Table 2: Description of interventions provided

Author	Intervention subgroup (category)	Intervention – detail	Intervention provided by	Educational component	Planned contacts/ month of follow-up	Intensity judgement
Blue[23]	A (1)	Home educational and support visits of decreasing frequency, optimising drugs and monitoring electrolytes, plus phone contact as needed and liaison with other professionals	Specialist nurse	CHF knowledge and treatment advice, diet & exercise, promotion of self-management.	1.5	high
Bouvy[33]	C (3,6)	Review in pharmacy and monthly phone follow-up. Intervention focused on drug use and reasons for non-compliance	Community pharmacist	Medication	1	low
Capomolla[31]	C (3,5)	Heart failure management programme delivered in a day hospital. Tailored therapy, physical training & counselling, correction of risk factors and education. Follow-up determined by need / symptoms.	Cardiologist, nurses, physiotherapist, dietician, psychologist & social assistant.	Monitoring weight, fluid restriction, nutrition & exercise, promotion of self-management	Unclear	high
Cline[34]	A (1)	2x30 minute educational visits in hospital plus 1 hour group oral and video presentation for patients and family after discharge plus follow up at easy access nurse clinic. Medication organiser offered. Nurse available by phone. One scheduled visit by nurse at 8 months	Study nurse	CHF knowledge, treatment adherence, promotion of self-management & use of patient symptom diary	0.5	low

Table 2: Description of interventions provided (cont)

Author	Intervention sub-group (category)	Intervention – detail	Intervention provided by	Educational component	Planned contacts/ month of follow-up	Intensity judgement
Cleland / Coletta[13]	B (2,3)	Home tele-monitoring (weight, BP, ECG recorded twice daily) or monthly phone-calls from a nurse	Cardiologist, specialist nurse	Unclear	unclear for tele-monitored group	high
de Lusignan[22]	B (2)	Remote monitoring and tele-consultation with clinicians via videophone in patients' homes. Weekly consult for 3-months then decreasing frequency	Study nurse & GPs, cardiologist physiologist	Unclear	2	high
Doughty[24]	D (5, 6)	4 individual and group outpatient education sessions plus liaison with, and 6 weekly follow up by, GPs & heart failure clinic.	Study nurse, cardiologist, GPs	Medication, exercise, diet, monitoring weight & self-management	1	high
Ekman[17]	C (3,5)	Nurse-monitored outpatient clinic or monthly phone contact by nurse. Written information to patients & regular liaison with primary care providers.	Clinic nurse	Medication, diet & promotion of self-management & weighing	1	high

Table 2: Description of interventions provided (cont)

Author	Intervention sub-group (category)	Intervention – detail	Intervention provided by	Educational component	Planned contacts/ month of follow-up	Intensity judgement
Gattis[20]	C (3,5)	Educational session by pharmacist who also optimised therapy & liaised with physicians & provided phone follow-up at 2, 12 & 24 weeks.	Clinical pharmacist	Medication changes discussed and medication education	0.66	low
Goldberg[35]	B (2,3)	Home tele-monitoring (weight and symptom checking daily)	Specialist nurse	CHF knowledge, daily weight, dietary & fluid restriction, symptom self-management - to both groups in hospital	daily	high
Goodyer[12]	A (1)	Three home visits focusing on medication. Provision of medication calendars & information leaflets.	Pharmacist	Counselling on correct use of medication	1	low
Grancelli[21]	C (3)	Telephone intervention with 5 objectives: diet and drug therapy compliance, symptom monitoring, control of oedema/weight, daily exercise.	Specialist nurse	CHF knowledge, diet & drug compliance, self-control techniques, help seeking if symptoms worsen	>1	high
Holland[11]	A (1)	Home visit by pharmacist to perform medication review and educate to improve medication compliance.	Pharmacist	Focused on medication	0.33	low

Table 2: Description of interventions provided (cont)

Author	Intervention sub-group (category)	Intervention – detail	Intervention provided by	Educational component	Planned contacts/ month of follow-up	Intensity judgement
Jaarsma[15]	A (1,3)	Educational programme for patient (& family) during hospital stay followed by phone call from nurse one week after discharge & one home visit to reinforce/continue education.	Study nurse	Education & promotion of self-management, sodium restriction, fluid balance & compliance	0.33	low
Kasper[25]	A (1,3)	Treatment plan devised by cardiologist. Regular phone calls (initially weekly then decreasing frequency) & monthly follow-up at clinic or home by nurse to implement plan & titrate medications as required. A pill sorter & written educational materials were provided.	Specialist nurse, cardiologist, primary physician	List of medications, 2g sodium-restricted diet & exercise advice.	3	high
Krumholz[18]	A (1,3)	One hour educational session at home or clinic followed by regular telephone calls (initially weekly then decreasing frequency) from nurse to support/monitor patients.	Specialist nurse	CHF knowledge, medication, health behaviour & symptom awareness.	1.5	high
Laramee[36]	C (3,5)	Early discharge planning and co-ordination of care, individualised patient/family education, enhanced telephone surveillance/follow-up, and promotion of optimal CHF medication and dosages.	Specialist nurse	CHF knowledge, diet & fluid advice, risk factor modification, exercise, symptom monitoring, prognosis & counselling	3.33	high

Table 2: Description of interventions provided (cont)

Author	Intervention sub-group (category)	Intervention – detail	Intervention provided by	Educational component	Planned contacts/ month of follow-up	Intensity judgement
McDonald[37]	C (3,5)	Education from nurse and dietician during admission plus follow up phone calls from nurse on discharge (weekly for 3 months) plus two extra clinic visits to nurse.	Specialist nurse, dietician	Medication, weight monitoring, salt restriction, dietary review	1.5	high
Naylor[26]	A (1)	Daily in-hospital visits to help optimise care, eight or more home visits over 3-months, plus telephone availability. Multiple home visits included assessment, treatment adjustment (in collaboration with physician) and patient/care-giver education.	Specialist nurse	Unclear but appeared wide-ranging	0.66	high
Philbin[29]	D (5)	Broad quality improvement intervention with standardised admission orders, health professional education, written information for patients and a home care pathway.	nurse, physicians, administrators	Teaching aids were given to patients – unclear what domains were covered	unclear	low
Rainville[14]	C (3,5)	Medication review pre-discharge plus education and provision of written information. Follow-up by phone at 3 and 7 days, 1, 3 & 12 months post-discharge.	Pharmacist & Specialist nurse	Medication, weight monitoring & risk modification	0.5	low

Table 2: Description of interventions provided (cont)

Author	Intervention sub-group (category)	Intervention – detail	Intervention provided by	Educational component	Planned contacts/ month of follow-up	Intensity judgement
Rich 1993[19]	A (1,3)	Education, dietician review, medication review and early visit by social worker pre-discharge. Daily hospital visits pre-discharge then 3 home visits by home care nurse in first week then decreasing frequency plus phone contact.	Specialist nurse, dietician, cardiologist, social worker, home care nurse	CHF and its treatment with medication cards given, dietary review, plus weighing advice	>1 (precise no. unclear)	high
Rich 1995[16]	A (1,3)	As above (Rich 1993)	As above	As above	>1	high
Riegel[8]	C (3,4)	Regular phone calls from nurse (approx. weekly depending on need) after discharge with management guided by decision support software. Written educational material also mailed monthly.	Specialist nurse	Medication adherence and dietary advice, promotion of symptom monitoring	2	high
Serxner[28]	C (4)	4 mailings of information over 12 weeks post-discharge.	Unclear	Medication, lifestyle, and risk factor advice	0.66	low
Stewart 1998[32]	A (1)	Counselling by nurse and/or pharmacist prior to discharge followed by home visit by nurse and pharmacist and referral for additional community-based support for those deemed to be in need.	Study nurse & pharmacist	Medication review and counselling	0.33	low

Table 2: Description of interventions provided (cont)

Author	Intervention sub-group (category)	Intervention – detail	Intervention provided by	Educational component	Planned contacts/ month of follow-up	Intensity judgement
Stewart 1999[38]	A (1,3)	Home visit by cardiac nurse 7-14 days post-discharge, with further follow up & visits as necessary & two follow up calls	Specialist nurse	Adherence, fluid & sodium intake, exercise, psychosocial support	0.5	low
Stromberg[39]	C (3,5)	Visit to nurse-led heart failure clinic 2 weeks after discharge. During visit treatment was optimised (in consultation with cardiologist) and patient given tailored education. Telephone follow-up to provide psycho-social support	Specialist nurse	CHF and its treatment, diet, smoking cessation, exercise, vaccination advice, symptom monitoring	0.1 – 0.2 visits, unclear number of phone calls	low
Varma[30]	D (5)	Hospital-based education & provision of information by pharmacist to encourage self-monitoring plus liaison with physicians & community pharmacists. Advice repeated in clinic 3-monthly	Research pharmacist	Medication, diet and self-management, daily weighing	0.4	low
Weinberger[27]	C (3,5)	In-patient education by nurse and visit to hospital from primary care physician. Phone call follow-up by nurse post-discharge & review of treatment plan at clinic.	Primary care nurse, primary care physician	Provision of educational materials	0.5	low

Intervention categories:
1 = One or more planned intervention visits in the patient's home by a health care professional to educate or improve their self-management (this excludes visits simply to take blood samples or carry out interventions such as wound care). [A]
2 = Home physiological monitoring or tele-visual contact with patients. [B]
3 = One or more planned telephone call or videophone call to the patient at home. [C]
4 = Educational or symptom self-management mailings to patient's home address. [C]
5 = No planned intervention home visits, instead, intervention occurring during hospital admission or during hospital clinic attendance. [D]
6 = No planned intervention home visits, instead, intervention occurring in general practice or a community clinic. [D]
Note: if intervention was categorised as 3 & 5, this was considered to be in sub-group C.