Supplementary file 1

Table S1. Degree of compliance scores of measurement components of the element "individual assessment of integrated social and health care" in SCS according to customized questionnaire scores[a]. *Mean (SD)*. N=21[b].

1. Values and preferences of the person	3.9 (1.0)
2. Functional and instrumental autonomy (basic ADLs, IADLs) (n=19)	3.3 (0.7)
3. Need for support in decision making (n=20)	2.6 (1.2)
4. Multidimensional assessment of the needs of the care recipient (n=12)	4.1 (1.2)
5. Social and family situation and environment	3.3 (1.2)
Basic social assessment (n=20)	3.7 (0.9)
Social diagnoses	3.2 (1.3)
Evaluation of social complexity criteria (n=20)	3.7 (0.9)
The person's support network	3.1 (1.3)
Dynamics of family relationships	3.2 (1.3)
Interaction with the community	2.8 (1.4)
Socioeconomic status and resources of the person and family in situations in which services not covered by universal health insurance are expected	3.2 (1.3)
6. Evaluation of the person's health situation (n=18)	1.8 (1.9)
System-based assessment (n=15)	1.9 (1.2)
Health diagnoses (n=18)	1.8 (2.2)
Identification and/or signs of frailty (n=18)	2.3 (1.7)
Categorization of complex patients (CCPs/ACPs) (n=18)	2.0 (2.2)
Specific assessment tailored to each group (n=17)	1.7 (2.2)
Assessment of the presence of pain (n=16)	1.3 (1.8)
Assessment of other symptoms (e.g., dyspnea) (n=16)	1.4 (2.0)
7. Detection of risks related to the person	2.6 (1.6)
Falls	2.5 (1.6)
Mistreatment, neglect, or abuse	3.4 (1.3)
Pressure ulcers (n=19)	2.4 (1.6)
Unwanted loneliness	3.0 (1.2)
Self-harm (n=20)	1.8 (2.0)
Other (n=8)	4.0 (1.1)
8. Protective and resilience factors (n=19)	1.6 (1.8)
9. Screening for frailty (n=19)	2.7 (1.3)
10. Safe use of medication at home	2.5 (1.9)
Review and reconciliation of medication in the home	2.8 (1.8)
Adherence to treatment (n=19)	2.4 (1.7)
Systems for preparing and preserving the medication	2.4 (2.3)
11. Safe use of equipment and other technology in the home (n=19)	3.1 (1.3)
12. Support and occupational therapy resources (n=10)	3.7 (1.3)
Screening for support product needs (n=10)	4.0 (1.1)
Availability of occupational therapy (n=10)	3.0 (1.9)
Occupational therapy assessment (n=10)	3.0 (1.9)
Bank of technical products in the territory (n=10)	4.2 (0.8)
13. Evaluation of care providers	3.1 (1.4)

Key contact persons and caregivers	3.4 (1.4)
Assessment of needs (n=20)	2.7 (1.7)
Risk of claudication	3.1 (1.3)
14. Conditions of the home	4.7 (0.6)
Habitability	4.6 (0.7)
Accessibility	4.6 (0.7)
State of cleanliness	4.8 (0.4)
Needs for adaptation of the environment	4.4 (1.2)
Other (n=11)	5.0 (0.0)
15. Use of resources and services in the home: remote assistance, home health workers, respiratory physiotherapy, physical/occupational therapy, home oxygen therapy, speech therapy, etc. (n=20)	3.1 (1.2)
16. Primary support received by the person and family or care providing environment (n=18)	2.9 (1.2)
17. Existence of an advanced care plan, especially in the case of ACPs (n=20)	1.0 (1.6)
18. Ethical implications of the care process (n=19)	2.0 (1.4)
19. Assessment of the person's quality of life, conducted using a quality-of-life assessment tool or scale (n=19)	1.2 (1.7)
20. The initial and subsequent assessments of the person meet timing and accessibility requirements (n=19)	2.2 (1.6)
The assessment of the person is unique and supplemented by health and social care professionals (n=18)	1.6 (2.0)
The record of the assessment is available to both social and health care professionals at the person's own home in order for them to view it (n=19)	0.6 (1.5)
The assessment is conducted during the first two weeks after joining the Integrated Social and Health HCS Program (n=18)	0.9 (1.5)
The assessment includes a diagnostic face-to-face visit to the person's home (n=19)	3.9 (1.4)
Periodic assessments are carried out at least annually or whenever the person's situation changes significantly (n=19)	3.9 (1.5)

[a]Scores range: 0 to 5. [b]Unless otherwise specified, the assessment corresponds to the 21 SCS that rated the attribute "individual assessment of integrated social and health care" with a score ≥3 in the screening questionnaire.

ACPs, advanced chronic patients; ADLs, activities of daily living; CCPs, complex chronic patients; HCS, home care services; IADLs, instrumental activities of daily living; SCS, social care services.

Table S2. Degree of compliance scores of measurement components of the element "single individual plan for integrated social and health care" in SCS according to customized questionnaire scores[a]. *Mean (SD).* N=18[b].

1. The person's care plan is unique	3.5 (0.9)
2. List of needs or problems that require intervention (n=17)	3.6 (1.0)
Specification of the priority problems of the person and their family and main caregiver (n=17)	3.5 (0.8)
3. Definition of objectives agreed upon with any care providers from other spheres	3.0 (1.1)
Expectations and objectives of the person and their family regarding the care process	2.6 (1.1)
4. Specification of the interventions and strategies that will be carried out (n=17)	3.1 (1.2)
Specification of the professionals or disciplines responsible for their execution (n=17)	3.0 (1.2)
5. Specification of the criteria that will be used to evaluate the results	2.5 (1.0)
6. The plan is jointly prepared with the person and the team	2.0 (1.8)
It is based on the interdisciplinary and integrated assessment of the person and their environment	2.0 (2.1)
It is prepared together with the person, the social and health interdisciplinary team and the person's key support network when necessary	1.8 (2.0)
It is prepared through a process of shared decision-making	2.3 (1.4)
7. The plan is implemented from the very start of the care service, and it is reassessed within the first 6 weeks and at least once a year (n=16)	2.8 (1.2)
8. The person can view the plan and keeps the current and up-to-date care plan (n=17)	1.5 (1.3)
9. The plan includes actions by the professionals from the various disciplines and home services that visit the person at home (n=17)	1.6 (2.0)
10. The plan is accompanied by a home information file specifying the key agreements and aspects to be taken into account in relation to the care recipient and their family	1.3 (1.9)

[a]Scores range: 0 to 5. [b]Unless otherwise specified, the assessment corresponds to the 18 SCS that rated the attribute "single individual plan for integrated social and health care" with a score ≥3 in the screening questionnaire.
SCS, social care services.

Table S3. Degree of compliance scores of measurement components of the element "shared protocols across health and social services" in SCS according to customized questionnaire scores[a]. *Mean (SD).* N=17[b].

1. Definition of the systems for organizing the teams according to the territory of action (n=16)	4.1 (1.6)
2. Collaborative planning of the service among the agents involved (n=16)	1.4 (1.7)
3. Systems for allocating cases and assigning the workload (n=16)	3.3 (1.6)
4. Interdisciplinary and multi-agency composition of the services included in the portfolio of the home care teams	1.2 (1.9)
5. Communication and messaging system for the practitioners involved in the care process (n=16)	2.0 (1.4)
6. Assignment of lead and co-lead caregivers for the person (n=16)	4.2 (1.4)
7. The team has access to the electronic case tracking system (n=14)	2.1 (1.3)
8. Existence of agile mechanisms for resolving any differences or conflicts of criteria arising between professionals and organizations	1.4 (1.8)
9. Existence of shared protocols for HCS (n=5)	1.6 (1.4)
10. Shared care routes for the integrated care service (n=15)	0.5 (1.0)

[a]Scores range: 0 to 5. [b]Unless otherwise specified, the assessment corresponds to the 17 SCS that rated the attribute "shared protocols across health and social services" with a score ≥3 in the screening questionnaire.
HCS, home care services; SCS, social care services.

Table S4. Degree of compliance scores of measurement components of the element "coordination between social and health multidisciplinary teams" in SCS according to customized questionnaire scores[a]. *Mean (SD)*.N=19[b].

1. Existence and application of a territorial functional plan that ensures the delivery of integrated care (n=8)	1.2 (1.7)
Application of the plan regarding the continuity of care with primary health care (n=6)	0.8 (1.4)
Application of the plan for continuity of care with the social-health care network (n=7)	1.2 (1.8)
Application of the plan for continuity of care with key hospitals (n=7)	1.2 (1.8)
Application of the plan for continuity of care with other specialized services (n=7)	1.1 (1.5)
Incorporation of volunteers and other community initiatives (n=8)	1.5 (1.6)
2. Conducting case conferences planned jointly between the social and health care teams	1.4 (1.8)
3. Responses to enquiries raised between the different parties involved in the care process	1.4 (2.0)
4. Information provided in the person's transitions between different services	1.5 (1.9)
5. Management of differences of opinion among the teams in accordance with established procedures (n=18)	1.1 (1.6)

[a]Scores range: 0 to 5. [b]Unless otherwise specified, the assessment corresponds to the 19 SCS that rated the attribute "coordination between social and health multidisciplinary teams" with a score ≥3 in the screening questionnaire.
SCS, social care services.

Table S5. Degree of compliance scores of measurement components of the element "integrated portfolio of services with joint social and health HCS projects" in SCS according to customized questionnaire scores[a]. *Mean (SD).* N=11[b].

1. Existence of a portfolio of social and health HCS	3.2 (1.9)
2. Description of the catalog of services	2.4 (1.9)
3. Periodic assessment of the programs described in the catalog of services	2.2 (1.6)
4. Existence of a personal platform or folder where the person and caregiver can interact with the key professionals (n=10)	0.8 (1.3)

[a]Scores range: 0 to 5. [b]Unless otherwise specified, the assessment corresponds to the 11 SCS that rated the attribute "integrated portfolio of services with joint social and health HCS projects" with a score ≥3 in the screening questionnaire.
HCS, home care services; SCS, social care services.