Characteristics of included studies.

Study	Sample size (=n)	Study population, setting, usual care	Mean age in years	Men (%)	Intervention content and coordinating activities	Intensity
Allen et al. (1996)	138	Women after CABG. Hospital (start pre-discharge) and outpatient clinic, USA. Usual care by primary provider, standard discharge teaching and physical therapy instructions, pre-discharge group class.	64	0%	I: Nurse-directed behavioural interventions with elements of self-efficacy construct, starting the day before hospital discharge with a videotape and workbook. Hospital-based smoking cessation counselling. Feedback on food questionnaire, short-term goals for diet, exercise and smoking cessation.	**Consultation**: first visit before hospital discharge, 1 follow-up counselling after one month. **Home visits**: 1 visit, after 2 weeks. **Telephone follow-up**: 1 phone call, after 2 months. ***Intensity**: intermediate*
Allen et al. (2002)	228	Hypercholesterolemia and CHD patients. Outpatient clinic, USA. Usual care by primary provider/cardiologist enhanced with feedback on lipids.	60	72%	I: NP (case manager) + cardiologist/primary provider participated in managing patient's lipids. NP had permission to prescribe and monitor lipid-lowering drug therapy. One outpatient visit 4-6 weeks after discharge to initiate a lipid management plan. Lipid testing, medication and lifestyle modifications were an integral part of lipid management. Nutritional counselling, physical activity, smoking cessation counselling and relapse prevention.	**Consultation:** first visit 4-6 weeks after discharge. 7 contacts per patient within 12 months. **Home visits:** 1 visit. **Telephone follow-up:** yes. **Duration:** average of 4.5 hours per patient **Intensity**: high
Allen et al. (2011)	525	African American or Caucasians CVD patients. Community health clinics, USA. Usual care from primary provider with enhanced feedback regarding CVD risk factors.	54	29%	I: Behavioural interventions to effect lifestyle changes. Aggressive pharmacologic management, lifestyle modification, identification of barriers to attainment of goals by a NP functioning as a case coordinator. Pre-appointment reminders. Specific algorithms for drug treatment were developed; a low-literacy Wellness Guide was developed specially for the study as a behavioural tool to promote lifestyle changes. Instructions to participate in a home-based exercise program.	**Consultation:** 7 visits within 12 months. **Telephone follow-up:** 6 contacts between the consultations. ***Intensity**: high*

Study	Sample size (=n)	Study population, setting, usual care	Mean age in years	Men (%)	Intervention content and coordinating activities	Intensity
Allison et al. (2000)	326	Instable AP or elective PCI patients without myocardial infarction from chest pain unit. Cardiovascular health clinic, USA. Usual care from cardiologist, one follow-up appointment within 48 hours after discharge.	58	56%	I: Risk factor modification plan by a nurse interventionist, pharmacologic lipid management, referrals, and additional follow-up as indicated (check lipids).	**Consultation:** 3 one-hour visits or more if indicated within 6 months after discharge. **Duration:** 3 hours or more ***Intensity**: intermediate*
Campbell et al. (1998)	1343	CHD patients, 19 general practices. North Scotland. Usual care from general practitioner.	66	58%	I: Nurse clinic visits contains (1) symptoms reviewing to identify poor control and referral, (2) assessing drug treatment, (3) blood pressure and lipid control, (4) behavioural risk factors were assessed. Feedback, goal planning and an agreed action plan were outlined on a take home form. Leaflets to help with dietary modifications and Stepping Out programmes to promote physical activity were available. Health visitors, district nurses or practice nurses run the clinics. A clinic coordinator provided support by phone.	**Consultation:** 2 to 6 visits within 12 months. **Duration:** first visit around 45 min., follow-up visits around 20 minutes. ***Intensity**: high*
Carlsson et al. (1997)	168	Acute myocardial infarction patients. Secondary prevention unit, Sweden. Usual care from general practitioner, 2 or 3 visits in one year. *Before randomization:* The first five weeks all patients were scheduled for two visits: at a nurse and one visit at a cardiologist. They were informed about CAD risk factors and the effect of lifestyle changes on the prognosis. All patients were invited to join an exercise program, with extra information about the positive effects of physical activity.	62	75%	I: 3- month period education program, individually and in group sessions: counselling for smoking cessation, dietary education -information orally and in writing- and physical activity. Continued with 2-3 times weekly exercise training sessions for 10-12 weeks (40 min.)	**Consultation:** 4 visits within ten months. **Duration:** total of 9 hours per patient. ***Intensity**: intermediate*

Study	Sample size (=n)	Study population, setting, usual care	Mean age in years	Men (%)	Intervention content and coordinating activities	Intensity
Carrington et al. (2013)	602	Elective and emergency patients with any cardiac diagnosis requiring ongoing management. Home visits, Australia. Usual care consists of ongoing care by their treating specialists physician and family physician. Access to follow-up health care services (including cardiac rehabilitation program).	70	72%	I: Home visit within 7-14 post index hospitalization according to GARDIAN system. Intensity of management by the cardiac nurse including repeat home visits, telephone coaching, and referral was adjusted accordingly. Detailed clinical report and recommendations were sent to the patient's specialist and family physician. Patients were able to contact the cardiac nurse for continued advice and support.	**Home visits:** 1 or more **Telephone follow-up:** average of 3.3 calls per patient (duration of 7.5 minutes) ***Intensity**: low*
DeBusk et al. (1994)	585	Acute myocardial infarction patients. Hospital (start pre-discharge) and outpatient clinic, USA. Usual care consists of follow-up care by internist, physician counselling on smoking cessation (50 dollar) and nutritionist counselling.	57	79%	I: (1) Nurse-initiated telephone contacts, (2) Computer-generated progress reports mailed to the patients, (3) visits for treadmill exercise testing, nutritional counselling, lipid lowering drug therapy (algorithms), or smoking relapse counselling by nurses. Nurses obtained permission to add a new drug; changes in dosage did not require permission.	**Consultations:** 4 visits to nurse case manager within 6 months. **Telephone follow-up:** max. 14 calls. **Duration:** 9 hours. ***Intensity**: high*

Study	Sample size (=n)	Study population, setting, usual care	Mean age in years	Men (%)	Intervention content and coordinating activities	Intensity
Gordon et al. (2002)	155	Diagnosed CAD patients. Cardiac rehabilitation clinic (I_1), outpatient clinic (I_2), and shopping mall kiosk/hospital outpatient complex (I_3), USA. No usual care, 3 interventions.	60	75%	All patients received a computer-generated cardiac risk factor report, goal level based on guidelines and an individualized action plan. Usual care by physicians. I_1: Cardiac rehabilitation program. 3 days/week, additionally education on CAD disease, risk factors and lifestyle modification. Included written materials, audiotapes, group education, one-on-one counselling. Referral for medication changes. $I_{2:}$ Physician-supervised, nurse-care-managed program. Education on CAD disease, risk factors and lifestyle modification. Included written materials, audiotapes, one-on-one counselling. Home-based exercise plan, nutrition, weight, stress management, smoking cessation program. Supervising physician made medication changes or referral. $I_{3:}$ Community-based program at a shopping mall kiosk or hospital outpatient complex. Administered by exercise physiologists. Counselling on site or via telephone, 1-2/week. Education on CAD disease, risk factors and lifestyle modification, ca. 15 min. Included written materials, audiotapes, one-on-one counselling. Home-based exercise plan, nutrition, weight, stress management, smoking cessation program. Referral for medication changes.	**Consultation:** 2 visits with the physician and nurse. **Telephone follow-up:** 4 calls ***Intensity****: intermediate*

Study	Sample size (=n)	Study population, setting, usual care	Mean age in years	Men (%)	Intervention content and coordinating activities	Intensity
Jiang et al. (2007)	167	First hospitalization with AP or myocardial infarction. Hospital (start pre-discharge) and home visits, China. Usual care unclear.	62	71%	I: Cardiac rehabilitation program: *Phase I: Hospital based patient/family education on seven topics:* (1) CHD and self-management principles, (2) medication management (3) angina prevention and management (4) physical exercise (5) dietary management (6) smoking cessation and (7) family support. *Phase II: Home-based rehabilitative care* (1) setting of daily behavioural goals (2) setting of goals for cardiac physiological risk control (3) goal directed self-management (4) log record (5) participated family members (6) follow-up care through home visits and telephone calls for monitoring, facilitating and reinforcing the self-management practice of the patients and supportive behaviours of family members.	**Consultation:** 3 months, intensity unclear **Home visits:** yes **Telephone follow-up:** yes ***Intensity**: intermediate*
Jolly et al. (1999)	597	Newly diagnosed patients with myocardial infarction and angina. General practices, United Kingdom. Usual care unclear.	64	71%	I: An undefined program to coordinate preventive care from hospital-home led by three specialist liaison nurses. Coaching of practice nurses to provide structured follow-up care and seek advice. Responsibility for coordinating follow-up care. Each patient received a record, which prompted and guided follow up at standard intervals.	**Consultations:** visit practice staff every 3-6 months. **Telephone follow-up:** yes, support of practice staff by phone. ***Intensity**: unclear*
Jorstad et al. (2013)	754	ACS patients. 11 outpatients clinic, The Netherlands. Usual care by cardiologist and cardiac rehabilitation programme.	58	80%	I: Nurse-coordinated prevention program in addition to UC based on guidelines. Focus on (1) healthy lifestyles (2) biometric risk factors (3) medication adherence. This included medication titration as needed. Referral to other health professions or treating physician for diabetes as needed.	**Consultations:** 4 visits in six months. ***Intensity**: high*
Khunti et al. (2007)	1316	CHD and CHF patients from 20 general practices, United Kingdom. Usual care from primary healthcare team, also open access to ECG and secondary care clinic.	70	62%	I: In addition to UC, two peripatetic nurse specialists trained in the management of CHD and CHF travelled between practices, where they held weekly clinics. Including assessment, conformation of diagnosis by investigations, medication management and titration and liaison between primary and secondary care.	**Consultations:** Weekly clinics, intensity unclear. **Home visits:** only for housebound patients with CHF. ***Intensity**: low*

Study	Sample size (=n)	Study population, setting, usual care	Mean age in years	Men (%)	Intervention content and coordinating activities	Intensity
Meisinger et al. (2013)	340	MI patients of ≥65 years. Hospital (start pre-discharge) and home visits, Germany. Usual care unclear.	75	62%	I: Intervention combining (1) case management and (2) disease management components: (1) identification of individual care problems, the facilitation of care coordination, (2) management of cardiac risk factors and the provision of information and individual education, including medication and medication adherence.	**Home visits:** Varying number of home visits (0-4), dependent on patients' needs and risk level. First consultation before discharge. **Telephone follow-up:** at least every 3 months, average of 19 minutes per phone call. **Duration:** Average of 117 minutes per home visit. ***Intensity**: low*
Moher et al. (2011)	2142	CHD patients from 21 general practices, United Kingdom. No usual care, 3 interventions.	66	68%	3 methods of promoting secondary prevention. I_1: Audit group. Audit of summary feedback by primary health care team at a practice meeting; amount of patients with CHD, proportion of patients with adequate assessment, data from other practices for comparison. I_2: GP group. Same information as audit group. Recall to general practitioner for patient assessment according to guidelines. Setting up a disease register and systematic recall of patients. I_3: Nurse group. Same information as GP group. Recall to nurse-clinic for patient assessment according to guidelines of secondary prevention. Nurses received education to implement it. Setting up a disease register and systematic recall of patients in a nurse led clinic.	**Consultations:** unclear ***Intensity**: unclear*
Voogdt-Pruis et al. (2010)	701	Patients with high risk for or documented CVD. Primary care, The Netherlands. Usual care from the general practitioner. Treatment protocol adhered to the Dutch guideline.	64	64%	I: Nurse consultation for cardiovascular risk management according to Dutch guideline with referral to other professions (dietician). Lifestyle and medical advice.	**Consultations:** 3 to 4 consultations within 12 months. ***Intensity**: intermediate*

Study	Sample size (=n)	Study population, setting, usual care	Mean age in years	Men (%)	Intervention content and coordinating activities	Intensity
Wood et al. (2008)	946 (hospital)	ACS or high-risk patients and their partners. Only hospital arm taken, 12 hospitals in Europe. Usual care unclear.	63	70%	I: Initial assessment of risk factors, lifestyle, drug treatment of patients and partners. Reassessment of patient and partner at 16 weeks, reassessment at one year. Medication titration by *cardiologist*. D*ieticians* (hospital) gave advice in terms of food and patterns and set realistic goals for patient and families. *Nurse* smoking cessation, quit date+ plan. Blood pressure cholesterol and glucose monitoring, education to improve medication compliance. *Physiotherapist* patterns, capacity, plan+ goals, step counter, 7-day activity recall diary.	**Consultations:** at least 8 sessions, plus a group workshop and exercise class in 4 months. ***Intensity**: high*
Young et al. (2003)	162	MI patients at hospital discharge, home visits. Canada. Usual care consists of follow-up by own cardiologist, information in cardiac teaching class and cardiac rehabilitation programme.	69	60%	I: Disease management program. A standardized pathway 'the nursing checklist', referral criteria for specialty care, communication system with the family physician and patient education.	**Home visits:** minimum of 6 home visits within 8 weeks. ***Intensity**: unclear*

Abbreviations: ACS: Acute Coronary Syndrome, AP: Angina pectoris, C: Control, CABG: Coronary arterial bypass graft, CHD: Coronary heart disease, CHF: Coronary heart failure, CVD: Cardiovascular disease, ECG: Electrocardiogram, GP: General practitioner, I: Intervention, MI: myocardial infarct, NP: Nurse practitioner, PCI: Percutaneous coronary intervention.