**Identification of records via other methods**

**Identification of studies via databases and registries**

Additional Records identified from: Government Initiatives

Examples: NIH Data Science Strategy 2018; NINR Artificial Intelligence Bootcamp 2020; NINR Precision Health: Smart Technologies, Smart Health Bootcamp, 2019; NINR NACNR Meeting Minutes Sept 2019; NIH All of Us; NIH HEAL Initiative; NIH PROMIS®; NIH Institutes and Centers that are funding Symptom Science (i.e., CFAR, RADx-UP); CMS National Health Expenditures Annual Reporting; and National Academies of Medicine Artificial Intelligence Healthcare System COVID-19 Update (i.e. telehealth):

Websites (*n*=7)

Organisations (*n*=6)

Thought Leader Statements (n=10)

Records removed *before screening*:

Duplicate records removed

(*n*=34)

Records identified from:

Total Databases (*n*=228)\*

Embase (*n*=26)

Scopus (*n*=54)

WoS (*n*=43)

CINHAL (*n*=23)

PsychInfo (*n*=2)

PubMed (*n*=63)

Google Scholar (*n*=17)

**Identification**

Records excluded

(*n*=82)

Records screened

(*n*=194)

Records sought for retrieval

(*n*=13) plus thought leaders

Records sought for retrieval

(*n*=112)

Records not retrieved

(*n*= 49)

**Screening**

Records excluded

(*n*=6)

-Retained as background information due to not enough room in journal’s final Reference count cutoff

Records assessed for eligibility

(*n*=13) plus thought leaders

Records assessed for eligibility

(*n*=63)

Reports excluded:

Reason 1 (*n*=31)

Model was disease specific

 Reason 2 (*n*=8)

Not enough room in journal’s final Reference count cut-off, but were used to inform writing logic.

Studies and reviews included:

(*n*=24)

Consensus Study Reports: (*n*=6)

Grey Literature Reports: (*n*=4)

Critical thought leader statements: (*n*=10)\*\*

Websites and Organizations: (*n*=7)

**Included**

*Note.* Supplemental Figure 1

\* Embase, Scopus, WoS, CINHAL, PsychInfo, were Research Question 1; PubMed and Google Scholar were Research Question 2.

\*\*Critical thought leader statements (lower level Hierarchy of Evidence) were included because they were a valuable source of information that could not be otherwise found in published research papers. Examples include: NINR program thought leader statements and design of SSM; Prominent Scientist critiques such as Developer of Symptom Science Center, Senior Scientist Model Developers, and Deans and Editors’ feedback on use of NIH SSM; insights on SDOH COVID-19 healthcare system integration needs and gaps for pandemic response (i.e., urgent need for rapid improved multi-sector collaboration for food access; SDOH EHR clinical informatics integration; AI gaps between acute care inpatient and outpatient settings; United Nations Development Programme for social justice and equitable distribution of resources).