Supplemental Table S1. *Characteristics of each Study Included in the Review.*

Study	Field	Region	Hospital type	Age group	Health criteria	N	Age: m(SD)	Race/ ethnicity	Sex
Altfeld 2013	IP	USA	University	65+	D/c with 7+ meds	720	74.5 (6.9)	W: 49.2% AA: 45.6% O: 5.2%	NR
Balaban 2015	IP	USA	Academic, public safety-net	General medical	1+ readmit risk factor	1510	64.7 (16.3)	W: 57.5% AA: 15.8% H: 15.7% O: 11.0%	NR
Barker 2012	IP	Australia	Public teaching	CHF	4+ meds, 48h LOS	120	72.6 (10.1)	NR	F: 54.2%
Basger 2015	PH	Australia	Private	65+	5+ meds	216	81.5 (7.1)	NR	F: 77.3%
Beck 2015	IP	Denmark	University	70+	Nutritional risk	71	85.0 (6.8)	NR	F: 67.6%
Brovold 2013	PT	Norway	University	70+	Acute medical	115	78.0 (5.2)	NR	F: 60.9%
Buurman 2016	IP	Nether- lands	Teaching	65+	48h LOS, risk for FD	674	79.9 (7.6)	NR	M: 42.1%
Clemson 2016	IP	Australia	NR	70+	No CI	400	80.5 (6.1)	NR	F: 61.8%
Coleman 2006	IP	USA	Nonprofit health system	65+	One of several conditions	750	76.2 (7.0)	W: 88.7% AA: 4.5% H: 6.8%	F: 50.3%
Courtney 2009	IP	Australia	Tertiary referral	65+	1+ readmit risk factor	122	78.8 (6.9)	NR	F: 62.3%
DelSindaco 2007	MD	Italy	NR	70+	Admitted due to CHF	173	77.5 (5.8)	NR	M: 52.0%
Edmans 2013	IP	UK	NR	70+	Health risks	433	83.0 (6.8)	W: 96.3%	F: 63.3%
Feldblum 2011	IP	Israel	University	65+	Nutritional risk	259	75.2 (5.8)	NR	M: 43.6%
Finlayson 2018	IP	Australia	Tertiary	65+	1+ readmit risk factor	222	77.6 (6.6)	NR	F: 73.0%
Gallagher 2003	NU	Australia	Tertiary, Community	any Female	Cardiac	196	67.5 (11.1)	NR	F: 100.0%
Gilbert 2020	IP	France	University and general	75+	2+ readmit risk factor	705	86.9 (5.4)	NR	F: 63.5%
Koelling 2005	IP	USA	University	CHF	LVEF	223	64.8 (14.2)	AA: 21.1%	F: 42.2%
Konradsen 2017	NU	Denmark	Medium- sized	General medical	Constipa- tion risk	59	72.0 (17.1)	NR	F: 59.3%
Lainscak 2013	IP	Slovenia	Pulmonary	COPD	Pulmonary function	253	71 (9)	NR	M: 71.9%
Legrain 2011	MD	France	University	70+	LOS 5+ days	665	86.1 (6.2)	NR	F: 66.0%

Li 2017	IP	China	Large tertiary	CHF	PA limitations	78	77.0 (4.0)	NR	M: 69.2%
Linden 2014	IP	USA	Acute and tertiary	CHF, COPD	None reported	512	66.8 (12.0)	NR	F: 57.6%
Lindhardt 2019	IP	Denmark	University	65+	None reported	330	75 (6.9)	NR	M: 45.8%
Low 2017	IP	Singapo-re	Large tertiary	General medical	Readmit risk	840	70.4 (13.6)	C: 69.0% M: 14.8% I: 14.2% O: 2.0%	M: 48.8%
Mcdonald 2002	IP	Ireland	University	CHF	None reported	98	70.8 (10.5)	NR	M: 66.3%
Meisinger 2013	IP	Germany	Tertiary	65+	MI	329	75.4 (6.0)	NR	M: 62.0%
Naylor 2004	IP	USA	Academic, community	65+	CHF	239	76.0 (6.7)	W: 64.0% AA: 36.0%	M: 42.7%
Pardessus 2002	IP	France	Geriatric	65+	Admitted for fall	60	83.2 (7.8)	NR	F: 78.3%
Parry 2009	IP	USA	Community	65+	One of several diagnoses	98	81.7 (NR)	W: 88.8% AA: 1.0% H: 10.2%	F: 68.3%
Pederson 2016	MD	Denmark	University	75+	Nutritional risk	208	86.1 (5.7)	NR	F: 83.2%
Preen 2005	IP	Australia	Tertiary	Chronic illness	Cardiac or respiratory	189	75.1 (10.9)	NR	F: 60.8%
Rytter 2010	IP	Denmark	NR	78+	LOS 2+ days	293	NR	NR	F: 66.2%
Sunde 2020	IP	Norway	General	65+	Mobility risk	88	78.3 (5.5)	NR	F: 48.9%
Terp 2018	IP	Denmark	University	65+	Nutritional risk	144	87.5 (6)	NR	F: 77.8%
Thygesen 2015	IP	Denmark	University	65+	Readmit risk factors	531	77.8 (7.6)	NR	F: 48.0%
Timonen 2002	IP	Finland	Primary-care hospital	75+	Difficult mobility, acute care	68	83.1 (3.9)	NR	F: 100.0%
Van Spall 2019	IP	Canada	Tertiary or quaternary	CHF	None	2494	77.7 (12.1)	NR	M: 50.0%
Vogler 2009	IP	Australia	NR	65+	No CI	180	80.0 (6.9)	NR	F: 79.4%
Wakefield 2008	IP	USA	Veterans	CHF	Admit for CHF	148	69.3 (9.6)	W: 93.9% AA: 3.4% NA: 2.7%	M: 98.6%
Wong 2008	IP	China	NR	General medical	Readmitted in 28 days	332	70.5 (12.2)	NR	M: 54.2%

Wong 2011	IP	China	Acute general	60+	No severe CI	555	Range: 77-97	NR	M: 51.4%
Wong 2014	IP	China	Acute general	General medical	No severe CI	610	Range: 60-95	NR	M: 47.5%
Yu 2015	IP	China	University	60+	CHF, no CI	178	78.6 (6.9)	NR	M: 51.1%
Zhao 2009	NU	China	Comprehe-nsive	60+	Angina or MI	200	72.2 (5.4)	NR	F: 51.0%

Note: IP=interprofessional; PH=pharmacy; PT=physical therapy; MD=medicine; NU=nursing; CHF=congestive heart failure; LOS=length of stay; FD=functional decline; CI=cognitive impairment; PA=physical activity; MI=myocardial infarction; W=white, Caucasian; AA=black or African American; H= Hispanic; C=Chinese; M=Malay; I=Indian; NA=Native American; O=another race/ethnicity; F=female; NR=not reported

Supplemental Table S2. *Definitions of each Transitional Care Component.*

Component	Definitions
Care continuity and coordination	-Help coordinate follow-up medical care and appointments -Improving communication between providers -Contact with community pharmacists -Discharge planning or writing and sharing of discharge note -Using medical record for cross-site communication -Support navigation of health system or patient hotline -Referring patient back to hospital when needed -Other coordination of care
Medication management	-Medication review and assistance with medication self-management -Address medication problems, including drug-related problems -Identify expired medications or check family medicine cabinet -Address medication adherence and barriers -Medication education or counseling
Symptom recognition	-Address knowledge of 'red flags' or attention to signs and symptoms -Daily symptom monitoring with symptom alerts -Symptom driven action plans, such as if symptoms worsen -Education regarding when to contact health professionals
Older adult engagement	-Encouraging patients to take active role in medical care -Maintaining personal health record -Active involvement in discharge planning -Identifying and incorporating patient priorities/goals into treatment plan -Mutual goal setting with review and support of progress
Community and social services	-Assess patient needs and adequacy of social support -Connecting to or activating appropriate community and social services -Follow-up on social service needs
Self-management	-Provide support and information for patient self-management -Identify opportunities for patient's self-management -Incorporate mutual goal setting for self-management -Provide equipment for monitoring, such as blood pressure, weight -Education on health-related lifestyle and adherence
Nutrition	-Nutritional assessment and develop nutritional care plan -Dietician assessment of intake, needs, and goals -Nutritional counseling -Nutritional and meal behavior to improve appetite and intake -Providing nutritional supplements
Function	-Follow-up on functional abilities -Functional assessment and goal setting -Training and motivational interviewing in activities of daily living -Performance of ADLs and IADLs -Testing and training in mobility and transferring
Home environment and accessibility	-Check on adjustment to home environment and inquire about needs -Assess availability of nursing and home care equipment -Test and installation of aids at home

	-Assess safety of the home environment -Environmental hazard identification and removal
Exercise	-Individualized exercise program -Aerobic exercise or walking program -Upper and lower extremities exercise, included resistance exercises -Balance, strength, flexibility training -Functional exercises like sit to stand or seated exercises
Disease management	-Management of geriatric conditions -Treatment adherence, advice, and therapy optimization -Assessment of medical condition to identify problems and intervene -Management of risk factors or needs related to medical conditions -Management of multiple chronic illnesses -Disease management education
Older adult education	-Educational and behavioral strategies to address learning needs -Health teaching and coaching -Health literacy assessment
Psychological and emotional support	-Coping and adjustment -Perceptions of control, self-efficacy, and social support -Motivational interviewing -Self-efficacy enhancement strategies such as encouraging support group use and realistic goal setting
Caregiver education	-Assess cg competency -Educational and behavioral strategies to address learning needs