Table S3 - Detailed list of the process and clinical indicators developed to monitor the implementation of the TRANSIT interventions program

Process and clinical indicators	Confirmed (✓) or challenged (✗) in appropriateness survey 1	2	Final decision of the research team
ANTHROPOMETRIC MEASUREMENTS			
Height and weight noted in the medical file	✓	-	Reframed
Height noted in the medical file	-	-	Selected
Weight noted in the medical file	-	-	Selected
Body-mass index noted in the medical file	-	✓	Selected
Target value for weight or body-mass index noted in the medical file	-	-	Selected
Recommendations for lifestyle and habits change concerning weight loss noted in the medical file	✓	-	Selected
Waist circumference noted in the medical file	✓	-	Selected
Target value for waist circumference noted in the medical file	-	-	Selected
Recommendations for lifestyle and habits change concerning the reduction of waist circumference noted in the medical file	✓	-	Selected
EVALUATION OF GENERAL AND CARDIOVASCULAR HEALTH			
Major chronic health conditions recorded in the medical file	✓	-	Reframed
Major chronic diseases noted in the medical file in the last year	-	-	Selected
Estimated Framingham CVD-risk noted in the medical file	✓	-	Reframed
Estimated Framingham CVD-risk noted in the medical file in the last 5 years	-	-	Selected
The form for the initial evaluation of cardiovascular health is included in the medical file	-	✓	Rejected
The form for the follow-up of cardiovascular health is included in the medical file	-	✓	Rejected
FOLLOW-UP AND TREATMENT OF HYPERTENSION			
Blood pressure noted in the medical file according to the guidelines • once a year in all patients • once every 3-6 months in hypertensives with non-pharmacological treatment • once every 3-6 months in controlled hypertensives • once every 1-2 months until 2 normal readings in a row are obtained in uncontrolled hypertensives	✓	-	Selected
Confirmation of hypertension diagnosis according to the guidelines noted in the medical file • 1 episode of hypertensive emergency • blood pressure > 180/110 mmHg at the second follow-up visit • blood pressure 140-179/90-109 mmHg + diabetes, damage to target organ or chronic nephropathy at the second follow-up visit • blood pressure ≥160/100 mmHg in average in the 3 last follow-up visits • blood pressure ≥140/90 mmHg in average in the 4-5 last follow-up visits • ambulatory or self-monitoring of blood pressure o day blood pressure: Systolic ≥135 or diastolic ≥85 o over 24 hours: Systolic ≥130 or diastolic ≥80	✓	-	Selected
Target value for blood pressure noted in the medical file	-	-	Selected
Patient self-reported education on use of sphygmomanometer	-	-	Selected
Patient education on use of sphygmomanometer noted in the medical file	-	-	Selected
Recommendation made concerning the use of a hypertension journal, when initiating treatment or when blood pressure uncontrolled, noted in the medical file	-	-	Selected
Patient self-reported use of a hypertension journal when initiating treatment or when blood pressure uncontrolled	✓	-	Selected
Initiation of pharmacological treatment according to the guidelines, noted in the medical file, when: • systolic blood pressure ≥160 or diastolic blood pressure ≥100 (all patients) • systolic blood pressure ≥140 or diastolic blood pressure ≥90 with CVD risk factors	✓	-	Selected
Recommendation by pharmacist for pharmacological treatment in patients with high risk, patients with moderate risk and unmet target values using lifestyle recommendations, noted in the medical file	✓	-	Reframed

Process and clinical indicators	Confirmed (✓) or challenged (✗) in appropriateness survey 1	2	Final decision of the research team
Suggestion from the pharmacist/nurse for treatment modification (medication change, dosage adjustment, recommendation on lifestyle, re-evaluation planned), noted in the medical file, when: • blood pressure ≥140/90 (all patients) • blood pressure ≥130/80 with diabetes or kidney disease	✓	-	Selected
FOLLOW-UP AND TREATMENT OF HYPERTENSION (CONTINUED)			
Dosage adjustments done by pharmacists/nurse/physician following current individual or collective prescription, noted in the medical file, when: • blood pressure ≥140/90 (all patients) • blood pressure ≥130/80 or diabetes or kidney disease	✓	-	Selected
Pharmaceutical opinion for antihypertensive medication included in the medical file when patient suboptimally adheres to treatment (<80% or >120%)	✓	-	Selected
Pharmaceutical opinion for antihypertensive medication included in the medical file	-	-	Selected
Adherence to pharmacological treatment noted in the medical file	✓	-	Rejected
FOLLOW-UP AND TREATMENT OF DYSLIPIDEMIA			
Lipid profile noted in the medical file within the last 3 years in patients without dyslipidemia diagnosis	✓	-	Selected
Target value for C-LDL noted in medical file	-	-	Selected
Confirmation of the need to initiate pharmacological treatment according to the guidelines noted in the medical file, in: • All patients at high risk of cardiovascular disease • Patients at moderate risk of cardiovascular disease when: o C-LDL > 3.5 mmol/L o Total cholesterol/C-HDL >5.0 o hsCRP >2 mg/L (♂ >50 years and ♀ >60 years) o Family history and hsCRP rates influence risk, after Reynolds score • Patients at low risk of cardiovascular disease when: o C-LDL ≥5,0 mmol/L	-	-	Selected
Initiation of pharmacological treatment, when high CVD-risk or moderate CVD-risk and target value unmet, noted in the medical file	-	-	Selected
Suggestion from the pharmacist/nurse for treatment modification (medication change, dosage adjustment, recommendation on lifestyle, re-evaluation planned), when C-LDL ≥2 mol/L or reduction of C-LDL <50% or apoB ≥0.8g/L, noted in the medical file	✓	-	Selected
Dosage adjustments done by pharmacists/nurse/physician following current individual or collective prescription, when target values unmet, noted in the medical file	✓	-	Selected
Pharmaceutical opinion for hypolipemic medication included in the medical file when patient suboptimally adheres to treatment (<80% or >120%)	✓	-	Selected
Pharmaceutical opinion for hypolipemic medication included in the medical file	-	-	Selected
Adherence to pharmacological treatment noted in the medical file	✓	-	Rejected
FOLLOW-UP AND TREATMENT OF DIABETES			
Blood glucose or glycated hemoglobine noted in medical file according to the guidelines • Fasting blood glucose: o once within the last 3 years (patient with 1 risk factor) • Glucose tolerance test when: o fasting blood glucose within 6.1-6.9 range with suspected type 2 diabetes or glucose intolerance • Glycated hemoglobine: o every 3 months, when diabetes with unattained target o every 6 months when diabetes with attained target	✓	-	Selected
Confirmation of diabetes diagnosis according to the guidelines noted in the medical file • Starving blood ≥ 7.0 mmol/L; or • Random blood glucose ≥ 11.1 mmol/L and diabetes symptoms (polyuria, polydipsia and unexplained weight loss); or • Blood glucose 2 hours after ingesting 75 g of glucose ≥ 11.1 mmol/L	✓	-	Selected
Target values for glycated hemoglobine noted in the medical file	-	-	Selected
Patient self-reported education on the use of glucometer	-	-	Selected

Process and clinical indicators	Confirmed (✓) or challenged (×) in appropriateness survey 1	2	Final decision of the research team
Patient education on use of glucometer noted in the medical file	-	✓	Selected
Recommendation made concerning the use of a blood glucose journal, when initiating treatment or when blood glucose uncontrolled, noted in the medical file	-	-	Selected
Patient self-reported use of a blood glucose journal, when initiating treatment or when blood glucose uncontrolled	✓	-	Selected
FOLLOW-UP AND TREATMENT OF DIABETES (CONTINUED)			
Initiation of pharmacological treatment, when target value unmet after 2-3 months lifestyle change or along with lifestyle change if A1C ≥9.0%, noted in the medical file	✓	-	Selected
Suggestion from the pharmacist/nurse for treatment modification (medication change, dosage adjustment, recommendation on lifestyle, re-evaluation planned), when target value unmet, noted in the medical file	-	-	Selected
Dosage adjustments done by pharmacists/nurse/physician following current collective prescription, when target values unmet, noted in the medical file	✓	-	Selected
Pharmaceutical opinion included in the medical file when patient suboptimally adheres to pharmacological treatment (<80% or >120%)	✓	-	Selected
Pharmaceutical opinion concerning the pharmacological treatment of diabetes included in the medical file	-	-	Selected
Patient self-reported counselling made by case-management nurse on diabetes self-management	-	-	Selected
Counselling made by case-management nurse on diabetes self-management noted in the medical file	✓	-	Selected
Foot examination performed by a nurse at least once a year or more than once in hypertensive patients, noted in the medical file	✓	-	Selected
Patient self-reported foot examination performed by a nurse at least once a year or more than once in hypertensive patients	-	-	Selected
Patient self-reported a recommendation made for retina examination in the last 2 years	-	-	Selected
Recommendation for retina examination made in the last 2 years, noted in the medical file62	✓	-	Selected
Adherence to pharmacological treatment noted in the medical file	✓	-	Rejected
FOLLOW-UP AND COUNSELING ON LIFESTYLE HABITS			
Smoking status noted in the medical file	✓	-	Selected
Target value for tobacco cessation noted in the medical file	-	-	Selected
Recommendations made on tobacco cessation noted in the medical file	✓	-	Selected
Adherence to tobacco cessation noted in the medical file	-	✓	Rejected
Alcohol intake noted in the medical file	✓	-	Selected
Target value for lowering alcohol intake noted in the medical file	-	-	Selected
Recommendations made on lowering alcohol intake noted in the medical file	✓	-	Selected
Salt intake noted in the medical file	×*	-	Reframed
Frequency of salty food intake or use of free running salt noted in the medical file	-	-	Selected
Recommendations made on reducing salt intake noted in the medical file	×†	-	Selected
Fat and cholesterol intake noted in the medical file	×‡	-	Reframed
Frequency of fat- and cholesterol-rich food intake noted in the medical file	-	-	Selected
Recommendations made on reducing fat and cholesterol intake noted in the medical file	✓	-	Selected
Adherence to healthier diet noted in the medical file	-	✓	Rejected
Level of physical activity noted in the medical file	✓	-	Selected
Target values for physical activity noted in the medical file	-	-	Selected
Recommendations made on physical activity noted in the medical file	✓	-	Selected
Adherence to increased level of physical activity noted in the medical file	-	✓	Rejected
Level of stress noted in the medical file	×§	-	Selected
Recommendations made on the management of level of stress noted in the medical file	✓	-	Selected
Adherence to treatment plan for stress management noted in the medical file	-	×§	Rejected
INTERPROFESSIONAL FOLLOW-UP			
The form for the nurse therapeutic plan included in the medical file	-	✓	Selected
Follow-up with family noted by case-management nurse in the medical file	-	✓	Selected
Reference by case-management nurse to other health professionals or community programs and resources noted in the medical file	-	-	Selected
Patient self-reported reference by nurse to other health professionals (nutritionist, kinesiologist, psychologist) to support lifestyle change	-	-	Selected

Process and clinical indicators	Confirmed (✓) or challenged (×) in appropriateness survey 1	2	Final decision of the research team
Patient self-reported meeting with other health professionals (nutritionist, kinesiologist, psychologist) to support lifestyle change	-	-	Selected
Progress notes from other clinicians (nutritionist, kinesiologist, psychologist) included in the medical file	-	-	Selected
INTERPROFESSIONAL FOLLOW-UP (CONTINUED)			
Suggestion made by the case-management nurse to patient to attend to free educational programs offered in the region noted in the medical file	-	-	Selected
Patient self-reported suggestion made by the case-management nurse to attend to free educational programs offered in the region	-	-	Selected
Patient self-reported attending to free educational programs offered in the region	-	-	Selected
Reference by the case-management nurse to community resource noted in the medical file	-	-	Selected
Patient self-reported reference by the case-management nurse to community resource	-	-	Selected
Patient self-reported using community resource	-	-	Selected
Laboratory tests ordered by the nurse according to collective prescriptions noted in the medical file	-	-	Selected
Dosage adjustments of medication performed by community pharmacists according to current collective prescriptions noted in the medical file	-	-	Selected
Patient self-reported dosage adjustments of medication performed by community pharmacists according to current collective prescription	-	-	Selected
MOTIVATIONAL INTERVIEWING AND USE OF PATIENT HEALTH BOOKLET			
Patient meeting with the case-management nurse to discuss lifestyle habits noted in the medical file	-	-	Selected
Patient self-report meeting with the case-management nurse to discuss lifestyle habits	-	-	Selected
Use of motivational interviewing techniques by the case-management nurse noted in the medical file	-	✓	Selected
Patient self-assessment of impact of health problems on quality of life noted in the medical file	-	✓	Selected
Patient self-report the self-assessment of impact of health problems on quality of life	-	-	Selected
Patient lifestyle change objective noted in the medical file	-	✓	Selected
Follow-up on lifestyle change objective noted in the medical file	-	-	Selected
Target values (weight, waist circumference, tobacco cessation, alcohol intake, physical activity, blood pressure, C-LDL, and A1C) tailored to patient noted in the medical file	-	✓	Reframed
Patient self-report lifestyle change objective (target) set with a health professional	-	-	Selected
Patient adherence to targeted healthier lifestyle noted in the medical file	-	-	Selected
Patient self-report the use of personal-health booklet	-	-	Selected
Use of personal-health booklet noted in the medical file	-	✓	Selected

Legend
* Score = 3, discordance = 21%, thus unapproved.
† Score = 7, discordance = 36%, thus no consensus.
‡ Score = 4, thus unapproved.
§ Score = 6, thus no consensus.