E-Health and regional integration of primary & referral based care for patients with chronic disease:
An overview of the core peer review literature 2009-2013

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ABSTRACT

As the leading causes of death shift to long-lasting non-communicable diseases, how to effectively integrate health resources through technology to provide tailored care is becoming a hot topic. We present an overview of the core peer review literature 2009-2013 on e-Health and regional integration of primary & referral based care for patients with chronic disease. The aim is to give a general view of the current study on the intersecting fields of integrated care, e-Health, and chronic disease. Core journals in one database (PubMed) and one additional journal (International Journal of Integrated care) were searched for English journal articles published between Jan 2009 and Dec 2013, focusing on adult patients with any condition except for AIDS, mental illness or addiction, or the articles about midwifery (focusing on chronic conditions pose a significant burden in terms of morbidity, mortality and health care costs). We identified 189 articles. These were sorted into 5 topics: defining integrated care; methods and tools, evaluation and quality; contextual, governmental, and managerial requirements for integrated care; case studies and experiences; and identified issues and future directions. The current paper includes a bibliographic essay for each of these topics.

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1. Executive summary

1.1 Overview

E-Health and regional integration of primary and referral based care for patients with chronic disease is a multidisciplinary topic exploring effective ways for integration of different fields: e-Health technology, disease and patient management, and models of regional collaboration between health care sectors. This topic is prone to be more general, and works with the relationships and interactions between different disciplines, rather than using a single discipline to explain one question.

To health systems worldwide, the greatest burden of disease has changed from communicable diseases to non-communicable diseases. The world population is living longer and dying at lower rates with the leading causes of death shifting to non-communicable diseases including multi-morbidity. In Australia, it is estimated that the prevalence of chronic diseases makes up more than 70% of Australia's overall disease burden, including death, disability and reduced quality of life. People with multiple chronic illnesses are major consumers of health care resources and require more presentations across different care services (private medical specialists, community health, general practice, allied health, and hospital inpatient and out-patient clinics) over a long period of their life. To reduce fragmentation between different health care services, improve the coordination and collaboration of multi-disciplinary professionals in health services; integrated care has gained increasing attention from managers, health care workers, policymakers and researchers in many countries as a strategy to improve health care delivery.

The technological tools of e-Health have emerged as a crucial accelerator of the movement toward integrated care. This paper is designed to support work on the hypothesis that developing integrated care requires overcoming barriers between primary and referral based care to provide the right care at the right time in the right place, and that e-Health will be central to much of this push toward better integration.

1.2 Search strategy

The search was restricted to articles published in the five calendar years 2009-2013, as we intended to obtain the novel ideas and current gaps. The search strategy had two steps. First, we performed an automated search of the core clinical journals of PubMed, and the

International Journal of Integrated Care (not a core journal of PubMed) for three keywords: chronic disease, e-Health, and integration of care. We also identified related terms for the latter two key words. For e-health, we used twenty-nine related terms as follows: ehealth* OR e-mail* OR email* OR internet* OR web-based* OR webbased* OR telemedicine OR tele-medicine OR telemonitoring OR tele-monitoring OR on-line communication OR online communication OR telecare OR tele-care OR telecure OR tele-cure OR telehomecare OR tele-home-care OR cybermedicine OR econsultation OR e-consultation OR remote consultation OR elearning OR e-learning OR ecare OR e-care OR telehealthcare OR tele-healthcar. For integration of care, we used five related terms: “disease management” OR “patient care management” OR “patient-centred care” OR “health planning” OR “delivery of health care integrated”. In PubMed, we screened the results by five filters: article type “journal articles”; text availability “abstract available”; species “humans”; language “English” and journal category “core clinical journals”. In total, this automated search yielded 415 abstracts, 119 form PubMed and 305 from Int.J. Integrated Care.

Secondly, the authors screened the 415 abstracts to identify items that met the following criteria： 1) The scope of the article concerned integrated care and/or e-Health programmes. 2) The article focused on adult patients with any condition except for AIDS, mental illness or addiction, or the articles about midwifery. After this hand screening, we had 189 items in total, 29 from PubMed and 160 from the Int. J. Integrated Care.

1.3 Structure for analysing the literature

We aimed to identify items that are most interesting, most relevant to our study, most common to current study, and most salient to current debates, as well as some identified as an opportunity for future research. In order to help others who are studying the interdisciplinary field of e-Health, integrated care, and chronic diseases to easily find out needed information, we sorted the literature into five main headings from the perspective of developing a study programme: 1) Defining integrated care. 2) Methods and tools, evaluation and quality. 3) Contextual, governmental and managerial requirements for integrated care. 4) Case studies and experiences. 5) Identified issues and future directions. We also specified subheadings listed in the table of contents for each of the main headings.

1.4 Conclusion

This review collected 189 items from PubMed and International Journal of Integrated Care in recent five years, which are highly related to the question of how to achieve integration of care for chronic disease patients by e-Health technology. E-Health and integrated care is becoming a common topic worldwide. For those interested in this topic, this bibliographic review provides a brief summary of current ideas.

2. Defining integrated care

Fifty-two items have been included in the category; they aim to picture a broad and fundamental understanding of integrated care, chronic disease management and /or e-Health technologies. The items are under three major subheadings:

- Term definition; Development of a guideline; Fundamental principles
- High level perspectives; A brief conceptual review
- From various perspectives

2.1 Term definition; Development of a guideline; Fundamental principles

Items under this subheading aim to define and provide fundamental principles, and background of integrated care, chronic disease management and /or e-Health technologies. There was a consensus among the literature that there is a need for a new definition of chronic disease management that incorporated elements of integrated care and e-Health technologies. Schrijvers (2009) identified the need for a new definition, elements characterising disease management and proposed a new definition encompassing the need for the definition to include the management of multiple chronic diseases and the inclusion of Health Information Technology. Viktoria Stein & Rieder (2009) concluded the outcomes from an expert workshop, one of the main themes is to define the common base for integrated care. Peytremann-Bridevaux & Burnand (2009) identified important elements of disease management programs and proposed a new definition of disease management, including the criteria of a multidisciplinary approach.

Other efforts made for definition were focusing on health and healthcare for integration. Cloninger (2010) described the positive health domain in person-centered integrative diagnosis, they gave the definition of positive health as a state of physical, material, emotional, social, ecological, and spiritual well-being. Groves (2010) introduced the conceptual basis around definitions of patient-centered healthcare and outlined principles of patient-centered healthcare from the perspective of the International Alliance of Patients' Organizations (IAPO).

Other information help us to understand the fundamental principles are Gleichweit & Baumer (2009) provided the development process of a national integrated health care guideline in Austria. Heath (2010) revealed how the perception of health care changed over time from an episodic acute care to a person-centered preventive care. The literature also examined terminology used. Toro (2011) analysed the terms used across the world and their implications in relation to chronic disease management and with respect to integration.

2.2 High level perspectives; A brief conceptual review

Literature under this subheading gives as overview or big scale perspective on integrated care, chronic disease management, and e-Health technologies. Goodwin et.al. (2008) discussed the eighth Annual Integrated Care Conference, provided background, and insights on the current standings of integrated care and the management of chronic illness. Goodwin et.al. (2011) collected research studies and conceptual essays on the topic of integrated care in his book, examining the contents of

each chapter and assessing the value of the contribution. Schrijvers & Goodwin (2011) discussed the current key issue towards the adoption of tehehealth and posed a question: what level of evidence is good enough to provide a convincing case for adoption of telehealth? Goodwin (2013) reviewed current studies on understanding integrated care from various aspects, such as different taxonomies, development models, and conceptual frameworks etc. Stein et.al. (2009) discussed the ninth International Conference on Integrated care, giving background on the broader topic of integrated care. Stein et.al. (2013) explained how integrated care has become an issue for politicians and health system planners worldwide. MacAdams (2011) reviewed the conceptual understandings underlying integrated care. Cheah (2011) concluded a number of key useful lessons from Conference on Integrated care- the first academic and practitioner focused event solely devoted to the challenges of Integration of Care in Asia. Bickenbach et.al. (2012) provided an overview of the current state of health care for aging population and identified the priority areas for bridging knowledge, policy, and practice. Leonardi et.al. (2012) offered international initiatives on bridging knowledge, policy, and practice. Milburn & Flowerday (2012) presented essential factors that we need to concern about when trying to achieve a scalable rollout of Telehealth from both the telehealth supplier and NHS provider's perspective. Hervert & Medd (2012) drew on findings and insights from recent pilot studies that demonstrate the successful use of virtual care coordination. They also highlighted key outcomes, demonstrating how telehealth can be successfully incorporated into a comprehensive care model.

The need and importance of integrated care for chronic disease management was outlined in the literature. Schrijvers (2008) outlined why integration between emergency medicine and chronic care management is important. Stein (2010) in her thesis analysed the reasons why integrated care is chosen, initiated, and highlighted underlying mechanisms and decision-making processes of integrated care. Van der Geer et.al. (2010) discussed the need for a revised health care strategy combined into a disease management system using a systematic approach and the opportunities for a disease management system for skin cancer. Szczygiel (2012) described the importance of primary care in structured managing and addressed how to manage chronic obstructive pulmonary disease.

The literature provided overviews of specific countries current situations regarding healthcare systems, integrated care, and chronic disease management, including Australia. Schrijvers (2008) outlined why integration between emergency medicine and chronic care management is important. Hutten (2009) gave a broad picture of the national strategic framework in Netherlands and discussed about tackling the burden of chronic diseases: the 'health by all' strategy. Mijnheer (2009) shared the experiences of integrated care in Eindhoven, and discussed the deficiencies in current management and the transformation of health care from reactive to proactive, for example, Mijnheer discussed the transition of the Chronic Care Model. Van der Geer et.al. (2010) discussed the need for a revised health care strategy combined into a disease management system using a systematic approach and the opportunities for a disease management system for skin cancer. Berchtold & Peytremann-Bridevaux (2011) outlined the status of integrated care in the last ten years in Switzerland. Somme & de Stampa (2011) outlined the status of integrated care in the last ten years in France. Amelung et.al. (2012) gave an overview of new forms of contracting that introduced and provided recommendations for the further development of integrated care in the German healthcare system. Struijs et.al. (2012) provided an overview of the use of a bundled-payment model in Netherlands by outlining three presentations of a workshop. Szczygiel (2012) described the importance of primary care in structured managing and addressed how to manage chronic obstructive pulmonary disease. Boulton (2012) discussed the key implementation issues to integrated care in 'countries in transition' in central/eastern Europe. Nuño et.al. (2012) summarized different models of integrated care in Spain, introduced how they manage patients with multiple chronic disease and disease.

2.3 From various perspectives

The various perspectives, patients, practitioners, managers, financers, of e-Health and care coordination and collaboration were explored in the literature. Cramm et.al. (2012) interviewed chronic obstructive pulmonary disease patients about their enrolment in disease management programs to gain their perspective on chronic disease management. Wallace et.al. (2010) identified factors associated with experiences of self-management support during primary care encounters, with the sole variable contributing to differences in experiences being literacy. Messinger-Rapport (2009) offered views from nursing home residents regarding chronic disease management.

Patients and providers' perceptions of care collaboration and organisational needs for integrated care were explored. Strandberg-Larsen & Krasnik (2008) examined and compared perceptions of clinical integration and identified associated strategic, cultural, technical, and structural factors identifying areas for improvement and current failings. Bruner et.al. (2011) examined providers' views of collaboration suggesting there are diverse perspectives on collaboration among staff based on professional roles and levels of education with positive views attributed to higher levels of education and upper administration. Peytremann Bridevaux et.al. (2011) explored the needs and expectations from both diabetic patients and healthcare professionals' perspectives, results should help the development and implementation of a program. Juhnke & Mühlbacher (2013) provided insight into patient and experts expectations of the organisation of integrated healthcare delivery systems. Johannessen et.al. (2013) explored different stakeholders' perspectives on the role of an intermediate unit in a clinical pathway for older patients with somatic diseases. Nicholson et.al. (2013) explored the perceptions and roles of frontline staff at the implementation and delivery phases of telehealth as part of the MALT (mainstreaming assisted living technologies) project. Toscan et.al. (2013) investigated care transitions from the perspective of patients receiving care and those providing care, identifying the need for healthcare system to engage patients and family caregivers in the process of care transitions.

Patients' willingness to use e-Health technologies is an important aspect of e-Health. Tom et.al. (2012) concluded that use patterns among parents of children with chronic disease show they are willing to use an integrated personal health record (PHR). Butt et.al. (2012) described a national study in Canada, which focused on chronic hepatitis C that illuminates the reasons for non-attendance at care from both the user and provider perspectives. Gorst et.al. (2013) explored the CHF and COPD patients' beliefs and perceptions about the use of telehealth; it is part of the MALT (mainstreaming assisted living technologies) project.

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Abstract

3. Methods and tools, evaluation and quality

There are one-hundred and three items having been covered under this category, the items showed a great variety in e-Health technology, methods and tools used to achieve integration and evaluation, as well as theory utilized to guild our understanding and research. Three subheadings shown as following:

- Technology; Methods
- Theory; Tools; Models
- Evaluation; Impact/effects of the use of e-Health technology; quality of Integrated care

3.1 Technology; Methods

The review of the literature detailed the technology used in e-Health, both generally and specifically, as well as methods used to achieve integrated care. E-Health technologies were described in various items. Melby & Hellesø (2010) identified an information and communication technology: an electronic interdisciplinary discharge summary, which aimed to promote integration of care across organisations. Kaufman et.al. (2011) described the process of using a randomized controlled trial to assess the feasibility of nurse-led DM (disease management) program with integrated home-based monitoring technologies (video conference technology and computerized medication organizer) for CHF (chronic heart failure) patients in Israel. Schwab et.al. (2013) described the technology behind continuous positive airway pressure adherence tracking systems. Lluch (2013) identified telehealthcare applications in supporting integrated care in eight European countries.

Specific technologies for e-Health were also described in the literature. Sampalli et.al. (2010) discussed the e-health technology SNOMED CT®, a technology that represents multidisciplinary terms and concepts in the domain for complex chronic conditions. Neus Padilla Just et.al. (2011) described the use of telephone follow-up for HF and COPD patients. The follow-up is monitored by computerized clinical practice guidelines, integrated in the clinical record, as well as by nursing methodology (NANDA-NOC-NIC). Chessell & Limited (2012) used a clinician monitoring solution-internet cloud based whilst patients utilise 3G smartphones in his project and provided a Telehealth market cost and technology leader service Whzan Telehealth Service as the results of his project. Sarrafzadeh & Sykes (2012) outlined the technology called WANDA, an end-to-end remote patient tele-monitoring solution for chronic conditions. Harris et.al. (2013) developed a method for coding Multidisciplinary Group Meeting (MDG) transcripts to deliver improvements in a North West London Integrated care Pilot. Yeo et.al. (2012) described the fully customised Delivering on Target (DOT) information technology (IT) system developed for the Singapore General Hospital (SGH) DOT Program. Behar et.al. (2012) introduced Sana, which is a cell phone-facilitated clinical information system that connects community health workers and medical specialists, to improve screening and diagnostics in resource-constrained settings. Pérez Cánovas et.al. (2012) mentioned a system for primary care (PC) electronic medical records (EMRs) that has been adopted across the region of Tenerife, Spain. In 2008, the use of the Drago AP system was extended to cover specialist outpatient appointments, an appointment diary called “Virtual Endocrinology” created a channel of communication between primary and specialised care. Hui et.al. (2013) conducted a programme to examine the use of iPad in the integrated care and Discharge Support (ICDS) by Link Nurses and Case Managers for older patients in Hong Kong. Spencer et.al. (2013) investigated use of I-neb Insight Online that is telehealth-based

Cystic Fibrosis (CF) patient management system. I-neb Insight Online has been available to all UK patients using the I-neb Adaptive Aerosol Delivery (AAD) System and will be available in Europe in the coming months.

Methods of integrating care that did not specifically involve e-Health technologies, such as research methods and corporation methods, were also discussed. Strandberg-Larsen & Krasnik (2009) identified 24 different methods used to measure integrated healthcare delivery with an emphasis on structural, cultural, and process aspects. Engebretson (2011) discussed how nurses can expand on ethnographic research to explore patient's constructions and explanatory models of health and healing and how they view chronic conditions and negotiate daily life. Kyriacou & Vladeck (2011) identified "simple, familiar, and relatively low-tech approaches to sharing critical patient information among collaborating organisations." Dinesen et.al. (2011) described the case study approach for the TELEKAT project. The data included documentary materials, participant-observation, qualitative interviews with healthcare professionals and COPD patients. Bahagon & Jacobson (2012) described the Clait Health Services (CHS) e-Health core components and behaviour change methodology that aims to develop collaborative care through e-Health. Beatriz Aller et.al. (2013) developed the CCAENA questionnaire to assess care continuity across levels from the patients' perspective. Nuño Solinís et.al. (2013) developed a questionnaire to assess interprofessional collaboration between two different care levels.

Broader methods, such as strategies and networks, were examined in the literature. Galluccio et.al. (2011) detailed how disease registries are being used to support care management for groups of patients with chronic diseases and play an important role in capturing and tracking key patient information. Berchtold & Peytremann-Bridevaux (2011) described physician networks in regional and/or cantonal levels, initiatives targeting chronic diseases, such as clinical pathways, and chronic disease management programs developed in Switzerland. Jaarsma et.al. (2013) developed a guide on Home Health in heart failure patients. Van Bussel et.al. (2013) described the Alberta Provincial Stroke Strategy (APSS), which utilises the telehealth technology.

3.2 Theory; Tools; Models

Items under this heading refer to specific theory, tools, and models used in chronic disease management, integrated care, and e-Health technologies. Models served for various purposes have been developed in the literature. Some of the models focused on integration and coordination between different health care users: Bratcher & Bello (2011) explained how the specialized diabetes care (SDC) centre model provides integrated diabetes care in one place – the "one-stop" approach, resulting in improved patient outcomes. Wilkie et.al. (2010) developed an ecological model of palliative care focusing on a holistic and comprehensive approach that involves improved communication among the healthcare team, patients, and their families. Nuño et.al. (2011) described the emerging models of integration in Spain focussing on two approaches: clinical process and organisational architecture of the health delivery system. Berry et.al. (2013) discussed the Wisconsin-based Gunderson Health model for an integrated care coordination program, which includes a system-wide electronic medical records database utilised by the team-based approach. Lewis (2013) provided lessens of integrating care for high-risk patients in England using the virtual ward model. The model attempts to integrate health and social care by offering multidisciplinary case management to high-risk patients.

An abundance of models for chronic disease management were identified. Villagra (2009) provided a population-based approach to obesity management focussing on the chronic care model, including information technology. González et.al. (2011) outlined the 'Valencia-La Fe' Department of Health comprehensive management model for chronic diseases, which aims to ensure continuity of care through coordination and integration of services across different levels of care. Sarfaty et.al. (2011) discussed how the Patient Centred Medical Home model (PCMH) is reinventing primary care practice and its implications for facilitating cancer screening and other preventative services. McCall & Cromwell (2011) discussed the commercial disease management model in the Medicare fee-for-service program. Toro (2011) outlined "the most relevant international models to improve the health of those living with two or more chronic conditions" and "various strategies and types of programme for patient education and self-management support". García Cerdán et.al. (2012) mentioned three inter-related types of continuity of care (CC): relational, informational and management. Results showed their case management model (care manager as a key role for optimising resources) facilitates the three main types of CC. Smidth et.al. (2013) combined elements from the Chronic Care Model and the theoretical model for complex interventions along with implementation strategies identified as efficient to develop a practice-based active implementation model for a chronic disease management program. Aspinall et.al. (2013) described a telehealth model in a rural county-Gloucestershire Care Services (GCS), which is a nurse-led, with the support from a dedicated non-clinical project manager and project administrator, care service model.

Financial models and approaches for economic aspects of integrated care were identified. Shields et.al. (2013) provided a 3-year budget impact model to estimate the associated budgetary impact-information required by payers to support informed decisions regarding the adoption of these services. Duimel Peeters (2009) described a new organisational model implemented in the region Maastricht, Holland, with the introduction of a Diagnosis-Based Costing method (DBC). Hildebrandt et.al. (2010) presented *Gresundes Kinzigtal's* population health gain approach， which involves the shared savings contract. The aim of the project is to improve quality of chronic care by integrating the primary care setting. Reich et.al. (2012) applied an econometric approach with a mixed-effects model to evaluate the efficiency of different integrated care models.

Evaluation models and performance analysis were another focus to explore. Schrijvers & Goodwin (2011) highlighted a new research model to evaluate telemedicine innovations MAST. The purpose of Mast has been to provide a structured framework for assessing the effectiveness and contribution to quality of care of telemedicine applications, based on user-needs of information for decision-making. Ketelaars (2011) applied a risk-based approach to integrated care providers that can be used to analyse care providers' performance through quality indicators and rank them. Ketelaars & Wijngaarden used a clinical logic model to identify indicators that provide insight into the performance of integrated care in order to answer the following questions: what are the key elements, where are the major decision points in care? And how does the patient flow through the care system? Rixon et.al. (2012) mentioned the Multi-level modelling was utilised to evaluate the effect of trial arm on HRQoL and COPD specific QoL in the Whole System Demonstrator (WSD) programme.

The literature also outlined various other healthcare models relevant to the topic. MacAdams (2011) examined the features of models of cost-effective care for the elderly. Gerber et.al. (2012) described how various health care models, such as the chronic care model, the medical home, and the shared care model, align with the prospective surveillance model can be integrated with models of cancer survivorship care delivery. Nuño et.al. (2012) summarized different models of integrated care in Spain,

highlighted two distinguished approaches. Welte (2012) showed in his study that the innovative reimbursement and delivery system models drove physician led telehealth. Van den Roeke et.al. (2012) built a conceptual model in order to conceptualise the cooperation process and explored the structures partnerships led to for multi-problem patients in deprived neighbourhoods. Hacibekiroglu et.al. (2013) outlined the three steps of a Patient-Centred, Evidence-Based, Interactive, Proactive model to reduce the incidence and prevalence of chronic disease, utilising e-Health technologies.

Frameworks for integrated care were outlined in the literature with frameworks for chronic disease management also being mentioned. Spreeuwenberg (2008) suggested approaches of the chronic care model and disease management can be integrated, further that the chronic care model can be used a framework for the development of a European way of chronic disease management. Arnold et.al. (2012) developed a framework for primary care providers to allow them to develop a patient-centred treatment program for patients with fibromyalgia. Stein et.al. (2009) identified integrated care concepts and frameworks, as well as approaches, methods and tools used in integrated care such as clinical guidelines and networking. Frølich et.al. (2010) used the chronic care model as a framework to implement and integrate four rehabilitations programs. Monsivais (2011) presented the clinically relevant continuum model as a framework for providers to "approach care from an evidence-based, culturally appropriate (patient-centred) perspective which takes into account the highest level of evidence available, provider expertise and patient preferences and values. Tsais et.al. (2012) developed a complex-adaptive systems (CAS) framework to describe and analyse data collected to assess the theoretical fit of a CAS perspective on integrated care. Kwo (2012) mentioned there are several types of integrated information systems architectures and listed eight elements of one of architectures- Kaiser's information systems architecture. Van Houdt et.al. (2013) examined five theoretical frameworks for exploring care coordination proposed by the Agency for Healthcare and Quality Research, identified fourteen key concepts and suggest these concepts be used as a base to develop or choose a framework for studying care coordination. Harterink et.al. (2013) developed a framework to identify the underlying mechanisms of integrated care delivery, highlighting the interproffesional collaboration among professionals. Valentijn et.al. (2013) proposed a conceptual framework combining the concepts of primary care and integrated care, in order to understand the complexity of integrated care with the guiding principles of person-focused and population-based care.

Theories used in some items to support the development of integrated care and ideas were suggested. Schrijvers (2008) outlined ideas on how to integrate emergency medicine and chronic care management, but provided no specific tools or methods. Wadmann et.al. (2009) compared policy strategies in relation to interorganisational network theory. Dinesen et.al. (2011) discussed network and innovation theory in developing an integrated technique for tele-rehabilitation of chronic obstructive pulmonary disease patients. Dinesen et.al. (2011) used the inter-organisational theory and learning theory in their TELEKAT project ('Telehomecare, chronic patients and the integrated healthcare system'). Dinesen (2012) applied the inter-organisational theory and learning theory in the project of using technology to promote community of practice among healthcare professionals. Butt et.al. (2012) used the multi-level ecological theory in their study to identify and describe the personal and systems factors related to not seeking, delaying, or deferring chronic illness care for hepatitis C.

Care pathways were a recurring tool in the literature to achieve integrated care. Sans Corrales et.al. (2012) highlighted establishment of disease-specific care pathways is a valid tool for improving the follow-up. Utens et.al. (2012) described care delivery pathways for chronic obstructive pulmonary disease in the Netherlands and England. Van Bussel et.al. (2013) described the Alberta Provincial

Stroke Strategy (APSS), an integrated strategy to improve access to stroke care, quality, and efficiency utilising telehealth and examined the process flow and structure of the care pathways. Dubuc et.al. (2013) developed Integrated care Pathways (ICPs) and organised them into a four step dynamic process.

3.3 Evaluation; Impact/effects of the use of e-health technology; quality of integrated care

Items under this heading are associated with the evaluation and impact/effect of integrated care, e-Health technologies, and chronic disease management. Ellerbeck et.al. (2009) evaluated the patient outcomes (cessation rates among smokers) associated with moderate- or high-intensity disease management, with higher-intensity disease management associated with increased abstinence. Evaluations of chronic disease management strategies and programs were found in the literature. McCall & Cromwell (2011) found that the commercial disease management programs that used nurse-based centres achieved modest improvements with no significant cost reductions. MacAdams (2011) identified to what extent Canadian provinces were implementing features of models of cost-effective care for the elderly and found a substantial improvement in the delivery of case management services. Cramm et.al. (2012) examined the effects on chronic obstructive pulmonary disease of being enrolled in disease management programs and found a significant improvement in care. Francisco Lucena et.al. (2012) mentioned a descriptive retrospective observational study utilised in assessing the impact of a new care pathway. Engels et.al. (2012) described the implementation and evaluation of a personalised care plan for people with an increased risk of cardiovascular disease in the Netherlands. Aberra et.al. (2013) evaluated the effectiveness of quality improvement (QI) measures in increasing the rate of hepatocellular carcinoma surveillance by comparing patients enrolled in the chronic disease management program to a previous cohort. Kennedy (2013) determined that an intervention to enhance self-management support in routine primary care, including a web based directory of local self-management resources, did not have a noticeable positive effect.

The evaluation of effect of integrated care on patient outcomes was explored in the literature. Heijnen et.al. (2012) evaluated the development of integrated stroke care in Maastricht, Netherlands, which improved outcomes for patients. Harden et.al. (2012) showed that an integrated paediatric-young adult joint transition clinic and care pathway that was established in 2006 for patients with kidney failure improved outcomes, as judged by reduced transplant failure rates. Horwitz et.al. (2012) evaluated the experiences of patients attending an innovative hepatitis C clinic that offers integrated care and service delivery finding a positive experience of healthcare, and highlighted the importance of integrated care. Tricco et.al. (2012) concluded quality improvement (QI) strategies showed improvements in diabetes care. Sorknaes et.al. (2013) investigated the effect of real-time teleconsultation between hospital-based nurses and patient with severe COPD discharged after hospitalisation with acute exacerbation of chronic obstructive pulmonary disease (AECOPD).

Many items in the review evaluated existing integrated care pilots. Halliday et.al. (2009) reviewed integrated care pilots programmes in UK to test and evaluate a range of models of integrated care that should help improve patient, carer, and service user outcomes. Ling et.al. (2010) described the evaluation of 16 integrated care Pilots in the UK that aims to address the needs of an aging population, the evaluation outcomes will be used to strengthen the evidence base for integrated care. Roland et.al. (2012) evaluated an existing six integrated care pilot programs in London, found case

management improved some aspects of care, and reduced secondary care costs. Curry et.al. (2013) presented the results of a year-long evaluation of a large-scale integrated care pilot in North West London. Greaves et.al. (2013) described an evaluation approach to measure the effect of the Northwest London Integrated care Pilot, enabling clarification of the pilot and providing a potential model for evaluation of similar interventions. Cramm et.al. (2013) compared the early implementation of eight cardiovascular disease management programmes initiated and managed by healthcare practices in various regions of the Netherlands. Fursse et.al. (2013) described the interim evaluation analysis of the inCASA project, which is an EU co-funded pilot project with the aim of developing an integrated health and social service model supported by innovative technology for frail and ageing population.

E-Health technologies were evaluated based on efficiency, patient outcomes and how well they supported integrated care and care collaboration. Sampalli et.al. (2010) determined SNOMED CT® to have a reasonable coverage of multidisciplinary concepts required to describe a complex and chronic condition. Melby & Hellesø (2010) discussed the impact of an electronic discharge summary implemented to improve communication and information exchange between municipal care services and the associated hospital in Norway. Okamoto et.al. (2011) concluded information sharing through electronic health records (HER) is a useful tool in supporting care integration among providers. De Vries et.al. (2011) investigated the effect of information and communication technology (ICT) guided disease management and telemedicine on the quality and efficiency of care in patients with heart failure after a hospitalisation, there are no results to date. Rixon et.al. (2012) described the aim of the Whole System Demonstrator (WSD) programme is to evaluate the effectiveness of Telehealth (TH) for patient with COPD. WSD is one of the largest pragmatic cluster randomised controlled trials evaluating TH in the UK. Results and conclusions were censored. Steventon et.al. (2012) provide findings from the Whole System Demonstrator (WSD) programme; results and conclusions are under embargo. Smithard et.al. (2012) assessed the impact of telehealth on hospital admissions, length of stay, GP contact, and nursing visits in a pilot study in UK. Pinnock et.al. (2013) determined telemetrically supported self-monitoring of chronic obstructive pulmonary disease did not appear to reduce hospital admissions or quality of life, but led to an increase in alerts, increasing the number of telephone calls and home visits. Smith et.al. (2013) showed that health IT (electronic health records, telemedicine, text message, or telephone support) has improved patient outcomes and care processes in paediatric obesity management through increased access to obesity treatment and rates of screening.

Items in the literature evaluated the coordination and collaboration between different levels of care. . Butt et.al. (2008) depicted “a novel complexity theory-based conceptual model for interprofessional health and social service partnerships (IHSSP) of front-line staff who provide chronic illness care”, to evaluate partnership effectiveness. Kyriacou & Vladeck (2011) presented finding from an evaluation of the feasibility, quality, and outcomes of linking health and social services though collaborations and identified seven critical success factors. Marichal Plannas et.al. (2012) carried out a study in a region of Spain in order to describe the characteristics of the pilot project on coordination between two levels of care and to assess the results. Results showed this coordination model positive achievement in treatment, patient education, follow-up, and self-management for heart failure. Olsen et.al. (2013) evaluated the prevalence of nursing transfer documents and identified patient and transfer characteristics associated with the effective communication of the health status of older patients. Busch et.al. (2013) discussed the improvement in continuity of care, shorter communication lines, low-threshold contact between professionals and promising future prospects by Parent and Child Centres (PCCs) which involve multidisciplinary teams in neighbourhood-based centres. Ledwidge et.al.

(2013) showed how newly diagnosed heart failure and prevalence of significant left ventricular (LV) systolic and/or diastolic dysfunction was reduced by implementing a screening program and collaborative care between primary care physicians and specialist cardiovascular service. Tol et.al. (2013) evaluated the level of involvement of primary care providers

Items in the literature evaluated models and frameworks for healthcare integration and chronic disease management. Reich et.al. (2012) determined the different integrated care models examined had the potential to improve care for patients with chronic diseases and reduce healthcare expenditure. González et.al (2011) evaluated the 'Valencia-La Fe' Department of Health comprehensive management model for chronic diseases finding a multidisciplinary approach reduced admissions and the length of hospital stay. Some items in the literature developed models or methods to evaluate other aspects of integrated care and disease management. Toro et.al. (2011) established "an evaluation framework to assess the healthcare integration pilots in the Basque Country that will make it possible to compare results at regional, national, and international levels." Goodwin et.al. (2008) discussed a method to measure the implementation and effectiveness of integrated care for people with chronic illness.

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AU: Greaves-F, Pappas-Y, Bardsley-M, Harris-M, Curry-N, Holder-H, Blunt-I, Soljak-M, Gunn-L, Majeed-A, Car-J
TI: Evaluation of complex integrated care programmes: the approach in North West London.
SO: *International Journal of Integrated Care,* vol. 13, Jan-Mar. (2013)
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AU: Halliday-K, Maslin-S, Queenborough-R
TI: Integrated care pilot programme-UK Department of Health.
SO: *International Journal of Integrated Care,* vol.9, Annual Conference Supplement, Dec. (2009)
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AU: Hildebrandt-H, Hermann-C, Knittel-R, Richter-Reichhelm-M, Siegel-A, Witzenrath-W
TI: Gesundes Kinzigtal Integrated Care: improving population health by a shared health gain approach and a shared savings contract.
SO: *International Journal of Integrated care,* vol. 10, Apr-Jun. (2010)

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AU: Horwitz-R, Brener-L, Treloar-C
TI: Evaluation of an integrated care service facility for people living with hepatitis C in New Zealand.
SO: *International Journal of Integrated Care,* vol. 12, Special Edition Integrated care Pathways, (2012)
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AU: Harden-PN, Walsh-G, Bandler-N, Bradley-S, Lonsdale-D, Taylor-J, Marks-SD
TI: Bridging the gap: an integrated paediatric to adult clinical service for young adults with kidney failure.
SO: *BMJ*, vol. 344, Jun. pp. e3718 (2012)
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AU: Hartgerink-JM, Cramm-JM, van Wijngaarden-JDH, BakkerTJEM, Mackenbach-JP, Nieboer-AP
TI: A framework for understanding outcomes of integrated care programs for the hospitalized elderly.
SO: *International Journal of Integrated Care,* vol. 13, Oct-Dec. (2013)
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Abstract

AU: Hacibekiroglu-S, Kucukkose-AF, Korucu-C, Kilic-A, Acemi-N
TI: Chronic disease management model in Acibadem Mobile Health.
SO: *International Journal of Integrated Care,* vol. 13, Telehealth and Telecare Conference Supplement, Nov. (2013)
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Conference Abstract

AU: Hui-E, Leung-J(SW), Wong-R (KM), Tse-L(YK), Tang-M(WS), Li- P(KT)
TI: Applications for the iPad in an integrated care and Discharge Support Programme for older patients in Hong Kong.
SO: *International Journal of Integrated Care,* vol.13, Nov. (2013)
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Conference abstract

AU: Harris-M, Greaves-F, Gunn-L, Patterson-S, Greenfield-G, Car-J, Majeed-A, Pappas-Y
TI: Multidisciplinary group performance – measuring integration intensity in the context of the North West London Integrated care Pilot.
SO: *International Journal of Integrated Care,* vol. 13, Jan-Mar. (2013)
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Abstract

AU: Jaarsma-T, Strömberg-A, Larsen-T
TI: Practical guide on home health in heart failure patients.
SO: *International Journal of Integrated Care,* vol. 13, Oct-Dec. (2013)
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Abstract

AU: Ketelaars-CAJ, Wijngaarden-JKv
TI: Monitoring integrated care with a clinical logic model.

SO: *International Journal of Integrated Care,* vol.9, Annual Conference Supplement, Dec. (2009)
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AU: Ketelaars-C
TI: Integrated care requires integrated supervision.
SO: *International Journal of Integrated Care,* vol. 11, Jan-Mar. (2011)
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AU: Kyriacou-C, Vladeck-F
TI: A new model of care collaboration for community-dwelling elders: findings and lessons learned from the NORC-health care linkage evaluation.
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Abstract

AU: Kaufman-G, Goldman-D, Kalter-O, Freimark-D, Silver-H, Shani-M
TI: Integrating home-based tele-monitoring in disease management (DM) program for community-dwelling patients with chronic heart failure (CHF).
SO: *International Journal of Integrated Care,* vol.11, 1st International Congress on Telehealth and Telecare, Jun. (2011)
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Conference abstract

AU: Kwo-D
TI: Systems architecture for integrated care.
SO: *International Journal of Integrated Care,* vol.12, 2nd International Congress on Telehealth and Telecare, Jun. (2012)
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Conference abstract

AU: Kennedy-A, Bower-P, Reeves-D, Blakeman-T, Bowen-R, Chew-Graham-C, Eden-M, Fullwood-C, Gaffney-H, Gardner-C, Lee-V, Morris-R, Protheroe-J, Richardson-G, Sanders-C, Swallow-A, Thompson-D, Rogers-A; Salford National Institute for Health Research Gastrointestinal programme Grant Research Group
TI: Implementation of self management support for long term conditions in routine primary care settings: cluster randomised controlled trial.
SO: *BMJ,* vol. 13, May. pp. f2882 (2013).
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Abstract

AU: Ling-L, Bardsley-M, Adams-J, Lewis-R, Roland-M
TI: Evaluation of UK Integrated care Pilots: research protocol.
SO: *International Journal of Integrated Care,* vol. 10, Jul-Sep. (2010)
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Abstract

AU: Lewis-GH, Vaithianathan-R, Wright-L, Brice-MR, Lovell-P, Rankin-S, Bardsley-M
TI: Integrating care for high-risk patients in England using the virtual ward model: lessons in the process of care integration from three case sites.
SO: *International Journal of Integrated Care,* vol.13, Oct-Dec. (2013)

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Abstract

AU: Ledwidge-M, Gallagher-J, Conlon-C, Tallon-E, O'Connell-E, Dawkins-I, Watson-C, O'Hanlon-R, Bermingham-M, Patle-A, Badabhagni-MR, Murtagh-G, Voon-V, Tilson-L, Barry-M, McDonald-L, Maurer-B, McDonald-K
TI: Natriuretic peptide-based screening and collaborative care for heart failure: the STOP-HF randomized trial.
SO: *Journal of the American Medical Association*, vol. 310, no. 1, Jul. pp. 66-74 (2013)
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AU: Lluch-M
TI: Incentives for telehealthcare deployment that support Integrated care: a comparative analysis across eight European countries.
SO: *International Journal of Integrated Care,* vol. 13, Oct-Dec. (2013)
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AU: Melby-L, Hellesø-R
TI: Electronic exchange of discharge summaries between hospital and municipal care from health personnel's perspectives.
SO: *International Journal of Integrated Care,* vol. 10, Apr-Jun. (2010)
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Abstract

AU: MacAdam-M
TI: Progress toward integrating care for seniors in Canada.
SO: *International Journal of Integrated Care,* vol. 11, Special 10th Anniversary Edition, (2011)
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AU: McCall-N, Cromwell-J
TI: Results of the Medicare Health Support disease-management pilot program.
SO: *New England Journal of Medicine,* vol. 365, no. 18, Nov. pp. 1704-1712 (2011)
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Abstract

AU: Monsivais-DB
TI: Promoting culturally competent chronic pain management using the clinically relevant continuum model.
SO: *Nursing Clinics of North America,* vol. 46, no. 2, Jun. pp. 163-169 (2011)
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Abstract

AU: Make-B, Belfer-MH
TI: Primary care perspective on chronic obstructive pulmonary disease management.
SO: *Postgraduate Medicine,* vol. 123, no. 2, Mar. pp. 145-152 (2011)
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Abstract

AU: McMahon-BJ, Block-J, Haber-B, London-T, McHugh-JA, Perrillo-R, Neubauer-R

TI: Internist diagnosis and management of chronic hepatitis B virus infection.
SO: *American Journal of Medicine,* vol. 125, no. 11, Nov. pp. 1063-1067 (2012).
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Abstract

AU: Neus Padilla Just-M, Ros del Hoyo-N, Àngels Raventós Castany-M, Fabrellas Padres-N, Coiduras Charles-A, Luisa Martí Aguasca-M
TI: Chronic patients telephone follow-up, an alternative face-to-face.
SO: *International Journal of Integrated Care,* vol.11, 1st International Congress on Telehealth and Telecare, Jun. (2011)
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Poster abstract

AU: Nuria Toro, Maite Paino, Iñaki Fraile, Ricardo Samper
TI: Evaluation framework for healthcare integration pilots in the Basque Country.
SO: *International Journal of Integrated Care,* vol. 12, Spanish Chronic Care Conference Supplement, May. (2011)
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Poster abstract

AU: Nuño-R, Sauto-R, Toro-N
TI: Integrated care initiatives in the Spanish Health System.
SO: *International Journal of Integrated Care,* vol.12, Spanish Chronic Care Conference Supplement, May (2012).
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Editorial

AU: Nuño Solinís-R, Berraondo Zabalegui-I, Sauto Arce-R, Martín Rodríguez-LS, Toro Polanco-N
TI: Development of a questionnaire to assess interprofessional collaboration between two different care levels.
SO: *International Journal of Integrated Care,* vol.13, Apr-Jun. (2013)
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Abstract

AU: Nicholson-J, Coates-L, Mountain-G, Hawley-M
TI: Barriers and facilitators to mainstreaming telehealth in the community-exploring staff views and roles at the implementation and delivery phase.
SO: *International Journal of Integrated Care,* vol. 9, Nov. (2013)
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Abstract

AU: Okamoto-E, Miyamoto-M, Hara-K, Yoshida-J, Muto-M, Hirai-A, Tatsumi-H, Mizuno-M, Nagata-H, Yamakata-D, Tanaka-H
TI: Integrated care through disease-oriented critical paths:experience from Japan's regional health planning initiatives.
SO: *International Journal of Integrated Care,* vol. 11, Special 10th Anniversary Edition, (2011)
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Abstract

AU: Olsen-RO, Hellzén-O, Enmarker-I

TI: Nurses' information exchange during older patient transfer: prevalence and associations with patient and transfer characteristics.
SO: *International Journal of Integrated Care,* vol. 13, Jan-Mar. (2013)
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Abstract

AU: Pérez Cánovas-ME, Llorente Gómez de Segura-I, Marrero Díaz-MD, Fuentes Galindo-MI, Cueto Serrano-M, Viñas Pérez-A
TI: Virtual consultations for provision of care to people with chronic diseases.
SO: *International Journal of Integrated Care,* vol.12, Spanish Chronic Care Conference Supplement, May (2012)
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AU: Pinnock-H, McCloughan-L, Todd-A,Hanley-J, Lewis-S, Krishan-A, MacNee-W, Plagiari-C, Sheikh-A, McKinstry-B
TI: Clinical effectiveness and service implications of telemonitoring for chronic obstructive pulmonary disease: the TELESCOT COPD randomised controlled trial.
SO: *International Journal of Integrated Care,* vol. 13, Telehealth and Telecare Conference Supplement, Nov. (2013)
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Abstract

AU: Rivas-C, Abbott-S, Taylor-SJC, Clarke-A, Roberts-CM, Stone-R, Griffiths-C
TI: Collaborative working within UK NHS secondary care and across sectors for COPD and the impact of peer review: qualitative findings from the UK National COPD Resources and Outcomes Project.
SO: *International Journal of Integrated Care,* vol. 10, Jul-Sep. (2010)
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Abstract

AU: Rixon-L, Hirani-SP, Cartwright-M, Beynon-M, Doll-H,Newman-SP
TI: A pragmatic cluster randomised controlled trial of telehealth on disease specific quality of life in patients' with chronic obstructive pulmonary disease and their health-related quality of life and psychological distress over 1 year in the Whole System Demonstrator programme.
SO: *International Journal of Integrated Care,* vol. 12, 2nd International Congress on Telehealth and Telecare, Jun. (2012)
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Conference abstract

AU: Roland-M, Lewis-R, Steventon-A, Abel-G, Adams-J, Bardsley-M, Brereton-L, Chitnis-X, Conklin-A, Staetsky-L, Tunkel-S, Ling-T
TI: Case management for at-risk elderly patients in the English Integrated care pilots: observational study of staff and patient experience and secondary care utilisation.
SO: *International Journal of Integrated Care,* vol. 12, Jul-Sep. (2012)
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Abstract

AU: Reich-O, Rapold-R, Thöni-M
TI: An empirical investigation of the efficiency effects of integrated care models in Switzerland.
SO: *International Journal of Integrated Care,* vol. 12, Jan-Mar. (2012)
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Abstract

AU: Spreeuwenberg-C
TI: The Chronic Care Model as vehicle for the development of disease management in Europe.
SO: *International Journal of Integrated Care,* vol. 8, Annual Conference Supplement, Jun. (2008)
VOL: 3-Methods and tools, evaluation and quality
Abstract

AU: Schrijvers-C
TI: The integration of chronic care and emergency medicine.
SO: *International Journal of Integrated Care,* vol. 8, Apr-Jun. (2008)
VOL: 3-Methods and tools, evaluation and quality
Editorial

AU: Stein-KV, Rieder-A
TI: Lost in transition—meeting the challenge through integrated care. Highlights from the 9th International Conference on Integrated care in Vienna.
SO: *International Journal of Integrated Care,* vol. 9, Annual Conference Supplement (2009)
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Conference proceedings

AU: Strandberg-Larsen-M, Krasnik-A
TI: Measurement of integrated healthcare delivery: a systematic review of methods and future research directions.
SO: *International Journal of Integrated Care,* vol. 9, Jan-Mar. (2009)
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Abstract

AU: Sampalli-T, Shepherd-M, Duffy-J, Fox-R
TI: An evaluation of SNOMED CT® in the domain of complex chronic conditions.
SO: *International Journal of Integrated Care,* vol. 10, Jan-Mar. (2010)
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Abstract

AU: Sarfaty-M, Wender-R, Smith-R
TI: Promoting cancer screening within the patient centered medical home.
SO: *CA: a cancer journal for clinicians,* vol. 61, no. 6, Nov-Dec. pp. 397-408 (2011)
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Abstract

AU: Schrijvers-G, Goodwin-N
TI: Adopting telehealth as a tool of Integrated care: what type of research is required to justify the investment?
SO: *International Journal of Integrated Care,* vol.11, Mar. (2011)
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Editorial

AU: Smithard-DG, Lee-K, Williams-S, Price-H, Lee-S
TI: Can teletechnology improve patient experience and reduce the use of health care resource?

SO: *International Journal of Integrated Care,* vol.12, 2nd International Congress on Telehealth and Telecare, Jun. (2012)
VOL: 3-Methods and tools, evaluation and quality
Conference abstract

AU: Sarrafzadeh-M, Sykes-R
TI: WANDA: an end-to-end solution for tele-monitoring of chronic conditions.
SO: *International Journal of Integrated Care,* vol. 12, 2nd International Congress on Telehealth and Telecare, Jun. (2012)
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Poster abstract

AU: Schrijvers-G
TI: Global payment for health services as a solution in the financial crisis in Europe.
SO: *International Journal of Integrated Care,* vol.12, (2012).
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Abstract

AU: Struijs-J, De Bruin-SR, Baan-CA
TI: Integrated care, financing and multimorbidity. How to bridge the gaps?
SO: *International Journal of Integrated Care,* vol.12, Annual Conference Supplement, Sep. (2012)
VOL: 3-Methods and tools, evaluation and quality
Conference abstract

AU: Steventon-A, Billings-J, Dixon-J, Bardsley-M
TI: Impact of telehealth on hospital use and mortality: provisional findings from the whole system demonstrator trial.
SO: *International Journal of Integrated Care,* vol.12, 2nd International Congress on Telehealth and Telecare, Jun. (2012)
VOL: 3-Methods and tools, evaluation and quality
Conference abstract

AU: Sans Corrales-M, Gardeñes Morón-L, Moliver Molins-C, Campama Tutusaus-I, Pérez Carcía-S, Rozas Martínez-M
TI: Health care pathways and expert patients: Do they improve outcomes?
SO: *International Journal of Integrated Care,* vol. 12, Spanish Chronic Care Conference Supplement, May (2012)
VOL: 3-Methods and tools, evaluation and quality
Conference abstract

AU: Shields-G, Chapman-AM
TI: Implementing home telehealth monitoring in patients with a chronic disease: a budget impact analysis.
SO: *International Journal of Integrated Care,* vol.13, Nov. (2013)
VOL: 3-Methods and tools, evaluation and quality
Conference abstract

AU: Spencer-T, Rabbetts-I, Black-A, Dyche-T, Pritchard-J
TI: A telehealth approach to Cystic Fibrosis management; I-neb Insight Online.
SO: *International Journal of Integrated Care,* vol.13, Nov. (2013)
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Conference abstract

AU: Schwab-RJ, Badr-SM, Epstein-LJ, Gay-PC, Gozal-D, Kohler-M, Lévy-P, Malhotra-A, Phillips-BA, Rosen-IM, Strohl-KP, Strollo-PJ, Weaver-EM, Weaver-TE; ATS Subcommittee on CPAP Adherence Tracking Systems
TI: An official American Thoracic Society statement: continuous positive airway pressure adherence tracking systems. The optimal monitoring strategies and outcome measures in adults.
SO: *American journal of respiratory and critical care medicine,* vol. 188, no. 5, Sep. pp. 613-620 (2013)
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Abstract

AU: Smith-AJ, Skow-Á, Bodurtha-J, Kinra-S
TI: Health information technology in screening and treatment of child obesity: a systematic review.
SO: *Pediatrics*, vol. 13, no. 3, Mar. pp. e894-902 (2013)
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Abstract

AU: Sorknaes-AD, Bech-M, Hounsgaard-L, Oestergaard-B
TI: The effects of real-time telemedicine consultations between hospital-based nurses and severe COPD patients discharged after exacerbation admissions.
SO: *International Journal of Integrated Care,* vol. 13, Nov. (2013)
VOL: 3-Methods and tools, evaluation and quality
Conference abstract

AU: Smidth-M, Christensen-MB, Olesen-F, Vedsted-P
TI: Developing an active implementation model for a chronic disease management program.
SO: *International Journal of Integrated Care,* vol. 13, Apr-Jun. (2013)
VOL: 3-Methods and tools, evaluation and quality
Abstract

AU: Toro-N
TI: When people live with multiple chronic diseases: a collaborative approach to an emerging global challenge.
SO: *International Journal of Integrated Care,* vol. 11, Jul-Sep. (2011)
VOL: 3-Methods and tools, evaluation and quality
Book review

AU: Tsasis-P, Evans-JM, Owen-S
TI: Reframing the challenges to integrated care: a complex-adaptive systems perspective.
SO: *International Journal of Integrated Care,* vol. 12, Jul-Sep. (2012)
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Abstract

AU: Tricco-AC, Ivers-NM, Grimshaw-JM, Moher-D, Turner-L, Galipeau-J, Halperin-I, Vachon-B, Ramsay-T, Manns-B, Tonelli-M, Shojania-K
TI: Effectiveness of quality improvement strategies on the management of diabetes: a systematic review and meta-analysis.
SO: *Lancet*, vol. 379, no. 9833, Jun. pp. 2252-2261 (2012)
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Abstract

AU: Tol-J, Swinkels-ICS, Struijs-JN, Veenhof-C, de Bakker-DH
TI: Integrating care by implementation of bundled payments: results from a national survey on the experience of Dutch dietitians.
SO: *International Journal of Integrated Care,* vol. 13, Oct-Dec. (2013)
VOL: 3-Methods and tools, evaluation and quality
Abstract

AU: Villagra-VG
TI: An obesity/cardiometabolic risk reduction disease management program: a population-based approach.
SO: *American Journal of Medicine,* vol. 122, no. 4, Apr. pp. S33-36 (2009)
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Abstract

AU: Van Bussel-EF, Jeerakathil-T, Schrijvers-AJP
TI: The process flow and structure of an integrated stroke strategy.
SO: *International Journal of Integrated Care,* vol. 13, Apr-Jun. (2013)
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Abstract

AU: Van Houdt-S, Heyrman-J, Vanhaecht-K, Sermeus-W, De Lepeleire-J
TI: An in-depth analysis of theoretical frameworks for the study of care coordination.
SO: *International Journal of Integrated Care,* vol. 13, Apr-Jun. (2013)
VOL: 3-Methods and tools, evaluation and quality
Abstract

AU: Valentijn-PP, Schepman-SM, Opheij-W, Bruijnzeels-MA
TI: Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care.
SO: *International Journal of Integrated Care,* vol. 13, Jan-Mar. (2013)
VOL: 3-Methods and tools, evaluation and quality
Abstract

AU: Wadmann-S, Strandberg-Larsen-M, Vrangbæk-K
TI: Coordination between primary and secondary healthcare in Denmark and Sweden.
SO: *International Journal of Integrated Care,* vol. 9, Jan-Mar. (2009)
VOL: 3-Methods and tools, evaluation and quality
Abstract

AU: Wilkie-DJ, Johnson-B, Mack-AK, Labotka-R, Molokie-RE
TI: Sickle cell disease: an opportunity for palliative care across the life span.
SO: *Nursing Clinics of North America,* vol. 45, no. 3, Sep. pp. 375-397 (2010)
VOL: 3-Methods and tools, evaluation and quality
Abstract

AU: Welte-I
TI: A physician led approach to telehealth-enabled care coordination: innovation in reimbursement and delivery system models to support physician engagement.
SO: *International Journal of Integrated Care,* vol.12, Jun. (2012)
VOL: 3-Methods and tools, evaluation and quality
Conference abstract

AU: Yeo-SQ, Harris-M, Majeed-A
TI: Integrated care for diabetes - The Singapore Approach.
SO: *International Journal of Integrated Care,* vol. 12, Jan-Mar. (2012)
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4. Contextual, governmental and managerial requirements for integrated care

Forty items have been identified highly related to this topic. The governing and managerial requirements, and any other requirements regarding to setting up a healthy context to support integrated care, chronic disease management and e-Health technology have been covered. Four subheadings under this category are:

- Platform; Relationship between stakeholders
- Role of technology; Role of different participants; Role of different levels of care
- Policy
- Coordination and collaboration between different levels of care

4.1 Platform; Relationship between stakeholders

This section of the review covers literature concerning the relationship between stakeholders and platforms concerning governing and managerial requirements as well as any other requirements for a healthy environment for integrated care. Noorlander (2008) mentioned a Dutch national COPD optimisation platform-PICASSO that helps to combine knowledge, experience, and resources to support new and existing COPD projects. They have had interesting data together with knowledge and structures for improving COPD care. Brazil et.al. (2008) described relationships among supportive cancer care (SCC) programs. This study identified several priorities to improve the coordination of cancer care in the community. Cramm & Nieboer (2011) identified the factor that contributed to successful interprofessional stroke teams as perceived by team members. Bjerkan et.al. (2011) described the planning process of the mandatory multidisciplinary plan for individual care, the 'Individual care Plan' introduced in Norway for patients with complex needs for coordinated care. Freeman (2012) pointed out evidence strongly suggests that patients generally want more relationship continuity than they are getting and that relationship continuity is linked with better patient and staff satisfaction. Coll et.al. (2013) mentioned the PITES platform in Spain. The PITES platform is a research infrastructure aiming to offer support to the collections of evidences on the new care provisioning models based on ICTs in scenarios related to chronic illness and dependency. Wieland et.al. (2013) demonstrated the understanding and practice patterns of primary care providers and subspecialty providers lead to few referrals to Gastroenterology/Hepatology providers for Nonalcoholic Fatty Liver Disease. Krishnan et.al. (2013) described Comparative Effectiveness Research (CER) as a means to address the expressed needs of patients, clinicians, and stakeholders in chronic obstructive pulmonary disease with stakeholder priorities focussing on evaluating health care delivery approaches.

4.2 Role of technology; Role of different participants; Role of different levels of care

Items under this heading focus on identifying and demonstrating the role of different participants, technologies, and levels of care. Some literature discussed the roles of different levels of care in integrated care. Miettunen et.al. (2013) had a deep discussion on the role of hospitals to current integrated service delivery. Unalan et.al. (2013) tried to unfold the role of primary care and the

preference of the patients and the families in order to be registered in home care services. Johannessen et.al. (2013) explored the role of an intermediate unit in a clinical pathway for older patients with somatic diseases.

However, majority of the studies were emphasizing on the discussion of the roles of healthcare providers and patients. Make & Belfer (2011) described the role of primary care providers is tailoring treatment plans to suit each patient's needs to provide optimal disease control and treat "the right patient for the right reason with the right therapy". Yawn (2011) outlined the role of physicians in devising and implementing an optimal management plan for chronic obstructive pulmonary disease patients. Nuño et.al. (2011) examined the trends toward integrated care in Spain, particularly relating to improvements relating to units or teams, case managers and other specified roles. Moranne et.al. (2012) described the role of Geriatricians in identifying patients, evaluating, and anticipating the impact of treatments, in conjunction with nephrologists, in a multidisciplinary approach to renal failure patients older than 75 years. García Cerdán et.al. (2012) mentioned three inter-related types of continuity of care (CC): relational, informational and management. Results identified the nurse-care manager is a key role for optimising resources and therefore facilitates the three main types of CC. Nicholson et.al. (2013) explored the perceptions and roles of frontline staff at the implementation and delivery phases of telehealth as part of the MALT (mainstreaming assisted living technologies) project. Dalsted et.al. (2012) articulated and discussed the active role of patients during their cancer trajectories at a Danish hospital.

The literature briefly examined the role of incentives, technology in Integrated care delivery. Smithard et.al. (2012) examined the role of telehealth in supporting users and their careers in a pilot study in UK. Lluch (2013) discussed the role of incentives in eight European countries where integrated care has been supported by information and communication technologies. Dubuc et.al. (2013) discussed the role of integrated care Pathways (ICPs), which once computerised will facilitate the exchange of information as well as the clinical decision-making process to meet the needs of frail and disabled community-dwelling older people.

4.3 Policy

Items in this section of the review relate to policy used to develop or improve integrated healthcare. The literature outlined policies and reforms in numerous countries, including Australia, regarding how to implement and improve integrated healthcare. Davies et.al. (2009) discussed the development of policy and management of integrated care in Australia over the past decade and current reforms being considered by the federal government. Wadmann et.al. (2009) described the policy initiatives to improve coordination of care in Denmark and Sweden, including clarifying responsibility and defining requirements. Schlette et.al. (2009) described policy developments and reforms in Germany to improve care coordination and strengthen primary care leading to new forms of care. Vedel et.al. (2011) described the policy reforms that have been implemented at a provincial level in Quebec, Canada to integrate healthcare services. Somme & de Stampa (2011) analysed policies implemented in the French health care system for the older and chronically ill population towards a more integrated care system. Jiwani & Fleury (2011) explored how policy, interests, and cultures may be mitigated to develop and sustain different models of integrated health care that are pertinent to the local contexts. Miettinen et.al. (2012) talked about the institutional complexity of the integrated rehabilitation system at the upper policy level in Finland, discussed how the policy has tried to overcome the negative effects of institutional complexity.

The impact and outcomes of policy and reform was also explored in the literature. Cumming (2011) concluded although key reforms aimed at delivering more integrated care to service users have been successful, few changes were identified in regards to the ways services are provided to users. Bardach et.al. (2013) discussed the positive effect pay-for-performance (P4P) incentives have on small practices with Electronic Health Record (HER) capabilities for chronic disease management. Jiwani & Fleury (2011) highlighted the key trajectories and outcomes of recent policy developments in Quebec and Ontario, Canada, toward integrated care delivery systems in the primary care sector ad regional networks. The literature also suggested reforms regarding how to implement changes in integrated care. McCarthy & Brajovic (2009) concluded middle-income countries could develop elderly and palliative care services through redirection of existing finance if new service objectives, staff skills, and integrated management are also brought in.

4.4 Coordination and collaboration between different levels of care

Items under this heading discuss how to facilitate coordination and collaboration. Guidelines and recommendations for coordination and collaboration were identified in the literature. Valentijn et.al. (2013) identified person-focused and population-based care as guiding principles for achieving integration across different levels of care with integration playing different roles on different levels, but ensuring connectivity between levels. Carlin (2009) outlined the guidelines and recommendations of pulmonary rehabilitation in regards to it being a multidisciplinary, comprehensive intervention by a team of health care professionals in partnership with primary care physicians; and how these were applied to disease management in primary care. Gavi & Hensley (2009) provided a summary of guidelines for management of type 2 diabetes as a means to provide a comprehensive approach to the diagnosis and management of prediabetes and type 2 diabetes in adults.

The literature also discussed concepts and methods to implement successful coordination and collaboration. Ketelaars (2011) suggested integrated care requires integrated supervision in order to implement integrated care effectively. Rivas et.al. (2010) found that collaboration between respiratory consultants, nurses, and general practitioners was facilitated by multidisciplinary peer review enabling them to meet, reconcile differences, and exchange information. Engebretson (2011) illustrated how ethnographic research applies to “culturally competent care at both the organisational and systems level, as well as in the patient/provider encounter.” Romøren et.al. (2011) analysed the perspectives and proposals of the previous and the recent reform initiatives in Norwegian which focusing on enhancing coordination between primary and secondary health care, and discuss how the integrated care measures been implemented in Denmark and Sweden. Sans Corrales et.al. (2012) described the process of coordination between primary care (PC) and specialised care (SC) to establish care pathways (CPs) for the following diseases: type 2 diabetes mellitus, heart failure, and chronic obstructive pulmonary disease. Marichal Plannas et.al. (2012) carried out a study to describe the characteristics of a pilot project on coordination between two levels of care: heart failure unit and programme for prevention and support on discharge (PiSA-IC). Machín Lázaro et.al. (2012) described a four years of project with the aim of establishing a medium unit (PCIM CCU) to address gaps between two levels of care and avoid the sense of imposition that can be felt in primary care with regards all that comes from the hospital.

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5. Case studies

This review shows thirty-two items drawing on experiences of integrated care from countries and regional case studies and pilots.

5.1 Case studies and experiences

The literature described integrated care, chronic disease management and e–Health technology experiences from numerous countries. Peytremann-Bridevaux & Burnand (2009) described chronic disease management programs active in Switzerland in 2007. Galluccio et.al. (2011) detailed several national systemic sclerosis registries in the UK, Germany, USA, Canada, Brazil, and Australia, as well as an international registry. Okamoto et.al. (2011) provides experiences from Japan's regional health planning initiatives. Müller et.al. (2012) gave the experience from two European projects about better integration of social care and healthcare services through ICT. Howitt & Darzi (2012) described two contrasting example in England: the GP-led health centres and the Integrated care Pilots, and recommended the integrated care Pilots approach. Müller et.al. (2012) gave the experience from two European projects about better integration of social care and healthcare services through ICT. Lluch (2013) selected eight European countries for an in-depth study on telehealthcare initiatives. Lewis (2013) provided lessens in the process of care integration from three case sites in England by using the virtual ward model for high-risk patients.

Regional cases studies were also discussed in the literature. Goodwin et.al. (2008) discussed the Future Health-Care project in a regional area of Sweden, which aims to integrate the medical rehabilitation of older people to meet individuals' needs. Duimel Peeters (2009) specified a program conducted in the region Maastricht, Holland, which aimed to optimise the quality of fragmented primary care for chronically ill within the existing budget restraints. Hildebrandt et.al. (2010) identified *Gresundes Kinzigtal*, one of few population-based integrated care approaches located in Southwest Germany, which organises care across all health service sectors and indications. Levine et.al. (2011) described an innovative homecare program based on a system of bidirectional communication between clients and health care professionals through a telephone-based web system in a regional health and social network, Quebec, Canada. Heijnen et.al. (2012) described the development of integrated stroke care in Maastricht, Netherlands, over 15 years. Reich et.al. (2012) performed a study involving data from Swiss residents that had compulsory health insurance with the Helsana Group, the largest insurer in Switzerland, to determine the efficiency of integrated care models. Range (2012) described the outcomes had been achieved in a remote monitoring for patients with long-term chronic illness in Northern Ireland. Van den Roeke et.al. (2012) built a conceptual model in two case studies in order to conceptualise the cooperation process and explored the structures partnerships led to for multi-problem patients in deprived nerghbourhoods. Bengoa (2013) provided one possible way forward to meeting the pressure of chronic disease through the system-wide transformation of the health care system in the Basque Country. Hui et.al. (2013) conducted a programme to examine the use of iPad in the integrated care and Discharge Support (ICDS) by Link Nurses and Case Managers for older patients in Hong Kong. Aspinall et.al. (2013) described a telehealth model in a rural county- Gloucestershire Care Services (GCS), which is a nurse-led care service model, with the support from a dedicated non-clinical project manager and project administrator.

The literature described various studies and programs implemented all over the world. Frølich et.al. (2010) described a project involving four multidisciplinary rehabilitation intervention programs for chronic conditions in Denmark. Melby & Hellesø (2010) presented findings from a study of a Norwegian project where an electronic interdisciplinary discharge summary was implemented, involving 49 healthcare providers. Moranne et.al. (2012) discussed the ongoing Parcours de Soins des Personnes Agées (PSPA) multicentre prospective study. Yeo et.al. (2012) detailed the Singapore General Hospital (SGH) Delivering on Target (DOT) Program launched in 2005 to "right-site clinically stable diabetic patients from the hospital to private DOT GPs. Shapiro-Mendoza (2012) described a multistate population-based surveillance system for monitoring sudden unexpected infant deaths (SUIDs) known as the SUID Case Registry pilot program. Francisco Lucena et.al. (2012) designed and implemented a new care pathway for complex frail patients with multiple pathologies, which represented a project in care coordination between levels of healthcare (primary care- hospitals-long-term care facilities) to ensure a community approach to such patients and continuity in their care. Machín Lázaro et.al. (2012) described a four years of project with the aim of establishing a medium unit (PCIM CCU) to address gaps between two levels of care and avoid the sense of imposition that can be felt in primary care with regards all that comes from the hospital. Butt & McGuinness (2012) described the process of development of a self-management resource by both users and providers. Sánchez Chamero et.al. (2012) described the processes of redefine cardiac care towards patient-based care through a model of care that provides specialised care tailored to the needs of the 'client' within the care system as well as of patients. Pérez Cánovas et.al. (2012) described a project that they extended the use of Drago AP system (a system for primary care (PC) electronic medical records (EMRs)) to cover specialist outpatient appointments, they also created an appointment diary called "Virtual Endocrinology" to improve communication between primary and specialised care. Chessell & Limited (2012) used the latest IT and communications technologies to develop a low-cost Telehealth solution, the result of the project is a Telehealth market cost and technology leader service Whzan Telehealth Service. Dinesen (2012) discussed how telerehabilitation technology affects interaction between healthcare professionals in the Telekat network in his case study. Zabalegui (2012) summarized results from the implementation of a new organisational model by Bidasoa integrated health organisation (IHO), two parts of the project have been highlighted: changing the model for the relationship between professionals; change in the healthcare model. Tol et.al. (2013) completed a study involving 800 Dutch dieticians to determine the level of involvement they had in bundled payments as a means of chronic care delivery.

Case studies of integrated care pilots were also explored in this section of review. Ling et.al (2010) described the 16 Integrated care Pilots in the UK to address the needs of an aging population. McCall & Cromwell (2011) detailed the Medicare Health Support Pilot Program that included eight commercial programs for disease management that used nurse-based call centres. Marichal Plannas et.al. (2012) carried out a study to describe the characteristics of a pilot project on coordination between two levels of care: heart failure unit and programme for prevention and support on discharge (PiSA-IC). Harris et.al. (2013) discussed a North West London Integrated care Pilot. Curry et.al. (2013) described an integrated care pilot in North West London aiming to integrate care across different levels of care for people with diabetes and those over 75 years.

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6. Future directions

Twenty-seven items in this review tried to identify issues found during the course of research and descriptions or suggestions for future research efforts.

6.1 Identified issues and future directions

The literature identified many obstacles and challenges to the integration of care. Borgermans et.al. (2008) performed a review of systematic reviews and identified six elements important in diabetes care programs and those hinder their standardisation; and they concluded that to date no single conceptual framework is applicable. Goodwin (2008) pointed out the issues of problem-recognition and diagnostic delays in primary care for integrated strategy and provided two main recommendations. Brazil et.al. (2008) analysed a coordination network and identified a diffuse system where centralization was greater in operational than administrative activities and a greater number of provider cliques were present at the operational level than administrative activities. Stein et.al. (2009) identified challenges and lessons learned from implemented integrated care models and strategies in practice, as well as challenges and barriers related to financing, organisation, delivery, and management of services. Kokko (2009) pointed out issues of municipal and public administration structures in Finland; and they try to solve the issues through rearranging primary health services. However, he expressed his concern: rearranging primary health services leads into fundamental questions of the benefits of integration, especially if extensive integration leads into the threat of the loss of identity for primary health care. Duimel Peeters (2009) pointed out one of the main barriers for further improving the equality of chronic care was the absence of performance-based financing.

Viktoria Stein & Rieder (2009) discussed the non-existence of a common terminology or standards in integrated care make it difficult to compare experiences and results, whether on a national or international level. Hellesø & Fagermoen (2010) highlighted and discussed three challenges to integrated care associated with the poor communication between hospital and community nurses during discharge planning, and they proposed efforts for the future. Dinesen et.al. (2011) identified obstacles in the co-innovation process when developing programs for tele-rehabilitation of chronic obstructive pulmonary disease patients in an inter-organisational context. Szelfer (2011) explained how advances in asthma research such as the availability of new tools and technologies to monitor the disease, have led to the identification of gaps in disease management prompting future efforts in disease management. Schrijvers & Goodwin (2011) discussed lack of robust evidence is often cited in telehealth as a barrier to adoption, as it is with many integrated care innovations more generally. Boulton (2012) discussed the key implementation issues to integrated care in 'countries in transition' in central/eastern Europe. Toscan et.al. (2012) determined the key factors related to poorly integrated care when hip fracture patients transition between care settings and support the need for collaborative practice. Szczygiel (2012) identified issues associated with palliative care for chronic obstructive pulmonary disease and practice-based commissioning, a multidisciplinary approach. Butt et.al. (2012) described a national study focused on chronic hepatitis C that illuminates the reasons of non-attendance at care from both the user and provider perspectives in Canada. Key themes contributing to non-attendance were previous negative experience, provider and/or client disease knowledge and communication, stigma, restrictive policies, treatment eligibility criteria, personal priorities, poverty and unstable lifestyles. Goodwin (2013) explained the reason for the continued

debate on the meaning and logic of integrated care is the polymorphous nature of a term that has been applied from several disciplinary and professional perspectives and one that is associated with diverse objectives.

Issues identified in the literature also included allowed for suggestions and ways to improve integrated care. Goodwin (2008) pointed out the issues of problem-recognition and diagnostic delays in primary care for integrated strategy and provided two main recommendations. Noorlander (2008) pointed out a great barrier towards structural improvement of COPD management is the current nihilism. To identify the treatable elements of the disease, to document and make known of the disease, and to make interventions measurable and implementable for the relevant stakeholder groups are essential. Schrijvers & Goodwin (2011) also provided the conclusions against the lack of evidence issue: research, service innovation and evaluation need to be much more closely in order to make 'real-time' evidence available. Piraino et.al. (2012) identified the need for transitional care intervention studies to include older patients at highest risk of rehospitalisation in order to make their findings generalizable. Ndumele et.al. (2012) showed that patients with usual sources of care and primary care sites have better health outcomes, therefore longitudinal care sites designed for continuous disease management are crucial in managing chronic diseases. Amelung et.al. (2012) pointed out the reasons for the high costs of care in German: the separation of the outpatient, inpatient and rehabilitation sectors, the poor information flow between the service providers and insufficient competition in healthcare provision. The authors also provided recommendations for the further development. Kwo (2012) discussed current telehealth and telecare projects often focus on technologies to support specific disease or social care problems, which can result in information silos that impede integrated care of the patient, he recommended paying enough attention to the wider information systems architecture. Schrijvers (2012) appealed to design new payment systems for health services based on the idea of global budgeting, bundled payment, and shared savings as a solution in the financial crisis in Europe. Olsen et.al. (2013) identified the need for nurses and managers to improve the exchange of written information to have effective communication of the health status of older patients.

Most items in the literature also included future directions of research with some going into more detail than others. Schrijvers and Goodwin (2010) provided an editorial outlining a summary of the *International Journal of Integrated care* to date and identifying expectations for the future. Vedel et.al. (2011) identified three important challenges to the Quebec healthcare system regarding the integration of services and suggested future efforts should focus on strengthening primary care to achieve better collaboration. Ling et.al. (2012) identified barriers and facilitators to successful integration of care that we should consider when planning future interventions. Prvu et.al. (2012) described how future directions focus on additional transitional care interventions to improve health outcomes and prevent rehospitalisation and adverse events for stroke and myocardial infarction (MI) patients. Chua (2013) analysed the integrated models and existing care programs for elderly in the Singapore. With the belief of different environmental factors that would stimulate and sustain different forms of integration, Chua studied the development of integrated care and looked at various strategies that they could adopt in future.

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