Appendix B_Supplementary file 1

Levels of care, Modes of services delivery	Author(s) Year	Country	Nurses' title(s)	Rehabilitation interventions provided by nurses	Other health workers	Nurse-led interventions	Task shifting	Comments about nurses' role
Studies with nurses in a managerial and clinical role (N=52)								
Multiple, Telerehabilitation	**Bekelman et al., 2015** [1]	United States	Nurse coordinator	Assessment of emotional functions Education and skills training for self-care and self-management Health status monitoring Monitoring of functional ability Psychological interventions Rehabilitation coordination and management not further specified	General practitioners	No	No	Each site had a collaborative care team consisting of a nurse coordinator (registered nurse) a primary care physician a cardiologist and a psychiatrist. The nurse was supervised by the site psychiatrist via as-needed calls with the lead psychiatrist and Dr Bekelman. The depression care component of the nurse intervention was standardized in a treatment manual that described detailed procedures for what to discuss with patients.
PHC, Outpatient	**Bleijenberg et al., 2016** [2]	Netherlands	Registered practice nurse	Assessment of frailty Case management Comprehensive geriatric assessment Follow up visits Management of urinary incontinence Monitoring of functional ability Multicomponent rehabilitation care or not specified	General practitioners	**Yes**	No	Twenty-one registered practice nurses delivered this care and were extensively trained during a 6-week training program (48 hours total). An expert panel of older adults nurses and GPs participated in the development of this program.
PHC, Home	**Bleijenberg et al., 2017** [3]	Netherlands	Registered nurse (RN)	Assessment of family and caregivers' needs knowledge and skills	None	**Yes**	No	The UPROFIT intervention was delivered by registered nurses and included a frailty assessment and a comprehensive geriatric assessment (CGA) at home followed by an individualized evidence-based care plan care coordination and follow-up. The HCP intervention was delivered by advanced practice nurses consisting of four home visits and three phone calls and was guided by the principles of health promotion empowerment partnership and family-centeredness.
		Switzerland	Advanced practice nurse (APN)	Assessment of person-centered goals Case management Comprehensive geriatric assessment				
			Community health nurse	Education and skills training for caregivers Education and skills training for self-care and self-management Follow up visits				

				Health status monitoring			
				Management of urinary incontinence			
				Monitoring of functional ability			
				Multicomponent rehabilitation care or not specified			
Multiple, Outpatient	**Blom et al., 2016 [4]**	Netherlands	Practice nurse	Assessment of cognitive functions	General practitioners	No	Yes	In the Netherlands all community-dwelling persons are registered at a GP. The GP or the practice nurse (under supervision of the GP) made an integrated care plan for participants with complex problems. The GP/practice nurse together with the older person formulated actions to be taken and evaluation plans for follow-up. Other care professionals were involved where needed (multidisciplinary consultation).
				Assessment of functioning			
				Assessment of person-centered goals			
			Research nurse	Case management			
				Follow up visits			
				Multicomponent rehabilitation care or not specified			
Multiple, Inpatient / Outpatient	**Buurman et al., 2016 [5]**	Netherlands	Geriatric-trained registered nurse	Assessment of environment	None	**Yes**	Yes	After the geriatric-trained registered nurse conducted the CGA the CCRN was contacted to visit the hospital to receive a personal handover of the CGA to initiate the personalized care and treatment plan (CTP) and to meet with the participant and informal caregiver to discuss their needs. After discharge the CCRN performed medication reconciliation answered the participant's questions and completed a needs assessment at a home visit. If a participant was discharged to a nursing home the CCRN also visited the nursing home.
			Community care registered nurse (CCRN)	Assessment of person-centered goals			
			Experienced trained research nurse	Comprehensive geriatric assessment			
			Advanced practice nurse (APN)	Discharge planning			
PHC, Telerehabilitation	**Cameron-Tucker et al., 2016 [6]**	Australia	Community nurse	Assessment of person-centered goals	None	**Yes**	No	Participants were contacted via telephone by specifically trained community nurses who acted as nurse health-mentors to support the home-walking action plan and any other health behavior plans.
			Respiratory nurse specialist	Education and counseling about healthy lifestyle behaviors			
				Education and skills training for self-care and self-management			
				Follow up visits			
				Therapeutic exercises			

PHC, Eldercare / Institution	**Clevenger et al., 2018 [7]**	United States	Advanced practice registered nurse (APRN)	Assessment of person-centered goals	Geriatricians	**Yes**	Yes	First Nurse-led Patient centered Medical Home model (PCMH) in which Advanced practice registered nurses (APRNs) are the first-line clinicians. Physician-APRN partnership varies; some physicians permit APRNs to manage issues influenced by cognitive impairment (e.g. falls medication management) whereas others authorize management only of dementia-related concerns. Unlike in other dementia care programs (where APRNs play adjunctive or case management roles) IMCC APRNs are the first-line clinicians. They collaborate with a neurologist and a Geriatricians but patients do not have physician appointments except when the APRNs order specialist consultations.
				Education and skills training for caregivers	Social workers			
			Geriatric nurse	Social care and support plan				
Multiple, Outpatient / Inpatient	**Coskun and Duygulu, 2021 [8]**	Turkey	Coordinator nurse	Assessment of health status	Dieticians	**Yes**	Yes	The Coordinator nurse took the patient's medical history hospital and clinic promotion providing training guide daily regular patient visits coordinating the healthcare services. The Clinic Nurses executed healthcare services in line with designated healthcare plan competing of the practices in the clinical pathway.
			Clinic nurse	Assessment of person-centered goals	Other physicians			
				Case management				
				Discharge planning	Physical therapists			
				Follow up visits				
				Multicomponent rehabilitation care or not specified				
Multiple, Outpatient	**Coventry et al., 2015 [9]**	United Kingdom	Practice nurse	Management in the use of medication	Other physicians	No	No	To better achieve integrated care a 10 minute collaborative meeting (by telephone or in person) between the patient and the psychological wellbeing practitioner and a practice nurse from the patient's general practice was scheduled. Psychological wellbeing practitioners also worked with the patient and practice nurse to check that patients adhered to antidepressants as prescribed dealt with concerns about side effects and helped to arrange drug reviews with the General practitioners if necessary.
				Rehabilitation coordination and management not further specified	Psychologists			

Multiple, Inpatient / Home	**Deng et al., 2020 [10]**	China	Nurse Community nurse	Case management Education and skills training for self-care and self-management Follow up visits Health status monitoring Multicomponent rehabilitation care or not specified	General practitioners Other physicians PRM physicians	No	No	A nurse in the community setting was designated as a coordinator to ensure the continuity of care delivery.
Multiple, Inpatient / Outpatient	**Ekelund and Eklund, 2015** [11]	Sweden	Nurse Municipal nurse	Assessment of frailty Assessment of person-centered goals Comprehensive geriatric assessment Discharge planning Follow up visits Multicomponent rehabilitation care or not specified Rehabilitation coordination and management not further specified	Occupational therapists Physical therapists PRM physicians Social workers	No	Yes	The intervention involved collaboration between a nurse with geriatric competence at the ED the hospital wards and a multi-professional team in the community with a case manager as the hub. Together they created a continuum of care for the older people from the ED through the hospital ward to their homes. At the ED a nurse with geriatric competence carried out a frailty screening. When the screening indicated that the older person was frail the nurse also completed a brief basic geriatric needs assessment and need of rehabilitation.
Multiple, Inpatient	**Everink et al., 2017** [12]	Netherlands	Discharge nurse Nurse practitioner District nurse	Assessment of functioning Case management Discharge planning Education and skills training for caregivers Multicomponent rehabilitation care or not specified	General practitioners Occupational therapists Physical therapists	**Yes**	Yes	A discharge nurse preceded dismissal from the hospital and gathered information about the patient's functional prognosis endurability teachability and trainability and the patient's and informal caregiver's needs and abilities. The triage is always performed under the responsibility of an elderly care physician from the geriatric rehabilitation facility. If the discharge nurse has doubts about the patient's eligibility for geriatric rehabilitation the elderly care physician should be consulted. The discharge nurse (in hospital) should always provide oral and written information about geriatric rehabilitation to the patient and the informal caregiver. The nurses in the geriatric rehabilitation facility should arrange home care prior to discharge of the patient. Once the patient is discharged from the geriatric rehabilitation facility the nurse practitioner or district nurse in
Multiple, Inpatient	**Everink et al., 2018** [13]	Netherlands	Discharge nurse Nurse practitioner District nurse	Assessment of functioning Case management Discharge planning Education and skills training for caregivers	General practitioners Occupational therapists Physical therapists	**Yes**	Yes	

				Multicomponent rehabilitation care or not specified				primary care should act as the patient's case manager.
Multiple, Telerehabilitation / Outpatient	**Finlayson et al., 2018** [14]	Australia	Gerontic nurse	Follow up visits	None	**Yes**	Yes	APGN will visit intervention patients undertake a health assessment and prepare a comprehensive transitional care plan. This process includes discussing the planned discharge plan with patient's caregivers doctor and ward nurses to individualize the plan. APGN will visit patients daily thereafter until discharge to establish and implement the program monitor progress and modify transitional care plan if required. After discharge home the APGN provides one in-home visit.
			Liaison nurse	Therapeutic exercises				
			Ward nurse					
			Advanced practice gerontic nurse (APGN)					
Multiple, Community	**Franse et al., 2018** [15]	United Kingdom	Geriatric nurse practitioner	Assessment of health status	Other physicians	**Yes**	No	Most positive effects of the UHCE approach were found in Rijeka. Possible explanations were a high morale to engage in activities among participants and regular monitoring of the care process by community nurses who had a personal relationship with the participants and acted as care coordinator in this study. Establishment of a trusted relationship is important for improvement of uptake and adherence to care interventions among older persons.
				Assessment of functioning				
		Greece	Community nurse	Assessment of person-centered goals				
		Croatia	Nurse	Assessment of emotional functions				
		Spain		Assessment of fall risk				
		Netherlands		Assessment of frailty				
				Case management				
				Follow up visits				
				Therapeutic exercises				
				Social care and support plan				
Multiple, Inpatient / Outpatient	**He et al., 2018** [16]	China	Nurse	Multicomponent rehabilitation care or not specified	General practitioners	No	No	The leader team comprised a medical specialist as well as nursing and allied health staff with stroke expertise.
					Physical therapists			

Multiple, Home / Community / Outpatient	**Hoedemakers et al., 2022** [17]	Netherlands	Nurse practitioner	Assessment of functioning	General practitioners	Yes	No	The CCFE is financed by a bundled payment aiming to stimulate collaboration between professionals. The bundled payment is a fixed amount of money per patient that covers all services provided by the General practitioners (GP) nurse–practitioner and physician assistant regardless of diagnoses medication review by the pharmacist telephone consultation by the Geriatricians non-individual-patient-related activities such as building a community network and overhead. To be included the health insurer does not require a specific diagnosis or the use of a screening tool. They trust that the GP and nurse practitioner.
			District nurse	Assessment of person-centered goals	Geriatricians			
				Case management	Social workers			
				Comprehensive geriatric assessment	Physical therapists			
				Multicomponent rehabilitation care or not specified	Occupational therapists			
				Therapeutic exercises				
Multiple, Inpatient / Outpatient	**Kam Yuet Wong and Ming Yeung, 2015** [18]	China	Nurse case manager	Assessment of functioning	None	No	No	In this study appointed holistic care managers (HCMs) acted as care providers and coordinators in the process of care. Nurses usually assume the role of a case manager supported by a multidisciplinary team in providing direct nursing interventions and negotiating care with multiple providers (Hammer 2005 Wong et al. 2011). These direct interventions include teaching self-administered treatment techniques counselling on appropriate health behavior reinforcing medication adherence and symptom management (Hammer 2005 Wong et al. 2008 Chow & Wong 2010). The negotiation and coordination of care by the nurse is crucial to ensure that the patients receive the appropriate type and level of care. The nurse case manager is a pivotal person in the programme providing direct interventions and coordinating input from the multidisciplinary team if needed.
				Assessment of environment				
				Behavioral interventions				
				Case management				
				Discharge planning				
				Education and counseling about healthy lifestyle behaviors				
				Education and skills training for caregivers				
				Education and skills training for self-care and self-management				
				Follow up visits				
				Multicomponent rehabilitation care or not specified				
				Therapeutic exercises				
Multiple, Inpatient / Home	**Kam Yuet Wong et al., 2022** [19]	China	Intervention nurse	Assessment of functioning	Neurologists	**Yes**	No	A nurse case manager played a pivotal role in care delivery and coordination under the multidisciplinary approach. The collaboration efforts were realized by having the MDT participate from the stage of protocol design to taking referrals from the nurse case manager (NCM) in
			Nurse case manager	Assessment of person-centered goals	Occupational therapists			
				Case management				
				Discharge planning	Physical			

				Education and skills training for caregivers	therapists			the intervention phase. The NCM delivered and coordinated planned events during the 12-week program to ensure continuity of care. A nurse-managed hotline was available throughout the 12 weeks. The intervention team involved the MDT and a nurse assigned as case manager who had the primary responsibility for conducting home visits and care coordination. As routine practice the discharged patients also received a nurse-initiated telephone call to follow up on their condition and reinforce the self-care and rehabilitation. The nurse would prepare patients for the home-based follow-up including goal-setting throughout the rehabilitation journey.
				Education and skills training for self-care and self-management	PRM physicians			
				Follow up visits	Speech and language therapists			
				Health status monitoring				
				Home visits				
				Problem solving skills training				
				Rehabilitation coordination and management not further specified				
				Therapeutic				
				Training for activities of daily living				
PHC, Home	**Kidd et al., 2015** [20]	United Kingdom	Stroke nurse	Assessment of person-centered goals	None	**Yes**	No	The stroke nurses were specialist community-based practitioners whose roles were to visit stroke survivors at home or in the community following discharge to support the transition between acute and primary care and address the long-term needs of stroke survivors post-discharge. The intervention took the form of a 'tailored self-management action plan' designed in a booklet format and created by nurses and stroke survivors working in partnership using a structured self-management assessment questionnaire and goal setting.
				Education and skills training for self-care and self-management				
				Home visits				
				Motivational interventions				
PHC, Eldercare institution / Telerehabilitation	**Kim et al., 2021** [21]	South Korea	Nurse	Assessment of functioning	Social workers	**Yes**	No	The intervention was conducted by a care team led by onsite SPEC coordinators typically a nurse–social worker pair who were trained and coached by the SPEC consultant. The consultant a nurse trained by the research team was responsible for facilitating and monitoring the implementation process including educating the onsite coordinators to do CGA and CP; demonstrating how to use the SPEC information system; coaching the care team to do ICCs; and being a resource for inquiries about implementation via onsite meetings and also a free messaging app.
				Assessment of frailty				
				Assessment of person-centered goals				
				Case management				
				Education and skills training for caregivers				

PHC, Community	**King et al., 2018** [22]	New Zealand	Gerontology nurse specialist	Assessment of functioning	General practitioners	**Yes**	Yes	The clinical nurse specialist (CNS) role is included as one of the four types of APN disciplines. Data analysis revealed two central themes from the older people perspective: "holistic expertise" and "communication". Two main themes were identified from the health professional perspective: "competency" and "service delivery." Results showed the gerontology nurse specialist role was highly regarded by both older people and the health professionals. The in-home CGA was identified as greatly beneficial.
				Assessment of medication				
			Practice nurse	Case management				
				Comprehensive geriatric assessment				
				Follow up visits				
				Monitoring of functional ability				
Multiple, Outpatient / Inpatient	**Ko et al., 2019** [23]	South Korea	Nurse	Activities of daily living skills training	None	**Yes**	Yes	The nurse was trained on the exercises protocol and safety measures of the individualized transitional care program (ITCP) to help participants repeat exercises daily that is from 1 day after hip arthroplasty to right before discharge.
				Assessment of emotional functions				
				Assessment of health status				
				Assessment of fall risk				
				Assessment of frailty				
				Discharge planning				
				Education and skills training for self-care and self-management				
				Emotional support				
				Motivational interventions				
				Therapeutic exercises				
PHC, Home	**Kono et al., 2016** [24]	Japan	Community care nurse	Assessment of cognitive functions	Other	No	No	Routine Preventive home visits (PHVs) were provided every 3 months for 24 months by community care nurses social workers or care managers who worked at all six community-based integrated centers in the three municipalities.
				Assessment of functioning	Social workers			
				Assessment of person-centered goals				
				Monitoring of functional ability				
				Rehabilitation coordination and management not further specified				
Multiple, Outpatient / Inpatient	**Koolen et al., 2020** [25]	Netherlands	Respiratory nurse	Assessment of person-centered goals	General practitioners	No	No	The respiratory nurse concentrated on the psychosocial functioning such as mood and social conditions interfering with coping the disease and self-management behaviors like medication use lifestyle factors and coping with exacerbations.
				Behavioral interventions	Occupational therapists			
				Case management	Physical			

				Education and skills training for self-care and self-management	therapists			
				Health status monitoring	Psychologists			
				Motivational interventions	Social workers			
PHC, Community	**Leung et al., 2016** [26]	China (Hong Kong)	Rheumatology nurse	Assessment of person-centered goals Education and skills training for self-care and self-management Peer support or peer support group Therapeutic exercises	None	**Yes**	Yes	A community based ASMP led by trained lay leaders.
Multiple, Outpatient	**Looman et al., 2016** [27]	Netherlands	Nurse practitioner	Assessment of functioning Assessment of person-centered goals Monitoring of functional ability Rehabilitation coordination and management not further specified Multicomponent rehabilitation care or not specified	Other physicians	No	No	After screening, frail older patients in the experimental group were visited by a nurse practitioner who assessed their functional cognitive mental and psychological functioning using EASYcare. The GP and nurse practitioner decided on treatment goals in consultation with the older people and their informal caregivers which were translated into a preliminary multidisciplinary treatment plan. This plan was determined in a multidisciplinary meeting attended by at least the GP the nurse practitioner and a secondary-line geriatric nurse practitioner. Case management was provided from the GP-practice by the nurse practitioner or by a secondary-line geriatric nursing practitioner depending on the complexity of the older people person's problems. The model required task reassignment and delegation between nurses and doctors and among GPs nursing home doctors and geriatricians.
PHC, Outpatient	**Looman et al., 2016** [28]	Netherlands	Nurse practitioner	Assessment of cognitive functions	General practitioners	No	No	
			Geriatric nurse practitioner	Assessment of emotional functions				
				Assessment of fall risk	Other			
			District nurse	Assessment of functioning Assessment of medication Assessment of person-centered goals Case management Management of urinary incontinence Multicomponent rehabilitation care or not specified Rehabilitation coordination and management not further specified	Physical therapists			

PHC, Telerehabilitation	**Lycholip et al., 2018** [29]	Netherlands	Heart failure nurse	Assessment of health status Education and skills training for self-care and self-management Health status monitoring	None	**Yes**	No	The heart failure nurses provided education and guidance of patients.
Multiple, Outpatient	**Mann et al., 2020** [30]	Australia	Enablement Officer	Case management Comprehensive geriatric assessment	General practitioners Occupational therapists Other physicians	No	No	Each patient has been assigned to an Enablement Officer (EO) (allied health or nursing). The service goes to where the client is; that is to the person's home or the GP clinic. OPEN ARCH provides a comprehensive assessment within the home environment to facilitate depth of understanding of personal circumstances and creation of a personalized care plan.
PHC, Community / Home	**Markle Reid et al., 2018** [31]	Canada	Registered nurse (RN)	Assessment of person-centered goals Case management Education and skills training for self-care and self-management Follow up visits Home visits Motivational interventions Peer support or peer support group	Dieticians Other	No	No	The registered nurses did home and telephone visits care coordination and system navigation to link clients to other health care professionals and community services as needed completed and send alerts (e.g. medication depressive symptoms diabetes complications) to communicate concerns with the primary care physician or other providers.
PHC, Home	**Metzelthin et al., 2015** [32]	Netherlands	Practice nurse	Assessment of frailty Assessment of person-centered goals Multicomponent rehabilitation care or not specified Rehabilitation coordination and management not further specified	General practitioners Occupational therapists Physical therapists	No	No	After a frailty screening (Step 1) people receive an in-home assessment by the practice nurse (Step 2). In a bilateral (i.e. GP and practice nurse) or extended team meeting (e.g. GP, practice nurse, occupational therapist, and physiotherapist) a preliminary treatment plan is formulated (Step 3).
Multiple, Inpatient / Outpatient	**Meunier et al., 2016** [33]	United States	Registered nurse (RN) Nurse-practitioner (NP)	Assessment of person-centered goals Management in the use of medication	Dieticians General practitioners	**Yes**	No	The PACE site was heavily focused on nursing care and staffed with a full-time NP three RNs two licensed practical nurses (LPNs) and several certified nursing assistants (CNAs). The

			Licensed practical nurse (LPN)	Rehabilitation coordination and management not further specified	Occupational therapists			full-time nurse practitioner (NP) who served as a primary care provider.
			Certified nursing assistant (CNA)	Social care and support plan	Physical therapists Social workers			
Multiple, Home / Outpatient / Inpatient	**Morri et al., 2021** [34]	Italy	Nurse Community nurse Nurse researcher	Assessment of functioning Multicomponent rehabilitation care or not specified	Physical therapists	No	Yes	In the hospital the nurses worked in a multidisciplinary team to evaluate the needs of each patient in terms of physiotherapy and care. The team then establishes the best post-discharge care pathway for each patient. The nurse-researcher collected the basic data of the individuals participating in the study. In home care the community nurses promoted independence in daily living activities such as eating bathing and getting dressed.
Multiple, Home / Community / Outpatient / Telerehabilitation	**Noh et al., 2021** [35]	Korea	Nurse	Assessment of person-centered goals Case management Cognitive training Education and skills training for self-care and self-management Emotional support Therapeutic recreation	Other physicians Social workers	No	Yes	The service was provided by the general manager care manager (nurse or social worker) care navigator (community-dwelling older adults) or cooperative physician at least once depending on the needs of participants and the type of service.
Multiple, Inpatient / Eldercare institution / Home	**Pannill, 2016** [36]	Netherlands	Community care registered nurse (CCRN)	Comprehensive geriatric assessment Discharge planning Follow up visits	General practitioners	No	No	The transitional care bridge program included transfer of patient management to a community care registered nurse (CCRN) with in-hospital in-person handover of care plans; an in-hospital CCRN visit with patients; CCRN home or nursing home visits with patients and caregivers after discharge; and handover to General practitionerss at 24 weeks.
Multiple, Inpatient / Home	**Rasmussen et al., 2016** [37]	Denmark	Nurse	Activities of daily living skills training Assessment of cognitive functions Assessment of environment Assessment of functioning Assessment of person-centered goals	Occupational therapists Other physicians Physical	No	No	The nurse participated in the home training if nursing intervention was needed. At least once in the home training period a follow-up visit by the team's nurse was done giving advice and information to the patient and/or relatives about subjects like stroke sequelae lifestyle (smoking

				Discharge planning	therapists			alcohol diet hypertension and more) medication fatigue depression incontinence etc. The nurse helped patients contacting their General practitioners to facilitate follow-up and control visits when needed.
				Education and skills training for caregivers				
				Multicomponent rehabilitation care or not specified				
				Provision and training in the use of assistive products				
				Rehabilitation coordination and management not further specified				
PHC, Outpatient	**Ruikes et al., 2016** [38]	Netherlands	Practice nurse	Social care and support plan	General practitioners	No	No	A case manager (either a nurse or social worker) was assigned to each participant. Case managers were responsible for the planning and logistics regarding the team meetings and for coordinating and monitoring care. For each participant using 5 chronically prescribed drugs a yearly medication review was held by the GP the nurse and a pharmacist.
			Community nurse	Assessment of person-centered goals				
			Nurse	Assessment of medication	Geriatricians			
				Case management				
				Follow up visits				
				Health status monitoring				
				Monitoring of functional ability				
				Rehabilitation coordination and management not further specified				
				Social care and support plan				
PHC, Community	**Shinkai et al., 2016** [39]	Japan	Public health nurse	Comprehensive geriatric assessment	General practitioners	No	No	The municipal public health professionals (four public health nurses and one nutritionist) shared a common goal and carried out routine tasks such as health education and consultations on healthy aging. The support of the leader in the local government was essential because of the long duration of this type of project and health professionals in the local government such as public health nurses and nutritionists had key roles in the community intervention.
				Education and counseling about healthy lifestyle behaviors				
				Education and counseling on physical activity or exercises				
				Monitoring of functional ability				
				Therapeutic exercises				
				Social care and support plan				
Multiple, Elder-care institution / Home	**Smith and Fields, 2020** [40]	Australia	Registered nurse (RN)	Case management	Dieticians	**Yes**	No	Clinical care provided as part of the transition care program where required is to be carried out by a registered nurse or under the direct or indirect supervision of a registered nurse or other professional appropriate to the service
				Discharge planning	Occupational therapists			
				Education and skills training for self-care and self-management	Psychologists			

				Multicomponent rehabilitation care or not specified	Social workers			delivery and in accordance with professional standards and guidelines. The role of nurses is clearly defined and described in the "Transition Care Program Guidelines" (2019) by the Australian Government.
				Provision and training in the use of assistive products	Speech and language therapists			
PHC, Community	**Sok et al., 2021** [41]	Korea	Geriatric nurse specialist	Cognitive training	None	**Yes**	Yes	The program was verified by an expert group consisting of 1 professor of rehabilitation medicine 1 professor of geriatric internal medicine 1 geriatric nurse specialist and 3 head nurses in the geriatric ward for the validity of contents and process of the cognitive/exercises dual-task program.
			Head nurse in the geriatric ward	Motivational interventions				
				Therapeutic exercises				
PHC, Home	**Taube et al., 2018** [42]	Sweden	Registered nurse (RN)	Assessment of emotional functions	Physical therapists	No	No	Case managers (nurses and physiotherapists) provided an intervention of general case management general information specific information and continuity and safety.
				Assessment of fall risk				
				Assessment of functioning				
				Assessment of health status				
				Assessment of medication				
				Assessment of person-centered goals				
				Case management				
				Emotional support				
				Follow up visits				
				Health status monitoring				
				Monitoring of functional ability				
				Social care and support plan				
				Social skills training				
				Therapeutic exercises				
Multiple, Inpatient / Home	**Tseng et al., 2016** [43]	China	Geriatric nurse	Assessment of emotional functions	Geriatricians	No	No	Geriatric assessment was first delivered by a geriatric nurse to assess and detect potential problems. Rehabilitation included in-hospital rehabilitation starting on the first day following surgery and 4 months of in-home rehabilitation both delivered by a geriatric nurse. The geriatric nurse provided a structured discharge assessment of caregiver competence resources family function elderly subject's self-care ability
				Assessment of environment				
				Assessment of fall risk				
				Assessment of functioning				
				Assessment of medication				
				Comprehensive geriatric assessment				

				Discharge planning				elderly subjects' and their family caregivers' need for community or long-term care services assessment of the home environment and referrals to community resources referrals. The geriatric nurse assessed fall risks and provided corresponding interventions at each home visit. High risk patients were followed up by a geriatric nurse who provided consultation according to suggestions of the Geriatricians and dietician. The nurse also assessed nutritional outcomes using the MNA at each home visit. Geriatric nurses assessed subjects' depressive symptoms before hospital discharge and at each home visit. At the same time the geriatric nurse provided individualized consultation and emotional support for these at-risk subjects.
				Education and counseling on nutrition				
				Follow up visits				
				Multicomponent rehabilitation care or not specified				
				Psychological interventions				
				Social care and support plan				
				Therapeutic exercises				
Multiple, Inpatient / Home	**Tseng et al., 2016** [44]	China	Geriatric nurse	Assessment of family and caregivers' needs knowledge and skills	Geriatricians	No	No	Continuous rehabilitation was delivered by geriatric nurses and Physical therapists to facilitate early postoperative mobility and to provide rehabilitation in the patient's home setting. The discharge planning component was delivered by geriatric nurses to assure continuity of care. The patient's adherence to follow ups in clinics was also monitored by the geriatric nurse. During the hospital stay each participant in the intervention program was seen once by a Geriatricians and a rehabilitation physician twice by a Physical therapists and six times by a geriatric nurse.
				Assessment of functioning	Physical therapists			
				Assessment of person-centered goals				
				Comprehensive geriatric assessment	PRM physicians			
				Discharge planning				
				Education and skills training for caregivers				
				Education and skills training for self-care and self-management				
				Follow up visits				
				Multicomponent rehabilitation care or not specified				
				Rehabilitation coordination and management not further specified				
				Social care and support plan				
				Therapeutic exercises				
Multiple, Inpatient / Home	**Tseng et al., 2021** [45]	Taiwan	Geriatric nurse	Assessment of person-centered goals	None	Yes	Yes	Geriatric assessment: delivered by geriatric nurse and Geriatricians with involvement of family caregivers. Discharge planning: geriatric nurse made a pre-discharge assessment with
				Comprehensive geriatric assessment				
				Discharge planning				

				Education and skills training for caregivers				necessary referrals and after discharge home environment assessment. Rehabilitation program: including both in-hospital and in-home progressed rehabilitation supervised by geriatric nurse with involvement of family caregivers. The geriatric nurse taught the in-home rehabilitation. Family caregiver training: delivered by geriatric nurse to help the family caregivers providing hip fracture and dementia care.
				Home visits				
				Therapeutic exercises				
PHC, Community	**Uittenbroek et al., 2017** [46]	Netherlands	Nurse	Assessment of person-centered goals	General practitioners	No	No	For Embrace a GP-led Elderly Care Team was assembled in which the GP remained responsible for writing prescriptions and implementing the interventions.
			District nurse	Education and skills training for self-care and self-management				
			Community nurse	Follow up visits	Geriatricians			
				Health status monitoring	Social workers			
				Monitoring of functional ability				
				Rehabilitation coordination and management not further specified				
				Social care and support plan				
PHC, Telerehabilitation	**Valdivieso et al., 2018** [47]	Spain	Nurse	Education and skills training for caregivers	None	Yes	No	The telephone support program is lead collaboratively by primary care teams and by hospital case manager nurses working in a Telemedicine Unit and is based on the preparation of personalized care plans for every patient that includes monitoring medication control surveys specific educational information for patients and caregivers and a health agenda.
			Hospital case manager nurse	Education and skills training for self-care and self-management				
				Follow up visits				
			Recruiting nurse	Health status monitoring				
				Social care and support plan				
Multiple, Telerehabilitation	**Wolf et al., 2016** [48]	Sweden	Registered nurse (RN)	Education and skills training for self-care and self-management	Other physicians	No	No	An introductory demonstration which required the patient to test the eHealth tools was provided by a registered nurse who was familiar with the study so that patients could start using the tools freely during their hospital stay.
				Health status monitoring				
				Monitoring of functional ability				
				Rehabilitation coordination and management not further specified				
PHC, Community / Home	**Wong et al., 2019** [49]	China (Hong Kong)	Registered nurse case manager (NCM)	Assessment of environment	Community health worker	**Yes**	No	The providers included a health-social care team led by a registered nurse case manager (NCM) and supported by community workers (CWs) and social workers (SWs). The health-social partnership team in the community
				Assessment of functioning				
				Assessment of person-centered goals	Social workers			
				Case management				

				Education and skills training for self-care and self-management				promotes ageing in place. It was recognized that the NCM can provide strong leadership and help to integrate others' work.
				Follow up visits				
PHC, Outpatient	**Zakrisson et al., 2016** [50]	Sweden	Asthma / COPD nurse	Education and counseling about healthy lifestyle behaviors	Dieticians	**Yes**	No	Almost all PHC centers in Sweden have an asthma / COPD clinic led by a specialized asthma / COPD nurse and mainly provide individual consultations. Nurses led meetings about disease and medication anatomy and physiology and about nutritional advice. This paper adds that one program is not enough there is a need for regular follow-ups in PHC. Also there is a difference in which nurses deliver interventions in which settings (more specialized health workers in the hospital).
			Primary health care nurse	Education and skills training for self-care and self-management	Occupational therapists			
				Education and skills training for caregivers	Physical therapists			
					Social workers			
PHC, Home / Community	**Zhang et al., 2017** [51]	China	Nurse	Assessment of emotional functions	Dieticians	No	No	Nurses or community physicians had the responsibility for designing the training modules and providing review and guidance to the program administrators.
			Rehabilitation nurse	Assessment of functioning	Other physicians			
			Cardiac nurse	Education and counseling about healthy lifestyle behaviors	Physical therapists			
			Community nurse	Education and skills training for caregivers				
				Follow up visits	Psychologists			
				Peer support or peer support group				
				Therapeutic exercises				
Multiple, Outpatient / Inpatient	**Zhang et al., 2018** [52]	China	Community nurse	Assessment of functioning	None	Yes	No	Nurse-led transitional care program in addition to usual care consisting of two phases: 1) pre-discharge phase (one week before discharge) with special assessments and health education and a booklet with information to consolidate knowledge and 2) post discharge phase (7 months) with four intervention schemes addressing health behaviors and health promotion.
			Nurse	Case management				
			Cardiovascular nurse	Discharge planning				
			Postgraduated nursing student	Education and counseling about healthy lifestyle behaviors				
				Education and skills training for self-care and self-management				
				Follow up visits				

Studies with nurses in a clinical role (N=12)								
PHC, Outpatient	**Barker et al., 2017** [53]	Australia	Rehabilitation nurse	Multicomponent rehabilitation care or not specified	Dieticians Occupational therapists Physical therapists Social workers Speech and language therapists	No	No	Community Rehabilitation northern Queensland (CRnQ) service.
Multiple, Inpatient / Outpatient	**Duncan et al., 2018** [54]	United States	Nurse coordinator Nurse practitioner Nurse	Assessment of person-centered goals	General practitioners Occupational therapists Physical therapists Speech and language therapists	No	No	The nurse administered the web-based PRO questionnaires to the patient or proxy at 2 time points over the phone and in person.
PHC, Community	**Godtfredsen et al., 2018** [55]	Denmark	Nurse	Education and counseling on physical activity or exercises	Dieticians General practitioners Physical therapists	No	No	Healthcare centers were led by multidisciplinary staff without doctors.
PHC, Outpatient / Community	**Inzitari et al., 2018** [56]	Spain	Primary care nurse	Follow up visits	General practitioners Geriatricians Physical therapists Social workers	No	No	Nurses promoted the achievement of shared goals and fostered empowerment during the follow-up visits in agreement of the community care approach.

Multiple, Inpatient / Outpatient	**Lindhardt et al., 2019** [57]	Denmark	Municipality nurse	Behavioral interventions	General practitioners	No	No	Follow-up was carried out in the patient's home by a nurse. The patient's GP and the municipality preventive consultant received a structured communication report with the assessment results prepared by the nurses who carried out the intervention. The municipality preventive consultant phoned the patients at home and provided information about relevant municipality activities they could join. Patients in this group took part in a motivational interview with an experienced municipality nurse (S.M.L.) skilled in this technique
			Staff nurse	Education and skills training for self-care and self-management				
				Follow up visits				
				Motivational interventions				
PHC, Home	**Mas et al., 2016** [58]	Spain	Nurse	Multicomponent rehabilitation care or not specified	Occupational therapists	No	No	Medical care was provided by Geriatricians. Nursing intervention was pivoting on geriatric care needs (based on cognitive nutritional and skin care protocols).
					Other physicians			
					Physical therapists			
PHC, Outpatient	**Mosleh et al., 2015** [59]	United Kingdom (Scotland)	Cardiac rehabilitation nurse	Education and skills training for self-care and self-management	Dieticians	No	No	The program is run by a multidisciplinary team (a cardiac rehabilitation nurse a physiotherapist and a Dieticians) and a psychologist and physician are available if needed.
				Therapeutic exercises	Physical therapists			
					Psychologists			
PHC, Outpatient	**Tarazona-Santabalbina et al., 2016** [60]	Spain	Nurse	Health status monitoring	Physical therapists	No	No	The intervention was performed by 8 experienced physiotherapists or nurses.
				Therapeutic exercises				
PHC, Telerehabilitation	**van der Weegen et al., 2015** [61]	Netherlands	Practice nurse (PN)	Assessment of person-centered goals	None	No	No	In the first consultation the PN raised awareness about the risks of physical inactivity and the PA level of the patient was discussed using the previously completed SQUASH questionnaire. In addition participants received a general and a disease-specific pamphlet about PA. During the second consultation a personal goal was set in minutes of activity per day based on the pre-measurement and the PN encouraged the participants to set up an activity plan to
				Education and counseling on physical activity or exercises				
				Education and skills training for self-care and self-management				
				Motivational interventions				
				Monitoring of functional ability				

							reach personal goals. In the last consultation activity results barriers facilitators and PA habits were evaluated and how the PN and patient would continue the lifestyle coaching was discussed.
PHC, Outpatient	**van Dijk-de Vries et al., 2015** [62]	Netherlands	Practice nurse	Assessment of emotional functions Assessment of functioning Assessment of person-centered goals Education and skills training for self-care and self-management Emotional support Problem solving skills training	None	No	Yes	After the training sessions Practice nurses (PNs) started to integrate SMS into their routine care practice. They applied SMS in all their consultations with patients with diabetes. SMS included a detection and follow-up phase. In European countries most patients with diabetes receive follow-up care in the primary care setting by nurses.10 Practice nurses (PNs) in the Netherlands work according to guidelines that focus on medical and behavioral management.
PHC, Community	**van Lieshout et al. 2018** [63]	Netherlands	Nurse Community nurse Psychosocial nurse	Cognitive training Education and skills training for self-care and self-management Problem-solving skills training Social skills training	Dieticians Physical therapists	No	No	A community nurse performed the meetings with additional psychosocial training at a local community center.
PHC, Outpatient / Community	**Woo et al., 2021** [64]	China (Hong Kong)	Nurse	Assessment of fall risk Assessment of person-centered goals Cognitive training Social care and support plan Therapeutic exercises Training for activities of daily living	Dieticians Optometrists Physical therapists	No	No	The medical component for these services (doctors nurses allied health) is variable and may be absent. Screening consultation (optometry physiotherapy nutritionist nurse) group program activities rehabilitation and day care are paid for by users.
Studies where nurses' role was not specified (N=4)								
PHC, Community	**Lou et al., 2015** [65]	China	Respiratory nurse	Multicomponent rehabilitation care or not specified	Dieticians General practitioners PRM physicians	No	No	Not specified

PHC, Home / Outpatient	**Oh et al., 2021** [66]	South Korea	Nurse	Multicomponent rehabilitation care or not specified	Dieticians Exercises professionals Other physicians	No	No	The multidisciplinary team consisting of doctors, physical education professionals, nurses, nutritionists and exercises experts.
Multiple, Tele-rehabilitation	**Piette et al., 2015** [67]	United States	Nurse	Multicomponent rehabilitation care or not specified	Other physicians	No	Yes	The IVR calls were developed by a panel including primary care physicians cardiologists nurses and experts in health behavior change and mHealth.
Multiple, Outpatient / Inpatient	**Quigley et al. 2021** [68]	Australia	Enablement Officer	Multicomponent rehabilitation care or not specified	Geriatricians General practitioners	No	No	Older people are referred from general practice and assigned an enablement officer (EO; nursing or allied health professional) and Geriatricians.

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