Intervention details

ADL

Table 1. Dorresteijn 2016[I] In-home cognitive behavioral program

1. Brief name	In-home cognitive behavioral program. A nurse-led in-home cognitive behavioral program to deal with concerns about falls and related activity avoidance
2. Why	Goals: - to help participants to learn how to deal with their concerns about falls and related avoidance of activity, in order to safely increase their physical, social, and functional activities. - to instill adaptive and realistic views about fall risks and to increase activity and safe behavior - to encourage independent living among older people for as long as possible with minimal burden for healthcare professionals and informal caregivers Rationale: - Based on, "A Matter of Balance", a multicomponent, cognitive behavioral group program which showed favorable effects on concerns about falls, activity avoidance and recurrent falls - Based on the principles of cognitive restructuring, focused on increasing self efficacy beliefs and feelings of control, setting realistic goals for increasing activity, changing the environment to reduce the fall risk and promoting physical activity to increase strength and balance - Set at home to facilitate involvement of frail older people and other people who prefer an in-home approach
3. What (materials)	- DVDs presenting stories of other people reporting concerns about falls and their solutions

	- Printed materials, including background information on the session's theme, checklists and worksheets to complete during or between the sessions - Action plans - Iconographical Falls Efficacy Scale (Icon-FES) to support te selection of activities to be trained by participants - Leaflet about fall hazards - For implementation analysis: A questionnaire to report on the programme's feasibility and usefulness, registration form for facilitators to report the time spent per session, participant's adherence and to what extent the protocol was followed, voice recordings of random sessions.
4. What (procedures)	- Program focused on fears of falling and daily activities avoidance. Uses cognitive restructuring techniques including motivational interviewing. Includes 3 main activities related with functional training: * education about fears of falling and daily activities avoidance, * development of tailored action plans related with those topics, * training of feared activities with supervision - Access to usual care on the participants' initiative, which included GP, physiotherapy and other therapists, hospital and day care, medical specialists and home-care.
5. Who provided	- Community nurses - The nurses were qualified in geriatrics, worked for home care agencies and received a 2-days training about the intervention program - Presumably various health professionals which services can accessed by participants' initiative in usual care.
6. How	- Individually or with a significant other, and face-to-face; - By telephone - Delivery was based on principles of cognitive restructuring and used goal setting and motivational interviewing
6b. How organised	- The facilitators were responsible for scheduling and conducting the sessions with the participants according to the program manual and timetable. - The participant's significant other was invited to participate with the expectation that this person could motivate the participant to perform the action plans developed in the program between the sessions.
7. Where	- At home - Three communities, Maastricht, Sittard-Geleen, and Heerlen, situated in the southeast of The Netherlands
8. When and how much	- Started after screening by postal questionnaire directed to community-dwelling people over 70. The screening selected participants who (1) reported at least some concerns about falls and associated activity avoidance, and (2) perceived their general health as fair or poor. The selected participants were considered frail based on (2). - 7 individual sessions (3 home visits (60, 60 and 75 minutes, respectively) & 4 telephone contacts (35 minutes each) - The first four sessions occurred weekly, and the last three sessions were every 2 weeks. - The program duration was 10 weeks.
9. Tailoring	- The action plans were tailored based on participants' needs and preference. This included the choice of the feared activity to be trained in the presence of the intervention facilitator

10. Modifications	Not mentioned
11. How well (planned)	- An analysis of the program implementation was planned and included: * Participants who received at least five of the seven sessions received a questionnaire about the program's feasibility and usefulness * Facilitators reported on the time spent per session, the participant's adherence with regard to homework assignments, and the extent to which the program was performed according to protocol. * Small voice recorders were used to gather objective data about the facilitator's performance according to the protocol. *Identification of barriers to implementation
12. How well (actual)	- Overall, both facilitators and participants considered the program acceptable and feasible. The program protocol was largely followed, according to the facilitators - The use of action plans decreased towards the end of the program; the use ranged from more than 70 % in the first sessions to 51 % in the latter sessions. - Additionally, the performance of an activity safely under supervision of the facilitator, was only performed by half of the participants. Difficulty in finding an appropriate activity was the main barrier.

Table 2. Siemonsma 2018[2] Functional Task Exercise (FTE)

1. Brief name	Functional Task Exercise (FTE). A home-based intensive functional training programme, focuses on training of those daily activities which are problematic for the elderly.
2. Why	Goal: - preventing age-related functional decline of the elderly, by providing the exercise programme. - to increase the functional independence of older adults in daily life. - enhances physical capacity with sustainable effects. Rationale: - is based on state-of-the-art knowledge about human movement sciences, action theory, motor learning, motivation, rehabilitation medicine, development of frailty and cognitive psychology - enduring effects are achieved because it enhances older people's physical capacity, and fits in with daily routines. - directly targets daily tasks in the domains that are affected early in the aging process.
3. What (materials)	Assuming training materials were used to train and educate the physiotherapists before their delivering the intervention.
4. What (procedures)	Training to staff: Physiotherapists were trained and educated (44 study hours) to carry out the FTE intervention. Referrals to intervention: Therapists received an open referral to help this person with their daily functioning. 12-week intervention programme: 1. The programme specifically targets four domains relating to movements and activities of daily living. In each training session, the participants perform tasks from at least two of the four domains.

	2. Exercises were closely linked cognition, perception and execution of tasks in relation to the older person's home environment. Training was problem-oriented, situational and task-specific and helped to build confidence. 3. Three phases, with increasing complexity and variability of the exercises step by step: i. Practice phase (2 weeks) -aims for participants to 1) learn how the exercises are performed, 2) get used to training, and 3) learn how to train at an appropriate intensity. ii. Variation phase (4 weeks) - Aim to build up the participants' physical capacities, and their ability to use variation and complexity in tasks. iii. Daily tasks phase (6 weeks) - consists of tasks resemble daily tasks; to train situations that closely match the participants' daily activities. Activities are trained beyond the level of variation and complexity, thus to build up reserve capacity. 4. Caretakers can be called in for guidance in the home situation to stimulate the participant to perform daily activities, and to stay active. 5. Physiotherapist conducted supplementary functional diagnostics in the domain of daily functioning; monitored progression regularly and adjusted the training intensity.
5. Who provided	Delivered by physiotherapists, who had been specially trained and educated (44 study hours), to deliver the functional training programme in the older person's home.
6. How	Delivered face-to-face, to each individual, in or around the participant's home.
6b. How organised	No details
7. Where	Location: Leiden, The Netherlands Venue: In (and around) the older person's home and environment. The country's infrastructure: - Preventive physical therapy (PPT) targeting daily functioning was the standard intervention available. -The viability of the FTE programme was financial sustainability for the therapists and the elderly, otherwise it would not be provided routinely if the costs were too high.
8. When and how much	Intervention started when the participant was referred to a physiotherapist in an open referral, to help this person's daily functioning. - Maximum of 18 session, 30 minutes each, within three months. - In each training session, participants performed exercises on at least 2 of the 4 targeting movement domains. Each exercise includes 3 sets of 5-10 repetitions.
9. Tailoring	1. During each of the 3 phases in the programme, the physiotherapist can complicate or simplify motor, environment, and cognitive aspects of the tasks in accordance with the abilities of each participant. Each aspect can be changed in a stable or a variable way. 2. The FTE was offered in (and around) the older person's home on an individual basis, thus enabling therapists to attune to individual problems and the person's environment. 3. The participant and physiotherapist together decided which daily activities needed training, to improve the ability to live independently.

	4. The physiotherapist monitored progression regularly, and adjusted the training intensity accordingly.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

ADL and exercise

Table 3. Gill 2002[3] Prehabilitation program (PREHAB)

1. Brief name	Prehabilitation program (PREHAB). A preventive, home-based individualized multicomponent physical therapy program.
2. Why	- Goal: to prevent functional decline among a heterogeneous group of physically frail, community-living older persons by focusing primarily on improving underlying impairments in physical capabilities. - Rationale: - Based in 2 home-based protocols designed to prevent falls and restore function after hip fracture - Based on 4 principles: (1) the program should identify and ameliorate underlying impairments in domains that are relevant to mobility and other ADLs; (2) the assessment protocol should be useful in identifying the interventions most relevant for individual participants; (3) the intervention protocol should be tailored to the combination of comorbidities, contraindications, and personal preferences of a diverse group of frail older persons and should involve instruction by the therapist, followed by unsupervised (or family-supervised) training and exercises; and (4) the training and exercise program should be safe for frail older persons and should not include equipment that is not feasible in home-based therapy. - The adherence strategies of the intervention were based on the Health Beliefs Model, the "negotiated approach" and Social Learning Theory
3. What (materials)	- Computerized decision tool (to determine appropriate interventions) that runs on notebook computers - Assessment and intervention protocols - Resistance bands - Written step-by-step instructions in large print with illustrations of recommended exercises - Daily exercise calendar - Foam blocks - A notebook to help organize the study materials, including the visit and adherence calendars, contracts, information and instruction sheets, and environmental assessment and recommendations. - Contracts with the goals of the intervention - List of local podiatrists - Safe footwear handout
4. What (procedures)	- Assessment for range of physical and functional activity and environmental assessment by the physical therapist.

	- Participants were intended to receive physical exercise (e.g., strength with resistance bands), and functional training (e.g., reaching a cabinet, toilet transfer, street crossing), supported by environmental adaptations (removal of loose rugs, improvement of lighting) - The participants were advised to continue exercises on their own and were regularly monitored and encouraged in periodic phone calls
5. Who provided	- The physical therapist provided the intervention - Other professionals were sometimes contacted as support to the physical therapist, namely a senior physical therapist, a home care nurse, and a physician
6. How	- Presumably face-to-face and individually (at home) - By telephone - Behavioral modification principles were used, including goal setting (verbally and in "contracts" with the physical therapist), and self-reward and other self-control reinforcement strategies.
6b. How organised	- The physical therapist was supervised and supported by a home care nurse and a senior physical therapist.
7. Where	- Bridgeport, Connecticut - At home
8. When and how much	- Started after the participants were 1. identified and screened for physical frailty during office visits to their primary care physicians; or 2. identified from the patient rosters of primary care physicians and screened for physical frailty in their home. Physical frailty was defined on the basis of slow gait speed (greater than 10 seconds) and inability to stand from a chair with one's arms folded. - An average of 16 visits of 45-60 minutes over a 6-month period were expected (variable based on need) - A monthly phone call for 6 additional months
9. Tailoring	- The intervention was tailored based on the participant's needs which activated specific protocols for action, based on algorithms / decision rules. - The number of visits was also tailored to the participants' needs. - The physical therapist incorporated the participant's preference in the interventions
10. Modifications	Not mentioned
11. How well (planned)	Several strategies were used to support adherence and implementation fidelity including: - monitoring adherence by using a daily exercise calendar, completed by the participant and reviewed by the therapist - closely linking identified impairments and interventions, to decrease the likelihood of protocol violations - agreeing on the goals of the intervention with the participant and discussing possible barriers - providing a notebook to organize all the intervention related materials - providing information about self-reward and self-control reinforcement strategies - providing professional support to the physical therapist
12. How well (actual)	- Participants who completed the program and those who ended it prematurely received an average of 9.7 and 7.2 interventions during an average of 14.9 and 9.5 home visits, respectively.

	- With few exceptions, most participants who met criteria for a specific intervention actually received that intervention. - Overall, adherence to the training program was high, with a completion rate of 73.4%, 78.4%, and 78.7% of the assigned exercises for balance, lower-extremity conditioning, and upper extremity conditioning, respectively. - Participants were much less likely to implement the environmental recommendations

ADL, aids and exercise

Table 4. Gitlin 2006[4] Advancing Better Living for Elders (ABLE) home-based occupational and physical therapy and home modification

1. Brief name	Advancing Better Living for Elders (ABLE) home-based occupational and physical therapy and home modification.
2. Why	Goal: to reduce difficulties in performing everyday tasks; to optimize performance and compensate for declining abilities Rationale: - By targeting modifiable environmental and behavioral factors that contribute to functional decline - Based on previous research showing success for interventions that are multicomponent and target areas that individuals self-identify as problematic and involve home modifications - Based on the Life Span Theory of Control as applied to the disablement process which emphasizes the role of a threat to personal control in the progression to disability resulting in negative consequences, and thus the importance of behavioural/control-oriented strategies to support intervention delivery. - Based on the Transtheoretical Model of behavior change which describes the process of health behaviour change focusing on personal decision-making. This modelled the behavioural/control-oriented strategies used to support intervention delivery.
3. What (materials)	- Home modification devices (grab bars, rails, raised toilet seats) - Education print materials (presumably related with environmental modifications, ADL training and/or exercise/fall prevention) were provided to the participants - Tailored written action plans for each participant (For the staff: training materials, tapes of sessions and documentation to support supervision activities)
4. What (procedures)	- ADL training (e.g., energy conserving techniques, presumably in everyday tasks) and environmental modifications (e.g., assessment of environmental barriers, equipment options) and training in their use by the occupational therapist. - Physical exercise, including balance and muscle strengthening and fall-recovery techniques by the physical therapist. - The delivery was supported by the use of problem-solving techniques. - Presumably access to usual healthcare services based on own's initiative was available.
5. Who provided	- Occupational therapist and physical therapist

	- The providers were licensed therapist who receive 35 hours of training on the intervention and supervision during the implementation (including regular supervision meetings and feedback on taped sessions)
6. How	- Presumably individually and face-to-face, based on home visit format - By telephone - Behavioural change techniques were central to the intervention delivery, including assessment of readiness to change, problem-solving use, reframing, among others. The participant was expected to actively engage with in problem-identification and strategy use.
6b. How organised	- The OTs and PT coordinated their actions during the intervention (not specified how) - An agency on aging provided the home modification materials
7. Where	- At home - Philadelphia, USA
8. When and how much	- Started after advertising through local social service agencies, agency on aging, and media announcements and phone screening that assessed for functional vulnerability (2 IADL or 1or+ ADL, HRCA Vulnerability Index 1or+); and when participants were 70 years old or more, cognitively intact (+23 MMSE), not receiving home occupational or physical therapy. - 5 occupational therapy contacts (four 90-minute visits and one 20 min telephone contact) and 1 physical therapy visit (90 minutes) were expected for 6 months + 3 OT phone calls (15 min) and 1 final home visit in the following 6 months. This schedule was adapted according with participants' need.
9. Tailoring	- The action plan was tailored based on initial assessment, in particular regarding behavioural strategies to support delivery. Participant's priorities were taken into account in considering how to focus the action plan. - The visit schedule was adapted to the participants' needs.
10. Modifications	Not mentioned
11. How well (planned)	To support intervention delivery, the providers received training and regular supervision and feedback (- The emphasis on behavioural change techniques in intervention delivery was also intended to support adherence to the intervention)
12. How well (actual)	Not mentioned

ADL, aids, education, exercise, multifactorial-action and review with medication review and self-management

Table 5. Szanton 2011[5] Community Aging in Place, Advancing Better Living for Elders (CAPABLE) intervention

1. Brief name	Community Aging in Place, Advancing Better Living for Elders (CAPABLE) intervention. A client centered home-based multi-component intervention including occupational therapist intervention, a nurse intervention and safety and access handyman services.
2. Why	Goal:

	- to target both individual (intrinsic) and environmental (extrinsic) disability factors in a population of low-income, disabled, predominantly African-American older adults. - to decrease functional difficulty/ to increase the participants' bio-psycho-functional capacity to function at home. Rationale: - Given the multi-factorial nature of many of the age-related conditions and their associated risk factors, the best interventions are likely multi-component with the components synergistically targeting multiple risks for disability. - Each service synergistically builds on the others by increasing the participants' bio-psycho-functional capacity to function at home. This is theorized to avert costly health utilization by increasing medication management, problem-solving ability, strength, balance, nutrition, and home safety, while decreasing isolation, depression, and fall risk. - The CAPABLE intervention is based on the best practices of patient-centered care and motivational interviewing.
3. What (materials)	1. Client-Clinician Assessment Protocol (C-Cap) guided the semi-structured clinical interview by the OT (not provided to the participant) 2. Home-modification devices - Provided to the participant 3. The RN provided resources to address future needs (e.g. pill box for medication management). 4. Health passport provided to participant by the nurse 5. Letters from the nurse to the PCP about medication 6. Referrals to PCP when participants don't have one 7. DVD's of Tai Chi exercises 8. List of assistive devices and repairs agreed with participant and emailed to "handyman" coordinator
4. What (procedures)	Multidomain assessment, planning and arranging - Environmental (aids and adaptations) assessment and planning by OT. - Functional activity assessment and planning by OT - The nurse was dedicated to diverse areas that included pain, depression, strength and balance, medication management and communication with PCP. Included negotiation of care goals using motivational interviewing and formulation of a behavioural plan. Medication review by primary care provider. Actioning: 1. Physical exercise training provided by the nurse 2. Education (embedded): - Provision of health-related information by the nurse, including pain management. - Teaching about medication use by the nurse. - Provision of information and advice to facilitate independent living by the OT, including fall-related information. - Self-management techniques, e.g., problem-solving, used by the OT and Nurse with the participant (separately) to achieve goals set in the care plans. 3.Aids, appliances, adaptations: - Fitting of home devices and provision of repairs by handyman. - Training to use aids and home modifications provided, by the OT. Selective actioning:

	1. If interest in Tai Chi, provides DVD's and tailored home visits from Tai Chi instructors 2. Problem-solving depression intervention for mood management if necessary. Routine review: - The strategies recommended by OT and nurse were refined and reviewed from session to session. Available usual care: Primary care provider is available.
5. Who provided	1. Occupational therapist 2. Nurse 3. Handy man team 4. Primary care provider (physician)
6. How	The home visits by the nurse, OT and the installation of devices or reparations of the handyman at home were presumably individual and face-to-face Participant and OT decided together about the environment modifications to be established The establishment of goals with the nurse was based on motivational interviewing
6b. How organised	Unidisciplinary care plans delivered by a multidisciplinary team: 1. Appointments for each intervention service were spaced across weeks so that participants had opportunities to practice new strategies or activities with the health professional and then on their own. 2. The OT securely emailed a list of agreed upon assistive devices and housing repairs to the Home Modification (HM) coordinator. Timing of the installation was coordinated between the OT and HM team to ensure that they were provided in a timely manner to meet the needs of the participant. The Principal Investigator authorized repairs hypothesized to increase participant safety and mobility. 3. The HM portion was contracted with Civic Works, a local non-profit AmeriCorps site. The HM coordinated the ordering of the assistive devices as well as the repair and modification supplies. 4. The nurse set a care plan which focused on medication management, increasing physical exercises, and pain management. The nurse sent letters to the PCP about medication, when needed. Budgets for renovations/ modifications: Average of $1300 allocated per household.
7. Where	Location: Baltimore city, US Venue: At home.
8. When and how much	When started - Individuals were recruited from the lists of three government and non-profit organization of low-income older adults awaiting home-based services in Baltimore City. Assessed as disabled based on difficulty with at least one Activity of Daily Living (ADL) or at least two Instrumental Activities of Daily Living. Persons were contacted first by letter and then a follow-up phone call. Duration of sessions: OT home visits 60 minutes - up to 6 sessions over 6 months RN home visits 60 minutes - up to 4 visits during the same 6 months as the OT sessions. The first RN session occurred within 10 days of the first OT session. HM - As many visits as need and may not need to include this (may not need to include this)

9. Tailoring	Components of the intervention were tailored to each participant's risk, goals and preferences, including the frequency of the visits, and the strategies put in place (including individualized training, tailored choice of environmental changes, and an individualized behaviour plan).
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 6. Szanton 2019[6] Community Aging in Place - Advancing Better Living for Elders (CAPABLE)

1. Brief name	Community Aging in Place - Advancing Better Living for Elders (CAPABLE). A biobehavioral-environmental intervention, which consists of an assessment-driven, individually tailored package of interventions by an interdisciplinary team of a nurse, occupational therapist, and handyman.
2. Why	Goals: - to reduce disability/improve specific limitation in daily functions among low income older adults - to address both personal and environmental risk factors for disability - to identify and meet functional, participant-centered goals related to pain, function, safety, engagement in care, medication adherence, and quality of life. Rationale: - Older adults of low income experience a higher prevalence of disability, and often have housing conditions that exacerbate the effect of disability. - Based on 4 overarching theoretical frameworks of resilience, competence-environment press, disablement process, and control; together inform the person-directed approach to the built environment and the individual that guides CAPABLE. - The CAPABLE pilot and a 1-arm study of the intervention have shown the expected positive effects.
3. What (materials)	- Client-Clinician Assessment Protocol (C-Cap) guided the semi-structured clinical interview focused on functionality and used by the OT - C-CAP RN, an assessment developed for this intervention, focused on various areas (e.g., medication, balance, depression) and used by the nurse - Assistive devices and medical equipment - Materials used in house repairs - Medication calendar provided to the participant by the nurse - Intervention "CAPABLE" notebook including educational materials, contact information and a calendar to integrate different sessions, provided by OT and nurse - Health passport provided to participant by the nurse - Letters from the nurse to the PCP about medication - Referrals to PCP when participants don't have one - DVD's of Tai Chi exercises - List of assistive devices and repairs agreed with participant and emailed to "handyman" coordinator - An intervention manual for training

	- Audiotapes of 10% of the sessions for supervision - Checklists to review audiotapes for supervision - Web-based calendar used by the research coordinator to alert staff about upcoming sessions
4. What (procedures)	Multidomain assessment, planning and arranging - Environmental (aids and adaptations) assessment and planning by OT. - Functional activity assessment and planning by OT - The nurse was dedicated to diverse areas that included pain, depression, strength and balance, medication management and communication with PCP. Included negotiation of a care goals using motivational interviewing and formulation of a behavioural plan. Medication review by primary care provider or pharmacist. Actioning: 1. Physical exercise training provided by the nurse 2. Education (embedded): - Provision of health-related information by the nurse, including pain management. - Teaching about medication use by the nurse. - Provision of information and advice to facilitate independent living by the OT, including fall-related information. - Self-management techniques, e.g., problem-solving, used by the OT and Nurse with the participant (separately) to achieve goals set in the care plans. 3.Aids, appliances, adaptations: - Fitting of home devices and provision of repairs by handyman. - Training to use aids and home modifications provided, by the OT. Selective actioning: 1. If interest in Tai Chi, provides DVD's and tailored home visits from Tai Chi instructors. 2. PEARLS depression intervention if necessary. Routine review: - The strategies recommended by OT and nurse were refined and reviewed from session to session. Available usual care: Presumably is mainly provided by the primary care provider/physicians. For staff: - Training based on written materials, sessions and observation - Supervision including: reviewing and feedback on audiotaped sessions, reminders of sessions and regular staff meetings Usual care presumably included primary care, as suggested by contacts with PCP.
5. Who provided	- An interdisciplinary team of a nurse, occupational therapist, and handyman (Other professionals were involved in activities like consulting and supervision, including the principal investigator and a pharmacist)
6. How	- Face-to-face and presumably individually and for the in-home sessions
6b. How organised	Unidisciplinary care plans delivered by a multidisciplinary team: - Communication between the OT, Nurse, and Handyman are enhanced by a secure share site which can be remotely logged into by the interventionists and enable electronic documentation

	- The OT coordinated with the handyman by sending the list of assistive devices and housing repairs agreed with the participant, and the handyman let the OT know when the work was completed - The Handyman portion is contracted with Civic Works which is an AmeriCorps site located in the urban area where the study is being conducted. The contractor at Civic Works coordinates the ordering of the assistive devices as well as the repair and modification supplies. The budget was $1300 - The nurse set a care plan which focused on medication management, increasing physical exercises, and pain management. A pharmacist and PCP were consulted/ contacted by the nurse for medication review when necessary. - A research coordinator coordinated the schedule for sessions. - The staff was supervised based on audiotapes in case presentations and supervisory sessions
7. Where	Location: Baltimore city, Maryland Venue: At home
8. When and how much	When started: - Status - low income - Assessed as had difficulty in at least 1 ADL or 2 IADLs - Participants enrolled in the study following contact by mail, government and community-based organizations and by an ambassador program. Sessions schedule: - There were generally 10 sessions over 4 months, 6 with the OT and 4 with the nurse. The sessions took 60 to 90 min. - Additionally, home visits by handyman. This number of sessions was adapted based on participants' need.
9. Tailoring	- The functional and multimodal assessments identified needs specific to each participant and subsequent activities were tailored based on that in terms of contact and frequency (e.g., number of visits/sessions) - The participants' preferences were integrated in the care plan which was discussed with the participant - If the medical review showed high-alert or <15 medications, this triggered a contact by the nurse to a pharmacist
10. Modifications	Not mentioned
11. How well (planned)	Several procedures were intended to assure fidelity: - staff training - the reminder calls to participants - the enactment of exercises learned with staff by participants - the supervision based on audiotapes, checklists, feedback and bi weekly meetings between staff and principal investigator
12. How well (actual)	Of the 152 participants, 141 (92.8%) completed 8 to 10 sessions and only 6 (3.9%) had fewer than 3 sessions, considered the minimal treatment threshold. Participants in the intervention group received a mean (SD) of 9.1 (1.86) home visits.

ADL, medication-review, nutrition and social-skills

Table 7. van Lieshout 2018[7] Supporting PRoactive lifestyle intervention in frailty and disability (SPRY)

1. Brief name	Supporting PRoactive lifestyle intervention in frailty and disability (SPRY). An interdisciplinary multicomponent intervention program consisting of four consecutive intervention components targeting the improvement of medication use, physical activity, psychosocial health and nutritional status.
2. Why	Goal 1. to increase safety, to prevent the negative effects of polypharmacy and to increase the reliability of drug use and intake. 2. The interaction between the cognitive, perceptual, and motor functions and the individual's dynamic environment is trained, focusing on physical fitness; and aims to improve muscle strength, walking speed and reduce fatigue. 3. To enhance self-confidence and self-management skills. 4. To create awareness regarding a healthy diet and increase self-care in nourishment Rationale Intervention based on the theoretical framework of frailty by Gobbens (2011). 1. Polypharmacy leads to inadequate pharmacotherapy and disease deterioration, and is a risk factor of frailty. 2. Physical fitness component is theoretically based on the program of de Vreede *et al.* (2005): interaction between the cognitive, perceptual, and motor functions is triggered. 3. Based on the theory of Putman (2015): a more developed social capital is related to better mental well-being and increased self-perceived health, i.e., an empowerment of social skills.
3. What (materials)	1. Upon randomisation, participants received additional information regarding the intervention goals and components. 2. For the social skills aspect of the SPRY program participants were asked to fill an assertiveness diary. 3. For the nutritional program participants were asked to fill in a diary to get an insight into their nutritional behavior. 4. A structured protocol for the physical fitness component.
4. What (procedures)	1. Medication review and Prescribing Optimisation Method (POM) interview. 2. 12-week physical fitness programme: physical activities and ADLs training around interaction between cognitive, perceptual, motor functions, and the individual's environment. 3. Empowerment of socials skills training : included enhancing self-confidence and self-management skills. 4. Nutritional Education: raising awareness of a healthy diet and increase in self-nourishment.
5. Who provided	1. Pharmacist conducted prescribing Optimization Method medication review with advice from General practitioner of the patient. 2. Physical therapist provided the physical fitness programme 3. Community nurse provided the Empowerment of social skills meetings 4. Dietitian assessed nutritional behaviour and provided nutritional education.
6. How	The SPRY-program was group-based with an average group-size of 8-10 older adults.

	1. The medication review was delivered individually to the participant. This was face to face at the Pharmacy. 2. The physical exercise component was delivered to participants mostly in pairs. This was face to face the local community gym. 3. The empowerment skills training was delivered face to face in a local community centre. 4. The nutritional component was also delivered face to face at a local community centre.
6b. How organised	"The interview was performed at the pharmacy and led by a pharmacist who consulted the general practitioner of the patient when it turned out that adaptations regarding the medications were needed." No further details.
7. Where	Country: Netherlands Area: A semi-rural community The intervention was delivered in various locations, according to the component. Including: 1. The Pharmacy 2. The gym 3. Community centre
8. When and how much	Duration: 23 weeks 1. Optimization of medication use- once at baseline 2. Improvement of physical fitness programme - 2x 1-hour meetings a week, for 12 weeks, at 12 weeks 3. Empowerment of social skills - 1x 2.5-hour meeting a week, for 5 weeks, at 5 weeks. 4) Optimization of nutritional status: up to 3x 2.5-hour meeting, at 3 weeks. 2. Maximum of 33 sessions
9. Tailoring	1. POM interview was performed at the pharmacy and led by a pharmacist who consulted the general practitioner of the patient when it turned out that adaptations regarding the medications were needed. 2. The physical activity component of the intervention was tailored to individual's capacity, and dynamic environment.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

ADL, nutrition and exercise

Table 8. Kukkonen-Harjula 2017[8] Individualized, multicomponent, long-term and supervised home-based physiotherapy

1. Brief name	Individualized, multicomponent, long-term and supervised home-based physiotherapy.
2. Why	Goals (the several components of the intervention encompass a variety of goals): - in general, to restore and increase the participant's functional capacity, especially in activities of daily living, to prolong duration of living at home.

	- the exercises for muscle strength, power and endurance, intend to enhance the participant's muscle strength, power and endurance, especially in lower limbs, in order to improve postural balance, ability to walk, prevent falls and functional capacity - the flexibility exercises intend to enhance the participant's range of motion especially in ankle joints and in large joints to maintain activities of daily living - the functional training intends to improve functional task performance - to nutritional counselling intends to reverse possible malnutrition, and ensure sufficient protein intake to prevent weight loss and sarcopenia. Rationale: - based on previous research showing positive effects of multicomponent exercise interventions in reducing frailty, physical function, and quality of life, and with greater effects if more than 5 months, more supervision and individualized. - the exercise components of the intervention are based on the Otago exercise program
3. What (materials)	- Borg Rating of Perceived Exertion Scale to measure exertion at each session and tailor exercises - Ankle weights, weight vests, kettlebells and dumbbells to support the provision of exercise - Mini Nutritional Assessment test and national nutritional guidelines are used to support the provision of nutritional advice
4. What (procedures)	- Physical exercise including muscle strength, power, endurance and balance exercises. The exercises follow a pre-determined progressive plan while also taking into account participant's needs (namely exertion in each session, performance and health status) - Functional training, including activities of daily living such as washing dishes, preparing meals, climbing stairs, among others. - Brief nutritional counselling is provided including recommendations of supplements if necessary - The overall plan is developed in the first session with the participant using goal setting techniques. These goals are evaluated regularly by the physiotherapist and the participant. - The physiotherapist encourages the participant to conduct exercise on their own or with community groups, in addition to the sessions provided by the intervention. - Access to usual care presumably based on the participant's own initiative, including services such as home care visits, GP, nurse and rehabilitation in primary care, and specialized medical care, among others.
5. Who provided	Physiotherapist
6. How	- Presumably face-to-face and individually, based on at home format - Goal setting techniques are used to develop an individual plan with the participant - The participant is encouraged to exercise on their own or in community groups, in addition to the exercise provided by the intervention
6b. How organised	- The participant has the same physiotherapist throughout the intervention
7. Where	- At home - Finland, in South Karelia Social and Health Care District (Eksote)

8. When and how much	- Started after participants' were 65 years old or older and assessed as having at least 1 point in the FRAIL questionnaire and at least 1 of the Fried's frailty phenotype criteria (2 of the phenotype criteria were slightly modified - to define "low physical activity," we used 30 minutes per week as a cut-off value, and for the slowness criterion, we used a common gait speed cut-off value of 0.46 m/s for both genders, which was based on the lowest quartile in the Short Physical Performance Battery). The assessment of Fried's criteria was always at home by a nurse. Participants were classified as pre-frail if they met 1 to 2 phenotype criteria and frail if they met 3 to 5. Participants had no severe illnesses that prevented them taking part in exercise training and a MMSE of 17 or more. - Two 60 minutes sessions a week for 12 months, in a maximum of 104 sessions. The actual number of sessions per participant was mean = 87, median = 96, range = 3 to 104
9. Tailoring	- The physiotherapist develops a plan with the participant and tailors exercises according with the participants' health status, condition and performance - The nutritional assessment is presumably tailored as it is based on the Mini Nutritional Assessment
10. Modifications	Not mentioned
11. How well (planned)	Adherence to the intervention was promoted by 1. choosing the home setting and 2. by providing supervision in the context of a long-term relationship with a physiotherapist (which is expected to improve motivation and enable more intense exercise).
12. How well (actual)	- The mean number of sessions per participant was 87, median 96, with range of 3 to 104 - On average 95 (91%) sessions were participated by 134 participants who completed the intervention. - One hundred and twenty-eight participants participated in >75% of the sessions.

Aids

Table 9. Borrows 2013[9] Occupational therapy (OT) from an independent living centre (ILC)

1. Brief name	Occupational therapy (OT) from an independent living centre (ILC) .
2. Why	1. To minimise an individual's dependence on others, and enabling them to remain in their own home. 2. ILCs aim to enable people to make an informed choice of equipment, and ensure people use it safely. 3. A permanent exhibition of products and equipment provides people with opportunities to see demonstration, to try the products and equipment, and to receive information which are suitable for their practical aspects of daily living.
3. What (materials)	1. Free impartial information and advice to facilitate independent living, e.g., practical solutions, and information on health and social care services. 2. Toileting and bathing equipment from the British Red Cross Medical Equipment Loan service at the ILC.

	3. Medical equipment loan service on a short-term basis, or by the community OT team if long-term use.
4. What (procedures)	1. Not receiving community OT services. 2. Initial interview to establish an individual's needs. 3. Exploring the options available to meet these needs. e.g., practical advice about disability equipment and adaptations, or teaching personal coping strategies, for example joint protection techniques. 4. Participants to try out the equipment and adaptations displayed. 5. Participants fitted equipment by themselves. 6. Free transport to ILC provided to study participants
5. Who provided	The unqualified OT Assistant Therapist (OTAT) who was based at the centre provided the intervention.
6. How	1. Provided Individually 2. Face-to-face 3. Interactivity: Needs assessment; and exploring options to meet needs, e.g., practical advice, personal coping strategies.
6b. How organised	Run by British Red Cross
7. Where	1. Location - An independent living centre (ILC), run and managed by The British Red Cross, Great Yarmouth Borough, UK 2. Facilities - Purpose-built room settings, imitating an indoor living environment, to showcase products a wide range of products for trial and demonstration. 3. Infrastructure - The British Red Cross Medical Equipment Loan service available at the ILC for some personal hygiene equipment, and short-term loan on medical equipment loan. Long-term use medical equipment provided by the community OT team.
8. When and how much	1. When started - within 2 weeks after randomization (referral). 2. Duration and number of sessions - usually a one-off visit to the ILC, approximately 1.5 hours
9. Tailoring	1. People to make an informed choice about the equipment that is right for them, and learn to use it safely. 2. Between the OTAT and participant - initial needs assessment interview, then to explore of the options available, to provide practical advice about disability equipment and adaptations, or to teach personal coping strategies, e.g., joint protection techniques.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 10. Tomita 2007[10] Smart Home Technology

1. Brief name	Smart Home Technology.
2. Why	Goal: to cope with disability Rationale: - Previous research has shown that assistive devices are effective in sustaining functional abilities, and enabling older adults to live longer in their own home.

	- The particular technology chosen (X10 ActiveHome) was preferred due to 1) likely being already in use, 2) allowing for retrofitting, 3) simple installation, 4) allowing to add other compatible products, 5) allowing to use up to 256 lighting and appliances, 6) compatible with other widely used computer systems, and thus allowing for integration
3. What (materials)	- X10 ActiveHome kit (including e.g., the Active Home software for Windows, and a remote control for lamps and appliances) - Stand-alone products as needed (e.g., door and window sensors, a motion sensor, among others) - Boss EveryWare a software that monitors the participant's activity - Computer and internet (if the participants did not have it)
4. What (procedures)	- Home assessment to decide how to fit aids and adaptations and select which ones would be more adequate for each person (based on their needs, desires and home environment) - Fitting of selected aids and adaptations + associated software in the person's home - Provision of computer training, particularly the ActiveHome software. - Ongoing support and troubleshooting in the use of the technology provided. - Presumably continued access to usual care (not specified)
5. Who provided	- A occupational therapist or nurse provided the initial home assessment. These professionals were trained on the intervention. - A computer engineer fitted the aids and adaptations provided - A geriatric nurse, specialized in computer education provided ongoing support
6. How	- Presumably individually and face-to-face, based on the home visiting format - By telephone in the first instance if support was needed after the initial installation
6b. How organised	- No house incurred more than $400 for the X10 products and other necessary materials.
7. Where	- Western New York - At home
8. When and how much	- Started when participants were assessed as having in activities of daily living (ADL) or instrumental ADL (IADL) due to chronic health conditions without cognitive impairment. Participants were 60 years of age, living alone and had interest in using a computer. - The initial assessment took 2.5 hours, and the installation 3 to 9 hours. - Ongoing support by telephone and home visit was provided as needed for the 2 years of the intervention. On average, participants were visited 5 times in the first year and 3 times in the second year.
9. Tailoring	- The provision of aids and adaptations was based on an initial assessment which tailored the retrofitting according with needs. The retrofitting was also tailored based on the participant's desire and the capacity of the house. - Ongoing support was also provided as needed (the participant contacted the intervention provider when problems arose).
10. Modifications	Not mentioned
11. How well (planned)	- Intervention fidelity was promoted by training intervention providers - Adherence was analyzed by collecting data on the use of technology provided and problems/solutions encountered
12. How well (actual)	- 100% accepted a computer, ActiveHome software, a lighting system, and a remote control chime for security/medication; 29% accepted power flash for

	window/door security; 23% accepted timing devices for a coffee maker; 19% accepted a motion detector; 12% accepted a wall switch for a light sensor. - After 2 years, 52% to 68% of the functions were in use. The primary reason for non-use was related to "failure." Participants chose only those functions that did not fail and that were most suitable and beneficial for them. Failure was not necessarily a malfunction of the system but rather a combination of unfriendly features of X10 and participants' unfamiliarity with the system. - After 2 years, all participants were using a computer, but only 65% were using ActiveHome. 68% of participants used the remote control and chimes, followed by wall switch (67%), power flash for window/door security (62%), and lighting (62%). 53% of participants used the motion detector and 52% the coffee maker.

Aids, cognitive training, telecoms, and monitoring

Table 11. Messens 2014[11] Health monitoring and sOcial integration environMEnt for Supporting WidE ExTension of independent life at HOME (HOME SWEET HOME)

1. Brief name	Health monitoring and sOcial integration environMEnt for Supporting WidE ExTension of independent life at HOME (HOME SWEET HOME).
2. Why	Goal: to extend independent life at home / reduce deterioration of health-related quality of life and function associated with age and chronic disease Rationale: - Based on previous research with health technology that shows a positive impact and offers promise to improve care, prevent domestic accidents by regular monitoring, promote social integration and efficiency - Based on previous research with some of the specific health technologies offered here in an integrated format
3. What (materials)	- Mambo device (phone and panic button) - Wireless blood pressure and heart rate sensor - Wireless weight scale - And other health monitoring devices for selected participants: wireless 1-lead ECG / Wireless 12-lead ECG. For participants with a diagnosis of diabetes: wireless glucometer. For participants with a diagnosis of COPD: wireless pulse oxi-meter. - Personal diary - Centralised database - Environmental sensors - Central and user-friendly unit to coordinate domestic services - Domestic adaptations for the house - Communication device with a screen similar to a TV set - Daily scheduler
4. What (procedures)	- Providing adaptations and aids to facilitate carrying out daily activities independently. This includes adaptations to the home, such as a system to control shutters, doors, windows, heating, etc. centrally, a navigation system to support traveling, and daily scheduler to support keeping up with appointments. - Providing sensors in the home, a panic button, and a response to these alarms as necessary - Providing a videoconferencing environment to support the person to communicate with family and friends, and health and social care professionals

	- Providing interactive games developed to train cognitive abilities - Providing health measurement equipment that is used daily to monitor physiological parameters and results in tailored actions (e.g., contacting health professionals, or a neighbour to assist). - Training is provided to support the use of all the equipment of adaptations provided - Access to available health services, based on the participant's own initiative. This includes for example, standard home, nursing and medical care, formal/informal care and contacts with GPs, and specialist physicians.
5. Who provided	- There was not a clear pattern in the professionals providing the intervention across sites. Center operators and technicians whose disciplinary background is not clear, consulting nurses and physicians and unspecified clinical staff are all mentioned.
6. How	- Presumably individually and face-to-face, for installation and training of devices at home - Some contacts happened by phone and video monitoring (e.g., to check on someone following an alert)
6b. How organised	Responsibilities are clearly documented. The services are organized differently depending on intervention site, so there is not a common organization pattern.
7. Where	- The installation and training in using devices was at home - In 4 sites in the European Union, including: Belgium (City of Antwerp), Catalonia (Town of Badalona), Ireland (North Eastern Region, Italy (Town of Latina)
8. When and how much	- Started when participants were 65 years or older, and were not completely dependent in ADLs. Participants were assessed as mild or moderately frail (Edmonton Frail Scale), did not have a full-time caregiver, were able to use the devices, had ISDN or ADSL services, and did not have significant medical conditions that would interfere with expression or provoke shortened life expectancy. - The number of contacts did not seem to be predetermined. There was at least a first contact for installation of devices and training and subsequent contact was presumably tailored according to need (alerts triggered by the devices, or need for equipment support). - Some of the devices (e.g., sensors) measure 24/7 - If applicable [not clear based on what, presumably some kind of assessment], physiological parameters are measured by the person regularly, daily or bi-weekly
9. Tailoring	- The devices provided are tailored based on the person's health needs - Contacts are also tailored based on the issues that may arise for different people - Instructions for the use of some of the devices (monitoring of physiological measures) can be further tailored to the person when changes are experienced. - Actions following alerts are presumably tailored based on the person's specific situation
10. Modifications	Not mentioned
11. How well (planned)	The analysis of fidelity was planned using use data from the devices and database and the participant's diary
12. How well (actual)	- The provision, training and use of health monitoring devices were the most successful. Some problems with reliability and battery life were identified

	- The technology to support communication was not used very much - The home adaptations were not implemented due to not being adaptable to the participant's homes and their unwillingness to alter the house, especially when rented - The daily scheduler was not used as the participant and/or family did not enter relevant events in the device - The navigation subsystem was used very little - The cognitive training was very popular

Aids, education and telecoms

Table 12. Gustafson 2021[12] Elder Tree

1. Brief name	Elder Tree. Low-cost web-based information and communication technology.
2. Why	Goal: to improve older adult quality of life and address challenges older adults face in maintaining their independence (for example, loneliness and isolation, falling, managing medications, driving and transportation), by enhancing autonomy, competence and relatedness. Rationale: - Based on previous research showing improvements in quality of life of eHealth interventions - Based on the self-determination theory which posits that feelings of competence, social connection, and intrinsic motivation or autonomy contribute to mental health, well-being, and quality of life - Based on previous experience in developing health technology, including collaboration of experts, older adults, caregivers, community and state partners - Information about falls prevention was adapted from the Stepping On falls prevention program, with permission of its authors
3. What (materials)	- Elder Tree, a private, secure information, support and communication website - Computer and internet service, if needed
4. What (procedures)	- Participants are provided with access and training to use an online technology that provides support related to daily activities, including isolation and loneliness, driving and transportation, caregiving (for the participants caregiver), medication management and falls prevention. The technology is tailored to the participant's needs based for example on their specific medical conditions. - The technology includes information, communication tools, tools for self-assessment, and other tools to be used at the service of the areas mentioned above (e.g., to do list with reminders, route planners). - Information on loneliness, driving and transportation, caregiving (for the participants caregiver), medication management and falls prevention is provided to all participants. - If necessary, a computer and internet service are provided. - In addition to the initial support in using the technology, participants are contacted by phone 1 week after the provision of the technology to provide any answers/solve issues that may have arisen. - Participants are also contacted as needed if their pattern of use changes or stops, to check on any problems - Participants continue to be able to access usual sources of information and communication (not specified).

5. Who provided	The disciplinary background of the intervention providers is not specified, these are described as being members of the research team. The person providing support regarding the use of the technology 1 month after provision was a county coordinator. [It is unclear who the coaches providing support through the website were - was it pre-programmed info (at least partially)? or members of the research team?]
6. How	- The technology was provided to the participants in their homes - the installation occurred face-to-face with participant and a caregiver (if the participant had one) - Further contacts with the participant occurred at a distance synchronously through telephone or presumably asynchronously through the website (coach answers/questions).
6b. How organised	- The person providing support regarding the use of the technology 1 month after provision was a county coordinator. - In the context of regional Aging and Disability Resource Centers, state funded agencies that connect older people and people with disabilities to information, assistance, and counselling.
7. Where	- At home - Three Wisconsin communities (urban, suburban, and rural) in Milwaukee, Waukesha or Richland County, [USA]
8. When and how much	- Participants were ≥65 years old and had at least one of these risk factors in the preceding 12 months: (a) one or more falls, (b) receipt of home health services, (c) skilled nursing facility stay, (d) emergency room visit, (e) hospital admission, and (f) sustained sadness or depression. People who were institutionalized in assisted living or needed bed/chair assistance and who were unable to use the technology were excluded. The recruitment was based on Aging and Disability Resource centers, 1st by giving presentations in several community places. Participants who give their contact information could receive a 10 dollar gift (drawn). Participants were contacted and eligibility was further assessed in a home visit. - The intervention run for 18 months
9. Tailoring	- The information provided by the technology is tailored based on the participant's specific conditions. - Additional contacts are also tailored based on the patterns of technology used, which allows to provide extra support when there is a change or absence of activity.
10. Modifications	Not mentioned
11. How well (planned)	Several activities were put in place to promote an effective implementation including: - developing the services in collaboration with older adults - rapid cycle testing of the technology, improving prototypes based on users' feedback - contacting all participants 1 month after installation to check for any problems - contacting the participants when the patterns of use change - collecting data on the server to identify when there are problems with the website - collecting data to identify which services are least used

12. How well (actual)	Not mentioned

Aids, multifactorial-action and review

Table 13. Liddle 1996[13] Occupational Therapy assessment at home, recommendations and follow-on

1. Brief name	Occupational Therapy assessment at home, recommendations and follow-on. OT assessment at home, recommendations and aids arranged and/or provided by nurse
2. Why	Goal: to maintain quality of life and independence Rationale: - based on previous research showing that geriatric assessment, provision of equipment decrease morbidity and mortality and increase quality of life - based on previous research showing that in-home preventive assessment prevents functional decline
3. What (materials)	- Occupational therapist initial assessment included a modified Health Assessment Questionnaire - Equipment provided as needed, including: grab rails, toilet surrounds, shower stools, pick-up tongs, shoe horns and back cushions - Recommendations to be put in place by the nurse
4. What (procedures)	- Environmental-functional assessment by an occupational therapist with formulation of recommendations (including aids) - Carrying out of OT recommendations (including accessing to usual care community services)and provision of equipment by nurse - Recommendations suggested by OT and arranged by the nurse facilitated the access to usual community care which included: GP, podiatrist or chiropodist, physiotherapist, community nurse, other community health worker, outpatient clinic, home care or meals-on-wheels.
5. Who provided	- Occupational therapist - Independent research nurse - Presumably, various professionals who provided usual community care
6. How	Presumably individually and face-to-face (based on home-consultation context)
6b. How organised	- An independent research nurse carried out the recommendations defined by the OT - The care planning does not mention or imply medication changes
7. Where	- At home - In the Northern Sydney Area, Australia
8. When and how much	- Started following a screening process that identified people with moderate to severe impairment in activities of daily living - At least 2 home visits, one for the OT assessment and another by the nurse
9. Tailoring	Recommendations and equipment provided are tailored based on OT assessment
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Available care

Table 14. Alegria 2019[14] Enhanced usual care

1. Brief name	Enhanced usual care. Usual care, as accessed through the community-based organisation, plus suicide screening and written material from the NIH on depression, anxiety, and physical health for elders.
2. Why	Not mentioned
3. What (materials)	- NIH booklet about caring for one's mental and physical health. - PHQ-9 and GAD-7 and, if necessary, the 5-item Paykel suicide questionnaire that could trigger an emergency referral - Audiotapes of calls for implementation fidelity analysis
4. What (procedures)	The control condition offered three components of enhanced usual care: 1. A call by research staff every 2 weeks to administer the PHQ-9, GAD-7, and the 5item suicide questionnaire. This allowed to identify relevant symptoms and connect participants to emergency responders as required. 2. Empathetic support if the participant expressed concern 3.An NIH booklet about caring for one's mental and physical health
5. Who provided	Research staff were involved in calling the participants. .
6. How	The support offered was on an individual basis e.g., the phone calls from the research staff, in order to assess mental health deterioration and refer to adequate services if necessary. The support was offered from a distance.
6b. How organised	Not mentioned
7. Where	- United states - Participants were linked to community-based organizations and community clinics serving low-income minorities or immigrants in Massachusetts, New York, Florida, or Puerto Rico.
8. When and how much	- The intervention started following recruitment of people identified as having low mood and mild-moderate disability who were enrolled in community-based organizations and clinics for low-income immigrants or minorities. - A call by research staff every 2 weeks to administer the PHQ-9, GAD-7, and the 5item suicide questionnaire.
9. Tailoring	- Empathetic support was provided if the participant expressed concern - An emergency responder was contacted in case of urgent need
10. Modifications	Not mentioned
11. How well (planned)	- Calls were audiotaped, and every 1st two interviews and random sample of 15% were analyzed for quality control.
12. How well (actual)	Not mentioned

Table 15. Arthanat 2019[15] Control

1. Brief name	Control. The group were not provided any ICT training from the study.
2. Why	Increased interest in acquiring ICT skills shown by older adults and awareness of their need for ICT training
3. What (materials)	Not mentioned.

4. What (procedures)	Usual care in community: community-based training programs, mostly workshop format
5. Who provided	Not mentioned.
6. How	Community-based training programs, mostly workshop format
6b. How organised	No description of organisation, beyond ad-hoc in relation to the intervention (ICT training).
7. Where	1. Country: USA 2. Infrastructure: - Increasing number of essential services, public and private become digital. - Internet adoption among those above 75 years of age is low at 34% with only 21% having access to broadband Internet (Pew Research Center, 2017) - shortfall in the availability of skills training programmes to assist older users, particularly in rural areas
8. When and how much	Not specified.
9. Tailoring	Not specified.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Six participants in the control group (14.3%) reported receiving some ICT training, through usually available workshop or family, during the 2-year period.

Table 16. Balaban 1988[16] Office-based care with family physician

1. Brief name	Office-based care with family physician.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual family physician in office care - Could not access home visits
5. Who provided	- Usual family physician
6. How	- Presumably face to face and individually on usual physician office care
6b. How organised	- In the context of a large urban family practice in an academic setting
7. Where	- In a family practice office - In the context of a large urban family practice in an academic setting
8. When and how much	- Started when participants were enrolled in the practice, were experiencing serious mobility impairment, chronic disease, and the contact with the practice was difficult or unlikely.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- 30% of these participants received home visits - Throughout the study period participants received 0.1 to 0.9 visits on average (In the intervention as planned these participants were not eligible for home visits)

Table 17. Barenfeld 2018[17] Conventional care

1. Brief name	Conventional care.
2. Why	Goal: to ensure that older persons are able to live as independently as possible in their own homes
3. What (materials)	Not mentioned
4. What (procedures)	- Access to community home help service based on needs assessment. May include meals on wheels, help with cleaning and shopping, assistance with personal care, safety alarms, transportation services, and home health care. - Access to rehabilitation and medical care - If an urgent need for community or health care services was identified, information was provided on where to receive help.
5. Who provided	Not mentioned. Presumably several medical and social care professionals accessible as part of conventional community health and social services
6. How	Not mentioned
6b. How organised	- Medical care is predominantly performed in the public sector (80%), and healthcare costs are financed mainly through taxes and government grants. Cities and municipalities are responsible for services for older persons. - Access to home help is decided based on needs assessment
7. Where	Location: Sweden - In an urban district in a medium-sized city with a high proportion of persons who were born abroad and whose socio-economic status is low - In the context of a publicly funded health care system that emphasises health-promoting and disease-preventive interventions and equal care for all and provides services to older people through municipalities - At home for conventional services home-help
8. When and how much	When started conventional care: On the person's own initiative. When started in this trial: - People with ≥70 years, and who had migrated from Finland, Bosnia and Herzegovina, Croatia, Montenegro or Serbia to Sweden were invited to participate; - Living in urban district; - Started when participants were independent of formal or informal help in daily activities.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 18. Bleijenberg 2016[18] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned

3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care based on participant's own initiative including primary care consultations, at home and by telephone.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Utrecht, in the Netherlands
8. When and how much	- Started after participants were assessed based on electronic medical records as having: 1. Multimorbidity (defined as a moderate-to-high frailty index score, which is a reflection of the proportion of health deficits present.), AND / OR; 2. Polypharmacy (defined as the actual chronic use of 4 or more different medications), AND / OR; 3. A care gap in primary care of > 3 years except for the yearly influenza vaccination. Participants were enrolled in GP practices and were 60 years old or older
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 19. Blom 2016[19] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care GP services which may include visits from the GP in the patient home and any referrals that may be needed.
5. Who provided	Access to GP and other primary care professionals
6. How	Not mentioned
6b. How organised	- The GP is the key player in providing care for older people, e.g., is in charge of all referrals.
7. Where	- GP practices in Leiden, Netherlands - In the context of a system of care in which all community-dwelling persons are registered at a GP - In the context of a system of care in which the GP is a key player in providing care to older people (e.g., responsible for all referrals). - In the context of a system of care that has been promoting an increased awareness of the need to work proactively with older patients
8. When and how much	- After a mail invitation by GP and a standardized screening to identify complex problems (problems in 3 or more domains).
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 20. Botjes 2013[20] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Presumably the available usual care in the region without the access to an electronic questionnaire and suggestions to deal with identified problems at a regional level. An electronic guide to national resources is available based on patients' initiative.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Almere, in the Netherlands
8. When and how much	- Started when people were over 65 years old and had multiple physical, social, and functional problems/ were frail [unspecified criteria]
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 21. Bouman 2008[21] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care based on participant's own initiative. Includes services such as GPs, outpatient care, physiotherapy, meals-on-wheels, among others.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In the south of the Netherlands
8. When and how much	- Started after the participant was assessed at self-perceived poor health by postal questionnaire, and not receiving or waiting to receive nursing home or home regular services. Participants whose GP did not agree to participate and who lived in large industrial areas, not in close proximity with the centre of town, were excluded.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned

11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 22. Brettschneider 2015[22] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual healthcare services was available based on participant's own initiative including services such as GP, formal and informal nursing care, outpatient physician services, pharmaceuticals, use of outpatient non-physician services (e.g., occupational therapy, physiotherapy, logopedics, sports therapy).
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Halle and Leipzig in Germany
8. When and how much	- Started after participants were assessed as impaired in at least 3 ADLs and care level (in the German long term care insurance system) no higher than 1 (needed assistance in more than two activities of basic nursing, e.g., personal hygiene, feeding, mobility, more than once a day). Participants were older than 80 years old and could be contacted based on recent post-discharge from hospital, enrolled in a GP practice, or based on the local official registry
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 23. Cameron 2013[23] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Multidomain assessment including frailty assessment (e.g., weight loss, walking speed...), and other domains such as psychological status, social participation. There is no indication that the results were shared with the participant, and there was no planning or arranging procedures in place. - Access to usual health care services based on participant's own initiative without significant cost. This includes GP and medical specialist consultations, and nursing and allied health interventions.

5. Who provided	The assessment was provided by a nurse.
6. How	Presumably individually and face-to-face for the multidomain assessment, but not explicitly specified.
6b. How organised	Australia has a system of universal health insurance so that all of its population has access to health care without significant cost.
7. Where	- Hornsby Ku-ring-gai, Sydney, Australia - It is not clear where the initial assessment took place
8. When and how much	- Started when participants were 70 years old or older and had recently been discharged from the hospital Rehabilitation and Aged Care service, and after participants were assessed as presenting 3 or more Fried Frailty Criteria.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	The intervention was implemented as planned.

Table 24. Carpenter 1990[24] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	- Aids such as bed, bath seats, toilet aids, wheelchairs & others provided presumably by request as part of usual care
4. What (procedures)	Not mentioned
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Andover town, including the surrounding housing estates but excluding the villages.
8. When and how much	- Started when the participants were 75 years old or older and were enrolled in a GP practice. The participant population came from Andover town, including the housing estates. Village areas were excluded. - The whole group was visited at the start and end of the project. only not visited regularly
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 25. Cesari 2014[25] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned

3. What (materials)	- Assessment instruments [Pepper Assessment Tool for Disability (PAT-D), Mini Mental State Examination (MMSE), 10-item Geriatric Depression Scale (GDS) [22,23], Mini Nutritional Assessment-Short Form (MNA-SF), and Brief Fatigue Inventory (BFI).], but these did not result in a intervention for all - A letter was sent to the GP informing about the person's participation in the trail, and signalling any emergency conditions
4. What (procedures)	- Multidomain assessment (including mood, nutritional status, medicines, disability) that did not result in a care plan - Usual care assessed based on the participant's own initiative - The GP could be given information about a pathological score that required immediate action
5. Who provided	[- The baseline assessment was provided by non-medical staff] - The GP was involved in providing usual care as initiated by the participant
6. How	[- There is an assessment at baseline that does not result in intervention for all provided presumably face-to-face and individually based on clinic visit]
6b. How organised	Not mentioned
7. Where	- rural area of Labastide-Murat, a small village located at about 150 km from Toulouse (France)
8. When and how much	- Participants were 60 years old or older and were assessed as pre-frail (i.e., presence of one or two frailty criteria) or frail (i.e. presence of three or more frailty criteria) according to the phenotype described by Fried *et al.* People living with serious health conditions or with recent health crises were not included. The FiND questionnaire was used to support screening for frailty.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 26. Clark 1997[26] Social activity control

1. Brief name	Non-professionally led social activities program
2. Why	Goal: to provide activity engagement, social involvement, and general programme participation Rationale: - It was not expected to affect physical health, daily functioning, or psychosocial well-being
3. What (materials)	Not mentioned
4. What (procedures)	- Group activities such as viewing films, visiting with one another, playing games, attending dances, and going on community outings were provided by non-healthcare professionals - Presumably access based on participants' own initiative to usual health and social care services, including for example: physician office visits and health-professional home visits.

5. Who provided	- Non-healthcare professionals, experienced in working with the public, with excellent social skills and who received 2 weeks of orientation - Unclear but likely some or all the professionals delivering the activities spoke Mandarin - Presumably health and social care professionals providing usual care services that were accessed based on participants' self-initiative
6. How	- In groups and presumably face-to-face
6b. How organised	- Supported by funding from the National Institutes of Health and the American Occupational Therapy Foundation
7. Where	- The location where the social activities took place is not explicitly mentioned - Los Angeles, California
8. When and how much	- Started when participants were living in federally subsidized apartment complexes for older adults and included participants from different cultures, namely, a large group of Mandarin-speaking older adults of Chinese heritage. Before the study, all participants were assessed for physical and mental health by a physician. - 4 group sessions 2h15min/months for 9 months
9. Tailoring	The social activities provided were tailored to the participants' interests
10. Modifications	Not mentioned
11. How well (planned)	- To assure that the participants were not influenced by other people receiving an alternative intervention, the ones receiving another intervention were asked to refrain discussing their activities with other people. - Intervention providers received 2 weeks of training on the intervention before it started
12. How well (actual)	Sixty-two percent of the participants attended at least half of the sessions (average percentage of sessions attended, 61%).

Table 27. Clark 1997[26] Usual care

1. Brief name	Usual Care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Presumably access based on participants' own initiative to usual health and social care services, including for example: physician office visits and health-professional home visits.
5. Who provided	Presumably health and social care professionals providing usual care services that were accessed based on participants' self-initiative
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	Los Angeles, California
8. When and how much	- Started when participants were living in federally subsidized apartment complexes for older adults and included participants from different cultures,

	namely, a large group of Mandarin-speaking older adults of Chinese heritage. Before the study, all participants were assessed for physical and mental health by a physician.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	To assure that the participants were not influenced by other people receiving interventions, the ones receiving interventions were asked to refrain discussing their activities with other people.
12. How well (actual)	Not mentioned

Table 28. Clark 2012[27] No treatment

1. Brief name	No treatment.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Presumably access based on participants' own initiative to usual health and social care services (not explicitly mentioned).
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Greater Los Angeles metropolitan area - In a variety of community-based sites, including 9 senior centers and 12 senior residences.
8. When and how much	- Started after recruitment in 21 sites including senior centers, senior housing residences and a retirement community. Potential sites were identified through resource books provided by the Area Agency on Aging, registries of senior housing, direct contact with local senior centers and key leaders of the older adult community. Half of the sites contacted participated. - The recruitment strategies included: written information, presentations, festive events with raffle tickets, follow-up meetings. Ethnically diverse people with 60 years-old or more were recruited and assumed to experience high risk of health disparity
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	- The level of interactions between participants receiving different interventions was measured to assess possible contamination
12. How well (actual)	Not mentioned

Table 29. Coleman 1999[28] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned

3. What (materials)	Not mentioned
4. What (procedures)	Not mentioned
5. Who provided	The physicians were board certified in Family Practice and did not have formal training or certification in geriatric medicine.
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	primary care physician practices that comprise an ambulatory clinic Seattle region of Group Health Cooperative of Puget Sound, a large Health Maintenance Organization located in western Washington State
8. When and how much	Not mentioned
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 30. Counsell 2007[29] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	- Primary care physicians use the electronic medical record system Regenstrief as part of usual care practice, which participants could access based on their own initiative
4. What (procedures)	Usual health care includes access to primary care, outpatient geriatric assessment and multispecialty clinic, inpatient ACE unit, skilled nursing facility, physician house calls program, community mental health center.
5. Who provided	Based on participants' own initiative to access usual health care services, there may have been contact with the primary care physician and other health professionals that provide usual care services
6. How	Not mentioned
6b. How organised	- In usual care, the primary care physician used an electronic medical record system to manage care (e.g., record diagnosis, order diagnostic tests and medications, review hospital discharge, etc)
7. Where	- Indianapolis, Indiana
8. When and how much	Started when participants had an annual income of less than 200% of the federal poverty level and one or more primary care visits in the past 12 months (in six community-based health centers affiliated with Wishard Health Services, an urban safety net healthcare system serving primarily medically indigent individuals in Indianapolis and staffed by Indiana University School of Medicine faculty and residents).
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 31. Cutchin 2009[30] Non-specific attention by provision of information

1. Brief name	Non-specific attention by provision of information.
2. Why	Goal: to provide nonspecific attention and support by non-occupational therapy personnel
3. What (materials)	- Information packet about local services for older adults as well as information on fall prevention from the Centers for Disease Control and Prevention
4. What (procedures)	- Provision of health promotion information including information about preventing falls and local services. - Presumably the participants were able to access usual healthcare services, based on their initiative
5. Who provided	- The personnel involved in the intervention were not occupational therapists (This presumably applies to the phone calls that are mentioned in the trial register but not in the protocol?)
6. How	- By mail - Phone calls are mentioned in the trial register but not on the protocol
6b. How organised	Not mentioned
7. Where	- At home - Orange County, North Carolina
8. When and how much	- Started after being identified as at risk for functional decline based on the Vulnerable Elders Survey (score 3 or more). - Informational phone calls(mentioned in the trial register only) were planned to occur twice during 1 year
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 32. Dalby 2000[31] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Not mentioned
5. Who provided	Overall health service. As and when needed to see a health professional.
6. How	Not mentioned
6b. How organised	In the context of primary care practices in which the provision of medical services is reimbursed on a capitation basis.
7. Where	Healthcare professionals setting. Ontario, Canada
8. When and how much	Started when at risk of functional decline and hospitalization

9. Tailoring	Not applicable
10. Modifications	Not applicable
11. How well (planned)	Not stated
12. How well (actual)	Not stated

Table 33. de Craen 2006[32] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Possible self-initiated access to usual care services, including for example, day care, community nurse, meals-on-wheels
5. Who provided	- Presumably other professionals involved in usual community care which the participant may have contacted by self-initiative
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In Leiden, the Netherlands
8. When and how much	- The participants were 85 years old and were participating in a prospective, population-based cohort study. The intervention started after a home visit by a research nurse who performed baseline measurements
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 34. Dorresteijn 2016[I] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual care on the participants' initiative, which included GP, physiotherapy and other therapists, hospital and day care, medical specialists and home-care.
5. Who provided	- Presumably various health professionals which services can accessed by participants' initiative in usual care.
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Three communities, Maastricht, Sittard-Geleen, and Heerlen, situated in the southeast of The Netherlands
8. When and how much	- Started after screening by postal questionnaire directed to community-dwelling people over 70. The screening selected participants who (1) reported

	at least some concerns about falls and associated activity avoidance, and (2) perceived their general health as fair or poor. The selected participants were considered frail based on (2).
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 35. Fabacher 1994[33] Usual care

1. Brief name	Usual care. Available usual care but not from the VA health care system.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Usual care: However, it was likely that some people did not have regular source of healthcare. Moreover, the participants were eligible but not enrolled in VA healthcare services at the time of recruitment, it is not clear if they accessed the services afterwards. Attention control: Control subjects received only follow-up telephone interviews every 4 months for 1 year after randomization. The purpose was to maintain contact and data collection, which are not intervention component but the regular contact may have an effect on the participant's health behaviour. Therefore, coded it as attention control.
5. Who provided	Presumably the healthcare professional available from the usual care, and the research team that maintained contact with the participants.
6. How	- Presumably the available means to access usual care. - Telephone calls for regular contact.
6b. How organised	Not mentioned
7. Where	Location: San Fernando Valley, a suburb of Los Angeles, US - In the context of eligibility to the VA healthcare system
8. When and how much	- Started when participants of 70 years or older, were eligible but were not enrolled in a VA outpatient clinic, were not demented or terminally ill.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 36. Fairhall 2015[34] Usual care

1. Brief name	Usual care.

2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care services based on the participant's own initiative. The services include GP care and community services, and involves medical management of health conditions, allied health input, assessment of care needs and provision of care.
5. Who provided	Not mentioned.
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Hornsby Ku-ring-gai, Sydney Australia
8. When and how much	- Started when participants were more than 70 years old, not receiving rehab and were assessed as pre-frail based on meeting 1 or 2 criteria from the Cardiovascular Health Study frailty criteria.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 37. Fischer 2009[35] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- On demand standard [usual care] without provision of home visits
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- In the context of a health and social systems that are active in senior-related initiatives but work in a uncoordinated way, which results in both over and undersupply.
7. Where	- Lower Saxony in Germany
8. When and how much	Participants were 68-79 years old and not in need of care (participants who are suffering from life-threatening diseases are excluded). Participants are contacted by post, and contacted after 5 days by phone, and motivated to participate.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 38. Ford 1971[36] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care services which presumably included physician and nursing care, based on participant's own initiative.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Cleveland, United States
8. When and how much	- Started after discharge from a chronic disease rehabilitation hospital (at least 1 week stay) to an area served by the visiting nurse association (mostly urban and suburbs). Participants were 50 years old or older.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- 34 in 150 participants who were not expected to receive nursing care actually received it based on the participant's own initiative

Table 39. Gene Huguet 2018[37] Standard primary healthcare treatment

1. Brief name	Standard primary healthcare treatment.
2. Why	Not mentioned.
3. What (materials)	Not mentioned.
4. What (procedures)	- Standard primary healthcare treatment from family physician, nurses and social workers, presumably at the participant initiation
5. Who provided	1. Family physicians 2. Nurses 3. Social Workers
6. How	Presumably face-to-face and individually in USA care services provided at the primary health center and in conventional nurses' visits.
6b. How organised	Not mentioned.
7. Where	Barcelona
8. When and how much	- Started following (1) selection from randomized list based on inclusion criteria (that included one or two Fried criteria), (2) invitation from a practice register by telephone until reaching sample size.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 40. Gill 2002[3] Educational control (EDUCATE)

1. Brief name	Educational control (EDUCATE). A program designed to provide attention and health education.
2. Why	Goal: to provide attention and health education
3. What (materials)	- Brief health-related questionnaire
4. What (procedures)	- Individual education sessions focused on general health practices and health promotion and tailored to the participant's needs (e.g., nutrition, medication management, physical activity, sleep).
5. Who provided	- The education program was provided by a trained health educator
6. How	- Presumably face-to-face and individually (at home) - By telephone
6b. How organised	Not mentioned
7. Where	- Bridgeport, Connecticut - At home
8. When and how much	- Started after the participants were 1. identified and screened for physical frailty during office visits to their primary care physicians; or 2. identified from the patient rosters of primary care physicians and screened for physical frailty in their home. Physical frailty was defined on the basis of slow gait speed (greater than 10 seconds) and inability to stand from a chair with one's arms folded. - 6-monthly home visits - monthly phone calls for 6 additional months
9. Tailoring	The education sessions were tailored to the participants identified needs (based on brief questionnaire).
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 41. Giné-Garriga 2020[38] Educational control sessions

1. Brief name	Educational control sessions.
2. Why	Not mentioned [It is implicit that the intervention is not expected to have an effect on sedentary behaviour and physical activity]
3. What (materials)	- Booklet about regular physical activity for health based on WHO recommendations
4. What (procedures)	- Providing education about a healthy lifestyle, including physical activity, fall prevention and healthy nutrition. In one location (Denmark), most recruits were receiving preventive home visits.
5. Who provided	Not mentioned
6. How	- In groups and presumably face-to-face

6b. How organised	Not mentioned
7. Where	- In primary care centre facilities or local leisure/community centres - In four European countries: Denmark (Odense), Northern Ireland (Belfast), Germany (Ulm) and Spain (Barcelona)
8. When and how much	- Started when participant were 65 years old or older, able to walk 2 minutes or more without help (they could use a walking stick). Participants were assessed has not having enough activity or having long sedentary periods (screening questions) and scored 4 or above in the Short Physical Performance Battery, which showed no major physical limitations. People with dementia, unstable medical conditions or had participated in a similar intervention before were not included. Some people (recruited from Denmark) were receiving preventive home visits. - Two 45 min sessions at weeks 5 and 11.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Measurement and analysis of intervention fidelity were planned including the use of an attendance registry.
12. How well (actual)	Not mentioned

Table 42. Gitlin 2006[4] No-treatment control group

1. Brief name	No-treatment control group.
2. Why	Not mentioned
3. What (materials)	- A Home safety booklet provided at the end of the intervention period
4. What (procedures)	- Presumably access to usual healthcare services based on own's initiative - The participants received a home safety booklet at the end of the intervention period
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Philadelphia, USA
8. When and how much	- Started after advertising through local social service agencies, agency on aging, and media announcements and phone screening that assessed for functional vulnerability (2 IADL or 1or+ ADL, HRCA Vulnerability Index 1or+); and when participants were 70 years old or more, cognitively intact (+23 MMSE), not receiving home occupational or physical therapy.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 43. Grimmer 2013[39] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Continued access to usual care services based on own's initiative (services not specified)
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Adelaide, south Australia
8. When and how much	Started after participants visited an emergency department with non-catastrophic health conditions without admission to hospital for further care. After 1 month, participants are assessed by telephone and enrolled in the study if they present a score of <55 on the Mental Component Score of the SF12, and are 65 years old or older
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 44. Gustafson 2021[12] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Participants continue to be able to access usual sources of information and communication (not specified).
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Three Wisconsin communities (urban, suburban, and rural) in Milwaukee, Waukesha or Richland County, [USA]
8. When and how much	- Participants were ≥65 years old and had at least one of these risk factors in the preceding 12 months: (a) one or more falls, (b) receipt of home health services, (c) skilled nursing facility stay, (d) emergency room visit, (e) hospital admission, and (f) sustained sadness or depression. People who were institutionalized in assisted living or needed bed/chair assistance and who were unable to use the technology were excluded. The recruitment was based on Aging and Disability Resource centers, 1st by giving presentations in several community places. Participants who give their contact information could

	receive a 10 dollars gift (drawn). Participants were contacted and eligibility was further assessed in a home visit.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 45. Gustafsson 2013[40] Usual care

1. Brief name	Usual care.
2. Why	Goal: to ensure that these persons are able to live as independent lives as possible, including living in their own homes.
3. What (materials)	- Safety alarms depending on request and needs assessment
4. What (procedures)	- Assessment of needs following request for municipal help - Accessing home help, such as meals on wheels and safety alarms, home medical care and primary health care clinic
5. Who provided	Not specified. Presumably social and medical care professionals working in the municipality.
6. How	Usual care may have included a variety of services such as home help and medical services that are presumably provided individually and face-to-face.
6b. How organised	- The access to usual home help and medical services requires that the participants initiate the request and undergo an assessment of needs.
7. Where	- Access to home help and medical care under participants initiation and provided at home or primary care clinic - In two urban districts of Gothenberg, Sweden
8. When and how much	- Started when participants were independent of help from another person in ADLs and pre-frail
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 46. Harari 2008[41] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	- Providers' training materials
4. What (procedures)	Presumably access to usual care services, which should include GP services based on the participant's own initiative
5. Who provided	The GP practices to which the participants may have had access (based on their own initiative) received training and support from geriatricians.
6. How	Not mentioned

6b. How organised	Not mentioned
7. Where	- In mainly outer urban areas of London, UK - In practices purposively selected for their interest in primary care for older people, location in suburban (that is, relatively without deprivation) areas of London, and routine use of electronic medical recording systems in clinical encounters.
8. When and how much	- Started when participants were 65 years old or older, enrolled in GP practices and did not need assistance in BADLs as assessed with a questionnaire focused on BADLs sent by post [PRA, Probability of Recurrent Admissions questionnaire]. Participants were also excluded if they had cognitive impairment or a terminal disease
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 47. Hay 1998[42] Usual on-demand care

1. Brief name	Usual on-demand care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Usual care includes on-demand access to comprehensive social, community, mental health, medical (including clinicians), laboratory, and outpatient services.
5. Who provided	Clinicians who provided usual on-demand care
6. How	(- Usual on-demand care presumably includes a variety of delivery methods, face-to-face and/or at a distance, individually and/or in groups, as suited to social, community, mental health, medical, laboratory, and outpatient services.)
6b. How organised	Not mentioned
7. Where	- In Burlington, Ontario (Canada) - In a publicly funded health service organization (HSO)
8. When and how much	- After screening positive in a screening and case finding questionnaire
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 48. Hay 1998[42] Usual on-demand care with assessment

1. Brief name	Usual on-demand care with assessment.
2. Why	The assessment was added to usual care in order to provide a control condition that accounts for the possibility of over sensitizing the elderly to their health with study interventions
3. What (materials)	- Comprehensive functional and social assessments questionnaires (implied)
4. What (procedures)	- Usual care includes on-demand access to comprehensive social, community, mental health, medical (including clinicians), laboratory, and outpatient services.
5. Who provided	- Research nurses - Clinicians who provided usual on-demand care
6. How	- The format of the assessment (individual, face-to-face...) is not specified (- Usual on-demand care presumably includes a variety of delivery methods, face-to-face and/or at a distance, individually and/or in groups, as suited to social, community, mental health, medical, laboratory, and outpatient services.)
6b. How organised	Not mentioned
7. Where	- In Burlington, Ontario (Canada) - In a publicly funded health service organization (HSO)
8. When and how much	- After screening positive in a screening and case finding questionnaire - Schedule and duration of assessment not mentioned
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 49. Hebert 2001[43] Usual care

1. Brief name	Usual care.
2. Why	Goal: to intervene/provide care after functional decline has started or even ended (as tertiary care)
3. What (materials)	Not mentioned
4. What (procedures)	Usual health care services including GP, geriatric services such as assessment and rehabilitation units, day hospital, geriatric outpatient clinic and day centres.
5. Who provided	GPs and presumably other geriatric health professionals in available usual care
6. How	Not mentioned
6b. How organised	- Presumably, GP provides referrals for other health professional and specialized services as part of usual care. - In the context of an universal public health insurance plan
7. Where	- Sherbrooke City, Quebec, Canada. - In a area in which geriatric services include assessment and rehabilitation units, day hospital, geriatric outpatient clinic and day centres.

8. When and how much	- People of 75 years old, living at home, using the Quebec Health Insurance Plan (a universal public plan) were sent the Sherbrooke Postal Questionnaire. Those identified as at risk (having >1 risk factor) were invited
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 50. Henderson 2005[44] Control

1. Brief name	Control. Community-nurse-based comprehensive assessment and provision of summary of identified needs but no further action taken.
2. Why	A comprehensive assessment was conducted to control for Hawthorne effect, and a summary provided that could be shared with GP for ethical reasons. Available usual care was intended to prevent disability and disease by providing financial incentives to GP assessment and case management of older people.
3. What (materials)	- Potential Health Concerns Tool; - Summary of identified needs. (A Comprehensive Assessment Tool was used here, but as a data collection rather than intervention tool) (Phone calls script was also used but the phone calls served the purpose of data collection)
4. What (procedures)	- Identifying needs via comprehensive assessment; (To control for "Hawthorne effect", no advice, referrals or case-management) - Providing a summary of identified needs; - Advising contact with GP in potentially serious health needs. (These were provided for ethical reasons) Available usual care: possibility to receive additional health assessments via GP.
5. Who provided	Available usual care: possible interaction with GP.
6. How	Not applicable
6b. How organised	No details provided.
7. Where	- Individual living units in metropolitan and fringe areas of south East Queensland, Australia; - A Medicare Enhanced Primary Care program incentives comprehensive health assessments.
8. When and how much	- After the presentation of the project in the participant individual living units, with professionals from the ILUs known by the participant.
9. Tailoring	Not applicable
10. Modifications	Not provided
11. How well (planned)	Not applicable
12. How well (actual)	Not applicable

Table 51. Hendriksen 1984[45] Usual community social and medical support

1. Brief name	Usual community social and medical support.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual community services, based on participant's own initiative. Usual services included, among others, GP care, home nursing case, home help, meals on wheels and aids provision.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In Roedovre, a suburb of Copenhagen
8. When and how much	- Started when the participants were 75 years old or more, and were registered with the municipal social welfare authorities
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 52. Hogg 2009[46] Usual care

1. Brief name	Usual care. Usual family physician care only.
2. Why	Goal: to curtail costs while continuing to improve the quality of care (QOC) for a growing number of chronically ill patients
3. What (materials)	Not mentioned
4. What (procedures)	The control patients received the usual physician care and had no contact with either the NPs or the pharmacist. Participants in this group has normal access to :hospitalization, use of emergency services, consultations with health professionals, alternative level of care, long-term care, and medication covered by government insurance plans.
5. Who provided	The study was conducted in a family health network with 8 family physicians, 5 nurses, and 11 administrative personnel. Participants in the Usual care group received usual care by the usual family physician.
6. How	Not mentioned
6b. How organised	Community-based group practice where patients are rostered, the family physicians are paid in a blended payment system primarily based on capitation. No details on how managed by physicians.
7. Where	Country: Canada. Setting: At a family health network - a type of group community-based practice that provides primary care services to rostered patients. The patients continued to see their family physicians in the office.
8. When and how much	Usual care.

9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 53. Holland 2005[47] Usual care

1. Brief name	Usual care. Including access to medical care and community resources
2. Why	Presumably for paying for the long-term care costs and receiving the necessary medical care, because the participants had purchased the CalPERS Long Term care insurance and continued to receive usual medical care.
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual medical care by PCP and other insured medical services - Access to community resources including activities like Tai Chi, water aerobics, nutrition programs, and health-focused programs (e.g., diabetes, mental health)
5. Who provided	- Primary care physicians provided medical care as usual
6. How	Presumably individually and face to face to PCP medical usual care. Community accessible activities include group activities.
6b. How organised	- Coverage for health services under their regular health maintenance organization benefit contracts
7. Where	Location: Sacramento, California, USA
8. When and how much	- Participants were members of the CalPERS health plan, with one or more chronic conditions and less than 2 ADLs compromised that self-selected to participate following a mail invitation
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 54. Howel 2019[48] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual health and social care services (including benefits) on participants' own initiative. The usual health and social care services include, for example, welfare rights service existing in the region, or meals at home.
5. Who provided	Presumably health and social care professionals providing usual care services that were accessed based on participants self-initiative
6. How	Not mentioned

6b. How organised	Not mentioned
7. Where	- North East of England - In areas with poor health outcomes and high levels of socioeconomic disadvantage - In urban, rural a semirural areas with no previous access to welfare rights advice services targeted to primary care patients
8. When and how much	- Started following recruitment from primary care in socioeconomically disadvantaged areas (based on deprivation score) without a targeted welfare rights advice service delivered to primary care patients. The participants received an invitation letter from their GP - if not interested to be involved they were asked to opt out.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 55. Imhof 2012[49] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- The participants could access usual care based on their own initiative. This included services such as family physicians, physiotherapists, OTs, etc.
5. Who provided	- Presumably usual care health providers.
6. How	Not mentioned
6b. How organised	- In the context of a country which has a policy of mandatory health insurance and a well-established system of community nurses and family physicians who provide basic health care for the population aged 80 and older.
7. Where	- Urban area in the German-speaking part of Switzerland
8. When and how much	- Started when participants who were 80 years old or older were invited through various healthcare and community services and invitation letter. Persons at the end of life or with a major psychiatric diagnosis or severe cognitive impairment, as measured using the Clinical Dementia Rating Scale, were excluded
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 56. Jitapunkul 1998[50] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not stated
4. What (procedures)	Since 1992, comprehensive community care services have been provided to Thai elderly in Klong Toey slum (CES project). These services include community rehabilitation, home health care, education programme and social care.
5. Who provided	Not stated
6. How	Not stated
6b. How organised	not described
7. Where	Thai elderly in Klong Toey slum Living in a poor urban area
8. When and how much	Not stated
9. Tailoring	None
10. Modifications	not mentioned
11. How well (planned)	not mentioned
12. How well (actual)	not mentioned

Table 57. Kerse 2014[51] Usual care

1. Brief name	Usual care. Including primary care and access to other medical and community services. This includes the use of CGA upon referral from primary care.
2. Why	Not mentioned
3. What (materials)	- Access to referrals from primary care to geriatrics community team
4. What (procedures)	- Access to primary care - Access to community services and (upon referral) geriatrics specialist multidisciplinary teams that provided a comprehensive assessment and coordination of support/rehabilitation services
5. Who provided	- Access to the GP and to other primary care practice professionals, and to a multidisciplinary team including a physiotherapist, occupational therapist, gerontology nurse, geriatrician, and social worker
6. How	- Presumably face-to-face and individually for available usual primary care and multidisciplinary geriatric team contacts (e.g., comprehensive assessment)
6b. How organised	- There is no evidence that any care planning following the usual care CGA is multidisciplinary - There is no evidence that coordination of care is being provided for all - In usual care, for selected participants, the multidisciplinary team coordinated care and gave feedback to primary care (that holds responsibility for participants' care)

	- Usual care, including primary care and community geriatric and support services, is publicly funded. Aging-related residential care is available after standardized assessment and is publicly subsidized on a means-tested basis.
7. Where	- In New Zealand - In 60 primary care practices in three District Health Board regions that were routinely using CGA to identify needs of older people. - In a publicly funded system of care in which primary care reaches 98% of older adults and a variety of geriatric services (entry to these not systematized).
8. When and how much	- Participants were enrolled in general practices that accepted to participate and were routinely using CGA to identify participant needs. Participants were 75 years old, or 65 years old if Maori, and were recruited though an invitation letter sent by the GP
9. Tailoring	Access to geriatric services presumably tailored by needs identified in primary care
10. Modifications	During the trial, all regional geriatric services were reformed to some degree, causing some disruption to the timing of patient assessment.
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 58. Kono 2004[52] Usual primary and community care

1. Brief name	Usual primary and community care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Usual care includes a needs' assessment that establishes the level of need and the accessible services - Access to usual care services based on participant's own initiative, including routine primary and community care.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- There is a Long-Term care Insurance system (put in place in the year before the current intervention took place) that determines the level of care and accessible benefits by using a screening conducted by the Welfare department of the city government.
7. Where	- In Saku City, a small Japanese agricultural town
8. When and how much	- Started after participants were screened as needing assistance by the Welfare Department of the city government. Participants were 65 years old or older who could walk independently, but still needed some assistance to live in their own community and went outdoors less than three times a week.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 59. Kukkonen-Harjula 2017[8] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual care based on the participant's own initiative, including services such as home care visits, GP, nurse and rehabilitation in primary care, and specialized medical care, among others.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Finland, in South Karelia Social and Health Care District (Eksote)
8. When and how much	- Started after participants' were 65 years old or older and assessed as having at least 1 point in the FRAIL questionnaire and at least 1 of the Fried's frailty phenotype criteria (2 of the phenotype criteria were slightly modified - to define “low physical activity,” we used 30 minutes per week as a cut-off value, and for the slowness criterion, we used a common gait speed cut-off value of 0.46 m/s for both genders, which was based on the lowest quartile in the Short Physical Performance Battery). The assessment of Fried's criteria was always at home by a nurse. Participants were classified as pre-frail if they met 1 to 2 phenotype criteria and frail if they met 3 to 5. Participants had no severe illnesses that prevented them taking part in exercise training and a MMSE of 17 or more.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 60. Lambotte 2018[53] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	[- A frailty assessment was provided but the results were presumably not shared with the participant and no care planning resulted from it] - Usual care
5. Who provided	Not mentioned
6. How	Not mentioned

6b. How organised	Not mentioned
7. Where	- Knokke-Heist, Ghent and Tienen in Flanders, Belgium
8. When and how much	- Participants were 60 years old or older and living in the community. The number of people to be recruited for different gender, age, marital status, living situation and migration background was pre-specified in order to obtain a sample that could be stratified based on these factors. Participants were assessed with the CFAI-plus and had to be at least mild frail on one of the 5 domains of frailty or feel frail based on the subjective assessment of frailty
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 61. Leung 2004[54] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Conventional care, which provides fragmented health and social services, such as home visits by community nurses and home help service, provided by existing care providers.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- In the context of a health care reform which aims to improve the health outcomes and cost efficiency of the health care system through a series of restructuring and financing initiatives.
7. Where	- In Hong Kong
8. When and how much	- Participants were 60 years old or older and suffered from one or more chronic illnesses such as chronic obstructive pulmonary disease, stroke, diabetes, and/or heart disease. Their participation followed the discharge from a rehabilitative hospital.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 62. Leveille 1998[55] Senior center activities

1. Brief name	Senior center activities.
2. Why	Not mentioned

3. What (materials)	- Schedule of senior center activities provided to participants - Presumably access to materials provided as part of accessible senior center activities, including the self-management workbook
4. What (procedures)	- Tour to senior center in which a schedule of activities was provided Access to activities provided by senior center that presumably include: - Depressive symptoms related sessions - Substance cessation programs - Physical training, including different types of exercises (e.g., swimming, walking, dancing, etc) - Chronic illness self-management course combining peer support, health promotion information and disease self-management concepts For staff: - Recruitment and training of mentors for peer support
5. Who provided	Access to activities provided by senior center that presumably include contact with: - Volunteer health mentors provided peer support - Trained lay leaders delivered the self-management program - Social worker supported people with depressive symptoms
6. How	- Presumably access to both individual and group face to face contacts as part of the senior center services - The provision of a schedule of activities can be considered delivery at a distance.
6b. How organised	Institutional level: - Partnership with Group Health Cooperative of Puget Sound (GHC), a health maintenance organization based in Seattle, and Pacificare, another large health care organization in the Pacific Northwest, and Northshore Senior Center, were the intervention took place. - GHC and Pacificare provided access to populations of community dwelling older adults with health issues; - Northshore provided the physical site for the intervention, organized and administered the LFP and the chronic disease self-management classes, and recruited and trained a cadre of mentors. - Investigators from GHC and the HPRC (Health Promotion Research Center at the University of Washington) worked with Northshore to design the intervention - Evergreen Healthcare, a hospital in the area, partnered with the Northshore Senior Center to help recruit Pacificare physicians who were practicing as part of the Evergreen Physicians Group and their patients. Evergreen Healthcare also provided funding that partially supported the GNP's salary. Individual level: - Self management group classes were conducted by trained lay leaders
7. Where	- At the senior center - Seattle, Washington
8. When and how much	- Started after referral from primary care provider, based on being on treatment for one or more chronic conditions (dementia and terminal disease excluded). - Participants could access the self-management group sessions which occupied 2 hours weekly for 7 weeks

	- Participants could access exercise activities, including the endurance, strength and flexibility program which met 3 times a week
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 63. Liddle 1996[13] Occupational Therapy assessment at home without recommendations or any follow-on therapy

1. Brief name	Occupational Therapy assessment at home without recommendations or any follow-on therapy.
2. Why	Not mentioned
3. What (materials)	- Occupational therapist initial assessment included a modified Health Assessment Questionnaire
4. What (procedures)	- Environmental-functional assessment by an occupational therapist with formulation of recommendations (including aids) NOT shared with the participant and not actioned. - Usual community care which included the possibility access by own's initiative: GP, podiatrist or chiropodist, physiotherapist, community nurse, other community health worker, outpatient clinic, home care or meals-on-wheels.
5. Who provided	- Occupational therapist - Presumably, various professionals who provided usual community care
6. How	Presumably individually and face-to-face (based on home-consultation context)
6b. How organised	Not mentioned
7. Where	- At home - In the Northern Sydney Area, Australia
8. When and how much	- Started following a screening process that identified people with moderate to severe impairment in activities of daily living - 1 home visit for OT assessment
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 64. Liimatta 2019[56] Standard usual care

1. Brief name	Standard usual care. Typical care including normal healthcare offered in the municipality health centre; and social care offered by the municipality.
2. Why	Goal:

	To offer social and health care services for older adults. Rationale: Older people have often multiple and complex health care needs.
3. What (materials)	Not mentioned.
4. What (procedures)	1. Typical care including the normal healthcare offered by the municipality health centre. 2. Local social and group activities offered by local volunteer and third-sector organizations. 3. Social services provided by the municipality, including the Finnish Social Insurance Institution (ISS).
5. Who provided	Not specified, presumably staff of healthcare centre and social services mainly.
6. How	Not specified, presumably by attending healthcare centre, local activities, and social services.
6b. How organised	Typical/ usual care including the normal health and social care offered by the municipality health centre.
7. Where	Location: Hyvinkaa, Finland (a mid-size Finnish town with 46,600 inhabitants.)
8. When and how much	When started: Status - not dependent (not receiving home help or nursing services) Not specified, presumably pts received care when required.
9. Tailoring	Not specified, presumably according to the practice of the usual health and social services.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 65. Loh 2015[57] Control group receiving written health education information

1. Brief name	Control group receiving written health education information.
2. Why	Not mentioned
3. What (materials)	- General health education booklet containing information on healthy lifestyle.
4. What (procedures)	- A general health education booklet was provided - Participants were advised to maintain their level of physical activity - A similar number of contact hours as the intervention group was mentioned but there was no information about what this would involve
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In a poor urban area in Klang Valley, Malaysia
8. When and how much	- Started when people were 60 years or above and residing in a low-cost government subsidized flat, were independently mobile with a walking speed of <1.24 m/s for females and <1.33 m/s for males, willing and able to attend a one-hour session twice weekly for 6 weeks, and not suffering from unstable

	cardiovascular disease, other uncontrolled chronic conditions, recent fractures and musculoskeletal diseases. Similar contact hours to the intervention group were briefly mentioned but it is unclear whether this occurred or what may have happened in these times. The intervention group involved approximately 20 sessions of 30 mins over 6 weeks.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 66. Lood 2015[58] Conventional care

1. Brief name	Conventional care.
2. Why	Goal: to respond to each person's needs.
3. What (materials)	Not mentioned
4. What (procedures)	Access to conventional elderly care from the municipality, that is, home-help services or home medical care based on each person's needs, on his/her own initiative
5. Who provided	Not mentioned. Presumably several medical and home-help professionals accessible as part of conventional community services
6. How	Not mentioned
6b. How organised	Conventional care was organized by the municipality
7. Where	- In Angered, Gothenburg, Sweden - In a suburban district of the mid-sized city in Sweden, one with a low general income level and a large proportion of people who are born abroad. - At home for conventional home-help and home medical care
8. When and how much	- People with ≥70 years, and who had migrated from Finland, Bosnia and Herzegovina, Croatia, Montenegro or Serbia to Sweden were invited to participate - Started when participants were independent of formal or informal help in daily activities
9. Tailoring	Provision of conventional care services was tailored to person's needs
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 67. Mann J 2021[59] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned

4. What (procedures)	- Access to usual medical care provided by the GPs, based on the participant's own initiative. The GP could refer participants to an outpatient clinic in hospital.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- No care coordination services are available outside of an hospital context, other services are fragmented and their access pathways are unclear.
7. Where	- Far North Queensland, Australia, in an area characterized by a higher rate of socioeconomic disadvantage compared with the rest of Queensland
8. When and how much	- Started when participants were 70 years old or older or 50 years old or older if indigenous and had multiple morbidities or a social situation that requires the attention of multiple healthcare providers or facilities as assessed by the GPs. Could also start when participants were younger if they are living with chronic or complex age-related conditions (previously only associated with older persons), such as early-onset dementia or arthritis, or another condition. Participants were not receiving geriatric or coordinated care.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 68. Melis 2008[60] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care based on participant's own initiative, including, for example, GP care, home care, meals-on-wheels, among others.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In the Netherlands
8. When and how much	- Started after referral by GP when the patient or informal caregiver had recently presented with a health problem. The request had to be related to cognitive disorders, behavioral and psychological symptoms of dementia, mood disorders, mobility disorders and falling, or malnutrition. The patient/informal caregiver and GP had to have determined a goal to be achieved. Participants also had to be experiencing limitation in cognition (Mini Mental State Examination equal to or less than 26, but higher than 20), instrumental activities of daily living (Groningen Activity Restriction Scale equal to or greater than 25) or mental well-being (MOS-20/subscale mental health equal to or less than 75). The participant was not experiencing an acute problem, the problem was not merely a diagnostic issue, and was not already receiving intermediate care.

9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 69. Meng 2005[61] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual care services including hospital, nursing home, home care and ambulatory care (e.g., physician services, preventive and screening services, outpatient care, etc.), as financed by Medicare A and B
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- In the context of Medicare, a national program that finances healthcare for adults age 65 and older, permanently disabled persons under age 65, and individuals with end stage renal disease, in a fee-for-service model.
7. Where	- In New York, West Virginia and Ohio, United States
8. When and how much	- Participants were enrolled in Medicare A&B in a practice in which physicians agreed to participate. Participants were assessed as having at least 2 or 3 limitations in ADL or IADLs respectively. Additionally, participants should have been hospitalized, been a nursing home patient or resident, or received Medicare home health care within the past 12 months, or had two or more emergency room visits in the past 6 months. Participants under 65, with long-term care insurance or enrolled in Medicaid were further excluded
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 70. Messens 2014[11] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to available health services, based on the participant's own initiative. This includes for example, standard home, nursing and medical care, formal/informal care and contacts with GPs, and specialist physicians.

5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In 4 sites in the European Union, including: Belgium (City of Antwerp), Catalonia (Town of Badalona), Ireland (North Eastern Region, Italy (Town of Latina)
8. When and how much	- Started when participants were 65 years or older, and were not completely dependent in ADLs. Participants were assessed as mild or moderately frail (Edmonton Frail Scale), did not have a full-time caregiver, were able to use the devices, had ISDN or ADSL services, and did not have significant medical conditions that would interfere with expression or provoke shortened life expectancy.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 71. Metzelthin 2013[62] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual healthcare based on participant's own initiative, including services from GP, practice nurse, allied professionals (i.e., occupational therapist, physiotherapist, speech therapist and dietician). The access is easy as nearly all people are covered by healthcare insurance, and the service is considered good and strongly focused on primary care.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- Participants were enrolled in GP practices that manifested interest in participating in the study, which may indicate a substantial interest in innovations for frail older people care. - Embedded in the Dutch National Care for the Elderly Programme.
7. Where	- Sittard, in the south of the Netherlands
8. When and how much	Started when participants were 70 years or older and assessed as frail (5 or higher on Groningen Frailty Scale), and were enrolled in GP practices that showed interest in participating.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 72. Moll van Charante 2016[63] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	- All baseline measurements on the risk profile of individual patients are made available for the GP.
4. What (procedures)	- Universal access to primary care in which the GP is a gatekeeper of additional care - Primary care includes a high standard of regular cardiovascular care which may involve secondary prevention and a more proactive primary prevention recommended for people older than 70 years. - The GPs were advised to refer patients with cognitive decline to a geriatric or neurologic outpatient clinic.
5. Who provided	Presumably mainly the GPs; and other healthcare professionals accessible through the usual care.
6. How	Presumably face-to-face and individually accessing GP and practitioner consultation in usual primary care
6b. How organised	- In the Dutch healthcare system, virtually all inhabitants are registered with a GP - The GP is the gatekeeper of care, who makes referrals to medical specialists when necessary. The specialists then report back to the GP. - All baseline measurements on the risk profile of individuals were made available to the GP who has the discretion to initiate treatments.
7. Where	- Netherlands - In general practices which are organised in health centres: 3-7 practices per centre, and presuming 1 GP per practice.
8. When and how much	When started: - Participants were enrolled with a participating primary healthcare centre. - free from cardiovascular diseases and dementia. - were contacted by letter and by their own GP.
9. Tailoring	- All baseline measurements on the risk profile of individual patients are made available for the GP. - received care as usual, according to the prevailing Dutch guidelines for cardiovascular risk management.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- Some participants started receiving treatments in response to the 2-year assessment. - 125 participants unduly received the intervention with an average of >2 visits per year - relatively high drop-out rate

Table 73. Monteserin Nadal 2008[64] Usual care

1. Brief name	Usual care .
2. Why	Not mentioned
3. What (materials)	The assessment included standardized instruments, namely: Charlson, Barthel and Lawton index, 5-Yesavage Depression Scale, Short Portable Mental Status Questionnaire (Pfeiffer's test), Mini-Nutritional Assessment Short Form, Gijón Social Scale
4. What (procedures)	- Multidomain assessment, including aspects related with nutrition, mood, physical and social domains, among others. The results were not shared with the participant and no other procedures followed from the assessment.
5. Who provided	- Trained nurses provided the assessment
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In Barcelona - The assessment took place in the primary care centre.
8. When and how much	- Started when participants were 75 years or older and were enrolled in a primary health care centre - The multidomain assessment session was presumably one session
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 74. Morey 2009[65] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care services, within the veteran affairs healthcare service.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Veterans Affairs Medical Center of Durham, North Carolina.
8. When and how much	- Participants were enrolled in the veteran affairs health services and were 70 years or older. Participants were assessed in a two-step process, first based on medical records and then based on the primary care provider judgement. The assessment determined if the participant was able to walk 30ft without other person's help, had no health conditions that may prevent safe physical activity and was not already exercising at least 150 min a week.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned

11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 75. Morgan 2019[66] Usual care and health promotion booklet

1. Brief name	Usual care and health promotion booklet.
2. Why	Not mentioned
3. What (materials)	Booklet on healthy ageing produced by Age UK and publicly available
4. What (procedures)	Usual care: - Primary care including GP appointments - Hospital in-/out-patient care - Urgent care Publicly available resources provided to participants: A booklet published by Age UK, on healthy ageing, containing health promotion messages, including topics such as healthy diet, physical activity and falls prevention.
5. Who provided	Not mentioned
6. How	The health information booklet was sent by post
6b. How organised	Not mentioned.
7. Where	Location: - United Kingdom - Areas of differing social deprivation across Bristol and South West area
8. When and how much	When started (usual primary care): Presumably when seeking GP's consultation.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 76. Newbury 2001[67] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual health care services, including GP practice, based on the participant's own initiative.
5. Who provided	Presumably GPs, when accessing primary care based on participant's own initiative, and other professionals being part of usual care services.
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Adelaide, urban Australia
8. When and how much	- Started when the participants were 75 years or older and were signed up to a variety of GP practices in which the GP agreed to participate

9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 77. Newcomer 2004[68] Usual and customary care management in PacifiCare's Secure Horizons (PCSH)

1. Brief name	Usual and customary care management in PacifiCare's Secure Horizons (PCSH). Including annual health screening, hospital discharge planning and event driven care coordination.
2. Why	Rationale: Standard intervention was based on the occurrence of utilisation event.
3. What (materials)	- Standardized risk-screening questionnaire including health status, demographics, service use, activities of daily living, income and access to transportation. - Referrals
4. What (procedures)	Available usual care from PCSH Insurance programme: - Health-plan-covered benefits and community-based programmes. - The intervention was based on the occurrence of a utilisation event.
5. Who provided	- Primary care physician, as part of PCSH care - Presumably a range of specialists that provide support through hospital discharge, care coordination following trigger events and disease management programs - Presumably other professionals that are part of senior community services
6. How	- Risk screening conducted by mail - Presumably individual face to face contact with PCP and specialists accessed through hospital discharge, care coordination following trigger events and disease management programs
6b. How organised	- Presumably the health plan beneficiaries had to seek the services or make claims at the occurrence of a utilisation event. - The available interventions options are those covered by PCSH health plan; and the community-based programmes.
7. Where	- In the context of the PacifiCare's Secure Horizons Medicare plan - San Diego, US
8. When and how much	- Started when participants were enrolled in health insurance program for at least 1 year; and at high risk for negative outcomes (80 years old or older or age 65 or older with at least one chronic condition)
9. Tailoring	Case management provision was tailored based on critical events experienced by the participant (e.g., illness).
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 78. Ng 2015[69] Usual care + nutritional placebos

1. Brief name	Usual care + nutritional placebos. Access to standard community-based social, recreational and day care rehabilitation services for older people. Additionally, participants were given placebo liquid capsules and tablet formulations.
2. Why	Rationale: To establish whether frailty among older individuals is reversible or can be reduced by usual care and nutritional placebos (in comparison with a combination of intervention: Physical exercise, nutritional supplementation, cognitive training).
3. What (materials)	Participants were given 3 types of placebo (taken daily for 24 weeks): 1. 200-mL of artificially sweetened, vanilla-flavored liquid (ingredients: non-dairy creamer, liquid caramel, sugar, and water) 2. 2 capsules and 1 tablet (ingredients: corn starch, lactose, magnesium stearate) that were identical in appearance to the active nutritional supplements (Iron, Folate, Vitamin B6, Vitamin B12, Calcium, Vitamin D).
4. What (procedures)	Access to usual care normally available to older people: 1. Standard care from health and aged care services, including primary and secondary level care from government or private clinics and hospitals 2. Community-based social, recreational, and daycare rehabilitation services. Nutritional placebos: 1. Interventional nurses administered the placebos (a sweetened drink, 2 capsules and 1 tablet). 2. Instructed to continue with usual diet, and not to replace meals with the placebo supplements.
5. Who provided	Interventional nurses: Administered the placebos to participants. Otherwise, assuming the typical healthcare, social, and community care professionals provided the standard usual care.
6. How	Not specified the arrangement for interventional nurses to administer the placebos.
6b. How organised	Standard care from health and aged care services, including primary and secondary level care, provided by the government or private clinics and hospitals; and community-based social, recreational, and daycare rehabilitation services.
7. Where	Locations: Singapore Usual care facilities and infrastructure for older people: - Health and aged care services, including primary and secondary level care from government, or private clinics and hospitals, - Community-based social, recreational, and daycare rehabilitation services.
8. When and how much	When starting intervention: 1. Potential participants were identified from among community residents in the southwest region of Singapore, from October 2009 to August 2012. 2. Prefrail and frail older adults were identified based on 5 CHS criteria. Placebo dose and during: 1. Assuming for the first 24 weeks 2. Daily dose: 200-mL liquid formula (non-dairy creamer, liquid caramel, sugar, and water), 2 capsules and 1 tablet (corn starch, lactose, magnesium stearate)
9. Tailoring	Not mentioned

10. Modifications	Not mentioned
11. How well (planned)	Treatment adherence measured monthly by estimating the proportion of supplements consumed.
12. How well (actual)	Mean level of compliance: 94% for control.

Table 79. Pathy 1992[70] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual care services based on own initiative - Participants were not screened for possible problems and could access health visitors but these were in place only in exceptional crisis situations
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- The GP practices where the intervention took place had never had scanning and regular home visiting procedures
7. Where	- Central Cardiff, South Wales
8. When and how much	Participants were 65 years old or older and were registered in a GP practice. Participants had not received screening or regular home visits before.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 80. Phelan 2007[71] Usual care

1. Brief name	Usual care. Care of older adults mainly based in primary care settings.
2. Why	Older adults care is mainly based in primary care settings because of the small proportion of trained geriatricians available.
3. What (materials)	Not mentioned
4. What (procedures)	Usual care: Mainly based in primary care settings, and presumably having access to geriatricians.
5. Who provided	Mainly primary care practitioner/physician (PCP)
6. How	Not mentioned
6b. How organised	- The participating primary care clinics were affiliated with Group Health Cooperative (GHC), a large health maintenance organization.
7. Where	Location: - Seattle, Washington, USA Venues: - The 2 participating primary care clinics affiliated with a large health maintenance organization, in which PCPs were receptive to the project.

8. When and how much	When started: People aged 75 or over, who were patients of one of the participating primary care practices, were selected by either randomly sampling or by their primary care physicians, to receive the invitation.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 81. Ploeg 2010[72] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned.
3. What (materials)	Not mentioned.
4. What (procedures)	The participants in the control group received usual care.
5. Who provided	The intervention was provided to patients of family physicians who were members of primary care networks in Hamilton, Ontario, Canada. The participants in the control group received usual care. Staff involved not mentioned.
6. How	The participants in the control group received usual care. They were followed up at 6 and 12 months.
6b. How organised	Not mentioned.
7. Where	1. Hamilton, Ontario, Canada. 2. The intervention was provided to patients of family physicians who were members of primary care networks in Hamilton, Ontario, Canada. 3. Primary care networks comprise networks of solo and small group practices of family physicians.
8. When and how much	1. Intervention started when participants were identified as being at risk of functional decline using the Sherbrooke questionnaire and randomised to the control group. 2. Duration of the study for the control group was 12 months. 3. Participants followed up at 6 and 12 months.
9. Tailoring	Not mentioned.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 82. Profener 2016[73] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned

3. What (materials)	Not mentioned
4. What (procedures)	Presumably access to usual healthcare services based on the participants' own initiative.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In Hamburg, Germany
8. When and how much	Participants were enrolled in this study after having enrolled in the LUCAS cohort study and being assessed as frail on the LUCAS function index, based on the LUCAS questionnaire. This questionnaire included some questions of the HRA-O and questions on psychological items, physical and mental activities, health literacy, income and use of urban activity space. Participants were 60 years old or older.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 83. Rockwood 2000[74] Comprehensive geriatric assessment and goal setting without specialized care

1. Brief name	Comprehensive geriatric assessment and goal setting without specialized care.
2. Why	Not mentioned
3. What (materials)	- Goal Attainment Scaling (GAS) to assess the participant and set goals - Evaluation forms and documentation related to the patient's goals and preferences - Referrals from family physician as part of usual care
4. What (procedures)	1. Multimodal assessment and planning, BUT the results were not communicated to the patient of their physician, and not actions followed from it. The assessment and planning included: - Comprehensive geriatric assessment by nurse; - Discussion of goals with the patient by nurse - Discussion of assessment and goals with 2 independent geriatricians by nurse - Discussion of assessment and previous inputs in a multidisciplinary team conference that finalized the plan. 2. Usual care by family physicians, including arranging geriatric medicine consultation as needed For the staff: - Training for nurses on being a geriatric nurse assessor
5. Who provided	- Geriatric nurse assessor - Primary care physician as part of usual care 2 geriatricians supported the care plan formulation Mobile Geriatric Assessment Team (MGAT) included: - 2 Geriatric nurse assessor

	- 4 Geriatrician - Physiotherapist - Occupational therapist - Social worker - Dietitian - Audiologist - Speech and Language pathologist The team supported care plan formulation
6. How	- Initial Assessment and goal setting by the nurse took place at the participants home, presumably individually and face-to-face. - The usual care received from the Primary Care Physician was delivered presumably individually and face to face.
6b. How organised	- Family physicians were informed about the participant's assignment to the control group in which no additional intervention was provided - The nurse was responsible for determining if further consultation was required after the 1st visit - The care plan incorporated the patient's input - The care planning did not explicitly mention medication change, but the measure of medication at baseline and the geriatric team context suggests medication review would likely be present. - The results of the assessment and the patient's input were discussed by the nurse with two geriatricians that provided advice on the care plan independently of each other - The care plan was further discussed in a multidisciplinary team conference
7. Where	- Rural Nova Scotia - Rural family practices in three counties - Initial assessment in the participants' home.
8. When and how much	- Initiated following referral based on criteria targeting frailty, defined as a vulnerable state of health, arising from the complex interaction of medical and social problems, resulting in a decreased ability to respond to stress, and associated with a decline in functional performance. Operationally, this consisted of any of the following: concern about community living, recent bereavement, hospitalization, or acute illness; frequent physician contact; multiple medical problems; polypharmacy; adverse drug events; functional impairment or functional decline; and diagnostic uncertainty. - Initial Assessment - one home visit. - Usual care by family physicians
9. Tailoring	1. The nurse decided if further consultation was required based on individual assessment 2. Goal setting was based on participants' needs and incorporated participants' preferences through a negotiation process.
10. Modifications	Not mentioned.
11. How well (planned)	- The reliability of the goal setting was assessed based two independent assessments by geriatricians - Nurses received training for the geriatric nurse assessor role
12. How well (actual)	GNA-geriatrician inter-rater reliability for the GSS ranged from 0.79 to 0.94 over the four assessments. Correlation coefficients were similar for both GNA assessors in comparison with a blinded geriatrician, for each nurse, and across the intervention and control subjects.

Table 84. Romera-Liebana 2018[75] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	As part of usual care, two group sessions regarding dietary advice, lifestyles, and home hazards are advertised among the participants
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	In Barcelona
8. When and how much	- Participants were 65 years old or older and were enrolled in participating primary healthcare centers. The opportunity to participate was offered to all patients meeting preliminary frailty criteria (Barber Questionnaire). Participants met at least 3 Fried modified frailty criteria and did not have very slow or rapid gait speed, or cognitive impairment.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- The two sessions about dietary advice, lifestyles, and home hazards were attended by 48% of people

Table 85. Rubenstein 2007[76] Usual care in a Department of Veterans Affairs ambulatory care center

1. Brief name	Usual care in a Department of Veterans Affairs ambulatory care center.
2. Why	Not mentioned
3. What (materials)	If serious conditions were identified, the study's physicians reviewed the information, then forwarded to patient's usual healthcare providers for appropriate follow-up.
4. What (procedures)	- Usual care but not enrolled in the outpatient geriatric services at the Sepulveda Ambulatory Care Center (SACC) of the VA Greater Los Angeles Healthcare System. - If serious conditions were identified, the study's physicians reviewed the information, then forwarded to patient's usual healthcare providers for appropriate follow-up.
5. Who provided	- Usual healthcare providers at an interdisciplinary primary care practice group, and the Sepulveda Ambulatory Care Center (SACC) of the VA Greater Los Angeles Healthcare System. - Study physicians reviewed information when serious conditions were identified and forwarded to patient's usual healthcare providers.
6. How	Assuming distant or face to face contacts as appropriate, for assessments and providing care to the patients.
6b. How organised	No details.

7. Where	Los Angeles, USA One of three interdisciplinary primary care practice groups, and at the Sepulveda Ambulatory Care Center (SACC) of the VA Greater Los Angeles Healthcare System. Geriatric care had been in place for over 25 years, but the participants were not enrolled in the outpatient geriatric services at SACC when joining this study. VA and non-VA healthcare services available.
8. When and how much	Intervention started when identified as at high risk (four or more of the 10 Geriatric Postal Screening Survey (GPSS)), i.e., impaired response in four or more areas of screening.
9. Tailoring	Patients were referred to and received care according to their needs, when identified by their usual care providers.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 86. Serra-Prat 2017[77] Usual Care

1. Brief name	Usual Care.
2. Why	Not mentioned.
3. What (materials)	Not mentioned
4. What (procedures)	There was no special intervention for the control group patients who received their usual care and recommendations.
5. Who provided	Not mentioned.
6. How	Usual care and recommendations.
6b. How organised	Presumably the usual arrangement and organisation from usual primary care.
7. Where	Location: Barcelona, Spain Setting: 3 primary care centers
8. When and how much	Upon consulting in primary care.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 87. Shapiro 2002[78] Waiting list presumably receiving usual care (not described)

1. Brief name	Waiting list presumably receiving usual care (not described).
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Not specified, presumably included available usual care, as participants were placed on waiting list.

	(Participants were assessed every 3 months and provided with services if they were found to be at high risk, but in this case, they were excluded from the study).
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- Participants were enrolled in a state program upon referral from healthcare services. The program provided social services following a uniform state-wide assessment. This assessment determined the level of risk and participants only received services if classified as high risk.
7. Where	- Florida
8. When and how much	- Started when participants were referred to receive social services by local hospitals, rehabilitation centers, and physicians. Participants were assessed as being at medium risk by an uniform state-wide assessment (based on chronic health conditions, activities of daily living limitations, and other measures of physical and psychological impairment) and put on a waiting list.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 88. Sherman 2016[79] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Presumably the participant had access to usual health and social care services based on his/her own initiative. These included: healthcare center (including district nurse usual services), home-help service, activities in the local community and county council facilities.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Stockholm County Council, comprising 5 geographical areas and both rural and urban communities - In areas supported by health care centers that include at least 3 district nurses
8. When and how much	Started after selection of 75 years old participants in health care centers willing to participate and which had at least 3 district nurses. The participants initial contact was by post.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned

11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 89. Stuck 1995[80] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual healthcare based on participant's own initiative. Services include primary care, home health care meals on wheels, community transportation, among others. There is no preventive care widely available, with the exception of very specific procedures (e.g., mammograms).
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- The usual care system is not comprehensive, community-oriented and universally accessible. Older patients receive services through either a fee-for service system or managed care.
7. Where	- Santa Monica (urban), Los Angeles, Unites States
8. When and how much	- Started after a general invitation based on voter-registration list. The participants reached were urban, reasonably healthy, middle-class and non-minority.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 90. Stuck 2000[81] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Access to usual healthcare services based on participant's own initiative, including primary care (mostly), specialists, and home care. The system is based on fee-for-service health insurance plans, by which specialist care can be accessed directly.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- The system of care is based on fee-for-service health insurance plans, and more than 99% of people are covered. This allows for direct access to specialist care
7. Where	- In Bern, Switzerland

8. When and how much	- Started when the participants were enrolled in a health insurance (as 99% of the people in the system of care) and were 75 years-old or more
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 91. Stuck 2015[82] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	- Providers' training materials
4. What (procedures)	Presumably access to usual care services, which should include GP services based on the participant's own initiative
5. Who provided	The GP practices to which the participants may have had access (based on their own initiative) received training and support from geriatricians.
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In Solothurn, mainly rural areas in Switzerland
8. When and how much	- Started when participants were 65 years old or older, enrolled in GP practices and did not need assistance in BADLs as assessed with a questionnaire focused on BADLs sent by post [PRA, Probability of Recurrent Admissions questionnaire]. Participants were also excluded if they had cognitive impairment or a terminal disease.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 92. Suijker 2016[83] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care based on participant's own initiative. Usual care services include primary care with GP and nurse care (may use chronic management protocols for diseases, such as diabetes and COPD), home care nursing, personal care, day care, and hospital care.
5. Who provided	Presumably the GP, when accessing usual care services based on participant's own initiative.
6. How	Not mentioned

6b. How organised	In usual care, the GP plays a central role as the first contact and gatekeeper of the healthcare system.
7. Where	- In the Netherland, north of Amsterdam (region Alkmaar) and within the city of Amsterdam (North and South-East). - In urban and rural communities
8. When and how much	- Started after a selection process that included people 70 years-old or older, registered in a GP practice, and at increased risk of functional decline based on a validated postal questionnaire sent by the GP (2 or more in the Identification of Seniors at Risk in Primary Care, ISAR-PC).
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 93. Szanton 2011[5] Attention control intervention

1. Brief name	Attention control intervention. Social and attention engagement involving reminiscing and sedentary activities chosen by the participants.
2. Why	Goal: to provide social attention and engagement, mirroring the amount of time spent on an alternative experimental intervention.
3. What (materials)	1. Materials involved in the reminiscence and sedentary activities chosen by participants, such as scrapbooks or family cookbooks. 2. Tracking sheet to document the time of each visit (signed by participants). These were checked by weekly by PI and RA.
4. What (procedures)	Attention control activities: - Sedentary activities which included reminiscence (making scrapbooks, or family cookbooks), selected based on the participant's preference and provided by a trained research assistant. Available usual care: Primary care provider is available.
5. Who provided	Research assistant who was not an OT or nurse
6. How	- Presumably home visits in an individual format, but it is not specified. - Activities like making scrapbooks imply a face-to-face interaction.
6b. How organised	- The sessions were provided by a trained research assistance. - Biweekly supervisory sessions between the PI and the RA tracked content of the attention-control visits
7. Where	Location: Baltimore city, US Venue: At home.
8. When and how much	When started - Individuals were recruited from the lists of three government and non-profit organization of low-income older adults awaiting home-based services in Baltimore City. Assessed as disabled based on difficulty with at least one Activity of Daily Living (ADL) or at least two Instrumental Activities of Daily Living. Persons were contacted first by letter and then a follow-up phone call. - Up to ten 60-minute sessions with RA

	- Biweekly supervisory sessions between the PI and the RA tracked content of the visits
9. Tailoring	The reminiscence and sedentary activities developed were chosen by the participants
10. Modifications	Not mentioned
11. How well (planned)	- The record of visits and supervision of the visits content can be considered strategies to assure the RA provided only social engagement, as intended.
12. How well (actual)	Not mentioned.

Table 94. Szanton 2019[6] Attention control intervention

1. Brief name	Attention control intervention. Social and attention engagement involving reminiscing and sedentary activities chosen by participants
2. Why	Goal: to provide social attention and engagement in individually tailored enjoyable activities. Rationale: to provide a rigorous comparison with an alternative individually tailored intervention
3. What (materials)	- Scrapbooks, card games, music, to support the activities developed - Printed National Institute on Aging materials on exercise, fall prevention, and home modification - Checklist to assess participants' preferences regarding particular sedentary activities - A tracking sheet for each session to document duration, signed by the participant - An intervention manual for training - Audiotapes of 10% of the sessions for supervision - Checklists to review audiotapes for supervision
4. What (procedures)	- Sedentary activities with assessment and regular review by a trained research assistant. Included sedentary activities such as reminiscence, selected based on the participant's preference. The activities were reviewed based on participants' feedback - Providing information (written) about caring for own health (e.g., exercise, falls) - Reminders of sessions in day before the session - Presumably the participants had access to PCP as part of usual care
5. Who provided	- Trained research assistant with no other role in the study than to visit these participants
6. How	- Face-to-face and presumably individually and for the in-home sessions
6b. How organised	- The staff was supervised based in audiotapes in case presentations and supervisory sessions
7. Where	Location: Baltimore city, Maryland Venue: At home
8. When and how much	When started: - Status - low income - Assessed as had difficulty in at least 1 ADL or 2 IADLs - Participants enrolled in the study following contact by mail, government and community-based organizations and by an ambassador program. Sessions schedule:

	- Participants usually 10 sessions/visits over 4 months, which took around 60 min.
9. Tailoring	Activities were tailored to participant's preference
10. Modifications	Not mentioned
11. How well (planned)	Several procedures were intended to assure fidelity: - staff training - the reminder calls to participants - the staff supervision based on audiotapes, checklists, feedback and bi weekly meetings
12. How well (actual)	- 57.4% of the participants received 8 to 10 visits - 30.4% of the participants received 4 to 7 visits - 12.2% of the participants received 1 to 3 visits

Table 95. Takahashi 2012[84] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Participants are informed about and can access a variety of services that are part of usual care, based on their own initiative. Usual care includes primary care and specialty office practice visits, home healthcare, post-hospital outpatient visits, a nurse-generated phone call progress report within 1 business day of hospital dismissal, and standard clinic phone triage during business hours, a 24-hour nurse triage line for questions, extended-hours care, and Mayo Clinic Express Care. [-If outcome assessment indicates a risk in depression memory loss or functional status scores, this is reported to the primary care physician. Here, this was regarded as an emergency mechanism and considered a minor action]
5. Who provided	Not mentioned (presumably a variety of professionals working in the services made available by request, including nurses and primary care and specialist doctors)
6. How	Not mentioned
6b. How organised	- The intervention occurred in the context of a Mayo Clinic's program
7. Where	- In Rochester and rural Kasson, Minnesota, [USA] - In the context of a Mayo Clinic's program
8. When and how much	- Participants were older than 60 years old with multiple chronic conditions, and enrolled in the Mayo Clinic's health services. Participants were identified as at risk based on the Elder Risk Assessment Index (ERA) which scores patients electronically based on administrative data which takes into account, age race, hospitalization, among others. Participants in 10% highest risk with scores greater than 15 were included. Participants with dementia and who felt they could not use the telemonitoring system were excluded.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 96. Thiel 2019[85] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care services based on the participant's own initiative, which may include medical care, usual medication, physiotherapy or no intervention.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Bochum, Germany
8. When and how much	Started after participants were assessed by phone or at home as frail (0.25 or more Frailty Index) and with no medical restrictions to exercise. Participants were 65 years old or older and were not engaging or planning to engage in regular exercise (more than once a week). Participants were informed of the study and invited to participate in several ways, including through: 1. clinical observational studies, 2. local social institutions, 3. nursing services, 4. newspapers.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 97. Thomas 2007[86] Control Group

1. Brief name	Control Group. No assessment results given and no advice from the functional assessment that was conducted.
2. Why	As Canada's elderly population continues to grow over the next few decades, its demand for community-based health services is also likely to grow. It is important to know whether helping seniors and their families in this third group identify their deficits (or potential deficits) may help them continue living in the community.
3. What (materials)	
4. What (procedures)	
5. Who provided	Four registered nurses were trained as interviewers. The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years.
6. How	The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years.

6b. How organised	not mentioned
7. Where	Newfoundland, Canada. Assessment took place at home. Authors suggest that culturally self-reliant and used to weathering hardship. Also strong mutual help networks in villages. Authors uncertain of quantity, quality and suitability of home care provision.
8. When and how much	The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years. At baseline and at each follow-up assessment (years 1 to 4), nurses compiled data
9. Tailoring	None
10. Modifications	None
11. How well (planned)	None
12. How well (actual)	None

Table 98. Tomita 2007[10] Usual care

1. Brief name	Usual care. Control condition, not described, presumably usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Not mentioned
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- Western New York
8. When and how much	- Started when participants were assessed as having in activities of daily living (ADL) or instrumental ADL (IADL) due to chronic health conditions without cognitive impairment. Participants were 60 years of age, living alone and had interest in using a computer.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 99. Tulloch 1979[87] Conventional patient-initiated care

1. Brief name	Conventional patient-initiated care.
2. Why	Not mentioned
3. What (materials)	Not mentioned

4. What (procedures)	- Conventional care self-initiated by the patient - Care may include reviews of problems identified through conventional care - The primary care center servicing these participants included generous nursing, administrative support and close liaison with social services
5. Who provided	- Presumably various health and social care professionals being part of usual care, following referrals resulting from self-initiated contact by the participants
6. How	Not mentioned
6b. How organised	The primary care center which was part of usual care liaised closely with social services
7. Where	- Oxford - Presumably at outpatient and specialist services and at home, based on patients' self-initiative to access usual care.
8. When and how much	- Started after general invitation based in practice register, to people aged 70 or more
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 100. van Dongen 2020[88] Regular care control group

1. Brief name	Regular care control group. Receives only regular care, and no intervention.
2. Why	Not mentioned.
3. What (materials)	Not mentioned.
4. What (procedures)	Available usual care (implied): 1. healthcare professionals from 4 regional care organisations (Zorggroep Apeldoorn, Viattence, Zorggroep Noordwest-Veluwe, and Opella). 2. general practitioner (GP)
5. Who provided	Including general practitioner (GP), others not mentioned.
6. How	Not mentioned.
6b. How organised	No details
7. Where	Country: The Netherlands Infrastructure (implied): 1. regional care organisations 2. community health service 3. local organisations, e.g., sports-promoting agency or prevention centre
8. When and how much	Regular care as usual.
9. Tailoring	Not mentioned.
10. Modifications	Not mentioned.
11. How well (planned)	Not applicable.
12. How well (actual)	Not applicable.

Table 101. van Heuvelen 2005[89] Educational programme

1. Brief name	Educational programme.
2. Why	Goal: to provide social interaction. "...did not contain the active elements..."
3. What (materials)	Not mentioned
4. What (procedures)	- Lectures with discussion about a variety of topics including, drug use, road safety, tax returns, nutrition, home safety, inheritance law, social legislation and home care provision.
5. Who provided	An expert on the lectures' topics.
6. How	- Presumably in group and face-to-face
6b. How organised	Not mentioned
7. Where	- Groningen, north of the Netherlands - Group sessions location not specified
8. When and how much	- Started when participants were enrolled in a longitudinal study which recruited people 57 years old or older, and without severe cognitive impairments. Participants were assessed for level of functional and physical activity in two questionnaire and excluded if (i) very active on both scales or (ii) very active on one scale and moderately active on the other scale. - 90 minutes once a week, for 18 weeks.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Strategies were put in place to facilitate participation: transport by taxi was offered, newsletters about the progress of the research were sent and the group leaders were instructed to give personal attention.
12. How well (actual)	- 75.4% of the participants attended 12 sessions or more

Table 102. van Hout 2010[90] Usual Care

1. Brief name	Usual Care.
2. Why	Not mentioned.
3. What (materials)	Not mentioned.
4. What (procedures)	Usual care varied from no care at all to regular primary care practise visits to home care involvement.
5. Who provided	Usual care varied from no care at all to regular primary care practise visits to home care involvement. Primary care physicians
6. How	Usual care varied from no care at all to regular primary care practise visits to home care involvement.
6b. How organised	
7. Where	Netherlands Primary care practise : usual care. (varied from no care at all to regular primary care practise visits to home care involvement). Primary care physicians
8. When and how much	Usual care varied from no care at all to regular primary care practise visits to home care involvement.

9. Tailoring	Not mentioned.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 103. van Leeuwen 2015[91] Usual care

1. Brief name	Usual care. Unrestricted primary care including PCP care and referrals to other healthcare services.
2. Why	Goal: to deliver high-quality chronic disease care
3. What (materials)	- Access to referrals by PCP to a variety of local care organizations
4. What (procedures)	- Access to primary care, including flu vaccination, and arrangements for further care by PCP, including specialized hospital care, in-home care and mental health support - Proactive care for people with specific chronic diseases (e.g., diabetes)
5. Who provided	- Possible contact with PCP and more specialized health professionals following PCP referrals
6. How	Not mentioned
6b. How organised	- PCPs act as gatekeepers to other local health and community services
7. Where	- In Amsterdam (urban) and West-Friesland (urbanised rural setting), Netherlands
8. When and how much	- Started following participants were identified by PCPs as frail, based composite definition of frailty (experiencing one or more limitations in either physical, psychological and/or social areas), and having 5 or more drugs prescribed in last 3 months (polypharmacy criteria) - Started following participants were identified as disability level 3 or higher, based on the Program on Research for Integrating Services for the Maintenance of Autonomy case-finding tool for disability (PRISMA-7)
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 104. van Lieshout 2018[7] Waiting list control

1. Brief name	Waiting list control. The control group received care as usual.
2. Why	Not mentioned.
3. What (materials)	Not mentioned.
4. What (procedures)	Received care as usual, were able to use regular health and welfare services.
5. Who provided	Usual care provided by regular health and welfare services
6. How	Usual care.
6b. How organised	No details

7. Where	Country: Netherlands Area: A semi-rural community
8. When and how much	Not mentioned
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned.

Table 105. van Rossum 1993[92] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	The participant may access a variety of services on his/her own initiative, including: home help and nursing, meals on wheels, GP, outpatient clinic, physiotherapy, among others.
5. Who provided	A variety of health and social care professionals which services are part of usual care and can be accessed by the participant on his/her initiative
6. How	Not mentioned
6b. How organised	- The GP has a key role in guiding patients through the medical system by providing referrals for other (e.g., outpatient) services - The area has a clear system of services and the municipalities and health care services supported the research project. No other changes in the system were expected
7. Where	- In Weert, a town in the south of the Netherlands, and some surrounding villages (60,000 inhabitants)
8. When and how much	- Started after selection of people between 75 and 84 who were not receiving regular home care, based on information provided by local authorities. The selected people were sent a postal questionnaire with a letter from the mayor recommending participation.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	- To guarantee that these participants did not receive home visits as intended, the nurses of the home nursing care organisation in the research area paid no unsolicited visits to the participants during the study
12. How well (actual)	Not mentioned

Table 106. Vetter 1984[93] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned

4. What (procedures)	- Participants could access usual care based on their own initiative. Health visitors were integrated in usual care but did not provide regular care to older people.
5. Who provided	Presumably healthcare professionals working in usual care
6. How	Not mentioned
6b. How organised	- In the context of a system of care where health visitors do not provide regular care for older people
7. Where	- In Powys (rural area) and Gwent (urban area), [United Kingdom]
8. When and how much	- Participants were more than 70 years old, and were selected from the 2 GP practices age-sex register.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 107. von Bonsdorff 2008[94] Usual care, including advice on healthy living habits

1. Brief name	Usual care, including advice on healthy living habits.
2. Why	Goals: 1. cost-free nurse practitioner services for all people. 2. Low cost and available general medical care and laboratory tests. All Finnish residents have health insurance 3. have a right to exercise. Rationale: - The national public health enactments obligate the local primary health care centers to provide the free/low-cost healthcare. - According to the Sports act, all Finnish residents also have a right to exercise.
3. What (materials)	Not mentioned
4. What (procedures)	Access to usual care, including nurse practitioner services, general medical care and lab tasks and access to exercise facilities and activities
5. Who provided	Access to nurse and medical care, presumably by GP.
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	Location: Jyvaskyla, Finland - In the context of a healthcare system that provides usual care services cost free or at nominal cost, and obliges municipalities to guarantee access to exercise services for all
8. When and how much	When started in this trial: Old people who volunteered, were screened as cognitively intact, were able to move outdoors independently but were physically sedentary.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 108. Wallace 1998[95] Senior center standard care

1. Brief name	Senior center standard care. Control group, recruited amongst the senior centre users and presumably receiving the senior centre standard care (not specified)
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Access to senior center resources such as meal programs
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	1. Northshore Senior Center provided the physical site for the intervention and a community base from which subjects for the trial could be recruited.
7. Where	- In Bothell, Washington - At the Northshore Senior Center, a community senior center serving a predominantly white and relatively well-educated community, run by Seattle-King County Senior Services - In partnership with the Group Health Cooperative of Puget Sound (GHC), a health maintenance organization based in Seattle, and the Health Promotion Research Center at the University of Washington
8. When and how much	- Started when (1) participants were enrolled in a senior center serving a predominantly white and relatively well-educated community, and (2) following screening tests and a brief evaluation by physician to exclude participants too disabled, cognitively impaired or ill.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 109. Walters 2017[96] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Participants had access to usual community health services based on their own initiative. These included primary care by GP, specialist care (e.g., dental optician), physiotherapy, home care among others. - An analysis of the services accessed by the participants revealed they mainly used primary care GP services and attended outpatient appointments.

	- Self-report data for other community health services indicated that NHS optician (43%), private podiatry (39%) and NHS dental services (22%) were most commonly used. - Privately funded care or support services (e.g. cleaners and ironing services) were used by 65%. - Unpaid help from friends or family was used by 65% of participants. Only 13% had used state care and support services (e.g. Age UK services). - The majority of participants did not report lifestyle changes.
5. Who provided	- Presumably a variety of health and social care professionals that provide usual care and were contacted based on participant's own initiative.
6. How	Not mentioned
6b. How organised	Not mentioned
7. Where	- In London and Hertfordshire, United Kingdom. This included urban and semi-rural communities with diverse socioeconomic, ethnic backgrounds and access to services.
8. When and how much	- Started when participants were assessed as mildly frail (Rockwood CFS), were 65 years old or over and registered with participating GP surgeries
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 110. Wong 2019[97] Usual care with placebo social calls

1. Brief name	Usual care with placebo social calls.
2. Why	(Social calls were included to increase social contact)
3. What (materials)	Not mentioned
4. What (procedures)	- Access to standard community services on a on-demand basis. These services may include health talks and physical check-ups at a community centre and GP and outpatient services. - Social contact was provided through monthly calls about a predetermined set of questions (e.g., about the participant's favourite program).
5. Who provided	- Student helpers, who received specific training on the intervention, provided the placebo social calls
6. How	- By telephone, presumably individually
6b. How organised	Not mentioned
7. Where	- Various districts of Hong Kong
8. When and how much	- Started when participants were enrolled in a district community centre, were 60 years old or more, and not engaged in other structured health or social programs - There were 3 monthly phone calls, that took 5 to 10 minutes.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned

11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 111. Yamada 2003[98] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	Presumably usual community care without home visits, as participants receiving home visits were excluded.
5. Who provided	Not mentioned
6. How	Not mentioned
6b. How organised	- In the context of a public service in which preventive home visits are mandatory but an effective strategy to implement them has not yet been put in practice - The cooperation of local primary care physicians was not obtained
7. Where	- In Sapporo city and Takahata town in north Japan
8. When and how much	- Started when participants were 65 years old or older and were not receiving home visits by nurses in existing programs. Participants were first selected based on voter registration and then assessed. Those who were fully dependent in either the mobility or the personal care item of the EQ-5D were excluded as 'disabled', and those who were independent in all IADL, or dependent in one or two IADL, but rated their own health as excellent, were excluded as 'healthy'. The included participants were dependent in IADLs but independent in ADLs
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Care voucher

Table 112. Meng 2005[61] Consumer-directed voucher

1. Brief name	Consumer-directed voucher.
2. Why	Goal: to promote empowerment and improve health status, functioning, and quality of life while reducing Medicare and total health care costs through the encouragement of greater consumer choice and control over personal health care decisions and management. Rationale: - Based on the hypothesis that freedom to choose services as needed will result in more adequate tailored care - Based on empowerment framework which emphasizes self-management

	- Based on previous research showing that consumer-directed care improves sense of security, unmet functional needs, and increases satisfaction, and that personal assistance is effective in helping people with disabilities meeting their functional needs.
3. What (materials)	- Participants received a catalogue that listed a wide range of personal assistance goods (supplies, durable medical equipment, consumable care goods).
4. What (procedures)	- Provision of a voucher to be spent by the participant as he/she wished on personal assistance services and goods, with the individualized support and advice of a voucher specialist - The participant could access a variety of services including in-home workers, respite care, transportation, home modifications, supplies, durable medical equipment, and consumable care goods not normally financed by Medicare. - 85% of the participants used personal assistance goods (adaptive and assistive devices, durable medical equipment, and home modifications) following the intervention - Access to usual care services including hospital, nursing home, home care and ambulatory care (e.g., physician services, preventive and screening services, outpatient care, etc.), as financed by Medicare A and B
5. Who provided	- A specialist on the benefits associated with the voucher provided individualized advice
6. How	- The means by which the participant contacts the voucher specialist and vice-versa are not specified
6b. How organised	- At the end of each month, receipts were submitted to the voucher specialist, who had the responsibility for authorizing payment. The participant was then paid for 80% of the amount of supplies, equipment, and services that qualified, up to $200 per month for 2 years. - Services reimbursed by traditional Medicare were not included. - In the context of Medicare, a national program that finances healthcare for adults age 65 and older, permanently disabled persons under age 65, and individuals with end stage renal disease, in a fee-for-service model.
7. Where	- Some of the services made accessible by the voucher would take place at home but these and other services were selected by the participant and not provided for all - New York, West Virginia and Ohio, United States
8. When and how much	- Participants were enrolled in Medicare A&B in a practice in which physicians agreed to participate. Participants were assessed as having at least 2 or 3 limitations in ADL or IADLs respectively. Additionally, participants should have been hospitalized, been a nursing home patient or resident, or received Medicare home health care within the past 12 months, or had two or more emergency room visits in the past 6 months. Participants under 65, with long-term care insurance or enrolled in Medicaid were further excluded - Participants received the 200$ voucher every month for 2 years
9. Tailoring	- Participants tailored the intervention based on their needs and preferences by using the voucher as they wished. A voucher specialist also provided advice in this process.
10. Modifications	Not mentioned

11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Care voucher, education, multifactorial-action and review with medication review and self-management

Table 113. Meng 2005[61] Combined home visiting nurse (HVN) and consumer-directed voucher

1. Brief name	Combined home visiting nurse (HVN) and consumer-directed voucher. A disease-management health-promotion nurse intervention with provision of a consumer-directed voucher.
2. Why	Goal: to promote empowerment to manage own health and interact effectively with health professionals, and improve health status, functioning, and quality of life while reducing Medicare and total health care costs through the encouragement of greater consumer choice and control over personal health care decisions and management. The use of personal home care services was particularly encouraged. Rationale: - Based on previous research on patient empowerment and self-efficacy, and on expanding patient involvement in their own care, which shows improvements in health behaviors and health and functional status - Based on the PRECEDE-PROCEED health education planning model, which emphasizes behavioral change techniques and is based on the Transtheoretical Model (TTM) of intentional behavior change developed by Prochaska and DiClemente (1983, 1985), the Health Belief Model (Becker, 1974), and Social Cognitive Theory (Bandura, 1977) to set goals that are tailored to affect health behavior change - The medication review aspect of the intervention was built from an interdisciplinary review of the literature and from a synthesis of successful strategies used to promote medication management and patient adherence - The physical activity aspect of the intervention was based on a CDC report and an exercise manual from the American College of Sports Medicine
3. What (materials)	- Two handbooks, Consumer Self-Care Strategies (developed for the demonstration) and Healthwise for Life (Mettler, Kemper, & Stilwell, 1996), were used by the patients with guidance and support from the nurses - Intervention protocol - Written information about specific diseases - Self-care and self-management videos - Snapshot reports: written reviews sent to physicians updating them on patients' status and care plans. - Participants received a catalogue that listed a wide range of personal assistance goods (supplies, durable medical equipment, consumable care goods).
4. What (procedures)	- Multidomain assessment, care planning (including medication review), regular follow-up and arranging of services as necessary, with ongoing liaising and coordination by the nurse - The nurse provided education focused on self-management

	- A variety of actions were provided selectively, based on the participants' needs (could include physical exercise, ADL training, nutritional advice, among others). - A health and social care voucher provided access to a variety of services including in-home workers, respite care, transportation, home modifications, supplies, durable medical equipment, and consumable care goods not normally financed by Medicare. The nurse recommended which services to use. - Access to usual care services including hospital, nursing home, home care and ambulatory care (e.g., physician services, preventive and screening services, outpatient care, etc.), as financed by Medicare A and B
5. Who provided	- The nurses provided the multidomain assessment, care planning, review and co-ordination, and delivered varied selective actions in regular home visits - The nurses were certified fitness specialists and received training before and during the intervention delivery on relevant topics - Presumably, a specialist on the benefits associated with the voucher was involved in converting it into services
6. How	- Presumably individually and face-to-face, based on home visiting format - At a distance and presumably individually by phone - Behavioural techniques, including self-management related goal setting, empowering and motivation enhancing techniques, were a central part of the intervention - The means by which the participant contacts the voucher specialist and vice-versa are not specified
6b. How organised	- Coordination and communication between professionals providing care and the patient was promoted through case conferences, which were reimbursed ($60 per conference to the primary care physician for up to 4 conferences) - Presumably, the case conference supported not only coordination but also resulted in multidisciplinary care planning. - Throughout the intervention nurses collaborated with relevant services such as primary care, health specialist and other formal and informal support systems (e.g., senior buses), liaising and troubleshooting problems. - The care planning included a focus on medication review, including medication education, monitoring, and medication goals. - Building a close relationship between nurse and the participant was emphasized, and presumably the nurse reviewing the participant was the same person throughout the intervention. - At the end of each month, receipts were submitted to the voucher specialist, who had the responsibility for authorizing payment. The participant was then paid for 80% of the amount of supplies, equipment, and services that qualified, up to $200 per month for 2 years. - Services reimbursed by traditional Medicare were not included. - In the context of Medicare, a national program that finances healthcare for adults age 65 and older, permanently disabled persons under age 65, and individuals with end stage renal disease, in a fee-for-service model.
7. Where	- At home - In New York, West Virginia and Ohio, United States
8. When and how much	- Participants were enrolled in Medicare A&B in a practice in which physicians agreed to participate. Participants were assessed as having at least 2 or 3 limitations in ADL or IADLs respectively. Additionally, participants should have been hospitalized, been a nursing home patient or resident, or received

	Medicare home health care within the past 12 months, or had two or more emergency room visits in the past 6 months. Participants under 65, with long-term care insurance or enrolled in Medicaid were further excluded - Initial home visit + an average of one monthly visit for 2 years. Visits take around 1 hour. - Additional home visits and telephone contacts as needed
9. Tailoring	- The care plan, including the strategies used by the nurses in the home visits and the intensity of the home visits, were tailored to the participants' needs. The nurse recommended how the voucher could be used, as part of the tailored care plan.
10. Modifications	Not mentioned
11. How well (planned)	Fidelity to the intervention was promoted through training before and during intervention implementation
12. How well (actual)	Not mentioned

Cognitive training, medication-review, nutrition and exercise

Table 114. Romera-Liebana 2018[75] Multifactorial intervention program- physical activity and diet, memory workshops and review of medication

1. Brief name	Multifactorial intervention program- physical activity and diet, memory workshops and review of medication.
2. Why	- Goal: to modify frailty parameters, muscle strength, and physical and cognitive performance, and reduce drug prescription, delaying the progression from frailty to disability in the elderly and thereby preventing home confinement or institutionalization - Rationale: based on previous evidence showing the relevance of a variety of factors to frailty and functional decline, including: protein intake, physical activity, cognitive performance, and polypharmacy, including the positive impact of interventions that target these factors isolated or in association.
3. What (materials)	- Hyperproteic shake (Meritene Activ; Nestlé Health Science-NHS) - Record sheet for each participant in the training program - Elastic resistance bands - Personalized e-mail regarding medication - Screening Tool of Older Persons' potentially inappropriate Prescriptions (STOPP) - Cognitive exercises materials
4. What (procedures)	- Providing physical exercise sessions including aerobic, balance and strength training. - Providing hyperproteic nutritional shakes at the end of each physical exercise session, and daily for a month - Providing "memory workshops" which consist of group sessions in which participants take part in practical exercises including several cognitive domains: memory, language, sensory activation and reasoning and calculation - Providing a review of the medication being taken by the participant, signalling possible problems (particularly with polypharmacy). This information is

	discussed in consultation between the GP and participant, and the GP develops tailored clinical solutions to change the medication. - As part of usual care, two group sessions regarding dietary advice, lifestyles, and home hazards are advertised among the participants
5. Who provided	- Physiotherapists provided the exercise sessions and presumably also organized the provision of the protein-rich products - Speech therapists based in a rehabilitation unit provided the cognitive training sessions - Doctors from the research group and the GP's participants were involved in the medication review - the first initiated the process and the GP conducted the actual sessions with the participant and made the final decisions regarding medication change.
6. How	- In groups (15-16 participants), presumably face-to-face for the exercise and cognitive training - Presumably individually and face-to-face for the consultation with the GP to discuss medication
6b. How organised	The changes in medication would be recommended by the doctors involved in the research project, but the final clinical decision would be taken by the participants' GP.
7. Where	- In the primary care center - In Barcelona
8. When and how much	- Participants were 65 years old or older and were enrolled in participating primary healthcare centers. The opportunity to participate was offered to all patients meeting preliminary frailty criteria (Barber Questionnaire). Participants met at least 3 Fried modified frailty criteria and did not have very slow or rapid gait speed, or cognitive impairment. - Physical exercise was provided in a 60-minute session twice a week on non-consecutive days for 6 weeks (12 sessions). - The protein shake was provided at the end of each exercise session and daily for 1 month. - Cognitive training was provided in 90-min sessions twice a week for 12 sessions. - The medication review includes up to 3 consultations between the GP and the participant. - Overall the intervention takes 12 weeks.
9. Tailoring	- The medication review was tailored to the participant situation.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- Participants attended a mean number of 13 sessions out of 24 - The two sessions about dietary advice, lifestyles, and home hazards were attended by 52% of people

Cognitive training, nutrition and exercise

Table 115. Ng 2015[69] Physical Exercise + Nutritional Intervention + Cognitive Training: Combination intervention

1. Brief name	Physical Exercise + Nutritional Intervention + Cognitive Training: Combination intervention. Participants in this group underwent all three aforementioned interventions.
2. Why	Goal: To reduce frailty, and frequencies of hospitalisation, falls, and dependency in activities of daily living among community-dwelling older persons. Rationale: 1. Important to establish whether frailty among older individuals is reversible with nutritional, physical, or cognitive interventions, singly or in combination. 2. Physical exercise has been widely and consistently shown to improve physical outcomes such as body composition, muscle function, mobility and balance. 3. Most studies of nutritional interventions in older persons have not clearly demonstrated improvements in physical performance and functional ability. 4. Some preliminary studies indicate that cognitive training improved or maintained gait speed, balance and daily functioning of older adults.
3. What (materials)	For staff's implementing exercise programme: - The program was designed according to American College of Sports Medicine guidelines for older adults. Nutritional supplements provided to each participant (taken daily for 24 weeks): 1. 200-mL Fortisip Multi Fibre (Nutricia, Dublin, Ireland) 2. 1 capsule of iron and folate supplement (Sangobion, Merck, Kenilworth, NJ) 3. 1 tablet of vitamin B6 and vitamin B12 supplement (Neuroforte, R.B. pharmaceuticals, Chennai, India) 4. 1 tablet of calcium and Vitamin D supplement (Caltrate, Pfizer, Singapore) Used in the cognitive training sessions: 1. Tasks were designed to be similar to the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS). 2. Materials: paper and pencil tasks, power-point projections, and cognitive games and block puzzles - for participants to learn and practise recall verbal and visual information strategies, and tasks to enhance attention and processing speed. 3. Matrix reasoning exercises, mazes, and tangram-like games - to enhance participant's reasoning and problem-solving abilities.
4. What (procedures)	3 components: 1. Supervised progressive physical exercise intervention: First 12 weeks: - Supervised group sessions (twice a week) of moderate intensity physical exercise, to improve strength and balance - Participants were encouraged to continue daily individualized exercise assignments at home. 13-24 weeks:12 weeks of homebased exercises - content not specified. 2. Nutritional intervention: - Each participant was provided the supplements (a ready-to-drink, high energy, nutritionally complete, fibre enriched, oral nutritional supplement drink;

	vitamin B6 and B12 tablet, vitamin D and calcium tablet, and iron and folate capsule) to take daily for 24 weeks, to augment caloric intake by 20% and provide about 1/3 of recommended daily allowances of vitamins and minerals, and - Encouraged to gain 0.5kg per week. 3. Cognitive training intervention: First 12 weeks: intensive training weekly classes in group to practise verbal and visual information recall, to enhance attention, processing speed, reasoning and problem-solving abilities. 13-24 weeks: fortnightly booster sessions to review and practise the cognitive skills learned in the first 12 weeks. Access to usual care normally available to older people: - Standard care from health and aged care services, including primary and secondary level care from government or private clinics and hospitals - Community-based social, recreational, and daycare rehabilitation services.
5. Who provided	A qualified trainer: conducted and supervised the group sessions and exercises (physical exercise intervention). Interventional nurses: Administering nutritional supplements; details of arrangement and how instructions were provided to participants not specified (nutritional intervention). Psychologist trainer and nurse facilitators: Conducted the interactive training activities, who also provided one-on-one help when participants needing greater assistance (Cognitive training).
6. How	Physical exercise intervention: First 12 weeks: Face-to-face, in group of 8-10 persons 13 -24 weeks: home-based exercises; details not specified. Nutritional intervention: Interventional nurses administered supplements; details of methods, timing not specified. Cognitive training: All sessions were face-to-face, in group of about 10 persons.
6b. How organised	The Organisations and organisational system involved are not described. Deliverer inter-relations: The only known relation is that the psychologist trainer and nurse facilitators conducted the cognitive training sessions together. - Unclear of the arrangement and any interactions between the staff delivering the interventions. Deliverer's responsibilities: 1. Qualified trainer tailored and supervised exercises for individual participants. 2. Interventional nurses administered nutritional supplements. 3. Psychologist trainer and nurse facilitators conducted the cognitive training sessions. It is not known how the session schedule for the 2 types of training was coordinated for the 24 weeks for each participant. Standard care from health and aged care services, including primary and secondary level care, provided by the government or private clinics and hospitals; and community-based social, recreational, and daycare rehabilitation services.

7. Where	Locations: Singapore Venues of intervention: Not specified where group sessions and administering nutritional supplements took place Equipment: Physical exercise session: - Dumbbells, ankle weights, chairs, foam, and rocker board Cognitive training: - power-point projections, and assuming appropriate facilities (e.g. tables, chairs) for participants to perform the tasks. Usual care facilities and infrastructure for older people: - Health and aged care services, including primary and secondary level care from government, or private clinics and hospitals, - Community-based social, recreational, and daycare rehabilitation services.
8. When and how much	When starting intervention: 1. Potential participants were identified from among community residents in the southwest region of Singapore, from October 2009 to August 2012. 2. Prefrail and frail older adults were identified based on 5 CHS criteria. Nutritional supplements dose and duration: 1. 24 weeks 2. Daily dose: 200-mL Fortisip Multi Fibre (300kcal, 49% carbohydrates, 35% fats, 35% protein, 4.6g fibres); (supplement capsule and tablets) 29mg iron, 1mg folate, 200 mg B12, 200 mg vit B6, 200 IU vitamin D, and 600 mg of calcium. Physical exercise sessions: 1. Moderate, gradually increasing intensity 2. 90 minutes, 2 days per week for first 12 weeks in classes 3. exercises based on a single set of 8 to 15 repetition maximum (RM), or 60% to 80% of 10 RM, starting with <50% 1 RM involving 8-10 major muscle groups. 4. Daily exercises at home, details not specified. Cognitive training: 1. 2-hour weekly intensive training group sessions for first 12 weeks 2. 2-hour fortnightly booster group sessions for subsequent 12 weeks.
9. Tailoring	Physical Intervention: - The exercise was of moderate, gradually increasing intensity, tailored to participants' individual abilities Nutritional intervention: - Given the variability in individual energy requirements, participants were encouraged to attain the maximal tolerable energy intake to gain 0.5 kg per week
10. Modifications	Not mentioned
11. How well (planned)	Treatment adherence measured monthly by estimating the proportion of supplements consumed or training sessions completed, i.e. averaged for 3 treatments in the combination group.
12. How well (actual)	Mean level of compliance: 88% for combination group

Education

Table 116. Barenfeld 2018[17] Promoting Aging Migrants Capabilities (PAMC)

1. Brief name	Promoting Aging Migrants Capabilities (PAMC). Weekly group-sessions and an individual follow-up home visit. Linguistically adapted, evidence-based, person-centered group-based health-promoting intervention.
2. Why	Goals: to maintain older community-dwelling persons' independence and ability to maintain or improve different aspects of health and quality of life (e.g., dependence in ADL, self-rated health, life satisfaction and engagement in activities) and to have an impact on the consumption of care. Rationale: ...by using a person-centred approach, which focuses on the capability and resources of the participants ...by using peer learning ...based on previous research showing that health promotion interventions support older people in managing their daily life and their experienced health ...based on a RCT using a very similar intervention that showed growing evidence of good results
3. What (materials)	- Booklet in written and audio format (CD) containing different aspects of health self-management in Swedish and the participants' mother tongue (Finnish, and Bosnian/ Serbo-Croatian) - Medical referrals were provided if there was risk of adverse effects for participants - Possible documentation of adaptations to the intervention as a result of collaborative audits
4. What (procedures)	Education - self management 1. Group sessions: - The meetings started with the professionals introducing one of the booklet topics. - The participants then discussed the relevance of the topic to their life and how it would impact their ability to manage daily life. - Participants were encouraged to describe themselves and their capability in daily life. - Group discussion provided opportunity for exchange of experiences and peer-learning between the participants. - Information about the available usual care was also provided. 2. Training or rehearsal for psychological strategies: - In line with the person-centered approach, the people were encouraged to use their capability and needs to make decisions regarding their own situations. - Group discussions during the group meetings varied in accordance with the participants' experiences, needs, and resources. - A follow-up home visit gave each participant the opportunity to pose any individual questions that had occurred after the last meeting. As in usual care: - Access to community home help service based in needs assessment. May include meals on wheels, help with cleaning and shopping, assistance with personal care, safety alarms, transportation services, and home health care. - Access to rehabilitation and medical care

5. Who provided	- A multidisciplinary team including an occupational therapist, a registered nurse, a physiotherapist, and a social worker - An interpreter when needed (-There were other professionals involved in supporting activities, namely the steering committee, and in implementation activities, such as translators, but these did not provide the intervention directly) - Possible access to several medical and social care professionals accessible as part of conventional community health and social services
6. How	- In a group of 4 to 6, presumably face-to-face - Individually and face-to-face for follow-up session
6b. How organised	Implementing and organising the intervention: - Three sponsors: the Sahlgrenska Academy at the University of Gothenburg, the city of Gothenburg, and the region of Västra Götaland. - A steering committee with representatives of the sponsors and the two other parties in the organisation (research and operative group). Representation on the steering committee enables the three sponsors to play a role in agreeing the final study protocol and review of study progress. The sponsors had no role in the analyses and interpretation of study data or the decision to submit results. - Collaboration was initiated with reference groups of older persons from the target group living in the city in question to gather knowledge and provide guidance on how to adapt the original intervention protocol to older persons in the target population. - Training the professionals on the intervention programme and person-centered approach - Auditing of intervention delivery (and need for changes) in collaborative meetings Meeting arrangement: - The study protocol detailed information about the responsible professionals. Each of the 4 members of the multidisciplinary team conducted one session and one of the team members (social worker) was a leader who stimulated continuity and group processes. - Interpreter would be arranged. - The intervention promotes a partnership between participants and professionals As in usual care: - Medical care is predominantly performed in the public sector (80%), and healthcare costs are financed mainly through taxes and government grants. Cities and municipalities are responsible for services for older persons. - Access to home help is decided based on needs assessment
7. Where	Location: Sweden Venues/ settings: - It is not clear where the group sessions took place - At home for the follow up session - In an urban district in a medium-sized city with a high proportion of persons who were born abroad and whose socio-economic status is low - In the context of a publicly funded health care system that emphasises health-promoting and disease-preventive interventions and equal care for all and provides services to older people through municipalities

	- At home for conventional services home-help
8. When and how much	When started intervention: - People with ≥70 years, and who had migrated from Finland, Bosnia and Herzegovina, Croatia, Montenegro or Serbia to Sweden were invited to participate; - Living in urban district; - Started when participants were independent of formal or informal help in daily activities. Sessions: - Senior meetings in 4 weekly sessions of 1.5-2 hours - Individual follow-up once, 2-3 weeks after last group session
9. Tailoring	- Group discussions were tailored to participants' experiences, needs and resources - The individual follow up was tailored to areas of personal interest - Participants could choose their preferred language to communicate
10. Modifications	Not mentioned
11. How well (planned)	- Improved implementation was promoted in intervention development by consulting with target participants and deliverers - Deliverers were trained, as a strategy to promote fidelity - Adaptations to the protocol were possible but the process for this was devised a priori and involved collaborative discussion decision and documentation
12. How well (actual)	- The intervention was implemented in accordance with the protocol. - Fifty-seven percent of the participants in the intervention group (n = 32) attended all four meetings, while 16% (n = 9) attended three meetings, 9% (n = 5) two meetings, and 11% (n = 6) one meeting only. Four people attended no meetings.

Table 117. Gustafsson 2013[40] Senior meetings and home visit

1. Brief name	Senior meetings and home visit. Health-promoting and disease-prevention intervention, including multi-dimensional and multi-professional educational senior meetings and one follow-up home visit.
2. Why	Main goal: to prevent or delay deterioration and support aging in place Other goals: - to prevent frailty, activity limitations and morbidity - to provide social and physical environment support - to affect life satisfaction and consumption of care Rationale: ...based on previous research showing that effective programs aim both at promoting health and preventing disability ...based on previous research showing that group education is a good model for making people change their risk behaviors and increases participants' knowledge, self-efficacy and awareness of their questions and needs ...based on the ability of a multidisciplinary team to better deal with the complexity of frailty
3. What (materials)	- Booklet produced for group meetings including health and self-care topics - As part of usual care: safety alarms depending on request and needs assessment

4. What (procedures)	- Developing the intervention with professionals and elder representatives, including meetings to discuss aspects such as logistics For participants: - Providing health-related information and advice to facilitate independent living in group sessions with a multiprofessional team. Topics included medication, and physical activity, for example, and the role of participants as experts was emphasized. - The provision of health-related information and advice was followed up in an individual home visits tailored to participants needs - Sharing and discussing personal experiences related with the themes of each session For staff: - Meetings were held throughout the study period in order to identify and deal with unexpected problems As part of usual care: - Assessment of needs following request for municipal help - Accessing home help, such as meals on wheels and safety alarms, home medical care and primary health care clinic
5. Who provided	An occupational therapist, a registered nurse, a physiotherapist and a qualified social worker planned and carried out the specific education sessions. The individual home visit that followed was provided by any of these professionals. The staff that conducted the groups was trained in group theory and practice. As in usual care, at participant initiation: Presumably social and medical care professionals working in the municipality services.
6. How	In groups of 4 to 6 participants, presumably face-to-face for senior meetings Home visit was presumably individually provided and face-to-face Usual care may have included a variety of services such as home help and medical services that are presumably provided individually and face-to-face.
6b. How organised	- In senior meetings, professionals acted as enablers and participants as experts - The multidisciplinary team members planned the group sessions together, being responsible for their specific themes. One of the members was present in all sessions to provide continuity. - The staff was employed by the urban districts where the interventions took place - The research and professionals team collaborated closely in developing intervention and its implementation - The access to usual home help and medical services requires that the participants initiate the request and undergo an assessment of needs.
7. Where	- Individual visit at home - The location of the group sessions is not specified - In two urban districts of Gothenberg, Sweden - Access to home help and medical care under participants initiation, provided at home or primary care clinic as part of usual care
8. When and how much	- Started when participants were independent of help from another person in ADLs and pre-frail - Four weekly group sessions, for approximately 2h including a coffee break - One follow-up home visit 2 or 3 weeks after the end of the group sessions
9. Tailoring	- The content of the senior meetings was tailored with members of the population of interest to match their preferences - Participants' experiences were a central element of the senior meetings

	- The home visit was tailored based on participants' needs.
10. Modifications	Not mentioned
11. How well (planned)	Several activities can be seen as strategies to promote the fidelity of the intervention: - Elder representatives and professionals participated in developing the intervention - A principal professional attended all four meetings in each round of the intervention to provide continuity
12. How well (actual)	- Ninety-seven percent of the participants in the senior meetings (n = 165) attended all four meetings, whereas 2% (n = 4) attended three meetings, and 1% (n = 2) attended two meetings - No known organized co-intervention took place and no adverse events were reported during the implementation

Table 118. Lood 2015[58] Senior meetings and home visit

1. Brief name	Senior meetings and home visit. A person-centred approach to health promotion.
2. Why	Goal: to (1) provide an arena for peer learning and discussions on different tools for health promotion in everyday life during the ageing process, and (2) prevent or delay dependence in daily activities, health decline, and frailty, for ageing persons who have migrated to Sweden, and in a different socio-economic context Rationale: ...by using a person-centred approach, which focuses on the capability and resources of the participants ...based on a RCT using a very similar intervention that showed to impact health-related outcomes associated with frailty ...by taking into account the specificities of people born abroad and who have migrated to Sweden from the Balkan Peninsula and Finland
3. What (materials)	- Booklet professionally translated to Finnish, and Bosnian/ Serbo-Croatian
4. What (procedures)	To develop the intervention: - Adapting the intervention with the input of deliverers, researchers, project leaders and reference groups (older people from the target participant group) to suit ageing people who have migrated to Sweden - Translating the booklet material For participants: - Providing health info and advice to facilitate independent living in group discussions and in an individual follow-up session - Engaging interpreters in activities provision when needed - Sharing experiences and learning in peer groups As in usual care: Access to conventional elderly care from the municipality, that is, home-help services or home medical care based on each person's needs
5. Who provided	- A multidisciplinary team including an occupational therapist, a registered nurse, a physiotherapist, and a social worker - An interpreter when needed

	(-There were other professionals involved in adapting the intervention namely project leaders for the research approach and external researchers when needed and translator) - Possible access to several medical and home-help professionals accessible as part of conventional community services
6. How	- In a group of 4 to 6, presumably face-to-face - Individually and face-to-face for follow-up session
6b. How organised	- Participants and health professionals (OT, physio, nurse, social workers) established a partnership in the senior meetings - Conventional care was organized by the municipality
7. Where	- It is not clear where the group sessions took place - At home for the follow up session - In Angered, Gothenburg, Sweden - In a suburban district of the mid-sized city in Sweden, one with a low general income level and a large proportion of people who are born abroad. - At home for conventional home-help and home medical care part of usual care
8. When and how much	- People with ≥70 years, and who had migrated from Finland, Bosnia and Herzegovina, Croatia, Montenegro or Serbia to Sweden were invited to participate - Started when participants were independent of formal or informal help in daily activities - Senior meetings in 4 weekly sessions - Individual follow-up once, 2-3 weeks after last group session
9. Tailoring	- Group discussions were tailored to participants' values, experience and choices - Participants could choose their preferred language to communicate - Provision of conventional care services was tailored to person's needs
10. Modifications	Not mentioned
11. How well (planned)	- Several goals were established to assess the feasibility of the intervention, taking into account research about cultural and linguistic diversity and the evaluations of the original protocol - These goals included the attendance to senior sessions was registered and a specific goal was established: more than 50% should participate in at least 2 senior meetings
12. How well (actual)	- All participants attended at least two of the senior meetings - 12 participants (86%) attended all four senior meetings - The remaining two participants attended three senior meetings

Education and multifactorial-action

Table 119. Gustafsson 2013[40] Preventive home visits

1. Brief name	Preventive home visits. Health-promoting and disease-prevention intervention based on preventive home visits.
2. Why	Main goal: to prevent or delay deterioration and support aging in place Other goals: - to prevent frailty, activity limitations and morbidity - to provide social and physical environment support

	- to affect life satisfaction and consumption of care Rationale: ...based on previous research showing that effective programs aim both at promoting health and preventing disability ...based on previous research indicating that preventive home visits reduce the disability burden if based on multidimensional assessment
3. What (materials)	- Protocol that guided the intervention - Fall prevention checklist - Brochure with information on the Swedish legislation and support on driving - Written information and advice about municipality activities (e.g., local meetings and physical exercise groups), including a local lifestyle magazine - As part of usual care: safety alarms depending on request and needs assessment
4. What (procedures)	- Developing the intervention with professionals and elder representatives, including meetings to discuss aspects such as logistics For participants: - Providing health-related information and advice to facilitate independent living in a single home visit, including fall prevention and information about the services available. These recommendations are presumably based on an assessment of the person, which includes a fall risk assessment. - The provision of information about several health topics seems to be intended for all, within a pre-structured plan. - Providing a physical exercise program - Arranging registration in available group activities (seems to be selective). For staff: - Staff training - Meetings were held throughout the study period in order to identify and deal with unexpected problems - Regular staff meetings were held to maintain the quality and standardization of the home visits As part of usual care: - Assessment of needs following request for municipal help - Accessing home help, such as meals on wheels and safety alarms, home medical care and primary health care clinic
5. Who provided	An occupational therapist, a registered nurse, a physiotherapist OR a qualified social worker provided the single home visit. As in usual care, at participant initiation: Presumably social and medical care professionals working in the municipality services.
6. How	Home visit was presumably individually provided and face-to-face Usual care may have included a variety of services such as home help and medical services that are presumably provided individually and face-to-face.
6b. How organised	- The care planning presumably involved in the home visit was unidisciplinary - There is no evidence that the home visitor played a care coordinating role - The staff was employed by the urban districts where the interventions took place - The research and professionals team collaborated closely in developing intervention and its implementation - The access to usual home help and medical services requires that the participants initiate the request and undergo an assessment of needs.
7. Where	- At home

	- Access to home help and medical care under participants initiation, provided at home or primary care clinic as part of usual care
8. When and how much	- Started when participants were independent of help from another person in ADLs and pre-frail -One home visit lasting 1h30-2h
9. Tailoring	The participants were given the opportunity to further elaborate in certain elements of the intervention protocol
10. Modifications	Not mentioned
11. How well (planned)	Several activities can be seen as strategies to promote the fidelity of the intervention: - Elder representatives and professionals participated in developing the intervention - Regular staff meetings were held to maintain the quality and standardization of the home visits
12. How well (actual)	- 100% of participants participated in the intervention - No known organized co-intervention took place and no adverse events were reported during the implementation

Education and risk-screening

Table 120. Monteserin Nadal 2008[64] Geriatric education intervention after a comprehensive geriatric assessment (CGA), which served as a screening

1. Brief name	Geriatric education intervention after a comprehensive geriatric assessment (CGA), which served as a screening. Patients at non-risk of frailty were provided with recommendations about healthy habits and adherence to treatment in group sessions, while patients at risk of frailty were visited individually by a geriatrician in the primary care setting.
2. Why	Goal: to reduce morbidity and mortality and reverse the risk of frailty Rationale: - by emphasizing the reduction of the risk factor of frailty in a multidisciplinary approach - based on a review of literature that showed that geriatric evaluation was effective in improving survival and function
3. What (materials)	- The assessment included standardized instruments, namely: Charlson, Barthel and Lawton index, 5-Yesavage Depression Scale, Short Portable Mental Status Questionnaire (Pfeiffer's test), Mini-Nutritional Assessment Short Form, Gijón Social Scale - For half the sample at risk of frailty there was a health report added to the medical record.
4. What (procedures)	- Multidomain assessment, including aspects related with nutrition, mood, physical and social domains, among others. - The assessment was used to screen for frailty based on clinicians agreed criteria and to inform the education sessions. - All participants received education, delivered in group for the participants not at risk, and individually for those at risk (51/49%). The education included topics related with health promotion, disease prevention and self-care, among others. The individual education was presumably more tailored and could include information about drug therapy, environmental modification and aids, among

	others. The individual recommendations were added to the participant's medical record. - Multidomain assessment, including aspects related with nutrition, mood, physical and social domains, among others. - The assessment was used to screen for frailty based on clinicians agreed criteria and to inform the education sessions. - All participants received education, delivered in group for the participants not at risk, and individually for those at risk (51/49%). The education included topics related with health promotion, disease prevention and self-care, among others. The individual education was presumably more tailored and could include information about drug therapy, environmental modification and aids, among others. The individual recommendations were added to the participant's medical record. - For participants identified as at risk specific recommendation in a variety of areas were also developed by a geriatrician and included in the participant's medical record
5. Who provided	- Trained nurses provided the initial assessment and the group education session - A geriatrician provided the individual education session
6. How	- Presumably face-to-face, in group (20 people or less) or individually
6b. How organised	- The care planning explicitly mentions medication changes but only for the selected participants that were referred for multidomain assessment
7. Where	- In Barcelona - The initial assessment and the individual education, and presumably the group session, took place in the primary care centre.
8. When and how much	- Started when participants were 75 years or older and were enrolled in a primary health care centre - The multidomain assessment session was presumably one session - The education took one session of 45 minutes to the non-frail subgroup of participant and over 30 minutes to the frail subgroup of participants.
9. Tailoring	- The mode of delivery of the education sessions was tailored based on the initial assessment - frail participants received education in an individual session, while non-frail participants were invited to a group session. The individual session was more tailored to the contents that were relevant for each participant than the group session. A patient was considered at risk for frailty when at least two of the following conditions were met: age 85 years or older, 9 or more points in the Gijón Social Scale, 2 or more points in the Pfeiffer test, 2 or more points in the Charlson comorbidity index, 1 or more points in the Yesavage Depression Scale, 91 or more points in the Barthel index, 12 or more points in the Mini-Nutritional Assessment Short Form, polymedication (higher than the mean number of drugs taken by the study population), more than 1 fall in the last 6 months and suffering daily urinary incontinence in the last 6 months.
10. Modifications	Not mentioned
11. How well (planned)	- The nurses that performed the assessment and the group sessions received training which presumably supported a consistent intervention delivery
12. How well (actual)	- 38.2% did not participate in the individual/group education session

Education, exercise, multifactorial-action and review with medication review and self-management

Table 121. Faul 2009[99] Assessment and Telehealth Intervention Group (ATIG)

1. Brief name	Assessment and Telehealth Intervention Group (ATIG). geriatric assessment services, brief self-management care plan intervention, telephone support
2. Why	Goal: to complement traditional care and follow the self-management principles outlined in the conceptual framework in order to reduce older adults risk of becoming frail and losing their functional independence prematurely Rationale: ...by informing and empowering older adults and providing interaction with prepared, proactive interdisciplinary practice teams in dealing with aging and chronic illness ...based on the self-efficacy perspective of social cognitive theory (Bandura, 1986, 1997)
3. What (materials)	- GEMS client website (with access to relevant information) - Various assessment tools such as: General Assessment Questionnaire, modified from the Guide to Physical Therapist Practice; American Physical Therapy Association, 2001; an Ecomap, and a Genogram; Sheafor, Horesjsi & Horesjsi, 1997, Physical Therapist Patient Management Systems Review - A written record of the assessment and care plan added to the medical file - Scrips for the phone calls - Handouts about health-related topics - An exercise software program
4. What (procedures)	- Providing a comprehensive assessment including functional status, physical mobility, mental health, environmental barriers at home. - Medication was assessed and the information was shared with the primary care physicians for necessary changes - Providing a care plan tailored the person's assessment, needs and preferences which selected among actions such providing advice about available community resources or how reduce fall hazards around the house - Providing an individualized physical exercise plan which is demonstrated to the participant - Providing information about chronic versus acute illness, self-management of chronic illnesses in general, self-management of both pain and fatigue, the importance of exercise, and overcoming common barriers to appropriate medical care - Providing routine follow-up on the care plan in 2 phone calls
5. Who provided	Interdisciplinary team consisting of a physical therapist professional, a physical therapist student and a social work student. All the intervention providers received training and supervision.
6. How	- Individually and face-to-face based on home visiting format - By telephone - Presumably the intervention deliverers used goal setting techniques such as breaking down a major goal in smaller realistic goals
6b. How organised	- The care plan was developed based on the contribution of the interdisciplinary team, including physical therapists and social workers, professionals and students

	- The physical therapy students were accompanied by a professional in the visits due to professional requirements - There was an effort to reconnect or forge new partnerships with community organizations - The assessment and care plan were shared with the primary care provider of the participant by adding the information to their medical file
7. Where	- At home - Louisville, Kentucky
8. When and how much	- Started when participants were 65 years+, literate, had a permanent address (excluding nursing homes), a primary care physician, no acute medical or mental health needs, nor any recent (past 6 months) major medical event (e.g., heart attack, stroke, major surgery) and not receiving home health care. - 3 home visits over a month, the first took 1 hour and the second took 2 hours - 8 phone calls
9. Tailoring	- The care plan was tailored based on the participants' assessment and their needs and preferences - Physical exercises were also tailored to the participant
10. Modifications	Not mentioned
11. How well (planned)	The delivery of the intervention as planned was supported by the training and supervision of the professionals involved
12. How well (actual)	- The majority of the calls focused on generic issues related with chronic illnesses rather than the planned focus on self-management

Table 122. Leveille 1998[55] Health Enhancement Program

1. Brief name	Health Enhancement Program. A community-based disability prevention, chronic disease self-management program, designed to promote the health and functioning of community-dwelling elderly persons
2. Why	Goals: to reduce risk factors for disability, especially through increased physical activity; to promote social activation; and to enhance medical management and self-management of chronic illness. Rationale: Based on the Buchner-Wagner model of disability, wherein predictors of disability can be modified to reduce susceptibility to functional decline. Based on previous research showing health promotion and exercise programs in senior centers are well accepted.
3. What (materials)	- Reports about patient participation sent to their primary care physician - Self-management workbook - Referrals to service center and community programs about reducing alcohol consumption and smoking - Nutrition tip sheets developed with registered dietitians - Referrals to service center social worker about depression symptoms
4. What (procedures)	For participants: - Multidomain assessment by geriatric nurse based on primary care info and baseline assessment - Development of a "health action plan" in session with patient, according to needs, goals and preferences - Arranging referrals for substance cessation and depressive symptoms support - Nurse periodically reviews progress in care plan

	- Depressive symptoms related sessions - Substance cessation programs - Peer support - Nutritional education - Physical training, including different types of exercises (e.g., swimming, walking, dancing, etc) - - Individual counselling on chronic illness self-management - Chronic illness self-management course combining peer support, health promotion information and disease self-management concepts For staff: - Recruitment and training of mentors for peer support
5. Who provided	- Geriatric nurse practitioner developed assessment, care plan, arrangements and review - Volunteer health mentors provided peer support - Trained lay leaders delivered the self-management program - Primary care physician reviewed medication with the nurse - Registered dietitians contributed to the nutritional advice - Social worker supported people with depressive symptoms
6. How	- Individual and group face-to-face sessions. Including face to face follow up visits. - Telephone contacts for progress review
6b. How organised	Institutional level: - Partnership with Group Health Cooperative of Puget Sound (GHC), a health maintenance organization based in Seattle, and Pacificare, another large health care organization in the Pacific Northwest, and Northshore Senior Center, were the intervention took place. - GHC and Pacificare provided access to populations of community dwelling older adults with health issues; - Northshore provided the physical site for the intervention, organized and administered the LFP and the chronic disease self-management classes, and recruited and trained a cadre of mentors. - Investigators from GHC and the HPRC (Health Promotion Research Center at the University of Washington) worked with Northshore to design the intervention - Evergreen Healthcare, a hospital in the area, partnered with the Northshore Senior Center to help recruit Pacificare physicians who were practicing as part of the Evergreen Physicians Group and their patients. Evergreen Healthcare also provided funding that partially supported the GNP's salary. Individual level: - The GNP contacted frequently with the participant's physician, receiving and sending health and participation-related information - The GNP collaborated with the physician in the medication review - The GNP produced referrals to substance use programs and the social worker - Self management group classes were conducted by trained lay leaders - The care planning explicitly mentions medication changes
7. Where	- At the senior center - At home - Seattle, Washington

8. When and how much	- Started after referral from primary care provider, based on being on treatment for one or more chronic conditions (dementia and terminal disease excluded). - Visits with nurse varied 1 to 8 (3 on average), and phone calls 1 to 22 (9 on average) - The self-management group sessions occupied 2 hours weekly for 7 weeks - One of the exercise activities, the endurance, strength and flexibility program met 3 times a week
9. Tailoring	- Health care plan tailored to identified needs, and participants' goals and preferences - Referrals based on identified needs - Exercise setting adapted to participants' preference - Exercise modality chosen based on participants' preference
10. Modifications	Not mentioned
11. How well (planned)	- A home alternative to group exercise activities was suggested to maximize compliance to physical activity
12. How well (actual)	- The self-management sessions were attended by 35 participants - Participants were reasonably willing to attend senior center programs, but participation in the more rigorous exercise programs was lower than expected. - The degree of participation in exercise, self-management classes and mentoring was not recorded

Education, exercise, multifactorial-action and review with self-management

Table 123. Holland 2005[47] Health Matters- community-based health coaching program

1. Brief name	Health Matters- community-based health coaching program. A menu of disability-prevention strategies, with health coaching, patient education on self-management of chronic illness, and fitness
2. Why	Goals: 1. empower the client to be effective at chronic disease self-management, 2. encourage health-promoting activity, and 3. teach the client and their family how to approach their physician with questions about the management of their condition, --To prevent disability, improve health status, and reduce healthcare use. Rationale: - Based on a conceptual model by Buchner and Wagner (1992; Wallace *et al.*, 1998) that describes disability as an outcome of frail health, with frailty being a state of reduced physiological reserve associated with increased susceptibility to disability. The model further proposes that some proportion of frailty is preventable through the identification and monitoring of risk factors and prevention programs geared to reversing physiological loss (e.g., exercise). - It is modelled after the Health Enhancement Program and Senior Wellness Program of Seattle, Washington.
3. What (materials)	Used by or sent to intervention providers: - Intervention protocols that guided referral to some activities - Referrals from nurse to certain activities such as social worker To send to healthcare providers:

	- Notices to Primary Care Physician (PCP) about participant's desires to attend fitness classes - Letters about progress of participants sent to PCP Provided to the participants: - PCP notifications to patients to prevent participation in inappropriate fitness classes - Health action plans and copies of these sent to PCP in mail - Newsletter containing information about all available activities and their schedules - (during exercise classes) Ankle and wrist weights for strength exercises - Book "Living a Healthy Life With Chronic Conditions" (Lorig *et al.*, 2000) - Catalogue of relevant community-based programs and health plan offerings given to participants - Fliers about the intervention classes
4. What (procedures)	Multidomain assessment, planning and arranging: - After the initial health assessment, the nurse health coach (NHC) developed a Health Action Plan with the participant. - The Health Action Plan provides a contract wherein both the participant and NHC take responsibility for the next steps. According to the health assessment, areas where health-related behaviour change could benefit the participant are identified. The Plan incorporates fitness and health education goals, identifies classes the participant can join, along with program and service referrals, e.g., social worker Reviewing and adjusting of the health care plan by nurse in regular contacts, also providing motivation and support, and monitoring adherence and progress Available Health Matters programmes and activities included: - Physical exercise program in regular classes including aerobics, strength training, balance training, and flexibility exercises - Provision of health-related information (1) in geriatrician led sessions including themes such as fall prevention, sleep, medication, depression, and accessing community resources and (2) as needed with the nurse - Teaching about contacting the PCP by nurse - Teaching about medication use by nurse - Providing information about accessible resources through the intervention program and in the community - Providing self-management skills classes focused on patient self-advocacy and health behavior change by problem solving and goal setting by two leaders, one of them a peer. - Counselling on mental-health related issues by social worker, for referred participants with higher anxiety and depression-related symptoms - Wellness related classes in some locations Support to the nurse and social worker: 2 consulting geriatricians were available to assist in understanding medical and psychiatric aspects of health care planning, and guiding any necessary interactions with other physicians. As in usual care: - Access to usual medical care by PCP and other insured medical services - Access to community resources including activities like Tai Chi, water aerobics, nutrition programs, and health-focused programs (e.g., diabetes, mental health)

5. Who provided	- Nurse health coaches conducted assessment, planned formulation arrangements and reviews to the plan and provided information about health conditions, medication and how to communicate with PCP - Social worker provided counselling on mental health related issues - Geriatricians provided support to nurses and social worker and conducted health related sessions for participants - Certified fitness instructors taught the physical exercise program - Two leaders at a time, including a lay person who is living with a chronic condition, conducted the self-managements skills sessions - Primary care physician provided medical care as usual, and to review and discourage any inappropriate enrolment in non-intervention physical exercise programs
6. How	- Individually and face to face for initial assessment and some counselling activities - In group and face-to-face in classes that included physical exercise, self-management skills, health related info provision - By telephone and email in reviewing of health plan by nurse - Presumably individually and face to face to PCP medical usual care. - Community accessible activities include group activities.
6b. How organised	Unidisciplinary care planning, without care coordination, with regular review: - The Health Action Plan was developed by the nurse health coach (NHC) together with the participant. - The NHC might consult the available geriatricians about the action plan when required. - The nurse sent health action plans to the PCP, and referrals to other professionals. Staffing: - One registered nurse responsible for 160 to 175 program participants - A staffing ratio of 0.5 full time equivalent (FTE) social worker per 1.0 FTE nurse health coach was budgeted for the program. - Consulting geriatricians were contracted to provide approximately 3 to 5 hours of consultation and classes per month but did not provide medical care to program participants Organisations, geography and finance of the Health Matters intervention: - The program was developed in consultation with the SWP, but it was independently operated by Eskaton a senior services agency in Sacramento, CA - “The California Public Employees Retirement System (CalPERS), the Long Term Care Group […], and the three major Medicare health plans available to CalPERS members in the Sacramento area (Kaiser, Health Net, and PacifiCare) [worked together] to develop and test a community-based disability prevention program” - Funded by $1 million grant from the California HealthCare Foundation. As in usual care: - Coverage for health services under their regular health maintenance organization benefit contracts
7. Where	Location: Sacramento, California, USA Venues: - Senior and community centers - Two churches and a senior housing complex

8. When and how much	- Participants were members CalPERS health plan, with one or more chronic conditions and less than 2 ADLs compromised that self-selected to participate following a mail invitation - Physical exercise sessions occurred 3 times a week for an hour - Self management course included 6 sessions - Geriatrician sessions about health topics occurred twice a month - Wellness-related classes occurred once a week - In-person review of the health plan occurred after 6 months - Phone review contacts at least quarterly
9. Tailoring	- Individualized health plan tailored based on previous assessment and participants' input - Referrals to health activities tailored based on need - Physical exercise tailored to participants' ability - Additional information about accessible activities provided as needed
10. Modifications	Not mentioned
11. How well (planned)	- Attendance to physical exercise and health related sessions was registered - The program's administrative system tracked the priorities put into the health action plan and the types of activities - Fitness classes that were not part of the intervention were discouraged - Adherence to health plan was encouraged and monitored by regular contact provided by nurses - Location of physical exercise sessions was designed to maximize proximity with participants - To encourage participation information about ongoing activities was regularly sent to participants
12. How well (actual)	- Everyone in the intervention group received the programme's monthly newsletter and an average of 11 hr of nurse coaching during the year. - About three-quarters claimed to have read a recommended book, Living A Healthy Life With Chronic Conditions (Lorig *et al.*, 2000) - About 30% of the intervention group attended health education classes, of which 40% only attended one class - Participation in classes was primarily done by those whose health action plan priorities related to depression, anxiety, or weight: "Battling the Blues" (n = 20 attended at least one session), a three-part series called "Do I Worry Too Much?" (n = 22), and a monthly weight loss information and support group (n = 19). Participation in the other classes was generally low. - The use of social workers was low among those in the Health Matters intervention group (8.9%), but about half (n = 22) of those with symptoms of depression or anxiety had at least one social worker visit. - More than 90% of participants were in exercise programmes at 12 months, and 30% had participated in one or more condition management classes.

Education, multifactorial-action and review

Table 124. Profener 2016[73] Preventive home visits

1. Brief name	Preventive home visits.
2. Why	Goal: to support an independent lifestyle at home and help avoid moving the elderly to inpatient care

	Rationale: - Based on the Albertinen home visit assessment program - Domains of the assessment were selected to be quick and feasible and to provide early detection of risk/minor impairments. - A multidimensional procedure is expected to be preferable to identify risks because the need for assistance is understood as the results of multifactorial causes - Frailty corresponds to characteristics that will make people specifically suitable and motivated to receive preventive home visits
3. What (materials)	- Several validated questionnaires were used as part of the multidomain assessment - A score system was developed to analyze the results of the assessment - A short written report on the assessment results and recommendations were presumably sent to the participant's GP (described as part of the original intervention, unsure the extent to which it was provided in the current study)
4. What (procedures)	- Multidomain assessment at home followed by a tailored care plan - Education specially focused on nutrition, physical activity and social participation was provided - The recommendations were reinforced in a 2nd visit at 6 months. - Community services were contacted to initiate diverse types of care as needed by the participant.
5. Who provided	A nurse and social worker, who had received specialized training, provided the home visits. It is not clear if participants were visited by both professionals, as a team, or only one of them.
6. How	Presumably face-to-face and individually based on home visit format.
6b. How organised	- The care plan was discussed in a multidisciplinary team that included a nurse, social worker and a GP (unclear if this is the participant's GP, but it is likely that it is). - The care planning mentions medication assessment and a drug plan but this is explicitly about drug compliance rather than medication change - Contacts with relevant community services were initiated following care planning - It is not clear if the review at 6-months is done by the same provider.
7. Where	- At home - In Hamburg, Germany
8. When and how much	- Participants were enrolled in this study after having enrolled in the LUCAS cohort study and being assessed as frail on the LUCAS function index, based on the LUCAS questionnaire. This questionnaire included some questions of the HRA-O and questions on psychological items, physical and mental activities, health literacy, income and use of urban activity space. Participants were 60 years old or older. - 2 home visits, 6 months apart were provided.
9. Tailoring	A score system was used to determine the level of support needed based on the assessment (from primary to tertiary care). At the same time, a multidisciplinary team collaborated in finding appropriate solutions for each participant.
10. Modifications	Not mentioned
11. How well (planned)	- The providers received training and supervision, which should have supported intervention fidelity

	- The second follow-up visit was intended to check adherence to recommendations
12. How well (actual)	- 36.8% of participants accepted to receive preventive home visits - Around half of those who rejected the visits mentioned impaired health or mental health as a reason.

Education, multifactorial-action and review with medication review

Table 125. Newcomer 2004[68] Enhanced Case Management (ECM)

1. Brief name	Enhanced Case Management (ECM). A prevention-oriented case management program including annual health screening, appointment monitoring, disease education, self-management support, and ongoing care coordination.
2. Why	Goal: - to provide a timelier and more comprehensive care, improve patients self-reported health and mental health status (rates of depression and social isolation), and reduce preventable health care use (hospital and emergency room) and nursing home admissions Rationale: - By proactively identifying and resolving self-management difficulties and by improving awareness and access to preventive health plan and community services - By promoting appropriate physician use - Based on previous research showing a reduction in health care expenditures with primary care coupled with case management
3. What (materials)	- Standardized risk-screening questionnaire including health status, demographics, service use, activities of daily living, income and access to transportation followed up as necessary by additional assessments - Letters from case managers to PCPs summarizing issues identified in screening - Geriatric depression scale (for some participants only) - Sharp appointment and encounter electronic data systems including medical charts and administrative data - Case manager electronic charts - Shared Language for Enhanced Documentation (SLED), an electronic record system and standard dictionary for case management procedures, interventions and outcomes - Medical and psychosocial referrals - Educational materials according with needs - Advance directives sent to PCPs (by participants, following education) - Diabetes checklists sent to PCPs (by participants, following education)
4. What (procedures)	Multidomain assessment, planning and arranging: - Risk assessment including health status, activities of daily living and socioeconomic information - Care planning and management including referrals (but not for usual care disease management programs for heart failure and diabetes), regular monitoring by contact with patient and by electronic system records Actioning: 1. Education/ information provision for self-management: - Coaching for self-empowerment, and education

	- Increasing communication from participants to PCPs, including presenting advance directives and diabetes checklists. 2. Multifactorial actions using the Standardized Language for Case Management (SLED) protocols, which includes 11 areas of needs: 1. Administration, 2. Cognitive/affective, 3. Disease, 4. Financial/legal, 5. Functional, 6. Home Environment/safety, 7. Lifestyle, 8. Medication, 9. Nutrition, 10. Social cultural, 11. Utilization
5. Who provided	- Nurse case manager - Primary care physician, as in standard care - Presumably other professionals that are part of senior community services - Home health specialists who provided medically necessary care and collaborated with case manager (in selected cases) - Presumably other specialists for whom participants were referred to as needed.
6. How	- Risk screening conducted by mail in the first instance - Risk screening conducted by telephone in selected cases in which there was no information or the information was incomplete - Risk screening conducted at home in selected cases in which there were concerns about the caregiver capability and/or critical safety deficits - Regular telephone contact between case manager and caregiver - Mail contact when telephone contact was not possible - Presumably individual face to face contact with PCP (as part of usual care) and specialists accessed through case manager referral
6b. How organised	Unidisciplinary care planning 1. Care planning and reviews were conducted by the case managers. 2. Internal multidisciplinary team coordination only: - The case managers kept the primary care physicians informed about actions involving their patients during the intervention. - The case managers made referrals to services when necessary. - ECM coordinated with but did not replace the medical groups' hospital discharge planning. Medication management - Medication adherence, an integral part of the assessment, could be monitored only through patient reporting during the periodic contacts and through patient records. - If polypharmacy or other irregularities with the medicals list were observed, the case manager telephoned the PCP and/or specialists to reconcile the medication list for proper dosing and frequency of administration. Implementation/ setting up - The ECM implementation was funded by the California Healthcare Foundation; in collaboration with PacifiCare/ Secure Horizons (PCSH) and the University of California-San Francisco. - Implementation was liaised between the project team and participating medical groups.
7. Where	- Risk screening conducted at home for a very small percentage of the participants (1%) - Presumably in specialist and community care contexts to which participants were referred to as needed by the case manager - San Diego, US

	- Based on a collaboration among Sharp HealthCare of San Diego, California, three affiliated medical groups, PacifiCare/Secure Horizons and the University of California-San Francisco
8. When and how much	- Started when participants were enrolled in health insurance program for at least 1 year; and at high risk for negative outcomes (80 years old or older or age 65 or older with at least one chronic condition) - Daily or weekly telephone contact in stages of more need - Monthly and quarterly telephone contacts in monitoring stages - Average of 7.7 hours/year of contact with case manager
9. Tailoring	- Risk assessment conducted by mail, telephone or at home according with individuals' circumstances - Additional assessment of depression and other conditions (e.g., cognitive impairment) when risk was detected - Frequency of contact and monitoring was tailored according with illness complexity, social support, utilization, and willingness to engage as set forth in the care plan - Care planning was influenced but not determined by protocol, being adapted case by case by the case manager - Participant, caregivers and family members were involved in care planning as needed - Educational materials content was tailored to participants' needs
10. Modifications	The care protocols were refined throughout the project
11. How well (planned)	- Treatment adherence was monitored by case managers based on physician use and scheduled appointments - Participants who were not keeping or scheduling the expected appointments were contacted by the case manager and the reasons for missed appointments were assessed
12. How well (actual)	- 42 participants who repeatedly missed appointments (or those whose PCP requested contact) were contacted by case managers

Table 126. Ploeg 2010[72] Preventative primary care outreach intervention

1. Brief name	Preventative primary care outreach intervention. Preventive primary care outreach is defined as a proactive, provider-initiated care above and beyond demand led routine care, provided in a community primary care setting.
2. Why	Goal : 1. The goal of the intervention is to identifying people at risk and provide early intervention to help to prevent or delay functional decline. To promote independence and control health and social costs. 2. To increase quality adjusted life years, higher functional status and self-rated health, lower mortality, and similar costs of health and social services Rationale: The intervention compared to usual care will result in higher health related quality of life. Also a reduction in mortality.
3. What (materials)	Provided materials : 1. Health promotion materials provided to participants covering topics including ; falls prevention, safe drug management, nutrition, upper and lower body strengthening exercises, colorectal screening, and influenza vaccinations.

	2. Some patients were assisted in obtaining bathroom equipment and mobility aids. 3. Referrals made to community health and support services Materials used as part of the delivery: 1. Following each follow up the nurse provided a card in the patients home outlining their interventions and any actions required (e.g., follow up with family physician). 2. Physician communication form faxed to the patient's family physician highlighting any problems and issues tackled by the nurse and also follow up actions. 3. Resident assessment instrument
4. What (procedures)	For the participant : 1. Initial comprehensive assessment (using the resident assessment instrument). 2. Health promotion and education (on topics such as chronic disease management). 3. Nurses encouraged participants to take part in their health care 4. Referral to community and health services (such as home care services, meals on wheels and outpatient clinics). 5. Nurses encouraged participants to adhere to the recommendations and monitored this through follow up home calls and home visits. For the staff : 1. Collaborative care planning: Worked closely with the participants family physician to implement the plan of care. This is by reporting any clinical assessment protocols that were triggered by the participant during the visit and any nursing actions as a result of this. Highlighting any follow up visits required by the family physician.
5. Who provided	The intervention was provided to patients of family physicians who were members of primary care networks in Hamilton, Ontario, Canada. 1. Three experienced home care nurses delivered the intervention. 2. The nurses worked closely with the family physicians 3. Also worked with other professionals such as pharmacist, dietitian, and physiotherapist) to implement the plan of care. 4. Research assistant. Intervention provided by a multidisciplinary team. Number of providers : 5.
6. How	The intervention is primary delivered to the participants in their home by nurses (face to face). Intervention delivered face to face via home visits. Also, through distance when using telephone follow up. Health education and promotion through health promotion materials (individually provided). Some participants were referred to outpatient clinics and to community services.
6b. How organised	- The care planning does not explicit mention medication changes, but these can be inferred based on use of MDS-HC/RAI-HC - The nurse works with the person and the family physician to plan and implement care collaboratively. Referrals are made to community health and social support services.

	After each home visit, nurses faxed a physician communication form to the patient's family physician. This form outlined the client assessment protocols that were triggered at the visit, nursing actions taken to tackle any problems, and areas of follow-up required by the physician. Nurses worked closely with the physician and other professionals (such as pharmacist, dietitian, and physiotherapist) to implement the plan of care.
7. Where	1. Hamilton, Ontario, Canada. 2. The intervention was provided to patients of family physicians who were members of primary care networks in Hamilton, Ontario, Canada. 3. Primary care networks comprise networks of solo and small group practices of family physicians. 4. Intervention is primary delivered to the participants in their home.
8. When and how much	1. Participants sessions were completed in their homes at baseline , 6 and 12 months. 2. The additional number and frequency of home visits varied (according to the needs of each participant). The average number of home visits per participant was 3. (minimum 1; maximum 7). 3. Patients received a mean of 1.17 telephone calls from the nurse. Number of sessions 5+.
9. Tailoring	1. The intervention can also be viewed as being tailored as some participants may receive referral other may not. 2.Some participants may receive bathroom equipment and mobility aids. (Also some participants may be encouraged to use calcium and vitamin D supplements). 3. At each assessment the participants would trigger new interventions and recommendations. 4. The number and frequency of home visits varied according to the needs of each participant.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	The mean number of home visits per patient was 3.03 (minimum 1; maximum 7), indicating that most patients received the planned three home visits over the year.

Table 127. Stuck 1995[80] Home-based geriatric assessment, follow-up and health promotion program

1. Brief name	Home-based geriatric assessment, follow-up and health promotion program.
2. Why	Goal: to reduce the risk factors for disability, improve health, survival, well-being and function, and reduce institutional health service utilization Rationale: - based on previous RCTs showing the benefits of in-home assessment, referral and follow-up programs on reducing mortality and nursing home and hospital use. - the intervention is expected to work by detecting new problems and suboptimal treatments, and by establishment of a long-term relationship with a visiting health professional which should improve adherence to recommendations

	- the home setting is expected to be particularly beneficial, by 1. allowing earlier preventive care, 2. providing insights into the person's habits, environment, resources, etc., and 3. making it easier for people to access care (no concerns about transportation)
3. What (materials)	- Written record of recommendations, coded with its related health problem - Written summary of personal health priorities and final recommendations by the nurse - Copy of the participant's individualized health maintenance schedule - Information about community resources - List of problems (current illnesses and others)
4. What (procedures)	- Multidomain assessment at home by a nurse including areas such as health, social and environmental assessments (among others). This assessment is repeated every year (during 3 years). - A care plan is developed between the nurse and geriatricians, and shared with the participant. The care plan includes recommendations such as concrete advice to deal with some conditions and referrals and health education. - The care plan is reviewed regularly and the nurse provides encouragement to implement recommendations in regular contacts. - Access to usual healthcare. Services include primary care, home health care meals on wheels, community transportation, among others.
5. Who provided	- Geriatric nurse practitioners contacted with the participant at all times during the intervention (including assessment, care planning and follow ups)
6. How	- Presumably face-to-face and individually (in the home visits) - By telephone for some of the follow up contacts - The nurses empowered the participant to communicate with their GPs (as a support to implement the recommendations that followed the assessment).
6b. How organised	- The care plan decision-making (and reviewing) is based on a multidisciplinary team including the nurse and the project geriatrician(s) - The care planning explicitly mentions medication changes - The nurse is responsible by all the direct contacts with the participant - Nurses also liaise with the participant's GP in special cases, and the interaction between nurse and GP was very variable.
7. Where	- At home - Santa Monica (urban), Los Angeles, Unites States
8. When and how much	- Started after a general invitation based on voter-registration list. The participants reached were urban, reasonably healthy, middle-class and non-minority. - The assessment was yearly for 3 years - There were follow-up visits every 3-months and regular phone contacts - Participants received a mean of 10.9 (SD=3.2) visits in 3 years.
9. Tailoring	The recommendations provided and additional contacts were tailored to each participant's needs.
10. Modifications	Not mentioned
11. How well (planned)	- An evaluation of implementation fidelity was planned. This involved documenting the process of care (problems identified, recommendations and adherence to these). - Adherence was determined based on participants self-report - The role of physician's cooperation in adherence was also analyzed.

12. How well (actual)	- For this 3-year intervention with 13 planned GNP visits, the 202 subjects received a mean of 10.9 GNP visits (SD 3.2). - The GNPs made 5694 specific recommendations to subjects throughout the study (a mean of 28.8 recommendations per subject). - As many as 54% of recommendations were not fully complied with. Adherence remained stable in the 3 years of study. - Higher physician cooperation and predicted higher participant's adherence - In the first year, 76.7% of subjects had at least one major problem identified that was either previously unknown or suboptimally treated. One-third of subjects had additional major problems identified during years two and three. A steady number of therapeutic and preventive recommendations was made each year (11.5 per person annually). Adherence was better for referrals to a physician than for referrals to a non-physician professional or community service or for recommendations of self care. Complete adherence to physician referrals indicated that the participant discussed recommendations with their physician but not necessarily that the physician adhered to the recommendation.

Education, multifactorial-action and review with medication review and self-management

Table 128. Coleman 1999[28] Chronic Care Clinics (CCC)

1. Brief name	Chronic Care Clinics (CCC). A new model of primary care, a package rather than a discrete intervention
2. Why	Meeting the needs of chronically ill patients can be improved by : Changing how primary care is delivered AND By increasing ancillary support Redesigning ambulatory care This all new service should consist of the following: * Explicit plans * Protocols * Systematic attention to the behavioral change needs of patients * Ready access to necessary expertise * Supportive information systems Recent evidence suggests redesigning practice can help meet the comprehensive care needs of older patients.
3. What (materials)	Physicians and team nurses received training in: Population based medicine How certain geriatric syndromes are managed / enhancing management strategies Study staff provided on the job coaching to Team nurses. Physicians were provided with: * Brief (one-page) evidence-based treatment strategies for selected geriatric syndromes *Health status assessment information which informed them of functional status and geriatric syndromes of interest for each CCC patient * Health status assessments highlighted geriatric syndromes. The key points for managing these syndromes were highlighted on a care planning worksheet.

	* A geriatrician from the research team held a one-off case based conference, replacing the weekly staff meeting. This was attended by intervention physicians and team nurses. The focal point here was the importance of creating a treatment plan which centred around geriatric care priorities. *Study staff provided teams with a care priority worksheet. This reminded teams of clinical priorities, critical information and health status information. *A handbook outlining procedures around Scheduling and patient notification protocols was provided.
4. What (procedures)	Implementing and organising A study nurse co-ordinated intervention delivery by * helping structure the visits * organising schedule of health professionals participating in the CCCs (e.g., pharmacist, social worker) * conducted self-management sessions with groups of patients Health assessment information and clinical priorities were outlined on a care priority worksheet, which study staff provide the teams with. * A physician and nurse met with the patient over an extended visit. Here they planned how the patients' chronic disease would be managed. *A pharmacist visit focussing on reducing polypharmacy and high-risk medications *A patient self-management group session lasting 45 minutes led by a team nurse or social worker. This focussed on self-management skills and group problem-solving for chronic health problems
5. Who provided	physician and nurse: supported sessions and visits with the patient around disease management Pharmacist in session with patient to talk about reducing polypharmacy and medication to do with functional decline Nurse OR social worker in self-management group
6. How	The care planning explicitly mentions medication changes.
6b. How organised	A study nurse helped structure the visits, schedule the health professionals who participated in the CCCs (e.g., pharmacist, social worker), and conducted self-management sessions with groups of patients. Initially, a study nurse helped coordinate the health providers between patient rooms. Study staff provided professionals with health assessment information and attempted to highlight the clinical priorities. As the study progressed, study staff gradually withdrew administrative and clinical support, eventually turning over all or nearly all functions to the existing clinical staff.
7. Where	Seattle region Group Health Cooperative of Puget Sound, a large staff Health Maintenance Organization located in western Washington State Intervention was delivered in primary care physician practices that had an ambulatory clinic Patient self-management group sessions took place in the practice Pharmacy sessions took place in the primary care examination room
8. When and how much	A scheduled half-day visits with the primary care team to take place every 3 - 4 months. Each scheduled half day visit consisted of: * 15 minutes session with the pharmacist * 45 minutes self-management group session led by a team nurse or social worker, that emphasized self-management skills and group problem-solving for

	chronic health problems (individual groups were encouraged to select the topics, some of which included physical activity, nutrition, and advanced care planning); and * Extended 30 min visit with the patient's physician and team nurse A health assessment would also take place to collect information around health status, chronic conditions and current medications. No time was allocated to this component of the CCC. When started: Frail older adults who were at high risk of hospitalization over the next 4 years, were identified by a computer based predictive index. This index had been previously developed and then validated.
9. Tailoring	In the extended (30 minutes) CCC visit, the patient, physician and team nurse developed a shared treatment plan, focussing on reducing disability. Topics for focus in the self-management groups were selected by the individual groups themselves. Topics could include physical activity, nutrition, and advanced care planning. Information about the participants health status, chronic conditions and current medication. was given to the practice team.
10. Modifications	After one year of the trial starting, the delivery system experienced an unprecedented change: To increase panel size and reduce costs, two randomised physicians agreed to voluntarily sever their package. This disruption affected physicians and nurses who were reassigned new responsibilities, many of which did not involve direct interaction with patients. One year in to the trial, the practice needed to increase their panel - but reduce costs. Because of this, two randomised physicians volunteered to sever their package and other physician and nurses were given new responsibilities. The study tried to ensure patients and practices remained in the groups they had been randomised to - or as close to the extent of the randomisation as possible.
11. How well (planned)	Patient adherence to the chronic disease management plan, developed during the CCC, was not measured or checked.
12. How well (actual)	A procedural handbook was provided to describe the scheduling and patient notification protocols. Improved management of certain age-related conditions could not be demonstrated 24 months after the CCC intervention. Patient self-reporting information and chart reviews were looked at to see if the redesign of primary care had led to improvements in elderly care processes or outcomes. Consistent improvements were not apparent. The intervention had no apparent effect on cost and utilization Intervention participants expressed high levels of satisfaction, showing patient value for more comprehensive approach to their primary care. Showing improvement in geriatric syndromes was difficult due to low participation levels in CCCs. Only 53% of intervention patients participated in two or more clinics. 29% of intervention patients did not attend any of the offered specialized clinics

Table 129. Counsell 2007[29] Geriatric Resources for Assessment and Care of Elders (GRACE)

1. Brief name	Geriatric Resources for Assessment and Care of Elders (GRACE). A collaborative model of care, involving a geriatric nurse practitioner and a geriatric social worker caring for the vulnerable older adult in collaboration with the patient's primary care physician
2. Why	Goal: to improve the quality of geriatric care so as to optimize health and functional status, decrease excess healthcare use, and prevent long-term nursing home placement for low income seniors Rationale: - Based on recent reviews of best practices for care of chronic conditions: a) specific targeting of elders at risk, low-income senior in this case; b) availability of collaborative expertise in geriatrics; c) integration of the program into primary care; d) coordination of care across all sites of care; e) integration of data systems that support physician's practice and facilitate monitoring of pertinent clinical parameters; and f) institutionally endorsed clinical practice guidelines - The approach intends to complement and support the role of the primary physician by helping to identify common but frequently unrecognized geriatric conditions and providing resources that aid in evaluating and treating these patients. - The approach intends to provide personalized care consistent with patient goals, consider the person's social support system, and engage older persons as active partners in their care.
3. What (materials)	- Primary care physicians use the electronic medical record system Regenstrief as part of usual care practice, which participants could access based on their own initiative - Care plans and care protocols - Electronic medical record and longitudinal tracking system as a support to ongoing care management
4. What (procedures)	- Multidomain assessment, planning and arranging, including medication review and advance care planning. Includes care planning with an interdisciplinary team and liaison with primary care physician. - The implementation is reviewed regularly by a nurse and social worker who do the assessment and contact with the participant. The ongoing case management is tailored but fixed/certain in1) an annual reassessment, 2) following hospital or nursing home admissions, 3) monthly phone contacts - All participants receive health-education and information about advance care planning. - Some participants receive recommendations and support on selected areas, as needed, including: difficulty walking/falls, chronic pain, urinary incontinence, depression, visual/hearing impairment, malnutrition/weight loss, dementia, caregiver burden - Usual health care includes access to primary care, outpatient geriatric assessment and multispecialty clinic, inpatient ACE unit, skilled nursing facility, physician house calls program, community mental health center.
5. Who provided	- Nurse practitioner and social worker contacted directly with the participants and liaised with the primary care physician

	- A wider team was involved in care planning, including a geriatrician, pharmacist, physical therapist, mental health social worker, and community-based services liaison
6. How	- Face-to-face and presumably individually (based on home-visit) - one third of the contacts - By telephone - two thirds of the contacts - Goal-setting and self-care are encouraged
6b. How organised	- The care plan is discussed in a wider interdisciplinary team (geriatrician, pharmacist, physical therapist, mental health social worker, and community-based services liaison) and with the participant primary care physician (the plan is integrated with primary care) - The nurse and social worker contact with the participant and coordinate care in an ongoing basis, and share all the information with the wider team. - The wider interdisciplinary team meets weekly to support implementation - The care planning explicitly mentions medication changes. - In usual care, the primary care physician used an electronic medical record system to manage care (e.g., record diagnosis, order diagnostic tests and medications, review hospital discharge, etc)
7. Where	- At home - Indianapolis, Indiana
8. When and how much	- Started when participants had an annual income of less than 200% of the federal poverty level and one or more primary care visits in the past 12 months (in six community-based health centers affiliated with Wishard Health Services, an urban safety net healthcare system serving primarily medically indigent individuals in Indianapolis and staffed by Indiana University School of Medicine faculty and residents). - Participants received a mean 18 and 17 contacts in year 1 and 2 of the study, respectively - All participants received at least 2 home visits and one monthly phone call. After emergency department visits or hospitalization there is always a home visit.
9. Tailoring	- The care plan was tailored to participants' needs, based on a comprehensive assessment. - The number, timing and content of patient contacts was also tailored to each participants' needs.
10. Modifications	Not mentioned
11. How well (planned)	Implementation fidelity was supported by: - regular meetings between the team, to review implementation and solve difficulties - training on the protocols and team work for all the members of the multidisciplinary team - use of electronical medical record and a web-based tracking system to support ongoing care management, coordination and continuity of care.
12. How well (actual)	- The interdisciplinary team meeting occurred within 30 days of enrolment in 85% of patients (mean 24.3 days; range 4-162 days). - Of the 12 GRACE protocols, a mean of 5.3 were activated per patient in Year 1 (range 2- 10) and Year 2 (range 2-11). - Adherence to GRACE interdisciplinary team suggestions was high in both years (81% in Year 1 and 79% in Year 2). Of the suggestions selected but not

	completed, 73% were not completed because patients disagreed and 4.7% because physicians disagreed with the suggestion, according to the GRACE support team. The remainder were not completed for logistical reasons (e.g., missed appointment), because the service was not available, or because the suggestion became no longer relevant.

Table 130. Meng 2005[61] Home visiting nurse (HVN)

1. Brief name	Home visiting nurse (HVN). Disease-management health-promotion nurse intervention.
2. Why	Goal: to promote empowerment to manage own health and interact effectively with health professionals, and improve health status, functioning, and quality of life while reducing Medicare and total health care costs through the encouragement of greater consumer choice and control over personal health care decisions and management. The use of personal home care services was particularly encouraged. Rationale: - Based on previous research on patient empowerment and self-efficacy, and on expanding patient involvement in their own care, which shows improvements in health behaviors and health and functional status - Based on the PRECEDE-PROCEED health education planning model, which emphasizes behavioural change techniques and is based on the Transtheoretical Model (TTM) of intentional behavior change developed by Prochaska and DiClemente (1983, 1985), the Health Belief Model (Becker, 1974), and Social Cognitive Theory (Bandura, 1977) to set goals that are tailored to affect health behavior change - The medication review aspect of the intervention was built from an interdisciplinary review of the literature and from a synthesis of successful strategies used to promote medication management and patient adherence - The physical activity aspect of the intervention was based on a CDC report and an exercise manual from the American College of Sports Medicine
3. What (materials)	- Two handbooks, Consumer Self-Care Strategies (developed for the demonstration) and Healthwise for Life (Mettler, Kemper, & Stilwell, 1996), were used by the patients with guidance and support from the nurses - Intervention protocol - Written information about specific diseases - Self-care and self-management videos - Snapshot reports: written reviews sent to physicians updating them on patients' status and care plans
4. What (procedures)	- Multidomain assessment, care planning (including medication review), regular follow-up and arranging of services as necessary, with ongoing liaising and coordination by the nurse - The nurse provided education focused on self-management - A variety of actions were provided selectively, based on the participants' needs (could include physical exercise, ADL training, nutritional advice, among others). - 76% of the participants used personal assistance goods (adaptive and assistive devices, durable medical equipment, and home modifications) following the intervention

	- Access to usual care services including hospital, nursing home, home care and ambulatory care (e.g., physician services, preventive and screening services, outpatient care, etc.), as financed by Medicare A and B
5. Who provided	- The nurses provided the multidomain assessment, care planning, review and co-ordination, and delivered varied selective actions in regular home visits - The nurses were certified fitness specialists and received training before and during the intervention delivery on relevant topics
6. How	- Presumably individually and face-to-face, based on home visiting format - At a distance and presumably individually by phone - Behavioural techniques, including self-management related goal setting, empowering and motivation enhancing techniques, were a central part of the intervention
6b. How organised	- Coordination and communication between professionals providing care and the patient was promoted through case conferences, which were reimbursed ($60 per conference to the primary care physician for up to 4 conferences) - Presumably, the case conference supported not only coordination but also resulted in multidisciplinary care planning. - Throughout the intervention nurses collaborated with relevant services such as primary care, health specialist and other formal and informal support systems (e.g., senior buses), liaising and troubleshooting problems. - The care planning included a focus on medication review, including medication education, monitoring, and medication goals. - Building a close relationship between nurse and the participant was emphasized, and presumably the nurse reviewing the participant was the same person throughout the intervention. - In the context of Medicare, a national program that finances healthcare for adults age 65 and older, permanently disabled persons under age 65, and individuals with end stage renal disease, in a fee-for-service model.
7. Where	- At home - In New York, West Virginia and Ohio, United States
8. When and how much	- Participants were enrolled in Medicare A&B in a practice in which physicians agreed to participate. Participants were assessed as having at least 2 or 3 limitations in ADL or IADLs respectively. Additionally, participants should have been hospitalized, been a nursing home patient or resident, or received Medicare home health care within the past 12 months, or had two or more emergency room visits in the past 6 months. Participants under 65, with long-term care insurance or enrolled in Medicaid were further excluded - Initial home visit + an average of one monthly visit for 2 years. Visits take around 1 hour. - Additional home visits and telephone contacts as needed
9. Tailoring	- The care plan, including the strategies used by the nurses in the home visits and the intensity of the home visits, were tailored to the participants' needs
10. Modifications	Not mentioned
11. How well (planned)	- Fidelity to the intervention was promoted through training before and during intervention implementation - A process evaluation study was planned to assess implementation, including the use of two databases in which professionals recorded what was actually

	delivered. Interviews and clinical notes from various professionals were also used.
12. How well (actual)	- Results showed high levels of participation, dose, and fidelity for the intervention components. The exceptions were the underutilization of the family conference visit (i.e., 27% of the participants did not have even one family conference visit of the four required and only 13.4% had all four visits), the Snapshot Report (i.e., only 230 reports were sent to physicians), and the Community Resources Database (i.e., the number of times used was inconsistent across the participants). - Over 96% of patients received home visits, a mean of 19.03 nurse visits (SD = 12.44, range 0 - 96) in all settings (home, hospital, nursing home, physician ' s office) over the average of the 579 days (SD = 228, range 26 - 732 days) participants enrolled in the demonstration. - Each patient had an average of 3.24 goals developed with the nurse (SD = 3.78, range 0 - 19). - Almost all patients used the Healthwise Handbook (97.9%) and/or Knowledgebase (75.6%) in their homes with nurses. - Almost all patients (99.2%) engaged in medication activities with the nurse. The nurses spoke with the patient about medication activities on average every six weeks or almost every visit (over 22 months/visits) - More than 97% of the patients had a documented empowering activity. The nurses spoke with the patient about empowerment activities once every six weeks or almost every visit (over 22 months/visits). The nurses spoke with the patient about disease management activities on average once every 12 weeks or once every four visits (over 22 months/visits across all patients in the nurse group). - 66.4% of patients' physicians were sent Snapshot Reports by the nurses, and at least one was sent for 32% of the patients (N=100).

Table 131. Metzelthin 2013[62] Prevention of Care (PoC) approach

1. Brief name	Prevention of Care (PoC) approach. An interdisciplinary primary care approach, in which frail older people received a multidimensional assessment and interdisciplinary care based on a tailor-made treatment plan and regular evaluation and follow-up
2. Why	Goal: to support frail older people to restore or continue the activities they need or enjoy, i.e., to reduce disability and prevent (further) functional decline, by identifying and targeting risk factors (e.g., cognitive impairment, depression) and problems in performing meaningful activities. Rationale: - Based on a previous systematic review showing the benefits of complex interventions to live independently. - Based on a narrative review that identified the following elements as promising to disability prevention: interdisciplinary primary care team, individualised assessments and interventions (tailor made care), self-management support, engagement in meaningful activities, case management, and long-term follow-up. - The intervention was developed based on the Intervention Mapping protocol for health promotion programmes, the input of a research team and a multidisciplinary task group - Based on a previous study that supported the feasibility of the intervention.

	- The delivery of the intervention is heavily based on self-management support techniques, in particular, the 5A Behavioural Change Model and the Stages of Change model. - Several other theoretical frameworks were used as a basis to the present intervention including: the Occupational Performance Process Model, guidelines for occupational and physical therapy on assistive technology and strategy training, the Dutch 'Strengthening your network' programme, as described by Hofman *et al.*, and the 'Friendship course' by Stevens *et al.*, and other relevant guidelines (e.g., Standard of Dutch College of GPs).
3. What (materials)	- Motivational interviewing tools, such as "Agenda setting" - Multidisciplinary guidelines on geriatric problems could inform the care plan as judged necessary
4. What (procedures)	- Multidomain assessment by the nurse, including domains such as medication, physical, psychological, social, environment, readiness for change, among others. Additional assessments by specific professionals could be triggered in selected cases, as judged needed by the nurse and GP. - Care planning in two stages: 1. With the professionals, usually 2 or more; 2. With the participant (the informal caregiver could be present too), using motivational techniques - The nurse contacted with the participant regularly for reviews. - A variety of interventions were selectively provided to the participant according to need and preference)as described above). These included 5 main areas: 1. Meaningful activities (occupational therapist), 2. Adapting the environment, activities or skills (with OT physiotherapist), 3. Social network and social activities (nurse), 4. Daily physical activity (physiotherapist), and 5. Stimulate health (GP and nurse). - The nurse reviewed the participant status at the end of the intervention and made arrangements for post-intervention care. - Access to usual healthcare was presumably available including services from GP, practice nurse, allied professionals (i.e., occupational therapist, physiotherapist, speech therapist and dietician). The access is easy as nearly all people are covered by healthcare insurance, and the service is considered good and strongly focused on primary care.
5. Who provided	- Mainly provided by a practice nurse who acted as a case manager and contacted regularly with the participant. - The GP was involved in the care planning in most cases and a physiotherapist, an occupational therapist, and other inpatient and outpatient professionals could also be involved in selected cases. - Training and supervision were provided to the professionals involved. The training included a 3-month period focused on the intervention approach and more general topics (e.g., geriatric syndromes).
6. How	- Face-to-face and individually or with the informal caregiver - By telephone - Motivational interviewing and self-management techniques were used to support delivery throughout the intervention
6b. How organised	- The care plan was developed by a multidisciplinary team in the majority of the cases, including the nurse and GP and in some cases other professionals as needed (physiotherapist and occupational therapist and other inpatient and outpatient specialists). Afterwards, the care plan was discussed and adapted

	with the participant (the informal caregiver could also be present) following self-management and motivational interviewing techniques. - The nurse worked as care manager organizing care, contacting the participant for monitoring and review regularly, informing other professionals about progress, and preparing for the end of the intervention. - Participants were enrolled in GP practices that manifested interest in participating in the study, which may indicate a substantial interest in innovations for frail older people care. - Embedded in the Dutch National Care for the Elderly Programme. - The care planning explicitly mentions medication changes
7. Where	- Sittard, in the south of the Netherlands - At home
8. When and how much	- Started when participants were 70 years or older and assessed as frail (5 or higher on Groningen Frailty Scale), and were enrolled in GP practices that showed interest in participating. - There was an initial home visit of 90 minutes for assessment and a second one to discuss the care plan - Following number of contacts was presumably tailored as needed. - There were up to 5 follow-up visits by the nurse.
9. Tailoring	- The care plan was tailored based on the participant's needs and preferences, using self-management and motivational interviewing techniques. - Guidelines for referral were provided but these did not seem to impact the care plan algorithmically - they were taken into account in the context of clinical judgement and participant's preference.
10. Modifications	Not mentioned
11. How well (planned)	Several strategies were used to promote and analyze fidelity: - professionals received 3 months of training pre- intervention and ongoing supervision. When there was no initiative to access supervision, this was directly offered. - a feasibility study - the format of the records on the assessment were made to match the structure of electronic patient records in hospital, in order to optimize multidisciplinary communication - logbooks and evaluation forms and semi-structured interviews and focus group were planned to analyze the intervention delivery
12. How well (actual)	- The evaluation of the logbooks showed that some parts of the protocol were insufficiently executed. Firstly, the problem analysis and the development of a preliminary treatment plan were often not done in a bilateral or an extended team meeting and only half of the treatment plans were discussed with the frail older person. Secondly, the toolbox parts were not frequently used in the treatment of frail older people. Thirdly, the extent of evaluation and follow-up, especially among the healthcare professionals, was limited. - 34% had only the multidimensional assessment conducted by the practice nurse during an initial home visit. The remaining older people received a tailor-made treatment followed by up to five follow-up visits by the practice nurse. - According to the evaluation forms completed by practice nurses, 75.8% of the older people included understood the aim and process of the PoC care approach. Their adherence to the commitments made with the practice nurse was assessed as (very) good for 72 older people (48.3%), sufficient for 46

	people (30.9%) and poor for 30 people (20.1%). Eleven people (7.4%) made no commitments, so this question was not applicable to them.

Table 132. Stuck 2015[82] Health Risk Assessment for Older Persons (HRA-O)

1. Brief name	Health Risk Assessment for Older Persons (HRA-O). A self-administered questionnaire leading to individualised computer-generated feedback reports, combined with nurse and GP counselling over a 2-y period
2. Why	Goals: 1. To identify risks for functional decline and problems intervention, 2. To achieve favourable change in health-related behaviour, 3. To facilitate preventative care use Rationale: - Based on previous research showing benefits of health risk appraisal programmes with older people, namely in improving health behaviour and decreasing costs. - Based on Verbrugge and Jette (1994)'s model of disability which emphasizes multidimensional risk factors. - Assessment and recommendations were based on an adaptation process that included a systematic literature review, expert input, focus groups and piloting - The techniques of behavioural change used were based on the transtheoretical model of behaviour change
3. What (materials)	- HRA-O questionnaire (including several previously validated instruments), electronic system, recommendations and separate written reports for the participant and his/her GP. - Referrals - Providers' training materials
4. What (procedures)	- A self-assessment questionnaire (HRA-O) was used to support a multidomain assessment, including areas such as medication, mood, pain, social support, physical activity, among others. This assessment was complemented by information gathered by a nurse in a home visit, as necessary. - The multidomain assessment questionnaire was used to generate recommendations (based on an algorithmic electronic system). These were sent to the participant and his GP, and discussed by GP, nurse, and geriatrician. - GP and nurse arranged appropriate referrals, provided selective care and reinforced recommendations as needed. - The multidomain assessment was repeated after a year - The nurse routinely contacted the participant to provide health education and reinforce recommendations. To support behavioral change the nurse used techniques such as negotiating realistic goals with the participant - Presumably the participant accessed other usual care services with the support of nurse and GP
5. Who provided	- Nurses - GPs Both nurses and GPs played a role in assessing, planning, arranging, coordinating and delivering selective interventions. Both received training and regular supervision by geriatricians.
6. How	- Presumably individually and face-to-face, based on home visiting format - Presumably individually and at a distance, based on phone calls and post communication.

	- Techniques to support behavioural change were emphasized by the nurse counsellors, who analyzed individual readiness to change, negotiated realistic goals with the older persons and promoted self-efficacy.
6b. How organised	- The care plan was first generated by the electronic system algorithm (based on previous evidence and guidelines), according to the participant reported needs, and then discussed and adapted collaboratively by nurse, GP and geriatrician, taking into account the participant's priorities. The case conference was repeated in the 2nd year. - The care planning explicitly mentions medication assessment and identifies risks that require medication change - It is not clear if the nurse following up on the participant's status was always the same person, but the reassessment at HRA-O probably involved the same GP (but note that this contact was made by post). - The nurse and GP promoted integration of care, collaborating with one another, contacting relevant organizations and facilitating referrals.
7. Where	- At home - In Solothurn, mainly rural areas in Switzerland
8. When and how much	- Started when participants were 65 years old or older, enrolled in GP practices and did not need assistance in BADLs as assessed with a questionnaire focused on BADLs sent by post [PRA, Probability of Recurrent Admissions questionnaire]. Participants were also excluded if they had cognitive impairment or a terminal disease. - One home visit every 6-months for 2 years - 2 contacts by post each year to answer the multidomain assessment instrument - One contact by phone at 3 months - Additional contacts (at home or by phone) as needed - Actual visits and phone calls were, respectively, 5.3 and 2.0 on average. - Actual home visit time was 105.2 min on average in the 1st year, and 128.1 in the second year. - Actual phone calls time was 18.6 min on average in the 1st year, and 1.2 in the second year.
9. Tailoring	- The intervention was tailored based on the participant's needs following an electronic system algorithm (based on previous evidence and guidelines). The recommendations were then discussed in a multidisciplinary team and took into account participant's priorities. - The number of contacts was also tailored to each participant's needs.
10. Modifications	Not mentioned
11. How well (planned)	The fidelity of the intervention was supported by: - Training and regular supervision of the providers - Previous feasibility studies that tested the adequacy of the assessment used and made necessary adaptations for acceptability by an older population - Planned documentation of the intervention, for scientific quality assurance and improvement
12. How well (actual)	- 85.6% of participants returned the multidomain assessment questionnaire - 9.4% needed assistance of another person to complete the questionnaire - Participants took an average of 75.5 minutes to complete the questionnaire (SD=34.1)

	- 58.8% received the intervention for the entire 2-y period, with a mean of 5.3 nurse counsellor visits and 2.0 telephone contacts - 10.8% participants declined nurse counselling, but received the PCP component of the intervention for the 2-y period

Education, multifactorial-action and review with self-management

Table 133. Hattori 2019[100] Community-based, multicomponent, multidisciplinary, individualized goal-directed, and time-limited intervention (CoMMIT) program plus standard care

1. Brief name	Community-based, multicomponent, multidisciplinary, individualized goal-directed, and time-limited intervention (CoMMIT) program plus standard care.
2. Why	To improve independence by encouraging self-management skills in an "adequate" lifestyle. Based on previously shown effectiveness of multicomponent interventions
3. What (materials)	- Original assessment sheet for comprehensive clinical assessment - Assessment sheet for self-management - Equipment for care goal activities that participants could use at home - Booklet for preventing long-term care needs + Standard care: allows the rental of assistive equipment
4. What (procedures)	The intervention included the following steps: - Comprehensive clinical assessment - Joint discussion and definition of a care goal, and presumably guidance on how to use social resources (mentioned in the trial register only) - Group meetings including motivational interview, training and/or supervision on themes like nutrition and physical, oral and social function, and planning for future needs. + Standard care which included the following steps: - General disability/needs assessment - Access to various long-term services, including home-visit, day-care, short-stay, at-home care
5. Who provided	The intervention was provided by a rehabilitation specialist, who could be either a physiotherapist or an OT, and received specific training, and by a care manager. Dietitians and dental hygienists also participate when relevant.
6. How	Individually and in groups of max 11 participants, presumably face-to-face.
6b. How organised	- Described as multidisciplinary, and they had meetings to discuss patients' goals and at least one case conference. There was a 'case manager' but it wasn't clear what the relationship between the case manager and the rehabilitation team was. It was unclear what the case manager did, except in relation to this intervention. - The care planning does not mention or implies medication changes
7. Where	- Neyagawa, Osaka, Japan - In a long-term care insurance system for people from mild to severe disability, annually reassessed, who are allowed to choose service providers. - At home - The location of group sessions is not mentioned

8. When and how much	5-month intervention, including 1 home-visit, up to 12 modules weekly lasting 2 to 3 hours, and 1 review module. The attendance to the modules was tailored/variable, from 1 to 12. The trial register mentions 17 sessions but it is not clear how these map into the above.
9. Tailoring	- Participants contribute to individual goals formulation and their change over time - Goal attainment and monitoring are individually assessed - Care customized to the goals - Co-creation of individual future plan + Standard care: participants are allowed to choose their service providers
10. Modifications	Not mentioned
11. How well (planned)	Intervention delivery supervision
12. How well (actual)	76% attended at least one module, 66% attended at least 7 modules.

Table 134. Moll van Charante 2016[63] Nurse-led intensive multifactorial vascular care intervention with regular follow-ups and assessments

1. Brief name	Nurse-led intensive multifactorial vascular care intervention with regular follow-ups and assessments.
2. Why	Goals: to reduce the incidence of dementia and cardiovascular disease, and the burden of functional disability in the elderly Rationale: - based on previous research showing the association between vascular and lifestyle risk factors and dementia and the potential to prevent dementia if these risk factors are addressed - risk factors are modifiable by medication or lifestyle interventions - A perspective on risk reduction for dementia will surely have a great impact on patients' and doctors' perception of preventive measures, thus stimulating all parties involved to put more effort in preventive measures to avert the heavy burden of dementia and vascular disease in the elderly.
3. What (materials)	- Devices to measure blood pressure, and blood glucose (implicit) - Detailed protocol guided the recommendations that followed assessment - Referrals (to exercise, dietician...)
4. What (procedures)	Cardiovascular risk assessment (e.g., diet, physical activity, weight, and blood pressure), care planning and referrals arranged by nurse with the GP supervision: - Medication was adapted based on assessment and according with national guidelines (presumably by the nurse with GP supervision). - Advice on lifestyle changes (e.g., increase physical activity level), and cardiovascular risk factors (e.g., blood pressure) was provided to participants if indicated as appropriate based on the risk assessment; supported by Motivational interviewing techniques. - Regularly reviewing and adjusting of the care plan by nurse. For the nurses: - Training during intervention provision - Supervision by the GP

	- Regular monitoring through visits to the nurses As in usual care: - universal access to primary care in which the GP is a gatekeeper of additional care. - The GPs were advised to refer patients with cognitive decline to a geriatric or neurologic outpatient clinic.
5. Who provided	- a practice nurse (with the supervision of GP). - in selected cases, there may have been contact with other specialized health professionals (for whom referrals were produced). - as in usual primary care mainly provided by GP.
6. How	Face-to-face, individual consultation with nurse. Presumably face-to-face and individually accessing GP and practitioner consultation in usual primary care
6b. How organised	- The intervention was coordinated by a practice nurse under supervision of the general practitioner (GP) - 1 academic hospital coordinated the intervention Usual care: - In the Dutch healthcare system, virtually all inhabitants are registered with a GP - The GP is the gatekeeper of care, who makes referrals to medical specialists when necessary. The specialists then report back to the GP. - All baseline measurements on the risk profile of individuals were made available to the GP who has the discretion to initiate treatments.
7. Where	- Netherlands - In general practices which are organised in health centres: 3-7 practices per centre, and presuming 1 GP per practice.
8. When and how much	When started: - Participants were enrolled with a participating primary healthcare centre. - free from cardiovascular diseases and dementia. - were contacted by letter and by their own GP. Intervention: Nurse-led sessions, every 4 months for 6 years, a total of 18 visits to the GP practice.
9. Tailoring	The recommendations were tailored to participants individual assessment results, according to a protocol that followed the national guidelines
10. Modifications	Not mentioned
11. How well (planned)	- The process quality of delivering the intervention at each of the 18 visits in the 6 years were monitored through regular monitor visits to the practice nurses. - Adherence of participants to the intervention regimen were recorded and reasons for noncompliance were explored. Dropouts were actively retrieved to minimize attrition. - Five educational sessions for all nurses were organised during the course of the study to strengthen the consistency of the intervention.
12. How well (actual)	- 544 participants received less than two visits per year before reaching an endpoint or end of study - relatively high drop-out rate

Exercise

Table 135. Giné-Garriga 2020[38] Exercise referral schemes enhanced by self-management strategies (ERS+SMS)

1. Brief name	Exercise referral schemes enhanced by self-management strategies (ERS+SMS).
2. Why	Goal: to reduce sedentary behaviour and increase physical activity with the final goal of long-term behaviour change, an improvement in health, physical function, quality of life as well as psychosocial outcomes. Self-management strategies are specifically aimed at increasing self-efficacy in reducing sedentary behaviour and at adopting/maintaining an active behaviour Rationale: - Prolonged sedentarism /reduced physical activity is associated with more chronic disease and mortality - Exercise referrals schemes in primary care have previously been shown to improve physical activity in the short-term - Self-management strategies based on social cognitive theory have been shown to increase self-confidence, power to act, and involvement in exercise, and are advocated in recent guidelines - The intervention in based on a systematic review on behaviour change techniques, focus groups, a logic model, and a feasibility study.
3. What (materials)	- Booklet with information of physical activity with tips about how to sit less and be more active - Yamax DigiWalker SW-200 pedometer - Activity diary (daily step counts, weekly time in PA / exercise and use of tips) - Training loads such as ankle wights and dumbbells - Borg Scale of Perceived Exertion used to measure the intensity of exercise in the sessions
4. What (procedures)	- Providing guided and supervised physical exercise of increasing intensity. The physical exercise sessions combined aerobic, strength, balance and flexibility activities. - Providing information tips about how to be more physical active - Providing support to establish physical activity goals, and strategies to keep motivated - Providing equipment (pedometer) to facilitate monitoring of physical activity and keep up with activity goals - Providing follow up encouragement and support to keep up physical activity In one location (Denmark), most recruits were receiving preventive home visits.
5. Who provided	- Qualified fitness instructors who received training on self- management techniques, and monitoring and support during the delivery
6. How	- Face-to-face, individually and in group - By telephone - Strategies to set personal goals, and to enhance motivation, self-monitoring and problem solving were provided separately to support the development of physical activity
6b. How organised	Not mentioned
7. Where	- In primary care centre facilities or local leisure/community centres - In four European countries: Denmark (Odense), Northern Ireland (Belfast), Germany (Ulm) and Spain (Barcelona)

8. When and how much	- Started when participant were 65 years old or older, able to walk 2 minutes or more without help (they could use a walking stick). Participants were assessed has not having enough activity or having long sedentary periods (screening questions) and scored 4 or above in the Short Physical Performance Battery, which showed no major physical limitations. People with dementia, unstable medical conditions or had participated in a similar intervention before were not included. Some people (recruited from Denmark) were receiving preventive home visits. - Two 45-60 min sessions a week for 16 weeks (32 sessions) of physical exercise - Seven sessions (one 40 min individual sessions, six 45-60 group sessions) and four 20 min calls were conducted along 30 weeks.
9. Tailoring	- The use of goal setting and problem solving techniques presumably supported the tailored delivered of the physical exercise activities
10. Modifications	Not mentioned
11. How well (planned)	Measurement and analysis of intervention fidelity were planned including the use of an observational checklists and attendance registries. In the observational checklists the intervention deliverer records the degree of fulfilment of each task and aim. [Other aspects of the delivery, such as perceived effects and contextual aspects are also analyzed with other methods (e.g., interviews)]
12. How well (actual)	Not mentioned

Table 136. Morey 2006[101] Attention control

1. Brief name	Attention control. One-off physical activity counselling followed by health education counselling not directed at behavioural modification.
2. Why	Goal not specified Rationale: The physical activity counselling was based on - The transtheoretical model of behavior change which has been previously shown to be successful when applied to physical activity - Motivational interviewing and self-efficacy, as defined by the social-cognitive theory - The PACE protocols and modified for a geriatric population with the support of the PACE developers - The Surgeon General's guidelines for physical activity (U.S. Department of Health and Human Services, 1996)
3. What (materials)	- Information about the physical activity counselling by the health counsellor appended to the participant's medical record - Physical activity plan contract - Project LIFE workbook including a photograph and contact information for the health counsellor and a series of pamphlets and written material on nine topics unrelated to physical activity. Two thirds of the materials were selected from the National Institute on Aging Age Pages (National Institute on Aging, n.d.). - A script used by the health counsellor in the phone calls discussing health topics.

4. What (procedures)	- Providing initial physical counselling with a health counsellor and a primary care physician. It includes discussion the person's conditions, of barriers, concerns, and results in a physical activity plan. - Providing information about health topics such as foot care, preventing falls, understanding laboratory results, etc (excluding physical activity) in written form and through regular scripted calls without attempting to change behaviour.
5. Who provided	- A health counsellor trained in exercise and lifestyle counselling provided the initial physical counselling - The primary care physician, trained in the counselling protocol, reviewed and endorsed the physical counselling plan - Subsequent calls focused on health education were presumably provided by the health counsellor (unclear if the same of different from the first session)
6. How	- The initial physical counselling was provided in presumably individually and face-to-face, based on a clinic-setting - The initial physical counselling integrated the use of principles and techniques based on the motivational interview
6b. How organised	- The intervention is based on a partnership between primary-care providers, counsellor and the participants - The health services were in a transitional phase of expanding health-promotion activities
7. Where	- The initial physical activity counselling took place in a clinic that was part of the Veteran's Health services - In Durham, [US]
8. When and how much	- Started when veterans aged 70 and older were being followed in geriatric and primary care clinics. Participants were free of terminal diagnoses, unstable angina pectoris or recent myocardial infarction, stroke with moderate to severe aphasia, or active substance abuse. Participants already engaged in regular PA also were excluded based on their affirmative response to one question that asked about moderate physical activity for 30 minutes or more on 5 or more days per week. - Presumably 1 physical activity counselling session - The health counsellor called each patient biweekly for the first 3 months and once a month for the remaining 3 months, for a total of nine phone calls averaging approximately 18 min in length.
9. Tailoring	The initial physical activity counselling was tailored to participant's condition, barriers, and to their level of motivation
10. Modifications	Not mentioned
11. How well (planned)	Plans were made to record the implementation of the phone calls. This included recording telephone call date, length, and specific exercise data into a database at the time of the call. In the event the call could not be completed in the assigned week, the health counsellor attempted to complete the call the following week and continued until the call was complete.
12. How well (actual)	- All of the health services providers contacted agreed to participate. These services assessed the intervention positively. - The rate of physician endorsement of the baseline physical activity counselling plan was almost 100% (99.4%). - Occasionally calls were not completed due to patient travel or illness, and call schedules were adjusted to accommodate this.

Table 137. Morey 2006[101] Enhanced usual care

1. Brief name	Enhanced usual care. One-off physical activity counselling plus usual care.
2. Why	Goal not specified Rationale: The physical activity counselling was based on - The transtheoretical model of behavior change which has been previously shown to be successful when applied to physical activity - Motivational interviewing and self-efficacy, as defined by the social-cognitive theory - The PACE protocols and modified for a geriatric population with the support of the PACE developers - The Surgeon General's guidelines for physical activity (U.S. Department of Health and Human Services, 1996)
3. What (materials)	- Information about the physical activity counselling by the health counsellor appended to the participant's medical record - Physical activity plan contract - Project LIFE workbook containing senior-citizen resource information, an Age Page from the National Institute on Aging ("Exercise: Feeling Fit for Life" [2005]), and a listing of services available through the VHAMC social workers.
4. What (procedures)	- Providing initial physical counselling with a health counsellor and a primary care physician. It includes discussion the person's conditions, of barriers, concerns, and results in a physical activity plan. - Providing written information about physical activity and social resources available
5. Who provided	- A health counsellor trained in exercise and lifestyle counselling provided the initial physical counselling - The primary care physician, trained in the counselling protocol, reviewed and endorsed the physical counselling plan
6. How	- The initial physical counselling was provided in presumably individually and face-to-face, based on a clinic-setting - The initial physical counselling integrated the use of principles and techniques based on the motivational interview
6b. How organised	- The intervention is based on a partnership between primary-care providers, counsellor and the participants - The health services were in a transitional phase of expanding health-promotion activities
7. Where	- The initial physical activity counselling took place in a clinic that was part of the Veteran's Health services - In Durham, [US]
8. When and how much	- Started when veterans aged 70 and older were being followed in geriatric and primary care clinics. Participants were free of terminal diagnoses, unstable angina pectoris or recent myocardial infarction, stroke with moderate to severe aphasia, or active substance abuse. Participants already engaged in regular PA also were excluded based on their affirmative response to one question that asked about moderate physical activity for 30 minutes or more on 5 or more days per week. - Presumably 1 physical activity counselling session
9. Tailoring	The initial physical activity counselling was tailored to participant's condition, barriers, and to their level of motivation

10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- All of the health services providers contacted agreed to participate. These services assessed the intervention positively. - The rate of physician endorsement of the baseline physical activity counselling plan was almost 100% (99.4%). - Occasionally calls were not completed due to patient travel or illness, and call schedules were adjusted to accommodate this.

Table 138. Morey 2006[101] High-intensity physical activity counselling

1. Brief name	High-intensity physical activity counselling. Physical activity counselling with high intensity follow up.
2. Why	Goal: to increase physical activity levels in older veterans Rationale: - physical activity has been shown to increase independence, reduce functional decline, and ameliorate adverse health effects of many chronic conditions - telephone counselling has been shown to increase sustained physical activity - the telephone counselling was based on the Activity Counselling Trial The physical activity counselling was based on - The transtheoretical model of behavior change which has been previously shown to be successful when applied to physical activity - Motivational interviewing and self-efficacy, as defined by the social-cognitive theory - The PACE protocols and modified for a geriatric population with the support of the PACE developers - The Surgeon General's guidelines for physical activity (U.S. Department of Health and Human Services, 1996)
3. What (materials)	- Information about the physical activity counselling by the health counsellor appended to the participant's medical record - Physical activity plan contract - Project LIFE workbook including a photograph and contact information for the health counsellor, the physical activity goal (to accumulate 30 min of moderate physical activity on 5 or more days of the week), a list of benefits of physical activity, the National Institute on Aging, 2001 workbook "Exercise: A Guide From the National Institute on Aging", a pedometer with instructions, a daily pedometer log, and a description of symptoms that should not be ignored. - The quarterly progress reports about the participant
4. What (procedures)	- Providing initial physical counselling with a health counsellor and a primary care physician. It includes discussion the person's conditions, of barriers, concerns, and results in a physical activity plan. - Providing written information about physical activity, a pedometer, and regular counselling calls about physical activity in which motivational techniques to support behavior change were used. The calls included a systematic assessment of physical activity status, support and reinforcement for behavioral changes, a discussion of barriers and problem solving to overcome barriers, and creation of new or maintained physical activity goals

5. Who provided	- A health counsellor trained in exercise and lifestyle counselling provided the initial physical counselling - The primary care physician, trained in the counselling protocol, reviewed and endorsed the physical counselling plan - Subsequent calls focused on further physical counselling were presumably provided by the health counsellor (unclear if the same of different from the first session)
6. How	- The initial physical counselling was provided in presumably individually and face-to-face, based on a clinic-setting - The initial physical counselling integrated the use of principles and techniques based on the motivational interview - The follow-up calls also included techniques to encourage increased physical activity, based on the motivational interview principles.
6b. How organised	- The intervention is based on a partnership between primary-care providers, counsellor and the participants - The health services were in a transitional phase of expanding health-promotion activities
7. Where	- The initial physical activity counselling took place in a clinic that was part of the Veteran's Health services - In Durham, [US]
8. When and how much	- Started when veterans aged 70 and older were being followed in geriatric and primary care clinics. Participants were free of terminal diagnoses, unstable angina pectoris or recent myocardial infarction, stroke with moderate to severe aphasia, or active substance abuse. Participants already engaged in regular PA also were excluded based on their affirmative response to one question that asked about moderate physical activity for 30 minutes or more on 5 or more days per week. - Presumably 1 physical activity counselling session - The health counsellor called each patient biweekly for the first 3 months and once a month for the remaining 3 months, for a total of nine phone calls averaging approximately 18 min in length.
9. Tailoring	The initial physical activity counselling was tailored to participant's condition, barriers, and to their level of motivation The follow up calls focused on physical activity were also tailored to the participant limitations and the plan devised in the initial counselling
10. Modifications	Not mentioned
11. How well (planned)	Plans were made to record the implementation of the phone calls. This included recording telephone call date, length, and specific exercise data into a database at the time of the call. In the event the call could not be completed in the assigned week, the health counsellor attempted to complete the call the following week and continued until the call was complete.
12. How well (actual)	- All of the health services providers contacted agreed to participate. These services assessed the intervention positively. - The rate of physician endorsement of the baseline physical activity counselling plan was almost 100% (99.4%). - Occasionally calls were not completed due to patient travel or illness, and call schedules were adjusted to accommodate this.

Table 139. Morey 2009[65] Multicomponent physical activity counselling program

1. Brief name	Multicomponent physical activity counselling program.
2. Why	Goal: to improve physical function of older veterans Rationale: - Based on the Nagi disablement model, which describes a continuum from pathology to impairment to functional limitations to ultimate disability. It was hoped that the pathway to disability would be broken by targeting impairments in cardiorespiratory and musculoskeletal systems, thereby reducing functional limitations (i.e., better functional status or physical function) and ultimately disability. - Based on the social cognitive theoretical framework, in which behavior influences and is influenced by within-person factors and factors in the social and physical environment. Following this theory, the intervention focused on concepts such as self-efficacy, self-monitoring, reinforcement, cognitive reframing, among others. - Based on the transtheoretical model of stage of change which guided the strategies to be used at different changes to support behavioural change
3. What (materials)	- A structured protocol, "Planning the First Step," adapted from the Physician-Based Assessment and Counseling for Exercise Project, is used in the individual counselling session - National Institute on Aging (NIA) exercise workbook ("Exercise: A Guide from the NIA") - Elastic bands of different resistances with instructions for use - An exercise poster depicting six key lower-limb strength exercises - A pedometer - Phone call protocol - Written progress report - Documentation of the PCP endorsements in the medical records
4. What (procedures)	- A physical exercise program including walking and strength training was provided - The program was tailored to the individual based on an individual counselling session and subsequent follow up and progress reports - Several behavioural techniques were used to support changes in physical activity, including endorsement of the program by the primary care providers, regular goal setting, reinforcement, discussion of barriers and problem-solving, encouragement and feedback. - Access to usual care services, within the veteran affairs healthcare service.
5. Who provided	- The individual session and phone calls were provided by a health counsellor with long experience in exercise counselling - The participant's primary care provider was also involved in the provision of reinforcement/ endorsement of the intervention
6. How	- Individually and face-to-face in the initial individual counselling session and initial PCP endorsement - By telephone, presumably individually, for the PCP and health counsellor calls - By post, for tailored progress report and printed motivational messages - Several behavioural techniques were used to support changes in physical activity, including endorsement of the program by the primary care providers, regular goal setting, reinforcement, discussion of barriers and problem-solving, encouragement and feedback.

6b. How organised	- The project was integrated in primary care by involving primary care providers in endorsing the program with the participants.
7. Where	- Veterans Affairs Medical Center of Durham, North Carolina. - The location of the individual counselling session is not made explicit - One of the endorsements of the program by the PCP was done in the primary care clinic
8. When and how much	- Participants were enrolled in the veteran affairs health services and were 70 years or older. Participants were assessed in a two-step process, first based on medical records and then based on the primary care provider judgement. The assessment determined if the participant was able to walk 30ft without other person's help, had no health conditions that may prevent safe physical activity and was not already exercising at least 150 min a week. - During the one-year program the participants received: 1 brief counselling session, 3 follow-up calls by the counsellor in the first 2 mths then one every month, 1 endorsement by the PCP followed by monthly automated phone calls, and quarterly mailed progress reports
9. Tailoring	The individual session was tailored to participant's personal functional goals and limitations, and the following recommendations and feedback also took into account individual specificities
10. Modifications	Not mentioned
11. How well (planned)	- Several procedures of the intervention were intended to promote adherence to physical activity, presumably including the calls from the health counsellor and endorsement by the primary care provider to reinforce physical activity behaviour. - PCP endorsements were documented in the medical records and analyzed for adherence
12. How well (actual)	- All participants completed the baseline counselling session, clinical endorsements by the providers were documented for more than 90% of study participants, and 98% of the automated telephone messages were successfully delivered - 85% of participants recalled receiving the PCP endorsement in the clinic, and 91% reported that the monthly PCP telephone endorsement motivated them to exercise.

Table 140. Morgan 2019[66] Physical Activity Facilitation

1. Brief name	Physical Activity Facilitation. Delivery of behaviour change techniques with motivational interviewing strategies to increase physical activity in older adults at risk of disability.
2. Why	Goals: - to increase physical activity in older adults at risk of disability, and by increasing physical activity, reduce disability, improve quality of life, and/or improve physical performance - to keep older people active and independent as they age Rationale: ...by encouraging individuals to incorporate physical activity into their everyday lives ...by addressing the core psychological needs of participants

	...based on the self-determination theory that asserts that 3 psychological needs need to be met for someone to modify their behaviour: autonomy, competence and relatedness ...based on previous evidence showing that physical activity in later life can prevent or delay age-related disability ...based on a previous Physical Activity Facilitation intervention that shown to be successful to increase physical activity in adults with depression, and a literature synthesis that identified motivators, barriers and challenges to physical activity in older adults
3. What (materials)	- Comprehensive manual to support training on the intervention for deliverers - Audio recordings and transcriptions of sessions to support deliverers and analyze fidelity - Worksheets provided to participants to assist with behaviour change techniques - Detailed logs of each session kept by deliverers
4. What (procedures)	Education using self-management techniques, delivered to participants individually: - Physical activity attitudes assessment, planning and arranging, which includes negotiating choice of physical activity and progression using motivational interviewing to engage and motivate a lifestyle change, and administrative telephone calls by the deliverers (for arranging). - Providing behavioural change techniques to support changes in physical activity, including, for example, action planning and goal setting. Usual care: - Primary care including GP appointments - Hospital in-/out-patient care - Urgent care
5. Who provided	- Planned to be delivered by nurses or healthcare workers but the actual disciplinary background is not mentioned - Deliverers received training on the intervention
6. How	- Face-to-face sessions - Telephone sessions - Individual sessions with the opportunity to involve a spouse, friend or close social partner of the participant
6b. How organised	Staffing and training arrangements: - 2 PAF facilitators were recruited locally, had previous experience working with older adults or in health or social care was desirable but not essential. - A 3-day training course provided to the PAF facilitators, covering the theoretical background to the intervention. - PAF facilitators will have access to regular and frequent supervision and support throughout the trial. - It is anticipated that if cost-effective, the PAF intervention could be delivered by nurses or healthcare workers. Interaction between PAF facilitators and GPs: - Participants' GPs are contacted following each enrolment and are briefed about the exclusion criteria, to ensure no patient is enrolled inappropriately.
7. Where	Location: - United Kingdom - Areas of differing social deprivation across Bristol and South West area

	- Primary care, in particular GP practices, are mentioned as setting but it's not explicit that this was where the face-to-face sessions took place
8. When and how much	When started (intervention): Status - At risk of disability and inactive. Session schedule: - One initial face-to-face session, up to two further face-to-face sessions, and up to nine telephone support sessions over the 6-month
9. Tailoring	- Session are highly tailored to participants' circumstances. - The schedule was tailored to suit participants' progress. - Participants could choose to involve a close partner (spouse, friend, other) in the intervention activities.
10. Modifications	Not mentioned
11. How well (planned)	- The deliverers kept detailed logs of each session as a strategy to analyze the fidelity of the intervention. - The collection of audio records and transcripts of the sessions was planned as a strategy to analyze the fidelity of the intervention.
12. How well (actual)	- Most of the intervention participants (31/34, 91%) received what was deemed the “minimum dose” of sessions, at least one face-to-face and five telephone sessions - The mean (standard deviation) length of time between the first intervention session and the final visit was 26 (2) weeks, suggesting that the intervention sessions were delivered for the intended period of 6 months. - Overall, the median amount of time spent in contact with a participant over the 6 months was 5h, with an interquartile range from 4 to 6h; these data were positively skewed as a minority of participants required considerably more contact time than average. - The deliverers recorded the start and end times of every contact with a participant.

Table 141. von Bonsdorff 2008[94] Screening and Counseling for Physical Activity and Mobility in Older People (SCAMOB)

1. Brief name	Screening and Counseling for Physical Activity and Mobility in Older People (SCAMOB).
2. Why	Goals: - increase physical activity, thereby decreasing mobility difficulties and the need for home care, and decreasing and postponing disability - initiate specific physical exercise and habitual physical activity - promote use of existing exercise services available for older people Rationale: Based on the social cognitive theory of health behavior change (Bandura, 1997), and transtheoretical model (Prochaska and DiClemente, 1982) and the motivational interviewing technique (Miller and Rollnick, 1991), to encourage the older people to make and continue with the behavioual changes in physical activities. ...based on previous evidence suggesting that physical activity prevents mobility limitation and disability, and that the present type of intervention (initial face-to-face + calls)promotes the effective use of exercise services

3. What (materials)	- Relevant information about participant gathered before the start of intervention - Personal physical activity plan - Physical activity schedule of available services - Referrals to exercise activities provided by physiotherapist - A written (illustrated) home-based exercise program
4. What (procedures)	Exercises 1. a written (illustrated) home-based exercise program was mailed to them as part of the intervention. 2. Physical activity schedule of the City of Jyväskylä 3 Tailored to the participant's needs: - Exercise group referrals to inexpensive exercise classes. - Physiotherapist demonstrating an individualized home-based gymnastics program and gave written instructions to perform it. Self-management (Physical activity counselling) - Physical activity assessment, planning and arrangement, resulting in an individual physical activity plan - Regular reviewing and adjusting of the plan - Encouraging behavioural changes with motivational support and problem-solving techniques Education (Group lectures) - Providing health related info, including home exercises. As in usual care: nurse practitioner services, general medical care and lab tasks and access to exercise facilities and activities
5. Who provided	- A physiotherapist - As in usual care: possible contact with nurse and medical care, presumably by GP.
6. How	- Individually and face-to-face in the initial assessment and planning session - By telephone for regular reviewing and encouragement - By post for provision of home-exercise program - Presumably in group and face-to-face for voluntary lectures
6b. How organised	Organisations and staff arrangement: - Co-operation of the University of Jyväskylä with the City of Jyväskylä Centre for Health and Social Services and Department of Sports and Physical Activity Services, which provided the exercise classes. This collaboration has been developed over many years making the innovative services a model of good practice. - Physiotherapists trained on behaviour change theories and motivational interviewing techniques - The participant’s physician was informed about the counselling by the physiotherapist - The physiotherapist provided referrals for community exercise classes Care planning Decided between the physiotherapist and participant.
7. Where	Location: Jyväskylä, Finland - Unclear where the initial face-to-face session took place - In the context of a healthcare system that provides usual care services cost free or at nominal cost, and obliges municipalities to guarantee access to exercise services for all

8. When and how much	When started: Old people who volunteered, were screened as cognitively intact, were able to move outdoors independently but were physically sedentary. Sessions: - 1 face-to-face sessions for 50/60 minutes, 6 phone calls for 10-15 minutes every 4 months and 2 optional health info sessions were planned. The vast majority of participants received 4-5 phone calls with the remaining receiving less.
9. Tailoring	- Personal physical activity plan tailored to participants needs and preferences, including a possible individualized home exercise program
10. Modifications	Not mentioned
11. How well (planned)	- The phone calls were used as a strategy to support participants' adherence
12. How well (actual)	- Adherence was high - All participants received the initial face-to-face session - Telephone calls were planned to take place every 3 months, but for practical reasons, such as not being able to reach the participant, they took place every 4 months. - Telephone support over 2 years 4-5 times n=302, 1-3 times n=14, 0 times n=2

Exercise and multifactorial-action with medication review

Table 142. Liimatta 2019[56] Comprehensive, multiprofessional preventive home visits (PHVs)

1. Brief name	Comprehensive, multiprofessional preventive home visits (PHVs). In addition to typical care including the normal health and social care offered by the municipality.
2. Why	Goal: The home visits aim to slow down the decline in health or functioning rather than an increase. Rationale: Preventive home visits for older people are suggested as preventive and proactive intervention, to support their health, functioning and well-being.
3. What (materials)	1. Oral and written instructions on how to perform the home visits given to the intervention delivery professionals. The intervention team planned and discussed the intervention protocol, and uniform instructions were given verbally and written on paper to everyone. 2. Assessment forms used by the team at visits. 3. Participant was given an information card with instructions and actions, and information about the different health and social services offered by the municipality and local volunteer and third-sector organizations. 4. The physiotherapist compiled individual exercise instructions and needed aids to the participants.
4. What (procedures)	Intervention: 1. The intervention protocol was planned and discussed together with all the team members, including the doctor, and uniform instructions were given personally and on paper to the team.

	2. The intervention was based on the comprehensive geriatric assessment (CGA). A set of structured assessments was performed by a multiprofessional team at the visits. 3. The team performing visits could consult a doctor from a geriatric ward if needed. 4. The team provided general information about local healthcare, social, and physiotherapy services available, and physical activity recommendations to pts. 5. Tailored instructions to exercise were provided to the participants, according to their needs and/or preferences. 6. If necessary, the team reminded participants to accomplish the given instructions; and/or contacted suitable healthcare or social services to arrange services and aids for the participants. 7. Participants were asked about their understanding of the instructions, and to action on the instructions. Usual care: Including normal healthcare offered in the municipality health centre, local social services and group activities
5. Who provided	Each participant received intervention from: 1. a nurse, with experience working with geriatric patients 2. a physiotherapist 3. a social worker - Training, oral and written instructions on how to perform the home visits were given to the professionals. 4. a doctor from a geriatric ward, was consulted by the above if needed.
6. How	The three home visits, presumably individually and face-to-face, were delivered during a time period of six to nine months-the nurse visit was first, the physiotherapist visit was second, and the social worker visit was last. The interval between each visit to the participant was circa three months
6b. How organised	- There is no evidence that the 3 professionals developing the care plan coordinated their findings and recommendations between each other, so the care planning seems to be unidisciplinary - Care coordination of services or between the intervention providers is not mentioned - The care planning by the nurse includes medication review, as suggested by the use of the RAI-HC Organisation: Unclear whether the nurse, physiotherapist, and social worker were especially recruited for this intervention (in this study), and their affiliation(s). Deliverer inter-relations: - The 3 professionals planned and discussed with a geriatrician the intervention protocol to standardise instructions to participants. - The 3 professionals consulted the geriatrician when necessary. - Assuming they coordinate the visits schedule with each other. - The physiotherapist and social worker checked the participant's understanding of the instructions from the previous professional visitor, assuming they would inform each other about their instructions provided to the participant. Responsibilities:

	Each professional was responsible of different aspects of a participant; conducted different type of assessment in each visit. They mainly made recommendations to pts, and would arrange contacts for the pts when necessary.
7. Where	Location: Hyvinkää, Finland (a mid-size Finnish town with 46,600 inhabitants.) - At home
8. When and how much	When started: Status - not dependent (not receiving home help or nursing services) Intervention schedule and each session length: 3 home visits in 6-9 months, circa 3 months between each visit - 1st nurse visit (1-1.5 hours) 2nd physiotherapist visit (1-1.5 hours) 3rd social worker visit (0.5-1.5 hours)
9. Tailoring	1. Information, instructions, and aids were given to participants according to their needs (results from the structured assessment conducted by each professional), and/ or preference. 2. Individual exercise instructions were compiled by the physiotherapist based on the test results, and participant's motivation and wishes. 3. If a need for services or concerns arose during the visit, the professionals helped the participant to contact the service providers, or arranged the suitable services.
10. Modifications	Not mentioned.
11. How well (planned)	The team members planned and discussed the intervention protocol, and uniform instructions were given verbally and written on paper to everyone delivering the home visits. This standardised, as far as possible, how the nurse, physiotherapist and social worker conducted the assessments, and provided the intervention accordingly.
12. How well (actual)	1. The professionals conducting home visits reported the structured assessments and planned interventions were carried out and concluded as planned. 2. Some home visits postponed, e.g., because of illness, but none cancelled.

Exercise and multifactorial-action with medication review and self-management

Table 143. Faul 2009[99] Assessment and Brief Intervention Group (ABIG)

1. Brief name	Assessment and Brief Intervention Group (ABIG). Geriatric assessment services, with a brief self-management care plan intervention
2. Why	Goal: to complement traditional care and follow the self-management principles outlined in the conceptual framework in order to reduce older adults' risk of becoming frail and losing their functional independence prematurely Rationale: ...by informing and empowering older adults and providing interaction with prepared, proactive interdisciplinary practice teams in dealing with aging and chronic illness

	...based on the self-efficacy perspective of social cognitive theory (Bandura, 1986, 1997) ...based on a successful telephone intervention for older adults with chronic arthritis developed by Parisier *et al.* (2006)
3. What (materials)	- GEMS client website (with access to relevant information) - Various assessment tools such as: General Assessment Questionnaire, modified from the Guide to Physical Therapist Practice; American Physical Therapy Association, 2001; an Ecomap, and a Genogram; Sheafor, Horesjsi & Horesjsi, 1997, Physical Therapist Patient Management Systems Review - A written record of the assessment and care plan added to the medical file - An exercise software program
4. What (procedures)	- Providing a comprehensive assessment including functional status, physical mobility, mental health, environmental barriers at home. - Medication was assessed and the information was shared with the primary care physicians for necessary changes - Providing a care plan tailored the person's assessment, needs and preferences which selected among actions such providing advice about available community resources or how reduce fall hazards around the house - Providing an individualized physical exercise plan which is demonstrated to the participant
5. Who provided	Interdisciplinary team consisting of a physical therapist professional, a physical therapist student and a social work student. All the intervention providers received training and supervision.
6. How	- Individually and face-to-face based on home visiting format - Presumably the intervention deliverers used goal setting techniques such as breaking down a major goal in smaller realistic goals
6b. How organised	- The care plan was developed based on the contribution of the interdisciplinary team, including physical therapists and social workers, professionals and students - The physical therapy students were accompanied by a professional in the visits due to professional requirements - There was an effort to reconnect or forge new partnerships with community organizations - The assessment and care plan were shared with the primary care provider of the participant by adding the information to their medical file
7. Where	- At home - Louisville, Kentucky
8. When and how much	- Started when participants were 65 years+, literate, had a permanent address (excluding nursing homes), a primary care physician, no acute medical or mental health needs, nor any recent (past 6 months) major medical event (e.g., heart attack, stroke, major surgery) and not receiving home health care. - 3 home visits over a month, the first took 1 hour and the second took 2 hours
9. Tailoring	- The care plan was tailored based on the participants' assessment and their needs and preferences - Physical exercises were also tailored to the participant
10. Modifications	Not mentioned
11. How well (planned)	The delivery of the intervention as planned was supported by the training and supervision of the professionals involved

12. How well (actual)	Not mentioned

Exercise and psychology

Table 144. Alegria 2019[14] Positive Minds Strong Bodies (PMSB)

1. Brief name	Positive Minds Strong Bodies (PMSB). A psychosocial intervention including individual cognitive behavioral therapy and group strength exercise training.
2. Why	Goal: to reduce mental and physical disability (improve in mood symptoms, and decelerate deterioration in physical functioning) for minority and immigrant elders through the efforts of community health workers and exercise trainers. Rationale: ...based on evidenced-based approaches to improve coping and functional restoration ...based on extensive literature on the effectiveness of CBT to cope with mood symptoms and exercise training to improve physical function ...by engaging community-based organizations in the delivery which offer easy access to activities, trusted personnel, prevent social loss, and lack of recognition of mood symptoms.
3. What (materials)	- Translated and culturally adapted manual used by community health workers to deliver the cognitive behavioural therapy (CBT) sessions. - Weighted vest provided for the exercise component. - Instructional video provided to guide exercises at-home. - Material preparation, intervention protocols, and weekly supervision were conducted in English, Spanish, Cantonese, or Mandarin. - PHQ-9 and GAD-7 and, if necessary, the 5-item Paykel suicide questionnaire that could trigger emergency referrals - Audiotapes of calls and Positive Minds (PM) intervention for implementation fidelity analysis - Checklist of PM session activities used to analyze intervention fidelity - Videotapes of Strong bodies (SB) sessions used to analyze intervention fidelity
4. What (procedures)	1. Positive minds (PM) Cognitive-Behavioural Therapy based intervention focused on psychoeducation, mindfulness, cognitive restructuring, noticing and overcoming unhelpful thought and creating a self-care plan. Motivational strategies were used by deliverers. 2. Strong bodies (SB) exercise training programme focused on resistance or power training. 3.A call by research staff every 2 weeks to administer the PHQ-9, GAD-7, and the 5item suicide questionnaire. This allowed to identify relevant symptoms and connect participants to emergency responders as required. For staff: - Intensive training and regular supervision
5. Who provided	- Community Health Workers recruited in collaboration with Site Leaders and trained by the primary author and licensed supervisors. - Exercise trainers were also involved in the intervention and were supervised by the second author. - Research staff were involved in calling the participants.

6. How	SB was a group intervention. This was the exercise component of the intervention. Part of this was delivered face to face and could be at a distance if the participant was unable to attend the class. (Via instructional video exercises) PM consisted on individual sessions, face-to-face or over the phone. This was the psychosocial aspect of the intervention with the goal of creating a self-care plan. Participants also received calls on a individual basis from the research staff, to assess mental health deterioration and refer to adequate services if necessary. This support was offered from a distance.
6b. How organised	- Community Health Workers were selected and trained from each collaborating community-based organization (CBO) and the Disparities Research Unit. Each CBO had a designated site leader who oversaw the intervention process locally
7. Where	- United states - Participants were linked to community-based organizations and community clinics serving low-income minorities or immigrants in Massachusetts, New York, Florida, or Puerto Rico. - Sessions were held at the community-based organizations and community clinics or in participants' homes
8. When and how much	- The intervention started following recruitment of people identified as having low mood and mild-moderate disability who were enrolled in community-based organizations and clinics for low-income immigrants or minorities. - Total of 46 sessions. 10 PM sessions and 36 SB sessions. - Three SB group sessions per week over 12−14 weeks for a total of 36 sessions. - PM consisted of 10 one-hour individual sessions over a 6-month period
9. Tailoring	- Sessions are tailored to the participant’s needs using a collaborative approach. PM deliverable in-person and over the phone. SB deliverable in-person and via video. - Manual and materials were linguistically adapted. - An emergency responder was contacted in case of urgent need
10. Modifications	Materials and components were tailored to language groups and culturally adapted as problems were identified through the course of the trial.
11. How well (planned)	- Calls were audiotaped, and every 1st two interviews and random sample of 15% were analyzed for quality control. - All PM sessions were audio recorded. Every two 1st sessions and random sample of 15% were reviewed for intervention fidelity. - The SB sessions were regularly videotaped, with 8.85% of the sessions checked for implementation quality. - CHWs and exercise trainers received biweekly supervision and feedback on fidelity and issues of clinical significance.
12. How well (actual)	- PM session fidelity was 80.5% (ranging from 76.9% to 83.7%) - SB sessions was 65.9% (ranging from 65.2% to 66.7%). - Of the 153 participants enrolled in PM, 105 (68.6%) completed all 10 sessions, 13 (8.5%) completed 4−9sessions, 15 (9.8%) completed 1−3 sessions, 10 (6.5%) declined or dropped out, and 10 (6.5%) discontinued because of medical reasons, death, or referral for suicidal ideation. - Of the 153 individuals enrolled in SB, 37 (24.2%) completed all 36 sessions, 21 (13.7%) completed 25−35 sessions, 39 (25.5%) completed 1−24 sessions, 21 (13.7%) declined or dropped out, and 35 (22.9%) did not initiate treatment due

	to hurricane-related lack of facilities in the Puerto Rico and Florida, failed/delayed medical clearance because of the hurricane, or death.

Table 145. Jing 2018[102] Baduanjin qigong plus cognitive-behavioral therapy (CBT)

1. Brief name	Baduanjin qigong plus cognitive-behavioral therapy (CBT). Combined functional therapy and progressive psychological intervention.
2. Why	Goal: To further improve physical and psychological health and well-being in the elderly housebound. Rationale: Based on previously shown success of Baduanjin qigong in the prevention and treatment of psychological and health problems, by combining physical activity, breathing regulation and psychological adjustment. Additionally based in the previously shown success of CBT in promoting individual change in thought and behavior for a variety of psychological and physical problems, including in housebound individuals.
3. What (materials)	Not mentioned
4. What (procedures)	For participants: - Baduanjin qigong training including breathing exercises and on the upper and lower extremities - CBT including focus on individual initiative to deal with owns psychological problems - Continued practice of Baduanjin qigong and CBT supported by encouragement calls For staff: initial intervention training
5. Who provided	Faculty members and graduate nursing students that received intervention training
6. How	Individually through home visits and telephone calls
6b. How organised	No details of organisational system.
7. Where	- In Tangshan, China - At home
8. When and how much	- Initiated when participants were housebound (left the house once per week or fewer over a period of at least 6 months). - 1 weekly call in the 1st month - 1 to 1.5 hours visits every 15 days in the 1st 3 months, and monthly from 3 to 6 months.
9. Tailoring	The cognitive behavioral therapy provided tailoring by focusing on individual psychological problems.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 146. van Heuvelen 2005[89] Physical activity and psychological training

1. Brief name	Physical activity and psychological training.

2. Why	Goal: generally, to improve physical and psychological fitness and self-reliance/disability. More specifically, to 1) teach the participants strategies that can remove blockages that prevent active participation in social life and 2) to increase endurance, strength and coordination Rationale: - The psychological training was based on elements of rational emotive therapy and was expected to activate several mechanisms, including increased self-efficacy and approaching behaviour and decreased feelings of anxiety and depressive symptoms. - The physical exercise was expected to activate several mechanisms related to improved brain function - Based on previous evidence which shows benefits of physical activity and interventions to cope with cognitive symptoms and other barriers to an active lifestyle - A combination of both physical exercise and psychological training was expected to increase benefits.
3. What (materials)	- Brain teasers were used in the executive function/problem solving training - Resistance bands for the physical exercise
4. What (procedures)	- Physical exercise sessions including strength, endurance and coordination - Psychological training including psychoeducation about aging and cognition and problem-solving, with exercises like setting goals in everyday tasks. The sessions also included relaxation.
5. Who provided	- Sports leaders with sports and Human Movement Sciences training - Provider of the psychological training is not specified
6. How	- In group, presumably face-to-face
6b. How organised	Not mentioned
7. Where	- Groningen, north of the Netherlands - Gyms in the living environment of the participants - Location of the psychological training group sessions is not specified
8. When and how much	- Started when participants were enrolled in a longitudinal study which recruited people 57 years old or older, and without severe cognitive impairments. Participants were assessed for level of functional and physical activity in two questionnaire and excluded if (i) very active on both scales or (ii) very active on one scale and moderately active on the other scale. - 70 minutes of physical exercise or 90 minutes of psychological training once a week alternately for 12 weeks; - For the last 6 weeks, there was psychological training every other week and exercise every week. - Overall 20 sessions
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Strategies were put in place to facilitate participation: transport by taxi was offered, newsletters about the progress of the research were sent and the group leaders were instructed to give personal attention.
12. How well (actual)	- 42% of the participants attended 12 sessions or more. 28% of the participants attended only 1 to 4 sessions

Exercise, multifactorial-action and review

Table 147. Wallace 1998[95] Community-Based Health Promotion Program

1. Brief name	Community-Based Health Promotion Program. A multicomponent disability prevention program consisting of a senior center-based intervention that involved a nurse assessment visit and follow-up interventions targeting risk factors for disability with a structured exercise program as the central component.
2. Why	Goal: to prevent or reduce functional decline and prevent disability Rationale: This is by changing certain behaviors, particularly physical activity Addressing risk factors such as alcohol misuse, smoking, poor nutrition and home safety hazards This is based on previous evidence showing the importance of physical exercise on the maintenance of health and function Prior work has shown that targeting risk factors for disability could lower the incidence of functional decline and falls
3. What (materials)	- CAGE questionnaire, to detect alcoholism - Pamphlet on the effects of alcohol in older adults and behavioral strategies for limiting use - Referrals to smoking cessation classes - Nutrition tip sheets - Self-administered hazard checklist
4. What (procedures)	-Review of risk factors for disability and development of a targeted health promotion plan, and introduction of supervised exercise program. Providing referrals to smoke cessation sessions and/or choice of self-help programs for smokers (by nurse) - Exercise program in groups, including balance exercises, strength training, walking/aerobic activity, flexibility exercises and cool-down phase (by trained exercise instructor). - Reviewing of the care plan. Contacting participants to review progress, motivate continued behaviour change, and identify problems with compliance (by nurse) - Presumably senior centre standard care was maintained, including access to senior centre resources such as meal programs
5. Who provided	Number of Intervention Providers :02 (Multidisplinary) - Registered nurse - Trained exercise instruction
6. How	- The first session with the nurse is face to face and presumably individual - The progress reviews are conducted by phone, at a distance and presumably individually - The exercise program is conducted in groups of 10 to 15, and face to face.
6b. How organised	1. Northshore Senior Center provided the physical site for the intervention and a community base from which subjects for the trial could be recruited. 2. GHC (Group Health Cooperative of Puget Sound (GHC), a health maintenance organization based in Seattle) presumably provided intervention deliverers - The care planning does not mention or imply medication changes
7. Where	- In Bothell, Washington

	- At the Northshore Senior Center, a community senior center serving predominantly white and relatively well-educated community, run by Seattle-King County Senior Services - In partnership with the Group Health Cooperative of Puget Sound (GHC), a health maintenance organization based in Seattle, and the Health Promotion Research Center at the University of Washington
8. When and how much	- Started when (1) participants were enrolled in a senior center serving a predominantly white and relatively well-educated community, and (2) following screening tests and a brief evaluation by physician to exclude participants too disabled, cognitively impaired or ill. - 1 initial session of 30 to 60 min, 3 exercise sessions a week for 6 months (26*3=78 sessions), 3 phone sessions at 1, 4 and 16 weeks for progress review.
9. Tailoring	- Care plan elaborated with the participant's input and targeted to individual needs - Alcoholism intervention adapted to participant's drinking - Smoking intervention adapted to participants (choice between 2 self-help programs and cessation classes).
10. Modifications	Not mentioned
11. How well (planned)	- Compliance was encouraged through 3 phone calls by nurse at 3, 4 and 16 weeks
12. How well (actual)	- Exercise program attendance was over 90% - The evaluation of compliance for smoking and alcohol interventions was limited by the small number of participants identified as needing them (1% and 8% respectively) - The nutritional tip sheets were read by 92% of the participants

Exercise, multifactorial-action and review with medication review

Table 148. Thiel 2019[85] High-Intensity Functional Exercise program (HIFE)

1. Brief name	High-Intensity Functional Exercise program (HIFE). A multimodal, resource-oriented, inter-professional intervention including the HIFE program- a standardized, physical exercise program
2. Why	Goal: to impact frailty, mobility, disability, falls, cognition, mood/depression, nutritional condition and quality of life. Rationale: - Based on previous research showing that the most effective interventions in aging are multimodal and emphasize physical activity - Based on the Guidelines for the Care of Elderly People with Frailty which recommend a detailed diagnosis based on a geriatric assessment - Based on previous pilot studies with the HIFE physical exercise program which show feasibility and effectiveness in care facilities
3. What (materials)	- Written instructions to deal with needs identified are provided in an information letter and linked to recommendations to consult other health professionals, as necessary
4. What (procedures)	- Multidomain assessment and care planning with provision of recommendations and referrals to other professionals. - The assessment included a medication review that would trigger a specific related recommendation if necessary

	- Physical exercise program including endurance, strength, balance and flexibility exercises and individually adapted to the participant - Participants were routinely followed up in regular home visits. - Access to usual care services based on the participant's own initiative, which may include medical care, usual medication, physiotherapy or no intervention.
5. Who provided	- Both the assessment and following recommendations and the physical exercise programme were delivered by trained physiotherapists
6. How	- Individually and presumably face-to-face, based on home visiting format - By telephone, if necessary
6b. How organised	- The care plan seems to be developed by the physiotherapist and in collaboration with the participant, and possibly his/her family
7. Where	- At home - Bochum, Germany
8. When and how much	- Started after participants were assessed by phone or at home as frail (0.25 or more Frailty Index) and with no medical restrictions to exercise. Participants were 65 years old or older and were not engaging or planning to engage in regular exercise (more than once a week). Participants were informed of the study and invited to participate in several ways, including through: 1. clinical observational studies, 2. local social institutions, 3. nursing services, 4. newspapers. - The intervention took 3 months during which participants were expected to exercise twice a week for 45 minutes, in a total of 24 sessions or more - There are at 6 home visits, and additional phone calls as needed
9. Tailoring	The multimodal recommendations, the physical exercise plan and the possibility of additional contacts were all tailored based on participant's needs, ability and preference (with possible participation of relatives/carers too).
10. Modifications	Not mentioned
11. How well (planned)	- The fidelity of the intervention was supported by training intervention providers, and providing a training calendar and diary to the participants - An analysis of fidelity and adherence was planned including data collection on variables such as compliance, intensity, refusal rate for physical exercises, among others
12. How well (actual)	Not mentioned

Exercise, multifactorial-action and review with medication review and self-management

Table 149. Cameron 2013[23] Multifactorial, multidisciplinary frailty intervention

1. Brief name	Multifactorial, multidisciplinary frailty intervention.
2. Why	Goal: to target the identified characteristics of frailty, functional limitations, nutritional status, falls risk, psychological issues and management of chronic health conditions and reverse frailty, improve functioning, mobility, depressive symptoms and quality of life. Rationale:

	- based on geriatric evaluation and management principles, in particular comprehensive geriatric assessment including multidisciplinary process, diagnose of individual needs, and co-ordination through case management. - based on previous research showing improvement in frailty both with multifactorial interventions (especially if taken regularly and over a prolonged period) and single interventions such as exercise programs and nutritional supplementation - the exercise program was based a systematic review on exercise for fall prevention by Sherrington and colleagues - the delivery of the intervention was supported by behavior change techniques supported by the Behavior Change Technique Taxonomy
3. What (materials)	- Exercise equipment (e.g., steps and weight vests) were provided as necessary - Exercise instruction booklets were provided
4. What (procedures)	- Multidomain assessment including frailty assessment (e.g., weight loss, walking speed...), and other domains such as psychological status, social participation. An additional comprehensive geriatric evaluation was provided by a multidisciplinary team. - The assessment was used to tailor the care plan based in algorithmic rules and, presumably, clinician input in case conferences. - There were regular reviews and ongoing reassessments by a case manager - A variety of interventions was put in place according to need, including nutritional interventions, medication changes, referrals to mental health professionals, among others. - 93% of the participants were enrolled in a home-based exercise program, including strength, balance and endurance training. - Access to usual health care services, which includes GP and medical specialist consultations, and nursing and allied health interventions.
5. Who provided	- Mainly provided by the physiotherapist. In addition, geriatrician, rehabilitation specialist, dietician, and nurse also contacted with all participants in a brief initial assessment. - The team was experienced in aged care, goal setting and multidisciplinary case conference
6. How	- Face-to-face and presumably individually (based on home visit format) - By telephone - Multiple behavior change techniques were put in place to support the compliance with the exercise program (e.g., goals setting, education, involvement of family and carers).
6b. How organised	- The care planning decision making was based on case conferences involving a multidisciplinary team (physiotherapist, geriatrician, rehabilitation physician, nurse and dietician) - The care planning explicitly mentions medication changes - The physiotherapist acted as case manager, carrying out reviews and being primarily responsible for each participant - The physiotherapist facilitated the coordination of the delivery of the intervention, contacting with the participant and with other parties involved in intervention delivery - Australia has a system of universal health insurance so that all of its population has access to health care without significant cost
7. Where	- At home - Hornsby Ku-ring-gai, Sydney, Australia

	- It is not clear where the initial assessment took place
8. When and how much	- Started when participants were 70 years old or older and had recently been discharged from the hospital Rehabilitation and Aged Care service, and after participants were assessed as presenting 3 or more Fried Frailty Criteria. - Overall there were a median of 10 face to face sessions (0 to 24) with more sessions reflecting more need for case management - One assessment by physiotherapist for 2 hours + assessment with interdisciplinary team for 20 minutes - Median of 4 telephone calls/participant (could reach 8). Home-care exercise program - 1 hour sessions with physiotherapist in median of 8 sessions - Participants were expected to keep exercising 20-30 min three to five times per week for 1 year.
9. Tailoring	The care plan was tailored based on the needs and problems identified in assessment and reassessments, in terms of procedures, equipment used and frequency of visits. The care plan followed some algorithmic rules based on the frailty criteria, but it is likely that there was also clinician input, based on the occurrence of frequent case conferences.
10. Modifications	Not mentioned
11. How well (planned)	- Adherence to the intervention was supported by several strategies namely: case management by the physiotherapist, and the use of behavioral change techniques. - The measurement and analysis of adherence was prep-planned using consistent methods of gathering and analyzing data, including estimation by the professional, self and proxy-reports and organized in a 5-point scale considered to have face validity (0%, 1 to 25%, 26 to 50%, 51 to 75%, and 76 to 100%).
12. How well (actual)	- The median amount of treatment received was 26 to 50% of that prescribed. -13% received no intervention, -29% received 1 to 25% of the intervention, - 16% received 26 to 50%, - 21% received 51 to 75%, - 21% received 76 to 100%.

Homecare

Table 150. Auvinen 2020[103] Usual public home care services

1. Brief name	Usual public home care services.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Professional home care, including home care for fitness and everyday tasks, and home health care. May include ad hoc medication review. - Usual community healthcare, including access based on participants' own initiative to primary care clinic, outpatient services and specialist care (e.g., mental health and dental care), and emergency services.

5. Who provided	- Nurses provide care at home regularly so presumably they delivered home care (other professionals may have been involved)
6. How	Usual home care provided presumably to the individual and face-to-face
6b. How organised	- Usual home care includes an important role for the nurse, who visits the person regularly - The centers were recruited from the interprofessional network constructed to establish guidelines for interprofessional collaboration in medication management of the aged, organized by the Finnish Medicines Agency (FIMEA)
7. Where	- At home - In five areas in Finland: Forssa, Haapajärvi, Lahti, Juva and Savonlinna.
8. When and how much	- Started when the participants were receiving home care. Participants had dizziness, orthostatic hypotension or have fallen, or used at least six medicines
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 151. Bernabei 1998[104] Standard care

1. Brief name	Standard care.
2. Why	Goal: To help elderly people stay at home Rationale: ...by responding to the demands of older people
3. What (materials)	Not mentioned
4. What (procedures)	Access to primary and community care services, including general practitioner's regular ambulatory and home visits, nursing and social services, home aids, and meals on wheels.
5. Who provided	- Presumably, health and social professionals involved in conventional primary and community care services, including nurses and general practitioner
6. How	- Access to a variety of primary and community-based care may presumably provide services face-to-face and at a distance, individually and in group
6b. How organised	- Primary and community care services are provided in a fragmented way as part of usual care
7. Where	- Rovereto, in northern Italy - In the context of a care system that includes a hospital geriatric evaluation unit, a skilled nursing facility, and a home health agency - Access to a variety of primary and community-based care may presumably provide services at home and specialized facilities
8. When and how much	- Started when the participants were recipients of home health/assistance services without a previous comprehensive geriatric assessment
9. Tailoring	- Assuming the healthcare and home care provisions were given according to the individual's needs
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 152. Dupuy 2017[105] Control group

1. Brief name	Control group. Participants were equipped of paper-based fake assisted living technology sensors; in addition to usual home care services.
2. Why	Caregivers are important resources for frail older people, acting as "human environmental support for ADL".
3. What (materials)	Paper-based fake sensors installed; otherwise, not specified.
4. What (procedures)	1. Public home care services provided by paid caregivers, by home visit, supporting domestic tasks, purchases, administrative tasks, and everyday functioning of the individuals. 2. Unclear whether the individuals received OT assessment before the paper-based fake sensors installation. 3. Unclear whether participants and caregivers were informed of the pretend purposes/ functions of the fake sensors.
5. Who provided	1. Paid caregiver providing home care services 2. Not specified otherwise.
6. How	Caregiver provided face to face support to the individual.
6b. How organised	Organisations: Public home care services for community dwelling older adults. Responsibilities: 1. Public home care services for community dwelling older adults. 2. The professional caregivers provided support for domestic tasks, purchases and administrative tasks in home visits; undertaking training with the older adults to understand and master the various functionalities of HomeAssist.
7. Where	Location: France Home care services provided at individual's home.
8. When and how much	Intervention started: Older people already receiving home care services, and their paid caregivers were recruited. Home care services schedule: 1. Frequency of caregivers visited the individuals depended on each individual's needs, e.g., 2 times/ month, once/ day. 2. Duration of each visit not specified. Unclear when and how the fake paper-based assistive technology sensors were installed.
9. Tailoring	1. Caregivers visited the individuals depended on each individual's needs, e.g., 2 times/ month, once/ day. 2. Caregivers mainly providing support for domestic tasks, purchases and administrative tasks.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 153. Fernandez-Barres 2017[106] Home care program

1. Brief name	Home care program.
2. Why	The public Primary Health Care services have developed a free of charge Home Care Program which covers homebound patients (of any age), most of whom are dependent, to ensure continuity of care, access to nursing and medical services, and equality in care of patients who for various reasons are unable to visit a Primary Health Care Center.
3. What (materials)	Not mentioned.
4. What (procedures)	The elderly people received regular Home Care visits, to ensure continuity of care, access to nursing and medical services, and equality in care of patients who for various reasons are unable to visit a Primary Health Care Center.
5. Who provided	Number of Intervention providers: 2+ Nurse Doctor
6. How	Face to face : 1. Initial Home Visits 2. Regular home care visits
6b. How organised	Free of charge Home Care Program.
7. Where	Intervention location : Reus and Tarragona counties (Spain), A random selection at 10 Catalan Health Institute Primary Health Care Centers.
8. When and how much	When started usual care (Home Care Program) for various reasons are unable to visit a Primary Health Care Center.
9. Tailoring	Usual care that is not tailored.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned.
12. How well (actual)	After the education intervention, the intervention group improved their nutritional knowledge by 1.5 points (8.2 ~ 1.4 Vs. 9.7 ~ 1.2; P < 0.001) according to the 11-item questionnaire. This improvement persisted throughout the 12-month follow-up. The effect of the intervention was B = 3.22 (P < 0.001) in the adjusted multiple linear regression model (Table 5). The baseline BMI (B = 0.17; 95%CI = 0.05, 0.28; P = 0.005) and baseline Barthel score (B = 0.03; 95%CI = 0.01, 0.06; P = 0.013) were the factors positively associated with the Mini Nutritional Assessment score after 12 months of follow-up.

Table 154. Fristedt 2019[107] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Usual care including primary care units, home care and home help, and hospital-based healthcare. Primary care is supposed to guide patients to the right level in the healthcare system

5. Who provided	- Presumably health and social care professionals involved in usual care, including primary care, hospital-based care, long-term health and social care.
6. How	Not mentioned
6b. How organised	- The state is responsible by the healthcare policy - The county council is responsible for organizing care - Municipalities are responsible for the long-term health and social care of older people - Long-term health and social care of older persons is provided by the municipalities or by private companies - Primary care is the first line of healthcare in primary care practices and at home, and guides patients to the right level in the healthcare system
7. Where	- In Southern Sweden
8. When and how much	- Started after assessment based on electronic records that selected "frail" elderly based on the following criteria: being community-dwelling persons aged > 75 years, having more than three chronic diagnoses, prescribed six or more pharmaceutical drugs for continuous use and with at least three hospital stays (> 24 hours in hospital) during the last six months.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 155. King 2012[108] Usual home care

1. Brief name	Usual home care.
2. Why	Goal: to substitute for acute care hospitalisation, to substitute for long-term care institutionalisation, or to prevent the need for institutionalisation and maintain individuals in their own home and community
3. What (materials)	- Support plans identifying the household activities in which the person needs help.
4. What (procedures)	- Professional home care including provision of personal care and household management. A brief description of what the person needs help with (support plans) is assessed every year and used by the support worker as a guide to action. - Other usual community healthcare services were presumably available to the participants. These included, for example, community therapy (OT, physiotherapist.), outpatient clinics, primary care, podiatry, etc.
5. Who provided	- Support workers/paid caregivers provided professional home care - Coordinators (non-health professionals) oversaw home care activities, and undertook assessments of the professional home care needs(BUT it is not clear if every participant received this assessment during the intervention period).
6. How	- Presumably individually and face-to-face (as services were provided at home).
6b. How organised	- Access to home care services depended on a centrally based assessment by the NASC (Needs Assessment Services Coordinator), which determines needs level and prioritises care. - Usual community care works independently (not coordinated).

	- There is mention to a "coordinator" in usual home care, but this person seems to act as a coordinator of the service, not a coordinator of individual care.
7. Where	- At home, in the context of one home care agency provider - In South Auckland, New Zealand
8. When and how much	- Started when the participants were receiving home care services. Access to these services depended on a centrally based assessment by the NASC (Needs Assessment Services Coordinator), which determines needs level and prioritises care centrally. - Support worker contact with older people would range from daily to fortnightly as a minimum.
9. Tailoring	- The support worker provided help with domestic chores according with the needs of the participants.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 156. Lewin 2013[109] Usual home care

1. Brief name	Usual home care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Assessment and care plan linked to home care service needs. Services consisted mostly of personal care visits to assist with bathing/showering, cleaning and laundry. - Presumably participants were able to continue accessing other community services which were part of usual care.
5. Who provided	- An usual care co-ordinator (the professional background is not specified) - It is not clear if the care co-ordinator provided direct care, but it is likely there were other professionals involved.
6. How	Presumably individually and face-to-face (as this is an at home intervention).
6b. How organised	- There is "coordinator" but it is not clear to each extent this person has functions of facilitating the coordination of individual care. - Provided by the Home and Community Care (HACC) programme, which is a not-for-profit organization jointly funded by the Commonwealth and State Governments.
7. Where	- At home - Perth suburbs, Western Australia
8. When and how much	- Started after referral to homecare services for assistance with personal care (first time or request for increase). These people were assessed and found eligible to this type of care, namely, they were in need of assistance with one or more tasks of daily living because of an ongoing disability (rather than needing acute or post-acute care). Participants were excluded if they had complex needs (requiring 15 hours or more of care/ week). - Most commonly, the intervention included 3 visits/week (personal hygiene) and a fortnightly additional visit (for cleaning)

9. Tailoring	The professional home care provided was tailored in individual needs (through and assessment and care plan presumably focused on home care activities).
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- Home-care staff may have promoted reablement principles that are not by design part of this intervention

Table 157. Mann WC 1999[110] Usual care

1. Brief name	Usual care.
2. Why	Not mentioned
3. What (materials)	- Possibility to access assistive devices and /or environmental interventions while in usual care.
4. What (procedures)	- Access to home-based senior services including: post-discharge and rehabilitation medical services, nurse care (aids and medical interventions), non medical services (e.g., meals-on-wheels, shop assistance)
5. Who provided	- Presumably other professionals accessible through usual care, such as doctors, nurses and providers of nonmedical services (e.g., personal care, meals on wheels).
6. How	- Accessible usual homecare provided presumably individually and at least partially face to face.
6b. How organised	Not mentioned
7. Where	- Presumably at home - Western New York, USA - In the context of a system of care that includes (1) a medically directed county agency that provides services to Medicaid-eligible homebound elderly persons, (2) hospital physical medicine and rehabilitation programs, providing short term rehabilitation, and (3) Visiting Nursing Association, serving both Medicare- and Medicaid-eligible persons
8. When and how much	- Started after referral by one of 3 sources: medically directed homecare service (when starting service), in-patient rehabilitation program (participants were discharged in the year before study), visiting nurse association (participant was receiving services) - Started after initial assessment - Started when no cognitive deficit was identified, but there was difficulty in 1 or more areas of the functional independence measure (FIM).
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 158. Rooijackers 2021[111] Usual home care

1. Brief name	Usual home care.

2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Home care including domestic services (e.g., cleaning, washing) and nursing care. The latter can be subdivided into personal care (e.g., assistance with bathing and dressing) and specialised nursing care (e.g. wound care, catheter insertion).
5. Who provided	Nurses and domestic support workers provided home care as usual Domestic support workers often have a low level of education and have limited possibilities to exchange their experiences with their colleagues or to join training activities. Each team is guided by a district nurse (baccalaureate-educated registered nurse). The other team members are vocationally-trained registered nurses or certified nurse assistants.
6. How	Presumably individually and face-to-face based on home visiting format
6b. How organised	- A team manager supervises team nurses who provide care. Domestic support workers are also coordinated by a team manager. They are linked to a working area, but not to a specific nursing team. - Nursing care is financed by healthcare insurance. In the Netherlands, nearly all citizens are covered by healthcare insurance and services are easily accessible
7. Where	- At home - South of the Netherlands - In the context of a large healthcare provider that offers home care services
8. When and how much	- Participants were 65 years old or older and were receiving home care, without serious cognitive or psychological problems, terminally ill or bedbound, or unable to speak Dutch. Participants were recruited following contacts be letter/flyer, phone and home visit. - The home care services usually include nurse's short visits several times a week, and domestic workers visits once per week for a couple of hours.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 159. Teut 2013[112] Usual Care

1. Brief name	Usual Care.
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	The Usual Care group (UC) received conventional, usual care without any influence due to the study
5. Who provided	family physicians, specialists, nurses, physiotherapists, and occupational therapists,
6. How	Not mentioned

6b. How organised	Patients (older adults living in 8 shared apartment communities with integrated nursing care) received conventional care by family physicians or specialists.
7. Where	Older adults living Apartment-sharing communities with integrated care. 8 such apartments took part in the trial. These are now a more popular residential option among older people in Germany. This type of daily living is much closer to a usual family life.
8. When and how much	Older adults were enrolled by the study physicians. All residents living in the 8 shared community apartments were invited to take part.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 160. van der Pols-Vijlbrief 2017[113] Usual care plus healthy diet information brochure

1. Brief name	Usual care plus healthy diet information brochure.
2. Why	Not mentioned.
3. What (materials)	1. a standard brochure of the Netherlands Nutrition Centre with general information about a healthy diet after the baseline examination was performed.
4. What (procedures)	The control group received a standard brochure of the Netherlands Nutrition Centre with general information about a healthy diet after the baseline examination was performed. Available standard intervention and usual care: - home care services - visits to general practitioner, dentist, therapists such as a dietician or a physiotherapist, social worker - hospital stays, admissions to other institutions, outpatient visits
5. Who provided	Home care (standard intervention): Health care worker
6. How	1. Assuming face to face home visits for home care services.
6b. How organised	1. Assuming the home care workers were responsible for the home care services. They identified those who might be at risk of undernutrition among their clients, to refer to the researchers. 2. Assuming the nutrition information brochure was given by the researcher at baseline home visit.
7. Where	Assuming home care services were provided at participant's home.
8. When and how much	When started (in this trial): Assessed as undernourished or at risk of undernutrition AND Status - receiving home care services and 65+ years old When started (to received home care): Not mentioned. Home care details not mentioned.
9. Tailoring	Not mentioned.

10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 161. Wolter 2013[114] Usual home care services (including nursing)

1. Brief name	Usual home care services (including nursing).
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Usual home care services, including nursing services, personal care, meals, medication and social engagement.
5. Who provided	The usual home care service includes care provided by nurses.
6. How	- Presumably individually and face-to-face, based on home care delivery
6b. How organised	- All home care services signed a cooperation agreement
7. Where	- At home - Urban and rural areas in Germany - In the context of a long-term care insurance system that aims at supporting home care and improving its quantity and quality by public funding this sector. This resulted in a enormous growth of these services, with different levels of quality
8. When and how much	- Started when participants were receiving home care, including nursing services, and needed long-term care according to German social care regulations - The home care providers were recruited by announcements in journals. - Provision of usual home care was presumably regular.
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Homecare and aids

Table 162. Mann WC 1999[110] Intensive Assistive Technology (AT) and Environmental Interventions (EI) service provision

1. Brief name	Intensive Assistive Technology (AT) and Environmental Interventions (EI) service provision.
2. Why	Goal: to promote independence and reduce health care costs for physically frail elderly people Rationale:

	...based on preliminary results showing a link between increased use of assistive technology and greater independence
3. What (materials)	- Devices for motor, hearing and vision impairments (e.g., wheelchair, hearing aids) and home modifications (e.g., hand railings, bathroom repair)
4. What (procedures)	- Comprehensive functional assessment of the person and home by OT - Arranging and providing assistive technology and environmental devices with support of nurse and technician - Regular reviewing of needs and AT-EI provision - (As in usual care) access to home-based senior services including: post-discharge and rehabilitation medical services, nurse care (aids and medical interventions), non-medical services (e.g., meals-on-wheels, shop assistance)
5. Who provided	- Occupational therapist conducted assessment, planned and put in place recommendations, assisted by nurse and technician experienced in home modifications. - Presumably other professionals accessible through usual care, such as doctors, nurses and providers of nonmedical services (e.g., personal care, meals on wheels).
6. How	- Assessment and modifications provided individually and face to face (inferred based on being a home visit). - Usual homecare provided presumably individually and at least partially face to face.
6b. How organised	- The nurse and technician in home modifications took an assisting role in relation to the occupational therapist
7. Where	- At home - Western New York, USA - In the context of a system of care that includes (1) a medically directed county agency that provides services to Medicaid-eligible homebound elderly persons, (2) hospital physical medicine and rehabilitation programs, providing short term rehabilitation, and (3) Visiting Nursing Association, serving both Medicare- and Medicaid-eligible persons
8. When and how much	- Started after referral by one of 3 sources: medically directed homecare service (when starting service), in-patient rehabilitation program (participants were discharged in the year before study), visiting nurse association (participant was receiving services). - Started after initial assessment - Started when no cognitive deficit was identified, but there was difficulty in 1 or more areas of the functional independence measure (FIM). - The OT home-visited 8.9 times on average (SD = 5.6) and the technician responsible for home modifications visited 2.4 times on average (SD = 2.3).
9. Tailoring	The recommendations of AT-EI are tailored to participants identified needs (in comprehensive assessment) and regularly reassessed and adjusted.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Homecare and medication-review

Table 163. Auvinen 2020[103] Finnish Interprofessional Medication Assessment (FIMA), plus usual home care services

1. Brief name	Finnish Interprofessional Medication Assessment (FIMA), plus usual home care services.
2. Why	Goals: a positive impact on functional capacity and on rational and safe use of medicines. The safe use of medicines aims to: 1. identify and correct medication discrepancies before harm occurs, 2. manage the risk and optimize the outcomes of medication treatment Rationale: - Effective and safe drug treatment plays an important role in the functional capacity and function of the elderly maintaining quality of life and supporting home-based survival - Polypharmacy and inadequate medicine use is common among home care patients - Interprofessional team approach is suggested to be advantageous when assessing patients with multiple diseases and complex medications, and relies on changing the multi-professional culture and practices
3. What (materials)	- Medication lists and health measurements - Medication review tools: SFINX (currently INXBASE), Pharao (currently RISKBASE) and RENBASE databases. SFINX is a drug-drug interaction (DDI) database; Pharao presents a risk profile of patients' medicines based on pharmacodynamic properties; RENBASE includes medicine-related information on safety and dosage with regard to renal function. - Patient information system
4. What (procedures)	- Medication review by nurse, pharmacist and physician. The review is based on information gathered by the nurse in home-visits (e.g., medication list), a pharmacist assessment who uses medication review tools, and physician clinical knowledge of the person (based on records). In some cases, the person participates in the medication review meeting with the professionals. The recommendations involved starting, stopping or changing the timing of the medication. - Professional home care, including home care for fitness and everyday tasks, and home health care. - Usual community healthcare, including access based on participants' own initiative to primary care clinic, outpatient services and specialist care (e.g., mental health and dental care), and emergency services.
5. Who provided	Nurse, physician and pharmacist, who received training on the intervention. The final decision-making seems to be more focused on the physician, but all of the professionals contribute to the decision-making.
6. How	In-home interview by the nurse and usual home care provided presumably to the individual and face-to-face
6b. How organised	- The final decision-making was centered around the physician, but all the professionals (nurse, pharmacist, physician)contributed to the decision-making through the interprofessional meeting - Team-work and efficient information sharing between the team members is emphasized

	- Usual home care includes an important role for the nurse, who visits the person regularly - The centers were recruited from the interprofessional network constructed to establish guidelines for interprofessional collaboration in medication management of the aged, organized by the Finnish Medicines Agency (FIMEA)
7. Where	- At home - In five areas in Finland: Forssa, Haapajärvi, Lahti, Juva and Savonlinna.
8. When and how much	- Started when the participants were receiving home care. Participants had dizziness, orthostatic hypotension or have fallen, or used at least six medicines - There was only one medication review
9. Tailoring	- The recommendations that followed the medication review were tailored to participants' needs; - When necessary, the participant and family participated in the multidisciplinary meeting. - When necessary, physician conducted an assessment at home.
10. Modifications	Not mentioned
11. How well (planned)	The fidelity of the intervention implementation was supported by training to the professionals involved, and supervision (by email and telephone) during the study.
12. How well (actual)	Not mentioned

Homecare and multifactorial-action

Table 164. Parsons J 2012[115] Standard homecare

1. Brief name	Standard homecare. Participants received a standard needs assessment, that informed the delivery of home care services in the traditional homecare models.
2. Why	Goals: Health services to enable older people to remain living at home, by promotion of health-related quality of life (HRQoL), autonomy, independence and social connectedness, often delivered at a critical juncture in an individual's functional status. Rationale: - Loss of functional ability by up to half of hospitalised older people during their stay, two-thirds of whom don't regain their previous functioning over the next 3 months. - Homecare may improve this situation, but often focuses on treating disease and 'taking care' of the participants.
3. What (materials)	Materials used in intervention delivery: 1. Support Needs Assessment (SNA) tool 2. Homecare support plan prepared by home care organisation and undertaken by homecare aides. 3. Client review
4. What (procedures)	Needs assessment: 1. Initial assessments- Support Needs Assessment (SNA) tool -to identify a goal for the homecare, areas including cognition, informal caregiver stress, safety,

	and nutrition, thus establish rehabilitation; conducted by the assessors of assessment agency. 2. Assessment findings were passed to the homecare organisation to develop a support plan. This provided concrete instructions to the support worker including detailed descriptions of tasks to be undertaken. Reviews: 1. No identified process for reviewing the services required by the participant in the service specifications for traditional homecare models. 2. The results of the review were provided to the assessment agency with recommendation for either discharge, increase in hours or maintenance of current service levels. If services were to continue, additional goals were agreed with the client. Homecare support services (Traditional homecare models): 1. Homecare organisation developed support plan for service delivery, addressing areas of deficit such as falls risk, decreased muscle strength, difficulty with showering, and other personal cares that may have prevented the older person from attaining his/her goal. 2. Categories of services delivered by homecare aides (support workers) to participants included: domestic tasks (e.g., vacuuming), personal care (e.g. showering assistance), shopping (with and/or without the client) and individualised activities (activities identified specifically for the individual client) were collected and analysed. Usual care: 1. Support Needs Assessment (SNA) tool is nationally standardized comprehensive geriatric assessment in New Zealand. 2. Allied health professionals care is available to participants upon referrals.
5. Who provided	1. Needs assessors 2. Homecare coordinators 3. Home care aides (also referred as support workers) - trained to a nationally accredited program (New Zealand Qualifications Authority Home and Community Support, Level 1 and 2) 4. Research team who reviewed the content of every support plan 5. Allied health professionals whom participants might be referred to.
6. How	1. Initial needs assessment was conducted individually with each participant, but not specified whether face-to-face or otherwise. 2. Homecare services provided to face-to-face to each participant individually.
6b. How organised	Organisations: 1. Assessment agency (located within the local health board) where needs assessors were based; and closely monitored the support plan as a cost management strategy. 2. Homecare organisation (5 private companies contracted by the health board to provide services), where a support plan was developed, and homecare coordinators based. 3. Research team reviewed the content of every support plan. Core team for intervention delivery: 1. Needs assessors conducting initial assessment, then passing the identified homecare aims and goals to homecare coordinators. This care planning seems to be unidisciplinary.

	2. Homecare coordinators developed homecare support plan for the participant, based on the initial assessment findings (goals, aims), and principles from training; and conducted client reviews. 3. Homecare aide (also referred as support workers) followed the concrete instructions in the support plan implement the specified services. *There is no evidence of systematic processes for organization of care *Medication is not mentioned as part of the needs assessment or following care planning Peer support: 1. Individualized training of the home care aide for specific cases (e.g., mobilizing safely outdoors or strategies to improve meal preparation) was undertaken by the home care coordinators (who were registered nurses).
7. Where	Location: Auckland, New Zealand Infrastructure: District Health Board Needs Assessment Service Coordination overlooks home-based support services.
8. When and how much	Intervention started: Upon a new referral to Counties Manukau District Health Board Needs Assessment Service Coordination (NASC) for home-based support services Duration and number of sessions, schedule and length of intervention: All appeared varied according to the needs of participants, identified between the participants and needs assessor in initial assessment and reviews.
9. Tailoring	1. After completion of the SNA tool, the needs assessor worked with the participant to identify the services that would be provided and how many hours were required. 2. Individualised activities predominantly focussed on assisting participants to access the community, or improving functional ability. 3. The results of the review were provided to the assessment agency with recommendation for either discharge, or changes in current service levels. If services were to continue, additional goals were agreed with the client.
10. Modifications	Not specified.
11. How well (planned)	1. Support plans details of categories of services delivered to participants in both groups and individualised activities were collected and analysed, to determine tasks implemented by support workers (homecare aides). 2. Number of client reviews undertaken by homecare coordinators were ascertained, albeit no identified process for review required for traditional homecare models.
12. How well (actual)	1. 15% (n= 14) of the support plans included individualised activities aiming at improving functional ability. 2. 1 participant was reviewed by homecare providers 6 months after service provision commenced. 3. 1 referral made to allied health professionals.

Table 165. Parsons M 2012[116] Usual care, including home-based services and residential care

1. Brief name	Usual care, including home-based services and residential care.
2. Why	Goal: to provide support services to the older people assessed as having high needs, with package of care to remain at home, or to enter residential care.

3. What (materials)	- A nationally standardised CGA as the support needs assessment tool.
4. What (procedures)	The needs assessors did not routinely provide continuity of care. Family physicians and healthcare providers accessed the coordinators through a central referral agency. A package of care consisting of a combination of family and community resources and services to facilitate the older person remaining at home.
5. Who provided	Needs assessor (and care coordinator, unclear if same or different) was centrally based, who assessed and coordinated the community services, or placement in residential care. Standard intervention was provided by a range of professionals in health and social services.
6. How	Presumably direct contact with older people, but unclear whether face-to-face, or otherwise, in accessing health and social services available.
6b. How organised	-"Many different models of case management can be seen across New Zealand. One of the more prevalent forms is Needs Assessment Service coordination (NASC). NASC provides an assessment and service brokerage facility for people requiring access to disability services." When high and complex needs are identified, the older person is offered either (i) a package of care combining family and community resources/services to help them to remain at home, or; (ii) if a package of care cannot help them to stay at home safely, they enter residential care. "assessed and coordinated by a centrally based needs assessor. The needs assessors did not routinely provide continuity of care, and family physicians and healthcare providers accessed the coordinators through a central referral agency. In short, the model represented a centralized approach, administered from the regional health authority" Funded by the district health boards.
7. Where	- In New Zealand, medium-sized city of Hamilton. - Presumably both at home and in residential care, depending on which available services were accessed.
8. When and how much	- Referral to intervention upon assessed as having high or very high need for residential placement is identified - No routine assessment, or continuous care provided by needs assessors.
9. Tailoring	Packages of care offered are tailored according to identified needs.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 166. Parsons M 2017[117] Usual care, including home-based services and residential care

1. Brief name	Usual care, including home-based services and residential care.
2. Why	Goal: to provide support services to the older people assessed as having high needs, with package of care to remain at home, or to enter residential care.
3. What (materials)	- A nationally standardised CGA as the support needs assessment tool.

4. What (procedures)	Needs assessment and access to health and social services in the community. Given participants had been assessed as having high or very high needs their package of care will have included formal home care services.
5. Who provided	Not specified - standard intervention was provided by a range of professionals in health and social services. Given the participants had been assessed as
6. How	Presumably face-to-face in accessing health and social services available.
6b. How organised	- The care planning does not mention or implies medication changes - "Many different models of case management can be seen across New Zealand. One of the more prevalent forms is Needs Assessment Service coordination (NASC). NASC provides an assessment and service brokerage facility for people requiring access to disability services." When high and complex needs are identified, the older person is offered either (i) a package of care combining family and community resources/services to help them to remain at home, or; (ii) if a package of care cannot help them to stay at home safely, they enter residential care. "assessed and coordinated by a centrally based needs assessor. The needs assessors did not routinely provide continuity of care, and family physicians and healthcare providers accessed the coordinators through a central referral agency. In short, the model represented a centralized approach, administered from the regional health authority" Funded by the district health boards.
7. Where	- In New Zealand, medium-sized city of Hamilton. - Presumably at the older people's residence, and appropriate healthcare settings, depending on which available services were accessed.
8. When and how much	- Referral to intervention upon assessed as having high or very high need for residential placement is identified
9. Tailoring	Packages of care offered are tailored according to identified needs.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 167. Tuntland 2015[118] Usual care

1. Brief name	Usual care. Conventional treatment offered to homebound persons
2. Why	Goal: To the assist in daily activities of people based on their self-reported limitations in daily activities, or provide rehabilitation. Rationale: Providing home-based help services to participants applying for home-based help.
3. What (materials)	Provided to participants (if needed): 1. Safety alarm, or assistive technology 2. Meals on wheels
4. What (procedures)	Assessing, planning, arranging: - Health-care providers in a central office responsible for the allocation of public health-services in the municipality.

	- People applied for, or were referred to, home-services based on their self-reported activity limitations. - Received the compensating help they applied for. - The standard treatment would be diverse. Available usual care services: 1. Personal or practical assistance (Home-helper, Nurse, Auxiliary nurse) 2. Meals on Wheels 3. Safety alarm or assistive technology 4. Rehabilitation (Occupational therapist, Physiotherapist, Speech therapist) 5. Day centre placement 6. Nursing home placement short-term 7. In-/Out-patient treatment 8. Social educators (social workers)
5. Who provided	Standard treatment was diverse, thus assuming different care and services were provided by the appropriate healthcare and social care personnel accordingly. Professionals/ personnel included: Home-helper, Nurse/Auxiliary nurse, Occupational therapist, Physiotherapist, Social educator, Speech therapist
6. How	Assuming care/ services mostly home-based, provided individually and face-to-face.
6b. How organised	1. People applying for, or referred to, home-based services. 2. Health-care providers in a central office responsible for the allocation of public health-services in the municipality. 3. The treatment was diverse, depending on the person's needs and abilities, e.g. personal assistance, rehabilitation
7. Where	Location: Voss, Norway Setting/ venue: Primary care delivered mainly at participant's home Infrastructure: 1. Voss is a rural Norwegian municipality 2. Municipalities in Norway started implementing reablement in 2012. As of 2014, 34 % of all Norwegian municipalities are offering reablement services and the growth continues. 3. In Voss municipality, there was a need for more services that encourage more activity in older adults; and for sustainable services in long-term care.
8. When and how much	When intervention started: People applying for, or referred to, home-based services based on their self-reported activity limitations: 1. after hospitalisation due to an acute illness, or 2. having gradually developed functional decline, but not needing hospitalisation or institution-based treatment. Schedule, number, and duration of sessions: - All varied, assuming according to needs of the individual. - No time limit for intervention period. - Average of 86 visits/ person in the first 3 months
9. Tailoring	1. People applied or were referred to the home-based services based on their self-reported activity limitations, according to their needs, e.g., personal/ practical assistance, Meals on Wheels, assistive technology. 2. Some people received rehabilitation based on their own efforts (abilities).

	3. Care and services were diverse, duration of intervention varied according to needs.
10. Modifications	Not specified.
11. How well (planned)	Not specified of any measures.
12. How well (actual)	Not specified.

Table 168. Whitehead 2016[119] Home care reablement

1. Brief name	Home care reablement. 6 weeks of homecare reablement delivered by social care workers (no routine Occupational Therapist input).
2. Why	Aims: - to assist the person to maximise their ability to carry out activities independently with the aim of reducing the amount of paid care worker input required in the long term. - to deliver cost-saving for social care services. Rationale: The Care Act 2014 has placed a statutory duty on local authorities in England to provide services that prevent or delay the need for other health and social care services, which may involve maximising independent living. Reablement is identified within The Care Act statutory guidance as an example of prevention and has been identified as one of the 'top-ten' prevention services for older adults.
3. What (materials)	1. Referral to OT (selective, when necessary), thus may receive equipment and adaptations prescribed by OT.
4. What (procedures)	1. received standard home care provided by paid reablement care workers from the homecare reablement services. 2. Visits from social care workers to assist with daily living tasks (with intention to reduce the amount of assistance required for ADLs). 3. If services are provided up to 6 weeks, assessment is made about person's need for ongoing home care, and/or referral to the local OT (available usual care).
5. Who provided	Number of intervention providers : 2+ 1. Reablement workers (social / paid care workers) 2. Reablement care team leader (social care team manager) After 6 weeks of reablement services, if necessary for referrals: 3. Occupational therapist 4. Possible but unclear: Community Equipment Service staff for fitting equipment. 5. After 6-week reablement service, if continuous homecare is required: home care agency/ paid home care staff
6. How	Face-to-face at home.
6b. How organised	1. Home care reablement is provided by reablement social/paid care workers, under the direction of a reablement care team leader. After 6 weeks of reablement services, if required: 2. Home care services required after the home care reablement services is provided by care agency. 3. Referrals to mainstream community OT team.

7. Where	United Kingdom The setting was a local authority homecare reablement service in England. The study will be conducted within one city council homecare re-ablement service in England. The service is divided into six geographical sub-teams. This RCT will be conducted within one subteam, which currently does not have routine input from an occupational therapist.
8. When and how much	Started following referral for home care reablement. Home care reablement provided up to six weeks. Home care can be extended and/or OT referrals for necessary period afterwards.
9. Tailoring	1. Length of home care reablement services, referrals to homecare and OT are tailored. 2. Support and assistance provided are tailored.
10. Modifications	An unanticipated issue which affected the recruitment rate was the introduction of new occupational therapists into the reablement service during the course of the study. Midway through the trial recruitment period, additional occupational therapists were employed to work within the service.
11. How well (planned)	1. Cost analysis 2. As part of the cost evaluation, a record will be kept of the number of times the occupational therapist visited each service user in the intervention group, the amount of time spent per visit and a log of what was carried out on each visit (in the form of a coded checklist). In addition, a record will be kept of the cost of equipment and minor adaptation services provided. Participants in both groups will report their use of health and social care services during the intervention and follow-up period.[120]
12. How well (actual)	An unanticipated issue which affected the recruitment rate was the introduction of new occupational therapists into the reablement service during the course of the study Midway through the trial recruitment period, additional occupational therapists were employed to work within the service. However, the new occupational therapists had insufficient capacity to work with every service user and were allocated to particular geographical subteams within the authority. Therefore, the study continued within two geographical subteams where the additional occupational therapists were not employed (this was later reduced to one).

Homecare and nutrition

Table 169. Fernandez-Barres 2017[106] Nutrition education intervention included in the Home Care Program

1. Brief name	Nutrition education intervention included in the Home Care Program.
2. Why	Goal: to prevent the increasing risk of malnutrition of dependent patients at risk of malnutrition. Rationale: - Older patients living in the community have a high prevalence of malnutrition. - Aged patients with difficulties to perform the Activities of Daily Living are more likely to have a caregiver and be included in a Home Care Program.

	- Difficulties to perform the Activities of Daily Living are associated with an increase risk of malnutrition. - Nutrition education interventions are effective in improving the nutritional status of elderly people without difficulties to perform the Activities of Daily Living.
3. What (materials)	1. Nurses provide individualized dietary advice as necessary, standardized ad hoc cards were developed, that contained appropriate dietary advice according to the patient's needs and the established objectives between care giver and nurse.
4. What (procedures)	Nutritional education targeting caregivers - The nurse explained the project and consequences of malnutritional to the caregiver and elderly person. - The nurses provided a standardised educational group session to caregivers provide nutritional education which focused on adapting the common dietary needs of elderly people. Routine review - The nurse visited the elderly person and caregiver monthly for up to 6 months, to monitor the nutrition status of the elderly person. - The nurse strengthened concepts delivered during the session (e.g., healthy diet design and cooking techniques), and established objectives with the caregiver to accomplish from one visit to the other, based on the topics of the group session. Available usual care The elderly people received regular Home Care visits, to ensure continuity of care, access to nursing and medical services, and equality in care of patients who for various reasons are unable to visit a Primary Health Care Center.
5. Who provided	Number of intervention providers: 2+ Unidisciplinary background : 1. Primary Health Care Center nurses 2. Formal and Informal caregiver Different nurses conducted the groups to avoid influence between them, but in the smaller centres the same nurse conducted both groups.
6. How	Individual group size 2+ This included the patient and the caregiver. The group sessions included 15 caregivers. Face to face : 1. Group educational sessions 2. Individual sessions. This was provided to the patient in the presence of the caregiver by the nurse. 3. Monitoring of the group intervention. (Via home visits) The intervention was delivered face to face to the participant.
6b. How organised	For the staff: training on intervention process and topics, including nutritional needs and standardization of education for caregivers" 1. Different nurses conducted the groups to avoid influence between them, but in the smaller centers the same nurse conducted both groups. 2. Free of charge Home Care Program (nursing and medical services provided by nurses and doctor from primary care).
7. Where	Intervention location :

	Reus and Tarragona counties (Spain), A random selection at 10 Catalan Health Institute Primary Health Care Centers. Part of the intervention was delivered at the Primary Health Care Center and also at the patient's home. Primary Health Care Center nurses monitored patients at home every month up to 6 months, and then at 12 months, in the presence of the caregiver.
8. When and how much	When started intervention Status - At risk of malnutrition, Caregiver-dependent, participating in Home Care Program (for various reasons are unable to visit a Primary Health Care Center). Duration of sessions: 1 hour group session. Duration of other home visits and sessions is unknown. The intervention group received up to 8 sessions over 12 months. The session schedule fixed : Educational session Home Visits Individual dietary monitoring Individual session about malnutrition (provided to the care giver and patient)
9. Tailoring	1. Nurses provide individualized dietary advice as necessary, standardized ad hoc cards were developed, that contained appropriate dietary advice according to the patient's needs and the established objectives between caregiver and nurse 2. Nurses strengthened concepts learned during the session (e.g., healthy diet design and cooking techniques), and established objectives with the caregiver to accomplish from one visit to the other, based on the topics of the group session. 3. Nurse provided further individual dietary monitoring of the patient in the presence of his caregiver.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned.
12. How well (actual)	After the education intervention, the intervention group improved their nutritional knowledge by 1.5 points (8.2 ~ 1.4 vs. 9.7 ~ 1.2; P < 0.001) according to the 11-item questionnaire. This improvement persisted throughout the 12-month follow-up. The effect of the intervention was B = 3.22 (P < 0.001) in the adjusted multiple linear regression model (Table 5). The baseline BMI (B = 0.17; 95%CI = 0.05, 0.28; P = 0.005) and baseline Barthel score (B = 0.03; 95%CI = 0.01, 0.06; P = 0.013) were the factors positively associated with the Mini Nutritional Assessment score after 12 months of follow-up.

Homecare, ADL, aids and multifactorial-action

Table 170. Whitehead 2016[119] Home care reablement plus Occupational Therapy

1. Brief name	Home care reablement plus Occupational Therapy. A targeted ADL programme, delivered by an occupational therapist incorporating goal setting,

	teaching/practising techniques, equipment/adaptations and provision of advice/support. This was in addition to home care reablement.
2. Why	The aims: - to maximize independence in ADL activities, including : washing, dressing, bathing and showering, feeding, indoor mobility, transfers, stair mobility, toileting, meal preparation and kitchen activities, outdoor mobility and community access. - to deliver cost-saving for social care services. Rationale: - The Care Act 2014 has placed a statutory duty on local authorities in England to provide services that prevent or delay the need for other health and social care services, which may involve maximising independent living. Reablement is identified within The Care Act statutory guidance as an example of prevention and has been identified as one of the 'top-ten' prevention services for older adults. - Occupational therapists are argued to have a particularly important role to play in delivering successful reablement outcomes as services aim to support individuals to manage daily living tasks independently; this is a core aspect of occupational therapy practice. Furthermore, occupational therapists are the only allied health profession to be employed within social care services in significant numbers and thus are already working as social care professionals.
3. What (materials)	1. Provision of community equipment and/or minor adaptations (such as grab rails, half-steps or threshold removal or replacements)
4. What (procedures)	1. Received standard home care provided by paid reablement care workers homecare reablement services. 2. Enhanced programme targeted at ADLs, delivered by an occupational therapist. Tailored programme to participants needs. 3. Goal setting using the TARGET (practising activities, and/or a graded process of re-learning and building the skills to manage ADL independently). 4. Equipment provision and environmental or activity modification. (Provision of community equipment and/or minor adaptations) 5. case management approach involving a minimum of weekly reviews and the coordination of the reablement episode and other services; and advice and information will also be provided to family members or carers. 6. If required, length homecare and OT services can be extended after 6 weeks (available usual care).
5. Who provided	Number of intervention providers : 4+ 1. Reablement workers (social / paid care workers) 2. Reablement care team leader (social care team manager) 3. Occupational therapist 4. Possible but unclear: Community Equipment Service staff for fitting equipment. 5. After 6-week reablement service, if continuous homecare is required: home care agency/ paid home care staff.
6. How	The intervention was provided in the home. Face to face home visits.
6b. How organised	1. A case management approach will be adopted by the occupational therapist involving a minimum of weekly reviews and the coordination of the reablement episode and other services. 2. The OTs are part of the social care services.

	3. Home care reablement is provided by reablement social/paid care workers, under the direction of a reablement care team leader. 4. Services required after the enhanced home care reablement programme is provided by care agency.
7. Where	United Kingdom The setting was a local authority homecare reablement service in England. The study will be conducted within one city council homecare re-ablement service in England. The service is divided into six geographical sub-teams. This RCT will be conducted within one subteam, which currently does not have routine input from an occupational therapist.
8. When and how much	Started following referral for home care reablement. Enhanced programme and home care reablement provided concurrently up to six weeks. Home care can be extended and/or OT referrals for necessary period afterwards.
9. Tailoring	1. A program will then be agreed with the participant, which will be tailored to the needs of each individual, but will include: practicing activities, and/or a graded process of re-learning and building the skills to manage ADL independently; equipment provision and environmental or activity modification. 2. Length of home care reablement services, referrals to homecare are tailored.
10. Modifications	An unanticipated issue which affected the recruitment rate was the introduction of new occupational therapists into the reablement service during the course of the study. Midway through the trial recruitment period, additional occupational therapists were employed to work within the service. However, the new occupational therapists had insufficient capacity to work with every service user and were allocated to particular geographical subteams within the authority. Therefore, the study continued within two geographical subteams where the additional occupational therapists were not employed (this was later reduced to one).
11. How well (planned)	1. Cost analysis 2. As part of the cost evaluation, a record will be kept of the number of times the occupational therapist visited each service user in the intervention group, the amount of time spent per visit and a log of what was carried out on each visit (in the form of a coded checklist). In addition, a record will be kept of the cost of equipment and minor adaptation services provided. Participants in both groups will report their use of health and social care services during the intervention and follow-up period.[120]
12. How well (actual)	An unanticipated issue which affected the recruitment rate was the introduction of new occupational therapists into the reablement service during the course of the study. Midway through the trial recruitment period, additional occupational therapists were employed to work within the service. However, the new occupational therapists had insufficient capacity to work with every service user and were allocated to particular geographical subteams within the authority. Therefore, the study continued within two geographical subteams where the additional occupational therapists were not employed (this was later reduced to one).

Homecare, ADL, aids and multifactorial-action with self-management

Table 171. Tuntland 2015[118] Reablement- time-intensive, multidisciplinary, multi-component and individualised

1. Brief name	Reablement- time-intensive, multidisciplinary, multi-component and individualised. home-based rehabilitation for older adults with functional decline.
2. Why	Goal: 1. To increase independence in daily activities, and enable people to age in place, be active and participate socially and societally. 2. To improve home-care services for older people needing care or experiencing functional decline. Rationale: 1. Urgent need for innovation in community health-care in order to achieve sustainability as the ageing population increases. 2. The Canadian Model of Occupational Performance and Engagement (CMOP-E) matches the client-centred reablement intervention, and was used as a theoretical framework. 3. In CMOP-E, occupational performance is perceived as the result of interaction and interdependence between the person(s), the environment, and the occupation(s). 4. A goal-directed and intensive intervention, taking place in the person's home and local surroundings, focusing on enhancing performance of everyday activities defined as important by the person.
3. What (materials)	Used in training and supporting intervention delivery staff: 1. A booklet in the participant's home illustrating and describing the simpler physical exercises or skills training for the home-care assistants 2. The Canadian Occupational Performance Measure (COPM) - a patient-specific measure which will be used to identify activity limitations and as a basis for formulating the goals. Used in intervention delivery: 1. Occupational therapist and physiotherapist used the COPM interview to identify activity limitations perceived as important by the participant. 2. This information was thereafter used to develop a rehabilitation plan, and to ensure congruence between the participant's needs, therapy priorities, and interventions. Provided to participants: A manual provided to the person, explaining the exercises to support the person's independent exercise training.
4. What (procedures)	Assessing, planning, arranging: 1. The occupational therapist and physiotherapist used the COPM to identify activity limitations perceived as important by the participant in a semi-structured interview. 2. The OT and physiotherapist developed a rehabilitation plan according to the COPM assessment. 3. Standard intervention: - People applied for, or were referred to home-services based on their self-reported activity limitations. - Received the compensating help they applied for.

	- The standard treatment would be diverse. Actioning: - Intervention training was provided in weekly therapist-assisted training, and in visits from the home-care personnel. - Intervention training content was tailored to the individual, which could include: 1. Functioning training (Training in daily activities), - e.g., dressing, food preparation. - Adaptations, e.g., advice on appropriate assistive technology, adapting the activity or the environment, in order to simplify activity performance. 2. Exercise programs such as indoor or outdoor walking with or without walking aids, incorporated into daily routines. Available usual care services: 1. Personal or practical assistance (Home-helper, Nurse, Auxiliary nurse) 2. Meals on Wheels 3. Safety alarm or assistive technology 4. Rehabilitation (Occupational therapist, Physiotherapist, Speech therapist) 5. Day centre placement 6. Nursing home placement short-term 7. In-/Out-patient treatment 8. Social educators (social workers)
5. Who provided	Multidisciplinary reablement team included: Intervention mainly delivered by occupational therapists, physiotherapists, and home-helpers and assistants; other professionals include nurses, auxiliary nurses, social educators. Professionals/ personnel included: Home-helper, Nurse/Auxiliary nurse, Occupational therapist, Physiotherapist, Social educator, Speech therapist.
6. How	Providing intervention: Intervention was home-based, provided individually and face-to-face, mainly by: 1. Occupational therapist and physical therapist used the COPM to identify activity limitations perceived as important by the participant; developed a rehabilitation plan; supervised the homecare personnel; provided weekly training to participants. 2. Health-care personnel encouraged and assisted the person in the daily training; provided home care.
6b. How organised	1. Unidisciplinary care planning: The OT or Physiotherapist developed the rehabilitation plan with the person for initiating the intervention. 2. Intervention delivery by multidisciplinary team: The OT and physiotherapist supervised the home-care staff to encourage and assist the person in daily training; and to provide simpler trainings to the person; while they provided weekly training to the person. 3. OT, Physiotherapist, and home-care staff had weekly informal lunch meetings, to communicate and follow-up about the participants. 4. The health-care providers were organised in an integrated, coordinated multidisciplinary team that worked together with the person towards shared goals. Implementing the intervention in the setting:

	1. The research team initiated the implementation of reablement in the municipality. 2. Intervention was implemented in the municipality after a period of administrative planning and competence building. 3. The competence-building was training provided to the whole multidisciplinary reablement team, given in lectures and seminars, and external courses. 4. Training included the ideology of self-management, and Canadian Occupational Performance Measure (COPM), a patient-specific measure which was used to identify activity limitations, and to formulate the goals in the reablement intervention. 5. New staff members were given extra attention in order to ensure adherence to the treatment. Supporting the intervention: 1. The therapists had weekly informal lunch meetings with the home-care staff to ensure good communication and follow-up of individual participants. 2. Simpler physical exercises or skills training, which could be provided by home-care staff, were demonstrated to them during the informal meetings.
7. Where	Location: Voss, Norway Setting/ venue: Primary care delivered mainly at participant's home Infrastructure: 1. Voss is a rural Norwegian municipality 2. Municipalities in Norway started implementing reablement in 2012. As of 2014, 34 % of all Norwegian municipalities are offering reablement services and the growth continues. 3. In Voss municipality, there was a need for more services that encourage more activity in older adults; and for sustainable services in long-term care.
8. When and how much	When intervention started: People applying for, or referred to, home-based services based on their self-reported activity limitations: 1. after hospitalisation due to an acute illness, or 2. having gradually developed functional decline, but not needing hospitalisation or institution-based treatment. Reablement intervention period: Average 10 weeks (actual), maximum of 3 months (planned). Reablement - schedule, number, and duration of sessions: - All varied, assuming according to needs of the individual. - Therapist-assisted training weekly sessions lasted at least 1 hour. - Average of 65 visits/ person in the first 3 months Standard usual care during intervention and post-intervention (after end of Reablement): Assuming that the standard usual care services, including home-based services, were also available during the intervention period (first 3m) and after the intervention (without time limit).
9. Tailoring	1. OT and Physiotherapist used the COPM to identify and prioritise the person's everyday issues that restrict or impact their performance in everyday living, in the initial interview. Rehabilitation plan was tailored for the person. 2. Therefore, the number and type of intervention elements varied across participants.

10. Modifications	Not specified.
11. How well (planned)	Maximum duration of 3 months.
12. How well (actual)	The intervention lasted on average 10 weeks.

Homecare, ADL, multifactorial-action and review with self-management

Table 172. King 2012[108] Restorative home care

1. Brief name	Restorative home care. A multifaceted approach to improve home care services
2. Why	Goals: 1) improvements in physical, psychological and social wellbeing, 2) restoration and maintenance of older people's physical function, aiding compensation for impairments, so that the highest level of function is achieved, and 3) improving the quality the services provided. Rationale: - based on components identified by a prior New Zealand study (Parsons *et al.* 2005), including Comprehensive Geriatric Assessment, goal facilitation, functional and repetitive ADL exercises, support worker training and enhanced supervision, care management, health professional training - based on previous studies showing the benefits of restorative approaches
3. What (materials)	- Multidomain assessment tool, TARGET (Towards Achieving Realistic Goals in Elders Tool)
4. What (procedures)	- Multidomain assessment, planning, arranging and regular review provided by a nurse coordinator, who discussed the goals with the participant and provided referrals. - ADL training was provided to all participants. The actual content of the ADL training was tailored to the care goal plan. - Presumably the participants continued to receive professional home care, including provision of personal care and household management. - Other usual community healthcare services were presumably available to the participants. These included, for example, community therapy (OT, physiotherapist.), outpatient clinics, primary care, podiatry, etc.
5. Who provided	- Support workers/paid caregivers provided ADL training and presumably continued to provide professional home care - Registered nurses worked as coordinators - conducted the initial assessment, created the care plan and reviewed it regularly, provided referrals and coordinated with the support workers
6. How	- Presumably individually both face-to-face and by telephone
6b. How organised	- Access to home care services depended on a centrally based assessment by the NASC (Needs Assessment Services Coordinator), which determines needs level and prioritises care. - Usual community care works independently (not coordinated). - The care plan decisions are taken by the nurse coordinator, in negotiation with the participant - The nurse coordinator provides referrals, contacts the participant regularly and supervises the support workers. - The care planning does not mention or implies medication change
7. Where	- At home, in the context of one home care agency provider

	- In South Auckland, New Zealand
8. When and how much	- Started when the participants were receiving home care services. Access to these services depended on a centrally based assessment by the NASC (Needs Assessment Services Coordinator), which determines needs level and prioritises care centrally. - Support worker contact with older people would range from daily to fortnightly as a minimum. - Planned contacts with the nurse coordinator included the initial assessment, a reassessment 12 months after and consultation/phone call every 3 months. - The actual intervention was received during between 4 to six months
9. Tailoring	- The multidomain care plan is adapted to the participant's needs, based on multidomain assessment, and established in partnership with the participant.
10. Modifications	Not mentioned
11. How well (planned)	Intervention fidelity was supported by training and support to the professionals providing the intervention. A pilot study to the assessment tool also supported intervention fidelity by checking its feasibility.
12. How well (actual)	- The planned three-monthly follow-up phone call or visit from the coordinator was received by 76.5% at three month, 70.0% at six months, and 89.2% at nine months. - For 52.3% no tasks were identified following the initial assessment. The most common tasks ascertained were referral to a health professional (13.6%) and provision of further information (13.6%). - The actual intervention was received during between 4 to six months

Table 173. Parsons M 2017[117] Community Flexible Integrated Restorative Support Team (Community FIRST)

1. Brief name	Community Flexible Integrated Restorative Support Team (Community FIRST). An intensive restorative home support (RHS) service.
2. Why	Goal: - promoting/improving functional status or independence in older people with high or very high needs, thereby preventing residential placement and improving survival. - to improve the quality of home care and maximise the ability of frail older people to continue living in their own homes for as long as possible Rationale: - Impact on independence by: comprehensive assessment, management of health crises, better integration of services. - based on (1) a supported discharge team established in south London shown to be successful in reducing institutionalization; (2) community-based care management models.
3. What (materials)	- TARGET, Towards Achieving Realistic Goals in Elders Tool, used to develop goal facilitation within the care plan; - TARGET e-based training; As part of usual care: - A nationally standardised CGA as the support needs assessment tool.
4. What (procedures)	For participants: - Being assessed with comprehensive geriatric assessment;

	- sets mutually agreed and meaningful short and long-term goals with care management coordinator, in developing care plan including exercise and ADL training through goal facilitation and participative decision process. Fully replaces home care with a restorative home support service. For staff (Non-regulated support workers): - have daily contact with health professional coordinators around care of the older people - Undertake a national training programme In the system of care: - Arranging bulk funding access. As part of usual care: needs assessment and access to health and social services in the community.
5. Who provided	A multidisciplinary team including: a trained support worker, physiotherapist, occupational therapist, and register nurse acting as a case manager coordinator. As part of usual care: a range of professionals providing health and social services.
6. How	Visits by the trained support worker are presumably face to face. The medium for CGA and if other people (e.g., carer) was present or not during visits is not specified. As part of usual care: Presumably face-to-face in accessing health and social services available.
6b. How organised	- The care planning does not mention or implies medication changes Case-finding was by completion of the support needs assessment tool, either by hospital staff when nearing discharge, or a central agency. A registered nurse case manager coordinator conducts assessment and along with PT and OT ("multidisciplinary team") develops plan and supervise the providers (support workers / therapy aids). The providing organisation is funded by a district health board through a bulk-funding (fee per patient) scheme.
7. Where	- In New Zealand, medium-sized city of Hamilton. - Visits by trained support worker at home. - In the context of a partnership between a charity (Presbyterian Support Northern) and the District Health Board. - Within a system of care that provides a fixed amount of money per patient (vs. fee per service).
8. When and how much	- Intervention started when high or very high need for residential placement is identified by the regional assessment agency; - CGA every 6 months; - Registered nurses/care coordinator at least every 2 weeks; - Support worker visits as required up to 4 times of day, every day.
9. Tailoring	- Care plan goals developed and agreed with the participant; - Number of support visits adapted to need. - As part of usual care: Packages of care offered are tailored according to identified needs.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	Not mentioned

Table 174. Rooijackers 2021[111] Stay Active at Home

1. Brief name	Stay Active at Home. Usual home care from staff who received 'Stay Active at Home', a reablement training program for homecare staff including assessment and planning, tailored advice, and a particular focus on physical activity and activities of daily living
2. Why	Goal: to improve the independence of homecare clients (secondary intervention delivery pathways) through equipping homecare staff with knowledge, attitude, skills and social and organizational support from colleagues and team managers to implement reablement in daily homecare practice (primary intervention delivery pathways). Rationale: - based on the theory of reablement (Aspinal *et al.*, 2016), which is closely related to the concept of Function Focused Care (Resnick *et al.*, 2012, 2013). - based on the principles of Reablement, home care services are meant to be goal-oriented, holistic and person-centred taking into account the capabilities and opportunities of older adults - based on behavioural change theories and the Bandura's self-efficacy theory (to motivate behaviour change in older adults) - based on a systematic process of adaptation of similar international programs to this new context - doing with instead of doing for older adults will stimulate older adults to be more active in daily life
3. What (materials)	- Training materials including newsletters, a manual, PowerPoint presentations, and short videos. - Materials that could be used with the older person included forms to assess the capabilities and opportunities of older adults (i.e. self-reflection list focusing on clients' participation in daily and physical activities; observation lists regarding (instrumental) activities of daily living; an ecogram to assess the social network); a goal-setting form for long- and short-term goals; an action plan: Who does what?; and, an exercise booklet for older adults including 10 Otago-based exercises and an exercise diary.[121]
4. What (procedures)	- The district nurses assessed the participant and developed with them (and possible support of other elements of the team) a care plan and goals. - Training in activities of daily living was an essential focus of the care plan - Physical exercise was another focus of the care plan - Nurses and domestic care workers presumably supported behavioural change by motivating them (e.g., compliments) and using a variety of behavioural change techniques (e.g., SMART goal setting). Self-management was thus an important part of the intervention deliverers action. - Home care including domestic services (e.g., cleaning, washing) and nursing care. The latter can be subdivided into personal care (e.g., assistance with bathing and dressing) and specialised nursing care (e.g. wound care, catheter insertion).
5. Who provided	Nurses and domestic support workers who received training on reablement, more specifically on how to assess older adults' capabilities, implement, goal setting and action planning, increase engagement in physical and daily activities, motivating older adults and their social network. The training

	included face to face meetings, practical assignments and newsletters, lasting for 9 months. Training materials that could be used with older people were also provided. Each team is guided by a district nurse (baccalaureate-educated registered nurse). The other team members are vocationally-trained registered nurses or certified nurse assistants.
6. How	Presumably individually and face-to-face based on home visiting format Behavioural change techniques were presumably used to motivate the participants
6b. How organised	- The care planning was presumably unidisciplinary as it seemed to be mainly under the responsibility of the nurses' team - It does not seem like the care plan included medicine review (no mention of this aspects) - A team manager supervises team nurses who provide care. Domestic support workers are also coordinated by a team manager. They are linked to a working area, but not to a specific nursing team. - Nursing care is financed by healthcare insurance. In the Netherlands, nearly all citizens are covered by healthcare insurance and services are easily accessible
7. Where	- At home - South of the Netherlands - In the context of a large healthcare provider that offers home care services
8. When and how much	- Participants were 65 years old or older and were receiving home care, without serious cognitive or psychological problems, terminally ill or bedbound, or unable to speak Dutch. Participants were recruited following contacts be letter/flyer, phone and home visit. - Participants received the intervention presumably for 12 months - The home care services usually include nurse's short visits several times a week, and domestic workers visits once per week for a couple of hours.
9. Tailoring	- The home care was presumably tailored based on the assessment and individualized care plans developed for each participant (that should take into account their abilities in ADL, social network, etc).
10. Modifications	Not mentioned
11. How well (planned)	Several activities were developed to promote the adequate implementation of the intervention, in particular, regarding the fidelity of the training provided to the staff: - The program went through a systematic adaptation process in collaboration with relevant stakeholders, which included a pilot study that led to adaptations in the staff training program - Training manuals and other materials were provided in advance to those training the staff - Assignments between the team meetings, the weekly newsletters with the 'Tip of the Week' and the booster session are particularly designed to improve and maintain fidelity. - A systematic process of process evaluation was developed to assess treatment fidelity, dose, adaptations and reach of the staff training program. This included a variety of data sources such as logbooks, registration forms, checklists, log data and focus group interviews with homecare staff (n= 23) and program trainers (n =4).

12. How well (actual)	- The extent to which homecare staff implemented reablement in practice varied. Perceived facilitators included digital care plans, the organization's lump sum funding and newly referred clients. Perceived barriers included resistance to change from clients or their social network, complex care situations, time pressure and staff shortages. - Homecare staff's average compliance to the program meetings was 73.4%, The majority of nursing team members (73.8%) and domestic workers (86.5%) attended at least half of the meetings and received a diploma. Eight nursing team members (12.3%) and 39 domestic workers (43.8%) attended all meetings. Main reasons for not attending meetings were illness or vacation. Additionally, on average, nursing team members and domestic workers conducted 55.4 and 57.6% of the practical assignments and consulted 76.5 and 42.1% of the weekly newsletters, respectively. - Staff members accepted the program, and particularly valued its practical elements and team approach. They experienced positive changes in their knowledge, attitude and skills about reablement, and perceived social and organizational support from colleagues and team managers to implement reablement.

Homecare, aids and telecoms

Table 175. Dupuy 2017[105] Equipped with HomeAssist, an ambient-assisted living (AAL) platform

1. Brief name	Equipped with HomeAssist, an ambient-assisted living (AAL) platform. HomeAssist consisted of assistive applications belonging to 3 domains of assistance: everyday activities, safety, and social participation; in addition to usual home care services.
2. Why	Goal: 1. The expected outcomes were the promotion of independent living of frail community-dwelling older adults, and the reduction of the caregiver burden. Rationale: 1. Extensive research efforts have been provided to develop technologies that support aging in place, and that reduce caregiver burden. 2. AAL devices are thought to provide home safety for the elderly, help with daily activities, and promote older adults' social participation by increasing connection and communication with their social network.
3. What (materials)	Provided to each individual: 1. A set of wireless sensors and two touch screen tablets. 2. A concise paper-based manual about using the assistive technology. 3. Training materials provided to individuals and their caregivers (unclear of the format). Materials to support delivery: 1. OT needs assessment to inform positions for installing the devices at individual's home.
4. What (procedures)	1. OT analysed the individual's routines, to inform the suitable positions for installing the tablets, sensors, and their positions. 2. The assistive technology platform was installed in the users' homes, including wireless sensors and 2 touchscreen tablets. 3. The main tablet was dedicated to sending notifications

	to the user about everyday activities and safety applications. Examples include prompting omitted everyday activities, reminders from calendar; sending signals to automated devices (e.g., night light), or the individual or caregiver, to ensure the individual's safety. 4. A dedicated tablet provided a simplified mailing system, which facilitated individual to send messages by voice, making video telephoning, and collaborative gaming apps (which the user could choose). Also, it informed of any social events organized by the town council. 5. Individual and caregiver undertook training sessions to learn to use the different assistive applications. 6. Usual care: Public home care services provided by paid caregivers, by home visit, supporting domestic tasks, purchases, administrative tasks, and everyday functioning of the individuals.
5. Who provided	1. Paid/ formal caregiver providing home care services 2. OT conducting assessment 3. Home automation specialist installed the assistive technology 4. Research team provided 24/7 helpline to support participants, but not delivering interventions.
6. How	1. Caregiver provided face-to-face support to individual. 2. Presumably training for individual and caregiver was provided at the individual's home, asynchronously. 3. Notifications sent from devices to individual, synchronously.
6b. How organised	Organisations: Public home care services for community dwelling older adults. Inter-relations: OT assessed and analysed participant's routines and home environment. The information was then pass to the Home Automation Specialist for installing the equipment. Responsibilities: 1. Public home care services for community dwelling older adults. 2. The professional caregivers provided support for domestic tasks, purchases and administrative tasks in home visits; undertaking training with the older adults to understand and master the various functionalities of HomeAssist. 3. OT assessed and analysed participant's routines and home environment. 4. A Home automation specialist installed the platform in the users' homes. 5. Research team provided 24/7 helpline to participants if they had a question or if the equipment malfunctioned.
7. Where	Location: France Interventions all provided at individual's home: 1. Home care services. 2. Assistive technology sensors and devices were installed. 3. Training on using the assistive technology applications (assumed).
8. When and how much	Intervention started: Older people already receiving home care services, and their paid caregivers were recruited. Assistive technology: 1. Training- first month after installation, total of 4 weekly sessions, circa 1 hour.

	2. Notifications sent to individual every day, presumably timing and frequency depending on needs and urgency. Home care services schedule: 1. Frequency of caregivers visited the individuals depended on each individual's needs, e.g., 2 times/ month, once/ day. 2. Duration of each visit not specified.
9. Tailoring	1. HomeAssist provides assistance in each of the three needs domains according to an online catalogue of assistive applications, which can be added or deleted depending on the individual's needs. 2. The tablets, sensors, and their positions were installed according to tablets, according to the individual's routines, as analysed by an occupational therapist. 3. Caregivers visited the individuals depended on each individual's needs, e.g., 2 times/ month, once/ day, mainly providing support for domestic tasks, purchases and administrative tasks.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Homecare, alternative-medicine and exercise

Table 176. Teut 2013[112] Integrative Medicine (IM) program

1. Brief name	Integrative Medicine (IM) program. A mix of different medical styles and practices also known as Conventional alternative medicine (CAM therapies): lifestyle modification around exercise and diet, external treatment by naturopathy, homeopathy and modification of conventional drug therapy.
2. Why	IM may lead to general change from conventional medicine towards a true integration of different medical styles and practices, including an improvement in the patient-practitioner relationship, to ensure that patients receive the best care possible: The use of non-conventional medical practices and styles can bring about a lot of change in how care and treatment is delivered. Plus, a focus on improving the patient-practitioner relationship may help maximise patient care. Its possible CAM therapies will add beneficial components to geriatric medical care through lifestyle management strategies such as sports (e.g., walking, swimming, gymnastics, yoga, tai chi, qi gong, and others) and nutrition. Theory / rationale: It is important to understand that the intervention was not designed to evaluate specific effects of homeopathic drugs, but to test a holistic geriatric treatment approach that included homeopathic treatment philosophy with lifestyle change. Goals: to support self-healing, ensure patients are getting the best care possible,
3. What (materials)	Ergometer training on a MOTOmed viva 2® device (Reck-Technik GmbH, Betzenweiler, Germany) , for walking Herbal teas, naturopathic wraps and compresses and herbal massage oils. A Naturopath will train nurses on how these are to be used. Freshly prepared fruit or vegetable juices regularly provided by caregivers

	MOTOmed viva 2® device (Reck-Technik GmbH,Betzenweiler, Germany); for walking as exercise.
4. What (procedures)	Nurses use herbal massage oils , naturopathic wraps and compresses in naturopathic and individualised homeopathic treatment A weekly 60-minute exercise group, supervised by sport therapists. Exercise included: walking; ergometer training on a MOTOmed viva 2® . Exercises were also for muscular strength, motoric skills, balance, and coordination. The conventional care by family physicians or specialists was continued. Family physicians were kept informed about these changes, and could contact the study physicians if they disagreed Modifications were made to patients' existing lifestyles through diet@ freshly prepared fruit or vegetable juices regularly provided by caregivers. Changes were also made to their exercise levels: Patients would attend a weekly one-hour exercise group, which focussed on walking via ergometer training on a MOTOmed viva 2® There were also other exercises for muscular strength, motoric skills, balance, and coordination. The conventional drugs the patients were on were also reviewed and where necessary altered.
5. Who provided	Naturopath trained nurses in providing herbal teas, applying naturopathic wraps, compresses and herbal massage oils to participants Homeopathic study physician - would modify homeopathic drug therapy and would answer GP / Physicians query around this conventional medicine and allow for the physician to alter this if necessary. Sports therapist to supervise each of the weekly group exercise sessions
6. How	Not mentioned
6b. How organised	Patients (older adults living in 8 shared apartment communities with integrated nursing care) continued to receive conventional care by family physicians or specialists. But the homeopathic study physician could alter conventional medication if necessary. Family physicians were regularly informed about any such changes and were asked to contact the study physicians if they disagreed. The sports therapists delivering the weekly sports program had been especially recruited for this study.
7. Where	Country: Germany. 8 shared apartment communities of older people - with Integrated nursing care and caregiving, took part in the trial. Across Germany, this type of accommodation is increasingly being used as a new residential option among older people in Germany. Compared to nursing homes and residential homes, it provides a closer equivalent to usual family life. apartment-sharing communities with integrated care have become a new and more popular residential option among older people in Germany, adding to the traditional choices of late-life residences, such as nursing homes or home care Patients that could not leave their beds due to illness received individual training in their beds
8. When and how much	Older adults were enrolled by the study physicians. 12-month intervention The exercise component / sports program was a weekly 60-minute exercise group, supervised by sport therapists.

9. Tailoring	Additional lifestyle modification - exercise and diet was planned around the patient's ability and need. If the patient could not leave their bed, due to illness, the exercise session would be delivered in their bed. Improving the patient practitioner relationship is a component of the intervention too. Modification of conventional drug therapy: the study homeopathic physician could change the conventional medication the patient was on.
10. Modifications	Not mentioned
11. How well (planned)	At the end of the trial, study physicians were asked to discuss how feasible the trial was. Study physicians were also asked to comment on their practical experiences.
12. How well (actual)	The rate at which caregivers complied with nutritional changes and naturopathic therapies was a lot lower. Carers' motivation influenced their adherence levels hence the variation in adherence between apartments. Female caregivers identified themselves very much with the study and observed good clinical results. Male caregivers: they were much more sceptical and were not as supportive of the intervention. Study Physicians discussed trial feasibility every 3 months. Overall study physicians felt intervention is feasible but elaborate and time consuming. Adherence to the sports program was very high. The training was implemented as a regular weekly group activity The adherence to nutritional changes and naturopathic therapies by the caregivers was substantially lower, and varied from apartment to apartment depending on the motivation of the caregivers. It turned out that it was not possible to practically measure these daily activities closely because caregivers and cooks could not be motivated to keep extra documentation on these activities The study physicians discussed the feasibility of the trial every 3 months. Overall, they judged the intervention itself as feasible but found it elaborate and time consuming. The amount of adherence and identification with this study differed between the caregivers; generally, it seemed the female caregivers identified themselves very much with the study and observed good clinical results, whereas male caregivers were much more sceptical and supported the interventions to a lesser degree Adherence to the sports program was very high The adherence to nutritional changes and naturopathic therapies by the caregivers was substantially lower, and varied from apartment to apartment depending on the motivation of the caregivers. It turned out that it was not possible to practically measure these daily activities closely because caregivers and cooks could not be motivated to keep extra documentation on these activities

Homecare, education, multifactorial-action and review

Table 177. Lewin 2013[109] Home Independence Program (HIP), a restorative home-care programme

1. Brief name	Home Independence Program (HIP), a restorative home-care programme.
2. Why	Goals: optimising functioning, preventing or delaying further functional decline, promoting healthy ageing, encouraging the self-management of chronic diseases, and removing or minimising the need for ongoing support services. Rationale: based on previous research showing positive effectiveness of restorative care approaches in general, and of this intervention in particular. This intervention has shown positive results in a pilot study, a 2-year operational trial and a non-randomised controlled trial.
3. What (materials)	- A file about local resources supported recommendations to participants when necessary
4. What (procedures)	- Multidomain assessment, and formulation of care plan with the patient. Each case also received input from weekly multidisciplinary case meetings. Arrangements following the care plan included referrals to specific health professionals and assisting in gaining social support. - The participants received support and follow up - Various actions were selectively provided for each participant, according to need. These actions included for example education, provision of aids, balance and endurance programmes for improving or maintaining mobility, medication, continence and nutrition management, among others. - Presumably participants were able to continue accessing other community services which were part of usual care.
5. Who provided	A nurse, a physiotherapist OR an occupational therapist had contact with the participant
6. How	Presumably individually and face-to-face (as this is an at home intervention) and by telephone. The participation of clients and families was promoted by using empowering communication
6b. How organised	- There seems to be coordination of care, for example by providing referral and coordinating the ending of the intervention with other services - The care plan received input from a multidisciplinary team, at least at review. - The care planning does not mention or implies medication change, beyond medication advice/education - The intervention as other home care services are provided by the Home and Community Care (HACC) programme, which is a not-for-profit organization jointly funded by the Commonwealth and State Governments.
7. Where	- At home - Perth suburbs, Western Australia
8. When and how much	- Started after referral to homecare services for assistance with personal care (first time or request for increase). These people were assessed and found eligible to this type of care, namely, they were in need of assistance with one or more tasks of daily living because of an ongoing disability (rather than needing acute or post-acute care). Participants were excluded if they had complex needs (requiring 15 hours or more of care/ week). - The intervention duration was up to 12 weeks or until goals were achieved (whichever first)

	- Sufficient service was defined as 3 visits.
9. Tailoring	The care plan was tailored to participant's needs based on a comprehensive multidimensional assessment
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Homecare, multifactorial-action and review

Table 178. Hall 1992[122] The British Columbia long term care program

1. Brief name	The British Columbia long term care program. The British Columbia long term care program includes needs' assessment to determine level of care, regular reviewing and access to professional home care services and other community services
2. Why	Goal: to enable those eligible for service to remain in their own homes for as long as it is possible and practical to do so.
3. What (materials)	Not mentioned
4. What (procedures)	- Screening, pre-admission assessment to determine level of care needed - Arrangement of needed services and regular review - Access to professional home care which could include: Homemakers, Meals on Wheels, Adult Day Care, Community Physiotherapy and Home Nursing. - Access to usual community health care, which included seniors' programs - Screening, pre-admission assessment to determine level of care needed - Arrangement of needed services and regular review - Professional home care which could include: Homemakers, Meals on Wheels, Adult Day Care, Community Physiotherapy and Home Nursing. - Access to usual community health care, which included seniors' programs
5. Who provided	- Community health nurse provides needs' assessment - Access to a variety of professionals that provide home care as needed (e.g., physiotherapist, nurse) - Presumably, access to other professionals that provide community health services
6. How	Not mentioned
6b. How organised	- Long term care program staff (usually community health nurse) arranges services on behalf of the clients based on the needs' assessment - The care planning does not mention or implies medication change, despite measurement of prescribed medications at baseline
7. Where	New Westminster, British Columbia
8. When and how much	- Started following enrolment in personal care at home, as determined by standardized regional assessment - Assessment reviewed at 3 months and at least a year thereafter
9. Tailoring	The professional home care arranged is presumably tailored based on the level of care needed identified by the standardized regional assessment.

10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 179. Markle-Reid 2006[123] Usual home care

1. Brief name	Usual home care.
2. Why	Goal: to provide homemaking and personal support by unregulated health care providers, to frail elderly persons who did not require professional home care services Rationale: to move away from a pure medical model to a more integrated model that supported the health and health and social needs of the person
3. What (materials)	- Eligibility screening form is presumably used as part of usual care reassessments for home care
4. What (procedures)	- Unspecified assessment and care plan and review by the usual home care services. The extent of care coordination and review was limited. - Access to personal home care and usual community care services such as social work, family physician, nutritionist, among others
5. Who provided	- Case managers (unspecified background) - Personal support worker
6. How	-Presumably face-to-face and individually based on home visit format.
6b. How organised	- There was minimal case planning and coordination - The care planning does not mention or imply medication changes
7. Where	- At home - In Ontario, Canada
8. When and how much	- Started following referral to personal homecare services by community, hospital (more frequently) or self-referral. The eligibility included requiring service for a variety of reasons including physical illness, physical disability, diminished physical ability, cognitive impairment, mental illness (18+), injury, postsurgical condition. The person was 75 years old or older - Participants should receive reassessments but these are otherwise unspecified.
9. Tailoring	- The case manager used set criteria, professional judgement and fiscal realities to determine the services the participant could access.
10. Modifications	The criteria to access to personal support services changed during the study, becoming more restricted and delayed. This meant that services recommended by the care plan developed were more difficult to implement
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 180. Parsons M 2012[116] Coordinator of Services for Elderly (COSE)

1. Brief name	Coordinator of Services for Elderly (COSE). Community-based client-centered care management system.

2. Why	Goal: - promoting/improving functional status or independence in older people with high or very high needs, thereby improving survival and avoiding care admission. - It was established with the aim of avoiding duplication in service provision. - offering older people a greater choice of service support, enabling them to remain safely in the community as long as they wish to. Rationale: - Impact on independence by: identifying resources, tailoring services to older person and his/her career, management of health crises, better integration of services. - based on community-based care management models.
3. What (materials)	- Assessment and medical records As part of usual care: - A nationally standardised CGA as the support needs assessment tool.
4. What (procedures)	For participants: - Assessed with comprehensive geriatric assessment; - COSE worker liaised with professionals and older people to coordinate care to meet the participant's needs, while sourcing locally available and suitable service in the community, to meet the participant's needs. - Purchasing specialist health services, e.g., OT, physiotherapy if rehabilitation was needed. For COSE worker: training on available funding stream and service eligibility of various options for participants. In the system of care: developing community partnerships. As part of usual care: needs assessment and access to health and social services in the community.
5. Who provided	Locally based care management model (COSE worker, who experienced nurses in the study), liaised and coordinated care between professionals and each older person. Standard intervention was provided by a range of professionals in health and social services.
6. How	Care manager delivered intervention at the older person's home.
6b. How organised	- The care planning does not mention or implies medication changes - Case-finding was by completion of the support needs assessment tool, either by hospital staff when nearing discharge, or by the COSE worker. "The COSE worker is a case manager, liaising with the GPs and practice nurses [... and] co-ordinates the appropriate community services, informal networks and medical care based on assessed need and GP liaison." "A COSE worker is assigned to a cluster of designated practices of General Practitioners (GP), but works independently of the practices. Importantly, the COSE worker is physically located in the community". Developed relationships with the local service providers. A "localized approach, administered and delivered from local primary care"
7. Where	- In New Zealand, medium-sized city of Hamilton. - Care coordination in the community, in the primary care setting in particular.
8. When and how much	- Referral to intervention upon assessed as having high or very high need for residential placement is identified; - Initial assessment and ongoing episodic review of variable frequency (for example 12 months and as required)

9. Tailoring	- Services adapted to older people's needs, including a reassessment when needs change. - As part of usual care: Packages of care offered are tailored according to identified needs.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 181. Ryvicker 2011[124] Home Health Aide (HHA) Partnering Collaborative

1. Brief name	Home Health Aide (HHA) Partnering Collaborative. A quality improvement initiative implemented into usual homecare and provided by a homecare organisation, to better integrate HHAs into the homecare team, and increase support for ADL improvements.
2. Why	Goals: 1. To improve relationships between professional and paraprofessional service providers within a large home healthcare organization and its partnering home health aide vendors. 2. To optimize the role of the HHA as part of the care team, resulting in an improved pairing of aide services with patients' needs, and increased aide's satisfaction and retention. 3. To improve patient's functional independence by changing the aide's role from "doer" to "supporter" of care, and by encouraging nurses and aides to work together to promote patients' involvement in their care. Rationale: 1. Structural barriers related to dispersed patients, and a widely distributed work force of the home healthcare agencies had struggled to integrate aide services into the care team. This lack of integration can impede aides' job satisfaction and retention, and also improvement in patient outcomes. 2. This collaborative engaged in a Plan-Do-Study-Act process for continuous testing changes and adaption to accelerate improvement in the peer-to-peer diffusion implementing process.
3. What (materials)	1. Outcomes Assessment and Information Set (OASIS): Routinely administered by nurses at patients' start of care, discharge, and 60-day recertification. 2. ADL Tool: Intended to enable nurses, HHAs and patients to collaborate on improving patient function. 3. Five Promises: Guideline for communication between staff and patient, and to promote positive and effective communication between all homecare staff. 4. Documentation of supervision: A measure to promote increased HHA support and supervision by field nurses.
4. What (procedures)	Assessing: 1. Outcomes and Assessment Information Set (OASIS): Nurses routinely conducted this documentation on the patient's functional status and progress (usual practice).

	2. ADL Tool: As first step of the tool, patient self-assessed independence in (transferring, ambulation, bathing, grooming, dressing), and identified areas requiring assistance. Using the Five Promises for continuous service plan review: 1. The homecare team staff used at every home visit. 2. The staff discussed and reviewed the progress with patient toward achieving his or her functional health goals; and any observations and concerns about the patient on the day. 3. Reviewed together any changes in service plan or duty sheets. Using the ADL Tool to structure goal-settings practices among staff and patients: 1. ADL tool intended to enable nurses, HHAs and patients to collaborate on improving patient function by structuring and setting goals. 2. It was distributed only to patients that fit certain functional criteria (criteria details unclear, but appeared not used with all patients), for self-assessment. 3. The Nurse, therapist, or both reviewed patient's self-assessment; then together they designed a care plan to promote independence at home. 4. HHA worked closely with patients and the clinicians on the care plan 5. Each week, the care team re-evaluated progress and identify further strategies.
5. Who provided	Multidisciplinary team: Each team consisted of 10-15 nurses, associated therapists (e.g. OTs, physical therapists), social workers and HHAs. Training for the staff: The whole team attended peer-led, interactive workshops before starting intervention delivery. 1. Peer-led, interactive workshops “jump-started” each phase. Clinicians and aides from the original collaborative and early adopter teams shared their experiences of the collaborative process. 2. Intervention teams received the tools, strategies, and quality improvement support developed in the pilot. 3. After learning about the ADL Tool, the Five Promises tool, and communication strategies within team and with patients, homecare team plan for implementation at the team level. Supporting the staff: 1. Clinicians supported and supervising HHA in meetings and documentations. 2. HHA service coordinators and frontline service manager coordinated work and services, while supervising and supporting the homecare team. They had regular team meetings with their teams, and regular phone calls between them. 3. Care planning with the ADL Tool and Five Promises were followed up during monthly team meetings with support from Collaborative's quality improvement specialists.
6. How	- Presumably individually and face-to-face, based on the home visit format - Presumably by phone as needed, as phone contacts were provided to the participant.
6b. How organised	Organisations: 1. The Visiting Nurse Service of New York (VNSNY): - a large, non-profit New York City homecare organization.

	- 77 teams, 21 partnering vendor agencies, and approximately 14,000 HHAs who provide care to 25,500 VNSNY's patients daily. - In this RCT study, 22 teams in VNSNY's four largest regions which had not participated in the earlier pilot were included (Phase 2). 2. VNSNY's affiliate agency- Partners in Care, and contracted multiple vendor staffing agencies, to ensure ready access to an ample aide work force. Homecare team (providing home visits and care services): 1. Home health aides (HHAs)spend more time in the patient's home than other members of the care team, who could provide observations to clinicians. Employed by multiple vendors and staffing agencies. 2. Clinicians (typically nurses, OT, physical therapists) assessed patient's needs (e.g., independence), and developed care plan. They supervised HHAs' implementation of individual care plans for patients (e.g., documentation for supervision), and provided biweekly face-to-face supervision. They tapered work hours of HHAs. Employed by VNSNY. 3. Social workers Staffing agency and the Collaborative: 1. VNSNY's frontline service manager (e.g., nurse) supervised the homecare teams, by discussing pressing team and patient issues, agency initiatives, and practice improvement. 2. Services from the HHAs (aides) managed by vendor agencies' coordinators (HHAs service coordinators), who worked with VNSNY's frontline managers to coordinate aide-patient assignments, aide scheduling, and the overall quality of aide services. 3. The frontline service managers and agencies' coordinators communicated regularly in weekly phone calls to address service problems. 4. The Collaborative's quality improvement specialists supported the implementing of the intervention, e.g., in monthly team meetings.
7. Where	Location: New York City (Bronx, Brooklyn, Manhattan, and Queens), USA Settings: Patient's home; Visiting Nurse Service of New York (VNSNY), non-profit New York City homecare organization. - Medicare and Medicaid are available health insurance options. - VNSNY provided homecare of an average of 25,500 patients daily.
8. When and how much	When intervention started: When admitted to home healthcare services provided by VNSNY. Most patients were admitted with some functional impairment related to chronic illness and/or hospitalization. They were assessed as being able to improve in at least one ADL. Duration, number, and schedule of sessions: All appeared to vary according to the patient's needs. - A routine reassessment was provided every 60-days, as part of the recertification process.
9. Tailoring	1. At home healthcare admission: Patients were assigned to the appropriate care service team based on their specific needs and location of residence. 2. Five Promises: HHA or clinicians discussed and reviewed patient's functional health goals and achievement at each visit. 3. ADL Tool:

	Patient's self-assessed performance, and needs required. Clinicians review and discussed with aides and patients to define a patient's goals, and plans for functional improvement.
10. Modifications	Early in the spread of the intervention, the collaborative faculty encouraged nurses to taper HHA work hours as patients gained independence. The faculty later de-emphasized this goal as the spread continued.
11. How well (planned)	1. A nurse survey related to the intervention indicated that out of 150 respondents. 2. Project documents, e.g., intervention tools and training materials. 3. Notes from semi-structured interviews with 13 service delivery team managers. 4. Notes from observation of 19 team meetings.
12. How well (actual)	1. Collaborative's "general communication" strategies - the Five Promises and weekly calls between team managers and HHA service coordinators, were widely accepted. 2. Clinician buy-in and application of the Collaborative's strategies were inconsistent. 3. Training was not consistent during Phase 2 (only eligible phase in this review). For Phase 1, Collaborative faculty recruited "early adopters" from the pilot period to champion the intervention and share their experiences with other staff. During Phase 2, peer momentum diminished as additional organizational priorities. 4. The Five Promises facilitated a substantial improvement in nurse-aide relationships. 5. Nurses perceived the ADL Tool as redundant with usual practice; thus, resistant to use it. 6. Though using the ADL Tool might reduce the HHAs' work hours, some HHAs perceived it as their skills being effective. 7. The homecare staff appeared not ready to implement self-management strategies for patients.

Table 182. Ryvicker 2011[124] Usual homecare

1. Brief name	Usual homecare.
2. Why	Goals: 1. To assess and act on patient's clinical and functional status. 2. To provide home healthcare to patient according to his/her needs. Rationale: Home health aides (HHAs) play a vital role in the care, well-being, and recovery of the patients.
3. What (materials)	Outcomes Assessment and Information Set (OASIS): Routinely administered by nurses at patients' start of care, discharge, and 60-day recertification.
4. What (procedures)	Assessing: Outcomes and Assessment Information Set (OASIS): Nurses routinely conducted this documentation on the patient's functional status and progress (usual practice). Supporting the intervention: 1. Nurse provided biweekly face-to-face supervision to HHA at the patient's home.

	2. HHA service coordinators coordinated work and services, while supervising and supporting the HHAs. 3. Frontline service managers supervised the homecare teams, and they held meetings biweekly. It was generally infeasible for HHAs to leave their patients to attend team meetings scheduled at the organization's regional offices.
5. Who provided	Multidisciplinary team: Each team consisted of 10-15 nurses, associated therapists (OTs, physical therapists), social workers and HHAs.
6. How	- Presumably individually and face-to-face, based on the home visit format
6b. How organised	Organisations: 1. The Visiting Nurse Service of New York (VNSNY): - a large, non-profit New York City homecare organization. - 77 teams, 21 partnering vendor agencies, and approximately 14,000 HHAs who provide care to 25,500 VNSNY's patients daily. - In this RCT study, 23 teams in VNSNY's four largest regions which had not participated in the earlier pilot were included (Phase 2). 2. VNSNY's affiliate agency- Partners in Care, and contracted multiple vendor staffing agencies, to ensure ready access to an ample aide work force. Homecare team (providing home visits and care services): 1. Home health aides (HHAs)spend more time in the patient's home than other members of the care team, who could provide observations to clinicians. Employed by multiple vendors and staffing agencies. 2. Clinicians (typically nurses, OT, physical therapists) assessed patient's needs (e.g., independence), and developed care plan. They supervised HHAs' implementation of individual care plans for patients, e.g., in biweekly face-to-face supervision. They tapered work hours of HHAs. Employed by VNSNY. 3. Social workers Staffing agency and the Collaborative: 1. VNSNY's frontline service manager (e.g., nurse) supervised the homecare teams, by discussing pressing team and patient issues, agency initiatives, and practice improvement. 2. Services from the HHAs (aides) managed by vendor agencies' coordinators (HHAs service coordinators), who worked with VNSNY's frontline managers to coordinate aide-patient assignments, aide scheduling, and the overall quality of aide services.
7. Where	Location: New York City (Bronx, Brooklyn, Manhattan, and Queens), USA Settings: Patient's home; Visiting Nurse Service of New York (VNSNY), non-profit New York City homecare organization. - Medicare and Medicaid are available health insurance options. - VNSNY provided homecare of an average of 25,500 patients daily.
8. When and how much	When intervention started: When admitted to home healthcare services provided by VNSNY. Most patients were admitted with some functional impairment related to chronic illness and/or hospitalization. They were assessed as being able to improve in at least one ADL. Duration, number, and schedule of sessions: All appeared to vary according to the patient's needs. - A routine reassessment was provided every 60-days, as part of the recertification process.

9. Tailoring	At home healthcare admission: Patients were assigned to the appropriate care service team based on their specific needs and location of residence.
10. Modifications	Not specified.
11. How well (planned)	1. A nurse survey related to the intervention indicated that out of 150 respondents. 2. Project documents, e.g., intervention tools and training materials. 3. Notes from semi-structured interviews with 13 service delivery team managers. 4. Notes from observation of 19 team meetings.
12. How well (actual)	1. Nurses had limited opportunity to provide face-to-face supervision to the HHAs, due to scheduling difficulties. 2. HHAs had conflicting schedules to attend team meetings and providing home visits to patients. 3. Few nurses had formal training in clinical supervision.

Table 183. Shapiro 2002[78] Community-Based Early Intervention Program

1. Brief name	Community-Based Early Intervention Program. Providing care planning, case management and selected services according to need
2. Why	Goal: provide case managed services earlier than clients would normally receive them to allow older adults to remain independent. Rationale: - based on previous literature showing the importance of independence to quality of life - previous research showing effectiveness of case management and preventive care
3. What (materials)	Not mentioned
4. What (procedures)	- Geriatric assessment (presumably covering several domains, as services that followed were varied) by a registered nurse - Care planning based on needs identified in the assessment and on a discussion with the participants and their caregivers, by the nurse - Coordination of services provided by a case manager - Regular review of needs and adjustment of services by a case manager - Most participants (95%) received homemaking services - Other services such as home-delivered meals, medical supplies and transportation were selectively provided as needed - Presumably the participants continued to be able to access usual care
5. Who provided	- A registered nurse carried out the multidomain assessment and care planning - A case manager, which background is not mentioned conducted the regular reviewing and arranging.
6. How	- Assessment conducted individually and face-to-face, based on home context - In the care planning, the caregiver was additionally involved - It is unclear how the case manager contacted the participant
6b. How organised	- Care planning was unidisciplinary, resulting from the contribution of a nurse, the participant and caregiver. - It is unclear whether medication management was part of the intervention. The involvement of a nurse in the process and the provision of consumable

	medical supplies do not seem enough to say that medication management occurred. - Participants were followed by a case manager who coordinated the services that were recommended to the participants based on assessment and care planning - Participants were enrolled in a state program upon referral from healthcare services. The program provided social services following a uniform statewide assessment. This assessment determined the level of risk and participants only received services if classified as high risk.
7. Where	- At home - Florida
8. When and how much	- Started when participants were referred to receive social services by local hospitals, rehabilitation centers, and physicians. Participants were assessed as being at medium risk by a uniform statewide assessment (based on chronic health conditions, activities of daily living limitations, and other measures of physical and psychological impairment) and put on a waiting list. - The intervention extended for 18 months - It is unclear how many sessions the assessment and care planning took. - Contacts with a case manager occurred at least every 3 months. Participants could also contact the case manager directly according to need.
9. Tailoring	- The services provided were tailored based on a care plan that took into account the assessment conducted and followed a discussion with the participants and their families. - Participants could also contact the case manager directly according to their need, resulting in a tailoring in the number of contacts.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Homecare, multifactorial-action and review with medication review

Table 184. Bernabei 1998[104] Integrated care, including social and medical care and case management

1. Brief name	Integrated care, including social and medical care and case management.
2. Why	Goal: to reduce functional decline, admissions to institutions and the use and costs of health services Rationale: ...by integrating social and medical services which responsibility may be poorly defined otherwise ...consistent with previous public policy recommendations ...by responding to the demands of older people
3. What (materials)	- Individualised care plans in agreement with general practitioners Materials used by case managers for assessment: - A modified and validated version of the British Columbia long term care programme application and assessment form

	- ADL and IADL scales, short portable mental status questionnaire and the geriatric depression scale. - Complete list of diagnose and drug treatments and the number of home visits provided by general practitioners.
4. What (procedures)	For participants: - Assessment and regular reassessment of physical, cognitive and daily function - Creation of individualized care plan that determines access to services - Monitoring of problems, provision of services, and extra help - Discussion of problems in the health professionals team meetings For staff: - Case managers received intensive training on case management skills and geriatric assessment technology In the system of care: - Establishment of a formal agreement between the municipality and the local health agency As in usual care: - Access to primary and community care services, including general practitioner's regular ambulatory and home visits, nursing and social services, home aids, and meals on wheels.
5. Who provided	- A case manager, who received training on case management and care planning - Community geriatric evaluation unit team including a geriatrician, a social worker and several nurses - The general practitioner As in usual care: - Presumably, health and social professionals involved in conventional primary and community care services
6. How	- Presumably individually and face-to-face. As in usual care: - Access to a variety of primary and community-based care may presumably provide services face-to-face and at a distance, individually and in group
6b. How organised	- The municipality and local health agency services are integrated based on formal agreement - The deliverers were already employees of existing services - Case managers and GPs collaborated in care planning - Problems were dealt with in weekly team meetings - The care planning does not explicitly mention medication changes, but these can be inferred based on the inclusion of a medication assessment which is used by the geriatric unit that develops the care plan
7. Where	- Rovereto, in northern Italy - At home - In the context of a care system that includes a hospital geriatric evaluation unit, a skilled nursing facility, and a home health agency As in usual care: - Access to a variety of primary and community-based care may presumably provide more services at home and in specialized facilities
8. When and how much	- Started when the participants were recipients of home health/assistance services without a previous comprehensive geriatric assessment - Assessments every 2 months during 12 months (6 sessions)

	- Team discussion every week
9. Tailoring	- Care managers provided extra support as requested by participants and their GPs - The care plan was tailored to each individual based on previous assessment
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 185. Fristedt 2019[107] Mobile Geriatric Team

1. Brief name	Mobile Geriatric Team. A person-centred intervention based on comprehensive geriatric assessment and delivered at home
2. Why	Goals: - improve communication flows between patients, their relatives and healthcare providers in combination with the proper adaptation of the delivery of medical as well as care measures. - to avoid unnecessary traditional healthcare utilization in the form of inpatient care and EMR visits, for example. Rationale: - Created as part of a national governmental initiative to improve quality of care through coordinated care for the sickest older people - Based on previous RCT results on a person-centered integrated heart failure and palliative home care intervention, which showed positive welfare effects in terms of increased patient well-being and reduced hospital care utilization
3. What (materials)	- Care plans - The team used several materials in order to develop their activities, including cars, mobile electronic patient records with updated list of medication, and laptops.
4. What (procedures)	- Multidomain assessment, planning and arranging by a geriatric team in collaboration with patient and relatives and municipality/home care staff. The assessment is based on Comprehensive Geriatric Assessments and includes a pharmaceutical review. - After the initial assessment and care plan formulation additional visits are initiated by the patient. - Usual care including home care and home help, and hospital-based healthcare. - The access to usual care EXCLUDED primary care, which was replaced by the multidisciplinary team care described here.
5. Who provided	- A geriatric team including physicians (geriatricians), nurses, working with staff from the municipality, and at times also involving occupational therapist and physiotherapists. - Presumably health and social care professionals involved in usual care, including primary care, hospital-based care, long-term health and social care.
6. How	- Presumably face-to-face (implied based on home visit), individually or with the patient's relatives. - The care plan was developed and implemented in collaboration with patients and his/her relatives and other staff from the municipality

6b. How organised	- The care planning explicitly mentions medication changes. - The state is responsible for the healthcare policy - The county council is responsible for organizing care - Municipalities are responsible for the long-term health and social care of older people - Long-term health and social care of older persons is provided by the municipalities or by private companies. - Primary care is the first line of healthcare in primary care practices and at home, and guides patients to the right level in the healthcare system - The team worked in collaboration with patients, relatives and home care staff from the municipality - The overall medical responsibility for the patient was temporarily transferred to the MGT physician (the geriatrician) from primary care during the intervention period - The enrolment of the MGT was not withdrawn unless the participant moved to a nursing home, stabilized, or died, and, in some individual cases, at the patient's request. If patients required palliative care, the MGT remained responsible but consulted an already-existing external palliative team, when necessary. - The MGT comprised, on average, 1.95 physicians and 3.2 nurses during 2016. They cared for a stock of around 95-100 patients, matching their capacity. - The MGT service was free of charge
7. Where	- At home - In Southern Sweden
8. When and how much	- Started after assessment based on electronic records that selected "frail" elderly based on the following criteria: being community-dwelling persons aged > 75 years, having more than three chronic diagnoses, prescribed six or more pharmaceutical drugs for continuous use and with at least three hospital stays (> 24 hours in hospital) during the last six months. - One visit for assessment and variable additional visits for at least 15 weeks, as initiated by the patient. An average of 11 physician and 4 nurse contacts were delivered.
9. Tailoring	The care plan was tailored to participants based on need and patient and relatives' preference. The frequency fo the visits were also tailored based on participants' preference, specifically, by depending on her/his own initiative.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 186. Wolter 2013[114] Resident Assessment Instrument in home care settings (including nursing)

1. Brief name	Resident Assessment Instrument in home care settings (including nursing).
2. Why	Goals: improve process quality by highly qualified care and thereby improve or stabilize functional abilities (ADL, IADL) and cognitive skills (MMST), improve

	quality of life (EQ-5D), and reduce institutionalization, thereby, increasing outcome quality. Rationale: - By providing more effective care, for example, by detecting deficits in the quality of care - Based on previous international studies showing the validity and effectiveness of the RAI-HC
3. What (materials)	- Resident Assessment Instrument-Home Care (RAI HC), including Minimum Data Set (MDS) and Client Assessment Protocols (CAPs)
4. What (procedures)	- Multidomain assessment with Resident Assessment Instrument-Home Care (RAI HC), by the home care nurse. The assessment guides care planning and recommendations that are presumably carried out by the nurse as part of professional home care. - Presumably there are periodic reassessments to review care plan and recommendations - Usual home care services, including nursing services, personal care, meals, medication and social engagement.
5. Who provided	- The RAI-HC assessment and related care planning and recommendations were provided by a home care nurse. - Nurses and other home care staff received training and support to implement (e.g., conferences, telephone calls). - The usual home care service also includes care provided by nurses.
6. How	- Presumably individually and face-to-face, based on home care delivery
6b. How organised	- The nurses are responsible by the assessment and care planning, and presumably, by implementing the recommendations - All home care services signed a cooperation agreement. - The care planning does not explicit mention medication changes, but these can be inferred based on the use of MDS-HC/RAI-HC
7. Where	- At home - Urban and rural areas in Germany - In the context of a long-term care insurance system that aims at supporting home care and improving its quantity and quality by public funding this sector. This resulted in a enormous growth of these services, with different levels of quality
8. When and how much	- Started when participants were receiving home care, including nursing services, and needed long-term care according to German social care regulations - The home care providers were recruited by announcements in journals. - Presumably there are periodic reassessments to review care plan and recommendations. - Provision of usual home care was presumably regular.
9. Tailoring	- The assessment provided was meant to tailor the care planning and care provided according to each participant's needs.
10. Modifications	Not mentioned
11. How well (planned)	Implementation fidelity was supported by 1. training for all home care staff (16h), and 2. advice and support during the implementation (user conferences, phone calls and on-site visits).

12. How well (actual)	- The intervention increased the proportion of care plans and especially of care plans that are up-to-date (but was not significantly different from not having an intervention) - The implementation process varied greatly between providers. Some were able to make intensive and rather effective use of RAI within a short period of time (i.e., using MDS, adapting care planning, using new nursing knowledge for team conferences and periodical evaluation of the situation of care). Other home care agencies did not make full use of RAI, even by the end of the study (i.e., rarely using MDS and often enacting a care plan). - Sites were classified as optimal (17 home care agencies with 108 clients, at t2) or suboptimal users (12 home care agencies with a final total of 160 clients), based on a factorial analysis on 22 questions (partially unspecified). - The nurses' feedback suggests that it takes about 1 year to implement RAI adequately. - The factors that influenced implementation were analyzed. This analysis identified the following factors leading to a successful implementation: a higher proportion of qualified staff, a lower perceived quantitative workload, a small size of care providers, the type of ownership (for-profit) and a late entry in study.

Homecare, multifactorial-action and review with medication review and self-management

Table 187. Markle-Reid 2006[123] Proactive nursing health promotion intervention

1. Brief name	Proactive nursing health promotion intervention.
2. Why	Goal: to bolster the participant's personal resources and environmental supports in order to reduce the level of vulnerability, enhance health and quality of life, and reduce the on-demand use of expensive healthcare resources. Rationale: - Based on the model of vulnerability (Rogers, 1997), which conceptualizes vulnerability and health as a result of personal resources, environmental support and biological characteristics - Based on a systematic review of previous research which showed effectiveness of home-based health promotion and preventive care, when the intervention involves assessment and regular home visits and people 75 years old or older
3. What (materials)	- Written forms for assessment and care plan - Staff training materials such as booklets, and information sheets - Referrals - Eligibility screening form is presumably used as part of usual care reassessments for home care
4. What (procedures)	- Multidomain assessment including areas such as physical, psychological and social functioning by the nurse - A care plan was created by the nurse based on the identified needs and patients' preferences, in cooperation with them and with other health professionals - The nurse provided referrals and maintained close links with other health providers

	- The nurse provided health promotion along with the visits - Review of the care plan was ongoing based on risk factors and the participant could also contact the nurse as needed - The delivery of the intervention was supported by problem-solving and empowerment techniques - Unspecified assessment and care plan and review by the usual home care services. The extent of care coordination and review by these services was limited - Access to personal home care and usual community care services such as social work, family physician, nutritionist, among others.
5. Who provided	- Registered nurse, who received specific training and regular supervision on the intervention - Case managers (unspecified background) - Personal support worker
6. How	-Presumably face-to-face and individually based on home visit format. Some of the sessions included the participant's primary support worker - Goal setting, empowerment and problem-solving techniques supported the delivery of the intervention, by enhancing self-efficacy and participation.
6b. How organised	- The care planning includes identifying and managing polypharmacy - A nurse maintained close links with other health providers, in addition to the minimal care coordination by an usual care manager - Nurses worked collaboratively with the client's primary homemaker, case manager, family physician, caregiver and/or other home care providers to coordinate the development, implementation, and evaluation of the plan of care. - The same nurse maintained regular contact with the participant - The intervention was supported by a collaborative model involving personal support agencies, the study nurse agencies, the researchers ana a steering committee
7. Where	- At home - In Ontario, Canada
8. When and how much	- Started following referral to personal homecare services by community, hospital (more frequently) or self-referral. The eligibility included requiring service for a variety of reasons including physical illness, physical disability, diminished physical ability, cognitive impairment, mental illness (18+), injury, postsurgical condition. The person was 75 years old or older - Participants were expected to receive at least 6 contacts for one hour in 6 months. An average of 3.94 visits and 1.84 phone calls, and a media of 5 visits and one phone call were actually received.
9. Tailoring	- The care plan and the frequency of additional contacts were tailored the participant’s needs and preferences and informed by a client-centred approach.
10. Modifications	The criteria to access to personal support services changed during the study, becoming more restricted and delayed. This meant that services recommended by the care plan developed were more difficult to implement
11. How well (planned)	- Engagement (at least one home visit or telephone contact that lasted for ‡10 minutes) was measured during the intervention To support intervention fidelity: - The staff received training and regular supervision - Collaborative links between relevant organizations were developed

12. How well (actual)	Overall compliance with the intervention was high: - 83.9% of participants received at least one home visit or telephone contact (engagement measure) - 86.5% of participants were contacted a minimum of once per month by the nurse - 91.9% of participants who completed the intervention (6 months) were visited a minimum of 3 times by the nurse

Homecare, multifactorial-action and review with self-management

Table 188. Hall 1992[122] Frail Elders Personalised Program (FEPP) plus British Columbia long term care program.

1. Brief name	Frail Elders Personalised Program (FEPP) plus British Columbia long term care program. FEPP- personalized nurse-delivered health promotion intervention, including multidomain assessment, personalized care plan, care and regular reviews regularly. Long term care program- needs' assessment to determine level of care, regular reviewing and access to professional home care services and other community services.
2. Why	Goals: - to assist frail elderly persons to live longer at home. - maintain total well-being of participants - to enable people to take charge of their lives Rationale: A study showed that the BC LTC program alone did not maintain many people at home
3. What (materials)	- Standard protocol guided the care plan formulation - Referrals to community services by the nurse
4. What (procedures)	- Multidomain assessment, planning and arranging by nurse, with regular review. emphasizing goal setting and skills' development and a counselling role by the nurse when necessary - Screening, pre-admission assessment to determine level of care needed - Arrangement of needed services and regular review - Access to professional home care which could include: Homemakers, Meals on Wheels, Adult Day Care, Community Physiotherapy and Home Nursing. - Access to usual community health care, which included seniors' programs
5. Who provided	- Nurse provides the multidomain assessment, planning and arranging with regular review, emphasizing goal setting and skills' development and assuming a counselling role if necessary - Community health nurse provides needs' assessment - Access to a variety of professionals that provide home care as needed (e.g., physiotherapist, nurse) - Presumably, access to other professionals that provide community health services
6. How	Presumably individually and face-to-face (home visit implied) The multidomain plan and recommended changes are delivered based on goals setting techniques and involve skills' development, with the nurse counselling as needed
6b. How organised	- Nurse provides referrals for community services based on multidomain assessment and care plan developed with the older person

	- Long term care program staff (usually community health nurse) arranges services on behalf of the clients based on the needs' assessment - The care planning does not mention or implies medication change, despite measurement of prescribed medications at baseline
7. Where	New Westminster, British Columbia
8. When and how much	- Started following enrolment in personal care at home, as determined by standardized regional assessment - Assessment reviewed at 3 months and at least a year thereafter - Several visits according to need
9. Tailoring	- A care plan is tailored based on people's preferences and needs identified in the multidomain assessment. - The frequency of visits by the nurse is tailored based on need. - The professional home care arranged is presumably tailored based on the level of care needed identified by the standardized regional assessment.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 189. Parsons J 2012[115] Restorative home-based care using Towards Achieving Realistic Goal in Elders Tool (TARGET)

1. Brief name	Restorative home-based care using Towards Achieving Realistic Goal in Elders Tool (TARGET). The intervention arm involved participants completing a goal facilitation tool with assessors to establish rehabilitation aims. Regular reviews were conducted to enact required changes to service delivery and to develop management plans with the client.
2. Why	Goals: 1. Restorative home care focuses on the restoration and maintenance of older people's physical function, so that the highest possible level of function is achieved. 2. Progressive restorative programs assist older people to identify life goals, and then home care aides engage with older people to help achieve the goals, often through engagement with relevant services. 3. To change the philosophy from one where delivery of care may create dependency to provision of care which maximises independence, self-esteem, self-image and quality of life, and reduces the care required. Rationale: - Up to 50% of hospitalised older people lose some functional ability during their stay, and 66% have not regained their previous functioning 3 months later. - Homecare has potential to improve this situation, it often focuses on treating disease and 'taking care' of the participants.
3. What (materials)	Training and implementing materials: 1. presentation of completed TARGETs Materials used in intervention delivery: 1. Initial assessment- Support Needs Assessment (SNA) tool + Towards Achieving Realistic Goal in Elders Tool (TARGET) + Goal ladder form + Nottingham Extended Activities of Daily Living Scale (NEADL) + EuroQoL 5D-3L

	2. Homecare support plan prepared by home care organisation and undertaken by homecare aides. 3. Client review
4. What (procedures)	Deliverer training: 1. Assessment staff and all homecare coordinators attended a standardised two and half days training programme before the start of the intervention. The programme developed a shared understanding concerning implementation of restorative home-based care and support; which required a considerable paradigm shift from standard homecare service delivery. 2. Following completion of training there were monthly peer-review sessions, comprising presentation of completed TARGETs and discussion around implementation of the service delivery plan. Needs assessment: 1. Set of initial assessments- Support Needs Assessment (SNA) tool + Towards Achieving Realistic Goal in Elders Tool (TARGET) + Goal ladder form + Nottingham Extended Activities of Daily Living Scale (NEADL) + EuroQoL 5D-3L - to identify a goal for the homecare, areas including cognition, informal caregiver stress, safety, and nutrition, thus establish rehabilitation; conducted by the assessors of assessment agency. 2. Participants completing the goal ladder with assessor to establish rehabilitation aims. 3. Assessment findings were passed to the homecare organisation to develop a support plan. This provided concrete instructions to the support worker including detailed descriptions of tasks to be undertaken. Regular reviews: 1. Regular reviews, undertaken by homecare coordinators, to enact required changes to service delivery; to develop management plans with the client. 2. The results of the review were provided to the assessment agency with recommendation for either discharge, increase in hours or maintenance of current service levels. If services were to continue, additional goals were agreed with the client. Homecare support services (Restorative home-base care): 1. Homecare organisation developed support plan for service delivery, addressing areas of deficit such as falls risk, decreased muscle strength, difficulty with showering, and other personal cares that may have prevented the older person from attaining his/her goal. 2. Categories of services delivered by homecare aides (support workers) to participants included: domestic tasks (e.g., vacuuming), personal care (e.g. showering assistance), shopping (with and/or without the client) and individualised activities (activities identified specifically for the individual client) were collected and analysed. Usual care: 1. Support Needs Assessment (SNA) tool is nationally standardized comprehensive geriatric assessment in New Zealand. 2. Referrals to allied health were made by needs assessors after initial assessment, if appropriate.
5. Who provided	1. Needs assessors - attended a standardised two and half days training programme on utilising TARGET tool, before the start of the intervention delivery.

	2. Homecare coordinators - attended a standardised two and half days training programme on utilising TARGET tool, before the start of the intervention delivery. 3. Home care aides (also referred as support workers) - trained to a nationally accredited program (New Zealand Qualifications Authority Home and Community Support, Level 1 and 2) 4. Research team who reviewed the content of every support plan 5. Allied health professionals whom participants might be referred to.
6. How	1. Initial needs assessment (with the use of TARGET) was conducted individually with each participant, but not specified whether face-to-face or otherwise. 2. Homecare services provided to face-to-face to each participant individually.
6b. How organised	Organisations: 1. Assessment agency (located within the local health board) where needs assessors were based; and closely monitored the support plan as a cost management strategy. 2. Homecare organisation (5 private companies contracted by the health board to provide services), where a support plan was developed, and homecare coordinators based. 3. Research team reviewed the content of every support plan. Core team for intervention delivery: 1. Needs assessors conducting initial assessment, then passing the identified homecare aims and goals to homecare coordinators. This care planning seems to be unidisciplinary. 2. Homecare coordinators developed homecare support plan for the participant, based on the initial assessment findings (goals, aims), and principles from training; and conducted client reviews. 3. Homecare aide (also referred as support workers) followed the concrete instructions in the support plan implement the specified services. *There is no evidence of systematic processes for organization of care *Medication is not mentioned as part of the needs assessment or following care planning Peer support: 1. Following completion of training for assessors and homecare coordinators, there were monthly peer-review sessions, comprising presentation of completed TARGETs and discussion around implementation of the service delivery plan. 2. Individualized training of the home care aide for specific cases (e.g., mobilizing safely outdoors or strategies to improve meal preparation) was undertaken by the home care coordinators (who were registered nurses).
7. Where	Location: Auckland, New Zealand Infrastructure: District Health Board Needs Assessment Service Coordination overlooks home-based support services.
8. When and how much	Intervention started: Upon a new referral to Counties Manukau District Health Board Needs Assessment Service Coordination (NASC) for home-based support services Duration and number of sessions, schedule and length of intervention: All appeared varied according to the needs of participants, identified between the participants and needs assessor in initial assessment and reviews.

9. Tailoring	1. The assessor used a goal-setting tool (Towards Achieving Realistic Goals in Elders Tool [TARGET]) during the initial assessment process of the participant to establish the aims of the rehabilitation episode. 2. Individualised activities predominantly focussed on assisting participants to access the community, or improving functional ability. 3. The results of the review were provided to the assessment agency with recommendation for either discharge, or changes in current service levels. If services were to continue, additional goals were agreed with the client.
10. Modifications	Not specified.
11. How well (planned)	1. Support plans details of categories of services delivered to participants in both groups and individualised activities were collected and analysed, to determine tasks implemented by support workers (homecare aides). 2. Number of client reviews undertaken by homecare coordinators was ascertained.
12. How well (actual)	1. 61.7% (n= 66) of the support plans included individualised activities aiming at improving functional ability. 2. 31 (28.7%) participant was reviewed by homecare providers 6 months after service provision commenced. Use of the TARGET tool did not lead to increased formal reviews. 3. 10 referrals made to allied health professionals. 4. 92 subjects (85%) identified goals in collaboration with assessors.

Homecare, nutrition, multifactorial-action and review

Table 190. van der Pols-Vijlbrief 2017[113] Personalized action plan targeting undernutrition, plus home care

1. Brief name	Personalized action plan targeting undernutrition, plus home care. Personalized action plan targeting undernutrition, and home care (standard intervention) multifactorial personalized intervention action plan, focused on eliminating or managing the underlying causes of undernutrition to prevent and reduce undernutrition.
2. Why	Rationale: 1. Undernutrition may result in increased dependence and social isolation. The underlaying causes are multifactorial and found in different domains, a preventive intervention should include a multifactorial approach. 2. It seems difficult to reverse undernutrition and its consequences once present, so preventing undernutrition may be a more (cost-)effective strategy. 3. The majority of older adults in western countries remains living independence at home with or without home care, and thus interventions that can be implemented in this setting is important. Goals: 1. By tackling the underlying determinants with a step by step, multifactorial personalised action plan to slow down of prevent undernutrition in community dwelling older adults.
3. What (materials)	1. Questionnaire screening tool (SNAQ65) (Pre randomisation). 2. Check list used in the assessment at baseline (Used as part of delivery not provided to the participant)

	3. Action plan provided to the participant in print along with a workbook. (Provided to the participant)Personalized action plan. 4. Standard brochure of the Netherlands Nutrition Centre. (Provided to the participant in the intervention group)
4. What (procedures)	Intervention: 1. A multidomain assessment: a checklist assessing 7 potential causes of undernutrition, including appetite, pain, physical activity level, oral health, need with grocery shopping. 2. Unidisciplinary care planning: Personalised action plan which includes a maximum of three components: Personal cause specific tips for own use, referring participants to neighbourhood initiatives, and advising participants to approach health care professionals. The action plan and relevant information were provided to the participant in print. 3. Routine review: Home visit at 3 months to discuss and adjust the action plan. The multidomain checklist was completed again to assess any actions undertaken by the participant and caregivers. Telephone calls at 1.5 and 4.5 months to discuss action plan and overcoming barriers. 4. At telephone and home visit follow-ups, the researcher provided motivation to the participant and caregivers to follow the action plan. Available usual care which participants would be recommended to seek help from: - visits to general practitioner, dentist, therapists such as a dietician or a physiotherapist, social worker - hospital stays, admissions to other institutions, outpatient visits Available standard intervention: home care services.
5. Who provided	Intervention delivery: 1. Researchers (for all) 2. GP, Dietitian, Occupational therapist, Physiotherapist, Podiatrist, Dentist, Prosthodontist, Speech therapist (optional, participants were recommended to approach these professionals from available usual care when appropriate). Home care (standard intervention): Health care worker
6. How	1. Face to face : Home Visits provided to the individual. The participants family or caregiver may also be present and provide an input in the personalised care plan. 2. Telephone calls to the participants. Researchers followed up participants.
6b. How organised	1. Assuming the home care workers were responsible for the home care services. They identified those who might be at risk of undernutrition among their clients, to refer to the researchers. 2. The researchers conducted all the assessments, personalised action plan, support to participants and their caregivers, conducting review follow-ups in the 6 months intervention period. 3. If care from healthcare professionals were required, the participants were recommended to approach their GP or the professionals. 4. The researchers would refer and provide information about local community initiatives activities to the participants, to improve their underlying causes of undernutrition risk.
7. Where	2 districts in the Netherlands: Amsterdam New-West and Hoorn Venues:

	1. participant's home: The multidomain assessment, personalised action planning, follow-ups, and assuming home care services. 2. Local initiatives activities: community centre, nursing home. 3. Assuming at GP practice, outpatient or inpatient settings, for healthcare.
8. When and how much	When started: Assessed as undernourished or at risk of undernutrition AND Status - receiving home care services and 65+ years old 3 fixed home visits: at baseline, 1 week, and 3 months. 2 fixed telephone calls: at 1.5 and 4.5 months. When started (to received home care): Not mentioned. Home care details not mentioned.
9. Tailoring	1. The personalized action plan included a maximum of three components per underlying cause: 1) personal cause-specific tips for own use, 2) referring participants to neighbourhood initiatives and 3) advising participants to approach health care professionals. 3.The involvement of partners, informal caregivers or family members in the development of the action plan.
10. Modifications	Not mentioned.
11. How well (planned)	Process evaluation at the end of the study.
12. How well (actual)	1. On average, 62.2% of the personalized action plan components were started. Different reasons explaining why no action was started included: 1) the cause was already well known and all action plan components were already started; 2) other underlying causes were more urgent; or 3) participants did not believe that the recommended action would solve the problem and therefore did not want to engage in it. 2. The evaluation showed that this intervention program is well capable of motivating older adults to use tips, neighbourhood initiatives and/or the advice of a professional to tackle undernutrition after there is an agreement that the specific underlying cause(s) need(s) action.

Meaningful-activities and education

Table 191. Clark 1997[26] Well Elderly Treatment Program

1. Brief name	Well Elderly Treatment Program. A preventive occupational therapy intervention for multiethnic, independent-living older adults.
2. Why	Goal: the intervention was expected to benefit elderly participants' physical health, daily functioning, and psychological well-being through (a) improving their specific health practices (e.g., exercise, use of joint protection techniques) and (b) increasing their general sense of purpose and meaning via engagement in personally meaningful activity Rationale: - On the basis of previous theory and research in occupational science, including qualitative preliminary studies, it was posited that the dynamics responsible for the success of the program consisted in enhancing the manner in which the elders (a) selected which occupations to perform and (b) experienced meaning in their occupations.

	- Emphasizes the nature of occupations as unfolding phenomena that are the generative product of multiple interrelated considerations such as the larger sociocultural order - Emphasizes the role of experiencing meaning in occupations as a key component of successful aging, based on previous qualitative study - Based on a qualitative study that identified in the target population a typology of relevant life domains. These played an important role in defining the topical content areas of the intervention - Based on the dynamic systems theory, as a framework to interpret change and stability in occupation, recognizing that the changes are not predetermined or linear - Based on the belief that optimal personal growth is facilitated by opportunities to embrace self-chosen risks in occupation.
3. What (materials)	Materials used in education sessions: - List of "25 Ways to Stay Healthy", developed by each participant - Lifestyle Redesign Journal developed by each participant about the activities developed during the intervention program - An instructional video on crime prevention.
4. What (procedures)	- Education sessions in group including related activities, on the following topics: I. Introduction to the Power of Occupations, 2. Aging, Health, and Occupation, 3. Transportation, 4. Safety, 5. Social Relationships, 6. Cultural Awareness, 7. Finances, 8. Integrative Summary - Individual sessions related with the above-mentioned topics supported a tailored approach - The intervention also provided opportunities of engagement in meaningful activities. This included for example a one-day fair in the treatment site dedicated to various occupations such as gardening and computer games. - In selected cases, as needed, functional training was also provided to support the ability of participants to do their preferred occupations. - Presumably access based on participants' own initiative to usual health and social care services, including for example: physician office visits and health-professional home visits.
5. Who provided	- Registered occupational therapists trained in working with older populations, who received training on the intervention and spoke Mandarin - A Los Angeles police officer participated in one of the education sessions
6. How	- Individual and group sessions (8-10 people) presumably face-to-face - Peer exchange was considered an important mechanism of delivery which was thought to support motivation and engagement in occupations such as using public transport - Psychological procedures were used to support the engagement in meaningful activities, including activities of self-reflection and goal planning, and techniques of active listening, building empathy and marking progress, used by the providers.
6b. How organised	- Supported by funding from the National Institutes of Health and the American Occupational Therapy Foundation
7. Where	- At home for individual sessions - The location where the group sessions took place is not explicitly mentioned - Los Angeles, California
8. When and how much	- Started when participants were living in federally subsidized apartment complexes for older adults and included participants from different cultures,

	namely, a large group of Mandarin-speaking older adults of Chinese heritage. Before the study, all participants were assessed for physical and mental health by a physician. - 2 hours/week for group sessions during 9 months - 1 hour/month for individual sessions during 9 months
9. Tailoring	- The type of activities in which the participants engaged was tailored based on what was meaningful to them - With the support of the OT the participant developed a personalized plan about the occupations that he/she could employ to adapt to personal changes - Some procedures, such as functional training, were provided selectively based on participants' need - The language spoke in the sessions was adapted according to the cultural heritage of the participants, namely, Mandarin-speaking leaders were present in all phases of the study
10. Modifications	Not mentioned
11. How well (planned)	- To assure that the participants were not influenced by other people receiving an alternative intervention, the ones receiving another intervention were asked to refrain discussing their activities with other people. - Intervention providers received 2 weeks of training on the intervention before it started
12. How well (actual)	Sixty-five percent of the participants attended at least half of the sessions (average percentage of sessions attended =60%).

Table 192. Clark 2012[27] Preventive lifestyle-based occupational therapy

1. Brief name	Preventive lifestyle-based occupational therapy.
2. Why	Goal: to reduced decline in independence, physical health, mental wellbeing and cognitive functioning among ethnically diverse older people by assisting elders in developing a personally meaningful, healthy lifestyle that is sustainable within the fabric of their everyday routines Rationale: - based on research demonstrating that older adults' activity and lifestyle patterns are modifiable and predict aging outcomes - based on a very similar intervention which showed reliable positive effects and cost-effectively for a wide range of outcomes, such as life satisfaction, role functioning and self-rated physical and emotional health
3. What (materials)	- Unspecified material used in the intervention were translated into Spanish and culturally adapted
4. What (procedures)	- Education sessions in group including related activities, on the following topics: I. Introduction to the Power of Activity, 2. Aging, Health, and Activity, 3. Transportation, 4. Safety, 5. Social Relationships, 6. Cultural Awareness, 7. Finances, 8. Integrative Summary - Individual sessions related with the above-mentioned topics supported a tailored approach - The intervention also provided opportunities of engagement in meaningful activities like community outings - In selected cases, as needed, functional training and aids were also provided. - Presumably access based on participants' own initiative to usual health and social care services (not explicitly mentioned).

5. Who provided	- Occupational therapists, who received 40 h training on the intervention and were supported in weekly or bi-weekly meeting with the on-site project director and manager
6. How	- Individual and group sessions (6-10 people) presumably face-to-face - Peer exchange was considered an important mechanism of delivery - Psychological procedures were used to support the engagement in meaningful activities, including activities of self-reflection and goal planning
6b. How organised	- Organized to avoid turnover in intervention providers and assure stability - Participants were compensated with money four participating in data collection activities
7. Where	- Greater Los Angeles metropolitan area - In a variety of community-based sites, including 9 senior centers and 12 senior residences.
8. When and how much	- Started after recruitment in 21 sites including senior centers, senior housing residences and a retirement community. Potential sites were identified through resource books provided by the Area Agency on Aging, registries of senior housing, direct contact with local senior centers and key leaders of the older adult community. Half of the sites contacted participated. - The recruitment strategies included: written information, presentations, festive events with raffle tickets, follow-up meetings. Ethnically diverse people with 60 years-old or more were recruited and assumed to experience high risk of health disparity - 2-hour group sessions every week for 6 months, and up to 10 hour of individualized treatment
9. Tailoring	- With the support of the OT the participant developed a personalized plan about the occupations that he/she could employ to adapt to personal changes - Some procedures, such as provision of aids, were provided selectively based on participants' need - The materials were adapted to Spanish and to the Hispanic cultural heritage. - The amount of individualized support was presumably tailored to participants' need.
10. Modifications	The adaption of the intervention to Spanish speakers and the Hispanic heritage took place in a second cohort enrolled in the study
11. How well (planned)	- The intervention providers received training and regular supervision support intervention fidelity - The intervention provider was kept the same during the project to support interpersonal familiarity and support adherence - The intervention providers and other staff reminded the participants of upcoming activities through a variety of means - The level of interactions between participants receiving different interventions was measured to assess possible contamination
12. How well (actual)	- On average, participants attended 56% of the scheduled sessions. Sixty-nine (17%) individuals did not attend any intervention sessions. Among participants who attended more than one session, the overall attendance rate was 70% - African American participants attended 9.7 group sessions and 1.2 individual sessions on average - Hispanic participants attended 11.6 group sessions and 4 individual sessions on average - Interpersonal conflict between participants occurred and was mostly successful dealt with by the intervention providers

Meaningful-activities and multifactorial-action with self-management

Table 193. Fischer 2009[35] Preventive home visits counseling service

1. Brief name	Preventive home visits counseling service.
2. Why	Goals: - to advise and educate the participants on the subject of healthy lifestyles and to work towards needs-based care, improving health-related self-management and supporting lifestyle change; - to improve the health status and quality of life of older people by raising their morbidity threshold, maintaining their independence for as long as possible, giving them interventions that meet their real needs and increasing their individual health resources through their activation (as in previous point). (From a systemic point of view, the project aimed to improve care management) Rationale: - based on a preventive perspective which aims to identify any problems early and promote an active lifestyle, and on theories that aim to activate behavioral change, such as stage models for health behaviour.
3. What (materials)	- STEP assessment a questionnaire including multiple domains of assessment (see procedures) - A manual with information about various areas (from physical health to financial support) guided the intervention delivery - A target agreement was created with the participants - An activation form which maps the participant's interests - WHOQOL-BREF questionnaire - A semi-structured questionnaire that maps the processes initiated in the visits in chronological order - A certificate and declaration of participation could be provided to te participants
4. What (procedures)	- Multidimensional assessment, including a geriatric assessment (asking about mobility, physical performance, medical symptoms, everyday skills, etc.), an assessment related with motivation and other measures, such as quality of life. - The health advisor/ counselor discussed and agreed goals with the participant, taking into account their needs, motivation and preferences. Self-management techniques are used in this process. - The health advisor may provide recommendations to contact service providers - Participants develop groups in which they chose activities in which to be engaged, relating to healthy behaviours.
5. Who provided	- Trained health advisors /case counselors conducted the home visits - All deliverers had knowledge of the systemic, solution-oriented advisory method and received training on gerontology/geriatric
6. How	- Presumably individually or with a partner (couples were randomized together), and face-to-face, based on home visits format - Telephone contacts are mentioned (but these do not seem to be routine) - Activities chosen and organized mostly by the participants were conducted in groups.
6b. How organised	- The care plannings is unidisciplinary, developed between the participant and the health advisor/ counselor

	- The care planning provided mentions medication but focuses on compliance rather than prompting medication changes - In the context of a health and social systems that are active in senior-related initiatives but work in a uncoordinated way, which results in both over and undersupply.
7. Where	- At home - Lower Saxony in Germany
8. When and how much	- Participants were 68-79 years old and not in need of care (participants who are suffering from life-threatening diseases are excluded). Participants are contacted by post, and contacted after 5 days by phone, and motivated to participate. - The intervention includes at least 3 home visits taking 60 to 120 minutes. These visits occurred in a period of 8 weeks. Additional visits and telephone calls were conducted as needed. - Only 48% received the number of 4 or more visits required to carry out a care management based on the STEP assessment. - The group activities occurred monthly
9. Tailoring	- The recommendations provided are based on the participants' needs and preferences. Additional visits are also tailored to the participant's need. In the group activities, the participants decide which topics/activities to focus on.
10. Modifications	Not mentioned
11. How well (planned)	- A pilot study was conducted, including a pre-test of the procedures to use in the main study, and necessary changes were implemented - The intervention deliverers received training and provided with a manual, to support the fidelity of intervention delivery. (-Several networking activities were put in place at a systemic level to support the study)
12. How well (actual)	- Coordination with GP services was less effective than expected - The STEP assessment with intervention implementation, was rejected by a majority of 52% - The doctors looked after the intervention group more intensively

Medication-review, nutrition and exercise

Table 194. Gene Huguet 2018[37] Interdisciplinary intervention

1. Brief name	Interdisciplinary intervention. Multifactorial and interdisciplinary intervention based on physical exercise, Mediterranean diet advice, assessment of inadequate prescribing in polypharmacy patients and social assessment
2. Why	Goal: to prevent frailty in community-dwelling elderly patients with incipient frailty Rationale - Multifactorial interventions have been shown to be effective in preventing or delaying frailty in frail elderly - Identifying and treating pre-frailty may prevent or delay frailty. Evidence suggests that the pre-frail elderly may respond better to interventions than already-frail people.
3. What (materials)	1. STOPP-START tool was used to support medication review

	2. Exercises and recommendations for home-performance using an illustrated pamphlet. 3. The Gijon test was used assess social risk 4. Presumably there is telehealth equipment provide to the participant.
4. What (procedures)	6-month multi factorial intervention based on 4 axes: 1.Medication assessment and planning. Treatment changes were recommended to individual family physicians. 2.Nutritional assessment and planning/ Nutritional or dietary education or advise Individual nutritional changes suggested in group session 3.Physical training Physical exercise program, including instructions about exercises and recommendations for home-performance using an illustrated pamphlet, agreed with the Hospital Clinic of Barcelona Rehabilitation Service. 4. Assessment and evaluation for home telecare. Review of personal and environmental conditions and social support. When needed, a telephone line to connect with the paramedical unit (which activates resources and follows up) was provided. Referral to usual care for high social risk. As in usual care: standard primary healthcare treatment from family physician, nurses and social workers, presumably at the participant initiation
5. Who provided	Number of intervention providers : 4+ (Multidisciplinary) 1. Family physicians led the physical exercise program 2. Nurse led the nutritional assessment and education and the physical exercise with the family physician 3. Social worker (social support) assessed the need for home telecare 4. A paramedic unit was accessible through home telecare. - It is not clear who performed the medication assessment. As part of usual care: Family physicians, Nurses, Social Workers
6. How	Individual : 1. Home telecare need (distance) assessed via telephone call. 2. Home telecare provided contact with paramedic unit by telephone. 3. Some physical exercise at home (self-instructed). 4. PHC home visit for those at high social risk, presumably face-to-face Group : 1. (Face to face) Nutritional sessions. Physical training Sessions at the PHC. Not clear if these are group or individual targeted. Group size for group activities not provided. Coded as 2+
6b. How organised	1. Physical exercise lead by PHC physician and expert nurse 2. Polypharmacy assessment and Treatment changes were recommended to individual family physicians. 3.Using Primary Healthcare Center (PHC) resources to prevent frailty in community-dwelling elderly patients with incipient frailty and determine the prevalence of pre-frailty.
7. Where	Intervention location is in Barcelona Part of the intervention is delivered at home: the exercise program and PHC visit (if required). Some exercises are presumably in the community, namely the nutritional assessment.

	Home tele care is set up in the participants' home.
8. When and how much	- Started following (1) selection from randomized list based on inclusion criteria (that included one or two Fried criteria), (2) invitation from a practice register by telephone until reaching sample size. 6-month intervention. 1. Exercise program : (1). Aerobic exercise (Walking 30-60 minutes a day for ≥ 3 days a week) (2) Program of exercises to gain strength, resistance, balance and coordination (26), with nine fortnightly sessions in the PHC for 6 months and at home 3-4 days a week. Fixed schedule Intensity/dose - (10 repetition recommended rising to 15 at two months with 1 min rest). 2. Nutritional group session. Session number and duration not provided. Fixed schedule 3. Assessment of the prescription. (Implied this happens once , duration and number of sessions not provided). 4. PHC visit varied as it only provided for the at high risk participants.
9. Tailoring	1. Medication recommendations were tailored based on medication review 2. Nutritional recommendations were tailored to the individual 3. The provision of home telecare was tailored based on a review of personal and environmental conditions and social support
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Participation in the intervention activities: 52 participants attended > 50% of physical exercise sessions; 51 participated in the dietary group session; 64 accepted the social intervention and had a home telecare service installed, and 62 participants had inadequate prescription, of which 30 were resolved (48,4%).

Monitoring

Table 195. Takahashi 2012[84] Daily home telemonitoring of older adults with high Elder Risk Assessment scores (TELE-ERA)

1. Brief name	Daily home telemonitoring of older adults with high Elder Risk Assessment scores (TELE-ERA).
2. Why	Goal: to identify and treat symptoms, functional decline, and other key changes in medical status before the patient requires acute care in an ED or hospital or long-term care in a skilled nursing facility. Rationale: - older frail population has difficulty recognizing important changes in status which can be captured by screening prior to functional decline - telemonitoring has been previously shown to have positive effects in chronically ill populations

3. What (materials)	- A computer device, the Intel Health Guide, records biometric and symptom data from patients in their homes and includes video monitoring, touch-screen questionnaire for daily progress reporting - Broadband Internet or 3G network
4. What (procedures)	- Providing the installation of home telemonitoring equipment, training and support - A set of parameters to be measured and the protocols that guide the identification of an abnormality are determined by a nurse based on the participant's medical conditions - Biometric monitoring daily - A touch-screen questionnaire is provided for the participant to fill in daily - When there is an abnormality, the system provides alerts and feedback. In these selected situations further assessment and care planning is provided by the nurse with the primary care physician support. This includes communicating with the patient to provide advice about what to do, which may include recommending access to other services such as outpatient and ED. - Participants are informed about and can access a variety of services that are part of usual care, based on their own initiative. Usual care includes primary care and specialty office practice visits, home healthcare, post-hospital outpatient visits, a nurse-generated phone call progress report within 1 business day of hospital dismissal, and standard clinic phone triage during business hours, a 24-hour nurse triage line for questions, extended-hours care, and Mayo Clinic Express Care. [-If outcome assessment indicates a risk in depression memory loss or functional status scores, this is reported to the primary care physician. Here, this was regarded as an emergency mechanism and considered a minor action]
5. Who provided	- A clinical assistant provides training and support regarding the telemonitoring device - Nurses determine the protocols to follow for each patient, monitor the measurements and determine further assessment and care as needed with the support of a primary care physician (- Presumably a variety of professionals working in the services made available by request, including nurses and primary care and specialist doctors)
6. How	- The data collected through the health monitoring device was reviewed asynchronously - When there is an identified need for further action, the participants is contacted at a distance by telephone, or face-to-face via telemonitoring. These contacts are presumably individual.
6b. How organised	- The selective care planning taking place when an alert is issued by the system is multidisciplinary with the collaboration of nurse and primary care physician. - Medication changes are not mentioned as part of the possible courses of action, although the involvement of nurse and PCP would make it likely that medication would be taken into account. The possibility of medication changes following the selective care planning is thus unclear. - The nurses were responsible by 100 participants/daily and look with the oversight of the PCP - The intervention was implemented in the context of a Mayo Clinic's program
7. Where	- At home - In Rochester and rural Kasson, Minnesota, [USA] - In the context of a Mayo Clinic's program

8. When and how much	- Participants were older than 60 years old with multiple chronic conditions, and enrolled in the Mayo Clinic's health services. Participants were identified as at risk based on the Elder Risk Assessment Index (ERA) which scores patients electronically based on administrative data which takes into account, age race, hospitalization, among others. Participants in 10% highest risk with scores greater than 15 were included. Participants with dementia and who felt they could not use the telemonitoring system were excluded. - Participants performed daily 5-10 minutes monitoring sessions for symptoms and biometric information - Additional contacts were provided as needed
9. Tailoring	- The health measurements and protocols to be used to prompt further action were individually chosen for each participant based on their specific medical conditions - When there is a need for further actions there presumably further clinical assessment and a tailored plan of care is created
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Multifactorial-action

Table 196. Borrows 2013[9] Routine community occupational therapy (OT) services

1. Brief name	Routine community occupational therapy (OT) services.
2. Why	Minimising an individual's dependence on others, and enabling them to remain in their own home.
3. What (materials)	1. Ongoing support, and directly provide appropriate equipment or adaptations, e.g., medical equipment. 2. Written information on the OT services in ILC
4. What (procedures)	1. Initial interview to establish an individual's needs 2. According to participant's needs, to provide ongoing support, and directly provide appropriate equipment or adaptations.
5. Who provided	Depending on the patient's clinical need: 1. Unqualified OT Assistant Therapist (OTAT), or 2. OT
6. How	1. Provided Individually 2. Face-to-face 3. Interactivity: Needs assessment, and providing ongoing support and appropriate equipment or adaptations. 4. Equipment fitted by Adult Care Services staff
6b. How organised	- Run by Great Yarmouth Adult Care Services community OT service - The care planning does not mention or implies medication changes
7. Where	1. Great Yarmouth, UK 2. Community OT is the current usual practice for patients referred into the Great Yarmouth community OT service. 3. Equipment then needed to be replaced for long-term use by the community OT team.

	4. Generally occurs in the patient's own home.
8. When and how much	1. When started - The community OT service first met the participants 3 to 8 months after randomization (referral) - same as usual waiting time. 2. Duration of session - First meeting: Community OT needs assessment - 0.5 to 2 hours. 3. Number of sessions - Possible further contacts for ongoing support, and providing appropriate equipment or adaptations.
9. Tailoring	1. Initial interview (Community OT assessment) - to establish an individual's needs. 2. (According to individual's needs) providing ongoing support, and appropriate equipment or adaptations. 3. Intervention was provided by an OTAT or OT depending on the patient's clinical need.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 197. Botjes 2013[20] EigenKrachtWijzer (EKW)

1. Brief name	EigenKrachtWijzer (EKW). A digital instrument in the form of a questionnaire and solution suggestions for improving the living situation
2. Why	Goal: to support citizens [and social workers] in clarifying questions about living, working, well-being and care and to independently find solutions to their question by increasing awareness of the responses available to them. The ultimate goal is that they can participate better and / or longer in the society. Rationale: - Based on a policy vision based on the stimulating self-reliance (own strength) of citizens. - Related to three main principles: ▪ stimulating citizens' own strength ▪ pointing to own strength examples during the process of clarifying questions ▪ become wiser about your own situation and possible solutions by going through the method. - Based on previous work on questionnaire development, with several partners and solution suggestions links (with social maps of relevant resources)
3. What (materials)	- EKW digital questionnaire including 15 topics, such as safety, health and finances - Access to computer and internet is implicit - Solutions presented to participants are based on social maps (of resources the person can access) - Instruction video to help with filling in the questionnaire - Digital summary of the questionnaire
4. What (procedures)	- Providing a multidomain assessment based on an electronic questionnaire including 15 domains, such as self-care, mobility, finance. - If needed, help is available to fill in the questionnaire - Possible solutions are generated based on the assessment and provided to the participant, based on maps of available resources. Participants should choose and act as they prefer based on the possibilities provided.

	- In some cases, a way to contact organizations will be given through the platform and there will be a possibility to share the questionnaire information. - A diverse variety of tailored actions presumably will follow from the possible solutions provided to the participants - An electronic guide to national resources is available based on patients' initiative, as in usual care.
5. Who provided	- In some cases, a volunteer of unspecified background helped the participant to access/fill in the questionnaire in the internet. This was as needed, and no other intervention provider is mentioned.
6. How	- Questionnaire filled in and recommendations received asynchronously via the internet - When needed, participants were supported by a volunteer in using the internet to access the intervention. This contact was presumably individual, and not further details are given about how it took place. - Emails were a specified mean of communication with organization providing some of the recommended solutions to the participants' identified problem
6b. How organised	- It's not clear by whom (uni- vs multi-disciplinary) the solutions were created. - The municipality and local organizations were involved in the project [-There is additional information about the organization but this seems to be related with the wider implementation of the intervention in other municipalities not in this study, or to be part of the intervention development]
7. Where	- Almere, in the Netherlands
8. When and how much	- Started when people were over 65 years old and had multiple physical, social, and functional problems/ were frail [unspecified criteria] - The project run for 6 months
9. Tailoring	- The recommendations that are presented to the participants are tailored based on their needs, identified through questionnaire - A volunteer also helps the participant as needed
10. Modifications	Not mentioned
11. How well (planned)	- Information about process-evaluation was collected, including aspects related with the experience of people receiving the intervention
12. How well (actual)	- Of the intervention group (109), 60 older people have indicated that they have the EKW completed, 35 older people did this independently, 25 older people with support. Of this group of 55 people received a digital summary of the EKW. - Support to complete the EKW was insufficient to ensure high participation. Fourteen elderly people who indicated a reason for not completing the EKW, despite the support provided, not having a computer and / or internet as a reason mentioned for not completing the EKW. - The experience of the intervention by participants revealed they considered it included relevant topics, was user friendly and used generally clear questions. Many participants could no longer remember the suggestions or were less satisfied with those.

Table 198. de Craen 2006[32] Unsolicited occupational therapy

1. Brief name	Unsolicited occupational therapy. Including the development of an individual support trajectory which included the implementation of assistive devices in daily activities

2. Why	Goals: to maintain health and promote independence and well-being of the oldest old/ to decelerate the increase in disability in high-risk elderly Rationale: - Based on the potential of active case-finding to identify high risk cases that would be missed otherwise - Based on previous studies that show unmet needs in terms of assistive technology - Based on a recent systematic review that showed beneficial effects of occupational therapy for community-dwelling elderly people - Based on the person- environment-occupation model as proposed by Law *et al.* which involves the participant in the decision-making process
3. What (materials)	- Application forms to access assistive devices to support mobility (e.g., walking frame), personal care (e.g., elastic shoe lace), and meal preparation (e.g., adapted cutlery)
4. What (procedures)	- Occupational therapy intervention which included assessment of needs regarding daily activity function and assistive devices. - For participants with identified needs (45%), the OT provided training and education about devices, and gave recommendations and information about useful services that could be accessed, taking into account the participant's preference. - The useful services for which the OT provided support and recommendation included usual care services, such as day care, community nurse, or meals-on-wheels
5. Who provided	- Occupational therapist - Presumably other professionals involved in usual community care for which the participant was recommended to by the occupational therapist
6. How	- Presumably individually and face-to-face, as implied by home-visit
6b. How organised	- The care planning does not mention or implies medication changes - The services recommended by the OT could be financed by the state or privately purchased, but were more often financed by the state.
7. Where	- In Leiden, the Netherlands - At home
8. When and how much	- The participants were 85 years old and were participating in a prospective, population-based cohort study. The intervention started after a home visit by a research nurse who performed baseline measurements - 2 or 3 home visits by the occupational therapist
9. Tailoring	- The OT recommendations were presumably based on the participants' needs and followed a client-centred approach, integrating the participant's preference in the decision-making process
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- Sixty-six of the 147 elderly needed information and instruction or lacked certain assistive devices or services that could benefit them. About half of these 66 subjects accepted the proposed intervention - a total of 50 devices and services was implemented. - Not all participants for whom an intervention was indicated complied with the proposed intervention. In most cases, those who did not comply either felt they

	were confronted with a problem for which they did not experience having a problem or felt it was not necessary to solve the problem.

Table 199. Grimmer 2013[39] Person-focused home-based personalized program

1. Brief name	Person-focused home-based personalized program.
2. Why	Goal: to prevent or delay the onset of functional decline Rationale: - based on a patient-centred philosophy - people experiencing low mental health quality of life should benefit from an early community-based intervention - based on an existing program for people identified as at risk previously implemented by a large provider of community aged care
3. What (materials)	Not mentioned
4. What (procedures)	- A comprehensive assessment and care planning with focus on function is provided. - The care plan includes a variety of possible care options selected according to the participant's need, such as exercise, home help, motivational interviewing, among others. - Presumably the participant is supported in accessing the services recommended in the care plan. - There is follow up as needed but not as routine practice - Continued access to usual care services based on own's initiative (services not specified)
5. Who provided	Occupational therapists or physiotherapists will conduct the home visits, and provide the assessment, care planning and arranging of the recommendations
6. How	Presumably individually and face-to-face, based on home visit format
6b. How organised	- The care plan is developed between home visitor (an OT or physiotherapist) and the participants and their family, not involving other health or social care professionals. - The care plan includes organization of home care and transport options, implying a certain degree of care coordination. - The median/person cost of the intervention approximates $2,100 (interquartile range (IQR) $350), which approximates the cost of one acute South Australian hospital bed-day - Implemented by an established large provider of community aged care which has used the intervention before
7. Where	- At home - Adelaide, south Australia
8. When and how much	- Started after participants visited an emergency department with non-catastrophic health conditions without admission to hospital for further care. After 1 month, participants are assessed by telephone and enrolled in the study if they present a score of <55 on the Mental Component Score of the SF12, and are 65 years old or older - The duration of the intervention varies based on need from 3to 14 weeks.
9. Tailoring	The care plan, including specific recommendations for action and the timetable of the intervention were adapted based on need and discussion with participants and their families.

10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 200. Hay 1998[42] Prospective care

1. Brief name	Prospective care. Prospective care in family practice, including screening for and treating health and lifestyle risks
2. Why	Goal: improve multidimensional functional capacity and expenditures for health services. Rationale: ...by identifying and treating previously unrecognized disorders using systems of screening and case finding ...based on previous RCTs on screening and case finding that show a reduction in disability, greater independence, reduction in hospital days, delayed institutionalization, improved morale and self-esteem, reduced mortality, and fewer physician office visits.
3. What (materials)	- Comprehensive functional and social assessments questionnaires (implied) - Highlighted assessment questionnaires performed with each patient (it's not clear if this includes only the comprehensive assessment questionnaires or also the eligibility ones) - Patient clinic record - Referral forms
4. What (procedures)	- Multimodal assessment using comprehensive functional and social assessments by research nurse - Arranging and planning by including results of assessment and referrals in the patients' clinic record (it's not clear if the results of the screening assessment that determined eligibility were also used here) - Usual care includes on-demand access to comprehensive social, community, mental health, medical (including clinicians), laboratory, and outpatient services.
5. Who provided	- Research nurses - Clinicians who provided usual on-demand care
6. How	- The format of the initial assessment (individual, face-to-face...) is not specified - Encounters following from referrals are delivered by phone and presumably delivered individually and face-to-face (in clinic) (- Usual on-demand care presumably includes a variety of delivery methods, face-to-face and/or at a distance, individually and/or in groups, as suited to social, community, mental health, medical, laboratory, and outpatient services.)
6b. How organised	- The research nurse conducted the comprehensive assessment - It's not clear who planned and arranged the referrals - There is no evidence that the care planning involved a multidisciplinary format - There is no evidence that the care planning took medication into account. Medication was assessed as part of the eligibility screening, but this does not seem to be taken into account in the intervention, that followed a comprehensive functional and social assessments (no indication that medication was involved)

	- There is no evidence that there was care coordination - Health professionals were expected to comply with the referrals added to patients' record
7. Where	- In Burlington, Ontario (Canada) - In a publicly funded health service organization (HSO) - Encounters following referrals could take place in office at the clinic
8. When and how much	- After screening positive in a screening and case finding questionnaire - Schedule and duration of assessment other contacts not mentioned
9. Tailoring	Referrals and on-demand care were tailored to the concerns identified in assessment
10. Modifications	Not mentioned
11. How well (planned)	- Patients compliance with the recommended referrals was assessed based on chart review
12. How well (actual)	- 62%, n = 97 participants kept all required follow-up appointments (100% compliant) - 11%, n = 17 participants kept one of two appointments (50% compliant) - 2%, n = 4 participants kept two of three appointments (66% compliant) - 25%, n = 38 participants did not keep any prescribed follow-up appointments (100% noncompliant). - Health professional compliance for the 118 compliant subjects was rated as follows: 84% (n = 99) showed 100% compliance, 11% (n= 13) were partially compliant, and 5% (n = 6) were 100% noncompliant.

Table 201. Siemonsma 2018[2] Preventive physical therapy (PPT)

1. Brief name	Preventive physical therapy (PPT). Regular physical therapy (usually consisting of muscle exercises, balance exercises, and walking exercises) from a physiotherapist.
2. Why	Goal: Aim of preventing age-related functional decline of the elderly, by providing the exercise programme.
3. What (materials)	Any exercises therapy and advise was up to the therapist's discretion. Treatment was according to protocols of The Royal Dutch Society for Physical Therapy.
4. What (procedures)	1. Therapists received an open referral to help this person with their daily functioning. 2. Physiotherapists provided any exercises therapy and advice.
5. Who provided	Delivered by physiotherapists, who did not receive additional training for the PPT programme. - 20% of the physiotherapists already had additional training in elderly care, varying from a course in falls prevention to a master in geriatrics.
6. How	Delivered face-to-face, to each individual, at a location of treatment which was decided by therapists' professional opinion.
6b. How organised	- The care planning does not mention or imply medication changes
7. Where	Location: Leiden, The Netherlands Venue: location of treatment decided by the therapists. The country's infrastructure:

	- Preventive physical therapy (PPT) targeting daily functioning was the standard intervention available. - Treatment was according to protocols of The Royal Dutch Society for Physical Therapy.
8. When and how much	Intervention started when the participant was referred to a physiotherapist in an open referral, to help this person's daily functioning. - Maximum of 18 session, 30 minutes each, within three months.
9. Tailoring	Assuming the physiotherapist decided on treatment location, the exercises, and advice, according to the participant's daily functioning.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Table 202. Stewart 2005[125] Occupational Therapy Led Assessment

1. Brief name	Occupational Therapy Led Assessment.
2. Why	Goal: keeping frail older people in the community, impacting dependency and costs. to maximise a person's independence, particularly regarding self-care, or diminish the physical impact of caring for the carer Rationale: ...by providing equipment or adapting the environment to optimise independence in completing a particular activity, such as installing a level access shower or stairlift, instead of providing additional services or improving bodily function.
3. What (materials)	- standard in-house assessment forms - Trust's newsletter and regional health authority emails to GPs, in which open meetings about the study were advertised - Letters to GPs informing about the patient's participation in the trial. These included a short flyer about the trial and a coloured slip confirming participation to add to patient's notes. - Monthly bulletin about study activities
4. What (procedures)	- Occupational therapist assessment at home: used standard in-house assessment forms to complete and record the assessment, after which appropriate interventions were initiated. At an institutional level: - Developing community partnerships in meetings and by providing information about the study - Supporting continued involvement of the partners by providing regular information
5. Who provided	Occupational Therapist
6. How	Initial assessment completed face to face in the person's home but then the interventions developed and how conducted isn't described.
6b. How organised	community partnerships were developed with OT and SW community services and GPs, through meetings and information provision at beginning and during the study. Relationship between assessor and provided services unclear. - The care planning does not mention or imply medication changes

7. Where	Measurements were completed in the participant's home. The occupational therapist (OT) arm subjects received an occupational therapy assessment, undertaken in the elderly person's home. Cambridgeshire
8. When and how much	Started following referral to specialized services (occupational therapy or social work services)
9. Tailoring	Both the occupational therapist and the social worker used standard in-house assessment forms to complete and record the assessment, after which appropriate interventions were initiated Appropriate interventions were tailored based on individual assessment
10. Modifications	Not stated
11. How well (planned)	Meetings and information provision were used as strategies to involve community services and promote interest
12. How well (actual)	A meeting to increase awareness of the project in the health and social care sector and support implementation served the purpose but was not well attended

Table 203. Stewart 2005[125] Social Worker Led Assessment

1. Brief name	Social Worker Led Assessment.
2. Why	Goal: keeping frail older people in the community, impacting dependency and costs. Rationale: ...by recommending personal care assistance to meet the needs of their clients in relation to care in the community policies.
3. What (materials)	- standard in-house assessment forms [From the paper about implementation] - Trust's newsletter and regional health authority emails to GPs, in which open meetings about the study were advertised - Letters to GPs informing about the patient's participation in the trial. These included a short flyer about the trial and a coloured slip confirming participation to add to patient's notes. - Monthly bulletin about study activities
4. What (procedures)	- Social worker assessment at home: used standard in-house assessment forms to complete and record the assessment, after which appropriate interventions were initiated. At an institutional level: - Developing community partnerships in meetings and by providing information about the study - Supporting continued involvement of the partners by providing regular information SW assessment more focused.
5. Who provided	Social Worker
6. How	Initial assessment completed either in the person's home or by telephone. The interventions developed and how conducted isn't described. some of the assessments were by telephone.
6b. How organised	community partnerships were developed with OT and SW community services and GPs, through meetings and information provision at beginning and during the study. Relationship between assessor and provided services unclear.

	- The care planning does not mention or imply medication changes
7. Where	Measurements were completed in the participant's home. The social worker (SW) arm received a social work assessment, often undertaken by telephone (39%). Cambridgeshire
8. When and how much	Started following referral to specialized services (occupational therapy or social work services)
9. Tailoring	Both the occupational therapist and the social worker used standard in-house assessment forms to complete and record the assessment, after which appropriate interventions were initiated Appropriate interventions were tailored based on individual assessment
10. Modifications	Not stated
11. How well (planned)	Meetings and information provision were used as strategies to involve community services and promote interest
12. How well (actual)	A meeting to increase awareness of the project in the health and social care sector and support implementation served the purpose but was not well attended

Table 204. Williams 1992[126] Post-discharge visit by a health visitor

1. Brief name	Post-discharge visit by a health visitor.
2. Why	Rationale: mentions recently-discharged over-75s being a high-risk group.
3. What (materials)	Questionnaire asking for details of discharge, patient characteristics, home circumstances, services received, informal support, need for formal support and needs for information on financial benefits. Health status was assessed by asking patients about their health and abilities. Questions related to four health status measures: physical status, mental status, disability level and ability to undertake personal selfcare.
4. What (procedures)	A Health Visitor makes an assessment based on a questionnaire in a one-off post discharge visit and takes actions as a result. Access to usual healthcare services based on participant's own initiative. The services available in the community included: GP, chiropody, home care, meal-on-wheels, among others.
5. Who provided	Health Visitor
6. How	- Presumably individually and face-to-face (inferred based on implied home visit)
6b. How organised	- The health visitor provided care coordination by arranging services the person needed. - The health visitor made decisions about actions to take on their own, in an unidisciplinary approach to care planning. - The care planning does not mention or implies medication change, beyond medication advice
7. Where	- In South Cumbria, the United Kingdom - The visits presumably took place at the participant's home
8. When and how much	- Started following discharge from hospital, mostly from geriatric and surgery specialties. Participants were over 75 years old and were assessed as not requiring district nursing services.

	One visit with no further visits from the Health Visitor Service unless there was observed need.
9. Tailoring	The actions took by the nurse were presumably tailored based on the participant's needs.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Multifactorial-action and review

Table 205. Challis 2004[127] Care management for older people at risk of care-home admission

1. Brief name	Care management for older people at risk of care-home admission.
2. Why	Goals Care management has developed as a mechanism for assessing those at risk and planning the care needed, including services which might obviate the need for placement Rationale The UK community care reforms were intended to ensure a more effective use of resources by placing responsibility for the assessment of need, care coordination and funding for publicly supported care-home placement with the local authority social services department.
3. What (materials)	Materials used as part of intervention delivery 1. Copy of relevant social services assessment documentation of each referral, provided to the research team by the care manager for recruiting the older people. 2. Social services assessment documentation (findings of care management assessment conducted by care management before recruitment to RCT)
4. What (procedures)	Implementing - arranging funding structure 1. Admissions were affected by the level at which decision-making takes place within a local authority. 2. Budgets require the sanction of more senior management in local authorities. 3. Care managers presented cases before a panel for consideration for care-home admission. The provision of specialist clinical information in the integrated assessment was part of this procedure, in that clinicians' recommendations Regular reviewing and adjusting care plan 1. Assuming referrals to social services care management could be new or recurrent. Care managers assessed or re-assessed for substantial levels of care, with active consideration being given to residential or nursing home admission. 2. Appeared that most placements did not took place immediately upon decision; and some people were provided home care package. Assuming they were reviewed regularly, because of the high risk of care home entry. Available usual care

	1. Multidomain assessment, planning and arranging (Care management assessment): i. Usual assessment conducted by care managers when an older person was referred to social services teams for assessment or re-assessment for substantial levels of care. There is no standard approach to determining need by social services departments and assessment approaches varied. ii. The health status of older people was usually assessed by specialist, e.g., psychiatric nurse, for opinions, before a complex home care package or care-home placement was approved. Potentially treatable health conditions which might obviate the need for placement given the proper intervention. iii. Given that the main inclusion criterion (at risk for needing care-home placement) for referral to the study was that care managers considered all older people to be candidates for placement. iv. Need indicators included relevant clinical factors of physical and cognitive functioning and behaviour; social factors; and the older person's own perception of their needs. 2. Had access to the full range of health and social care services including hospital, day care, treatment services, and residential and nursing home placement.
5. Who provided	Care management provided by a multidisciplinary team: 1. Social services care manager 2. Social services care management team leader 3. District or community psychiatric nurse 4. GP
6. How	Assuming reviews were conducted with individual older person; face-to-face; assuming as domiciliary visit.
6b. How organised	Organisations 1. In the UK since the community care reforms of the 1990s, the assessment of older people prior to publicly funded placement in homes has been the responsibility of the local social services departments. 2. A management panel in a local authority controls and approves the decision and budgets for care-home admissions, according the cases presented by the social services care managers. Team structure and work arrangement 1. Usually in UK, the health status of older people at the point of admission to care homes, and identified potentially treatable health conditions are examined by engaging specialist staff (e.g., psychiatric nurse) in placement decisions. 2. Before recruitment to RCT, Care managers conducted the usual assessment, and decided the actual care package or placements. 3. They were the key professional arranging the care package for the older person at home, or admissions to care homes, through assessing and re-assessing for substantial levels of care. The care management process - screening for eligible problems, assessment, arranging the care plan, monitoring and review with their team leaders. - The care planning does not mention or imply medication change, beyond the involvement of specialized health professionals in the assessment - The care planning decisions lie with the care manager, in a unidisciplinary approach - The care manager presumably provides care coordination by selecting, arranging and monitoring services for the older person

7. Where	Location: older person's home Country: UK (Manchester and Macclesfield)
8. When and how much	Intervention started Older people were referred to the social services teams for older people, for assessment or re-assessment for substantial levels of care, and after usual care management assessment completed by care manager. Duration, number and schedule of sessions - Unclear of duration of review(s) - Unclear whether how often reviews took place.
9. Tailoring	1. The care management process - screening for eligible problems, assessment, arranging the care plan, monitoring and review. 2. Based on the care management assessment, the social services care manager arranged a 'care package' for older people at home, or publicly funded (through the local authority) admissions to residential or nursing homes.
10. Modifications	Not specified.
11. How well (planned)	Not specified.
12. How well (actual)	Not specified.

Table 206. Cutchin 2009[30] Preventive home visit by occupational therapist

1. Brief name	Preventive home visit by occupational therapist.
2. Why	Goal: to assess the older person's situation and provide information and advice to optimize function and psychosocial outcomes that relate to well-being. Rationale: - Based on previous research showing positive outcomes of preventive home visits - Based on previous research showing positive outcomes comprehensive OT interventions - Based on principles of Danish preventive home visits, the ICF (WHO framework on functional and disability) and the American Occupational Therapy Association's practice framework (focusing on the individual and social/environmental context, its impact on functional ability, occupation and participation, and subsequently on the physical and mental well-being).
3. What (materials)	- Assessment instrument used to determine participant's needs which included a variety of areas such as context/environment, social, pain, etc. - Intervention manual
4. What (procedures)	- Multidomain assessment (main focus on social/environmental context and functional ability related to participation) and care planning with the participant's the collaboration. Tailored recommendations follow (content not specified). - The care plan, and participant's status is reassessed and reviewed regularly. - There is no provision of medical/health care. - Presumably the participants were able to access usual healthcare services (not specified).
5. Who provided	- Occupational therapists who received training on the intervention and supervision
6. How	- Presumably individually and face to face (based on home visiting format)

	- Detailed recommendations are sent to the participant by mail. - The recommendations are expected to be put in place be the participants, there is no evidence that arranging support was provided.
6b. How organised	- Care planning is unidisciplinary by occupational therapist with supervision of OTs too. - There is no evidence that the OT coordinated with other services as part of their recommendations (with the expectation of referrals in case of medical or safety emergency). - The reviewer was presumably the same OT visiting the participant throughout the intervention - The care planning does not mention or implies medication changes
7. Where	- At home - Orange County, North Carolina
8. When and how much	- Started after being identified as at risk for functional decline based on the Vulnerable Elders Survey (score 3 or more). - 4 home visits across 12 months
9. Tailoring	The care plan recommendations were tailored based on an initial assessment and regular reviews, and the participant's preference. The assessment covered pre-set domains but the structure of it could be altered based on participant's contribution.
10. Modifications	Not mentioned
11. How well (planned)	Fidelity and fidelity analysis were promoted by: - Training providers based on a manual and course - Regular supervision meetings for providers - Measuring adherence of the providers to the intervention protocol - Measuring adherence of the participants to recommendations
12. How well (actual)	Not mentioned

Table 207. Hattori 2019[100] Standard care

1. Brief name	Standard care.
2. Why	To prevent people with disabilities from requiring more caregiving time and support independent living
3. What (materials)	Standard care: allows the rental of assistive equipment
4. What (procedures)	Standard care included the following steps: - General disability/needs assessment - Access to various long-term services, including home-visit, day-care, short-stay, at-home care
5. Who provided	Presumably several health professionals involved in long-term services in place in the region.
6. How	Mainly at home, presumably face-to-face
6b. How organised	Since the case manager role was not described except for a couple of interactions with the main deliverers of the intervention, it seems likely that case management is part of usual care, although what precisely is unclear. - The care planning does not mention or implies medication changes
7. Where	- Neyagawa, Osaka, Japan

	- In a long-term care insurance system for people from mild to severe disability, annually reassessed who are allowed to choose service providers - Mainly at home
8. When and how much	Not mentioned
9. Tailoring	Standard care: participants are allowed to choose their service providers
10. Modifications	Not applicable
11. How well (planned)	Not applicable
12. How well (actual)	Not applicable

Table 208. Henderson 2005[44] Community Preventive Health Model for over 75s living alone

1. Brief name	Community Preventive Health Model for over 75s living alone. Community-nurse-based comprehensive assessment and case management.
2. Why	To maintain the health status and delay functional decline, by early identification of needs and intervention. Consequently, aims to prevent health resources use (including residential care) and reduced quality of life. Based on a conceptual framework that incorporates previous research on programs of preventive assessment and follow-up home care. The conceptual framework includes 5 components: 1) Targeting before crisis/referral; 2) Linking with a Community Nurse; 3) Comprehensive Community Health Assessment; 4) Initiation of services/referrals as required; and 5) Case Management by Telephone.
3. What (materials)	- Comprehensive Assessment Tool (activities of daily living, cognitive and social functioning, quality of life and general health status, drug use, continence, nutritional status, medical screening and accommodation standards); - Summary of identified needs, recommended interventions and follow-up plan; - Phone calls script; - Referral letters; (For staff) - Staff training information handout.
4. What (procedures)	- Identifying needs via comprehensive assessment; - Provision of health advice and referrals; - Regular contact with case manager for relationship building, monitoring of needs, plan of care and compliance. Available usual care: possibility to receive additional health assessments via GP. Staff training: - 1 session before the intervention start, focused on teaching about the research processes, supplying material, documentation and equipment, assure commitment, and promoting professional development. Consistency was trained and tested. - 1 refresh session for clarifications.
5. Who provided	Registered community nurse and gerontological specialist working as a case manager. Available usual care: possible interaction with GP.

6. How	- Individual contact, face-to-face in the first session and followed by phone calls. - The care planning does imply medication changes (medication change is described but as a result of identifying a particular problem, rather than as a routine part of the care plan)
6b. How organised	Community nurses conducted a case management role (single point of contact and care plan development). Case managers "could and should" exchange information such as the care plan and results of assessments with family physicians, but there is no sense that they were integrated in the practice. Resources were accessed by the client themselves, by referral, or access was facilitated.
7. Where	- Individual living units of in metropolitan and fringe areas of south East Queensland, Australia; - A Medicare Enhanced Primary Care program incentives comprehensive health assessments.
8. When and how much	- 4 sessions, 3-monthly for 1-year, for a maximum of 2 hours; -Started in response to presentation of the project in the participant individual living units, with professionals from the ILUs known by the participant.
9. Tailoring	- Health advice and referrals tailored to individual assessment; - Regular monitoring of individual needs followed by necessary adjustments; - Possibility to decline services
10. Modifications	Not provided
11. How well (planned)	- Test of inter-rater reliability during training for intervention providers; - Quality control of data collection; - Possibility to clarify the doubts and inconsistencies in intervention delivery.
12. How well (actual)	- One intervention provider dropped out and had to be replaced; - 41% of interventions recommended were complied with, 16% were partially complied with, 16% were not complied with (+ 24% missing data).

Table 209. Hendriksen 1984[45] Scheduled medical and social preventive home visits

1. Brief name	Scheduled medical and social preventive home visits.
2. Why	Goal: to improve the quality of life of the elderly which may reduce demand for admission to hospitals or nursing homes (Implicit - to identify and address unrecognised medical and social needs) Rationale: - There are unrecognised medical and social needs that cause morbidity and acute care admission - Based on previous studies that show favourable effects of prevention strategies - A posteriori, the authors suggest the effects are due to increased activity of the participant, increased home help, aids and home modification (which improved social network and supported activity), and increased care coordination.
3. What (materials)	- A structured questionnaire was used in the initial assessment
4. What (procedures)	- Multidomain assessment focusing on social and health conditions. Through collaboration with the participant, needs were identified and access to adequate services was arranged and coordinated. - The care plan was regularly reviewed

	- The participants accessed usual community services with the support of the home visitor. These included, for example, GP care, home nursing case, home help, meals on wheels, aids, among others.
5. Who provided	- A medical student and two nurses who had been working as home nurses.
6. How	- Presumably individually and face-to-face (based on home visiting) - Contacts by phone, based on participant's own initiative - The interviewers were always the same for each participant, to promote a better relationship
6b. How organised	- The home visitor coordinated the access to community services with the participants. - There were meetings between the nurses and the medical student who delivered the intervention but these seem more about support to problems than routine case discussions. - The intervention was funded the municipality and other research funds. - The care planning does not mention or implies medication changes.
7. Where	- At home - In Roedovre, a suburb of Copenhagen
8. When and how much	- Started when the participants were 75 years old or more, and were registered with the municipal social welfare authorities - 0.5 to 1.5 hours visits every 3 months for 3 years (12 sessions) - Additional visits and phone calls were provided as needed
9. Tailoring	- The recommendations provided were presumably tailored to the participant's needs. - Extra contacts (visits and telephone) were available as needed, based on the participant's preference
10. Modifications	Not mentioned
11. How well (planned)	The intervention fidelity was supported - by a previous pilot study on intervention delivery with the same intervention providers, which showed no interindividual differences in working procedure. - by ongoing support (exchanging of experiences and psychological support) provided within the delivery team.
12. How well (actual)	Not mentioned

Table 210. Imhof 2012[49] Advanced Practice Nurse In-Home Health Consultation Program

1. Brief name	Advanced Practice Nurse In-Home Health Consultation Program.
2. Why	Goals: promote self-care ability and skill, increase physical exercise and training Rationale: - developed based on the principles of health promotion, empowerment, partnership, and family-centeredness, as described in behavioral change theories - based on previous research showing promising results in disease management programs promoting self-care and programs focused on specific symptoms such as falls
3. What (materials)	Not mentioned

4. What (procedures)	- A comprehensive geriatric assessment was conducted and served as basis to a care plan developed by nurse and participant in home visits. The assessment included areas such as health status, family network, nutrition, etc. - The care plan included several recommendations related to different health-concerns selected according to participant need and preference. Support in organization of care was also provided. - The care plan was regularly reviewed. - The participants could access usual care based on their own initiative. This included services such as family physicians, physiotherapists, OTs, etc.
5. Who provided	- Advanced Practice Nurse provided the intervention. These APN had specialist training, were experienced and received additional training and supervision on the intervention.
6. How	- Presumably individually and face-to-face based on the home setting - At a distance, via telephone
6b. How organised	- The care planning was unidisciplinary, involving the nurse and the participant. - There does not seem like the care planning included medication change as one of the possible actions - medication use is recorded at assessment but no mentioned among the possible selective actions that were part of the care plan. - In the context of a country which has a policy of mandatory health insurance and a well-established system of community nurses and family physicians who provide basic health care for the population aged 80 and older.
7. Where	- At home - Urban area in the German-speaking part of Switzerland
8. When and how much	- Started when participants who were 80 years old or older were invited through various healthcare and community services and invitation letter. Persons at the end of life or with a major psychiatric diagnosis or severe cognitive impairment, as measured using the Clinical Dementia Rating Scale, were excluded - The intervention ran for 9-months and included four in-home visits (mean length 46 ± 6 minutes) after 4, 12, 24, and 36 weeks, and three telephone calls (mean length 17 ± 4 minutes) after 8, 18, and 30 weeks. Total intervention time per participant averaged 4 hours. - The assessment included two additional sessions conducted at home
9. Tailoring	- The interventions were selected based on an assessment which identified needs and the concerns in which participants had chosen to focus
10. Modifications	Not mentioned
11. How well (planned)	Several activities were put in place to promote an effective implementation, including: - Providers training - Use of a detailed intervention protocol with discussion of discrepancies from set procedures - Regular clinical briefing sessions for the providers to support delivery - The intervention deliverers kept records of what was actually implemented
12. How well (actual)	Not mentioned

Table 211. Kono 2004[52] Preventive home visits

1. Brief name	Preventive home visits. Visits to ambulatory housebound elders by public health nurses.
2. Why	Goal: promoting physical and psychosocial parameters, and functional improvement. Rationale: - Based on previous research showing positive effects of preventive home visit programs on functional decline, admission to nursing homes, mortality and readmission. - Previous research on home visits in Japan that shows effectiveness in saving medical care costs - Early preventive interventions using comprehensive geriatric assessment may be particularly beneficial for ambulatory housebound elders
3. What (materials)	Not mentioned
4. What (procedures)	- Multidomain assessment including physical function, psychosocial parameters and home environment, followed by tailored recommendations and offers of private and public home care services - Regular follow-ups by the nurses are provided every 3 months. - Usual care includes a needs' assessment that establishes the level of need and the accessible services
5. Who provided	- Public health nurses provided the initial assessment and subsequent home visits
6. How	- Presumably individually and face-to-face based on home visiting format
6b. How organised	- There is a Long-Term care Insurance system (put in place in the year before the current intervention took place) that determines the level of care and accessible benefits by using a screening conducted by the Welfare department of the city government. - The care planning was developed by the nurse following a unidisciplinary approach - The care planning does not explicitly include medication changes - There is no evidence that the nurses coordinated the services recommended to the participants
7. Where	- At home - In Saku City, a small Japanese agricultural town
8. When and how much	- Started after participants were screened as needing assistance by the Welfare Department of the city government. Participants were 65 years old or older who could walk independently, but still needed some assistance to live in their own community and went outdoors less than three times a week. - Visits were expected to happen approximately every three months for 18 months (6 visits) - Actual number of visits was 4.3±3.0 (median number 3; numbers of range 1-20).
9. Tailoring	The recommendations and home care services were tailored based on needs identified by the nurses in the assessment
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	- The mean number of home visits by public health nurses in the intervention group was 4.3±3.0 (median number 3; numbers of range 1-20) over the 18 months.

Table 212. Kono 2012[128] Preventive home visits

1. Brief name	Preventive home visits. Program composed of regular structured assessments and individualized care recommendations
2. Why	Goal: to provide efficient community-based preventive care with an impact on functional and psychosocial aspects, and subsequent healthcare costs. Rationale: ...by targeting specific care needs ...by including multidimensional geriatric assessment, shown to reduce disability in previous studies
3. What (materials)	- Coding system for care problems assessed - Coding system for recommendations - Records of the contributions of the participants and their families - Referrals for urgent medical treatment or admission to hospital
4. What (procedures)	* Multidomain assessment, planning and arranging by community care nurses, care managers and/or social workers - The assessment focused on: locomotion, activities of daily living, social activities, health status, and possibility of abuse - Case management including recommendations such as consulting family and local community, providing information, advice and/or referrals regarding social and health issues. * The assessment and recommendations were reviewed regularly at least every 6 months. Additional contacts were provided as needed As in usual care: - Needs assessment based on a national standardized face to face examination and computer-aided assessment system. Results in a certification in one to seven levels of increasing need. - The certification process is usually repeated at 6 months after first assessment and every year thereafter. - The certification of care need provides access to formal facility-based care (including hospital/clinics, nursing homes, group homes, and respite care) and community-based care (including adult day care, home aid, home modifications, and partial visiting nursing care).
5. Who provided	- Community care nurses, care managers and social workers, affiliated to community-based comprehensive care centers. Unclear if the visitor is always the same for the same participant. - Other social and health professionals, part of usual care services, are presumably involved following recommendation and/or referral.
6. How	- Individually and face-to-face- - Additional contacts by telephone included as needed As part of usual care: - National assessment based on face-to-face contact, presumably individual, and computer-based system - Access to a variety of facility and community-based care may presumably provide services face-to-face and at a distance, individually and in group

6b. How organised	- The care planning following the usual care needs assessment was determined by a multidisciplinary team. The certification process is repeated at 6 months, after the first assessment, and every year thereafter, resulting in multiple multidisciplinary meetings. On the other hand, there is additional assessment and care planning by the home visitor, which is unidisciplinary. - Medication review was not included in the assessment and/or care plan. - Coordination of care was one of the actions taken by the home visitor. - In the context of a long-term care insurance system created in 2000 that organized community-based integrated care centers in each municipality to assess and provide care for older people.
7. Where	- At home - In three suburban municipalities of Izumiotsu, Sennan, and Misaki, in Osaka, Japan - In the context of a mandatory long term care insurance system that certifies older people's level of need and reimburses home and institutional care expenses
8. When and how much	- Started after a certification of low-level need based on standardized nation-wide assessment that includes people who are able to walk and do not have serious cognitive disorders, but who do have difficulties in instrumental activities of daily living - Started after long term care services had not been used for at least the past 3 months - Home visits for assessment and care management every six months for 2 years - Additional contacts when needed
9. Tailoring	- The recommendations are tailored to the identified needs - The elders and /or the family members contributed and commented on the recommendations - Additional contacts were put in place when needed
10. Modifications	Not mentioned
11. How well (planned)	- A coding system for recommendations was developed to ensure consistency between home visitors
12. How well (actual)	- All four visits were completed for the majority of participants (1st visit 87 %, 2nd visit 85.7 %, 3rd visit 83.9 %, and 4th visit 83.9 %) - A total of 13 additional home visits between the routine home visits were provided to 11 elders in the intervention group.

Table 213. Kono 2012[128] Usual care

1. Brief name	Usual care. System of mandatory public long-term care insurance, including a need assessment and access to facility and community-based care
2. Why	Not mentioned
3. What (materials)	Not mentioned
4. What (procedures)	- Needs assessment based on a national standardized face to face examination and computer-aided assessment system. Results in a certification in one to seven levels of increasing need. - The certification process is usually repeated at 6 months after first assessment and every year thereafter

	- The certification of care need provides access to formal facility-based care (including hospital/clinics, nursing homes, group homes, and respite care) and community-based care (including adult day care, home aid, home modifications, and partial visiting nursing care).
5. Who provided	- Presumably, social and health professionals in facility and community-based care that could be accessed in the usual care system.
6. How	- National assessment based on face-to-face contact, presumably individual, and a computer-based system. - Access to a variety of facility and community-based care may presumably provide services face-to-face and at a distance, individually and in group
6b. How organised	- The care planning following the needs assessment was determined by a multidisciplinary team. The certification process is repeated at 6 months, after the first assessment, and every year thereafter, resulting in multiple multidisciplinary meetings - Medication review was not included in the assessment and/or care plan. - There is no evidence that care coordination was taken place. - In the context of a long-term care insurance system created in 2000 that organized community-based integrated care centers in each municipality to assess and provide care for older people.
7. Where	- In three suburban municipalities of Izumiotsu, Sennan, and Misaki, in Osaka, Japan - In the context of a mandatory long term care insurance system that certifies older people's level of need and reimburses home and institutional care expenses
8. When and how much	- Started after a certification of low-level need based on standardized nation-wide assessment that includes people who are able to walk and do not have serious cognitive disorders, but who do have difficulties in instrumental activities of daily living - Started after long term care services had not been used for at least the past 3 months - The assessment should be repeated 6 months after the first certification and every year thereafter
9. Tailoring	Not mentioned
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- Although participants had been certified as needing long term care services, they were not using them for at least the last 3 months.

Table 214. Kono 2016[129] Usual care

1. Brief name	Usual care. Home-visits and preventive benefit care management
2. Why	Goal: to enhance prevention of severe disability among ambulatory frail older adults Rationale: ...by building social community-based care, in municipal community-based integrated care centers, rather than primary care settings
3. What (materials)	- Narrative descriptions of level of care examination

4. What (procedures)	- Standardized assessment of level of needs - Municipal care management including unstructured assessment - Routine follow-up is provided every 3 months
5. Who provided	- Visits were provided by community care nurses, social workers or care managers, based on community integrated centers. Unclear if every participant received care from all the different professionals. - Level of care was assessed by independent investigators and certificate board members.
6. How	Individually and face to face.
6b. How organised	- Presumably the home visitors would make decision about the person's care (unidsiciplinary) but this is not specified - Care coordination is not mentioned as a feature of home visitor's action - There is no evidence that medication was routinely took into account the unstructured assessment and care plan provided - In the context of a long-term care insurance system created in 2000 that organized community-based integrated care centers in each municipality to assess and provide care for older people.
7. Where	- In Japan, Osaka (three suburban municipalities Daito, Sennan and Misaki) - At home
8. When and how much	- Started in the context of a low level of care assessment which includes people typically ambulatory, without serious cognitive disorder, with little difficulty in IADLs in general. - 8 visits every 3 months for 2 years
9. Tailoring	- Level of needs assessment guides subsequent access to care
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 215. Lambotte 2018[53] Detection, Support and Care of Older people: Prevention and Empowerment (D-SCOPE)

1. Brief name	Detection, Support and Care of Older people: Prevention and Empowerment (D-SCOPE). A multidimensional detection and prevention program for frail community-dwelling older adults providing tailored care and follow-up.
2. Why	Goal: to detect frail community-dwelling older adults who previously went unnoticed and to improve their access to care and support. To increase their frailty-balance, quality of life, meaning in life, life satisfaction, mastery, community inclusion and ageing well in place. Rationale: -Based on research showing that a % of older people in need to not receive any care - Based on the idea that the needs insufficiently addressed are due to lack of continuity and coherence in the care system - Based on Baltes and Smith research which highlights the need to consider strengths and resources of older adults (and not only losses/frailty) - Based on literature reviews and preliminary studies [content not specified]

	- The content of the intervention was developed in collaboration with representatives of different home care and support levels (e.g., GPs, home care organizations, universities, older people's organizations, etc.)
3. What (materials)	- Comprehensive Frailty Assessment Instrument (CFAI) - Referrals
4. What (procedures)	- Providing a multidimensional frailty assessment based on the Comprehensive Frailty Assessment Instrument (CFAI). The assessment included the physical, cognitive, psychological, social and environmental domains - Providing additional assessment of competence, needs and preferences of the older person, resulting in interventions agreed with the participant, and referrals as needed - The interventions recommended will be based on what is available in the municipality - Providing regular follow-up on how the intervention is being delivered
5. Who provided	- A professional from the social service of the municipality provided a home visit, including assessment and care plan and telephone follow-up. Providers were experienced in home visiting and received training in key aspects of the intervention
6. How	- Presumably face-to-face and individually based on home visiting format - At a distance, by telephone for the follow-up
6b. How organised	- The care planning and referrals (if needed) were unidisciplinary, devised by the professional from the social service of the municipality. - The intervention provider accompanies the participant in any referrals triggered by the intervention
7. Where	- Knokke-Heist, Ghent and Tienen in Flanders, Belgium - At home
8. When and how much	- Participants were 60 years old or older and living in the community. The number of people to be recruited for different gender, age, marital status, living situation and migration background was pre-specified in order to obtain a sample that could be stratified based on these factors. Participants were assessed with the CFAI-plus and had to be at least mild frail on one of the 5 domains of frailty or feel frail based on the subjective assessment of frailty - 2 home visits - Monthly phone calls for 6 months
9. Tailoring	The care plan, including recommendations and referrals took into account the person's competences, needs and preferences
10. Modifications	Not mentioned
11. How well (planned)	Plans were made to collect and analyze data on the fidelity of the intervention and other aspects of process evaluation. The plans included a quantitative questionnaire to measure the number of older adults that participated in the second home visit (1), started the intervention (2) and, dropped-out during the intervention (3). The intervention deliverer also kept a logbook of the intervention contacts, support provided and problems. Focus groups were also planned, focused on the opinions about the program
12. How well (actual)	Not mentioned

Table 216. van Rossum 1993[92] Preventive home visits

1. Brief name	Preventive home visits.
2. Why	Goals: - to impact the perceived state of health, well-being, and the functional and mental state of the elderly. - to impact the use of health and social services, and mortality - to prevent or postpone institutionalization Rationale: - Based on previous studies showing that regular visits by public health nurses, with repeated assessment of functional abilities and professional advice improve health and reduce institutionalization
3. What (materials)	- Checklists about various areas (e.g., functional state, medication, social contacts) guided the information provided and questions that assessed the persons' needs - Decisions about recommendation for each participant, in different areas, were supported by flowcharts - Referrals and recommendations by the nurse to usual care services - Summaries of each visit by the nurse
4. What (procedures)	- Multimodal assessment, planning and arranging based on checklist and flowcharts that cover topics such as functional state, medication and social contacts. Health advice and recommendations/referrals to other services are provided. - The nurse recommends a variety of usual care services to the participant. NOTE that the participant still needs to apply for the services. The services include, among others: home help and nursing, meals on wheels, GP, outpatient clinic, physiotherapy. - The participant is visited and reviewed regularly and additional visits are provided as needed - The nurses are available by phone for any additional contact needed - The nurses do not perform physical examination or provide curative care. In selected cases, nurses instruct participants about how to use aids.
5. Who provided	- A public health nurse with experience in home nursing care and employed specifically to deliver the present intervention - A variety of health and social care professionals which services are part of usual care and that are recommended by the nurse.
6. How	- Presumably face-to-face and individually, in the home visits provided by the nurse - By the phone, in contacts initiated by participants and their relatives as needed
6b. How organised	- The care planning does not mention or implies medication change, beyond practical tasks around medication (e.g., how is it stored) - The GP has a key role in guiding patients through the medical system by providing referrals for other (e.g., outpatient) services - The area has a clear system of services and the municipalities and health care services supported the research project. - The nurse recommended/referred the participant to other usual care services, but it was still the participant who made the request

	- One nurse worked on a full-time basis and visited 146 subjects, while the other two nurses worked part-time (0.5 FTE) and visited 74 and 72 subjects respectively
7. Where	- In Weert, a town in the south of the Netherlands, and some surrounding villages (60,000 inhabitants) - At home
8. When and how much	- Started after selection of people between 75 and 84 who were not receiving regular home care, based on information provided by local authorities. The selected people were sent a postal questionnaire with a letter from the mayor recommending participation. - 4 visits by the nurse per year in 3 years - 12 visits - The visits lasted 45 to 60 minutes, gradually decreasing during the intervention period - Extra visits were provided as necessary mainly initiated by the nurse - Contact by phone call was available and occurred about once a fortnight mainly initiated by participants' relatives.
9. Tailoring	- The number of extra visits and the recommendations provided by the nurse are tailored based on the participants' needs. - The participants' preference was taken into account regarding the topics discussed in the visits.
10. Modifications	Not mentioned
11. How well (planned)	To promote a standardized delivery by different professionals, checklists and flow charts were used, and the visits were discussed in weekly meetings between deliverers and the principal investigator (including presentation of case reports)
12. How well (actual)	- Only 2% of the visits were not carried out (for absence of the participant or ill-health of the nurse) - 53% of the referrals provided by the nurse were carried out - In 13% of the referrals, the participants contacted the service, but the care had either been refused by the service, or had not yet been realized within the three-month period. - In 24% of the referrals, the participant did not comply with the advice. This often concerned the voluntary services (33% of the referrals made to these services were not followed up), exercise programs (64%), home help (28%), and, to a lesser extent, the GP (18%). - Generally, there were no significant differences between the visits of different nurses (on time or general procedures).

Table 217. Vass 2005[130] Preventive home visits as in usual practice [unstandardized]

1. Brief name	Preventive home visits as in usual practice [unstandardized].
2. Why	Goal: to “give feelings of security and well-being, to give advice and guidance about activities and possibilities for support and to facilitate that the older persons make better use of own resources and sustain their functional ability for as long as possible” Rationale: - previous trials have shown that preventive home visits to older adults have beneficial effects on hospitalisation, mortality and functional ability

3. What (materials)	Not mentioned
4. What (procedures)	- Home visits presumably included an unstandardized multidomain assessment to identify relevant health and social problems - The health visitor was expected to offer general health promotion advice and guidance - The assessment was presumably followed by tailored practical and personal support recommendations and referrals to GP if a health check was needed (not provided in the visits) - Routine follow-up was provided - Access to usual healthcare was available, including services such as district nurse, home assistance, meals on wheels, transportation, rehabilitation, and aids and appliances for handicapped persons.
5. Who provided	- The visits were primarily provided by district nurses or physiotherapists/occupational therapists
6. How	Presumably individually and face-to-face, based on the home visit format
6b. How organised	- The care planning does not mention or imply medication changes - It is not clear whether the professionals visiting the participant at follow-up are the same person - GPs are not an integrated part of the home visiting program - In Denmark, the counties are responsible for hospital and specialised geriatric and psychogeriatric treatment and rehabilitation, the municipalities for home and institutional care and long-term rehabilitation. GPs are organised in independent, private practices funded by the counties, and are responsible for health problems in the primary care sector, but they have no community service authority. Hospital, general practice, and community services are all fully financed through taxation.
7. Where	- At home - In Denmark
8. When and how much	- Started when participants were 75 or 80 years old and enrolled in GP practices offering home visits, good rehabilitation, and GPs who could provide preventive care. Enrolled after being invited based on the civil registration office through a letter with or without a proposed date, or a phone call. The study was also mentioned in local newspapers. - 2 annual home visits for 3 years
9. Tailoring	- The kind of support provided was presumably based on the problems identified.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- During the 3-study years, 61% of the participants received at least on visit - Some professionals received information about the standardized procedures which was not intended, due to contact colleagues working on intervention municipalities

Table 218. Vetter 1984[93] Health visitors visits

1. Brief name	Health visitor visits. Health visitors working with elderly patients, conducting one unsolicited visit a year and the follow up resulting from that visit.

2. Why	Goal: to identify medical and social problems early in elderly people. Rationale: - regular surveillance will allow to identify and treat health issues earlier - based on previous studies showing less disability for older people receiving regular unsolicited visiting
3. What (materials)	- Notes of the visits, kept by the health visitors - Referrals
4. What (procedures)	(- There is a baseline assessment conveying a variety of domains, but it is not mentioned that this contributes to subsequent intervention) - Home visitors presumably carried out a clinical assessment of the person and developed recommendations according with their clinical judgement. These could include health promotion advice and referrals to social and health services, and were presumably selected as needed. - Participants were reviewed at least after one year. Some participants identified as in more need by the health visitors were visited more often - Participants could access usual care based on their own initiative.
5. Who provided	- Health visitors provided the intervention. These professionals were specifically employed to work on this study and had a caseload of 281 or 296 (in different sites)
6. How	- Presumably face-to-face and individually or with household, based on home visiting format.
6b. How organised	- The care planning is presumably unidisciplinary, based on the health visitor's clinical judgement - There is no evidence that the health visitor prompted medication changes - In the context of a system of care where health visitors do not provide regular care for older people - There were 2 health visitors with caseload of 281 and 296 people
7. Where	- At home - In Powys (rural area) and Gwent (urban area), [United Kingdom]
8. When and how much	- Participants were more than 70 years old, and were selected from the 2 GP practices age-sex register. - The intervention ran for two years, including a visit at least every year, and additional visits as needed
9. Tailoring	- The care recommendations and referrals provided by the health visitors were presumably tailored to the participants' needs. The number of visits was also tailored based on the level of need
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	The health visitors' notes showed that the health visitor In Gwent made more visits-4364 compared with 528 by the health visitor In Powys-in the two years of the study. Table VI shows that the health visitor in Gwent also made twice as many referrals-357 compared with 165-to a wider range of services.

Table 219. Williams 1992[126] Health Visitor Assistants timetabled visits, following post-discharge visit by a health visitor

1. Brief name	Health Visitor Assistants timetabled visits, following post-discharge visit by a health visitor.
2. Why	Goal: to improve health status [Rationale is quite unclear, focused on the actions taken: the improvement was expected to happen based on actions aimed at reducing disability by providing aids, and actions in other areas like financial advice]
3. What (materials)	- Checklist of 20 categories of problems used to record the actions taken in each visit.
4. What (procedures)	A Health Visitor makes an assessment based on a questionnaire in a one-off post discharge visit and takes actions as a result. - The health visitor assistant (nurse) makes timetabled visits and takes selective action presumably based on a multidomain assessment of the participant's status (the assessment is not specified). giving of counselling support or advice. - The actions are reviewed regularly and include arranging the access to services available in usual healthcare system such as chiropody, home care, meals-on-wheels, and GP, among others. - Other actions include advising on medication and aids and appliances, financial benefits, mobility, eating, feet and carer relief
5. Who provided	Health visitor (initial visit) - Community-based registered general nurses who work with the Health Visitor Service, known as Health Visitor Assistants (timetabled visits)
6. How	- Presumably individually and face-to-face (inferred based on implied home visit), and sometimes (4% of visits) asynchronous and indirect contact through the participant's carer.
6b. How organised	- The health visitor provided care coordination by arranging services the person needed. - The health visitor made decisions about actions to take on their own, in an unidisciplinary approach to care planning. - The care planning does not mention or implies medication change, beyond medication advice
7. Where	- In South Cumbria, the United Kingdom - The visits presumably took place at the participant's home
8. When and how much	- Started following discharge from hospital, mostly from geriatric and surgery specialties. Participants were over 75 years old and were assessed as not requiring district nursing services. - 8 visits in total, including two at fortnightly intervals, three at monthly intervals and three at two-monthly intervals, in that order.
9. Tailoring	The actions took by the nurse were presumably tailored based on the participant's needs.
10. Modifications	Not mentioned
11. How well (planned)	- The data on what actions were taken in each visits was recorded to support the analysis of intervention implementation
12. How well (actual)	- 60% of participants had the full eight HVA visits; 77% had six or more visits. - Most visits (76%) resulted in no recorded action. 29% of participants had no actions recorded

Multifactorial-action and review with medication review

Table 220. Bouman 2008[21] Systematic home visits

1. Brief name	Systematic home visits. Visits to elderly people with (perceived) health problems by home nurses.
2. Why	Goal: to maintain or improve functional abilities, perceived health and quality of life of the participants, and reduce the use of institutional care services Rationale: - based on a previous literature review that showed positive effects when multidimensional geriatric assessment and multiple follow-up visits were provided and at risk older adults were targeted - based on a previous study that showed positive effects with a home visiting programme for participants with perceived poor health - based on Yura and Walsh's nursing model which has four steps: diagnosis, planning of activities, carrying out the activities and evaluation.
3. What (materials)	- The EasyCare questionnaire was used in the initial assessment along with additional checklist about vision hearing and medication, and the Geriatric Depression Scale and the Mini Mental State Examination - Handbook of Nursing Diagnosis was used to set up goals and actions - Unspecified guidelines on geriatric topics were used for advice and referral
4. What (procedures)	- Multidomain assessment by a nurse includes domains such as sensory impairments, cognitive and psychological domains, health and function. - A care plan is subsequently developed and agreed upon with the participant, and reviewed regularly in subsequent home-visits. Progress is also monitored through regular phone calls between visits. - The care plan includes 3 main types of actions by the nurse: advice, information and referrals. Subsequent actions are expected to be enacted by the participant, with the support of the nurse. - Access to usual care is maintained, including services such as GPs, outpatient care, physiotherapy, meals-on-wheels, among others.
5. Who provided	- Experienced home nurses from the local home care organisation delivered visits and phone calls - The nurses received training on the protocol, including needed skills, relevant topics and pilot visits. - The nurses received supervision by an experienced public health nurse.
6. How	- Face-to-face and presumably individually, based on home visit format - By telephone - The nurse promoted good communication by assuming an empathic attitude
6b. How organised	- The intervention was implemented in co-operation with a large home care organisation - The care planning decision making was made by the nurse with occasional advice requested from other specialists of the home care organisation - The care plan was reviewed always by the same nurse - The care planning included medication assessment and recommendations for medication change (through GP). - The nurses sent information about assessment and care planning to the participant GP but it was optional for the GP to contact the nurse or become involved.
7. Where	- At home

	- In the south of the Netherlands
8. When and how much	- Started after the participant was assessed at self-perceived poor health by postal questionnaire, and not receiving or waiting to receive nursing home or home regular services. Participants whose GP did not agree to participate and who lived in large industrial areas, not in close proximity with the centre of town, were excluded. - 8 home visits, approximately every 2 months for 1.5 years for 60 to 90 minutes, were expected. An average of 7 visits for 65.1 minutes was actually received. - 6 follow-up telephone calls were received on average - Daily phone consultation was available between 9 and 9.30, accessed based on the participant's own initiative
9. Tailoring	- The care plan is tailored to the participant's identified needs (through the initial assessment) and preferences/experience, and agreed with the participant. - Extra visits can be provided as needed.
10. Modifications	Not mentioned
11. How well (planned)	Several activities were put in place to promote and analyze how well the intervention was implemented: - Training and regular supervision for the providers - Each nurse was assigned to a number of GP practices to facilitate the cooperation with GPs - The phone calls provided were meant to promote compliance of the participants with the recommendations - At each visit nurses could, for reasons of feasibility, treat a maximum of three problems. - The topics discussed at each visit, treated problems, advice given and referral to other services, and compliance with previous advice (and reasons for non-compliance), were registered for each visit by the nurse. The time spent on the visits, including the travelling and preparation time and the time spent on telephone contacts were also registered.
12. How well (actual)	- In total, 95% received visits, on average seven visits per person with six follow-up telephone calls. 78% of participants completed the 8 visits predicted. - In 91% of all visits, one or more problems were treated: on average 10 problems per person with 11 interventions (38% referrals, 45% advice, and 17% information). The overall adherence rate to referrals and advice was 61%. The compliance rate was 65% for referrals and 58% for advice. The average time spent on the in-home visits was 65.1 minutes. The program was feasible, and the participants and nurses appreciated it.

Table 221. Brettschneider 2015[22] Preventive home visits

1. Brief name	Preventive home visits.
2. Why	Goal: to identify self-care deficits and risks for self-care deficits in the socioeconomic supportive dimension, the social integrative dimension and finally the health dimension, ultimately preventing nursing home admission and making it possible for elderly people to stay longer at home Rationale:

	- based on previous literature reviews that show positive results with preventive home visits, in particular when there is a multidimensional assessment to identify risk factors in improvement and tailored interventions.
3. What (materials)	- Assessment tools, including: Mini Nutrition Assessment, Geriatric Screening AGAST, Geriatric Screening by Lachs, Clock-Completion Test - Case conference documentation, including individual recommendations - Information material to support recommendations provided to the participants
4. What (procedures)	- Multidomain assessment at home, by a nursing scientist, sociologist or psychologist, and development of a care plan based on discussion in a multidisciplinary team - The care plan is shared with the participant including specific instructions, informative material and presentation and mediation of local offers. - Information and general recommendations regarding fall prevention was provided to all participants - The implementation of the recommendations is monitored in one subsequent visit, including an assessment of obstacles/facilitators and a recommendation "boost" - Access to usual healthcare services was presumably maintained, including services such as GP, formal and informal nursing care, outpatient physician services, pharmaceuticals, use of outpatient non-physician services (e.g. occupational therapy, physiotherapy, logopedics, sports therapy).
5. Who provided	- A nursing scientist, a psychologist and a sociologist provided the home visits, including the assessment and 2 follow-up visits
6. How	- Presumably face-to-face and individually (based on home visit format). If possible, the relatives were present in at least one of the home visits (2nd visit in which the recommendations were first discussed). - The participant was expected to implement the recommendations
6b. How organised	- The participant was visited always by the same provider, who reviewed the progress on the recommendations - The care plan was discussed and agreed by a multidisciplinary team that could include nurses, a general practitioner, a nutritionist, a geronto psychiatrist, a physiotherapist, a psychologist and a social worker. The particular make out of the team was determined by the professional that contacted with the participant and which invited the professionals as the case required. - The care planning included an analysis of polypharmacy, to which the above-mentioned team would presumably provide adequate recommendations. - It is unclear to what extent care coordination was provided - the participant was expected to put in place the recommendations him/herself but a close contact with several service providers is also mentioned.
7. Where	- At home - Halle and Leipzig in Germany
8. When and how much	- Started after participants were assessed as impaired in at least 3 ADLs and care level (in the German long term care insurance system) no higher than 1 (did not need assistance in more than two activities of basic nursing, e.g., personal hygiene, feeding, mobility, more than once a day). Participants were older than 80 years old and could be contacted based on recent post-discharge from hospital, enrolled in a GP practice, or based on the local official registry

	- 3 visits in seven weeks. 1st two visits with 2-3 weeks in between followed by a 1-month interval to the 3rd and last visit. - The 2nd visit in which recommendations were explained to the participant took 20 to 40 minutes.
9. Tailoring	- The care plan was tailored based on needs identified by the initial assessment, as determined by a multidisciplinary case conference. - Additional support was provided as requested by the participant.
10. Modifications	Not mentioned
11. How well (planned)	The 3rd and last visit assessed adherence to recommendations and intended to assess obstacles/facilitators to adherence
12. How well (actual)	- A total of 37 problem areas were identified - 5 or more problem areas were identified in 37% of the participants

Table 222. Cesari 2014[25] Multidomain Intervention to preveNt Disability in ElDers (MINDED)

1. Brief name	Multidomain Intervention to preveNt Disability in ElDers (MINDED). A multidomain person-tailored preventive intervention based on physical activity, cognitive training, and nutritional modification.
2. Why	Goal: to prevent mobility disability and dependency Rationale: - Based on previous evidence showing beneficial effects of single or different combinations of preventive interventions (in particular, physical activity, cognitive training, and healthy diet) in preventing functional loss - Based on previous research showing multidisciplinary interventions are effective in improving morbidity, disability, hospitalization, institutionalization, and mortality
3. What (materials)	- Assessment instruments [Pepper Assessment Tool for Disability (PAT-D), Mini Mental State Examination (MMSE), 10-item Geriatric Depression Scale (GDS) [22,23], Mini Nutritional Assessment-Short Form (MNA-SF), and Brief Fatigue Inventory (BFI).], - Copy of all the proposed interventions will be sent by mail to the general practitioner of the participant.
4. What (procedures)	- Multidomain assessment (including mood, nutritional status, medicines, disability) - Further specific assessments according with identified needs and development of a therapeutic plan and recommendations as needed - Interventions for physical, nutritional and cognitive domains were presumably recommended as needed - when recommended these interventions included pre-specified elements. - Medicine change was presumably one of the possible recommended interventions - Routine follow-up of the recommendations with possible modifications to improve adherence
5. Who provided	- The baseline assessment was provided by non-medical staff - The second visit with further assessment and care planning was provided by the geriatrician - A neuropsychologist, nutritionist, and physical therapist provided assessment and recommendations as needed

	[- The general practitioner received recommendations and could discuss these with the other professionals]
6. How	- Presumably face-to-face and individually based on clinic visit format in visits 1 and 2 - By telephone for the follow-up questions
6b. How organised	- The care plan was primarily developed by a geriatrician with the participation as needed of a neuropsychologist, a nutritionist and a physical therapist - A copy of all the proposed interventions were sent to the general practitioner of the participant. The general practitioner could accept or refuse the provided suggestions, and discuss the program directly with the geriatrician.
7. Where	- rural area of Labastide-Murat, a small village located at about 150 km from Toulouse (France) - in a rehabilitation center
8. When and how much	- Participants were 60 years old or older and were assessed as pre-frail (i.e. presence of one or two frailty criteria) or frail (i.e. presence of three or more frailty criteria) according to the phenotype described by Fried *et al.* People living with serious health conditions or with recent health crises were not included. The FiND questionnaire was used to support screening for frailty. - 2 visits to the clinic for assessment and care planning - 4 phone calls at 1, 3, 6, and 9 months, for 15 minutes except for the call at 6 months which will be 30 minutes.
9. Tailoring	Further assessments, the care plan, and modifications to the initial recommendations were tailored to the participant's needs.
10. Modifications	Not mentioned
11. How well (planned)	Plans were made to promote and measure adherence, including: - involving local authorities in the project - collecting data on the implementation of the recommendations with the participants during the intervention and introducing modifications as necessary
12. How well (actual)	Not mentioned

Table 223. Challis 2004[127] Integrated assessment

1. Brief name	Integrated assessment. Care management with additional clinical assessment by old age psychiatrist or geriatrician, for older people at risk of care-home admission.
2. Why	Goals 1. The specialist assessment was integrated into the care management assessment process in order to aid decision-making as to the appropriate level of care needed. The study has implications both for current policy and the future role of specialist old age medicine. 2. Assessment was seen as a mechanism enabling a closer correspondence between identified needs and the level of services provided including, where appropriate, admission to care homes. Rationale 1. Since the UK community care reforms, there has been variability in assessment practices and a relative lack of specialist health care expertise in the assessment process.

	2. Studies indicate that the addition of a specialist clinical contribution to assessments may confer significant benefits. 3. Effective community-based care for older people requires the integration of assessment approaches by old age psychiatry, geriatric medicine and social services care management. 4. A clinical assessment may be useful in identifying potentially treatable health conditions that might obviate the need for placement, given the proper intervention, and may redirect some older people to more appropriate forms of care.
3. What (materials)	Materials used as part of intervention delivery 1. Copy of relevant social services assessment documentation of each referral, provided to the research team by the care manager for recruiting the older people. 2. Social services assessment documentation (findings of care management assessment conducted by care management) 3. Standard referral information supplied by the care manager to the specialist clinician for clinical assessment visit. 4. All clinical assessments included the use of standardized scales of cognitive function (Molloy & Standish, 1997), depression (Yesavage *et al.* 1983) and activities of daily living (Mahoney & Barthel, 1965). 5. Clinical assessment report of findings provided to care managers and GP.
4. What (procedures)	Implementing - arranging funding structure 1. Admissions were affected by the level at which decision-making takes place within a local authority. 2. Budgets require the sanction of more senior management in local authorities. 3. Care managers presented cases before a panel for consideration for care-home admission. The provision of specialist clinical information in the integrated assessment was part of this procedure, in that clinicians' recommendations Arranging specialist clinical assessment 1. The research team made contact with a participating clinician of the speciality relevant to the older person's condition requested by the care manager, either a geriatrician or old age psychiatrist. 2. Clinicians received standard referral information supplied by the care manager. 3. Each assessment was undertaken as a domiciliary visit with a standardized reporting process to the social services department who referred the case. Multidomain assessment, planning and arranging (Care management assessment) 1. Clinical assessors conducted assessments on cognitive function, mood and activities of daily living using standardised scales, and a brief physical examination. 2. They reported to care managers with basic demographic information concerning the client and carer, a diagnosis of conditions and indication of prognosis in the short term (3 months) and longer term (1 year), an outline of the older person's care needs and recommendations including treatment options, e.g., community care, active treatment, and care-home placement. A copy of each assessment was sent to the older person's general practitioner to ensure the appropriate flow of information to relevant health personnel; or they liaised directly with the general practitioner.

	3. Need indicators included relevant clinical factors of physical and cognitive functioning and behaviour; social factors; and the older person's own perception of their needs. Regular reviewing and adjusting care plan 1. Assuming referrals to social services care management could be new or recurrent. Care managers assessed or re-assessed for substantial levels of care, with active consideration being given to residential or nursing home admission. 2. Appeared that most placements did not took place immediately upon decision; and some people were provided home care package. Assuming they were reviewed regularly, because of the high risk of care home entry. 3. Care managers found the clinical assessment provided new information useful for care planning, to make additional referrals, enable the person to remain at home longer, provide enhanced access to a care home where necessary, and to support the provision of additional funding for enhanced community services or care-home placement. Available usual care 1. (Before recruitment for RCT for all participants) Usual assessment conducted by care managers when an older person was referred to social services teams for assessment or re-assessment for substantial levels of care. There is no standard approach to determining need by social services departments and assessment approaches varied. 2. Had access to the full range of health and social care services including hospital, day care, treatment services, and residential and nursing home placement.
5. Who provided	Care management and clinical assessment provided by a multidisciplinary team: 1. Social services care manager 2. Social services care management team leader 3. Specialist in geriatric medicine, or old age psychiatry, operating at consultant or specialist registrar level. 4. GP
6. How	1. Clinical assessment conducted with individual older person; face-to-face; as domiciliary visit. 2. Assuming reviews were conducted in the same way.
6b. How organised	Organisations 1. In the UK since the community care reforms of the 1990s, the assessment of older people prior to publicly funded placement in homes has been the responsibility of the local social services departments. 2. A management panel in a local authority controls and approves the decision and budgets for care-home admissions, according the cases presented by the social services care managers. Team structure and work arrangement 1. The research team discussed the eligible persons with the care manager involved with each case who provided a copy of the relevant social services assessment documentation (usual care management assessment conducted before recruitment to RCT); then made contact with a participating clinician of the speciality relevant to the older person's condition requested by the care manager, either a geriatrician or old age psychiatrist (from secondary care settings). Wherever possible, a clinician was selected within the older person's geographical area who would probably be responsible for any treatment required if continuing consultant care was identified.

	2. Clinicians undertaken each clinical assessment as a domiciliary visit, following receipt of standard referral information supplied by the care manager with a special standardised reporting process to the social services department. There were various patterns of demands on the time of specialist clinicians, in particular between time spent in hospital and community settings. They reported to care managers about the assessment findings, the older person's care needs, and treatment options recommendations. 3. A copy of each assessment was sent to the older person's GP to ensure the appropriate form of information to relevant health personnel; or the clinicians liaised directly with the GP. 4. Actual care package or placements relied on decisions by care managers, who were still free to accept or ignore the recommendations of clinicians. They were the key professional arranging the care package for the older person at home, or admissions to care homes, through assessing and re-assessing for substantial levels of care. The care management process - screening for eligible problems, assessment, arranging the care plan, monitoring and review with team leader. - The care planning does not mention or imply medication change, beyond the involvement of specialized health professionals in the assessment - Although there are recommendations provided based on the specialist assessment, the care planning decisions still seem to lie with the care manager, in a undisciplinary approach - The care manager presumably provides care coordination by selecting, arranging and monitoring services for the older person
7. Where	Location: older person's home Country: UK (Manchester and Macclesfield)
8. When and how much	Intervention started Older people were referred to the social services teams for older people, for assessment or re-assessment for substantial levels of care, and after usual care management assessment completed by care manager. Duration of clinical assessment 1 hour approximately Number and schedule of sessions At least 1 clinical assessment. Unclear whether how often reviews took place.
9. Tailoring	1. The care management process - screening for eligible problems, assessment, arranging the care plan, monitoring and review. 2. Assessment conducted by specialist clinicians included cognitive function, mood and activities of daily living using standardised scales, and a brief physical examination. Based on the findings, they provided information concerning the client and carer, a diagnosis of condition and indication of prognosis, an outline of the older person's care needs and recommendations including treatment options. A copy was sent to the older person's general practitioner to ensure the appropriate flow of information to relevant health personnel. 3. The social services care manager arranged a 'care package' for older people at home, or publicly funded (through the local authority) admissions to residential or nursing homes.
10. Modifications	Not specified.
11. How well (planned)	Not specified.

12. How well (actual)	- Clinicians made recommendations to care managers in 98% of cases. No specific recommendations could be made for the remaining. - Most (n=108, 85%) of these 127 recommendations advocated some form of community care or active treatment, with only 19 (15%) specifically advocating care home admission.

Table 224. Dalby 2000[31] Preventive home visits

1. Brief name	Preventive home visits.
2. Why	Goal: to improve combined rate of deaths and admissions to an institution and the rate of health services utilization among frail elderly people living in the community Rationale: ...by timely recognizing and preventing health problems ...based on previous trial evidence that shows promise for community-based screening and intervention ...by minimizing the negative effects of age-related changes and risk factors and to promote positive functional consequences based on the functional consequences theory of gerontological nursing (-» this last info is currently coded for materials but I think it would fit better here in rational although it may include some materials that are implicit Timely recognition and prevention of health problems among elderly people have been shown to improve their health. However, in order to be effective, intervention strategies should be delivered to those at increased risk for deterioration in health. Cadman and associates and subjects who suggested that screening programs, which include intervention and follow-up, should be subjected to the rigours of a randomized controlled trial before implementation. Limited information exists on the impact of preventive home visits in a Canadian setting
3. What (materials)	For participants in the VN group, the visiting nurse used the “functional consequences theory” of gerontologic nursing, the goals of which are to minimize the negative effects of age-related changes and risk factors and to promote positive functional consequences. Follow-up visits and phone calls were conducted as needed over the course of the 14-month trial to provide vaccinations, monitor, promote health and provide psychosocial support. - Participants' medical record - Care plan
4. What (procedures)	Comprehensive, multimodal assessment A care plan was developed together with the primary care physician, the patient, the family, carers and other health care professionals. The nurse reviewed each person’s medical record and completed a comprehensive assessment addressing physical, cognitive, emotional and social function, medication use, and the safety and suitability of the home environment. Follow-up visits and phone calls were conducted as needed over the course of the 14-month trial to provide vaccinations, monitor, promote health and provide psychosocial support. The nurse served as a case manager by integrating community services and agencies (e.g. homecare), into the participants’ care plan.

5. Who provided	- A nurse conducted the multimodal assessment, planning and arranging and reviewed the plan and actions regularly. - The primary care physician and other health professionals contributed to the care plan.
6. How	The nurse reviewed each person's medical record and completed a comprehensive assessment addressing physical, cognitive, emotional and social function, medication use, and the safety and suitability of the home environment. A care plan was developed together with the primary care physician, the patient, the family, carers and other health care professionals. Follow-up visits and phone calls were conducted as needed over the course of the 14-month trial to provide vaccinations, monitor, promote health and provide psychosocial support. The nurse served as a case manager by integrating community services and agencies, (e.g. homecare), into the participants' care plan.
6b. How organised	- In the context of primary care practices in which the provision of medical services are reimbursed on a capitation basis. - The care plan development was shared by health professionals, patient, family and caregivers - The care was managed by a nurse who integrated community services and agencies in the care plan - The case manager nurse was affiliated with the primary care practice resulting in a close liaison with the primary care physician. - The care planning does not explicit mention medication changes, but these can be inferred based on PCP involvement - The case manager took responsibility for ongoing monitoring, providing vaccinations, psychosocial support and promoting health.
7. Where	At home, the initial assessment was done. Then based on the care plan and any suggestions made, phone calls with the Nurse at home or going to healthcare professionals setting Ontario, Canada
8. When and how much	Started after initial assessment was complete. Follow-up visits and phone calls were conducted as needed over the course of the 14-month trial
9. Tailoring	The nurse reviewed each person's medical record and completed a comprehensive assessment addressing physical, cognitive, emotional and social function, medication use, and the safety and suitability of the home environment. A care plan was developed together with the primary care physician, the patient, the family, carers and other health care professionals. Care plan and follow up frequency were tailored to needs assessment and incorporated the input from participant, family and caregivers.
10. Modifications	Not stated
11. How well (planned)	Not stated
12. How well (actual)	Not stated

Table 225. Fabacher 1994[33] The Home Assessment Program for Successful Aging (HAPSA)

1. Brief name	The Home Assessment Program for Successful Aging (HAPSA). Program of in-home geriatric assessments as a means of providing preventive health care and improving health and functional status of community-living elderly veterans.
2. Why	Goals: 1. detection of unrecognized medical and psychosocial problems in older adults; 2. development of a method of alerting patients and their primary physicians of problems; 3. making specific recommendations to patients for improving health based on assessment findings; and 4. promotion of patient compliance in following these recommendations. Rationale: - Home visits by health care professionals to elderly persons can uncover many unmet medical and psychosocial needs, which are often unapparent or underreported when patients are seen in an office setting. - home visits allow a thorough assessment process, with observation of patients' ability to perform activities of daily living and function on a day-to-day basis as well as looking for environmental problems and hazards, none of which are possible in the office. - It can bring into contact with the healthcare system persons who would not ordinarily access the system, or persons fearful of visiting a physician.
3. What (materials)	- Protocol for initial assessment - Welch Allyn Tone Audioscope (hearing screening) - Snellen chart (vision screening) - Health behavior inventory and battery of validated geriatric assessment screening instruments (e.g., ADLs, IADLs, gait and balance); - Blood sample from the participant - Faecal sample from the participants and cards to test faecal occult blood -Letter sent to the participant, describing findings and recommendations - Referrals to health care providers -Structured interview form for follow-up visits
4. What (procedures)	For participants: - Multidomain assessment including medical, functional, psychosocial and environmental assessment by a physician's assistant or research nurse. - Provision of recommendations based on assessment findings and discussion with geriatrician - Health education by a physician's assistant or research nurse (e.g., diet, fall prevention, smoke cessation) - Regular reviewing, adjusting and assisting for compliance, in visits by trained volunteers By participants: - Sharing of findings and recommendations with the physician was encouraged For volunteers that provided follow up visits: - Recruitment from community and veteran organizations - Initial 20-hour training about principles and practice of geriatric assessment (e.g., interview skills) and the HAPSA goals - Supervision, by accompanying volunteers in at least 2 visits

5. Who provided	- Physician's assistant or research nurse trained in geriatrics - Geriatrician - Trained volunteer health visitors, mostly retired nurses and social workers, accompanied by staff (presumably from the research team).
6. How	- Individually and face-to-face in the home-visits. - Initial assessment findings and personalised recommendations sent by mail.
6b. How organised	- The physician's assistant or research nurse reviewed the assessment results with a geriatrician - Recommendations were sent to the participant shortly after the assessment and were not shared directly with the personal physician - this was dependent on participants' initiative. - The volunteers that reviewed and assisted for compliance were recruited from community and veteran organizations - Volunteers were accompanied in at least 2 visits to guarantee appropriate visits.
7. Where	Location: San Fernando Valley, a suburb of Los Angeles, US - In the context of eligibility to the VA healthcare system Venues: - the participant's home. - possibly at healthcare settings for recommended treatments.
8. When and how much	- Started when participants of 70 years or older, were eligible but were not enrolled in a VA outpatient clinic, were not demented or terminally ill. - In an initial visit of 1 to 2 hours (mean 1.4 hours) and 3 follow up visits every 4 months for a year
9. Tailoring	- Recommendations tailored to the needs identified. - Health education tailored to specific topics relevant to each person.
10. Modifications	Not mentioned
11. How well (planned)	- Follow-up visits were (among other things) a strategy to promote compliance - The supervision of staff was implemented to assure consistency in intervention delivery - Compliance was regularly measured
12. How well (actual)	- Overall compliance with recommendations was 76% - The lower levels of compliance were around 30% for smoking and alcohol consumption - 53% of patients complied with all recommendations, 42% complied with at least one but not all, and only 5% complied with none of the recommendations - For recommendations that were seen by participants as less important, compliance was dependent on follow up visits and education - Non-compliance was mostly due to participants not agreeing with the recommendation (44%) followed by lack of motivation to change (34%)

Table 226. Fairhall 2015[34] A multifactorial interdisciplinary treatment program for pre-frail older people (Pre-FIT)

1. Brief name	A multifactorial interdisciplinary treatment program for pre-frail older people (Pre-FIT).
2. Why	Goal: to prevent progression to frailty/reduce pre frailty and improve mobility Rationale:

	- By increasing reserve capacity and reducing the impact of potential stressors which often result in becoming frail - Based on a previous intervention which has been found to reduce frailty and improve mobility in frail older people (Frailty Intervention Trial) - Based on principles of geriatric evaluation and management. - Based on previous studies showing improved function in pre-frail people following exercise programs.
3. What (materials)	Not mentioned
4. What (procedures)	- Providing a frailty assessment and a more detailed assessment based on geriatric principles were provided - Providing a multidomain care plan created to each participant based on the results of the assessment. The care plan included several possible action selected based on the participants' need, including, nutritional advice, a physical exercise program, referrals to psychiatrist/psychologist, among others. - The creation of the care plan is informed by an interdisciplinary team. - Medication review was part of the possible actions following from the assessment. - Care coordination, including supporting in arranging and liaising with different services is provided - Regular review of the care plan goals is also provided.
5. Who provided	- An experienced physiotherapist conducts the assessment, provides interventions and coordinates care. - An interdisciplinary team comprising a geriatrician, a rehabilitation physician, a dietician and a nurse also participate in intervention delivery as necessary. - All the above-mentioned professionals are presumably involved in case conferences that guide care planning.
6. How	- Presumably individually and face-to-face based on home visiting format.
6b. How organised	- Case management and regular case conferences were provided to assist with coordinating the interdisciplinary delivery of the intervention - The physiotherapist worked as a care coordinator, liaising with the participant, family, health professionals and service providers, plus coordinating services.
7. Where	- At home - Participants may selectively use services in the community or outpatient, based on their tailored care plan - Hornsby Ku-ring-gai, Sydney Australia
8. When and how much	- Started when participants were more than 70 years old, not receiving rehab and were assessed as pre-frail based on meeting 1 or 2 criteria from the Cardiovascular Health Study frailty criteria. - The intervention runs for a year. The number of contacts was presumably variable based on tailored care plan.
9. Tailoring	The interventions are tailored based on an assessment including frailty characteristics and other aspects, and reassessed over time.
10. Modifications	Not mentioned
11. How well (planned)	- Adherence was promoted by including goal setting, a flexible time frame for intervention delivery, recording of exercise completion, involvement of family and carers, tailoring, and interventions to be varied, sustainable and enjoyable.

	- Plans were made to measure and analyze adherence, including global level of adherence and goal attainment.
12. How well (actual)	Not mentioned

Table 227. Ford 1971[36] Home nursing care for chronically ill patients

1. Brief name	Home nursing care for chronically ill patients.
2. Why	Goals: to maintain or improve the function of chronically ill, elderly people and to facilitate the patient's access to other health services and increase their use for appropriate purposes Rationale: - Based on chronic illness recommendations which focus on the role nurses in home care programs that replace institutionalization - Based on a previous study which showed that home care decreased the need for hospital care
3. What (materials)	- Referral form from the hospital to the nurse included details about the participant in a variety of areas such as diagnosis, medication, treatments and nursing, social work, physical and occupational therapy. - Records of the participant case were kept by the nurse throughout the intervention period, including the dates and content of each visit. - Records were organized in a new system that included activity records (for each visit describing broad categories of function) and narrative records (progress, care plan goals, environment, contacts with other professionals)
4. What (procedures)	- Multidomain assessment based on information gathered pre-discharge (sent to the nurse) and the nurse own assessment in home visits. Overall the assessment included aspects related with medication, diagnosis, treatment, social, psychosocial aspects, social work, exercise, among others. - The nurse develops a care plan with the person. Other health professionals are available as consultants but there does not seem to be routine cooperation with them to determine the care plan. - Each care plan results in selective actions according to need, which may include referrals to other professionals of the home care organization (e.g., physical therapist, home aide, physician) and care by the nurse (e.g., medication), and in the coordination of these actions. - The nurse provides health education and advice about a variety of topics. - The nurse provides routine follow-up and presumably adapts the care plan accordingly. - Access to usual care services which presumably included physician and other community resources, with recommendations and support from the nurse.
5. Who provided	- Nurses who received training and regular supervision by a variety of health professionals who act as consultants - Other professionals provided selective actions according to need (e.g., physical therapists)
6. How	- Presumably individually and face-to-face, based on home visiting format
6b. How organised	- The nurse acts as a care coordinator by communicating on behalf of the patient with other health professionals inside and outside of the home care agency. - The nurse seems to be the main responsible for the care plan, although other professionals are available to be consulted as needed

	- Most participants received care by the same nurse throughout the intervention - The care planning includes possible medication prescription. - Several other professionals in the broader organizational system supported the intervention by coordinating actions between the nurses providing the intervention and the research staff, or acting as research staff (not necessarily providing but coordinating data collection, for example). - The participants paid for the care provided, as usual, with adjustments for those who could not meet the full payment
7. Where	- At home - Cleveland, United States
8. When and how much	- Started after discharge from a chronic disease rehabilitation hospital (at least 1 week stay) to an area served by the visiting nurse association (mostly urban and suburbs). Participants were 50 years old or older. - Minimum of one visit every 3 months for a year, and every 6 months in the following year. More visits were provided as needed. Actual visits included one visit every 10 days on average for 33%, one visit in 10-20 days on average for 35%, one visit every 20 days on average 23% participants. Fewer or no visits were provided to 9% of participants.
9. Tailoring	The care provided was tailored based on the needs and preferences of the participant and their family (e.g., focusing on the problems which were of major concern/interest to them). The frequency of the visits was also tailored to the participant's needs.
10. Modifications	Not mentioned
11. How well (planned)	To promote the intervention being delivered as intended: - A pilot study was developed to inform what changes to the intervention may be necessary - Organizational cooperation in an already structured organization was promoted through supervision with the research staff - An existing organization was chosen to make the most of existing links with other agencies and the procedures already in place - Records of the nurse visits were kept and allowed for an analysis of frequency and content of the visits
12. How well (actual)	- 5 of the 150 participants did not receive nurse visits - The most frequent range of total visits was 21 to 40 per participant. Actual visits included one visit every 10 days on average for 33%, one visit in 10-20 days on average for 35%, one visit every 20 days on average 23% participants. Fewer or no visits were provided to 9% of participants. - At the end of the study 42.7% of the participants were still receiving nursing services

Table 228. Fox 1997[131] Standard comprehensive health assessment, with limited verbal health plan counseling and without written health plan

1. Brief name	Standard comprehensive health assessment, with limited verbal health plan counseling and without written health plan. Standard comprehensive health assessment as part of the Preventive Health Care for the Aging (PHCA) program
2. Why	Goal: health prevention

3. What (materials)	1. Health history including information about demographics, health care providers, diagnosis, medication, among others. 2. Nutritional diary - food and drink intake 3. Presumably, materials used in physical exam to measure height, weight, blood pressure, among others. 4. Pamphlets and promotional health material provided to the participants 5. A health care plan was discussed but not provided in written format to the participant 5. Referrals (medical or for community services) - provided as needed. 6. Health screening results and a list of referrals was provided to participants at the nurse discretion 7. Records of counselling duration and topic 8. A data system is used to record counseling and referrals 9. A standardized visit encounter form is used to record referrals and used in following up participants
4. What (procedures)	1. Multidomain assessment, planning and arranging. PHSA Comprehensive Health assessment (CHA) - Health history - Nutritional assessment - food and drinks diary - Physical examination - Medication was assessed and presumably the participants were referred/recommended related actions if risks were found. 2.Risk Identification 3. Provision of health-related information 4. Provision of individualized health recommendations through limited verbal health plan counseling (No written health plan) 5. Arranging of referrals (medical, dental and/or community services) as needed, and following up with the participants on medical and dental referrals specifically
5. Who provided	1. Public health nurses - Nurses attended a three-day training conference to update knowledge on assessment practices and health promotion, disease prevention, and management of chronic diseases. - Training on intervention implementation
6. How	Presumably individually and face to face based on consultation format (with physical examination) Distance and individually in selected cases: 1. Follow up phone calls
6b. How organised	- In the context of a well-established preventive health care for the aging program funded by the Department of Health focused on health prevention and targeting people trough clinic site placement and outreach - Physicians sometimes called the nurses to confirm they saw the person referred to them - The care plan was developed by the nurses with the participant in a unidisciplinary format
7. Where	- At community-based public health clinics - Services are provided in community settings which may include senior centers, nutrition sites, senior housing facilities, and churches. - 4 counties two rural and 2 urban and suburban in California, US

8. When and how much	- Started when participants were 60 years old or older and were participating for the first time in an established statewide public health prevention program delivered in both rural and urban clinics which targeted low-income older adults - Initial comprehensive health assessment, followed by health plan and verbal health recommendations. Number and duration of sessions not specified. - If referrals were provided to physicians and dentists, the nurse followed up with the participants on these within 3 months. Assessments were repeated, and previous actions reviewed, annually.
9. Tailoring	Health plan and verbal recommendations tailored to the risks identified in the multimodal assessment and to participants preferences.
10. Modifications	Not mentioned.
11. How well (planned)	- Adherence was an important focus of the study and plans were made to measure it in a variety of ways with detailed records kept of what was recommended and what was implemented
12. How well (actual)	- 13% of participants were in the complete adherence category - 48% of participants were in the moderate adherence category of the treatment group were - 38% of participants were not adherent - 13% of participants reported economic barriers to adherence

Table 229. Harari 2008[41] Health Risk Appraisal for Older Persons (HRA-O)

1. Brief name	Health Risk Appraisal for Older Persons (HRA-O). A self-administered questionnaire, leading to computer-generated individualised written health promotional feedback, and clinical information integrated into general practice information-technology systems.
2. Why	Goals: 1. To identify risks for functional decline and problems intervention, 2. To achieve favourable change in health-related behaviour, 3. To facilitate preventative care use Rationale: - Based on previous research showing benefits of health risk appraisal programmes with older people, namely in improving health behaviour and decreasing costs. - Based on the Health Risk Appraisal for Older Persons (HRA-O) originally developed through an evidence-based process at the University of California, Los Angeles - Assessment and recommendations were based on an adaptation process that included a systematic literature review, expert input, focus groups and piloting - The assessment includes a domain related with behavioural change based on the transtheoretical model of behaviour change
3. What (materials)	- HRA-O questionnaire (including several previously validated instruments), electronic system, recommendations and separate written reports for the participant and his/her GP. - Electronic patient record - Reminders to the GP when the participant is assessed and to the participant at 6 months by post (to keep up recommendations) - Referrals - Providers' training materials

4. What (procedures)	- A self-assessment questionnaire (HRA-O) was used to support a multidomain assessment, including areas such as medication, mood, pain, social support, physical activity, among others. - The multidomain assessment questionnaire was used to generate recommendations (based on an algorithmic electronic system). These were sent to the participant and his/her GP. - GP acted on and reinforced recommendations based on their own decision-making. Thus, reinforcement and health education by the GP may have been done proactively, in opportunistically consultation, or not at all. This may have included referrals to relevant services - Reminders of the participant's recommendations were presented electronically to the GP when accessing the participant's record - One written reminder encouraging the recommendations was sent to the participants at 6 months.
5. Who provided	- GPs decided about further contacts and services needed based on the recommendation produced electronically. - GPs received training and regular supervision by geriatricians. - Practice nurses are mentioned too and also received training, but their role in the intervention is not made explicit.
6. How	- At a distance and presumably individually based on post communication. - The assessment and computerized recommendations included an analysis of readiness for change to support behavioural change.
6b. How organised	- The care plan was first generated by the electronic system algorithm (based on previous evidence and guidelines), according to the participant reported needs. The GP received these recommendations and decided on how to proceed. - The care planning is based on an assessment that includes medication aspects and these presumably informed possible recommendations for medication change. - The GP may have had some role in coordinating services for the participant (by referrals, and contacting relevant organization) but this was not by intervention design and is better characterized as usual care practice - There is a follow-up contact that consists on a reminder card encouraging previously sent recommendations, without direct contact with the participant
7. Where	- In mainly outer urban areas of London, UK - In practices purposively selected for their interest in primary care for older people, location in suburban (that is, relatively without deprivation) areas of London, and routine use of electronic medical recording systems in clinical encounters.
8. When and how much	- Started when participants were 65 years old or older, enrolled in GP practices and did not need assistance in BADLs as assessed with a questionnaire focused on BADLs sent by post [PRA, Probability of Recurrent Admissions questionnaire]. Participants were also excluded if they had cognitive impairment or a terminal disease. - 3 contacts by post which included: 1) multidomain assessment instrument to self-administer, 2) feedback on the assessment with recommendations, 3) reminder of recommendations 6 months later. - Additional contacts related with the recommendations based on each GP decision making.

9. Tailoring	- The intervention was tailored based on the participant's needs following an electronic system algorithm (based on previous evidence and guidelines). - The number and type of further contacts and services provided was tailored by the GP (who could act on the recommendations according with their clinical judgment).
10. Modifications	Not mentioned
11. How well (planned)	The fidelity of the intervention was supported by: - Training and regular supervision of the providers - Previous feasibility studies that tested the adequacy of the assessment used and made necessary adaptations for acceptability by an older population - The response to patients and providers to receiving the feedback from the assessment was not rigorously measured - The use of an accompanying covering letter from the GP, stamped address return envelope and association with a university which are factors identified in a systematic review on increasing response rates to postal questionnaires
12. How well (actual)	- 87.9% of participants returned the multidomain assessment questionnaire - 27.3% had the assistance of another person to complete the questionnaire - Participants took an average of 50.6 minutes to complete the questionnaire (SD=33.0)

Table 230. Hebert 2001[43] Multidimensional preventive programme

1. Brief name	Multidimensional preventive programme. For older people at risk of functional decline, including nurse-led assessment and referrals.
2. Why	Goal: to prevent functional decline and improve well-being and perception of social support, and to impact health care use Rationale: ...by early detection and surveillance of risk ...by using a structured and validated assessment of risk ...based on a previous literature review and a feasibility study that showed significant effects of this programme on autonomy and well being
3. What (materials)	- Standardized instruments to assess a variety of areas (e.g., Geriatric Depression Scale, Payette's Malnutrition Risk Questionnaire) - Report of the assessment and recommendations sent to the GP - Medical information about diagnoses from the GP - Referrals to specialized health services
4. What (procedures)	- Multidomain assessment by nurse, including 12 dimensions (such as medication, fall risk, depression, etc.) - Referrals and/or recommendations provided directly or in liaison with the GP (e.g., memory clinic, balance and gait rehabilitation, occupational therapy, etc.) - Periodic monitoring of referrals/recommendations progress - As part of the implementation: arranging the sharing of medical information - As in usual care: Access to usual health care services including GP, geriatric services such as assessment and rehabilitation units, day hospital, geriatric outpatient clinic and day centres.
5. Who provided	- Trained nurse

	- As in usual care: GPs and presumably other geriatric health professionals in available usual care
6. How	- Assessment conducted individually and face to face - Monitoring of recommendations conducted individually and on the telephone
6b. How organised	- Nurse and GP liaised throughout the intervention including: (1) the access to GP info following authorization, (2) sharing of intervention assessment results, and (3) nurse request for GP help for referrals. - The intervention was ecological, i.e., integrated in the existing health care system without duplicating services. - In the context of a universal public health insurance plan - The care planning explicitly mentions medication changes
7. Where	- Multidomain assessment at home - Sherbrooke City, Quebec, Canada. - In a area in which geriatric services include assessment and rehabilitation units, day hospital, geriatric outpatient clinic and day centres.
8. When and how much	- People of 75 years old, living at home, using the Quebec Health Insurance Plan (a universal public plan) were sent the Sherbrooke Postal Questionnaire. Those identified as at risk (having >1 risk factor) were invited - 1 assessment session and subsequent monthly calls for monitoring
9. Tailoring	- The referrals and/or recommendations were tailored to the risks/needs identified in the multidomain assessment - Contacts by the nurse were tailored based on individual recommendations, and contact as needed was made available.
10. Modifications	Not mentioned
11. How well (planned)	The monitoring of recommendations served as a strategy to verify compliance
12. How well (actual)	- Interventions were recommended in 90% of the cases - in the remaining 10% no intervention was needed - There was high compliance of participants and GPs for medication but low for referrals to specialized resources. The low compliance was mainly due to subject's refusal.

Table 231. Hogg 2009[46] Anticipatory and Preventive Team Care (APTCare)

1. Brief name	Anticipatory and Preventive Team Care (APTCare). Anticipatory and preventive care from a collaborative team: family physicians, 1 nurse practitioner, and a pharmacist.
2. Why	Goal: 1. to ensure strong social supports for patients; 2. to improve the quality of care for a growing number of chronically ill patients, to optimise patient care in the home. Rationale: 1. Reforming the delivery of primary care services has become a high priority in Canada as a result of problems with access to care, reports of care gaps, and concerns about the aging population. 2. Home-based multidisciplinary team management involving an NP, a pharmacist, and a general practitioner working collaboratively within a family practice may optimise care to the patients at risk of poor health outcomes.

3. What (materials)	1. Twenty-two patients received a telehealth system in the home for remote monitoring of clinical parameters. The system included a comprehensive set of electronic vital sign devices (i.e., blood pressure monitor, weight scale, glucometer, pulse oximeter, and peak flow metre). 2. A log of discussions with study staff and clinicians used to inform the process evaluation, including elements of collaboration was maintained by the study administrator. 3. NPs attended a five-day work- shop with experts in geriatric assessment. They created a comprehensive health assessment document, which they used to guide data gathering in the home during the patient enrolment process. 4. Weekly meetings with study staff, monthly meetings with the NPs and pharmacist, and monthly meetings with coinvestigators were documented in minutes. 5. Extensive review of the patient electronic medical records (EMR) prior to home visit. Data collected in the home, formed the basis of a comprehensive care plan. 6. To coordinate care, the NPs kept a log of activities, such as travel, administration, care plan development, collaboration with physicians, collaboration with the team, planning and research activities.
4. What (procedures)	There was an addition to the team of 1 pharmacist and 3 Nurse Practitioners. Who performed the following: 1. Comprehensive chart reviews 2. Home Visits 3. Medication Management review 4. Individualized care plan created, that outlined management goals and health issues that the team of providers would work towards. Participants also had the following support : 1. Health related information was provided to participants (education programme). 2. Support and training for using the telehealth technology. 3.Support and information about medication safety. To help meet care management goals and self-care and disease management.
5. Who provided	multidisciplinary team: 1 pharmacist and 3 NPs were added to the family practice (each patient was assigned to only one NP). Each patient's NP developed an individualized care plan in collaboration with the patient and in consultation with the pharmacist and the patient's family physician.
6. How	1. This intervention was provided to the individual. 2. Home visits were face to face. 3. The pharmacist and nurse practitioners delivered their care almost exclusively in the patients' homes or by telephone contact. 4. The NPs provided coverage for one another's' patients when an NP was absent. Both performed comprehensive chart reviews and home visits for each patient at the start of the study. 5. After agreement on the initial care plan, the NPs and pharmacist communicated and planned care with physicians through the EMR, by phone or face to face, depending on the urgency of the situation.
6b. How organised	- The care planning explicitly mentions medication changes. - Nurse practitioners took a case management (chronic conditions only) role. They and a pharmacist were integrated in a family practice network and

	collaborated in developing a care plan, ongoing management and monitoring. This was done in negotiation/consultation with the patient's physician. Although "integrated" they were geographically separated from the physicians' clinic. Nurse practitioners and the pharmacist were paid for by research funds. "Community-based group practice where patients are rostered, the family physicians are paid in a blended payment system primarily based on capitation." Physicians continued to see patients regarding diabetes care as this attracted a fee.
7. Where	Country: Canada. Setting: At a family health network - a type of group community-based practice that provides primary care services to rostered patients. Included with 8 family physicians, 5 nurses, and 11 administrative personnel serving 10 000 patients in a rural area near Ottawa, Ont. Care was provided in patients homes by telephone contact, home visits and few clinical visits taking place in the practice. The patients continued to see their family physicians in the office.
8. When and how much	Recruitment of patients and intervention started: October 2004 and March 2005, if identify as having frequent visits to ED or family practice in past year; or high service use profile or polypharmacy. Intervention duration was 12 to 18 months: 3 fixed sessions with nurse practitioner, frequency of informal communication varied.
9. Tailoring	1. An individualised care plan was developed by the nurse practitioner in collaboration with the participant and in consultation with the family physician and pharmacist. The care plan identified the participant's active health issues and listed the management goals that the participant and providers would work towards over the course of the intervention; tailored to the participants health condition; reviewed, implemented and adapted throughout the study period 2. Education sessions provided to participants with similar medical concerns. 3. The pharmacist conducted medication management review, and identify appropriate actions with the participants.
10. Modifications	All intervention participants were originally intended to receive the support of a home telehealth monitoring system. However, the unit was unavailable for the first 6 months of the study, and the objective was changed to a feasibility evaluation.
11. How well (planned)	Methods to evaluation collaborative processes and process evaluation: 1. The content of the electronic messaging "to-do" system - part of the EMr and serves as a communication conduit between clinicians, was reviewed to examine multidisciplinary collaboration. 2. Reviewed the frequency and types of contacts in progress notes logged by NPs and the pharmacist. 3. Daily log: The pharmacist and NPs captured the time spent on various activities, the instances of collaboration along with details of the process, and other information they thought was relevant. 4. Administrator's log: discussions with study staff and clinicians that was used to inform the process evaluation, including elements of collaboration 5. Minutes of meetings among staff.
12. How well (actual)	1. NPs'log of activities showed that most of their time was spent on care plan development and home visits. 2. Some monitoring took place in the APTCare clinicians' office when a patient went in for diagnostic testing or dropped by for a social visit after seeing the

	physician in the clinic. However, this form of interaction was less than ideal because it did not always provide the privacy needed for proper patient-provider communication. 3. Since the physicians billed for diabetes visits, they continued to see all diabetic patients quarterly, even though the NPs could have managed the care. 4. After three months of monitoring the project, the study researchers reiterated the focus of the NP role on the team, even though the physicians preferred that the role not be so narrowly defined.

Table 232. Kono 2016[129] Preventive home visit programme

1. Brief name	Preventive home visit programme. A unique structured assessment with treatment recommendations tied to an ongoing programme for quality assurance.
2. Why	Goal: to prevent functional decline, maintain independence and enhance prevention of severe disability in older adults living at home Rationale: - By introducing frequent visits and a multidimensional assessment, standardized to assure quality of care. - Based on previous shown effect of preventive home visits in maintaining independence in frail older adults living at home - (As in usual care) by building social community-based care, in municipal community-based integrated care centers, rather than primary care settings
3. What (materials)	- Structured assessment sheet of care needs, including health, mental health, activities, and participation - Recommendation sheet specifying the needs identified, the steps of preventive care taken, specific recommendations and the client response - (As in usual care) Narrative descriptions of level of care examination
4. What (procedures)	- Structured interview about health, mental status, activities and participation - Assessment of participant and family needs in 8 key areas - The assessment and presumably the care planning that followed, included aspects of medication - Care management including (1) establishing relationships between participants and home visitors; (2) providing specific recommendations; or (3) coordinating services. - Routine follow-up is provided every 3 months As in usual care: - Standardized assessment of level of needs.
5. Who provided	- Visits were provided by community care nurses, social workers or care managers, based on community integrated centers. Unclear if every participant received care from all the different professionals. - Researchers provided supervision to staff. - (As in usual care) level of care was assessed by independent investigators and certificate board members.
6. How	Individually and face to face.
6b. How organised	- Care planning was developed by the home visitors (unidisciplinary) - Coordination of services is mentioned as part of the care plan, but not described. - The care plan took into account medical history and medication, presumably resulting on medication related actions as needed.

	- In the context of a long-term care insurance system created in 2000 that organized community-based integrated care centers in each municipality to assess and provide care for older people.
7. Where	- In Japan, Osaka (three suburban municipalities Daito, Sennan and Misaki) - At home
8. When and how much	- Started in the context of a low level of care assessment which includes people typically ambulatory, without serious cognitive disorder, with little difficulty in IADLs in general. - 8 visits every 3 months for 2 years - Additional contacts as necessary
9. Tailoring	- Patient and family preferences are taken into account in the care needs assessment - Additional visits according to need
10. Modifications	Not mentioned
11. How well (planned)	- Analysis of the assessments and recommendations developed - Regular check and validation of quality of interventions by researchers
12. How well (actual)	- The home-visits were implemented for the majority of participants (first visit, 87.7%; second, 79.3%; third, 78.1%; fourth, 70.8%; fifth, 73.6%; sixth, 72.0%; seventh, 70.1%; and eighth, 74.0%), and additional visits were not conducted. - Visit compliance decreased from 87.2% at the first visit to 70.1% at the eighth visit. Of note, visit compliance remained at approximately 70% after the fourth visit.

Table 233. Leung 2004[54] Case Management Project for the Community Dwelling Frail Elderly

1. Brief name	Case Management Project for the Community Dwelling Frail Elderly. Including assessment, care planning, coordination of care and tailored recommendations
2. Why	Goals: to facilitate the discharge from a rehabilitative hospital, in order for people to remain in their own home independently without being admitted to institutions/hospitals unnecessarily; to achieve integrated, quality, and cost-effective care. Rationale: - based on previous research recommending an holistic approach to elderly care, integrating medical, health, and social care for the continuum of care - based on the holistic nature of case management - screening potential risk and tailoring care accordingly will manage risk and link people to the care they need most.
3. What (materials)	- Medium Data Set - Home care (including triggered protocols in an electronic version), Hong Kong version - Computer program providing health and hospitalization patters (Integrated Patient Administration System, IPAS) - Care plan - Referrals
4. What (procedures)	- Comprehensive assessment of needs using the MDS-HC, which includes several domains, and an informal carer assessment. The assessment is conducted by a case manager. - The assessment triggers care planning which is discussed with the person, caregiver and, if needed, a multidisciplinary team.

	- Following care planning the care manager provides tailored recommendations and arranges care (e.g., through referral). - Needs and care planning are regularly reviewed by the case manager with the person and through online records.
5. Who provided	- Provided by case managers who were a nurse or social worker depending on the needs in each case. - Support and advice were also available from an interdisciplinary consultant team comprising geriatricians, senior social workers, a geriatric nursing specialist, a clinical psychologist, and rehabilitation therapists. Through monthly case conferences, all team members could contribute to enhance the care plans and services.
6. How	- Face to face in the home visits, with the participant and their informal caregiver - At a distance, via telephone
6b. How organised	- The care planning was multidisciplinary - primarily developed by the case manager (nurse or social worker), but routinely supported in case conferences with a multidisciplinary team. - The MDS-HC includes medication review as an element in the assessment and recommendations triggered by the assessment. - Case managers actively coordinated with relevant services, initiating referrals, conducting follow up contacts, formulating strategies for better cooperation, etc. - In the context of a health care reform which aims to improve the health outcomes and cost efficiency of the health care system through a series of restructuring and financing initiatives.
7. Where	- At home - In Hong Kong
8. When and how much	- Participants were 60 years old or older and suffered from one or more chronic illnesses such as chronic obstructive pulmonary disease, stroke, diabetes, and/or heart disease. Their participation followed the discharge from a rehabilitative hospital. - Home visits and telephone consultations were provided regularly, usually biweekly. - The number of sessions for the assessment, or mean number of sessions per participant, are not specified.
9. Tailoring	- The care plans were tailored based on the participant and caregiver's assessment/identified needs. There were four main groups (no impairment, mild , moderate or severe impairment) in which participants were classified and which guided the care recommendations. The reviews/monitoring could be more regular according to need.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 234. Melis 2008[60] Dutch EASYcare Study Geriatric Intervention Programme (DGIP)

1. Brief name	Dutch EASYcare Study Geriatric Intervention Programme (DGIP). A nurse-led home visiting multidisciplinary program to intervene on geriatric syndromes in vulnerable older people who live at home.
2. Why	Goal: to improve functional performance, health-related quality of life, and caregiver burden, in independently living older people with common geriatric problems Rationale: - based on a problem-based selection approach performed by the GP which was expected to increase continuity of care through better timing and targeting of the intervention, and more engagement of the general practitioner, the patient and the caregiver. - the benefits of a problem-based selection have been shown in previous nonrandomised studies -the involvement of the GP in the intervention model was also expected to improve continuity of care, preventing negative effects -the involvement of an informal carer was emphasized and considered a precondition for an effective intervention - the recommendations were based on best nursing practice, because literature has pointed at the possibility that the effects of home visiting programmes are related to the home visitor's performance in conducting the visits - the intervention was piloted in a previous feasibility study
3. What (materials)	- EASYcare instrument was used in the geriatric assessment - Guidelines that structured recommendations, based on the best nursing practice
4. What (procedures)	- Multidomain assessment at home by a nurse with geriatrician support, including function, cognition, mood and goal setting domains. - A tailored care plan was developed based on the assessment and discussed in interdisciplinary meetings. These included mostly referrals. - Regular follow-up including assessment and management of each participant's situation - Supported access to usual care, including, for example, GP care, home care, meals-on-wheels, among others.
5. Who provided	- Geriatric specialist nurses, geriatricians, and GP
6. How	- The home visits were provided face-to-face and individually or with the informal caregiver when possible.
6b. How organised	- The care plan was discussed in interdisciplinary meetings between the nurses, geriatricians and GP. Other professionals could be contacted if necessary. - The nurses conducted the main part of the intervention, while they were coached by geriatrician. - The GPs provided referrals, medication changes and other interventions - The informal carer was invited to have an active role in the intervention - The care planning explicitly mentions medication changes
7. Where	- At home - In the Netherlands
8. When and how much	- Started after referral by GP when the patient or informal caregiver had recently presented with a health problem.

	The request had to be related to cognitive disorders, behavioral and psychological symptoms of dementia, mood disorders, mobility disorders and falling, or malnutrition. The patient/informal caregiver and GP had to have determined a goal to be achieved. Participants also had to be experiencing limitation in cognition (Mini Mental State Examination equal to or less than 26, but higher than 20), instrumental activities of daily living (Groningen Activity Restriction Scale equal to or greater than 25) or mental well-being (MOS-20/subscale mental health equal to or less than 75). The participant was not experiencing an acute problem, the problem was not merely a diagnostic issue, and was not already receiving intermediate care. - Participants received a maximum of six follow-up visits over 3 months. On average 3.8 visits were actually received.
9. Tailoring	The care plan is tailored to the patient's needs and negotiated with him/her. Presumably, the number of follow-up visits is also tailored to need.
10. Modifications	Not mentioned
11. How well (planned)	- Both patient/caregiver and physician adherence rates to recommendations, and possible predictors, were investigated by collecting data on the recommendations given, GP compliance based on electronic system and participants or informal caregivers' compliance based on phone contacts.
12. How well (actual)	- Overall, physician adherence was 75% and was better than patient adherence (51% complete/partial adherence). Adherence levels increased when both patients, caregivers and physicians received recommendations. - Patients received on average 2.2 (SD = 1.2) recommendations - GP adherence was better for recommendations concerning medication (88%) than referrals (57%).

Table 235. Rubenstein 2007[76] Case finding and referral model of geriatric care

1. Brief name	Case finding and referral model of geriatric care. includes telephone assessment, case finding referral, focused geriatric assessment in a specialty clinic for selected patients, and limited case management and follow up by telephone, all following postal screening.
2. Why	Goal: to improve recognition of geriatric conditions and healthcare outcomes, including less functional decline and fewer hospitalizations Rationale: ...by identifying older people in high need/risk and their unrecognized geriatric conditions using systematic screening and evaluation processes and subsequently increasing geriatric and rehabilitation services.
3. What (materials)	- Structured interview focused on target geriatric conditions and other problems identified - Letter to the participant with recommendations, referrals, and appointments. - Copy of telephone screening results, care plan, referrals, recommendation and progress added to medical record.
4. What (procedures)	For participants: - Structured telephone geriatric assessment (in clinic just for participants who could not be assessed by telephone) - Recommendations and referrals including the geriatric medicine primary care clinic and home-based primary care

	- Follow-up calls to monitor adherence and changes, and to provide additional referrals and recommendations as needed For staff: - Supervision by study geriatricians - Informal interdisciplinary team meeting about participants' care plan
5. Who provided	- Physician assistant with geriatric expertise acting as case manager - Geriatricians acting as supervisors For selected participants: - Geriatric clinic staff, including: geriatric medicine faculty, physician assistant, internal medicine staff, geriatric psychiatrist, geriatrician with expertise in urinary incontinence, and physical therapist. - Presumably home-care service staff.
6. How	Assessment and follow-up individually and by telephone. For selected participants: individual face-to-face contact in assessment, geriatric clinic care and home care services.
6b. How organised	A physician-assistant case manager conducted telephone assessments and "case management" including referrals and recommendations. The physician-assistant was supervised by geriatricians. They either developed a care plan or brought them to an assessment clinic where they were discussed in an "informal interdisciplinary team meeting" (although unclear what the other disciplines were). The primary care provider was informed of the results. - The care planning does not explicit mention medication changes, but these can be inferred based on the provision of pharmacy consultations as referrals and the involvement of a physician assistant in the care planning
7. Where	Los Angeles, USA One of three interdisciplinary primary care practice groups, and at the Sepulveda Ambulatory Care Center (SACC) of the VA Greater Los Angeles Healthcare System. Geriatric care had been in place for over 25 years, but the participants were not enrolled in the outpatient geriatric services at SACC when joining this study. VA and non-VA healthcare services available. Referrals to assessment and services which could take place at home for the homebound, or the geriatric clinic if telephone assessment could not be adequately.
8. When and how much	Intervention started when identified as at high risk (four or more of the 10 Geriatric Postal Screening Survey (GPSS)), i.e. impaired response in four or more areas of screening. All participants: 1 initial structured assessment + 1 call 1 mth after assessment + 1 call every 3 mths for the remaining 35 months of the study Selected participants: 1 or 2 assessment visits at geriatric clinic + other contacts following referrals for geriatric clinic, home based care or others.
9. Tailoring	- Assessment takes into account the problems identified previously for each individual - Care tailored by case manager to the needs identified
10. Modifications	Not mentioned
11. How well (planned)	- Follow-up calls as strategy to encourage adherence - For the first study year, the participant adherence to recommendations was described.

12. How well (actual)	- The overall adherence rate to referrals was 74% in the first, 60% in the second year and 50% in the 3rd year. - Highest adherence rates were observed for referrals to the eye clinic (85%), geriatric medicine and primary care clinics (83%), audiology (80%), prosthetics (79%), urinary incontinence clinic (78%), and geriatric psychiatry clinic (77%). Adherence rates were lowest for referrals to mental health clinics (32%) and rehabilitation services (48%). - Chart review showed that many participants did not receive the intensity of evaluation or treatment that had been expected.

Table 236. Stuck 2000[81] In-Home Geriatric Health Visits in Elderly Residents (EIGER)

1. Brief name	In-Home Geriatric Health Visits in Elderly Residents (EIGER). An in-home comprehensive geriatric assessment program.
2. Why	Goal: reduce and/or delay disability/ maintain independent and reduce institutionalization, hospitalization and health care costs in older people Rationale: - Based on the model by Verbrugge & Jette (1994) that associates a variety of risk factors (biological, psychological, environmental, extra and intra-individual) to the development of dependence in aging. Preventive home visits are proposed as a strategy to detect and identify these risk factors. - Based on previous evidence showing that preventive home visits are beneficial to older people in terms of survival and living at home. - Based on a similar intervention strategy used in an earlier trial in Santa Monica (California) [ID - Rubenstein 1994 in our review]
3. What (materials)	- Structured form with geriatric assessment tools - Medical and social history records - Results from the baseline and yearly interviews - Letter with selected findings of the assessment and recommendations to the physician, when agreed with the participant - List of 24 predefined problem categories was used by the nurse in the care planning - Resource materials such as list of recommendations for social work referral or patient instructions for pelvic continence training
4. What (procedures)	- Multidomain assessment at home by the nurse, including areas such as sensory impairments, environment, social support, among others. - A care plan including specific recommendations was developed based on the assessment and baseline interview information, with the involvement of the nurse, a geriatrician and a wider multidisciplinary team as necessary. - The nurse provided health education, encouragement to self-care and compliance and attempted to improve the ability of the person to discuss issues with their physicians. - Participant's status (including the need for adapting the care plan) and compliance with recommendations were regularly reviewed - Information about the assessment were passed on to the GP (if the participant gave permission to do so), or discussed on the phone (for complex/urgent issues) - Access to usual healthcare services including primary care (mostly), specialists, and home care. The system is based on fee-for-service health insurance plans, by which specialist care can be accessed directly.

5. Who provided	- Experienced public health nurses visited the participants - The care plan was discussed with a geriatrician and with members of a consulting team as necessary (including a physical therapist, an occupational therapist, a social worker, a psychiatrist, and a lawyer) - Nurses received training and support from the geriatricians and the consulting team
6. How	- Presumably individually and face-to-face (based on at home context) - In exceptional circumstances there were telephone contacts from the nurse
6b. How organised	- The care planning decision-making is centered in the nurse and geriatrician with the possibility to consult a wider multidisciplinary team (physical therapist, an occupational therapist, a social worker, a psychiatrist, and a lawyer) - The care planning does not explicit mention medication changes, but these can be inferred based on the analysis of "appropriateness of medication use" and the involvement of a geriatrician in the decision making - The geriatrician coordinates with the participant's GP to avoid interfering with their role (more than 90% of participants' primary care physicians were contacted) - The system of care is based on fee-for-service health insurance plans, and more than 99% of people are covered. This allows for direct access to specialist care
7. Where	- At home - In Bern, Switzerland
8. When and how much	- Started when the participants were enrolled in a health insurance (as 99% of the people in the system of care) and were 75 years-old or more - Home visits every 3 months during 2 years, in a total of 8 visits for approximately 1 hour - Yearly multidomain (re)assessments taking approximately 2 hours - On average, the participants received 8.5 ± 2.9 home visits (mean ± SD) during the 2 years of the intervention
9. Tailoring	- The care plan was tailored the participant's needs based on the assessment.
10. Modifications	Not mentioned
11. How well (planned)	To support the fidelity of the implementation and allow for its analysis, the following strategies were used: - Supplemental training for nurses and support during the implementation - Data collection on intervention process, including client adherence with recommendations.
12. How well (actual)	- There were 3 nurses, and one of them gave significantly lower recommendations than the other two. This difference is not accounted for by regional differences. - Differences in problem identification were found particularly for problems that required clinical judgment (e.g., chronic obstructive pulmonary disease, medication management, social and environmental problems). - Physician adherence to preventive recommendations was lower than in a previous similar study (Santa Monica).

Table 237. Suijker 2016[83] Functional decline In Transition (FIT)

1. Brief name	Functional decline In Transition (FIT). A comprehensive geriatric assessment, an individually tailored care and treatment plan based on multifactorial interventions and nurse-led care coordination.
2. Why	Goals: - The primary goal was to prevent functional decline in community-dwelling elderly people of 70 years and older; - Secondary goals were: To prevent hospital and nursing home admissions, disability, to improve quality of health and quality of life, and to describe met and unmet care needs (elderly and care-givers). - The intervention was also designed to identify and treat geriatric problems in an early stage, and to improve care coordination between healthcare professionals. Rationale: - based on previous evidence that shows that complex interventions can help elderly people to independently continue living at home, largely through prevention of the need for nursing-home care. - based on previous reviews and meta-analyses that have identified features that have a beneficial effect in functional decline: a systematic comprehensive geriatric assessment, with multiple home visits, an individually tailored CTP, based on multifactorial, evidence-based interventions and nurse-led collaborative care coordination - the CGA, in particular, is based on a previous study including an expert panel and older volunteers with experience in healthcare - based on the importance of selecting people at risk of functional decline which may represent a group with broader opportunities for preservation of independent functioning.
3. What (materials)	- Toolkit consisting of standardized protocols for the 24 most prevalent geriatric conditions in the CGA following international guidelines and were based on evidence or on current best practice; - The CGA includes several validated questionnaires, e.g. Fear fo Falling, FES-I; Short Nutritional Assessment Questionnaire (SNAQ); MMSE, and others. - Comprehensive inventory of all collaborating healthcare professionals and the overall care coordination that may already be in place or is (still) needed
4. What (procedures)	- Multidomain assessment, including four main domains (physical, functional, mental and social functioning), and areas such as caregiver burden. - The care plan is developed based on protocols and clinical discussion between the nurse and the GP, and the patient. - The nurse coordinates the implementation of the recommendations (e.g., contacting other healthcare professionals) and regularly reviews the participant's status. The nurse may also provide tailored advice/recommendations (e.g., which social activities are available). - Usual care services which include primary care with GP and nurse care (may use chronic management protocols for diseases, such as diabetes and COPD), home care nursing, personal care, day care, and hospital care.
5. Who provided	- The intervention was provided by health care nurses (usually just one or two different nurses contacted with the participant), in liaison with the participant's GP. - The nurses were experienced, trained in elderly care, received a 10-day training and a regular refresher course on elderly care and the intervention.

6. How	- Presumably face-to-face (based on home visits), and individually and/or with the caregiver. - By telephone - Empowerment to of the participants was emphasized
6b. How organised	- The care plan decision-making was developed and carried out by a multidisciplinary team constituted by the nurse and the GP. - Nurse and GP met weekly to discuss assessment and care plans. - The care planning explicitly mentions medication changes. - The nurse coordinates all care and treatment contacts (including with other healthcare professionals), including discussing the care plan with the participant. - The GP retains formal responsibility for the care provided to the participant - In usual care, the GP plays a central role as the first contact and gatekeeper of the healthcare system.
7. Where	- At home - In the GP surgery - In the Netherland, north of Amsterdam (region Alkmaar) and within the city of Amsterdam (North and South-East). - In urban and rural communities
8. When and how much	- Started after a selection process that included people 70 years-old or older, registered in a GP practice, and at increased risk of functional decline based on a validated postal questionnaire sent by the GP (2 or more in the Identification of Seniors at Risk in Primary Care, ISAR-PC). - There were up to 8 contacts per year (varied 3 to 8). The first contact included the CGA and took 40-60 minutes. Other visits took around half an hour, and telephone contacts around 5 minutes. The visits took place every 6 to 8 weeks, or at shorter intervals if necessary.
9. Tailoring	- The care plan, and the number and timing of the home visits was tailored to participant's needs and expectations
10. Modifications	Not mentioned
11. How well (planned)	Several strategies were used to support and/or analyze implementation fidelity; - training for intervention providers (10-day), refresher courses every six weeks, and 2 critical reviews of cases/per provider - the feasibility of the intervention was tested in a pilot study of 20 older adults - the participant's informal caregiver was invited to participate, as a strategy to enhance adherence - the providers are kept relatively constant (one or 2 nurses), to support a strong and trusting relationship with the participant - collection of data and analysis of the rate of fully implemented care plans and factors facilitating/inhibiting implementation
12. How well (actual)	- 77.0% (934/1209) received a CGA and 76.6% (926/1209) received a care plan - Although many geriatric conditions were identified in the CGA, only one condition per participant was recognized as a problem and only one intervention was initiated - The nurse discussed 61.6%(575/934) of the CGAs with the general practitioner. The CGAs that were not discussed with the GP (38.4%; 359/934) involved participants declining care or with no unmet care needs.

	- After one year, 77.4% (698/898) of the care plans were evaluated with the participants - During the intervention, the mean number of home visits was 3.2 (SD 1.5)

Table 238. Thomas 2007[86] Functional assessment- results given and offered referrals

1. Brief name	Functional assessment- results given and offered referrals. Functional assessment with results given to participant who was offered referrals to health/ social services.
2. Why	As Canada's elderly population continues to grow over the next few decades, its demand for community-based health services is also likely to grow. It is important to know whether helping seniors and their families in this third group identify their deficits (or potential deficits) may help them continue living in the community.
3. What (materials)	In intervention group 2, the results of the annual assessments were shared with the elder and the unpaid primary caregiver, and the elder was offered referrals to health and social services if needed. Laptop computers running Microsoft Excel 7.0 for Windows ran the RAI-HC scoring software developed by InterRAI.
4. What (procedures)	In intervention group 2, the results of the annual assessments were shared with the elder and the unpaid primary caregiver, and the elder was offered referrals to health and social services if needed. In group 2, the results of the assessments were validated by the elderly person and caregiver, and the interviewer offered to contact appropriate community services for any needed social or health services.
5. Who provided	Four registered nurses were trained as interviewers. The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years.
6. How	The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years. Care recipients assigned to intervention groups 1 and 2 were assessed annually for 4 years, using the RAI-HC. This information was sought directly from the care recipient, but in certain circumstances some information was provided by the caregiver. The results of the assessment were explained to both the elderly person and the caregiver and were validated through further discussion with the nurse- interviewer. In group 2, the results of the assessments were validated by the elderly person and caregiver, and the interviewer offered to contact appropriate community services for any needed social or health services.
6b. How organised	- The results of assessments were explained to the person and caregiver and the nurse offered to make referrals and other contact with services on their behalf. Authors were uncertain of quantity, quality and suitability of home care provision so unlikely there was any integration with them. - The care planning does not explicit mention medication changes, but these can be inferred based on the use of MDS-HC/RAI-HC
7. Where	Newfoundland, Canada. Assessment took place at home. Authors suggest that culturally self-reliant and used to weathering hardship. Also strong mutual help networks in villages.

	Authors uncertain of quantity, quality and suitability of home care provision.
8. When and how much	The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years. At baseline and at each follow-up assessment (years 1 to 4), nurses compiled data
9. Tailoring	In group 2, the results of the assessments were validated by the elderly person and caregiver, and the interviewer offered to contact appropriate community services for any needed social or health services.
10. Modifications	None
11. How well (planned)	None
12. How well (actual)	None

Table 239. Thomas 2007[86] Functional assessment results shared and advice given

1. Brief name	Functional assessment results shared and advice given. Functional assessment with results given to participant who was invited to take appropriate action.
2. Why	As Canada's elderly population continues to grow over the next few decades, its demand for community-based health services is also likely to grow. It is important to know whether helping seniors and their families in this third group identify their deficits (or potential deficits) may help them continue living in the community.
3. What (materials)	In group 1, the elderly person and caregiver were invited to use the assessment information as they wished. Laptop computers running Microsoft Excel 7.0 for Windows ran the RAI-HC scoring software developed by InterRAI.
4. What (procedures)	In intervention group 1, the results of the annual assessments were shared with the elder and the unpaid primary caregiver, and they were invited to take any action they felt appropriate. In group 1, the elderly person and caregiver were invited to use the assessment information as they wished.
5. Who provided	Four registered nurses were trained as interviewers. The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years.
6. How	The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years. Care recipients assigned to intervention groups 1 and 2 were assessed annually for 4 years, using the RAI-HC. This information was sought directly from the care recipient, but in certain circumstances some information was provided by the caregiver. The results of the assessment were explained to both the elderly person and the caregiver and were validated through further discussion with the nurse- interviewer. In group 1, the elderly person and caregiver were invited to use the assessment information as they wished.
6b. How organised	- The results of assessments were explained to the person and caregiver who were invited to use the information as they wished, i.e., no referrals were made on their behalf.

	- The care planning does not explicit mention medication changes, but these can be inferred based on the use of MDS-HC/RAI-HC
7. Where	Newfoundland, Canada. Assessment took place at home. Authors suggest that culturally self-reliant and used to weathering hardship. Also, strong mutual help networks in villages. Authors uncertain of quantity, quality and suitability of home care provision.
8. When and how much	The interviewers visited and assessed subjects at baseline and repeated the visit and assessment annually for 4 years. At baseline and at each follow-up assessment (years 1 to 4), nurses compiled data
9. Tailoring	In group 1, the elderly person and caregiver were invited to use the assessment information as they wished.
10. Modifications	None
11. How well (planned)	None
12. How well (actual)	None

Table 240. Tulloch 1979[87] Geriatric screening and surveillance program

1. Brief name	Geriatric screening and surveillance program.
2. Why	Goal: identifying and managing health problems Rationale: based on previous research showing that geriatric screening programs, in various contexts, find unrecognized health problems
3. What (materials)	- Medical questionnaire sent by post to the participants, which was part of the initial assessment - Referrals
4. What (procedures)	- Multidomain assessment, planning and arranging followed by referrals to relevant services - Regular review of the assessment with further referrals as needed - Referrals as needed to usual care services, including outpatient services, health visitors, physiotherapists, chiropodist, and social services. - The primary care center servicing these participants included generous nursing, administrative support and close liaison with social services
5. Who provided	- A nurse provided the initial assessment - The geriatric clinic included practice nurses and health visitors - Presumably various health and social care professionals working on usual care settings, to whom participants were referred to following assessment and reviews.
6. How	- Face-to-face and individually in home-visit by nurse, and visits to surgery and/or geriatric clinic - A questionnaire that was part of the initial assessment was sent by post.
6b. How organised	- There is no clear case manager or person responsible for decision-making. The geriatric clinic was the centre of decision, but we don't know if there was a team approach to the decision-making - The geriatric clinic provided referrals for community resources based on the assessment and reviews - The primary care center which was part of usual care liaised closely with social services

	- The care planning does not explicit mention medication changes, but these can be inferred based on the resolution of medical problems and routine Hb and serum folate assays
7. Where	- Oxford - At home for the initial assessment (first visit) - At the surgery or at home (if needed) for the initial assessment (second visit) - At the geriatric clinic for reviews. - Presumably at outpatient and specialist services and at home, based on patient referrals to usual care that followed the assessment and reviews.
8. When and how much	- Started after general invitation based in practice register, to people aged 70 or more - Two session for initial assessment, approximately 2 weeks apart. - Reviews at the geriatric clinic occurred for 2 years
9. Tailoring	- The location of the physical examination that was part of the initial assessment was performed at the participants' home instead of the surgery, if required. - Specific assessment procedures following the initial assessment and referrals were presumably based on participants' need.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 241. van Hout 2010[90] Preventive home visiting program

1. Brief name	Preventive home visiting program.
2. Why	Goal : Preventive home visits by nurses may prevent functional decline, institutionalization, and mortality if they target vulnerable older persons, include multidimensional assessments, and individualized care plans. Rationale : Primary care physicians increasingly lack the time and tools for proactive care, systematic assessment, long-term monitoring and management of chronic diseases, Proactive visiting of older frail patients by nurses may improve service levels and prevent adverse health trajectories.
3. What (materials)	Staff : 1. Laptop used by the nurses. 2. Care Plan that is kept at the participants home to allow other health care professionals to add notes and read. 3. A national Dutch guideline on home care nursing of frail elderly patients was available No materials provided to the participants.
4. What (procedures)	1. Initial assessment of health risks and care needs. (This is CGA however it is not referred to as this). 2. Nurses recommending interventions based on the RAI-HC. 3. Designing an individually tailored care plan taking into consideration patient preferences. The nurse executing the care plan.

	4. Nurses leaving a copy of the care plan at a person's home to inform other visiting health professionals and to encourage them to add notes to the care plan. 5. Preventive home visits. Nurses visited a patient at least four times a year in order to execute and monitor the care plan, evaluate changes in care needs, and adapt the care plan when needed. 6. Urgent medical matters, the nurses could consult the Primary care physicians. 7.Reassessment of participants after one year and protocol is repeated.
5. Who provided	Community Nurses Primary care physicians Number of providers : 2+ Multidisciplinary.
6. How	Intervention is provided to the Individual in face-to-face at-home visits.
6b. How organised	It appears one nurse was allocated per person. They made recommendations and agreed the care plan with the individual. There was little apparent interaction with other professionals: a copy of the care plan was left with the person and the nurse spoke to the primary care physician in case of urgent matters. The care planning included medication review, as suggested by the use of the RAI-HC.
7. Where	Netherlands Primary Care Practise Intervention provided to the participants at home.
8. When and how much	1. When identified by a postal survey. 2. Initial assessment of health and risks 45 to 75 mins. 3. Number of sessions : 5+ home visits. 4.The home visits were fixed sessions to execute, monitor and adapt the plan.
9. Tailoring	1. The care plan was individually tailored. It was developed based on protocols from the RAI-HC but took into consideration the preferences of the individual. 2. The number of sessions were fixed however more could be offered if needed by the individual.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	90% of participants were assessed with the RAI-HC.

Table 242. Vass 2005[130] Preventive home visits

1. Brief name	Preventive home visits. Structured visits with professionals that received an educational program focused on relevant gerontological and geriatric problems, especially on the importance of tiredness as an indicator of frailty
2. Why	Goal: to prevent or delay the onset of impairments and enhance active life expectancy by encouraging health visitors to focus on early signs of disability and encourage physical activity in elderly persons, and to promote interdisciplinary follow-up including the GPs. Rationale:

	- Based on previous studies showing that tiredness in daily activities predicts the onset of functional limitations, disability, use of social and health services and mortality - Based on relevant geriatric and gerontological documentation - Based on the disablement process which indicates impairment may be avoided through early action, medication review, visitation and referral to relevant professionals - Based on the hypothesis that by empowering older adults, confidence, self-esteem and self-care will be improved, preserving or increasing functional capacity and reducing needs.
3. What (materials)	- Standard assessment tool - Referrals to relevant services - Mapping of physical activity resources - Records about the use of the tiredness in daily activities measure - Training educational materials for staff
4. What (procedures)	- Multidomain assessment based on a standard tool, with a particular focus on tiredness in daily activities and related health mental and social factors in the home visits, with possible referrals/recommendations to relevant services. - GPs were also expected to integrate a multidomain assessment in their practice - Counselling to initiate or continue physical activity was emphasized for all - Routine follow-up was provided - Access to usual healthcare was available, including services such as district nurse, home assistance, meals on wheels, transportation, rehabilitation, and aids and appliances for handicapped persons.
5. Who provided	- Key persons who were trained on the intervention (and provided the home visits) - GPs were involved and expected to change their practice based on training provided by the intervention
6. How	- Presumably individually and face-to-face, based on the home visit format - The intervention delivery focused on techniques to empower the participants and on good communication techniques (by the home visitor)
6b. How organised	- Interdisciplinary care coordination is emphasized, and the visitors are expected to maintain close contact with the participant's GP. The GP is also expected to rely on the visitors, for example, to reinforce physical activity recommendations - In terms of care planning organization, it seems like there was a first stage of decision making by the visitor, and then a possible 2nd stage of decision making by the GP, but it is not clear if the professionals discussed recommendations with each other. - The care planning explicitly mentions medication review and possible medication changes - It is not clear whether the professionals visiting the participant at follow-up are the same person - In Denmark, the counties are responsible for hospital and specialised geriatric and psychogeriatric treatment and rehabilitation, the municipalities for home and institutional care and long-term rehabilitation. GPs are organised in independent, private practices funded by the counties, and are responsible for health problems in the primary care sector, but they have no community service authority. Hospital, general practice, and community services are all fully financed through taxation.

7. Where	- At home - In Denmark
8. When and how much	- Started when participants were 75 or 80 years old and enrolled in GP practices offering home visits, good rehabilitation, and GPs who could provide preventive care. Enrolled after being invited based on the civil registration office through a letter with or without a proposed date, or a phone call. The study was also mentioned in local newspapers. - 2 annual home visits for 3 years
9. Tailoring	- Preventive home visits were expected to take into account individual variation
10. Modifications	Not mentioned
11. How well (planned)	- Adherence to the standardized procedures recommended to the home visits was promoted based on regular training and supervision of key persons and GPs. - The use of a measure of tiredness in daily activities was registered for adherence analysis - Detailed information on number of home visits, the relationship between the home visitors and the participants, and the participants' own evaluation of the visits was collected - Information on the actual implementation of the program was collected with home visitors and the head of the preventive program in each community involved
12. How well (actual)	- During the 3-study years, 57% of the participants received at least on visit - With few exceptions all municipality health visitors received educational intervention as planned. - After the first staff educational session, 80% of the preventive home visitors (PHVs) said they would assess functional ability at every visit, and after the second session, all PHVs confirmed they would use tiredness in daily activities as a trigger for further action. After the third session, 1 year after starting, all intervention municipalities had 'mapped' their communities' physical activity; 15 of the 17 municipalities delivered all their written material to the research team. - After the first year of education, all visitors confirmed that they had incorporated the following simple messages: be alert of tiredness in daily living, focus on resources, and remember the general practitioner. - Not all preventive home visitors received our educational intervention directly. In larger communities this was implemented through the key persons. Not all GPs participated in the offered small-group education

Table 243. Yamada 2003[98] Preventive home visits based on Minimum Data Set-Home Care

1. Brief name	Preventive home visits based on Minimum Data Set-Home Care.
2. Why	Goals: to provide human interaction, maintain quality of life and change health behaviours. Rationale: - based on demonstrated effectiveness of multidimensional assessments to prevent functional decline - based on the essential nature of human interaction in home visits

3. What (materials)	- The Minimum data Set-Home Care was used as basis for a comprehensive assessment, including the client assessment protocols, which trigger selective advice for up to 30 domains - A training manual was created and used to stress the primary objective of the visits was human interaction.
4. What (procedures)	- Assessment based on the Minimum Data Set-Home care by public health nurses at home. The assessment triggered protocols for selective recommendations in up to 30 domains (e.g., falls, social function). The nurses could change the recommendations based on clinical expertise. - Regular visits were also provided, allowing for routine reviews. - Presumably usual community care was still available
5. Who provided	- Public health nurses (PHN) carried out the home visits in which assessment, care planning and subsequent advice, with regular reviews, occurred. - The PHN received training, were experienced in public health and received supervision mid trial.
6. How	- Presumably individually and face to face based on home visiting format
6b. How organised	- Medication review is an inherent part of the MDS-HC and can be considered to have taken place. - The care planning was unidisciplinary, based on the MDS-HC triggers and the nurse's clinical expertise. - The visits were documented by the public health nurses and supervised mid-trail. - In the context of a public service in which preventive home visits are mandatory but an effective strategy to implement them has not yet been put in practice - The cooperation of local primary care physicians was not obtained
7. Where	- At home - In Sapporo city and Takahata town in north Japan
8. When and how much	- Started when participants were 65 years old or older and were not receiving home visits by nurses in existing programs. Participants were first selected based on voter registration and then assessed. Those who were fully dependent in either the mobility or the personal care item of the EQ-5D were excluded as 'disabled', and those who were independent in all IADL, or dependent in one or two IADL, but rated their own health as excellent, were excluded as 'healthy'. The included participants were dependent in IADLs but independent in ADLs - The intervention run for 18 months, with visits every 3 to 6 months, according to need. The assessment could take up to 3 visits.
9. Tailoring	- The care planning was tailored to the participants needs' assessment
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Multifactorial-action and review with medication review and self-management

Table 244. Fox 1997[131] Standard comprehensive health assessment, with extensive health plan counseling and written health plan

1. Brief name	Standard comprehensive health assessment, with extensive health plan counseling and written health plan. Standard comprehensive health assessment as part of the Preventive Health Care for the Aging (PHCA) program
2. Why	Goal: to improve adherence to behavior change recommendations and thereby prevent or slow the rate of disease progression and reducing the risks of disability and death Rationale: - Based on previous research showing benefits of health promotion in other populations - People may need information about preventive actions that can improve their health - Adherence and a collaborative approach when setting up goals promotes health behaviour - Based on goal setting techniques used with the person to break down the desired behaviour in easier components / goals - Written instruction act as a reminder and increase adherence - the nutrition recommendations are based on the USDA Food Pyramid and the "Food Guide for Mature Adults"
3. What (materials)	1. Health history including information about demographics, health care providers, diagnosis, medication, among others. 2. Nutritional diary - food and drink intake 3. Presumably, materials used in physical exam to measure height, weight, blood pressure, among others. 4. Pamphlets and promotional health material provided to the participants 5. A written health plan and recommendations were provided to the participants 6. Referrals (medical or for community services) - provided as needed. 7. Health screening results and a list of referrals was provided to participants at the nurse discretion 8. Records of counselling duration and topic 9. A data system is used to record counseling a referrals 10. A standardized visit encounter form is used to record referrals and used in following up participants
4. What (procedures)	1. Multidomain assessment, planning and arranging. PHSA Comprehensive Health assessment (CHA) - Health history - Nutritional assessment - food and drinks diary - Physical examination - Medication was assessed and presumably the participants were referred/recommended related actions if risks were found. 2.Risk Identification 3. Provision of health-related information

	4. Provision of individualized health recommendations including written personal health plan to specify goals + objectives + time frames for accomplishment of behavior recommendations 5. Arranging of referrals (medical, dental and/or community services) as needed and following up with the participants on medical and dental referrals specifically
5. Who provided	1. Public health nurses - Nurses attended a three-day training conference to update knowledge on assessment practices and health promotion, disease prevention, and management of chronic diseases. - Training on intervention implementation
6. How	Presumably individually and face to face based on consultation format (with physical examination) Distance and individually in selected cases: 1. Follow up phone calls - The individualized counselling presumably used techniques of behaviour change involving goal setting, namely creating simpler short-term goals with the person/
6b. How organised	- In the context of a well-established preventive health care for the aging program funded by the Department of Health focused on health prevention and targeting people trough clinic site placement and outreach - Physicians sometimes called the nurses to confirm they saw the person referred to them - The care plan was developed by the nurses with the participant in a unidisciplinary format
7. Where	- At community-based public health clinics - Services are provided in community settings which may include senior centers, nutrition sites, senior housing facilities, and churches. - 4 counties two rural and 2 urban and suburban in California, US
8. When and how much	- Started when participants were 60 years old or older and were participating for the first time in an established statewide public health prevention program delivered in both rural and urban clinics which targeted low-income older adults - Initial comprehensive health assessment, followed by health plan and written health recommendations. Number and duration of sessions not specified. - If referrals were provided to physicians and dentists, the nurse followed up with the participants on these within 3 months Assessments were repeated, and previous actions reviewed, annually.
9. Tailoring	Health plan and verbal recommendations tailored to the risks identified in the multimodal assessment and to participants preferences. Health plan was further tailored to participants' needs and preferences by detailing methods and time frames.
10. Modifications	Not mentioned.
11. How well (planned)	- Adherence was an important focus of the study and plans were made to measure it in a variety of ways with detailed records kept of what was recommended and what was implemented
12. How well (actual)	- 32% of participants were in the complete adherence category - 43% of participants were in the moderate adherence category of the treatment group were

	- 26% of participants were not adherent - 5% of participants reported economic barriers to adherence

Table 245. Phelan 2007[71] Senior resource team (SRT)

1. Brief name	Senior resource team (SRT). Interdisciplinary geriatric specialists working with primary care providers and patients, to enhance the geriatric focus of care.
2. Why	Goals: To improve the quality of care, and to reduce disability and hospitalizations for older adults Rationale: - By interacting with a trained physician in geriatrics concerning a small number of patients, a Primary Care Physician's knowledge about management of older adults and self-efficacy to provide care for older adults would increase. - The intervention incorporated effective methods of clinical behaviour change (e.g., patient/specific reminders of recommendations and suggestions) to facilitate adherence of the primary care providers; and enable patients to feel able to take responsibility for their care.
3. What (materials)	- Standard clinical screening tools to assess areas such as ADLs, falls and depression - Written goals and action plan provided to patient and PCP (primary care physicians).
4. What (procedures)	For participants: - Multidomain assessment, planning and arranging following the initial interview by the nurse, who discussed and developed an action plan with geriatrician and the patient's PCP. - Medication review by geropharmacist, who reviewed each participant's medication list and made recommendations to the nurse before the follow-up visit; and after the follow-up visit, telephoned called each patient who had medication changed to discuss any of the patient's concerns. - The follow-up visit took place 2 weeks after the initial visit, in which the nurse and geriatrician discussed and agreed the action plan with the patient and family, focusing on the patient preferences. A copy of the goals and action plan was given to the patient and the PCP. - Regular follow-ups conducted by the nurse to mainly to support self-management. For staff: - Meetings between members of the team providing the intervention -Meetings between team providing the intervention and (1) the research team (2) behavioral scientist of the research team to review progress, troubleshoot problems and monitor compliance with intervention principles. Usual care: Mainly based in primary care settings, and presumably having access to geriatricians.
5. Who provided	- 1 Geriatrician - 2 Gerontological advanced registered nurse practitioners - 1 Geropharmacist - Primary care practitioner/physician (PCP)
6. How	For participant: - Individually and face to face for the initial assessment and first follow-up, then regular face to face or telephone call follow-ups.

	- Individually and by telephone shortly after medication changes suggested and made at the first follow-up visit.
6b. How organised	- The participating primary care clinics were affiliated with Group Health Cooperative (GHC), a large health maintenance organization - The SRT (geriatrician, nurses and pharmacist), met weekly to address team operations and ensure a standard approach was being followed with each patient - Nurse and geriatrician reviewed assessment results and agreed on clinical priorities - The geriatrician discussed the patients' care with the PCP, including PCP preferences for involvement, and means of communication with the team - Nurse and geriatrician discussed the initial action plan with patient, including his/her preference - Geriatrician or nurse were informed about pharmacist recommendations
7. Where	Location: - Seattle, Washington, USA Venues: - In clinic for initial assessment visit and first follow-up to discuss action plan with patient and family. - The 2 participating primary care clinics affiliated with a large health maintenance organization, in which PCPs were receptive to the project.
8. When and how much	When started: People aged 75 or over, who were patients of one of the participating primary care practices, were selected by either randomly sampling or by their primary care physicians, to receive the invitation. Intervention schedule: For participants: - At least 2 sessions including initial assessment (1h) and discussion of care plan with patient and family 2 weeks later. Variable number of additional sessions for medication review, and follow up on self-management and barriers. For staff: - Weekly meetings between the members of intervention team - Bi monthly meetings between team providing the intervention and the research team - Weekly meetings between team providing the intervention and behavioral scientist of the research team
9. Tailoring	- The participant collaborated in the formulation of the goals and the care plan - Medication review follow-up tailored to participants' need - Follow-up provided based on patient's level of interest
10. Modifications	Not mentioned
11. How well (planned)	- Meetings between members of intervention team and with the research team to ensure standard approach and adherence, and to troubleshoot problems
12. How well (actual)	- 74% of patients invited to see the SRT scheduled an appointment and were evaluated - Most of these participants made their initial visit within 1 to 3 mths - Average of 2 visits, 6 phone calls and 2 interactions between the PCP and the SRT

Table 246. van Leeuwen 2015[91] Geriatric Care Model

1. Brief name	Geriatric Care Model. A multifaceted intervention based on the chronic care model, which was designed to guide and enhance the comprehensive and interdisciplinary delivery of care.
2. Why	Goals: The primary aim is to improve quality of life. The secondary aims are: 1. More maintenance of functional ability, a decrease in unmet care needs, a decrease in acute hospital admissions; 2. Among the informal caregivers of participating older frail persons: a reduction in perceived care load and a better quality of life; 3. High quality care and efficient care. Rationale: ... by targeting health risks and care needs at an early stage, stimulating active involvement of older adults in the care process, and improving coordination between healthcare professionals ...based on the Chronic Care Model ...based on previous success of integrated care models in improving quality of care and health-related outcomes and benefits for informal caregivers
3. What (materials)	- Web-based Community Health Assessment version 9.1 of the Resident Assessment Instrument (RAI-CHA), including Client Analysis Protocols - Care plan - RAI-output reviews - Minutes of team meetings
4. What (procedures)	For participants: - Multimodal assessment and creation of a care plan, with a focus on multidisciplinary team input and on integrating the participants' preferences - The RAI and linked CAP include recommendations for medication changes as needed - Reviewing assessment and care plan regularly As in usual care: - Access to primary care, including flu vaccination, and arrangements for further care by PCP, including specialized hospital care, in-home care and mental health support - Proactive care for people with specific chronic diseases (e.g., diabetes)
5. Who provided	- Practice nurses that contacted directly with the patient - An expert geriatric team consisting of an experienced geriatric nurse and an elderly care physician that review assessments and care plans, train and supervise staff and arrange care - Other professionals involved as needed, including pharmacist and physiotherapist The nurses also received training and supervision: - Initial training on the assessment instrument and motivational interview techniques - Additional training during delivery on relevant topics - Team meetings for supervision and support - Individual coaching when necessary - Multidisciplinary team reviews for extra support
6. How	- Face-to-face and presumably individually - By telephone

6b. How organised	- Collaboration between practice nurses that contacted directly with participants and PCPs, to develop and make arrangements related with the care plan - The care plan was reviewed and altered with the participant in meeting with practice nurse. - Practice nurse reports complex patients to the geriatric team that reviews situation - Expert teams review multimodal assessment outputs - Exchange between nurses in supervision - The geriatric teams set up and maintain regional networks of local organisations - The nurses delivering the intervention received training on motivational interviewing, and presumably included this in the care plan discussions with the participant
7. Where	- At home - In Amsterdam (urban) and West-Friesland (urbanised rural setting), Netherlands
8. When and how much	- Started following participants were identified by PCPs as frail, based composite definition of frailty (experiencing one or more limitations in either physical, psychological and/or social areas), and having 5 or more drugs prescribed in the last 3 months (polypharmacy criteria) - Started following participants were identified as disability level 3 or higher, based on the Program on Research for Integrating Services for the Maintenance of Autonomy case-finding tool for disability (PRISMA-7) - Multimodal assessment every 6 months for 50 to 90 minutes - Discussion of care plan with patient 2 weeks after first assessment - In selected cases, re-evaluation in 3 months - Multidisciplinary team meetings at least twice in 6 mths
9. Tailoring	- Care plan tailored to needs and to patient's preferences - Extra visit at 3 months when needed - Inclusion of relevant health professionals in case discussion, as needed
10. Modifications	Not mentioned
11. How well (planned)	- One of the features of the RAI assessment used was to help standardize the deliverers' routine and thereby support the fidelity of the intervention - The authors analyzed the level of implementation, namely, the fidelity at the patient, care professional and organizational level - The fidelity analysis was based on Carroll's framework and included the content (active ingredients of the intervention), coverage, frequency and duration of the intervention. Potential moderators of fidelity were also analyzed - The adherence measurements and frequency of each active ingredient of the interventions were defined by the authors. - Qualitative data collection (e.g., semi-structured interviews) were used to identify the facilitators an barriers to the implementation.
12. How well (actual)	- Adherence to the geriatric assessments and care plans was high, but decreased over time. - Adherence to multidisciplinary consultations was initially poor, but increased over time.

	- Individual differences in adherence between practice nurses and primary care physicians were moderate. - Nurses deviated from protocol due to contextual factors and personal work routines. - Throughout the intervention period, geriatric expert team members organised 18 educational sessions, 9 of which featured short seminars by care professionals of regional care organizations aimed at educating practice nurses about available community resources - 20/21 practice nurses completed the 3-day motivational interviewing training program; 17/21 completed the RAI-CHA assessment training. 21/21 said they highly valued the motivational interview training, but did not always consider the RAI-CHA training to be sufficiently educational or useful.

Multifactorial-action and review with self-management

Table 247. Walters 2017[96] HomeHealth

1. Brief name	HomeHealth. A manualised home-based behaviour change multicomponent health promotion service for vulnerable older people delivered by trained non-specialist support workers.
2. Why	Goal: to increase independence, health and well-being in older people who are starting to become frailer through addressing key areas of mobility, nutrition, psychological well-being and social isolation Rationale: - Based on 3 theories focusing on successful ageing and behaviour change, namely, the asset-based approach, Baltes' theory of successful ageing, behavioural science approach using the COM-B model - Based on 4 evidence reviews, qualitative review and contacts with stakeholders and the public.
3. What (materials)	- HomeHealth intervention manual for provider training - "Resource packs (educational information for the service providers, local services to signpost to and resources to hand out to clients, such as leaflets) within key areas (e.g. mobility and nutrition) - Equipment (e.g. weights and resistance bands) to supply to clients when necessary - Forms to be completed with the client: goal-setting, action-planning, making contingency plans"
4. What (procedures)	- Multidomain assessment and care planning focused on mobility, nutrition, psychological well-being and socialising. - The care plan was negotiated with the participant and regularly reviewed and adapted as necessary - The support worker arranges the access to services identified as necessary (e.g., access to ongoing emotional support) - Exercise, education and environmental change (e.g., provision of adaptations such as removal of obstacles in the house) were emphasised. - Behaviour change techniques were emphasized in the intervention delivery, for example by detailing achievable goals in a step-by-step action plan, encouraging self-monitoring or advising on strategies to maintain motivation, among others.

	- Participants had access to usual community health services which included primary care by GP, specialist care (e.g., dental optician), physiotherapy, home care among others.
5. Who provided	- A non-specialist support worker experienced in working with older adults and trained in behaviour change techniques, communication skills, exercise, nutrition and mood. - The training included 4 half-day sessions delivered by experts. - Regular supervision was also provided during the intervention, and expert clinical input was available as necessary.
6. How	- Face-to-face, both individually and with the person and family carer. - Subsequent appointments could also include telephone of skype contacts as appropriate - There was an important emphasis in behavioural change techniques to support the delivery, including for example, goal-setting, reinforcing self-efficacy, and breaking down the tasks in manageable steps.
6b. How organised	- The care plan was decided between the participant and the support worker, in an unidisciplinary approach to care planning - The support worker organized care, liaising with GPs, therapist or other services as needed. - The care planning does not mention or implies medication change (medication data is collected but as part of service use)
7. Where	- At home - In London and Hertfordshire, United Kingdom. This included urban and semi-rural communities with diverse socioeconomic, ethnic backgrounds and access to services.
8. When and how much	- Started when participants were assessed as mildly frail (Rockwood CFS), were 65 years old or over and registered with participating GP surgeries - Participants were expected to receive 6 sessions, with 6 other added, if necessary, over 6 months. The median of sessions received was 5. - The session included “a longer first appointment of approximately 1-2 hours and subsequent appointments of 30-60 minutes”
9. Tailoring	- “The intervention was tailored according to the needs and goals of the participant. The goals set, number and duration of appointments, involvement of others, and BCTs used were tailored through an in-depth baseline assessment and discussion of each client’s issues and progress at each appointment”
10. Modifications	No intervention modifications
11. How well (planned)	- Intervention adherence/fidelity was assessed with mixed methods, including documentation of attendance, content of sessions, goals set and progress towards goals by the service providers and questionnaires and interviews with service recipients. Audio-recorded intervention appointments were assessed against a fidelity checklist by the process evaluation lead - To support intervention fidelity training and support was provided to the support workers - Consultation with key stakeholders took place and supported the practicalities of service delivery and collaborations necessary to deliver the intervention.
12. How well (actual)	- The intervention was largely delivered as intended - 96% of participants identified at least one goal

	- Fidelity to the intervention (including use of BCTs) was 72.1% overall per random audio-recorded appointment assessed. - The overall appointment attendance rate was 126 out of 138 (91.3%). The median number of appointments across the two areas was five (range 1-8 appointments). - As planned, the service covered a range of domains, with goals identified tailored to the individual.

Table 248. Wong 2019[97] Health-social partnership intervention programme

1. Brief name	Health-social partnership intervention programme. Home-based health-social partnership intervention programme, with nurse case management and self-care empowerment
2. Why	Goal: to engage and empower community-dwelling older adults to take action to prevent diseases, maintain and promote health and functioning, and manage chronic illnesses and disabilities by assessing and resolving their health and social problems proactively, building up their self-care confidence and providing referrals to other community health care services. Rationale: - based on a systematic review of health promotion that identified multifaceted strategies and interprofessional care as preferable - a health-social partnership was identified as particularly important to address existing needs - based on the three levels developed in Bronfenbrenner's ecological theory: the microsystem, mesosystem and macrosystem levels - the self-efficacy techniques used were based on Bandura's self-efficacy theory (microsystem) - the assessment used was based on previous research and theory on the Omaha system (mesosystem) - the organization of the intervention in terms of care management and coordination was based on Gittel's relational coordination theory (macrosystem)
3. What (materials)	- Omaha system structured assessment - Booklet about health education - Newspaper clips of celebrities who have similar situations to those of the older adults and who are successfully performing self-care management. - Referrals and information systems - Referral form - Standardized protocols for organization between services
4. What (procedures)	- Multidomain assessment by the nurse including 4 main areas: environmental, psychosocial, physiological and health-related behaviour. - The nurse and the participant co-developed a care plan and the nurse provided health-education - Several self-efficacy techniques were used to promote self-care behaviours, for example, verbal encouragement and incentives. - Following the care plan the nurse provided referrals for relevant services, as needed. - The progress of the participant was followed-up and reviewed regularly by the nurse and the community worker.

	- Access to standard community services on a on-demand basis was still available. These services may include health talks and physical check-ups at a community centre and GP and outpatient services.
5. Who provided	- Nurse case managers, who received specific training on the intervention - Community workers supervised by the nurse for some of the follow-up contacts - The team had regular supervision through regular case conferences
6. How	- Presumably individually and face-to-face, based on home visit format - By telephone - The use of techniques to promote self-efficacy and self-care behavior was emphasized, including, for example, verbal encouragement, exploring past successful experiences of health-related self-care, incentives, etc.
6b. How organised	- The nurse organized care for the participant in co-ordination with other services (e.g., by providing referrals), based on predetermined coordination protocols. However, the nurse did not provide all follow-up contacts, but rather supervised community workers in this task - There were regular case conferences including at least the nurse and the social worker, resulting in modifications to the care plan as needed. - The care planning does not mention or implies medication changes (medication adherence is measured but only as an outcome)
7. Where	- At home - Various districts of Hong Kong
8. When and how much	- Started when participants were enrolled in a district community centre, were 60 years old or more, and not engaged in other structured health or social programs - There were 8 planned contacts, half by the nurse and half by the community worker each one providing 2 home visits and 2 phone calls. The home visits took 30 to 60 minutes, and the phone calls 6 to 12 minutes.
9. Tailoring	The care plan was tailored to the participant's identified needs, based on a structured comprehensive assessment, and co-developed with him/her.
10. Modifications	Not mentioned
11. How well (planned)	Intervention fidelity was promoted by: - Providing training on the intervention to the providers - Recording of home visits and telephone conversations for review and evaluation - Regular case conference meetings
12. How well (actual)	Not mentioned

Multifactorial-action with medication review

Table 249. Balaban 1988[16] Home visit program and usual office-based care

1. Brief name	Home visit program and usual office-based care.
2. Why	Goal: to provide medical care to patients who potentially could benefit from home visits, to improve the function and well-being of the patient and family, and additionally impact psychological status, mortality and health services use. Rationale: seems humane and represents an alternative for decreasing hospitalizations, nursing home placements, and utilization of other services

3. What (materials)	- Social services referrals (not clear if provided to the participant or not provided but part of the delivery)
4. What (procedures)	- Assessment of medical and social needs prioritised the scheduling. - Home visit, presumably involving assessment and care planning. It is likely medicines were reviewed due to the involvement of a programme physician. - Provision of care presumably based on an assessment, including diagnostic and therapeutic medical care, follow-up post hospital discharge, education and counseling and social services referrals. (Unclear if assessment was at home, and what providers were responsible for what parts of the intervention) - As in usual care: access to family physician in office care
5. Who provided	- Intervention program physician - Nurse 2 above mainly, often accompanied by family practice residents, medical and nursing students and other health care providers. - As in usual care: access to usual family physician in office care
6. How	- Home visits, presumably provided face to face and individually - As in usual care: Presumably face to face and individually on usual physician office care
6b. How organised	- Physician and nurse (who may be accompanied by other health professionals), are involved in care provision but it is uncertain who was responsible for care planning - There is no evidence that care was coordinated. - In the context of a large urban family practice in an academic setting
7. Where	- In the context of a large urban family practice in an academic setting - At home - As in usual care: access to a family practice office
8. When and how much	- Started when participants were enrolled in the practice, were experiencing serious mobility impairment, chronic disease, and the contact with the practice was difficult or unlikely. - Variable number of home visits based on needs - All the participants that did not drop out, moved or died received at least one home visit - Throughout the study period participants received 2.0 to 3.8 visits on average
9. Tailoring	- The schedules of home visits were tailored to the needs identified
10. Modifications	There were (non-specified)modifications to the intervention program throughout the evaluation period.
11. How well (planned)	Not mentioned
12. How well (actual)	- All the participants that did not drop out, moved or died received at least one home visit (2.0 to 3.8 visits on average) - 58% of the surviving participants were still receiving home visits at follow up

Table 250. Mann J 2021[59] Older Persons ENablement And Rehabilitation for Complex Health conditions (OPEN ARCH)

1. Brief name	Older Persons ENablement And Rehabilitation for Complex Health conditions (OPEN ARCH). A comprehensive, multidimensional geriatric assessment with care coordination.

2. Why	Goal: to facilitate timely access to the most appropriate care in the community that if provided early, could enable the older person's health to be supported such that they can remain living in the community and not require hospital attendance or admission. Rationale: - Previous research showing better health outcomes when care is provided early in a person's illness - Based on previous studies targeting people at risk and providing a comprehensive assessment and care coordination that showed improvement in hospital admission and length of stay - Based on the Geriatric Evaluation and Management (GEM) model of care - Based on four core values: preventative health care provided closer to home; alignment of specialist and generalist care; care coordination and enablement; and primary care capacity building. - Based on a model that is culturally safe to be applied in indigenous populations
3. What (materials)	Not mentioned
4. What (procedures)	- Providing a standardized comprehensive geriatric assessment looking into medical, psychosocial and functional capabilities. - Providing a care plan including diagnosis, problem identification, goal setting, treatment, rehabilitation support and follow up, discussed in case conference - The recommendations include suggestions for medication optimization - Support to carry out recommendations, in particular to access and coordinated the access to various existing services - The care coordinator may also provide individual advice related with dealing with particular health conditions - Presumably the care coordinator follow- ups with the person as needed, in the course of accessing care - Providing a reassessment and plans to transfer care before the end of the intervention
5. Who provided	- A specialist in geriatric medicine conducted the assessment - Care coordinators (health professionals from background)supported the implementation of the care plan - The GP and above professionals discussed and decided on the care plan
6. How	- Presumably face-to-face and individually, based on consultation or home visiting format
6b. How organised	- creates a direct path from the GP to the geriatrician - the GP remains as the central medical decision-maker, with the care coordinator and geriatrician providing specialist advice to the GP regarding the suggested course of treatment and required supports.- case conferencing at least to establish the initial care plan and the review before the end of the intervention, and information shared in real time - care coordination provided as needed, contacting various existing services - informal and in-service training of the primary care staff was provided (unclear whether this was sporadic or systematic)
7. Where	- In primary care facilities or at home, as more adequate for the participant. - Far North Queensland, Australia, in an area characterized by a higher rate of socioeconomic disadvantage compared with the rest of Queensland

8. When and how much	- Started when participants were 70 years old or older or 50 years old or older if indigenous and had multiple morbidities or a social situation that requires the attention of multiple healthcare providers or facilities as assessed by the GPs. Could also start when participants were younger if they are living with chronic or complex age-related conditions (previously only associated with older persons), such as early-onset dementia or arthritis, or another condition. Participants were not receiving geriatric or coordinated care. - Participants received at least a first assessment, a following contact with the care coordinator. Additional contacts were likely, presumably as needed.
9. Tailoring	- The care provided including specific recommendations, contacts, and care coordination support, was tailored to the participant's needs as assessed in a comprehensive geriatric assessment. - The location of the initial assessment was also tailored to the participant, and could occur at home when preferrable.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Table 251. Newbury 2001[67] Home health assessment reported to the person's nominated GP

1. Brief name	Home health assessment reported to the person's nominated GP.
2. Why	Goal: to find unmet health needs and problems and facilitate their resolution and decrease by notifying the patients nominated GP Rationale: - based on previous research which showed the existence of unmet needs in older people - based on previous shown benefits of health assessments in preventive home visits, in particular those that focus on functional rather than purely bio-medical problems. - based on previous review of evidence which emphasizes the need for a standardized assessment, and trained professionals as deliverers, and shows better results in people who are 75 years-old or more. - the areas of standardized assessment were chosen based on previous studies that showed their relevance (e.g., the incidence of hearing problems in older people), and focus on functional ability.
3. What (materials)	- "Access" database to manage the assessment data - Written report to the participant's GP
4. What (procedures)	- Multidomain assessment by nurses, including areas such as sensorial impairments, nutrition, cognition, ADLs, medicine and compliance. - Analysis of the assessment results by the nurse and GP to identify relevant problems. - The information about the assessment and problems identified was then sent to the participant's GP. - Access to usual health care services, including GP practice. The GP was expected to act on the assessment information sent.

5. Who provided	- Nurses conducted the home visits. These providers were trained on the assessment protocol. - A GP reviewed the results of the assessment and identified problems to be sent to the participant's GP with the assessment results - The participant's GP who provided care as part of usual care was expected to act on the assessment information sent.
6. How	- Presumably face-to-face and individually (home visits)
6b. How organised	- The nurse and GP involved in the intervention identified relevant problems based on the assessment, but the care planning decision making was outsourced to the participant's GP to whom the assessment information was sent. There were no reminders of this information sent to the GP. - The care coordination was limited to sending the assessment results to the GP. - The care planning explicitly mentions medication changes.
7. Where	- At home - Adelaide, urban Australia
8. When and how much	- Started when the participants were 75 years or older and were signed up to a variety of GP practices in which the GP agreed to participate - One 90 minutes home visit.
9. Tailoring	The report generated by the intervention identified the participant specific needs and was intended to influence subsequent tailored action by usual care GP.
10. Modifications	Not mentioned
11. How well (planned)	- A pilot study assured the feasibility and adequacy of the assessment protocol and database to deal with this data. - To ensure consistency, the nurses received training on the assessment protocol by the GP who led this research. - To ensure consistency all the reports were checked by the same researcher GP, before being sent to the participant's GP.
12. How well (actual)	- There was a degree of subjectivity in how the problems were identified based on the assessment. - Participants received the intervention as planned, the assessment was straightforward to implement and the assessment data that informed the intervention was complete - The reporting of problems between participants was consistent. - The mechanism by which the problem was resolved was not always apparent from the assessment, so it's uncertain to what extent the participant's GP took action based on the information sent to them

Table 252. Rockwood 2000[74] Interdisciplinary Mobile Geriatric Assessment Team (MGAT)

1. Brief name	Interdisciplinary Mobile Geriatric Assessment Team (MGAT). Comprehensive geriatric assessment, specialized care and usual care
2. Why	Goal : 1. To respond to multiple medical and social problems, in the common, but constrained, environment of frail older patients without nearby access to specialized care.

	2. To incorporate patient preferences by using goal setting, a process that requires judgment and negotiation Rationale or Theory 1.Poor targeting of patients, lack of control over recommendations, and unresponsive measures all contribute to the lack of success of interventions based on comprehensive geriatric assessment for some outcomes. 2.More recent trials of CGA versus usual care have demonstrated modest benefits 3. Patient-centered tests that incorporate individualized, clinical judgments have been argued to avoid misleading results.
3. What (materials)	- Goal Attainment Scaling (GAS) was used to set the intervention goals - Geriatric nurse assessor's standardized evaluation forms (CGA identifying problems in 10 domains) documented the intervention and contributed to analyze implementation fidelity - Evaluation forms and documentation related to the patient's goals and preferences - Information on patient preferences documented the intervention and contributed to analyze implementation fidelity - Referrals from family physician as part of usual care
4. What (procedures)	For the Participant: 1. Multimodal assessment, planning and arranging which included: - Comprehensive geriatric assessment by nurse; - Discussion of goals with the patient by nurse - Discussion of assessment and goals with 2 independent geriatricians by nurse - Discussion of assessment and previous inputs in a multidisciplinary team conference that finalized the plan. 2. Individualized discipline-specific assessments (not specified, as necessary) 3. Provision of specialized geriatric care (e.g., occupational therapy, physiotherapy, social work, speech pathology, dietitian) as necessary This was in addition to usual care by family physicians. For the staff: - Training for nurses on being a geriatric nurse assessor
5. Who provided	Intervention primarily delivered by the Geriatric nurse assessor. (Usual care from primary care physician). 2 geriatricians supported the care plan formulation Mobile Geriatric Assessment Team (MGAT) included: - 2 Geriatric nurse assessor - 4 Geriatrician - Physiotherapist - Occupational therapist - Social worker - Dietitian - Audiologist - Speech and Language pathologist The team supported care plan formulation and presumably the specialized assessments and interventions. Apart from the Geriatric Nurse Assessor, care from other health professionals depended on the requests for the consultations. Therefore, not all participants in this group will receive care from each of the health professionals.

6. How	- Initial Assessment, goal setting and follow up visits by health professionals took place at the participants home, presumably individually and face-to-face. - As in usual care, the Primary Care Physician was also accessible. When accessed, the care is presumably delivered to the individual and face to face.
6b. How organised	- The nurse was responsible for determining if further consultation was required after the 1st visit - The care plan incorporated the patient's input - The results of the assessment and the patient's input were discussed by the nurse with two geriatricians that provided advice on the care plan independently of each other - The care plan was further discussed in a multidisciplinary team conference - The care planning did not explicitly mention medication change, but the measure of medication at baseline and the geriatric team context suggests medication review would likely be present in the care planning. - Management of clinical problems was carried out in conjunction with the family physician and related health care professionals (occupational therapy, physiotherapy, social work, speech pathology, dietitian) in addition to usual care - Family physicians, patients and caregivers were informed in case of emergency identified by the nurse
7. Where	- Rural Nova Scotia. - Rural family practices in three counties - Initial assessment in the participants' home and follow ups also take place in the participants' home.
8. When and how much	- Initiated following referral based on criteria targeting frailty, defined as a vulnerable state of health, arising from the complex interaction of medical and social problems, resulting in a decreased ability to respond to stress, and associated with a decline in functional performance. Operationally, this consisted of any of the following: concern about community living, recent bereavement, hospitalization, or acute illness; frequent physician contact; multiple medical problems; polypharmacy; adverse drug events; functional impairment or functional decline; and diagnostic uncertainty. - Initial Assessment - one home visit. - Intervention patients received, on average, three interdisciplinary consults (range, 1-6) between baseline and 3-month follow-up.
9. Tailoring	1. The nurse decided if further consultation was required based on individual assessment 2. Goal setting was based on participants' needs and incorporated participants' preferences through a negotiation process. 3.Individual discipline specific assessment and interventions, as well as preventive recommendations, were tailored to participants' needs
10. Modifications	Not mentioned
11. How well (planned)	- The reliability of the goal setting was assessed based two independent assessments by geriatricians - Nurses received training for the geriatric nurse assessor role
12. How well (actual)	GNA-geriatrician inter-rater reliability for the GSS ranged from 0.79 to 0.94 over the four assessments. Correlation coefficients were similar for both GNA assessors in comparison with a blinded geriatrician, for each nurse, and across the intervention and control subjects.

Table 253. Sherman 2016[79] Preventive home visits by district nurses

1. Brief name	Preventive home visits by district nurses.
2. Why	Goal: this intervention aimed to impact self-reported health. The aim of preventive home visits in general is to prevent diseases, delay the onset of impairment and promote health. Rationale: - Previous research reviews have shown favourable effects of preventive home visits on improving functional status, increasing quality of life, reducing hospital admission, reducing the use of health and social services, preventing falls, reducing costs and reducing mortality - Previous research has shown that PHV are particularly effective in people with < 77 years-old. - Based on the nursing process as described by Yura and Walsh (1973), a person-centered model which includes assessment of health, planning, diagnosis of health needs, nursing intervention and evaluation of nursing care
3. What (materials)	- A health dialogue guide, created for this study, was used by the nurses in the home visits. This included, among others, questions about social networks, nutrition, activity and sleep. - Other assessment tools were used in the home visit as needed - Equipment to check blood pressure - Prescriptions for health aid products were provided in selected cases - Documentation of the visits were added in the participant's medical record.
4. What (procedures)	- Multidomain assessment, planning and arranging in a home visit by the district nurse. - The assessment follows a predetermined set of questions that included social network, nutrition, activity, sleep and others, and could be complemented with other assessment tools, blood pressure check, and medication check. - The planning and arranging included the tailored prescription of health aids, and co-ordination of care. - 50% of the participants were followed-up in the health care center and at home. This follow-up could be focused on a variety of areas (checking blood pressure, providing more information...) - The nurse took a person-centered approach - The nurse provided written information about available services and safety at home - Presumably the participant had access to usual health and social care services based on its own initiative and/or with the coordination support of the district nurse. These included: healthcare center, home-help service, activities in the local community and county council facilities.
5. Who provided	- District nurses who are employed by health care centers - The nurses received training regarding the intervention and support throughout - As part of usual care organizational structure, district nurses work on a broad range of activities in a holistic approach, and collaborate with family doctors and other healthcare professionals.
6. How	- The home visit was provided presumably individually and face-to-face. - Previous contacts to schedule the visit were made by the nurse by letter and telephone.

	- In some cases, there were follow-up contacts which were presumably face-to-face, at home or in health care center. - The nurse used a person-centered approach
6b. How organised	- The care planning decision process was unidisciplinary, carried out by the nurse. - The care planning does not explicit mention medication changes, but these can be inferred based on assessment of medication side effects and interactions - In usual care, the district nurse has a leading role and is the manager of a team of registered nurses/support workers delivering care to patients in their homes and works closely with family doctors and others staff in the health care center and local community - The district nurses were employed by the health care centers and these had at least three district nurses - The district nurses fitted the PHVs in their normal work schedules in the health care centers.
7. Where	- At home - Stockholm County Council, comprising 5 geographical areas and both rural and urban communities - In areas supported by health care centers that include at least 3 district nurses
8. When and how much	- Started after selection of 75 years old participants in health care centers willing to participate and which had at least 3 district nurses. The participants initial contact was by post. - One first 60 min session at home for all - Half the participants received a follow up session
9. Tailoring	- The nurses care assessment, care plan, and arrangements were tailored to the participants needs, for example with health aids prescribed only in selected cases - The occurrence of follow-up was also determined with the patient and nurse according to need
10. Modifications	Not mentioned
11. How well (planned)	The intervention providers received training on the intervention and support throughout the its implementation, which presumably supported intervention fidelity.
12. How well (actual)	Not mentioned

Multifactorial-action with medication review and self-management

Table 254. Blom 2016[19] Integrated Systematic Care for Older PEople (ISCOPE)

1. Brief name	Integrated Systematic Care for Older PEople (ISCOPE). A monitoring system to detect the deterioration in somatic, functional, mental or social health followed by the elaboration of a care plan executed by the GP
2. Why	Goals: to (1) detect the deterioration in somatic, functional, mental or social health, (2) lead to more coherent care, (3) restore, maintain or maximise functional independence, or to compensate for loss of autonomy by

	appropriate support (functional approach)and (4) improve personal quality of life Rationale: ...based on the need to address multiple problems with older people in an integrated way ...based on a proactive model of care that screens, prioritizes goals and empowers the patient to pursue them ...based on two main principles: timely detection of problems ad coherent, coordinated care ...based on previous research showing that similar interventions (including a care plan, multidisciplinary consultation and a case manager) are cost-effective, improve quality of life and satisfaction
3. What (materials)	- Inventory of existing health problems - Care plan - Referrals - Electronic Patients Record (ERP) in which were included: (1) screening results used to formulate care planed and (2) forms to register intervention process - List of community resources (to be used by the staff) - Small booklet about how to create a care plan (to be used by the staff)
4. What (procedures)	For the participant: - Multimodal assessment, planning and arranging, by GP or practice nurse. The care plan included, for example, medication review, referral to home care or social work or consultation with other caregivers. - Reviewing and adjusting multidomain care plan only when the participant experienced a trigger event such as hospital or nursing home admission, after a fall, new diagnoses, etc. - The participant could access any other GP services as part of usual care. As part of the implementation: - Creating electronic forms related with the intervention in the system usually used by the PCPs - Staff training - As part of staff training, GPs and nurses were advised on (1) organizing information about resources that could be recommended to participants, and (2) organizing the roles of the staff on the PCP. To support the staff: - Extra training about resources for older people - Possibility to consult regularly with a variety of specialists
5. Who provided	- The GP or the general practice nurse - Other care professionals were involved when needed
6. How	- Presumably face to face in individual (or individual with family) consultation
6b. How organised	- The GP is the key player in providing care for older people, e.g., is in charge of all referrals. - The GP practice was the main center of action and registration of the activities developed - When the care plan was developed by the nurse (rather than the GP), the GP provided supervision - The GP or nurse developing the care plan decided on the involvement of other care professionals - The support of specialist is presumably dependent on the request of the staff ("can be consulted"), rather than a regular supervision.

	- As the care planning was developed by the GP or the nurse and other professionals were consulted only episodically, the care planning was unidisciplinary - The care planning included medication review, presumably leading to changes in medication as needed, based on the GP direct involvement in the care plan actions - The GP was responsible for the execution and evaluation of the care plan and on insuring that those involved were informed, suggesting the GP was working as a care coordinator.
7. Where	- Discussion about the care plan could occur at the GP clinic or at home - GP practices in Leiden, Netherlands - In the context of a system of care in which all community-dwelling persons are registered at a GP - In the context of a system of care in which the GP is a key player in providing care to older people (e.g., responsible for all referrals). - In the context of a system of care that has been promoting an increased awareness of the need to work proactively with older patients
8. When and how much	- After a mail invitation by GP and a standardized screening to identify complex problems (problems in 3 or more domains). - The number and/or duration of sessions is not specified - The GP (or nurse) took around 2-3 months to develop the care plan
9. Tailoring	- The care plan was tailored according to the participant's identified needs and personal preferences. - The involvement of care professionals of different disciplinary backgrounds was tailored according to need.
10. Modifications	Not mentioned
11. How well (planned)	- Focus groups were carried out to identify incentives and barriers to intervention implementation
12. How well (actual)	- In 15% (n = 43) of cases, the GP did not prepare the care plan due to time constraints or other logistic problems. Three GPs did not manage to make any care plan at all. - No data on the fidelity to the intervention after the initial establishment of the care plan is available

Nutrition and exercise

Table 255. Loh 2015[57] MultiComponent Exercise and theRApeutic lifeStyle intervention (CERgAS)

1. Brief name	MultiComponent Exercise and theRApeutic lifeStyle intervention (CERgAS).
2. Why	Goal: to improve physical performance, nutrition status and oral health, and maintain independent living Rationale: - Based on previous research showing that multi-faceted approaches, and multi-component exercise interventions in particular, have been successful in changing behaviour and addressing functional difficulties and other important health related indicators - Based on the importance of nutrition and oral health for health and well being

	- Based on the Health Belief Model which takes a person's confidence to take action (self-efficacy) into account, their perceived susceptibility to a condition, perceived severity of potential sequelae and evaluation of perceived benefits versus barriers. This is a basis to improve engagement and adherence in behavioural change. - The nutrition sessions were based on recommended dietary guidelines
3. What (materials)	- kit containing home exercise pamphlets illustrating simple, self-guided home-based exercise movements and a DVD to use on the rest of the days - booklet on safety precautions, instructions and photographs of home-based exercises - games, quizzes and handouts about nutrition - cash and/or household items reward for active participation in nutrition group sessions - summary sheets including legible and simple tips to encourage healthy eating - presumably written sheets with tips about oral care
4. What (procedures)	- Providing exercise sessions including strength, motor fitness and cardiovascular exercises, designed to increase in difficulty. Recommendations for exercise at home and weekly walks are also provided. - Providing sessions about healthy eating for older adults, including common problems, and recommendations based on dietary guidelines. The sessions include talks and hand-on activities where active participation is emphasized - Providing advice about oral health care - Motivational techniques such as goal setting and peer support (among others) were integrated in the previous components and supported their delivery
5. Who provided	- A qualified fitness instructor and trained exercise leaders provided the exercise sessions - A dietician or nutritionist provided the sessions about nutrition - It is not clear who provided the sessions about oral health care
6. How	- Presumably face-to-face contact in group sessions - By telephone, if participants are absent for two consecutive classes - Motivational techniques such as goal setting were integrated in the sessions and supported their delivery
6b. How organised	Not mentioned
7. Where	- In a poor urban area in Klang Valley, Malaysia - The exercise sessions occurred in a common facility area, presumably in the governmental supported flats the participants were living in
8. When and how much	- Started when people were 60 years or above and residing in a low-cost government subsidized flat, were independently mobile with a walking speed of <1.24 m/s for females and <1.33 m/s for males, willing and able to attend a one-hour session twice weekly for 6 weeks, and not suffering from unstable cardiovascular disease, other uncontrolled chronic conditions, recent fractures and musculoskeletal diseases. - 12 exercise sessions taking 30 min, twice a week for 6 weeks - 6 nutrition sessions taking 30 min - 2 oral care sessions - The trial register mentions bi-weekly calls but in the protocol, it seems like calls only happen when the person does not attend the exercise sessions for 2 consecutive sessions
9. Tailoring	Not mentioned

10. Modifications	Not mentioned
11. How well (planned)	- A process evaluation was planned including the collection of information about attendance, satisfaction, enablers and barriers.
12. How well (actual)	Not mentioned

Table 256. Serra-Prat 2017[77] Nutritional assessment plus physical activity programme

1. Brief name	Nutritional assessment plus physical activity programme. The intervention includes nutritional assessment and consequent interventions accordingly, and a physical activity programme.
2. Why	Goal: Using an intervention in the form of a nutritional and physical activity program to prevent frailty or frailty progression in community-dwelling pre-frail older people. Rationale: - Poor muscle strength is the most prevalent frailty criteria in community-dwelling older people. - Muscle wasting and poor muscle strength seem to be reversible by training programmes to revert pre-frailty or prevention progression to frailty. - There is abundant evidence on the impact of nutrition and physical activity on muscle mass and strength, functionality and physical performance.
3. What (materials)	1. A leaflet illustrated the physical exercises programme. 2. Healthy eating for seniors leaflet. 3. Referral to the nutritional unit for further assessment for the at risk participants.
4. What (procedures)	Multidomain assessment, arranging and planning 1. Screening for malnutrition using the Mini Nutritional Assessment (a multidomain assessment). 2. Physical exercise programme: - An initial training session - aerobic exercise; and exercises for strengthening arms, strengthening legs and balance and coordination to be done at home regularly. 3. Regular phone calls to enhance adherence. Selective nutritional assessment, arranging and planning - People screened as at risk of malnutrition were referred to the local hospital's Nutritional Unit for further assessment, follow-up, and establishment of the dietary recommendations and corrective measures. Available usual care - Provided by the primary care centres.
5. Who provided	Presumably delivered mainly by the Research Nurse. Does not mention who provides the nutritional and exercise components of the intervention.
6. How	1. Presumably the initial training and malnutrition assessment is delivered face to face to the individual. 2. Leaflets about the physical activities and nutritional advice were given. 3. A nurse telephoned the participants regularly to enhance adherence to the intervention.

6b. How organised	Insufficient information to identify all the professionals delivering the intervention, and the arrangement of the whole intervention, but presumably the Research Nurse(s) would involve in most parts of the intervention. Presumably the initial Mini Nutritional Assessment was conducted in the primary care centre. Presumably all participants received the nutritional advice leaflet, and the initial physical training session and illustrated exercises programme leaflet for practising at home. Care planning for the selective nutritional intervention: presumably the referral was made unidisciplinarily by the professional who conducted the initial nutritional assessment.
7. Where	Location: Barcelona, Spain Settings: - 3 primary care centers; and - local hospital if nutritional intervention is required.
8. When and how much	When started: - Event - consulting in primary care; and - Status - 70 years or over, screened as pre-frail. 1. Physical exercise programme - 1 initial training session was held in the primary care centre. - Then participants followed the illustrated physical exercises leaflet to practise at home at the recommended frequency. 2. Nutritional assessment and intervention - Presumably the participants were initially screened by the primary care centre. - If screened as at risk, then referred for further assessment and follow-up, presumably the number of these sessions varied.
9. Tailoring	According to the initial nutritional assessment, people at risk were referred to further assessment and dietary recommendations.
10. Modifications	Not mentioned
11. How well (planned)	To enhance adherence, a nurse monitored compliance by regular telephone contact with the patients.
12. How well (actual)	Of the 61 patients assigned to the intervention group and followed up for 12 months, 29 (47.5%) were considered to have adhered well to the study intervention.

Table 257. van Dongen 2020[88] ProMuscle, combining resistance exercise and protein supplementation

1. Brief name	ProMuscle, combining resistance exercise and protein supplementation. Included an intensive support intervention implemented by physiotherapists and dietitians, and a subsequent voluntary moderate support intervention.
2. Why	Rationale: - Metabolic changes, physical inactivity, and insufficient dietary intake are causal factors in the development of sarcopenia. - Progressive resistance exercise and increased protein intake enhances physical functioning, quality of life, muscle strength and lean body mass in frail elderly, and reduces healthcare costs/utilization. Goals:

	- to improve dietary and exercise behaviour (intermediate outcomes), leading to long-term outcomes effects in physical functioning and muscle strength. - to prevent or postpone loss of independence, and to contribute to quality of life.
3. What (materials)	1. Provided to healthcare professionals (HCPs): - researchers provide a 1 h general information meeting, a more detailed 1.5 h training session - detailed implementation manuals to the HCPs before the intervention starts - implementation manual to the exercise trainers for the moderate support intervention. 2. Provided/ used to participants: - 3-day food diary - recommended mainly dairy-based protein-rich products for 12 weeks, and checklist of consumption - bi-monthly newsletter via e-mail - an information leaflet that includes information on available moderate support intervention activities, and exercises and dietary suggestions
4. What (procedures)	1. 12-week intensive support intervention period (weeks 1-12) - The intervention comprises supervised and tailored resistance exercise training with a focus on the leg muscles - a tailored dietary intervention focused on increasing protein intake. Recommended dairy-based protein-rich products provided for free. 2. 12-week moderate support intervention period (weeks 13-24), optional to participants. - Similar exercise group sessions - Nutrition workshops 3. All sessions free of charge to participants. 4. Training and support for healthcare professionals (HCPs): - contact HCPs in another intervention location to share information - Halfway of programme: joint peer discussion, and evaluation - municipal health service provided instructions and implementation manual to the exercise trainers for the moderate support intervention. - research team functioned as helpdesk. Available usual care: 1. healthcare professionals from 4 regional care organisations (Zorggroep Apeldoorn, Viattence, Zorggroep Noordwest-Veluwe, and Opella). 2. general practitioner (GP)
5. Who provided	1. Physiotherapists 2. Dietitians 3. Care sport connectors (brokers whose role is to connect the primary care and the sports sector) 4. Health promotion employee of the municipal health service
6. How	Face-to-face meeting: 1. Exercise training: about 6 (4-7) participants 2. Dietary intake evaluation: one-to-one 3. Nutrition workshops: group meeting Phone consultation: 1. Additional dietary consultation when necessary
6b. How organised	The intensive intervention was run by the "community health service in collaboration with the selected municipalities and local organisations, such as a

	sports-promoting agency or prevention centre." The follow-on moderate intensity group exercise sessions were run by "local sports clubs, gyms, or in collaboration with care sport connectors (brokers whose role is to connect the primary care and the sports sector)." under instruction and financed by the municipal health service. The nutritional "workshops are implemented by a health promotion employee of the municipal health service, in collaboration with a dietitian."
7. Where	Country: The Netherlands Infrastructure: 1. healthcare professionals from four regional care organisations (Zorggroep Apeldoorn, Viattence, Zorggroep Noordwest-Veluwe, and Opella). 2. community health service, collaborating with the selected municipalities and local organisations, e.g. sports-promoting agency or prevention centre. 3. Exercise sessions locations: local sports clubs, gyms, or in collaboration with care sport connectors (brokers whose role is to connect the primary care and the sports sector) 4. Equipment for exercise sessions: leg press, leg extension, lat pulldown, vertical row, and chest press (Technogym BV, Rotterdam, The Netherlands) 5. Nutrition workshops location: local center.
8. When and how much	1. Intensive support intervention started following response to public invitation, presentation and screening: - 24 sessions progressive resistance exercise training (twice a week for 12 weeks, 1 hour long) - 1 individual 15-min dietary evaluation consultation at 6-week, to aim at least 25 g at each main meal 2. Moderate support intervention started after the intensive intervention. - Group exercise sessions (twice a week, 1 hour) - 5 nutrition workshops (1.5 hours)
9. Tailoring	1. Physiotherapists tailored individual resistance-exercise programmes, based on baseline maximum strength test on leg press an extension machine. 2. Dietitians tailored dietary advice, discussed regular dietary habits and preferences, adjusted if needed. 3. Participants could choose what and whether to attend activities offered in moderate support intervention.
10. Modifications	Not mentioned.
11. How well (planned)	1. Attendance of dietitian consultation and resistance exercise trainings, and training intensity - assessed through attendance lists and registration forms. 2. Dietary protein intake - assessed through 3-day food records - Trained research dietitians checked the records during a home visit at baseline, and through telephone at 12-week and 24-week - macronutrient and energy intakes were calculated
12. How well (actual)	1. Number of participants (%) attended intensive support intervention: - Training exercise sessions average = 83.6% - Dietary intake consultations = 98.8% - Dietary evaluation consultations = 91.5% 2. moderate support intervention:

	- training sessions = 56.1% of participants attended, average 63.6% of all sessions - nutrition course = 59.8% of participants attended, average 76.8% of all meetings 3. Protein intake changes (target 25g/meal) (baseline/ 12-week/ 24-week): Breakfast= 14.7g/ 25.4 g/ 21.9 g Lunch = 21.5g/ 31.1g/ 27.0g

Psychology

Table 258. Jing 2018[102] Cognitive-behavioral therapy (CBT)

1. Brief name	Cognitive-behavioral therapy (CBT). Short-term psycho-social approach.
2. Why	Goal: To improve physical and psychological health in the elderly housebound. Rationale: Based on previously shown success of CBT in promoting individual change in thought and behavior for a variety of psychological and physical problems, including in housebound individuals.
3. What (materials)	Not mentioned
4. What (procedures)	For participants: - CBT including focus on individual initiative to deal with owns psychological problems - Continued practice of CBT supported by encouragement calls For staff: initial intervention training
5. Who provided	Faculty members and graduate nursing students that received intervention training
6. How	Individually through home visits and telephone calls
6b. How organised	No details of organisational system.
7. Where	- In Tangshan, China - At home
8. When and how much	- Initiated when participants were housebound (left the house once per week or fewer over a period of at least 6 months) via individual invitation. - 1 weekly call in the 1st month - 1 to 1.5 hours visits every 15 days in the 1st 3 months, and monthly from 3 to 6 months.
9. Tailoring	The cognitive behavioral therapy provided tailoring by focusing on individual psychological problems.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	Not mentioned

Risk-screening

Table 259. Bleijenberg 2016[18] Utrecht Periodic Risk Identification and Monitoring system (U-PRIM) using routine healthcare data

1. Brief name	Utrecht Periodic Risk Identification and Monitoring system (U-PRIM) using routine healthcare data.
2. Why	Goal: to enhance the care of frail older patients in general practice and preserve their daily functioning Rationale: - The frailty screening intervention is based on recommendations in the literature - Based on a panel management approach - The choice of the criteria is based on frailty, disability and morbidity literature, health professionals' opinion and small pilot studies
3. What (materials)	- Electronic monitoring system and Electronic Medical Records data - Report based on the previous including a "frailty index" - Current usual care standards and guidelines were presumably used by the GP to act on the report
4. What (procedures)	- Regular risk screening based on electronic medical records results in a report that is sent to the GP and expected to be used to support care planning and arranging based on current guidelines - Access to usual care based on participant's own initiative including primary care consultations, at home and by telephone.
5. Who provided	- A staff member who received guidance on the electronic system, generated the risk report - The GP was expected to act on the report following usual care protocols
6. How	Not mentioned
6b. How organised	The GP was advised to act upon the reports according to the current standards and guidelines.
7. Where	- Utrecht, in the Netherlands
8. When and how much	- Started after participants were assessed based on electronic medical records as having: 1. Multimorbidity (defined as a moderate-to-high frailty index score, which is a reflection of the proportion of health deficits present.), AND / OR; 2. Polypharmacy (defined as the actual chronic use of 4 or more different medications), AND / OR; 3. A care gap in primary care of > 3 years except for the yearly influenza vaccination. Participants were enrolled in GP practices and were 60 years old or older - The electronic report is produced and sent to the GP every 3 months
9. Tailoring	Not mentioned.
10. Modifications	Not mentioned
11. How well (planned)	The risk assessment report sent to the GPs was produced by a staff member who received guidance, supporting the fidelity of the intervention. Manuals, ICT assistance and proactive contact were also provided - this was intended to support the correct use of the report system and to promote collaboration of intervention providers
12. How well (actual)	Not mentioned

Table 260. Bleijenberg 2016[18] Utrecht Periodic Risk Identification and Monitoring system (U-PRIM) using routine healthcare data plus U-CARE Nurse-led multidisciplinary intervention program

1. Brief name	Utrecht Periodic Risk Identification and Monitoring system (U-PRIM) using routine healthcare data plus U-CARE Nurse-led multidisciplinary intervention program.
2. Why	Goal: to enhance the care of frail older patients in general practice and preserve their daily functioning, their physical functioning and enhance their quality of life. Rationale: - The frailty screening intervention is based on recommendations in the literature - The choice of the criteria is based on the frailty, disability and morbidity literature, health professionals' opinion and small pilot studies - Based on previous reviews that show positive effects of complex interventions in particular for a multidisciplinary, multifactorial approach with tailor-made interventions - The multidomain care planning and arranging and possible interventions planned for a selected group of participants was based: 1. on the chronic care model, emphasizing improved clinical information system, decision and self-management support and better access to community resources, 2. a structured approach that included, a literature review, guidelines review, assessment of the face validity by registered practice nurses, and compilation of expert opinions
3. What (materials)	- Electronic monitoring system and Electronic Medical Records data - Report based on the previous including a "frailty index" - Current usual care standards and guidelines were presumably used by the GP to act on the report - Groningen Frailty Indicator questionnaire (GFI), the INTERMED for the Elderly (IM-E), and the Groningen Wellbeing Indicator (GWI) - For a selected group of participants further assessment instruments were used
4. What (procedures)	- Regular risk screening based on electronic medical records results in a report that is sent to the GP and expected to be used to support care planning and arranging based on current guidelines - Further screening of risk status focused on frailty. Groningen Frailty Indicator of 4 or less receive additional care. [- For a selected group of participants (GFI 4 or higher, 62.9% of the participants) a nurse performs a multidomain assessment at home, discusses care planning with GP and other relevant professionals, implements care as needed in a variety of areas and coordinates care.] - Access to usual care based on participant's own initiative including primary care consultations, at home and by telephone.
5. Who provided	- A staff member who received guidance on the electronic system, generated the risk report - The GP was expected to act on the report following usual care protocols - A nurse presumably interpreted the results of the Groningen Frailty Indicator questionnaire (GFI), the INTERMED for the Elderly (IM-E), and the Groningen Wellbeing Indicator (GWI), for which training and supervision were provided.

	- For a selective group of participants, a multidomain assessment and tailored interventions were provided by trained and supervised nurses and GPs.
6. How	- The assessment of risk based on the GFI, INTERMED and GWI, was performed at a distance, by post (the participants returned the questionnaire to the GP practice) [- A selected group of participants received care presumably individually and face-to-face, at home]
6b. How organised	- The GP was advised to act upon the reports according to the current standards and guidelines. - For a selected group of participants, a nurse, the GP and other health professionals as necessary, collaborated to develop a individualized care plan. The nurse coordinated follow-up care.
7. Where	- Utrecht, in the Netherlands - A selected group of participants received a multidomain assessment by a nurse at home
8. When and how much	- Started after participants were assessed based on electronic medical records as having: 1. Multimorbidity (defined as a moderate-to-high frailty index score, which is a reflection of the proportion of health deficits present.), AND / OR; 2. Polypharmacy (defined as the actual chronic use of 4 or more different medications), AND / OR; 3. A care gap in primary care of > 3 years except for the yearly influenza vaccination. Participants were enrolled in GP practices and were 60 years old or older - The electronic report is produced and sent to the GP every 3 months - A selected group of participants received at least one visit at home and further follow up visits as needed
9. Tailoring	- The care provided depends on the level of frailty of the participants. - Additional tailoring is received by selected frail participants (less than 75%) who are offered additional multidomain assessment, and individualized recommendations and visits.
10. Modifications	Not mentioned
11. How well (planned)	Intervention fidelity was promoted and/or analyzed by 1. Providing training and regular supervision to intervention providers. 2. The risk assessment report sent to the GPs was produced by a staff member who received guidance, supporting the fidelity of the intervention. Manuals, ICT assistance and proactive contact were also provided - this was intended to support the correct use of the report system and to promote collaboration of intervention providers 3. Registering possible barriers (and facilitators) and type and dose of nursing care [applies ONLY for selected group of participants that were considered frail] 4. Conducting a pilot study of 6-weeks in which barriers, strengths, limitations and time invested was measured in a daily diary and feasibility in clinical practice was confirmed [applies ONLY for selected group of participants that were considered frail]
12. How well (actual)	- The intervention was perceived by the staff as feasible. - For the selected group of participants identified as frail only one-third of the older people who reported to have (some) problems at one or more conditions (e.g., cognition or nutrition) did receive further diagnostic assessment, suggesting the program was suboptimally implemented.

Table 261. Carpenter 1990[24] Dependency surveillance

1. Brief name	Dependency surveillance. Surveillance using a questionnaire administered by volunteers
2. Why	Goal: to maintain health of the elderly at home Rationale: - by identifying problems and initiating action for this group.
3. What (materials)	- Materials involved in the training session for the volunteers going over the project aims and principles. They were also introduced to the questionnaire - Winchester disability rating scale - Referrals and records of those referrals - Aids such as bed, bath seats, toilet aids, wheelchairs & others
4. What (procedures)	Non-professional volunteers regularly visited old people at home and completed the Winchester disability rating scale with the older person. Participants scoring an increase of >5 on the Winchester disability rating scale were referred to their GP. Winchester disability rating scale, developed for the project questionnaire, consisting of 18 items covering reported but NOT OBSERVED activities of daily living, including items on, for example, carers, home conditions, and companionship. Participants who have specific requests for aids were referred to the relevant agency via the general practice. This presumably applies to only a selected group of participants that put forward specific requests.
5. Who provided	- Non-professional volunteers recruited through mother and toddler groups and church groups.
6. How	- Presumably individually and face-to-face, based on home visiting format
6b. How organised	- Volunteers were recruited through mother and toddler groups and church groups. - Referrals for aids and GP were provided
7. Where	- The participant population came from Andover town, including the housing estates. Village areas were excluded. - At home
8. When and how much	Started when the participants were 75 years old or older and were enrolled in a GP practice. The participant population came from Andover town, including the housing estates. Village areas were excluded Participants were visited at the start of the project and then revisited at regular intervals. Namely, participants with no disability were visited every six months and participants with some disability or severe disability were visited every 3 months, for 3 years.
9. Tailoring	The regularity of the visits was tailored based on the level of disability. For those with no disability volunteers visited every six months and for those with some disability or severe disability every three months.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned
12. How well (actual)	- The rate of provision to the study group began to exceed that of the control group by the ninth month of the project and continued to exceed it for the

	following year. During the final year referral rates for aids and services were higher for the control group.

Table 262. Jitapunkul 1998[50] Regular surveillance with a simple questionnaire and then referral to Health Care Professional

1. Brief name	Regular surveillance with a simple questionnaire and then referral to Health Care Professional.
2. Why	The ideal goal of maintaining elderly people within the community highlights the need for a surveillance to identify high risk elderly and to offer successful intervention. A limited number of studies in Western countries have been conducted and showed some benefits in having a surveillance programme. Goal: to maintain elderly people in the community Rationale: based on previously shown benefits of surveillance programmes
3. What (materials)	- Screening questionnaire including Barthel ADL Index, Chula ADL Index and fall-surveillance questions - Referrals to health and social services - Prescription to aids and/or drugs
4. What (procedures)	Functional assessment, every three months in their own home, by non-professional personnel. The cases and/or their care-givers were interviewed using a short questionnaire* designed for the home visiting programme. The elderly who had problems according to the criteria were visited and assessed by nurses and/or a geriatrician. Following assessment, appropriate actions were taken including education, prescribing drugs and/ or aids, providing a rehabilitation programme, referring to nearby health centre or hospital, and contacting with or referral to a social service organisation including governmental and non-governmental organisations. The selected cases were visited by professional staff until their problems were solved or their health status was stable. As in usual care, comprehensive community care was accessible including community rehabilitation, home health care, education programme and social care.
5. Who provided	non-professional personnel conducted the quarterly interviews. the home-visit personnel had to report to nurses or a geriatrician who were working in the comprehensive community care services (CES project). Then nurses and/or a geriatrician went to visit these selected elderly people.
6. How	Over three years the cases were visited every three months, in their own home, by non-professional personnel. the home-visit personnel had to report to nurses or a geriatrician who were working in the comprehensive community care services (CES project). Then nurses and/or a geriatrician went to visit these selected elderly people. Individual face to face
6b. How organised	The non-professional personnel reported the results of their visits to participants to nurse and/or geriatrician that then took action - The care planning explicitly mentions medication changes but only for the selected participants that were referred for multidomain assessment
7. Where	Thai elderly in Klong Toey slum Living in a poor urban area At home

8. When and how much	Additional visits by medical professionals were provided as needed
9. Tailoring	- The visits with professional staff were tailored based on the assessment of functional needs - Intervention was tailored based on nurse and/or geriatrician assessment
10. Modifications	not mentioned
11. How well (planned)	not mentioned
12. How well (actual)	not mentioned

Table 263. Kerse 2014[51] Brief Risk Identification Geriatric Health Tool (BRIGHT)

1. Brief name	Brief Risk Identification Geriatric Health Tool (BRIGHT). A proactive case finding strategy with usual care, including primary care and access to other medical and community services
2. Why	Goal: to identify those at risk of decline or with unmet need in order to improve quality of life and reduce disability, hospitalisation and residential care placement for older people Rationale: ...based on previous evidence showing that intense geriatric assessment and management are effective in increasing disability-free life in community settings
3. What (materials)	- Brief Risk Identification Geriatric Health Tool (BRIGHT) tool, including 11 questions about health and ADL - Referral by the practice nurse to regional publicly funded geriatrics assessment and rehabilitation services - Establishing memoranda of understanding and subcontracts with District Health Boards to facilitate provision of usual care services As part of usual care: - Access to referrals from primary care to geriatrics community team
4. What (procedures)	- Risk assessment that triggered referrals for available usual care service (when BRIGHT tool score was 3 or higher). Triggered referrals were to a geriatric specialist multidisciplinary team that provided a comprehensive assessment and coordination of support/rehabilitation services For staff: - Training in the primary care practices At the organization level: - Establishing signed contracts with District Health Boards to facilitate delivery of usual care As in usual care: - Access to primary care who may also refer to the geriatrics team.
5. Who provided	- GP contacted participants to functional assessment - A practice nurse processed the screening tool results and provided referrals when necessary - Usual care services included access to the GP and to other primary care practice professionals, and a multidisciplinary team including a physiotherapist, occupational therapist, gerontology nurse, geriatrician, and social worker

6. How	- Assessment tool provided by post - Presumably face-to-face and individually for available usual primary care and multidisciplinary geriatric team contacts (e.g., comprehensive assessment)
6b. How organised	- There is no evidence that any care planning following the usual care CGA or BRIGHT tool screening is multidisciplinary - There is no evidence that coordination of care is being provided for all - Practices were provided funding for 1 day per month of a practice nurse's salary to complete the BRIGHT recall process, and regional geriatrics services were bulk funded to provide additional assessment services to trial participants. - Research team and participating District Health Boards collaborated to facilitate the provision of usual care to participants - In usual care, the multidisciplinary team coordinated care for selected participants and gave feedback to primary care (that holds responsibility for participants' care) - Usual care, including primary care and community geriatric and support services, is publicly funded. Aging-related residential care is available after standardized assessment and is publicly subsidized on a means-tested basis.
7. Where	- In New Zealand - In 60 primary care practices in three District Health Board regions that were routinely using CGA to identify needs of older people. - In a publicly funded system of care in which primary care reaches 98% of older adults and a variety of geriatric services (entry to these not systematized).
8. When and how much	- Participants were enrolled in general practices that accepted to participate and were routinely using CGA to identify participant needs. Participants were 75 years old, or 65 years old if Maori, and were recruited though an invitation letter sent by the GP - The BRIGHT toll screening is repeated annually for 3 years
9. Tailoring	- The provision of referrals for usual care services was tailored based on the functional assessment - As in usual care, further access to geriatric services was presumably tailored by needs identified in primary care
10. Modifications	During the trial, all regional geriatric services were reformed to some degree, causing some disruption to the timing of patient assessment.
11. How well (planned)	Not mentioned
12. How well (actual)	The majority (88%) of the intervention group received, completed, and returned the BRIGHT tool to practices

Table 264. Pathy 1992[70] Case finding and surveillance at home

1. Brief name	Case finding and surveillance at home.
2. Why	Goal: to identify unreported problems and needs [and presumably improve care and health related outcomes] Rationale: - Older people have unreported problems and needs that may benefit from identification and management - Focusing on at-risk group based on a screening process should be more resource effective

	- A focus on functional impairment screening should be particularly relevant to uncover unreported symptoms and signs
3. What (materials)	- A postal questionnaire which served as a screening tool and a stamped addressed envelope were sent to the participant - Referrals to GP and/or community services
4. What (procedures)	- A screening questionnaire involving several domains (health, medication, independence, social activities, etc.) was sent by post and returned by the participants - The screening questionnaire was analyzed by a nurse which identified if further care was needed - Participants for which further care was needed (presumably based ion the nurse clinical judgement) received home visits by the nurse. - The visits presumably provided further clinical assessment, and resulted in care planning in the form of recommendations selected according to participant's need, such as health advice and referrals. - The screening was presumably repeated every year - Access to usual care services based on own initiative was presumably available
5. Who provided	- Provided by a health visitor nurse. The nurses worked part time specifically for this project and did not participate in the care of other patients from the GP practice.
6. How	- Participants were contacted first at a distance by post and if needed, visited at home. - At home, delivery was presumably individual or with a family/friend cohabiting (households were randomized together), and face-to-face.
6b. How organised	- The care planning for participants identified as in need by the screening questionnaire was presumably unidisciplinary, carried out by the health visitor nurse - The health visitor nurse was integrated in the GP practice but solely dedicated to working with these participants - Medication change was probably a possible result of the intervention, which took into account medication in the screening and happened in the context of a GP practice and possible involvement of the GPs. - The GP practices where the intervention took place had never had screening and regular home visiting procedures
7. Where	- At home - Central Cardiff, South Wales
8. When and how much	- Participants were 65 years old or older and were registered in a GP practice. Participants had not received screening or regular home visits before. - The project run for 3 years, the screening was presumably taking place every year - Home visit schedule and frequency was presumably dependent on need.
9. Tailoring	- The provision of home care visits and further assessment and care planning by the nurse was tailored based on the screening. The care provided at home for selected participants was presumably also tailored.
10. Modifications	Not mentioned
11. How well (planned)	Not mentioned

12. How well (actual)	40% of the participants were found as not in need in the screening and were not visited

Telecoms

Table 265. Arthanat 2019[15] Individualized Community and Home-Based Access to Technology Training (i-CHATT)

1. Brief name	Individualized Community and Home-Based Access to Technology Training (i-CHATT). A novel home-based individualized inter-generational information communication technology (ICT) training program.
2. Why	Goal: 1. to promote self-efficacy with ICT learning 2. increased ICT range and frequency of ICT activities use as measured by the range of ICT activities 3. positivity toward ICT, and better perceived independence in activities involving ICT. Rationale: 1. facilitating self-efficacy and confidence in use of ICT required streamlined content, clear instructions, and personalized sessions tailored to older adults' abilities and preferences.
3. What (materials)	Coaches: 1. training as part of a service learning project for the university OT students' assistive technology course. 2. compiled notes on their visit to debrief with the researchers, and plan next visit. Participants: 1. ICT priority checklist used to assess each participant's need and skills. 2. A loaned Apple iPad to for the 2-year follow-up period.
4. What (procedures)	An orientation session: 1. participants given information about the training, and introduced to their personal coaches prior to the home visits. 2. A lab session on Windows and IOS accessibility, and ICT applications for aging. 3. Participants' ICT experience, needs, and priorities of using ICT were assessed. Home-based training: 1. Goal setting: short-term goals and long-term goals on using ICT. 2. Between meetings, the coaches discussed with researchers and planned for next visit. 3. A community Facebook© group to encourage participants to share updates and experiences of using ICT applications. 4. During the visits, coaches reviewed participant's progress, provided and motivation to advance and sustain ICT activities. 5. No formal training after 3rd visit, but participants could obtain further support from coaches if requested. 6. Usual care in community: community-based training programs, mostly workshop format
5. Who provided	1. Coaches are undergraduate senior students in the occupational therapy program, in New Hampshire

	2. Two coaches per participant for the entire intervention period.
6. How	1. Home-based training visits 2. Community Facebook© group 3. Before the second visit, participants updated coaches with progress via phone and email. 4. Coaches on call to troubleshoot problems
6b. How organised	Trainers were assigned to individuals. Trainers were supervised by researchers.
7. Where	1. Training took place at participant's home 2. Country: USA 3. Infrastructure: - Increasing amount of essential services, public and private become digital. - Internet adoption among those above 75 years of age is low at 34% with only 21% having access to broadband Internet (Pew Research Center, 2017) - shortfall in the availability of skills training programmes to assist older users, particularly in rural areas
8. When and how much	When started: following response to a public invitation and screening. Once 15 participants were randomized for each of 3 cohorts. Number of sessions: 9 Duration of each session: 90 minutes to 2 hours. Schedule: 3 sessions per months for 3 months. After end of 3-month training, participant could receive optional further support.
9. Tailoring	1. Individualized approach and the content, driven by participant's needs, context, and comfort level. 2. Coaches set goals with participants in discussion. 3. Optional further support available if required.
10. Modifications	Not mentioned.
11. How well (planned)	Not mentioned.
12. How well (actual)	Not mentioned.

Welfare-advice

Table 266. Howel 2019[48] Domiciliary welfare rights advice and active assistance

1. Brief name	Domiciliary welfare rights advice and active assistance.
2. Why	Goals: - to support users to make successful benefit claims, hence increasing their income and access to material resources. - to maximise welfare benefit uptake among independent living older people in order to test the hypothesis that access to additional resources might improve health outcomes and well being Rationale: - Previous research shows there is a strong positive and progressive relationship between access to financial and material resources and health outcomes. Such social welfare benefits are hypothesised to improve health-related quality of life, mediated by reduced stress, the adoption of more advantageous social arrangements and healthier behaviours. These changes in

	turn are hypothesised to enable greater choice and control over life circumstances, leading to healthier choices and greater independence. - Historically in the UK, there has been substantial under-claiming of such financial and non-financial social welfare benefits among those with low incomes and poor health - In a pilot study that supported the present intervention, 58% of the participants were awarded previously unclaimed benefits. - A systematic review on the effects of welfare rights advice services identified studies that demonstrate the financial and material benefits of those services.
3. What (materials)	- Intervention procedure checklists were used by the providers to promote intervention fidelity - Audio-recordings of some sessions were collected and used to analyze intervention fidelity
4. What (procedures)	- Welfare rights advice consultations, including (1) a full benefit entitlement assessment, (2) discussion of current entitlement and options for action, including new claims, (3) active assistance with benefit claims, (4) follow up and management of claims until these are resolved. - Access to usual health and social care services (including benefits) at least some of which facilitated by the welfare rights advisor, as mentioned above. The usual health and social care services include, for example, meals at home, or provision of aids and adaptations.
5. Who provided	- Welfare rights advisors, who were employed by a local authority, Citizens' Advice Bureaux (CAB) or freelancers - The WRAs received training (half-day workshop) on intervention-related topics
6. How	- Mostly face-to-face and individually - Telephone was used to follow-up contacts were appropriate
6b. How organised	- The intervention was funded by welfare rights advice services in the 10 participating local authority areas in the North East and by a contingency fund of ≈£28,000 which was secured from the North East Strategic Health Authority in 2012. - In the majority of sites, the intervention was provided by local authorities. In other cases, freelance Welfare right advisors and paid staff from the Citizens Advice Bureau provided the intervention.
7. Where	- At home - North East of England - In areas with poor health outcomes and high levels of socioeconomic disadvantage - In urban, rural a semirural areas with no previous access to welfare rights advice services targeted to primary care patients
8. When and how much	- Started following recruitment from primary care in socioeconomically disadvantaged areas (based on deprivation score) without a targeted welfare rights advice service delivered to primary care patients. The participants received an invitation letter from their GP - if not interested to be involved they were asked to opt out. - The home-visits include one or more sessions and follow-up meetings or phone calls as necessary until recommendations' completion - The visits lasted 1-3 hours.
9. Tailoring	The recommendations suggested by the welfare advisor, and the number and duration of contacts were tailored to the participant's needs and preference.

10. Modifications	Due to cuts to local government funding during the study, it was not possible for delivery of the intervention to every participant by a welfare rights advisor from their nearest local government department. In these circumstances, a qualified and trained welfare rights advisor was allocated to every client from an alternative, nearby local government department.
11. How well (planned)	- Intervention fidelity was supported by: checklist used by providers and training. An analysis of fidelity was also planned, with collection of session's audio recordings and information about the timing and completion of the participants' case - Information was provided to GPs in primary care practices involved in recruitment - A qualitative study was planned to explore aspects related with implementation such as the acceptability of the intervention to participants and stakeholders
12. How well (actual)	- Intervention was received as intended by 335 (88%), with 84 (22%) identified as eligible for additional benefits and awarded additional benefit entitlements - Number of intervention arm participants seen as intended within 2 weeks by their allocated welfare rights advisor was 5 (1.5%) and within 4 weeks 37 (11%). Median number of days from study entry to first welfare rights advisor visit was 58 days (IQR: 40-89), range 0-403 days. - The analysis of 7 recordings of initial sessions showed these were carried out systematically, were consistent with the protocol for intervention delivery and included appropriate assessment of financial and health status, and all relevant applications for eligible means and non-means tested awards and benefits.

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