Additional file 3. Characteristics of included studies

No.	Title and year of publication	Authors, country and study period	Study design	Condition assessed/ Practice setting	Form of collaborative practice	Professionals involved/ Mode of delivery	Program name/ Intervention	Sample size (IG/CG)*	Sample characteristics	Main results	JBI
1	A multidisciplinary approach to weight management and reproductive care: a retrospective cohort study on weight loss through personalized and patient-centered care. 2025	SCHON, Samantha et al. United States of America 2021–2023	Retrospective cohort study	Obesity and reproductive disorders (such as infertility, polycystic ovary syndrome [PCOS], endometriosis or abnormal uterine bleeding) Secondary care	The multidisciplinary team meets before each session to discuss each patient, allowing the creation of a personalized weight loss plan that considers reproductive goals . In addition, data are shared through the electronic medical record.	Dietitian (registered dietitian), social worker and physicians specialized in maternal-fetal medicine (MFM), obesity medicine and reproductive endocrinology and infertility (REI). Telehealth	Michigan Interdisciplinary Clinic for Obesity and Reproduction (MICOR)	237 patients	Women with obesity (mean BMI 43.5 ± 7.3 kg/m²) and reproductive disorders, with a mean age of 32.9 ± 5.5 years . Most (88.2%) wished to become pregnant and 61.6% had a diagnosis of infertility.	Participants willing to postpone pregnancy for at least 3 months achieved significantly greater weight loss at 3 months (−4.8% vs. −2.5%, p = 0.004) and at 6 months (−6.5% vs. −2.6%, p = 0.02). This group was more likely to achieve > 10% weight loss at 3 months (14.0% vs. 2.20%, p = 0.031) and > 5% at 6 months (61.4% vs. 28.6%, p = 0.024). Women who achieved > 5% weight loss at 6 months had higher pregnancy rates in the first 6 months of trying (34.1% vs. 7.7%, p = 0.004) . The decision to postpone pregnancy was the only significant predictor of achieving clinically relevant weight loss (> 5%) at 6 months	81.8 %
2	Analysis of the association of multidisciplinary team care and education intervention in patients with early-stage diabetic kidney disease in Taiwan. 2026	Lo et al. Taiwan 2023–2024	Quasi-experimental study (single arm with pre- and post-test comparison)	Type 2 diabetes mellitus (T2DM) and early-stage diabetic kidney disease (DKD) Secondary care	Multidisciplinary cooperation with regular communication between educators/dietitians and attending physicians; documentation of progress in the shared electronic medical record; and direct feedback via an internal system for timely medication adjustment	Physicians (endocrinologists, nephrologists), nurses, diabetes and nephrology educators, dietitians, hypertension specialists and occupational therapists. In person and telemedicine	Integrated Diabetes and Early Chronic Kidney Disease (CKD) Care Program	355 patients	Mean age 63.0 ± 12.8 years; predominantly male (53.2%); main inclusion criteria: T2DM on glucose-lowering drugs, HbA1c ≥ 6.5% and enrolment in the integrated care plan for diabetes and early CKD	Significant reductions in HbA1c (7.51% to 7.10%), systolic and diastolic blood pressure, total cholesterol, LDL cholesterol and albuminuria (log UACR) . Insulin and statin use increased, but the number of types of antihypertensive agents used decreased. BMI did not decrease significantly.	66.7 %
3	An Internet-Based Diabetes Management Platform Improves Team Care and	Welch, G. et al. United States of America 2010–2012	Parallel-group randomized controlled trial	Poorly controlled type 2 diabetes (T2DM) Primary care	Use of an internet-based "diabetes dashboard" that functioned as a clinical decision support system	Diabetes nurses, diabetes dietitians and primary care providers (physicians). In person	Diabetes Dashboard intervention (also referred to as the Comprehensive Diabetes Management Program)	399 patients IG: 199 CG: 200	Mean age 55 years; predominantly female (~60%); urban Latino/Hispanic individuals	The IG had a significantly higher rate of patients achieving the HbA1c target of < 7% (15.8% in the IG vs. 7.0% in the CG) .	53.9 %

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	Outcomes in an Urban Latino Population. 2015				. The tool allowed sharing of clinical data, risk alerts and session summary reports, which were emailed to physicians to support decision-making and medication adjustment recommendations				diagnosed with type 2 diabetes and glycated hemoglobin (HbA1c) > 7.5%.	The adjusted mean HbA1c at follow-up was lower in the IG (8.4%) than in the CG (9.2%) . There was a significant reduction in diabetes distress and social distress in the intervention group compared with the control group . There were no significant differences between groups in blood pressure, BMI or improvement in depression status.	
4	A randomised controlled clinical trial of nurse-, dietitian- and pedagogist-led Group Care for the management of Type 2 diabetes. 2008	Trento et al. Italy 2004–2006	Randomized controlled clinical trial	Type 2 diabetes mellitus (T2DM) Secondary care	Work of a multiprofessional team (nurses, dietitians and physicians) acting as facilitators under pedagogical supervision, with redistribution of roles and responsibilities among members . Group sessions were followed by brief individual consultations with the physician to review laboratory results and clinical problems.	Nurses, dietitians, pedagogists and physicians. In person	Group Care	49 patients IG: 25 CG: 24	Patients with a mean age of 64.6 years (IG) and 68.1 years (CG), predominantly male (59% of the total sample) . The main inclusion criteria were patients with T2DM not treated with insulin who had never been exposed to the Group Care model	After 2 years, the Group Care group had significantly lower levels of HbA1c (7.6% vs 8.4%), serum insulin and HOMA index (insulin resistance) than the control group . In addition, there was a reduction in fatalistic attitudes towards the disease and an improvement in quality of life. There was no significant reduction in BMI or blood pressure	61.5 %
5	Combined diabetes-renal multifactorial intervention in patients with advanced diabetic nephropathy: Proof-of-concept. 2017	Fogelfeld et al. United States of America 2008–2012	Stratified randomized controlled trial (proof-of-concept study)	Type 2 diabetes mellitus and advanced chronic kidney disease (CKD) (stages 3–4) Secondary care	Integrated visits in which the patient saw the entire team of specialists in a single appointment, coordination of treatment protocols across specialties and case management with frequent telephone follow-up.	Endocrinologists, nephrologists, nurse practitioners, dietitians/diabetes educators and research coordinators. Predominantly in person (individual clinic visits and an initial group dietary instruction), complemented by telehealth via telephone contact for case management.	Intensive multifactorial-multidisciplinary intervention (or combined diabetes-renal care)	120 patients IG: 60 CG: 60	Low-income adults (18 to 70 years) with a mean age of approximately 57 years, predominantly male (58%), with inclusion criteria based on a diagnosis of type 2 diabetes and stage 3–4 CKD with albuminuria.	The intervention significantly reduced progression to end-stage renal disease (13% in the IG vs. 28% in the CG) and was more effective in reducing the albumin/creatinine ratio (62.6% vs. 42.6%) and in achieving the glycated hemoglobin target of < 7% (50% vs. 31.6%) compared with usual care. There was a significant increase in BMI (32.7 to 33.5 kg/m²).	53.9 %

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										There was no significant impact on blood pressure.	
6	Delivery of Multifactorial Interventions by Nurse and Dietitian Teams in a Community Setting to Prevent Diabetic Complications: A Quality-Improvement Report. 2008	Senior et al. Canada 2004–2005	Quasi-experimental study	Diabetes associated with hypertension and/or albuminuria (microalbuminuria or macroalbuminuria). Primary care	Multidisciplinary teams using standardized algorithms and protocols, support from a central team of specialists via telehealth (training), clinical support via fax and visit reports sent to family physicians.	Registered nurses, registered dietitians, endocrinologist, nephrologist, advanced practice nurse, pharmacist and social worker. In person	Diabetic Nephropathy Prevention Program	424 patients	Mean age 59 ± 13.3 years; 52.8% men; mean diabetes duration of 12 years . Criteria: age ≥ 17 years, diabetes with hypertension/albuminuria and creatinine < 2.26 mg/dL.	Significant improvement in blood pressure (133/74 to 129/71 mmHg), HbA1c (8.1% to 7.5%) and LDL cholesterol (104 to 93 mg/dL) . Prescription of proven therapies (ACE inhibitors, statins and antiplatelet agents) increased, and a greater proportion of patients achieved clinical targets.	44.4 %
7	Dietitian-coached management in combination with annual endocrinologist follow up improves global metabolic and cardiovascular health in diabetic participants after 24 months. 2012	Battista et al. Canada 2007–2010	Quasi-experimental study	Type 1 and type 2 diabetes mellitus. Secondary care	Joint model of care in which the dietitian acts as a coach in coordination with the endocrinologist, including adjustment of pharmacotherapy by the dietitian after consultation with the physician.	Dietitians, endocrinologists and pharmacists. In person and telemedicine	Joint dietitian–endocrinologist model of care.	101 patients IG: 51 CG: 50	Participants aged 33 to 78 years (mean ~60 years); predominantly female (77% in the IG and 66% in the CG) . Inclusion criteria: diagnosis of T2DM with HbA1c ≥ 7.0% or T1DM with at least one cardiovascular risk factor (such as hypertension or dyslipidemia)	The intervention group (IG) showed a significant improvement in glycemic control (0.6% reduction in HbA1c vs. 0.3% in the control group) . In addition, there was a significant reduction in weight (−0.7 kg in the IG vs. a 2.1 kg gain in the CG), improvement in BMI and waist circumference and a marked reduction in daily caloric intake. Only diastolic blood pressure decreased significantly (p = 0.049)	66.7 %
8	Effectiveness of multidisciplinary intervention on blood pressure control in primary health care: a randomized clinical trial 2016	Kuhmmer et al. Brazil 2013	Parallel randomized controlled trial	Uncontrolled systemic arterial hypertension (including patients with diabetes mellitus). Primary care	Partnership between multidisciplinary teams and Family Health Strategy (FHS) teams, involving standardized interprofessional training, shared health workshops and the use of jointly developed health education manuals for pharmaceutical care,	Physicians (general practitioners and a cardiologist for training), nurses, nursing technicians, pharmacists, dietitians, physical educators and social workers. In person	Multidisciplinary program (based on the Family Health Support Center model) and personalized care.	256 patients IG: 128 CG: 128	Participants aged over 40 years (mean approximately 60 years), mostly female (69% in the CG and 73% in the IG), diagnosed with uncontrolled hypertension (BP ≥ 140/90 mmHg or ≥ 130/80 mmHg for	Both interventions were effective, with significant reductions in systolic blood pressure (11.8 mmHg in the CG and 12.9 mmHg in the IG) and diastolic blood pressure after 6 months (p < 0.001) . There was no statistically significant difference between personalized care and the group-only multidisciplinary program	69.2 %

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					nutrition and physical activity.				people with diabetes).	in blood pressure control (p = 0.60 for systolic) or BMI (p = 0.454) . Medication adherence and physical activity increased in both groups	
9	Effectiveness of the I²AO² interdisciplinary programme led by nurses on metabolic syndrome and cardiovascular risk: a randomized, controlled trial. 2018	Fernández-Ruiz, V. E. et al. Spain 2013–2016	Randomized controlled clinical trial	Metabolic syndrome (MetS) and cardiovascular risk (CVR) Primary care	Monthly team meetings for ongoing evaluation of the project, with the nurse acting as the coordinating link between the different professionals, the patient and the community.	Physicians, qualified nurses, dietitians, psychologists and physical activity and sport science professionals. In person	Intervention: I2AO2 (Interdisciplinary Intervention Against Overweight and Obesity)	74 patients IG: 37 CG: 37	Adults with overweight (BMI 25–29.9 kg/m²) or obesity (BMI ≥ 30 kg/m²) and a diagnosis of metabolic syndrome . Mean age was 62.8 years in the control group and 59.4 years in the experimental group, with a balanced sex distribution (approximately 50% women).	There was a progressive and significant reduction in all clinical, biochemical and anthropometric parameters in the experimental group . Remission of metabolic syndrome in the intervention group was 83.8% at 12 months and remained stable one year after the end of the intervention, whereas prevalence increased in the control group . At the end of follow-up (24 months), 100% of the experimental group had low or moderate cardiovascular risk. There was a significant reduction in BMI in the IG over the 24 months of follow-up.	61.5 %
10	Effectiveness of the MOVE! Multidisciplinary Weight Loss Program for Veterans in Los Angeles. 2013	Romanova et al. United States of America 2006–2009	Quasi-experimental study	Overweight and obesity, often associated with hypertension, hyperlipidemia and type 2 diabetes. Primary care	Practice delivered by a multidisciplinary team that led group education sessions and used shared electronic medical records to monitor clinical data.	Physicians, dietitians, physical and recreational therapists and psychologists. In person	MOVE! Weight Management Program for Veterans (MOVE!)	382, of whom 377 were included in the final analysis.	Mean age 60 years, predominantly male (87.7%), with inclusion criteria based on veterans with BMI > 30 kg/m² (obesity) or BMI 25.0–29.9 kg/m² (overweight) with associated comorbidities	Before the program, veterans gained on average 1.4 kg per year; after one year of participation in MOVE!, they showed a mean loss of 2.2 kg . The study showed that the intervention was effective in reversing the weight gain trajectory and maintaining weight loss over three years	55.6 %
11	Effect of interdisciplinary care on weight loss: a randomised controlled trial. 2017	Tapsell et al. Australia 2014–2016	Single-blind randomized controlled trial	Overweight and obesity. Primary care	Interdisciplinary care integrating the expertise of different professionals with medical supervision for shared decision-making and behavioral support.	Physicians, accredited dietitians, exercise physiologists, psychologists, nurses (in the control group) and health coaches. In person and telemedicine	HealthTrack study	377 patients IG: 251 (125 in the intervention group and 126 in the intervention + nuts group)	Community-dwelling adults (25–54 years) with BMI between 25 and 40 kg/m² . The final analyzed sample was predominantly female (74%), with	The interdisciplinary protocol produced significantly greater and more sustained weight loss than usual care (p < 0.001) . A greater proportion of participants in the intervention groups achieved the clinically	84.6 %

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								CG: 126	a median age of 45 years and a median BMI of 32 kg/m²	relevant target of 5% weight loss at 3, 6 and 9 months. Blood pressure did not improve significantly in the group-by-time analysis (p = 0.551)	
12	Effect of interdisciplinary obesity care on metabolic markers and body weight in people with type 2 diabetes in a rural setting: A randomised controlled trial. 2025	Murfet et al. Australia 2015–2019	Pragmatic, single-center, non-blinded randomized controlled trial (RCT)	Type 2 diabetes mellitus and obesity (BMI > 30 kg/m²). Secondary care	Team-based interdisciplinary care, with coordinated assessments and treatment plans developed in partnership with the participant.	Nurse practitioner, dietitian, physiotherapist or exercise physiologist, psychologist, endocrinologist and diabetes educator. In person and telemedicine	AMOS (Assessment and Management of Obesity and Self-maintenance)	224 patients IG: 113 CG: 111	Mean age 57.5 to 58.2 years; predominantly female in the IG (60%); criteria: adults (18–75 years) with type 2 diabetes and BMI > 30 kg/m².	The IG had greater mean weight loss (−9.0 kg vs −2.3 kg) and BMI reduction (−3.5 vs −0.6 kg/m²) at 24 months than the CG . There was a sustained improvement in HbA1c (between-group difference of −0.63%) and a smaller decline in renal function (eGFR) in the intervention group. Blood pressure results were considered inconclusive.	53.6 %
13	Evaluating the impact of onsite diabetes education teams in primary care on clinical outcomes. 2020	Gucciardi et al. Canada 2009–2015	Historical cohort study	Type 2 diabetes mellitus Primary care	Collaborative care management through case conferences, communication via written notes in medical records, specialist recommendations for medication optimization sent to physicians and guideline-based clinical decision support.	Educator teams composed of nurses and dietitians, primary care physicians (PCPs) and, at some sites, multidisciplinary teams that included pharmacists. In person, complemented by remote support (telephone and email)	Integration of Diabetes Education Teams (DETs)	771 patients IG: 487 CG: 284	Adults (≥ 18 years) with type 2 diabetes and HbA1c ≥ 7% . Mean age was 58 years in the IG and 61.7 years in the CG, predominantly male in both groups (56.5% in the IG and 53.2% in the CG).	The intervention group was significantly more likely to achieve the HbA1c target (≤ 7%) than the control group (OR 3.849) . The mean reduction in HbA1c levels was significantly greater in the intervention group (−0.007) than in the control group (−0.002) . No statistically significant differences were observed between groups for LDL cholesterol, blood pressure or TC/HDL ratio.	77.8 %
14	Evaluation of a multidisciplinary Tier 3 weight management service for adults with morbid obesity, or obesity and comorbidities, based in primary care. 2014	Jennings et al. 2011–2013 United Kingdom	Cohort study	Morbid obesity or obesity associated with comorbidities such as hypertension, depression, type 2 diabetes and sleep apnea. Primary care	Weekly multidisciplinary team meetings for case discussion and internal referrals ; communication between the service physician and the patient's general practitioner (GP) or secondary care	Lead general practitioner (with a special interest in bariatrics), obesity specialist nurses (OSNs), dietitian, psychological therapist, exercise professional, health trainer, consultant endocrinologist and	Fakenham Weight Management Service (FWMS)	230 patients	Mean age 52.7 years (SD 13.6); 70% women . The main inclusion criteria were age > 18 years and BMI ≥ 40 kg/m², or BMI ≥ 30 kg/m² with obesity-related comorbidities and/or waist	102 participants (44.3% of the total cohort) achieved the primary target of ≥ 5% weight loss at 12 months. Mean weight loss at 12 months was 10.2 kg among completers (n = 117) and 5.9 kg for the full baseline sample using BOCF analysis (n = 230). There were statistically significant improvements	63.9 %

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					specialists when clinically appropriate ; and a clinical management group that included patient representatives.	public health consultant. In person			circumference ≥ 102 cm (men) or ≥ 88 cm (women)	in quality of life (EQ-5D-5L), physical activity levels and fruit and vegetable intake, as well as reductions in blood pressure, HbA1c levels in patients with diabetes and BMI.	
15	Evaluation of Weigh Forward: A group intervention delivered by dietitians and psychologists within a National Health Service specialist weight management service. 2018	Moffat et al. United Kingdom 2015–2017	Prospective cohort study	Severe and complex obesity. Secondary care	Joint facilitation of group sessions and integrated initial assessment (patients attended assessment appointments with a dietitian and a psychologist to enter the program)	Dietitians and psychologists. In person	Weigh Forward	166 patients	Mean age 47.5 years; predominantly female (80.0%); main inclusion criteria: age ≥ 18 years, BMI ≥ 35 kg/m² (or ≥ 30 with associated health problems) and previous failure in community weight loss services	Weight loss: mean of 5.6 kg at 6 months among completers; 35.2% of completers lost ≥ 5% of their initial weight. Psychological variables: significant improvements, with reductions in depression, anxiety and binge eating, as well as improved emotional regulation. Quality of life: improvement in the psychological and environmental domains (WHOQOL-BREF), but a reduction in physical health scores. Attrition: high dropout rate, with only 38.6% of participants returning for the 12-month follow-up	63.6 %
16	Feasibility of an interdisciplinary program for obesity management in Canada. 2012	Wharton et al. Canada 2009–2011	Retrospective cohort study	Obesity (and associated conditions such as hypertension, hyperlipidemia and type 2 diabetes). Secondary care	Interdisciplinary team with task sharing: bariatric educators provide nutrition education and weight loss strategies, while physicians treat causal factors and comorbidities; educational workshops are delivered jointly by different specialists.	Physicians, behavioral therapists, registered dietitians, bariatric educators, exercise specialists and trained technicians. In person	Wharton Medical Clinic (WMC) obesity management program	2,739 patients	Mean age 49.3 years; 77.6% female; main inclusion criteria: patients referred by physicians for obesity treatment, with a mean baseline BMI of 40.6 kg/m²	Patients with ≥ 6 months of follow-up (n = 289) lost on average 5.4 kg (4.3% of body weight); 47% achieved ≥ 5% weight loss and 17% achieved ≥ 10%. Visit frequency was the main predictor of weight loss, regardless of age or BMI.	63.6 %
17	Impact of a chronic care model based on patient empowerment on the management	Musacchio et al Italy 2011	Quasi-experimental study	Type 2 diabetes mellitus Secondary care	Training and alignment of the most appropriate care processes / follow-up visits by nurses and dietitians / shared electronic medical	Diabetologists, dietitians and nurses In person and telemedicine	SINERGIA - Physician consultations in complex cases	1,004 patients	Patients with type 2 diabetes who had achieved stabilization of the disease and therapy (HbA1c < 7%	Increase in the number of patients achieving HbA1c < 7%: 32.7% to 45.8% (p < 0.0001). Reduction in the percentage of patients with high-risk levels (≥ 140/90	66.7 %

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	of Type 2 diabetes: effects of the SINERGIA programme 2011				record / periodic evaluation of the care provided using electronic medical record data		- Diabetes self-management education - Email, telephone and SMS: to maintain contact and provide feedback to patients		without a recent need for medication changes)	mmHg), from 62.1% to 58.5% (p = 0.0057). The proportion of patients achieving LDL-c < 100 mg/dL increased from 39.7% to 47.3% (p < 0.0001)	
18	Impact of an integrated care program on glycemic control and cardiovascular risk factors in patients with type 2 diabetes in Saudi Arabia: an interventional parallel-group controlled study 2018	Tourkmani et al Saudi Arabia 2013–2014	Randomized controlled trial	Type 2 diabetes mellitus (T2DM) Primary care	- Weekly team meetings to review care plans - Improved communication and coordination of the multidisciplinary team	Senior family physician, clinical pharmacy specialist (case manager), dietitian, diabetes educator, health educator and social worker In person and telemedicine	N/A - Frequent clinical consultations - Monitoring of results - Diabetes education and dietary counseling - Promotion of self-care; booklet for home blood glucose monitoring; dose adjustment and assessment of the need for insulin titration - Encouragement of medication adherence; social support; reminders; telephone calls	263 patients 195/68	Adults aged 18 years or older with T2DM, inadequate glycemic control and associated cardiovascular risk factors (hypertension and dyslipidemia), receiving diabetes care at the WHC Chronic Disease Center	The IG reduced the percentage change from baseline in HbA1c (−27.08%, p < 0.001), fasting glucose (−17.0%, p < 0.001), total cholesterol (−9.93%, p < 0.001), LDL cholesterol (−11.44%, p = 0.005), systolic blood pressure (−1.49%, p = 0.046) and diastolic blood pressure (−3.41%, p < 0.001), with a relative increase in body weight (3.72%, p < 0.001). The reductions in these parameters in the IG were significantly greater than the respective changes in the CG	61.5 %
19	Impact of pharmacist-involved collaborative care on the clinical, humanistic and cost outcomes of high-risk patients with type 2 diabetes (IMPACT): a randomized controlled trial 2017	Siaw et al Singapore 2014	Randomized controlled trial	Type 2 diabetes mellitus Secondary care	- Active communication	Clinical pharmacists, physicians, diabetes nurse educators and dietitians In person and telemedicine	IMPACT - Circle of care: the physician refers patients to the other professions, and the pharmacist follows up patients through consultations or telephone calls - Dietitians and nurses provide motivational and educational care	411 patients 214/197	Chinese, Malay and Indian patients aged ≥ 21 years with uncontrolled diabetes (HbA1c > 7%) associated with polypharmacy and multiple comorbidities (such as hypertension, dyslipidemia, ischemic heart disease and kidney disease)	The IG had a reduction in glycated hemoglobin from 8.6% ± 1.5% at baseline to 8.1% ± 1.3% at 6 months (p = 0.04) The difference between groups was 0.5% (p = 0.04) The difference in mean SBP between the two groups was not significant (IG: −2.3 mmHg; CG: 1.5 mmHg; p = 0.12) Changes in mean LDL (IG: −1.9 mg/dL; CG: 1.2 mg/dL; p = 0.35), TG (IG: −13.4 mg/dL; CG: 5.2 mg/dL; p = 0.58) and BMI (IG: 28.2 kg/m²; CG: 28.5 kg/m²) between the two groups were not significant	76.9 %

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20	Interdisciplinary speed dating augments diabetes self-management education and support to improve health outcomes 2020	Whitley et al United States of America 2016	Quasi-experimental study	Diabetes mellitus (type 1 and type 2) Primary care	- Recording of the "speed dating" in the electronic medical record - Referral of recommendations to other professionals and to the family physician - Coordinated work: each profession was responsible for a set of technical tasks	Physician, pharmacist, nurse or dietitian, case manager and clinical psychologist In person	N/A - Diabetes self-management education class - 30-minute "speed dating" sessions with five different professionals	69 patients 40/29	Adults with type 1 or type 2 diabetes followed at the family medicine clinic who were referred by their physicians to attend the diabetes self-management education and support (DSMES) class	The IG had a reduction in glycated hemoglobin from 9.7% ± 2.4% to 8.5% ± 2.3% (p = 0.003) and in LDL-c from 107.9 ± 36.5 mg/dL to 83.2 ± 27.3 mg/dL (p = 0.003) Among those with baseline glycated hemoglobin > 8%, IG participants were more likely to achieve the target than CG participants (p = 0.03) There was no significant difference between groups in BMI (p = 0.71) or blood pressure (p = 0.65 for systolic and 0.92 for diastolic pressure)	66.7 %
21	Long-term effects of the multidisciplinary risk assessment and management program for patients with diabetes mellitus (RAMP-DM): a population-based cohort study 2015	Jiao et al China 2013	Prospective cohort study	Diabetes mellitus (insulin-dependent and non-insulin-dependent) Secondary care	The nurse performed an assessment and classified patients by risk stratification, which guided physicians in defining long-term follow-up and, together with glycated hemoglobin levels, in referral to the multidisciplinary team that provided health education	Associate consultants in family medicine, registered nurses, advanced practice nurses and allied health professionals (optometrists, dietitians, podiatrists and physiotherapists) In person	RAMP-DM - Screening for complications - Risk assessment and stratification - Multidisciplinary health education - Periodic reassessments	18,188 patients 9,094/9,094	Patients with diabetes aged ≥ 18 years regularly followed up at outpatient clinics. The mean age of both groups was 64 years, and about 87% used oral glucose-lowering drugs	The IG had significantly lower levels of HbA1c (7.13% vs 7.25%; p < 0.001), systolic blood pressure (130.12 vs 132.35 mmHg; p < 0.001) and diastolic blood pressure (71.60 vs 73.23; p < 0.001) The IG had 399 events vs 608 in the CG: adjusted HR 0.629 (95% CI 0.554–0.715; p < 0.001). BMI was not significant (p = 0.54)	100.0 %
22	Multidisciplinary Team Care May Slow the Rate of Decline in Renal Function 2011	Bayliss et al United States of America 2005–2009	Retrospective cohort study	Stage 3 chronic kidney disease (CKD) associated with diabetes mellitus and/or hypertension Primary/secondary care	The team developed a care plan based on the input of all members, using shared electronic medical records	Nephrologist, clinical pharmacist specialized in nephrology, diabetes nurse educator, renal dietitian, social worker and nephrology nurse In person and telemedicine	N/A Educational classes on CKD; medical and multidisciplinary team consultations; and support via telephone or email for medication adjustments and review of behavioral changes	2,002 patients 233/1,769	Adults with stage 3 CKD (GFR 30–59 mL/min) and comorbidities, referred by their primary care physicians. Mean age 68.2 years; 44.36% women; mostly White (68.18%); mean of 4.45 chronic conditions and mean BMI of 29.83 kg/m²	The IG had a smaller mean annual decline in GFR than the CG (1.2 vs. 2.5 mL/min per 1.73 m²; p < 0.0001). Percentage of time at the blood pressure target (BP ≤ 130/80 mmHg): IG 41.35% and CG 45.38% (p = 0.1600). Final LDL: IG 88.87 mg/dL and CG 91.59 mg/dL (p = 0.4143). Final glycated hemoglobin (A1c, patients with diabetes only): IG 7.30 and CG 7.37 (p = 0.7848). The proportion of individuals at the blood pressure target	90.9 %

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										did not differ from the CG (p = 0.16).	
23	Optimization of Care for Adult Outpatients With Type 2 Diabetes Through the Diabetes Self-Management Multidisciplinary Program: A Randomized Clinical Trial 2022	Garcia et al Brazil 2017–2019	Randomized controlled trial	Type 2 diabetes mellitus Secondary care	A coordinator was responsible for managing the flow of the meeting and ensuring that all participants saw all professionals. All professionals met at the end and recorded their assessments and plans in the electronic records	Nurse, pharmacist, dietitian, physical educator and social worker In person	MP Individualized consultations with each of the five health professionals in rotating stations (15 minutes at each station)	96 patients 48/48	Adults with type 2 diabetes (A1C > 7.5%) attending outpatient endocrinology care at a hospital. The sample consisted mainly of women (60%), with a mean age of 59 ± 9 years and diabetes duration of 16 ± 10 years.	In both groups, HbA1c at 12 months did not differ from baseline: delta (D) of 0.52% in the CG (95% confidence interval [CI] 1.07 to 0.04, p = 0.08) versus a delta of 0.30% in the IG (95% CI 1.05 to 0.44, p = 1.00), nor between groups (p = 0.33). The decrease in HbA1c (D 0.56% [95% CI 1.04 to 0.08], p = 0.02) relative to baseline was not observed at the end of follow-up. No significant changes were observed in weight, BMI, blood pressure or lipid profile	84.6 %
24	Optimizing the Treatment of Hypertension in the Primary Care Setting 2007	Didier; Guimarães Brazil 2004	Quasi-experimental study	Hypertension Primary care	Organization of monthly interdisciplinary educational lectures and common goals (blood pressure control and cardiovascular risk factors)	Cardiologist, nurse, dietitian, social worker and nursing technician In person	N/A Individual consultations and group activities through regular educational lectures	88 patients	Adults over 18 years of age, treated by the author for more than one year, with at least two medical consultations in the previous year. Most patients were female, 69 (78.41%), with a mean age of 58.03 ± 9.9 years; 54 (65.06%) self-identified as non-White, and 76 (92.69%) had at most completed elementary school	Median blood pressure (BP) decreased from 166.00/96.00 mmHg to 146.75/85.25 mmHg after 6 months (p < 0.0001) and to 134.00/80.00 mmHg after 12 months (p < 0.0001). Half of the sample showed a reduction of 28 mmHg in systolic pressure and 14 mmHg in diastolic pressure, and 75% a reduction of 10 mmHg in both. The percentage of controlled BP (< 140/90 mmHg) increased from 10% to 48.81% in 12 months, a 4.77-fold increase (p < 0.0000). Median total cholesterol decreased from 217 mg/dL to 194 mg/dL (p < 0.004)	66.7 %

No.	Title and year of publication	Authors, country and study period	Study design	Condition assessed/ Practice setting	Form of collaborative practice	Professionals involved/ Mode of delivery	Program name/ Intervention	Sample size (IG/CG)*	Sample characteristics	Main results	JBI
25	Outcomes in an Interdisciplinary Diabetes Clinic in Rural Primary Care 2019	King et al United States of America 2014–2017	Quasi-experimental study	Type 2 diabetes mellitus Primary care	The team used brief meetings before and during appointments to coordinate care and discuss each patient's individual barriers Paired appointments (by two professionals) Key patient data were recorded on a whiteboard visible to the entire team	Certified diabetes educator/dietitian, case manager, pharmacist, nursing staff, family medicine resident, psychologist and family medicine attending physician In person	N/A Initial screening and successive consultations with several professionals on the same day.	94 patients	Patients with type 2 diabetes referred by their primary care physician, with previous treatment failure and HbA1c ≥ 9% at referral. Women accounted for 54% of the sample, and the mean age was 57 ± 13 years.	There was a significant difference between baseline HbA1c, 10.25% (88.5 mmol/mol) ± 1.4% (range 73 to 104 mmol/mol), and the most recent HbA1c, measured 6 to 18 months after the initial consultation, 8.4% (68.3 mmol/mol) ± 2.2% (range 44 to 92 mmol/mol; $z = -7.022$, $p < 0.001$). There was a significant correlation between the reduction in HbA1c and the improvement in self-care scores ($r = 0.483$, $p = 0.031$). There was no difference in SBP or DBP after the intervention.	66.7 %
26	TeleHealth Improves Diabetes Self-Management in an Underserved Community: Diabetes TeleCare 2010	Davis et al United States of America 2005–2006	Randomized controlled trial	Type 2 diabetes mellitus Primary care	The diabetes self-management education team, composed of a dietitian and a nurse educator, was physically based at an academic health center. They interacted with patients and the local team mainly via interactive videoconferencing, allowing remote delivery of group and individual education sessions. A licensed practical nurse (LPN) was hired specifically to work at the community health centers, serving as the physical link between the remote academic team and the participants and assisting during the intervention sessions.	Dietitian, certified diabetes nurse educator, licensed practical nurse (LPN) Telemedicine	Diabetes TeleCare Thirteen education sessions (individual and group) via interactive videoconferencing by the self-management education team at the academic health center, while participants were at the primary care clinic. Make-up sessions were held by telephone (mobile and landline), fax and a telehealth-enabled retinal camera.	165 patients 85/80	Adults aged 35 years or older diagnosed with type 2 diabetes, with glycated hemoglobin > 7%, seen at one of the participating community health centers in the previous year.	The Diabetes TeleCare intervention showed a statistically significant reduction in glycated hemoglobin at 6 and 12 months compared with usual care ($p = 0.004$), with the intervention group reaching a mean of 8.2% vs 8.6% in the control group at one year. There was also a significant improvement in LDL cholesterol at 12 months in the intervention group ($p = 0.02$) and a marked increase in retinal examinations (81.2% vs 38.8%; $p < 0.0001$). No significant differences between groups were observed for blood pressure, BMI, waist circumference or albumin-to-creatinine ratio.	61.5 %

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27	The Effects of Nurse-Led Multidisciplinary Team Management on Glycosylated Hemoglobin, Quality of Life, Hospitalization, and Help-Seeking Behavior of People with Diabetes Mellitus 2019	Ni et al China 2014–2016	Quasi-experimental study	Type 2 diabetes mellitus Primary care	The community nurse had a coordinating and liaison role between participants and primary care physicians, ensuring a continuous flow of information between levels of care. During individual follow-up, nurses identified treatment barriers and health problems and provided periodic feedback to general practitioners on each individual's progress. In addition, nurses and physicians identified specific needs and referred patients to the multidisciplinary team.	Specialists from a large university hospital (endocrinologists, dietitians, psychologists, cardiologists, nephrologists and specialist nurses), one general practitioner and four community nurses In person and telemedicine	N/A The intervention was structured in three modalities: group health education sessions, individualized counseling and provision of educational materials, comprising 20 group education sessions and monthly individual monitoring.	179 patients 88/91	Adults aged 35 years or older diagnosed with type 2 diabetes. 53.1% of the sample were female, 92.2% were married, most were retired or unemployed (88.8%) and 39.1% had diabetes complications at baseline.	After 24 months, the IG had a 1.08% reduction in glycated hemoglobin, while the CG had a 0.45% increase ($p = 0.001$). Quality of life scores (SF-36) also improved in the IG compared with the CG ($p < 0.001$), and the risk of diabetes-related hospitalization was markedly reduced ($p = 0.028$). The IG showed an increase in trust in and help-seeking from nurses (from 12.5% to 57.3%) compared with the CG ($p < 0.001$)	77.8 %
28	The Long-Term Dietitian and Psychological Support of Obese Patients Who Have Reduced Their Weight Allows Them to Maintain the Effects 2021	Iłowiecka et al Poland 2018–2021	Randomized controlled trial	Obesity Secondary care	Care was shared in group meetings and individual sessions conducted jointly by a dietitian and a psychologist. To build new habits, the psychologist applied elements of cognitive behavioral therapy (CBT) and motivational interviewing (MI). This integration aimed not only at dietary prescription but at permanent behavior change and relapse prevention. The professionals also collaborated on the methodological design, the analysis of biochemical and clinical parameters and care coordination	Qualified dietitians, physician and psychologist In person and telemedicine (due to COVID-19)	N/A In phase 1, a personalized energy-restricted diet (deficit of 500–800 kcal/day) and encouragement of physical activity were offered. In phase 2, the IG received nutrition education based on the Ten Top Tips (TTT) method and elements of CBT and MI, focusing on permanent habit change. The CG received no additional care after weight loss. Owing to the COVID-19 pandemic, phase 2 was adapted to an online format.	36 participants 18/18	Individuals with obesity (BMI ≥ 30 kg/m²) aged 21 to 49 years. The sample consisted of Caucasian individuals (22 women and 14 men), with a mean age of 35.58 ± 9.85 years and a mean baseline BMI of 35.04 ± 3.80 kg/m².	The IG maintained weight loss (reduction of 3.83 ± 6.09 kg at 30 months; $p = 0.01634$), while the CG showed a non-significant weight gain after the end of the active intervention (+2.48 ± 6.24 kg; $p = 0.10954$). There were significant differences between the IG and CG in BMI (−1.27 vs +0.72 kg/m²), visceral adipose tissue (VAT) (−0.58 vs +0.45 L) and waist circumference (−4.83 vs +1.83 cm) at the end of 30 months. In phase 2, both groups had an increase in fasting glucose.	76.9 %

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29	Treatment of Difficult-to-Control Blood Pressure in a Multidisciplinary Clinic at a Public Hospital 2003	Tao et al United States of America 2000	Prospective cohort study	Difficult-to-control hypertension Secondary care	Diagnosis was made by consensus: two physicians assessed the causes of uncontrolled blood pressure and, in case of disagreement, discussed them to reach a common diagnosis. In addition, the multidisciplinary team delivered simultaneous interventions through individualized education on diet, physical exercise and medications. The physician and nurse worked together during visits, reinforcing medication adherence and educational goals.	General internists, nurse health educator, pharmacist and dietitian In person	N/A After the consensus diagnosis, individualized treatment plans were offered, with individualized education by a nurse, pharmacist and dietitian, simplification of the medication regimen and close monitoring of adherence; follow-up visits were scheduled every two weeks in the first month and monthly thereafter until blood pressure was controlled.	50 patients	Individuals with blood pressure persistently > 140/90 mmHg despite concomitant use of three or more antihypertensive agents, with uncontrolled blood pressure for at least three months. The sample consisted of an urban, poor and disadvantaged population, 94% African American and 6% Hispanic/Latino. Mean age was 63 ± 11 years, predominantly female (66%).	After follow-up, 58% of patients achieved and maintained the target blood pressure at 6 months; 8% improved but did not maintain the target at two consecutive visits; 12% did not improve; and 22% were lost to follow-up. The most common causes of previous failure were volume overload and poor medication adherence. The most successful drug intervention was the optimization of diuretic therapy.	63.3 %
30	Western Negev Mobile Diabetes Care Program: a model for interdisciplinary diabetes care in a semi-rural setting 2002	Maislos; Weisman; Sherf Israel 1998–1999	Quasi-experimental study	Type 1 and type 2 diabetes mellitus Primary care with care typical of tertiary care	Continuous interdisciplinary care and teamwork, with interaction between the mobile specialist team and local primary care teams for case discussion and definition of therapeutic strategies. Treatment strategies for specific patients were often established after informal discussions between the mobile team and local physicians and nurses. The nurse was responsible for coordinating program activities and planning team meetings at the local facilities.	Diabetologist, a diabetes nurse educator and a dietitian, in addition to local ophthalmologists and consultation services in neurology, vascular surgery, orthopedics and podiatry at the referral medical center In person	Western Negev Mobile Diabetes Care Program The multidisciplinary team regularly traveled to local primary health care facilities to see patients close to their homes. Care used a computerized protocol for real-time data entry and retrieval during consultations. At the first visit, all patients received nutritional counseling, a specialist medical assessment and an educational session with the nurse. The intervention included periodic eye examinations, measurement of microalbumin	492 patients	Individuals diagnosed with type 1 or type 2 diabetes who made at least two visits to the mobile clinic during 1998 and 1999 and lived in the Western Negev region. The sample was 58% women, with a mean age of 60 years (SD 11) and a mean time since diabetes diagnosis of 10 years (SD 8)	Individuals showed reductions in BMI (30.05 to 29.82 kg/m²; $p < 0.0001$), systolic pressure (143 to 140 mmHg; $p < 0.001$), diastolic pressure (85 to 84 mmHg; $p < 0.05$), HbA1c (9.6% to 8.7%; $p < 0.01$) and fasting glucose (206 to 185 mg/dL; $p < 0.001$), as well as an improvement in LDL (137 to 129 mg/dL; $p < 0.01$) and a significant increase in HDL (40 to 46 mg/dL; $p < 0.0001$).	55.6 %

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							excretion and close monitoring of laboratory parameters.				

* IG, intervention group; CG, control group. JBI, Joanna Briggs Institute (percentage of critical appraisal criteria met).