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# BMJ Open Identifying practices of information transfer between the hospital and primary care for older adults: a scoping review protocol

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## ABSTRACT

**Introduction** Transition of care from hospital to primary care has been recognised globally as a high-risk scenario for older patients' safety by the WHO. Indeed, sub-optimal care transitions are associated with increased mortality, morbidity and adverse events.

Improving communication through timely and accurate clinical information transfer has been identified as a key component of optimal care transitions. However, timely and accurate clinical information transfer from hospital to primary care varies across countries and institutions. Information transfer practices are heterogeneous, in some places depending on individual initiative and sometimes not occurring at all.

To improve current practices, we will conduct a scoping review to identify the current and suggested practices of information transfer between hospital-based physicians or pharmacists and the primary care team of older patients.

**Methods and analysis** This scoping review will be conducted using Arksey and O'Malley's methodological framework, augmented by Levac *et al* and the JBI Manual for Evidence Synthesis, and the findings reported according to the PRISMA extension for Scoping Reviews. We will use a search strategy developed with a specialised librarian to search four databases (MEDLINE, Embase, CINAHL and AgeLine) and reference lists of selected studies. All studies adhering to our iteratively created eligibility criteria outlined by the population, concept and context elements will be included. The data extraction table will also be constructed iteratively with the research team, and results will be presented tabularly and qualitatively.

**Ethics and dissemination** Ethics approval was obtained. We plan to disseminate the results as scientific communication (peer-reviewed journal and presentations) and during a deliberative dialogue workshop with key stakeholders in order to generate recommendations to improve current practices in our own clinical setting, potentially to be adapted and scaled up with our collaborators provincially, nationally and internationally.

## STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ We will follow a widely used, well-established framework for scoping reviews, including recent updates and suggestions, to ensure a methodologically sound review following up-to-date guidelines
- ⇒ A specialised librarian codeveloped the search strategy, which will include all journal articles since 2000 found across several big databases to maximise comprehensiveness and reflect the current practices.
- ⇒ An iterative and collaborative approach will be used at each stage to ensure relevance to the needs of the knowledge users, which includes family physicians, nurse practitioners, geriatricians, provincial policymakers and regulatory bodies.
- ⇒ Grey literature review for this study, which may contain valuable information, was beyond our resources.
- ⇒ Quality assessment of the articles included is beyond the scope of this study.

This protocol has been registered on the Open Science Framework: <https://osf.io/eg958>.

## INTRODUCTION

The transition of care (ToC) is a crucial period and has been recognised globally as a high-risk scenario for patient safety by the WHO.<sup>1</sup> According to the American Geriatrics Society, ToC refers to the 'set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location'.<sup>2</sup> It should ideally involve timely communication of the comprehensive care plan of the patient between sending and receiving clinicians, preparation of the patient and caregiver, medication reconciliation, follow-up plan

and patient education.<sup>2-4</sup> However, ToC is often suboptimal, which can be associated with increased mortality, morbidity and adverse events.<sup>1</sup>

In particular, poor ToC planning for patients discharged from inpatient to outpatient settings can lead to poor outcomes, like unplanned hospital readmission and medication errors.<sup>5-8</sup> A North American prospective cohort study from a tertiary care academic hospital by Forster *et al* in 2003 found that nearly 20% of patients discharged from hospitals experienced an adverse event, with a third of them being preventable through better care during the transition from hospital to home, specifically pointing to communication between hospital and primary care professionals (PCPs).<sup>9</sup> A Swedish study from 2021 stated that medication-related information was not sent to PCPs for 34% of patients discharged from the hospital, even though PCPs have stressed the importance of 'clear and structured documentation regarding which medications need to be followed up after discharge'.<sup>10</sup> In contrast, efforts aiming at 'facilitating the coordination of care and communication between hospital and primary care providers and pharmacists' have been shown to reduce rehospitalisation and emergency department visits, improve the primary care team's access to information, and increase patient satisfaction and quality of life across several countries.<sup>11</sup>

In high-income countries, delivering high-quality ToC continues to be challenging due to the focus on acute, episodic treatment.<sup>12-14</sup> A systematic review by Kripalani *et al* in 2007 aiming to 'characterise the prevalence of deficits in communication and information transfer at hospital discharge' found that communication between hospital and primary care teams at patient discharge occurs infrequently (3%–20%). They concluded that 'deficits in communication and information transfer at hospital discharge are common and may adversely affect patient care'.<sup>15</sup> The WHO has highlighted improving patient safety during ToC as a key component in their *Global Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harms in Healthcare*.<sup>16</sup>

In particular, this can have a greater negative impact on vulnerable populations, such as older patients (≥65 years) who have more complex health issues and need to undergo several care transitions between specialised, emergency and primary settings.<sup>11 17 18</sup> They often have multimorbid conditions and are polymedicated. Primary care physicians play a crucial role in the care of these patients, often being at the centre of the various levels and types of care that the patient receives.<sup>19</sup> They are responsible for implementing specialist recommendations, follow-up care and future referrals, having a major role in the continuity of care between the health sector and community.<sup>20</sup> Therefore, it is vital that primary care teams receive information regarding the care of these patients, such as new diagnoses and medication changes, from other healthcare settings in a timely and accurate manner.

Our overarching objective is to produce evidence that can inform strategies to improve clinical information

transfer from the hospital to primary care settings for older adults. There is currently no comprehensive portrait of these practices worldwide. Mapping such practices is the first step to inform clinical practices and policies to improve patient care. Therefore, we will conduct a scoping review aiming at identifying the current and suggested practices of information transfer between hospital-based physicians or pharmacists and the primary care team of older adults. This scoping review will be part of a larger environmental scan, including interviews and surveys, to nurture a deliberative dialogue workshop that will help improve our practices.

## METHODS AND ANALYSIS

We will conduct a scoping review, defined as a study 'to map the literature on a particular topic or research area and provide an opportunity to identify key concepts; gaps in the research; and types and sources of evidence to inform practice, policymaking, and research'.<sup>21</sup> Our scoping review will follow the methodological framework developed by Arksey and O'Malley, which includes the following stages: identifying the research question; identifying the relevant studies; study selection; charting the data; collating, summarising and reporting the results; and an optional consultation stage.<sup>22</sup> We will also refer to the enhancements of this framework suggested by Levac *et al* and the JBI Manual for Evidence Synthesis for further details and guidance at each step.<sup>23 24</sup> We will report the scoping review using the PRISMA extension for Scoping Reviews (PRISMA-ScR).<sup>25</sup> This protocol has been registered on the Open Science Framework: <https://osf.io/eg958>. This review was started in May of 2024, and we aim to be complete by December of 2025.

We will use the Clinical Adoption Framework to guide our scoping review, which has the overarching goal of producing evidence to inform strategies for improving clinical information transfer from the hospital to primary care settings for older adults. This framework was first proposed by Lau *et al* in 2011 to further the understanding of barriers and facilitators of the implementation of Health Information Systems across Canada and contextualised in 2016 to eHealth innovation adoption in the Handbook of eHealth Evaluation: An Evidence-based Approach.<sup>26 27</sup> This framework details the micro, meso and macro dimensions of a clinical innovation adoption, including the diverse barriers and facilitators that impact the adoption of an innovation. As information transfer is widely recognised as a key element of optimal care transition, the absence of widespread implementation might be related to micro, meso or macro barriers that need to be identified and taken into account. Using this framework will help us develop our data extraction table and guide our stakeholder consultation.

### Framework stage 1: identifying the research question

We followed a collaborative iterative process to define and refine our research question. This collaborative iterative

process encompassed the following: (1) informal discussions with researchers and clinicians met during presentations at local, national and international conferences, as well as 1-on-1 interviews with key stakeholders, including family physicians organisations and medical regulatory bodies; (2) pilot searches of the literature performed with the librarian; (3) and a formal consultation with our team of experts (including geriatricians, primary care physicians, health services researchers, quality improvements specialists, a librarian and an anthropologist). This iterative process allowed us to gain familiarity with the existing literature and tailor our research question to our end objective of improving practices in the clinical setting.

Our final research question is as follows: what are the current or suggested practices of information transfer from hospital-based physicians or pharmacists to the primary care team of older adults? As suggested by Levac *et al*, certain concepts in the question should be defined.<sup>24</sup>

- ▶ We used the terms ‘current’ or ‘suggested’ to ensure comprehensiveness by including practices that are already implemented, practices that are being tested (including interventional studies) and practices that have been proposed to be a possible alternative to current ones (e.g., suggested by hospital physicians, associated pharmacists or the primary care team of older adults in interviews or focus groups).
- ▶ ‘Information transfer’ refers to the who, when, how and to whom surrounding the transfer of clinical information. Clinical information refers to any data regarding a patient’s health presented by a health-care worker (e.g., health assessments, diagnoses or drug changes), including, but not limited to, both discharge summaries and consultant notes.
- ▶ We narrowed down to hospital-based physicians or pharmacists since practices from these parties are the most relevant and implementable in our clinical settings, as we aim to improve the communications practices from these stakeholders. Communication between allied health professionals (e.g., hospital physiotherapist to community physiotherapist) may have their own standardised practices and be less relevant for our settings.
- ▶ Primary care refers to the healthcare team in the community that will continue the care of the older adult. This team is often multidisciplinary and can consist of general practitioners, nurses and clinical pharmacists.<sup>28</sup>
- ▶ Older adults refer to our specific patient population (≥65 years).

This research question will broaden our understanding of what is out there to ultimately help us address our objective: to improve the information transfer of clinical information from the hospital to primary care settings for older adults.

### Framework stage 2: identifying relevant studies

Our search strategy was co-created with a specialised librarian (AQ). As scoping reviews are conducted to

ensure comprehensiveness in a given area of research, we will not exclude based on the type of article at the title and abstract screening stage.<sup>22 29</sup> However, during the full-text review, we will exclude protocols, conference abstracts and letters to the editors, as they would not contain enough information for our data extraction.

For databases, we will search across MEDLINE, Embase, CINAHL and AgeLine. The search terms were developed iteratively. The first iteration included terms relevant to geriatric practice, primary care and communication. After an initial informal screening of the literature, two key points were identified: pharmacists play a vital role in information transfer, and transitional care practices often include information transfer. Therefore, the search terms were updated to reflect these discoveries and included terms relevant to the care of older adults, geriatric medicine or geriatrics, pharmacists, primary care, communication and transitional care. Once relevant literature is identified, a forward and backward snowball search of the references of included studies will be conducted. A sample of our search strategy on MEDLINE can be found in [table 1](#). Our initial search yielded a total of 4039 papers to be screened.

Regarding the grey literature review, we initially conducted a preliminary exploration of resources across several Canadian provinces using the grey literature checklist provided by Canada’s Drug and Health Technology Agency.<sup>30</sup> However, in the province we work, there is a stark discrepancy between deontological obligations and practice, which required us to interview multiple professionals and regulatory bodies to elicit. After discussion and consultation with the research team, it was decided that the feasibility of doing such a review at a national or even global scale to ensure broader relevancy of our findings was beyond our resources. We understand that this limitation may overlook some important information, which we will acknowledge in our final report.

### Framework stage 3: study selection

We developed our eligibility criteria in an iterative process, as recommended, as we became more familiar with the literature.<sup>22 24</sup> Two researchers (DY, CGS) created the initial eligibility criteria.

A calibration and inclusion-exclusion refinement exercise between two reviewers (DY, CGS) was performed using random samples of 50 titles and abstracts. After each batch, the two reviewers met to consolidate differences and refine the inclusion and exclusion criteria. This process led us to perform an independent reviewer screening for 18% of the entire database-identified records. This process will be repeated for the full-text review, with batches of 10 samples, and any new reviewers. We will use the Covidence platform for the review. Two reviewers will independently conduct the full title and abstract screening. Then, independent screening for full-text review will start once a level of agreement >80% (strong agreement) is achieved.<sup>31</sup> Based on the calibration exercise, where the inclusion rate was around 10%,

**Table 1** Medline search strategy

#	Search terms	Number of results
1	general practitioners/ or physicians, family/ or physicians, primary care/ or primary health care/	123 857
2	(family doctor* or family physician* or family practitioner* or general physician* or general practice* or general practitioner* or primary care* or primary medical care*).mp,jw.	322 330
3	1 or 2	357 168
4	Geriatrics/ or geriatricians/ or health services for the aged/ or Geriatric Assessment/ or Geriatric Nursing/	91 736
5	(geriatric* or gerontology*).mp,jw.	232 888
6	4 or 5	243 673
7	Interdisciplinary Communication/ or Communication/ or Hospital Communication Systems/	125 053
8	(communicat* or transition*).mp.	1 151 099
9	continuity of patient care/ or hospital to home transition/ or patient discharge/ or patient handoff/ or patient transfer/ or transitional care/	71 750
10	(discharg* adj3 (care plan* or procedure* or plan* or process* or patient* or order* or hospital* or home*)).mp.	157 195
11	("continuance of care" or "continuity of care").mp.	10 328
12	7 or 8 or 9 or 10 or 11	1 324 217
13	3 and 6 and 12	1285
14	Pharmacists/	23 246
15	exp Hospitals/	330 427
16	14 and 15	1608
17	((clinical or hospital) adj3 pharmacist*).mp.	8012
18	16 or 17	8976
19	3 and 12 and 18	273
<b>20</b>	<b>13 or 19</b>	<b>1519</b>

we can expect around 400 papers to be selected for full text review during the title and abstract screening.

The population, concept and context elements can be used to outline our final inclusion criteria.<sup>29</sup> To keep the review within the scope of our objective, we also had several exclusion criteria. These will be justified, and limitations will be acknowledged.

### Population

We will include hospital-based healthcare workers and primary care teams involved in the care of older adults. Notably, the initial criteria focused on physicians, but this was expanded to other healthcare workers once we identified pharmacists as key stakeholders on information transfer. However, we will exclude studies that only involve allied health professions in different settings (e.g., occupational therapists in hospitals to community occupational therapists). Although this limits the scope of our study, we chose this criterion since their systems may drastically differ and not be implementable for physician or pharmacist communication. The patient population is hospitalised adults over the age of 65 (or studies where over 50% of the population is over 65) discharged to the community.

### Concept

We will investigate how clinical information is transferred from the hospital-based healthcare team to the primary care team: who sends the information, when it is sent, how

is it sent, and to whom it is sent, as well as consent-related features (e.g., is patient's consent required, in which format, and who collects it?). We will also collect information on transfer effectiveness or impact on patients' outcomes and barriers and facilitators to the implementation and sustainability of the described practice at the micro, meso and macro levels. This will include literature detailing current existing practices, interventional studies exploring new practices, strategies to improve transfer of information or what healthcare workers believe should be the optimal practices. To increase our comprehensiveness, at the title and abstract stage, we will also include studies that discuss new models of integrated care, transitional care interventions or health service interventions as per the Cochrane Effective Practice and Organisation of Care taxonomy,<sup>32</sup> as these studies may further discuss information transfer.

Clinical information refers to any data about a patient's health documented by a healthcare worker, including discharge summaries and consult notes. For example, health assessments, diagnoses or drug changes.

Studies that do not detail how information transfer occurs do not contribute to our objective. They will be excluded if they only state that the clinical information was sent to the primary team, without specifying how. Likewise, studies will be excluded if they simply state that a problem with information transfer exists, without providing a potential solution. Furthermore, studies that

mainly focus on the content of clinical information, rather than how information transfer occurs, will be excluded, as our focus is not on the improvement of the content of the information to be transferred.

### Context

We are aiming to investigate information transfer practices within the context of older adults discharged from the hospital to their community, where they will be followed by their primary care providers. Therefore, the setting of included studies is any acute care setting (e.g., emergency department, intensive care units or wards) where older adults are admitted and primary care settings where older adults are followed up in the community. For emergency departments, studies will be considered even if patients are not admitted but only consulted acutely. We will exclude studies that discuss information transfer from outpatient settings, skilled nursing facilities, geriatric day hospitals or rehabilitation centres since our objective is specific to the inpatient setting to primary care. In these settings, the referring physician, often the family physician, is clearly identified, which could streamline the information transfer back to them; this is not the case for admitted patients.

We will consider studies published after 2000 to capture current practices, accounting for the increasingly more common use of the internet in households and hospitals, which may be more relevant to practices today.

### Types of sources of evidence

Any type of published research found in our searches adhering to the aforementioned criteria will be included, including qualitative, quantitative and mixed methods studies. Conference proceedings, abstracts and protocols will be excluded at the full-text review.

### Framework stage 4: charting the data

Our data extractions table will be constructed in an iterative process with an initial sample of included full text. Similar to the study selection process, the reviewers will independently extract data from a set of evidence, which will be compared for agreement. The data extraction table will then be consolidated for the rest of the data extraction. Tentatively, we will extract the following data from included sources of evidence:

- ▶ Authors, publication year and location.
- ▶ Type of evidence (e.g., observational study, interventional study, case report, government guideline).
- ▶ Settings of the evidence (e.g., emergency department to primary care, geriatric ward at an academic centre to primary care).
- ▶ Aims and purposes of the evidence (e.g., to implement a new model of care, to assess the effectiveness of a transitional care model).
- ▶ Details of information transfer practices, including who sends the information (e.g., administrative or healthcare provider), when the information is sent (e.g., on or before discharge), to whom the

information is sent (e.g., family physician, community pharmacist, multidisciplinary primary care team) and how the information is sent (e.g., phone, mail, fax, secured email).

- ▶ Any particular or notable information provided by the authors related to information transfer (e.g., consent-related features, information transfer effectiveness or associated patient outcomes, barriers and facilitators to the implementation, and sustainability of the described practice at the micro, meso and macro levels, as detailed in the Clinical Adoption Framework).<sup>26</sup>

### Framework stage 5: collating, summarising and reporting the results

As recommended by Levac *et al*, this stage will be done in three steps.<sup>24</sup>

First, for the data analysis, we will provide a descriptive summary detailing key information on the evidence included, such as quantity, year of publication and types of evidence.<sup>22</sup> Qualitative information from the data extraction will also be provided. These will be presented in a table. Second, a descriptive presentation of the analysis will be provided, with a discussion on the relevance to the original research objective.<sup>24</sup> Third, we will discuss the relevance and clinical implications of our findings, including implementability and practicality, and note any potential limitations.

### Stage 6: consultation

Due to the clinical nature and potential implications of our study, this stage is necessary for us to gain feedback from experts and stakeholders on the relevance and practicality of our findings. The goal of this step is to do a readiness, feasibility, implementation and transferability assessment of our findings.<sup>22</sup> We will explore to which extent some of the practices identified in the scoping review could be implemented in our clinical setting, but also provincially, or internationally.

We will obtain feedback about our results from our provincial and international team of experts that initially helped us iteratively develop the protocol, through interviews with key informants (e.g., nurses, physicians, medical regulatory bodies and organisations, and patient partners). Additional relevant experts will be identified through recommendations from currently involved experts.

We will also conduct a deliberative dialogue workshop, convening interested parties from our organisation to elaborate contextualised and ready-to-be-implemented recommendations to improve our practices. A deliberative dialogue workshop is the method of choice to bring together multiple stakeholders to generate evidence-based and actionable recommendations for practice. This activity will consist of two 30-min meetings and one 1-hour meeting over a month-and-a-half period, to take into account professionals' workloads. It will engage approximately eight key stakeholders involved in the care



of frail older adults at our institution: two physicians and residents, two members of the multidisciplinary team, two administrative staff and two representatives of the medical archives. During the first meeting, we will present our results. During the second meeting, the professional facilitator will conduct a brainstorming session to gather ideas and reflections on the possible solutions. During the third meeting, the professional facilitator will conduct the generation of the strategy.

### Patient and public involvement statement

Given the clinical nature of our study, patient and public involvement will be important. Our research question was initially informed by the experiences of geriatricians working in our province, frustrated with the difficulties of communicating with family physicians, hindering patient care. As outlined in our consultation stage, we have and will continue to involve stakeholders in our project. So far, we have involved physicians, nurses, medical regulatory bodies, patient's rights representatives and quality improvement departments to iteratively develop our protocol. These parties will continue to be involved as we identify studies and extract data to ensure the relevancy and practicality of our results, and our results will be disseminated to them. As mentioned, we plan to conduct a deliberative dialogue workshop with relevant stakeholders to generate recommendations based on these results to practice. We are also currently in discussion with patient partner groups at our institution to get patient involvement in this project through both the deliberative dialogue and dissemination stages.

### Ethics and dissemination

Ethics approval was obtained from the McGill University Health Centre Research Ethics Board for an environmental scan encompassing this scoping review (2023–9021). We plan to disseminate the results of this scoping review as a research publication in a peer-reviewed journal; scientific presentations at local, national and international conferences; and during a deliberative dialogue workshop with key stakeholders to generate recommendations to improve current practices in our own clinical setting, potentially to be adapted and scaled up with our collaborators provincially, nationally and internationally.

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**Contributors** CGS and DY conceived the research question and study design. All authors contributed to refining the study design. AQ helped design the eligibility criteria and search strategy. CGS, DY and MA performed the preliminary literature screening. CGS and DY drafted the manuscript. All authors read, edited and approved the contents of this manuscript. CGS is the guarantor of this study.

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**Competing interests** None declared.

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