**Table 2**. Characteristics of the Intervention

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| **Study** | **Intervention theoretical domains & Constructs** | **Link Worker Training** | **Link worker qualifications & backgrounds** | **Services provided** | **Intervention location, duration & follow ups** | **Intervention delivery** | **Mode of intervention delivery** |
| 1.Gray et al 2021 | Shaping knowledge, feedback and monitoring, goal setting, social support, advocacy, navigation | 40 hr of comprehensivetraining, including didactic sessions,In-class exercises and field practice. Health coaching and motivationalinterviewing delivered by a professional healthcoach and Certified Diabetes Educator,Diabetes self-management educationCompetency Test prior to working with clients. Biweekly training sessions with Health coach | High school or equivalent degrees and5–8 years of experience as CLWs, Latina and bilingual in Spanish/English, from the communities the project served. | education, assistance, client advocacy, social support,informal counselling, and linkages to community resources, blood glucose monitoring, healthy eating, physical activity, medicationtaking, and smoking cessation | Home based, community resource locations | CLWs met with participants in their homes at baseline, with follow-up visits at 0.5, 1.5, 3.5, and 7 months and an optional 10-month visit.Total Interventions:All but one received at least four CLW visits. | Face to Face |
| 2.Bossche et al (2021) | Social support, coaching, advocacy, navigation | 2 online training modules of 2 hrs with entailed communication skills, signposting, recognizing alarming signals presented by patients and safety measures to prevent COVID- 19 infection | NR | Offer presence to patients who were socially isolated or who felt lonely or anxious, information on social distancing, navigation to healthcare facilities | Community resource locations8 weeks durationFollow up: baseline, 8 weeks | Aimed for a total of 8 contacts up to 2 hours per contact over 8 weeks Total interventions: NR | Telephone, text messages, WhatsAppmessages, e-mails or postcards, Skype meetings, park walks |
| 3.Ramirez et al (2020) | Community-based participatory research methods drawing on theoretical frameworks such as social cognitive theory, stress and coping theory, and health behaviour change theory | NR | NR | Social work and psychosocial services referrals, child /elderly care, transportation, and financial services; accessing and planning future medical appointments for treatment follow-up, fertility education, guidebook, journaling, onward referral to community services | Community resource locations12 months durationFollow up: baseline, 3, 9, 15 months | Survivors in the PN-LCNS group accessed the standard services (PN-only services) 2.70 times on average (median, 2; range, 1-9) and the LCNS services about twice on average (median, 2; range, 0-16). PN-only survivors accessed the PN-only services on average 2.69 times (median, 2; range, 1-11), and there were 3 PN-only survivors who accessed the LCNS services (2, 3, and 9 times).Total Interventions: NR | Telephone |
| 4.Mercer et al (2019) | The Glasgow Deep End Links WorkerProgramme (LWP); theory of community-oriented primary care  | NR | NR | Forge relationships between general practices and community organizations, and support patients to access the nonmedical services and encourage self determination | Clinics; home visits; community resource locations9 months durationFollow up: baseline, 9 months | As requiredTotal interventions: 868 | One to one, face to face, telephone |
| 5.Kangovi et al (2018) | Individualized Management for Patient-Centred Targets (IMPaCT) is a standardized intervention based on Participatory action research framework to help low-income patients achieve health goals within the domains of coaching, social support, and advocacy | One month-long training that covers topics such as action planning and motivational interviewing. | High school diploma | CLWs helped patients identify long-term supports for after the intervention ended. Included neighbours, family members, church, or a weekly CLW-facilitated support group, exercising and helping participants apply for social services; sourcing lower cost medication; onward referral to community based mental health care and drug addiction treatment. |  NR6 months durationFollow up: baseline, 6, 9 months | Min 24 contacts; Total interventions: NR | Individualised or group face to face; telephone |
| 6.Spencer et al (2018) | The Racial and EthnicApproaches to Community Health (REACH)Detroit Partnership is a community-basedparticipatory research (CBPR) approach; DSME curriculum, “Journey to Health/El Camino a La Salud, ”grounded in theempowerment method that emphasizes a collaborative approach to facilitate self-directed behaviour change among individuals with long-term health issues  | CLWs underwent 160 h of CLW training; 80 h of diabetes education; home visit experiences; training in human subjects protocols; behaviour modification strategies; cultural competency and CPBR principles; trained in empowerment-basedApproaches; motivational interviewing and goal setting. | Spanish-fluent Latinas who had completedhigh school or had a GED; recruited from the southwest Detroitcommunity | Improve communication skills with their providers and facilitated necessary referrals to other service systems; set goals using the five-step goal-setting model, which included 1) exploring a participant-identified problem,2) discussing the emotional impact of the problem, 3) selecting a self-management goal,4 ) developing an action plan 5) executing and evaluating the action plan | Community resource locations6 months durationFollow up: baseline, 6, 12, 18 months | 11 x 2-hr group sessions of 8–10 participants held every 2 weeks; 2 x 60-min home visits each month; 1 clinic visit with the participantand his or her primary care provider; phone calls every 2 weeksTotal interventions: NR | Individualised and group face to face; telephone calls |
| 7.Carrasquillo et al (2017) | Miami Healthy Heart Initiative community-level intervention in which the CLWs successfully link Latinos participants in underserved settings with assistance with nonmedical social services, health education; patient navigation under the framework of chronic care model; self-management support; clinical information; healthcare organization and community resources | 75-hour training curriculum, including CLW-specific skills (35 hours); type 2 diabetes clinical and behavioural interventions (20 hours), includingmotivational interviewing training; basic researchmethods on human participants research(20 hours); CLW trainees shadowed 5 patient home visits with another CLW before receiving their initial cases; ongoing periodic CLW training on issues such as CLW skills, clinic and insurance navigation; cardiovascular disease and type 2 diabetes care every 2 months. | Lead CLW were non-medical staff; CLW supervisor – MSc qualification | Health education, patient navigation obtaining appointments, reminders; preparation checklists, medication refills, assistance with behavioural health linkages, communication with the clinician about patient care issues, and ≥1 clinic visit with the patient); health coaching (helping patients to prioritize concerns beforeclinician visits, bringing their medications; ensuring they informed clinicians during the visit about elevated home blood pressure or glucose level readings); assisted with nonmedical services, such as housing, employment, legal and financial assistance, food resources; linkages to existing community social service providers. Bimonthly exercise groups. | Domiciliary; clinic; Community resource locations12 months durationFollow up: baseline, 12 months | 4 home visits and12 calls during the 12 months & bimonthly exercise groupsin parksTotal interventions: median number of home visits received was 5 (interquartilerange (IQR), 2-7), the median number of CLW visits with the patient to the clinic was 1 (IQR, 0-2), and median numberof telephone calls was 20 (IQR, 12-32); Participants (126 (84%)) received at least 12 CLW contacts in the year | Individualised and group face to face; telephone calls. |
| 8.Kangovi et al (2017) | Individualized Management for Patient-cantered Targets (IMPaCT) is a standardized intervention to help low-income patients achieve health goals within the domains of coaching, social support, and advocacy | Month-long college accredited training covering topics such as action planning and motivational interviewing. CLWs had on-the-job training through apprenticeship with a senior CLW. Weekly monitoring of CLW by manager. | Recruited from communityQualifications: NR | 3 stages: actionplanning, tailored support, and connectionwith long-term support, Weekly patient support group, CLWs communicated with their patients at least once per week for 6 months through telephone, text, or visits | Domiciliary; community resource locations6 months durationFollow up: baseline, 6, 9 months | Average of 38.4 hrs with each patient over the 6-month intervention period. 35% participants participated in 3 ormore sessions of the peer-support groupTotal interventions: NR | Face to face; interviews; meetings; group classes |
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| 9.McDermott et al (2015) | “Getting better at chronic care” which aimed to evaluate the impact of a Health Service Model in which a case management approach by local community-based health workers supported by an Indigenous clinical outreach team in 12 primary care services in remote far north Queensland communities over an 18 month period | All health workers at the commencement of the study received an intensive 3-week training in clinical aspects of diabetes and other chronic conditioncare, including how to support patients in self-management skills, advice on medications, routine foot care, nutrition, smoking cessation; follow up referrals to other providers, and scheduled tests; 2 week refresher workshops on “Good clinical and reflective practice” | Recruited from communityNR | Indigenous health worker working as part of the primary care team. Roles included helping patients make and keep appointments, understand their medications and nutrition the effects of smoking and where appropriate, work with the family to help support the patient in self-management. | Domiciliary; clinic 18 months duration Follow up: baseline, 18 months | Delivery: NRTotal Interventions: NR | Individualised face to face  |
| 10.Spencer et al (2013) | CLW Model as part of the Racial and Ethnic Approaches to Community Health (REACH) Detroit Partnership. Using a socioecological model, family, health system, and community-level interventions weredeveloped to address sources of diabetes disparities at eachlevel | CLW were underwent more than 80 h of training. CLW were trained inempowerment-based approaches including self-determination and autonomy motivation theory; motivational interviewing used to elicit participants’ goals and help participants formulate their own action plans. | Ethnicallymatched with their assigned participantsQualifications: NR | Reach Detroit community activities provided free, publicly available healthy eating demonstrations, physical fitness activity (e.g., dance and exercise classes, walking clubs); weekly community farmers’ produce market; CLWs helped participants improve their self-management skills; patient–provider communication skills; facilitated necessary referrals to other service systems | Domiciliary; community resource locations; clinic12 months durationFollow up: baseline, 6, 12 months | Home visits (2 per month, each about 60 min in length) to address participants’ specific self-management goals; 1 clinic visit with the participant and his or her primary care provider; Eleven culturally tailored 2-h group sessions of 8–10 participants were held every 2 weeks at community locations; CLW phoned once every 2 weeksTotal interventions: NR | Individualised and group face to face; telephone |
| 11.Spencer et al (2011) | CLW Model as part of the Racial and Ethnic Approaches to Community Health (REACH) Detroit Partnership. Using a socioecological model, family, health system, and community-level interventions weredeveloped to address sources of diabetes disparities at eachlevel | CLW were underwent more than 80 h of training. CLW were trained inEmpowerment-based approaches including self-determination and autonomy motivation theory; motivational interviewing used to elicit participants’ goals and help participants formulate their own action plans. | Ethnicallymatched with their assigned participantsQualifications: NR | Trained CLWs, known in this study as family health advocates, promoted healthy lifestyle and diabetes self-management activities as part of the “Reach Detroit Community program” | Domiciliary; community resource locations; clinic12 months duration Follow up: baseline, 6 months | Home visits (2 per month, each about 60 min in length) to address participants’ specific self-management goals; 1 clinic visit with the participant and his or her primary care provider; Eleven culturally tailored 2-h group sessions of 8–10 participants were held every 2 weeks at community locations; CLW phoned once every 2 weeksTotal interventions: NR | Individualised and group face to face; telephone |
| 12.Babamoto et al (2009) | “Amigos en Salud” (Friends in Health) cultural intervention composed of diabetes educ. and assessment of patients understanding, knowledge deficits, evaluated health behaviours, such as frequency / intensity of physical activity, dietary habits, medication adherence, and self-monitoring practices | 6-week training curriculum included clinic policies and procedures, CLW roles and responsibilities, diabetes standards, self-management strategies incorporating patient cultural and spiritual beliefs, health behaviour change theory to help connect the healthcare system with the community  | High school degree or a GED degreeLayperson recruited from the surrounding community, clinic, and local organizations. | CLWs conducted individual educational sessions based on ADA standards with participants and their family members. The 10-week ADA education sessions were tailored to the participants’ needs, such as knowledge, identified problems, goals, and level of progress; routine follow-up calls to monitor self-management progress, review barriers and problem solve | Domiciliary; clinic6 months duration Follow up: baseline, 6 months | Weekly individual ADA educational sessionsTotal interventions: 11.3 mean | Telephone; face to face |

CLW- Community Link Worker; NR - not reported; PN-LCNS- Patient Navigation-Livestrong Cancer Navigation Services; PN - Patient Navigation; HRQOL- Health Related Quality of Life; CI- confidence Interval; EQ-5D-5L - a standardized measure of self-reported health-related quality of life that assesses 5 dimensions at 5 levels of severity; HbA1c-haemoglobin; BMI - body mass index; SBP-systolic blood pressure; CPD-cigarettes per day; PL - Peer leader; LDLC- low-density lipoprotein cholesterol; EUC-Enhanced Usual care; PHQ-9 Patient Health Questionnaire-9; PHQ 2 Patient Health Questionnaire- 2; LDL- Low Density Liporotein; CDC- Centre for Disease Control; ADA- American Diabetes Association; GED- General Educational Development Test.