Appendix A

Data Extraction Matrix for Articles

Author, Date, & Country	Design /sample Method	Purpose of study	Type of Model	Outcomes	Limitations
Marshall et al. (2008) Canada	Qualitative description participants 21 physicians and 6 community nurses Data collected through survey, interviews, focus groups.	To describe the shared-care model that was created in the Niagara West region of Ontario and discuss the interventions and outcomes that pertains to family physicians and primary caregivers.	Shared care model	Physicians felt that the most imperative component of the care model was having access to palliative care consultations around the clock. Practice-based education was felt to be the next most important component. Physicians also felt that patients greatly benefited from access to a more comprehensive palliative home care team and from the coordinated, seamless integration of services. The community nurses most valued the improved trust and working relationships between themselves & family physicians, whom they now felt were more confident and available to discuss treatment plans. They also felt less alone in handling complex issues that arose in the home setting. Support from the APN enhanced their problem-solving skills, which in turn improved their confidence in decision making.	Can’t generalize conducted in one setting Canada and small sample size.
Sussman et al. (2011) Canada	Qualitative comparative case study 43 participants (10+ from each region) were recruited	The purpose of this study was to explore whether a set of modifiable health system factors could be identified that are associated with population palliative care outcomes, including less acute care use and more home deaths.	Palliative care system model	Pattern analysis revealed six factors that discriminated between regions: overall palliative care planning and needs assessment; a common chart; standardized patient assessments; 24/7 palliative care team access; advanced practice nursing presence; and designated roles for the provision of palliative care services.	The retrospective accounts provided by key informants may have been subject to recall bias, which would have impacted findings. A further issue is that case studies involving large geographic areas may lack the detail to capture local pockets of relative excellence or deficiency in palliative care provision.
Aoun et al. (2012)	Qualitative study	This article describes the	Personal alarm	The personal alarm model of care resulted in	Risk of bias because of

Australia	Phenomenology Twenty six palliative care patients of Silver Chain Hospice Care, in Western Australia, were randomly assigned to either having a personal alarm or additional care-aide hours in their home.	experiences of terminally ill ‘home alone’ people using one of two models of care aimed at maintaining participants’ need for independent living, focusing on the effect of these two models of care on their physical, social and emotional needs	model of care Care-aide model of care	benefits that can be grouped under two themes: Imparting a sense of security and providing peace of mind; and dealing with feelings of isolation. The care-aide model of care resulted in benefits that can be grouped under four themes: Easing the burden of everyday living; supporting well-being; enhancing quality of life and preserving a sense of dignity; and reducing loneliness and isolation.	this research financially supported by an Australian Research Council linkage grant, Silver Chain Hospice Care Service and Mandurah Rotary Club.
Jack et al. (2013) UK	A mixed-methods study . Sample was 75 healthcare professional. Data collection done by focus group, electronic survey, & semi-structured interviews.	To explore healthcare professionals’ perspective of hospice at home service that has different components, individually tailored to meet the needs of patients.	Hospice at home service	Reported the impact and value of each of the components of the service, as helping to support patients to remain at home, by individually tailoring care. They also positively reported that support for family carers appeared to enable them to continue coping, rapid access to the service was suggested to contribute to faster hospital discharges and the crisis intervention service was identified as helping patients remain in their own home, where they wanted to be.	Sample bias exists as it was not possible to compare a sample of patients who were not referred to the service with this group.
Downing et al. (2015) Sub-Saharan Africa	A mixed-methods study Data collection done from document, semi-structure interviews with staff from hospital & local stakeholders’	In this study evaluating seven palliative care programs in two African countries, Kenya and Malawi, a preliminary analytical framework was developed from which three models of palliative care at primary, district, and specialist levels were identified.	Specialist service model, district hospital model, and community model.	These models are similar to those found in the literature, But although these models appear to simply mirror the geographical and service site in which they are based, there are unique characteristics of each model that go beyond the physical place of care and reflect a particular set of values, an ethos and a system structure that shapes services and their delivery, staff and patient knowledge about and attitudes to palliative care, and the overall vision of palliative care.	The participant and the sample size were not mention in this study.
Jack et al. (2016) UK	A prospective descriptive qualitative study purposive sampling of 41 participants (16 patients and 25 family caregivers	To explore patients’ and family caregivers’ experiences and perceptions of Hospice at Home care.	Hospice at Home model of care.	This model of care was able to provide holistic care for terminally illness which positive consequences on patients, families & caregivers.	The study is limited through being based on one service, but the element evaluated, that of Hospice Nurses are

					probably the common denominator of most Hospice at Home services globally. Joint interviews are noted as a potential weakness due to a lack of ‘privacy’ of accounts.
de Graaf et al. (2016) Netherlands	Quantitative study retrospective cross-sectional design 130 patients were enrolled, of whom 107/130 (82%) died and 5 dropped out.	To explore whether hospice assist at home service enables patients at home to express end-of-life preferences and die in their preferred location.	Hospice assist at Home service	Supports patients to die in their preferred place of death. Shared responsibility of proactive care in primary care collaboration enabled patients to express preferences. Hospice care should focus on local teamwork, to contribute to shared responsibilities in providing optimal palliative care.	Can’t generalize conducted in Netherlands only.
Tan et al. (2016) Singapore	Quantitative study retrospective study design 914 participants were included in study and divided in two group the comparison group 593 and intervention group 321.	To evaluate the impact of an integrated hospice home care programme on acute care service usage and on the share of home deaths.	Integrated hospice home care programme	The share of hospital deaths was significantly lower for programme participants after adjusting for difference at baseline, the intervention group had statistically lower visit emergency visit at 30 days, 60 days, and 90 days prior to death.	Can’t generalize conducted in Singapore only.
Yin et al. (2017) China	Qualitative study. Data collected from palliative care practitioners in China and review of the Global Directory Of Palliative Care Services by the International Association for Hospice and Palliative Care	To describe the program development and infrastructure at the palliative care programs of three institutions, using these as examples to discuss how to accelerate palliative care access in the most populous country in the world.	Palliative care programs in Chengdu, Kunming, and Beijing.	These palliative care deliveries in China deliver a comprehensive program. Despite the numerous challenges such as the limited training opportunities & stigma on death and dying. These programs were able to overcome challenges & offer services to patients with advanced diseases & to advance this discipline in China through visionary leadership, collaboration with other countries to acquire palliative care expertise.	The participant and the sample size were not mention in this study. Data collection method was not clearly mention