Appendix 1 (as provided by the authors): Characteristics of the interventions[1] (reproduced under Creative Commons Attribution License 4.0 International).

CDPM practitioner training	Theoretical training on: - Motivational interviewing - Function of the respiratory system - Function of the cardiovascular system - Diabetes - Risk factors - Existing CDPM services Practical training: Three-week mentoring in specialized CDPM services facilities.
Preliminary clinical evaluation	The clinical evaluation of participants includes: Anthropometric characteristics Medical history Medication Functions (respiratory, cardiovascular, endocrine, gastro-intestinal) Lifestyle habits and risk factors Patient’s preoccupations and objectives Previous interventions (nutrition, physical activity, respiratory, smoking cessation), Recent changes (weight, alcohol consumption)
Disciplines involved in the intervention	The interventions, based on a referral from a family physician or nurse, are provided by professionals in the following disciplines: Clinical coordination Nursing Physical activity therapy Nutrition Respiratory therapy Smoking cessation therapy
Implemented interventions	The interventions implemented are: Self-management support Education on diseases (diabetes, COPD, asthma,

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	cardiovascular) Education on risk factors (pre-diabetes, high blood pressure, dyslipidemias, obesity, physical inactivity, smoking) Counseling on medication Motivational interviewing Education about nutrition Education about physical activity Counseling on smoking cessation
Tools and support material	Each intervention is supported by print and other material to ensure that patient engagement is maintained even between the interventions. These include documents on: Chronic disease management Asthma, COPD Diabetes Cardiovascular Metabolic syndrome Hypo/hypertension Tools for smoking cessation Stress management Blood pressure monitoring journal Personal objectives journal Physical activity journal
Communication & coordination	The CDPM practitioners in our study work within primary care settings which enhances communication with primary care physicians, nurses and staff. The clinical coordinator ensures optimal communication and transition of care between the project team, the primary care professionals and specialized services. Special attention is given to the distinction of tasks fulfilled by project CDPM practitioners and tasks fulfilled by primary care nurses.
Integration	Prior to the implementation of interventions, a pre-implementation evaluation is conducted to identify the needs for CDPM services and the contextual factors of the participating PC clinics in the follow-up of CD patients. The pre-implementation evaluation of the project promotes the sharing of a common positive vision of an intervention that focuses on prevention, earlier support for patients in the course of their disease, interprofessional collaboration, services integration, motivational

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	interviewing and self-management support.
Participating primary care professionals	Participating primary care professional include: Family physicians (63) Nurses (5) Participating primary care settings: Four (4) clinics Four (4) family medicine groups
Participating specialists	Participating specialists include: Cardiologists Internal medicine specialists Endocrinologists Pneumologists

Reference:

1. Fortin M, Chouinard MC, Bouhali T, et al. Evaluating the integration of chronic disease prevention and management services into primary health care. *BMC Health Serv Res* 2013;13:132.

Subjects who had a reliable improvement in the self-management domains.

Domain (heiQ)	**Subjects with reliable improvement, n (%)**	
	Intervention (Total = 166)	**Control (Total = 166)**
Health directed behaviour	48 (28.9)	28 (16.9)
Positive & active engagement in life	31 (18.7)	21 (12.7)
Emotional wellbeing	38 (22.9)	22 (13.3)
Self-monitoring and insight	24 (14.5)	10 (6.0)
Constructive attitudes and approaches	36 (21.7)	15 (9.0)
Skill and technique acquisition	51 (30.7)	30 (18.1)
Social integration & support	23 (13.9)	20 (12.0)
Health service navigation	29 (17.5)	15 (9.0)

Appendix to: Fortin M, Chouinard M-C, Dubois M-F, et al. Integration of chronic disease prevention and management services into primary care: a pragmatic randomized controlled trial (PR1MaC). *CMAJ Open* 2016. DOI:10.9778/cmajo.20160031. Copyright © 2016 Joule Inc. or its licensors

Other variables in Intervention and Control groups at baseline and after 3 months.*

	Group	Baseline		3 months		Mean difference (Baseline vs. 3 months)		
		n	Mean (SD)	n	Mean (SD)	Within group*	Between-groups**; Cohen's d	p***
Score SEM-CD	Intervention	153	7.5 (1.8)	152	8.0 (1.6)	0.5 (0.3 to 0.8)	0.2 (-0.1 to 0.5); 0.18	0.21
	Control	160	7.3 (2.0)	158	7.7 (1.7)	0.4 (0.2 to 0.6)		
PCS	Intervention	155	42.7 (9.7)	155	45.8 (9.3)	3.1 (1.8 to 4.4)	1.6 (0.2 to 3.1); 0.04	0.03
	Control	161	44.6 (10.6)	160	45.4 (10.0)	0.9 (-0.1 to 1.8)		
MCS	Intervention	155	46.7 (10.7)	155	49.8 (9.9)	3.1 (1.7 to 4.5)	1.1 (-0.5 to 2.7); 0.04	0.19
	Control	161	47.9 (10.8)	160	49.4 (9.4)	1.5 (0.3 to 2.9)		
SF-6D	Intervention	154	0.683 (0.131)	153	0.729 (0.134)	0.044 (0.026 to 0.062)	0.021 (0.00 to 0.043); 0.00	0.05

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	Control	160	0.715 (0.129)	159	0.729 (0.126)	0.012 (-0.002 to 0.026)		
BMI (Kg/m^2)	Intervention	152	32.0 (7.2)	148	31.5 (7.4)	-0.31 (-0.95 to 0.46)	-0.27 (-1.14 to 0.61); 0.04	0.55
	Control	155	31.2 (7.0)	157	31.2 (6.8)	0.02 (-0.42 to 0.53)		

* Mean with 95% confidence interval. Mean difference = mean score 3 months – mean score Baseline.

** Mean with 95% confidence interval. Mean difference = adjusted mean 3 months ‘Intervention’ – adjusted mean 3 months ‘Control’.

*** ANCOVA comparing scores after 3 months, adjusted for baseline.

SEM-CD = Self-Efficacy for Managing Chronic Disease; HRQoL = Health Related Quality of Life; PCS = Physical Component Summary of SF-12v2; MCS = Mental Component Summary of SF-12v2; SF-6D = Single index of SF-12v2; BMI = Body Mass Index.

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