

Supplementary table 2. Effectiveness of the interventions administered in the studies

Studio	Model	Intervention	Type of result			Funding mode	Study conclusion
			Effective	Partially effective	Ineffective		
<b>Battersby 2007<sup>35</sup></b>	SA HealthPlus	<ul style="list-style-type: none"> <li>§ Audit and feedback</li> <li>≠ Care pathways</li> <li>≠ Case management</li> <li>≠ Teams</li> </ul>	<ul style="list-style-type: none"> <li>• Level of dependency</li> <li>• Use of services (e.g. screening or vaccination programmes)</li> <li>• Costs of care (e.g. costs of in-patient care or costs of homecare)</li> </ul>	<ul style="list-style-type: none"> <li>• Consumer-professional interactions experience</li> <li>• Self-care abilities, self-efficacy</li> <li>• Quality of life, life satisfaction</li> <li>• Rate of prescribing medications</li> <li>• Usage of specific services (e.g. Use of outpatient treatment)</li> </ul>	<ul style="list-style-type: none"> <li>• Choices offered</li> <li>• Costs of specific interventions (e.g. educational, medical)</li> <li>• Admission to hospital</li> </ul>	* Public hospitals, * Medical Benefits Schedule (MBS) * Pharmaceutical Benefits Schedule (PBS), * Department of Veterans Affairs and regional domiciliary services	The two-year trial was not able to demonstrate a sufficient reduction in hospital admissions to pay for the costs of coordinated care.
<b>Beck 1997<sup>29</sup></b>	Cooperative Health Care Clinic (CHCC)	<ul style="list-style-type: none"> <li>§ Inter-professional education</li> <li>§ Audit and feedback</li> <li>≠ Site of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Satisfaction with care</li> <li>• Carer satisfaction</li> <li>• Provision of or use of technical aids</li> </ul>	<ul style="list-style-type: none"> <li>• Use of services (e.g. screening or vaccination programmes)</li> <li>• Readmission rate to hospital</li> <li>• Costs of specific interventions (e.g. educational, medical)</li> <li>• Admission to hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Level of activities of daily living</li> <li>• Duration of hospitalisation</li> <li>• Usage of specific services (e.g. use of outpatient treatment)</li> </ul>	Covered by one Health Maintenance Organisation (HMO)	Group visits for chronically ill patients reduce repeat hospital admissions and emergency care use, reduce cost of care, deliver certain preventive services more effectively and increase patient and physician satisfaction.
<b>Boult 2013<sup>36</sup></b>	Guided care (GC)	<ul style="list-style-type: none"> <li>≠ Teams</li> <li>≠ Site of service delivery &amp; Comprehensive geriatric assessment</li> </ul>	-	<ul style="list-style-type: none"> <li>• Satisfaction with care</li> </ul>	<ul style="list-style-type: none"> <li>• Quality of life and life satisfaction</li> <li>• Morbidity and mortality</li> <li>• Admission to hospital</li> <li>• Readmission rate to hospital</li> <li>• Usage of specific services (e.g. use of outpatient treatment)</li> </ul>	Covered by fee-for-service Medicare Parts A and B, a Kaiser Permanente Medicare health plan or TriCare insurance.	Guided Care improves high-risk older patients' ratings of the quality of their care and reduces their use of home care, but it does not appear to improve their functional health.
<b>Coleman 1999<sup>31</sup></b>	Model 'Chronic Care Clinics' (CCC)	<ul style="list-style-type: none"> <li>§ Inter-professional education</li> <li>§ Educational outreach visits or academic detailing</li> <li>§ Tailored interventions</li> <li>≠ Shared care</li> </ul>	<ul style="list-style-type: none"> <li>• Carer satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• Satisfaction with care</li> <li>• Provision of or use of technical aids</li> <li>• Self-examination</li> </ul>	<ul style="list-style-type: none"> <li>• Level of anxiety, depression, mood and wellbeing</li> <li>• Quality of life, life satisfaction</li> <li>• Side effects of drug</li> <li>• Costs of care (e.g. costs of in-patient care and homecare)</li> <li>• Admission to hospital</li> </ul>	Covered by one HMO	The findings suggest the need for developing greater system-wide support for managing geriatric syndromes in primary care.

<b>Coleman 2001</b> <sup>32</sup>	A model of primary care group visit intervention	‡ Triage	<ul style="list-style-type: none"> <li>• Readmission rate to hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Admission to hospital</li> </ul>	-	Covered by one HMO	Monthly group visits reduce emergency department utilisation for chronically ill older adults.
<b>Counsell 2007</b> <sup>42</sup>	The Geriatric Resources for Assessment and Care of Elders (GRACE) model.	‡ Site of service delivery	<ul style="list-style-type: none"> <li>• Quality of life, life satisfaction</li> </ul>	-	<ul style="list-style-type: none"> <li>• Satisfaction with care</li> <li>• Level of activities of daily living</li> <li>• Morbidity, mortality</li> <li>• Admission to hospital</li> <li>• Length of stay in hospital</li> <li>• Readmission rate to hospital</li> </ul>	None	Integrated and home-based geriatric care management resulted in improved quality of care and reduced acute care utilisation in a high-risk group.
<b>Cucinotta 2004</b> <sup>44</sup>	Model of home assistance	‡ Site of service delivery	<ul style="list-style-type: none"> <li>• Morbidity, mortality</li> <li>• Readmission rate to hospital</li> </ul>	-	<ul style="list-style-type: none"> <li>• Admission to hospital</li> </ul>	None	A lower rate of mortality, readmission to hospital and institutionalisation in older subjects receiving home care were observed.
<b>Dubbert 2002</b> <sup>20</sup>	Seniors Telephone Exercise Primary Care Study (STEPS)	§ Educational materials § Reminders	<ul style="list-style-type: none"> <li>• Complications, complication rate</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of patient-held records or notes when required</li> <li>• Partner or family support</li> <li>• Exercise</li> </ul>	<ul style="list-style-type: none"> <li>• Level of anxiety, depression, mood, wellbeing</li> <li>• Quality of life, life satisfaction</li> </ul>	Participants were paid \$15 for completing each visit to help defray their expenses	Simple and relatively inexpensive nurse contacts can motivate older primary care patients to walk for exercise, and this activity is associated with measurable health benefits.
<b>Duggleby 2018</b> <sup>28</sup>	My Tools 4 Care (MT4C)	§ Educational meetings	-	-	<ul style="list-style-type: none"> <li>• Quality of life, life satisfaction</li> <li>• Self-care abilities, self-efficacy</li> </ul>	None	Despite no significant differences between groups in terms of the primary outcome variable (mental component score), the significant differences in terms of one of the hope factors suggest that MT4C had a positive influence on the lives of participants.
<b>Ford 2019</b> <sup>27</sup>	Goal setting	§ Educational outreach visits or academic detailing ‡ Continuity of care	<ul style="list-style-type: none"> <li>• Agreement between personal values for outcomes and choice</li> </ul>	-	<ul style="list-style-type: none"> <li>• Improved communication with provider</li> <li>• The decision/s made</li> <li>• Quality of life, life satisfaction</li> <li>• Morbidity, mortality</li> <li>• Level of patient-centred care</li> <li>• Rate of prescribing medications</li> </ul>	None	Participants set between one and three goals on a wide range of subjects, such as chronic disease management, walking, maintaining social interactions and leisure, interests and weight management. Participants found goal setting acceptable and would have liked more frequent follow-up. GPs unanimously liked goal setting and felt it delivered more patient-

							centred care, and they highlighted the importance of training.
<b>Fried 2017</b> <sup>26</sup>	Tool to Reduce Inappropriate Medications (TRIM)	‡ Health information systems	<ul style="list-style-type: none"> <li>• Carer satisfaction</li> <li>• Communication skills/techniques</li> </ul>	-	<ul style="list-style-type: none"> <li>• Factors affecting compliance</li> <li>• Rate of prescribing medications</li> <li>• Quality of care</li> </ul>	None	TRIM improved communication around medications and accuracy of documentation. While there was no association with prescription, the small sample size provided limited power to examine medication-related outcomes.
<b>Harpole 2005</b> <sup>43</sup>	Pre-planned analyses of Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)	§ Educational meetings	-	<ul style="list-style-type: none"> <li>• Level of anxiety, depression, mood, wellbeing</li> <li>• Quality of life, life satisfaction</li> </ul>	-	None	The presence of multiple comorbid medical illnesses did not affect patient response to a multidisciplinary depression treatment programme. The IMPACT collaborative care model was equally effective for depressed older adults with or without comorbid medical illnesses.
<b>Hochhalter 2010</b> <sup>41</sup>	Making the Most of Your Healthcare	§ Educational meetings ‡ Triage	-	<ul style="list-style-type: none"> <li>• Level of activities of daily living</li> </ul>	-	None	The intervention requires refinement to reach persons not already engaged in their healthcare and to strengthen its effects.
<b>Jonkers 2012</b> <sup>23</sup>	Minimal Psychological Intervention (MPI)	‡ Comprehensive geriatric assessment	<ul style="list-style-type: none"> <li>• Level of activities of daily living</li> <li>• Self-care abilities, self-efficacy</li> <li>• Level of anxiety, depression, mood, wellbeing</li> <li>• Social activity</li> </ul>	-	-	None	We recommend further evaluation of the MPI, including emphasis on detection and watchful waiting.

<b>Köberlein 2016</b> <sup>40</sup>	Case Management	<ul style="list-style-type: none"> <li>‡ Site of service delivery</li> <li>▣ Prescribing</li> </ul>	<ul style="list-style-type: none"> <li>• Quality of care</li> <li>• Reporting of adverse events</li> </ul>	-	-	None	Inter-professional collaboration increased medication safety. Working across disciplinary boundaries allowed for a decrease in drug-related problems and brought up aspects outside the purview of the primary care physician.
<b>Lamers 2010</b> <sup>22</sup>	Minimal Psychological Intervention (MPI)	<ul style="list-style-type: none"> <li>§ Educational meetings</li> <li>‡ Site of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Level of anxiety, depression, mood, wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Quality of life, life satisfaction</li> </ul>	-	None	The nurse-led MPI appears to be a feasible and moderately effective method of managing minor-to-moderate depression in chronically ill older persons. However, we cannot rule out attention-placebo effects and the recent disappointing economic finding. The evaluation showing only a 63% chance of the MPI being cost effective. From a clinical point of view, however, it is of interest to further evaluate adaptations of the MPI, with a stronger emphasis on detection, watchful waiting and mental health problems in general.
<b>Leveille 1998</b> <sup>30</sup>	Collaborative model	<ul style="list-style-type: none"> <li>§ Inter-professional education</li> <li>§ Patient-mediated interventions</li> <li>‡ Site of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Provision of or use of technical aids</li> <li>• Duration of hospitalisation</li> </ul>	<ul style="list-style-type: none"> <li>• Others (consumption of alcoholic beverages)</li> <li>• Level of activities of daily living</li> <li>• Social activity</li> </ul>	<ul style="list-style-type: none"> <li>• Level of anxiety, depression, mood and wellbeing</li> <li>• Quality of life and life satisfaction</li> <li>• Diet</li> <li>• Exercise</li> <li>• Costs of care (e.g. costs of in-patient care, costs of homecare)</li> <li>• Admission to hospital</li> <li>• Rate of readmission to hospital</li> </ul>	Covered by two independent HMO	The Collaborative model improves function and reduces hospitalisation rates in chronically ill older adults. Linking organised medical care with complementary community-based interventions may be a promising area for research and practice.

<b>Lin 2006</b> <sup>34</sup>	Improving Mood, Providing Access to Collaborative Treatment IMPACT	<ul style="list-style-type: none"> <li>§ Inter-professional education</li> <li>‡ Site of service delivery</li> <li>▣ Prescribing</li> </ul>	-	<ul style="list-style-type: none"> <li>• Priority setting</li> </ul>	-	<ul style="list-style-type: none"> <li>* Fee-for-service</li> <li>* Veterans Affairs</li> <li>* Prepaid plans</li> </ul>	Systematic depression management was more effective than usual care in decreasing pain severity among patients with arthritis with lower initial pain severity but did not have greater benefits than usual care on pain among patients with higher initial pain severity.
<b>Meng 2005</b> <sup>21</sup>	The Medicare Primary and Consumer-Directed Care Demonstration	<ul style="list-style-type: none"> <li>§ Educational meetings</li> <li>▣ Voucher schemes</li> <li>▣ Voucher schemes &amp; Shared care</li> </ul>	-	<ul style="list-style-type: none"> <li>• Priority setting</li> </ul>	-	<ul style="list-style-type: none"> <li>*Centres for Medicare and Medicaid Services</li> <li>*Medicare provided payment (\$60 per-office visit) to the primary care physicians * Covered by one HMO</li> </ul>	The implementation of disease-management–health-promotion nursing interventions should not lead to a greater probability of skilled home health care or personal assistance services use, whereas the provision of consumer-directed vouchers should result in an increased probability of personal assistance services use, as intended.
<b>Moral 2015</b> <sup>25</sup>	Motivational Interviewing (MI)	<ul style="list-style-type: none"> <li>§ Educational meetings</li> <li>§ Educational outreach visits or academic detailing*</li> </ul>	<ul style="list-style-type: none"> <li>• Factors affecting compliance</li> <li>• Patient compliance (with treatment, medication)</li> </ul>	-	-	None	A face-to-face motivational approach in primary care helps older patients with chronic diseases being treated by polypharmacy to achieve an improved level of treatment adherence than traditional strategies of providing information and advice.
<b>Poot 2019</b> <sup>37</sup>	Integrated Systematic Care for Older People (ISCOPE)	<ul style="list-style-type: none"> <li>§ Audit and feedback</li> <li>§ Educational outreach visits or academic detailing</li> <li>‡ Teams</li> </ul>	-	-	<ul style="list-style-type: none"> <li>• Satisfaction with care</li> </ul>	None	The satisfaction of General Practitioner care does not change during the administration of improved person-centred integrated care.
<b>Schäfer 2018</b> <sup>39</sup>	Chronic Care Model and Narrative Based Medicine	<ul style="list-style-type: none"> <li>§ Educational outreach visits or academic detailing</li> <li>▣ Prescribing</li> </ul>	-	-	<ul style="list-style-type: none"> <li>• Knowledge about expected and undesired effects of treatment</li> <li>• Satisfaction with care</li> <li>• Self-care abilities, self-efficacy</li> <li>• Quality of life, life</li> </ul>	None	Intensifying the doctor–patient dialogue and discussing the patient's agenda and personal needs did not lead to a reduction of medication intake and did not alter

					satisfaction <ul style="list-style-type: none"> <li>• Rate of prescribing medications</li> <li>• Usage of specific services (e.g. use of outpatient treatment)</li> </ul>		health-related quality of life.
<b>Scott 2004</b> <sup>33</sup>	Cooperative Health Care Clinic (CHCC)	§ Educational meetings § Continuous quality improvement ‡ Group versus individual care	<ul style="list-style-type: none"> <li>• Advance directives</li> <li>• Satisfaction with care</li> <li>• Quality of life, life satisfaction</li> <li>• Costs of care (eg. costs of in-patient care, costs of homecare)</li> <li>• Admission to hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge of risk, accurate risk perception</li> <li>• Patient satisfaction with the information provided</li> </ul>	<ul style="list-style-type: none"> <li>• Level of activities of daily living</li> <li>• Rate of prescribing medications</li> <li>• Usage of specific services (e.g. use of outpatient treatment)</li> </ul>	Non-profit group model	The CHCC model resulted in fewer hospitalisations and emergency visits and increased patient satisfaction and self-efficacy, but no effect on outpatient use, health or functional status.
<b>Toots 2019</b> <sup>68</sup>	Umeå Dementia and Exercise Study (UMDEX)	§ Educational meetings	-	<ul style="list-style-type: none"> <li>• Self-care abilities, self-efficacy</li> </ul>	-	None	In older people with dementia living in nursing homes, a high-intensity functional exercise programme alone did not prevent falls when compared with control group.
<b>Touchette 2012</b> <sup>24</sup>	Medication Therapy Management (MTM)	§ Educational meetings ▣ Prescribing	<ul style="list-style-type: none"> <li>• Agreement between personal values for outcomes and choice</li> <li>• Rate of prescribing medications</li> </ul>	<ul style="list-style-type: none"> <li>• Reporting of adverse events</li> </ul> Side effects of drugs	<ul style="list-style-type: none"> <li>• Admission to hospital</li> <li>• Usage of specific services (e.g. use of outpatient treatment)</li> </ul>	None	This specific design of MTM was associated with reduced drug-related problems (DRPs) but did not reduce potential risk or health care visits.

§ Implementation Strategies, ‡ Delivery Arrangements, ▣ Governance Arrangements, ° Financial Arrangements