Supplemental Table 1. Description of person-centered integrated care interventions

Level	Interventions
Clinical level: Interventions aimed coordinating care at the individual patient level.	**Self-management support**: A portfolio of techniques and tools to help patients to acquire the skills and knowledge to manage their own illness. It includes: 1) health education and/ or treatment; 2) behavioral and motivation support, and 3) active patient involvement or participation in the care process(1-4). **Case management:** Allocation of coordination tasks to an appointed individual (a case manager) or a small team who may or may not be responsible for the direct provision of care. The case manager (or team) takes responsibility for guiding individual patients through the complex care process in the most efficient, effective, and acceptable way, using phone, mailings or visits (3). **Integrated care pathway** (also defined as clinical follow-up or clinical pathway): Structured multidisciplinary care plans which detail essential steps in the care of individual patients with a specific clinical problem and describe the patient's expected clinical course (3,5).
Professional level: Interventions aimed at coordinating care among different healthcare providers.	**Multidisciplinary care team** (also defined as interdisciplinary teams or clinics)**:** A group of professionals who communicate with each other regularly about the care of a defined group of patients and participate in that care. It includes: 1) participation of professional caregivers from different disciplines, 2) revision of professional roles, and 3) regular team meetings (3,6). **Continuity of care:** The degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context. It includes (1) Informational continuity: The use of information on past events and personal circumstances to make current care appropriate for each individual. (2) Management continuity: A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs. (3) Relational continuity: An ongoing therapeutic relationship between a patient and one or more providers(7,8).
Organizational level: Interventions aimed at coordinating care among different organisational units.	**Disease management**: A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. It includes: 1) population identification process, 2) evidence-based practice guidelines, 3) collaborative practice model, 4) self-management education for patients, 5) process and outcomes measurement, 6) routine reporting, feedback loops and benchmarking(9,10). **Managed care programs** (also defined as integrated delivery system): Health insurance plans intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases. The programs may be provided in a variety of organizational settings, such as health maintenance organizations (HMO's), preferred provider organizations (PPOs), integrated delivery system (IDS) or accountable care organizations (ACOs)(11,12).

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