical literature reinforces this caution. Bahr and colleagues found inconsistent effects across postdischarge telephone studies, while Lisby and colleagues' randomized nurse-led discharge intervention did not significantly reduce readmissions despite a comprehensive discharge approach. Conversely, some observational studies have reported lower readmission among patients completing telephone follow-up, but these relationships may also be influenced by patient selection and successful contact.

Future digital-navigation research should therefore use a multidimensional outcome framework. Important measures include unresolved medication discrepancies, successful follow-up, symptom escalation quality, patient understanding, preventable emergency utilization, time to issue resolution, patient experience, and equitable service reach. Readmission should remain part of this framework rather than becoming its sole definition of success.

6.3 Safety, Digital Equity, and Nursing Workload

Digital navigation can improve accessibility only when the digital channel matches the patient. A smartphone application may be convenient for one person and an exclusionary barrier for another. Telephone contact, caregiver-supported communication, accessible message formats, language support, and other alternatives should remain available. A system that reports excellent outcomes among digitally confident users but routinely fails to reach disadvantaged patients would risk widening rather than reducing continuity gaps.

Safety also depends on explicit escalation governance. Symptom algorithms and questionnaires may help organize information, but automated systems should not independently reassure patients when clinically important uncertainty exists. The nurse must have clearly defined pathways for contacting medical teams, pharmacies, community services, rehabilitation professionals, or emergency care. Medication discrepancies similarly require collaboration; electronic medication-reconciliation research demonstrates that safe transitions often involve process redesign across professional groups rather than nursing action in isolation.

Finally, implementation must account for nursing workload. A digital system capable of generating large numbers of reminders and symptom alerts can create additional work if thresholds are poorly designed. Future evaluations should measure nurse time per patient, number of alerts requiring review, percentage of alerts leading to meaningful action, after-hours responsibilities, and the capacity of navigation teams. Effective digital transformation should prioritize clinically meaningful information rather than increasing the volume of messages nurses must process.



7. Conclusion

Nurse-led digital navigation offers a plausible approach for strengthening continuity during the vulnerable transition from hospital to home. Its potential contribution lies in creating an organized route through which patients can clarify medications and discharge instructions, confirm follow-up arrangements, report changing symptoms, and reach the appropriate professional without having to independently reconstruct a fragmented care pathway.

The present simulation models higher continuity across early contact, medication-problem resolution, follow-up completion, symptom escalation, and 30-day connection with the planned care pathway. Overall continuity was modeled at 84% under nurse-led digital navigation compared with 61% under conventional follow-up. Medication questions or discrepancies represented the largest category of simulated postdischarge problems. These values are illustrative and must not be interpreted as evidence of real clinical effectiveness.

Existing evidence supports nurse-led transitional care and suggests that telephone follow-up can address patient information and communication needs. At the same time, systematic reviews and randomized studies demonstrate that effects on readmission are inconsistent. This evidence supports a measured interpretation: digital navigation should be designed to improve continuity and problem resolution, with reductions in avoidable acute-care use treated as a potential downstream outcome rather than a guaranteed consequence.

Future empirical research should evaluate nurse-led digital navigation through prospective multicenter designs and include clinical safety, medication continuity, appointment completion, patient understanding, health-service utilization, equity, digital accessibility, nurse workload, and cost. Digital tools should strengthen rather than replace nurse–patient communication. The most defensible model is therefore one in which technology makes postdischarge needs visible and nurses use professional judgment and coordination to ensure that those needs reach the appropriate point of care.

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