

The 48 included scientific articles identifying the stage in the PwCC journey, and providing summaries and content analysis including identified chronic care quality dimensions and determinants

Scientific article (Author(s), year of publication, Title)	Stage in the PwCC Journey	Summary	Analysis		
			Findings	Dimensions identified	Determinants & actions identified
1. Hung et al, 2007. Rethinking Prevention in Primary Care: Applying the Chronic Care Model to Address Health Risk Behaviors.	At high risk (risk control)	Chronic Care Model (CCM) as a framework for preventing health risk behaviors such as tobacco use, risky drinking, unhealthy dietary patterns, and physical inactivity was examined. Adaptation of the CCM for preventive purposes may offer a useful framework for addressing important health risk behaviors.	Focuses on good practice management and organization of care, and translates applicability to prevention. Proposes a patient-centred care approach that is proactive,planned and includes goal setting, problem-solving and follow-up support.	Effectiveness Person-centredness	Healthcare organization Self-management Leadership & governance (facility level)
2. Lewanczuk et al. Innovations in primary care: Implications for hypertension detection and treatment	Diagnosis	Recent advances in the fields of primary care and chronic disease management have led to the development of frameworks wherein chronic diseases such as hypertension can be more effectively managed. Such paradigms integrate the primary care physician, the specialist, technologies, and a wide variety of health system and community resources to provide optimal care to the patient with hypertension. The present review highlights many of the advances in primary health care delivery in	Health Care Organization: identification of patients and triaging patients to appropriate levels of care; Delivery System Design: newly diagnosed treated at the family physician level, whereas patients with resistant or complex diseases are managed by a specialized team. Information system: An electronic central registry provides valuable data to public health officials that enable preventative or screening measures for hypertension to be targeted at high-risk populations. Decision Support: Decision support embedded within electronic charts can provide support at a primary	Effectiveness Continuity	Leadership & governance (systems level) Healthcare organization Delivery system design Self-management Health information system Decision support

		Canada that apply to hypertension.	care level. Self Management: Key role of family physician in introducing and continually encouraging patient self-management.		
3. Hung et al, 2008. The Chronic Care Model and Relationships to Patient Health Status and Health-Related Quality of Life	Follow-up (at high risk or with poor control)	Little is known about the relationship of the CCM to patient-level health measures. This study describes the implementation of the CCM as adapted for prevention and health behavior counseling in primary care practices, and examines relationships between the CCM and patient health measures, including general health status unhealthy days, and activity-limiting days, and health-related quality of life. Adapting the CCM for prevention may serve to reorient care delivery toward more proactive behavior change and improvements in patient health outcomes.	Incorporation of electronic records to track outcomes; forming the team with medical assistant, registered nurse and physician - working together closely and systematically ; assigned roles: RN to develop individualized care management plan for high risk patients or patients with poor control; updates their care plans and communicates with the physician as needed	Effectiveness Person-centredness Continuity	Delivery system design Health information system
4. Hroschikoski et al, 2006. Challenges of Change: A Qualitative Study of Chronic Care Model Implementation	Follow-up (general)	The Chronic Care Model (CCM) provides a conceptual framework for transforming health care for patients with chronic conditions; however, little is known about how to best design and implement its specifics. Many barriers to the change process were identified, including too many competing priorities, a lack of specificity and agreement about the care process changes desired, and little engagement of physicians.	Overall health care organization must support a redesigned delivery system; modern clinical information systems; systematic decision support; self-management support for patients; and links to available community resources.	Effectiveness Person-centredness Continuity	Healthcare organization Delivery system design Decision support Self-management Community resources & linkages

		Effective models of organizational change and detailed examples of proven, feasible care changes still need to be demonstrated			
5. Janssen et al, 2015. Individual care plans for chronically ill patients within primary care in the Netherlands: Dissemination and associations with patient characteristics and patient-perceived quality of care	Follow-up (general)	The use of individual care plans (ICP) within primary chronic illness care was examined. Compared with patients without an ICP, patients with an ICP more often reported that the care they received was patient-centred, proactive, planned, and included collaborative goal setting, problem-solving, and follow-up support.	Individualised care plans provide chronically ill patients with proactive, holistic, coordinated care that is tailored to their needs and preferences	Effectiveness Person-centredness	Care coordination Collaborative care Self-management
6. Kaissi et al, 2006. Assessing Chronic Illness Care for Diabetes in Primary Care Clinics	Follow-up (general)	The degree to which the CCM dimensions, as represented in the Assessment of Chronic Illness Care (ACIC) survey, are implemented in primary care practices and their relationship with selected quality of care process measures for Type 2 diabetes was examined. Administrative staff were more likely to rate their clinics higher on each structural dimension in the ACIC survey than caregivers or the external observer. Decision support, and to a lesser degree delivery system design and self-management, were most frequently correlated with quality of care measures. Redesigning primary care practices to improve	Organization of the Practice/Clinic:1. Organizational commitment for diabetes management; Community linkages: Linking primary care clinicians to diabetes specialists and educators; Self Management support: Assessment and documentation of self-management needs and activities, addressing concerns of patients and families, effective behaviour change interventions and peer support; Decision Support: Evidence-based guidelines for diabetes, Involvement of diabetes specialists in improving primary care and provider education for diabetes care ; Delivery System Design: Delivery System Design: Practice team functioning and team leadership, Appointment system and	Effectiveness Person (and family) centredness Continuity (Equitability)	Healthcare organization Decision support Delivery system design Self-management Community linkages

		the quality of diabetes care requires accurate assessment of the structures of care directly related to quality measures. A version of the ACIC tool tailored to diabetes management can be used to examine structural dimensions in primary care clinics but may be more valid if completed by caregivers or an independent observer than by administrative staff.	Follow-up, Planned visits for diabetes management and Continuity and coordination of care; Clinical Information Systems. A registry (list of patients with diabetes), Reminders to providers, Feedback available to team, Information about relevant subgroups of patients needing services and patient treatment plans		
7. Lim et al, 2018. Aspects of Multicomponent Integrated Care Promote Sustained Improvement in Surrogate Clinical Outcomes:A Systematic Review and Meta-analysis	Follow-up (not in good control of the condition)	The sustained effectiveness of multicomponent integrated care implementing the CCM in type 2 diabetes was examined. Team-based care with better information flow may improve patient-provider communication and self-management in patients who are young, with suboptimal control, and in low-resource settings.	Not all CCM elements need to be implemented to effect change and improve quality of care. Significant were: reorganization, self-management education, health information systems, and mechanisms to improve HCP-PwCC communications (through personal reports, use of peers). Integration of care seems to play an important role	Effectiveness Person-centredness	Healthcare organization Self-management Health information systems Care integration
8. Ludt et al, 2012. Identifying factors associated with experiences of coronary heart disease patients receiving structured chronic care and counselling in European primary care	Follow-up (general)	In patients suffering from coronary heart disease (CHD), factors associated with patients' experiences of receiving structured chronic care and counselling at the patient and practice level were investigated. At the practice level, performance scores reflecting quality management ($p = 0.013$) and CHD care ($p = 0.009$) were associated with improved assessment of the structured chronic care and counselling received. However,	Patients' perceived quality of care varies. Poor ratings of chronic care were given by people with CHD with less contacts with HCPs and/or with comorbidities/multimorbidities	Effectiveness Person-centredness	Healthcare organization Leadership and governance (facility level)

		<p>good practice management and organisation of care were positively reflected in patients' assessments of receiving structured chronic illness care. This highlights the importance of integrating patient experiences into quality measurements to provide feedback to health care professionals.</p>			
<p>9. Lyon et al, 2011. An organized approach to chronic disease care</p>	<p>Follow-up (general)</p>	<p>The development of chronic care teams does not require additional staffing. In this setting, there was shifting of roles and responsibilities and staff training and education to achieve the necessary skill sets. High-performing clinical teams organized to provide proactive care are a tremendous resource in managing chronic diseases. By clearly defining team roles, honing care delivery processes, using the right tools, and actively engaging patients, patients outcomes can be improved.</p>	<p>Creation of a chronic care team increases efficiency and HCW satisfaction but does not necessarily translate to satisfaction of all PwCCs</p>	<p>Effectiveness Efficiency Person centeredness</p>	<p>Healthcare organization Delivery system design Decision support HRH satisfaction Engagement</p>
<p>10. Vrijhoef et al, 2009. Quality of integrated chronic care measured by patient survey: identification, selection and application of most appropriate instruments</p>	<p>Follow-up (general)</p>	<p>Health care is becoming more user-centred and, as a result, the experience of users of care and evaluation of their experience and/or satisfaction is taken more seriously. Patients' perspectives were sought and instruments for integrated chronic care were analysed through questionnaires and focus group discussions</p>	<p>The PACIC was formulated to measure implementation of the CCM, and has 5 subscales: patient activation, delivery system design and decision support, goal setting, problem solving and follow-up/coordination.</p>	<p>Effectiveness Timeliness (Accessibility) Person centeredness Continuity</p>	<p>Delivery system design Decision support Self-management</p>

		among patients with chronic illness. Because of its psychometric characteristics, perceived applicability and relevance, the Patient's Assessment of Chronic Illness Care (PACIC) is the most appropriate instrument to measure the experience of people receiving integrated chronic care.			
11. Petrelli et al, 2021. Chronic Care Model in Italy: a narrative review of the literature	Follow-up (general)	Literature reviewed demonstrated the effectiveness of CCM for managing patients with heart failure in primary care settings and significant improvements in clinical outcomes, the reduction of inappropriate emergency room access for chronic patients, and the improvement of patients' overall health with diabetes. The CCM organizational model is effective in improving the management of metabolic control and the main cardiovascular risk factors. Furthermore, this modality also allows doctors to dedicate more space to patients in the disease's acute phase. The CCM, with its fundamental pillars of empowering self-management of care, could represent a valid alternative to health management. The managers of health services could consider the CCM for the improvement of the treatments offered.	Community resources are mobilized through direct interaction with stakeholders (volunteer groups, self-help groups, centers for the elderly, third sector in general). Quality of care: innovative introduction into care processes. Support for self care - direct patient focus on all self-care and educational interventions Organization in specific teams: mainly general practitioner, specialist doctors from specifically trained nurses. Use of evidence-based guidelines: support for evidence based clinical and care decisions and evidence-based practice. Efficient and modern information structures: integration and sharing of care information between all actors involved in the care process. The effectiveness of the CCM has been demonstrated in the management of chronic diseases in primary care settings and significant improvements in clinical outcomes, reduction in	Effectiveness Efficiency Person centeredness Continuity	Healthcare organization Decision support Health information systems Self-management Resource generation / mobilization

			<p>inappropriate access to the emergency department for chronic patients and improvement in the overall health of diabetic patients. The CCM organisational model is effective in improving the management of metabolic control and major cardiovascular risk factors. In addition, this modality also allows physicians to devote more space to patients in the acute phase of the disease.</p> <p>In particular, studies have reported that professional involvement in the implementation of CCM contributes to improved clinical care and good chronic disease management in primary care.</p>		
12. Lall et al., 2018 Models of care for chronic conditions in low/middle-income countries: a 'best fit' framework synthesis	Follow-up (general)	<p>A synthesis of qualitative findings regarding care for chronic conditions at primary care facilities in LMICs was done. All themes of the CCM were represented in primary studies. Four additional themes for the model were identified: a focus on the quality of communication between health professionals and patients, availability of essential medicines, diagnostics and trained personnel at decentralised levels of healthcare, and mechanisms for coordination between healthcare providers.</p>	<p>An adapted CCM that includes: the quality of communication between health professionals and patients, emphasis on the availability of essential medicines, diagnostics and trained personnel at decentralised levels of healthcare, and mechanisms for coordination between healthcare providers.</p> <p>Dimensions: effectiveness, efficiency, continuity, person centered care and equitability.</p> <p>Determinants Health Services and support to HS, people/health facility staff) Attributes - only in terms of training? Focus on the quality of communication between health professionals and patients,</p>	<p>Effectiveness Equitability Safety Accessibility including timeliness Person centeredness Continuity</p>	<p>Healthcare organization Delivery system design Health information systems Decision support Self-management Healthcare coordination Community linkages Resource generation</p>

			availability of essential medicines, diagnostics and trained personnel at decentralized levels of healthcare, and mechanisms for coordination between healthcare providers emphasized		
13. Mateo et al, 2019. Specific model for the coordination of primary and hospital care for patients with diabetes mellitus.	Follow up	To assess, in a population with DM from a healthcare area, the impact on health, quality of care, and effectiveness in the use of resources of a specific model of shared management of patients with DM. No significant changes were seen in process indicators related to laboratory practices or examinations in the health area. The proportion of patients with acceptable metabolic control [glycosylated hemoglobin (HbA1c) level < 8%] was 49% in 2015 and 45% in 2017. The number of admissions related to acute myocardial infarction (AMI) and stroke remained constant, but there was an increase in the standardized ratio of major lower limb amputations (1.5 vs. 1.9). Of the 295 patients referred from PC to HC, the proportion of adequate referrals increased from 40% in 2015 to 76% in 2017 (P = .001). In the referred patients, a significant improvement was seen in the mean difference in glycosylated hemoglobin levels (HbA1c; 1.14 ±	Demonstrates efficiency: proportion of adequate referrals increased from 40% in 2015 to 76% in 2017. Emphasis on degree of metabolic control. Quality is not defined. Attributes in materials to measure blood glucose levels. (Very clinical outcomes oriented).	Effectiveness Efficiency	Healthcare organization Delivery system design

		<p>1.73%; 95% CI: 0.73---1.55; P = .0001) and cholesterol (11.28 ± 40 mg/dL; 95% CI: 2.07---20.48; P = .012).</p> <p>This study shows that an intervention based on a chronicity care model adapted to patients with DM improves certain aspects related to the quality of care and the degree of metabolic control.</p>			
<p>14. Adams & Wood, 2016. Redesign of chronic illness care in children and adolescents: evidence for the chronic care model</p>	<p>Follow-up (children and adolescents)</p>	<p>The CCM is an improvement framework that has demonstrated success in improving the care of children and adolescents with chronic disease. More research is needed to identify priority conditions for improvement efforts, to better understand the mediators of health outcomes in pediatric chronic disease, and to rigorously demonstrate the effectiveness of new models of chronic illness care. The evidence to date suggests that the CCM may be useful in guiding the redesign of care delivery systems to improve the health outcomes of young people with chronic disease.</p>	<p>Self-management support: interventions to facilitate patient self-monitoring, medication adherence, healthy lifestyle decisions, and positive coping skills Delivery system design - Interventions to promote proactive/planned care, accessibility, and team-based care. Clinical decision support - Interventions to reduce variations in care, increase adherence to guidelines, and increase the accessibility of specialist expertise (Clinical practice guidelines; provider education; local expert or ‘champion’; collaborative care with subspecialists; telephone consultation and facilitated subspecialty referrals). Clinical information systems: Use of information technology to support population management, monitor change implementation Community resources: Interventions to facilitate access to community programs that</p>	<p>Effectiveness Accessibility Person centeredness Continuity</p>	<p>Healthcare organization Delivery system design Decision support Self-management Clinical information systems Collaborative care Engagement Community linkages Financing mechanisms (incentives)</p>

			support disease self-management or address social needs. Healthcare organization: Changes to provider organizations, regulating agencies, and payers that incentivize and remove barriers to improvement efforts		
15. Enderlin et al, 2013. Review of current conceptual models and frameworks to guide transitions of care in older adults	Follow-up (elderly)	Older adults are at high risk for gaps in care as they move between health care providers and settings during the course of illness, such as following hospital discharge. These gaps in care may result in unnecessary re-hospitalization and even death. This article reviews trends in transitions of care, models, partnerships, and health literacy.	Interesting for the flow (transitions of care for older adults is a priority for improving care outcomes across all settings) Emphasis on “partnership” approach, which actively involves older adults, their families and caregivers in addition to healthcare providers (person centered dimension); investing in geriatric nurses who must address health literacy needs when partnering with older adults and their families/caregivers and thus can play key roles across the myriad of healthcare settings to help assure seamless care transitions for older adult patients	Effectiveness Efficiency Person centeredness Continuity	Delivery system design Health literacy / engagement / partnerships
16. Sendall et al, 2016. A structured review of chronic care model components supporting transition between healthcare service delivery types for older people with multiple chronic diseases	Multimorbidity (elderly)	Older people with chronic diseases often have complex and interacting needs and require treatment and care from a wide range of professionals and services concurrently. This paper identified the components of the chronic care model (CCM) required to support healthcare that transitions seamlessly between hospital and ambulatory settings for people over 65 years of	Stresses that (dimension) patient-centred care is improved by "incorporating all the components of the CCM" and that “Health system organisation was not explicitly identified in any model”.	Effectiveness Person-centredness continuity	Clinical information systems Self-management Community linkages

		<p>age who have two or more chronic diseases. Reviewed literature (n=4) reported only using a few components of the CCM – such as clinical information sharing, community linkages and supported self-management – to create an integrated health system. The implementation of these components in a health service seemed to improve the seamless transition between hospital and ambulatory settings, health outcomes and patient experiences.</p>			
<p>17. Hopman et al, 2016. Effectiveness of comprehensive care programs for patients with multiple chronic conditions or frailty: A systematic literature review</p>		<p>Papers describing comprehensive care programs targeting multimorbid and/or frail patients were reviewed on the effectiveness of the programs regarding improvement of patient and caregiver related outcomes; healthcare utilization and costs were estimated. Providing comprehensive care might result in more patient satisfaction, less depressive symptoms, a better health-related quality of life or functioning of multimorbid or frail patients, but the evidence is insufficient. There is no evidence that comprehensive care reduces the number of primary care or GP visits or healthcare costs. Regarding the use of inpatient care, the evidence was</p>	<p>Providing comprehensive care might increase multimorbid or frail patients' satisfaction with care and improve their health-related quality of life or functional status; however, reviewed evidence is insufficient.</p>	<p>Effectiveness Person-centredness</p>	<p>Comprehensive care</p>

		insufficient. No evidence was found for a beneficial effect of comprehensive care on caregiver-related outcomes.			
18. Parchman & Kaissi, 2009. Are elements of the chronic care model associated with the cardiovascular risk factor control in type 2 diabetes	Complications	Control of modifiable risk factors for cardiovascular (CV) disease, the most common cause of morbidity and mortality among people with Type 2 diabetes is dependent on both patient self-care behaviors and the characteristics of the clinic in which care is delivered. Good control of the three risk factors used in this study (glycosylated hemoglobin, blood pressure, low density lipoprotein) was positively associated with community linkages and delivery system design but was inversely associated with clinical information systems. Patients who were in the maintenance stage of change for all four self-care behaviors were more likely to have all three risk factors well controlled. Risk factors for CV disease among patients with diabetes are associated with the structure and design of the clinical microsystem where care is delivered. In addition to focusing on clinician knowledge, future interventions should address the clinical microsystem's structure and	Structures and processes aimed to the implementation of the CCM are important to improve outcomes and improve quality of care.	Effectiveness Person-centredness	Delivery system design Decision support Clinical information systems Self-management

		design to reduce the burden of CV disease among patients with Type 2 diabetes.			
19. Litzelmann et al, 2019. Caregiver Well-being and the Quality of Cancer Care	Informal caregiver	Caregiver well-being has both direct and indirect effects on the quality of cancer care, including care received from the healthcare team, from the caregiver themselves, and in relation to patients' own self-management. Nurses have a key role in providing psychosocial care to patients and their caregivers, and in supporting system-level change.	Care quality across patient, provider, and caregiver: involvement of caregivers in decision making; stronger family-centered care model will be critical for providing adequate support for caregivers. Psychosocial care of patients and their informal caregivers is important.	Effectiveness Person (and caregiver) - centredness	Self-management Psychosocial care Collaborative care
20. Dugoff et al, 2013. Setting Standards at the Forefront of Delivery System Reform: Aligning Care Coordination Quality Measures for Multiple Chronic Conditions	Follow-up (multi-morbidity)	Care coordination processes are challenging to measure in this regard because there are few guidelines on what are the appropriate care coordination processes. Measures mainly addressed continuity of care, followed by communication, care transitions, and cross-cutting care. Few measures addressed patient-centered care in ways relevant to people with multiple chronic conditions who are the most in need of care coordination. Quality measures are needed to evaluate the full spectrum of care for people with MCCs that can be compared across providers, regardless of the complexity of these conditions.	The quality measures used or proposed to improve care coordination should consider five key areas: continuity, communication, care transitions, patient-centered care and measures that can apply to multiple conditions. Continuity of care includes the capacity to monitor and respond to change, support self-management goals, and link to community resources. Communication includes interpersonal communication and information transfer. Patient centered care includes creating a proactive plan of care, assessing needs and goals, and aligning needs and resources. Care transition includes facilitation transitions as coordination needs change and facilitate transitions across settings.	Effectiveness Patient-centredness Continuity	Self-management Community linkages Care coordination

<p>21. Brand et al, 2014.Chronic disease management: Improving care for people with osteoarthritis</p>	<p>Follow up</p>	<p>A systematic review was undertaken to examine effectiveness, cost effectiveness and barriers to the use of osteoarthritis-chronic disease management (OA-CDM) service models. Overall, reported model effectiveness varied, and where positive impacts on process or health outcomes were observed, they were of small to moderate effect. There was no information about cost effectiveness. There is some evidence to support the use of collaborative care / multidisciplinary case management models in primary and community care and evidence-based pathways / standardisation of care in hospital settings. Multiple barriers were identified.</p>	<p>System improvement can be carried out through an integrated approach, covering human resources management issues, provider participation and incentives and lack of disincentives.</p> <p>The CDM model is similar to the CCM as to elements but with more detailed themes per element: [1] Organization of health care: Coherent plan for system improvement, visible support and promotion by healthcare leaders, provider participation, incentives and lack of disincentives. [2] Delivery system design: Team roles and scope of practice, care delivery and coordination, planned visits and proactive review. [3] Patients self-management: Interactive patient education, support for patient education, support for behaviour change, collaborative decision making, goal setting and problem solving and supported by resources and tools. [4] Decision support: Standardisation of care using guidelines and reminders, Integration of tools into everyday practice (eg patient decision aids and computerized reminders). [5] Clinical information systems: Patient registry, use of systems in care management (reminders, recall), feedback of performance data to providers/patients. [6] Community</p>	<p>Effectiveness Person-centredness</p>	<p>Leadership & governance (facility level) Healthcare organization Delivery system Design Decision support Self-management Clinical information systems Collaborative care Performance (quality) improvement Human resources Financing mechanisms (incentives)</p>
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			resources: linkages for patient and provider		
22. Buja et al 2018. Developing a new clinical governance framework for chronic diseases in primary care: an umbrella review	Follow up	An umbrella review of all systematic reviews published by the Cochrane Effective Practice and Organisation of Care Group was conducted to identify organisational interventions in primary care with demonstrated evidence of efficacy. All primary healthcare systems should be patient-centred. Interventions for patients and their families and should focus on their values; on clinical, professional and institutional integration and finally on accountability to patients, peers and society at large. These interventions should be shaped by an approach to their clinical management that achieves the best clinical governance, which includes quality assurance, risk management, technology assessment, management of patient satisfaction and patient empowerment and engagement. This approach demands the implementation of a system of organisational, functional and professional management based on a population health needs assessment, resource management, evidence-based and	Patient centred care: care based on continuous healing relationships among health professionals, patients and their families care that is customised based on patients' needs and values ensuring patient is the source of control; Quality management : defined as degree to which the healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current profession knowledge; contains two facets quality assurance and quality improvement. Quality assurance includes activities and programs intended to assure or improve quality of car. Quality improvement involves the process of attaining a new higher level of performance or quality. Risk management involves clinical incidents reporting. Health Technology assessment) refers to systematic assessment of properties and effects of a health technology addressing the direct and intended effects of technology as well as its direct and unintended consequences.	Effectiveness Efficiency Safety Person-centredness	Health care organization Delivery system design Decision support Health Information systems Care integration Partnerships with society Collaborative care Empowerment and engagement Leadership & governance (systems and health service levels) Continuous quality improvement

		<p>patient-oriented research, professional education, team building and information and communication technologies that support the delivery system. All primary care should be embedded in and founded on an active partnership with the society it serves. A framework for clinical governance will promote an integrated effort to bring together all related activities, melding environmental, administrative, support and clinical elements to ensure a coordinated and integrated approach that sustains the provision of better care for chronic conditions in primary care setting.</p>			
<p>23. Belland & Hollander, 2011. Integrated models of care delivery for the frail elderly: international perspectives</p>	<p>Follow-up (elderly)</p>	<p>There were two types of models of integrated care delivery for the frail elderly identified. One was a smaller, community-based model that relied on cooperation across care providers, focused on home and community care, and played an active role in health and social care coordination. The second type was a large-scale model that could be applied at a national / provincial / state, or large regional health authority, level, had a single administrative authority and a single budget, and included both Home / community and residential services. Irrespective of which</p>	<p>The article distinguishes between broad categories of integrated care for the elderly (community based and state or provincial level models) and scores them on the following: admission procedures; organizational intraorganization; information management; financing modalities. For the community models, these elements seem to contribute to success: (i) a focus on a high care needs population; (ii) a reliance on cooperation across care providers and care provider organizations to ensure that care providers participate in the continuum of care; (iii) multi-</p>	<p>Effectiveness Equitability (Accessibility) Continuity</p>	<p>Health care organization Delivery system design (facility & community based) Health information systems Financing Care coordination Care integration</p>

		<p>model is adopted, some of the key factors to be considered are how care can be coordinated effectively across different types of services, and how all the care provider organizations can be coordinated to ensure continuity of care for frail elderly persons.</p>	<p>disciplinary care teams that include geriatricians; (iv) an active role for physicians in the overall management of care of the client; (v) inter-organizational care coordination across home and community-based services and with residential and acute care institutions; (vi) reliance on already existing budgets for home and community care providers in the continuum of care; (vii) a focus on community-based care; and (viii) in some cases, an integrated information system and a home care classification system. For the state run programs: (i) a single administrative authority mandated by legislation or policy to manage the overall system of care; (ii) a single funding envelope; (iii) direct control over a wide range of services including home and community care, residential care and some acute care services; (iv) case management with consultation, as required, with physicians. While a range of disciplines can be consulted as needed, multi-disciplinary teams per se are not used; and (v) a system-wide client classification system that classifies clients into the same levels of care need, irrespective of the site of care. Irrespective of which model is adopted, some of the key factors to</p>		
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			consider are how care can be coordinated effectively across different types of services, and how all the care provider organizations involved can be coordinated to ensure continuity of care,		
24. Kanter et al, 2013. Complete Care at Kaiser Permanente: Transforming Chronic and Preventive Care	All steps	The Chronic Care Model (CCM) aims to transform care for patients with chronic illnesses through six interrelated system changes: health system, delivery system design, decision support, clinical information systems, self-management support, and community resources. It has stimulated innovative models of primary care redesign, including the patient-centered medical home. However, the quality impact of large-scale redesign implementing system changes across conditions and extending them into wellness and preventive care has been much less frequently reported. In addition, little has been reported on redesign spanning settings outside of primary care and entailing increased collaboration between all health care team members to provide person-focused, evidence-based care. Kaiser Permanente Southern California (KPSC) developed and	Improvement of comprehensive delivery system and expanded and integrated existing clinical information systems, decision support, work flows, and self-management support is successful in covering care gaps related to elderly care, advance directives, posthospital care, immunizations, health maintenance, and pregnancy care.	Effectiveness Person-centredness Continuity	Delivery system design Decision support Clinical information systems Care integration Self-management

		<p>implemented a comprehensive delivery system redesign and expanded and integrated existing clinical information systems, decision support, work flows, and self-management support—collectively referred to as Complete Care. This was applied to 26 chronic conditions. On 51 HEDIS metrics, KPSC improvement using Complete Care averaged 13.0%, compared with 5.5% improvement in the national HEDIS 50th percentile.</p>			
<p>25. Chiu et al, 2020. Advancing palliative care in patients with CKD: from ideas to practice</p>	<p>End of life</p>	<p>A palliative approach was established and integrated within routine care of patients with CKD glomerular filtration rate categories 4 and 5 (G4-G5), making use of 4 pillars of palliative care as guidance: (1) patient identification, (2) advance care planning, (3) symptom assessment and management, and (4) caring of the dying patient and bereavement.</p>	<p>End of life inclusion in CKD care. Network structure and organization enables culture and practice changes through shared learning and collaboration. Contextualization of strategies to local settings and practice patterns is critical. Involvement of diverse frontline health professionals and patient voices throughout the process ensures relevance and effectiveness A rich and accessible information system with a relevant data set is essential for guiding improvement. Person centered dimension is central: patients and health professionals, are working together to deal with the important patient issues that haven't received sufficient focus in the past.”</p>	<p>Effectiveness Person-centredness Continuity</p>	<p>Decision support Organization of care Delivery system design Care collaboration Engagement Clinical information systems</p>

			"Process measures are used rather than outcome measures in the context of this gradual culture change due to a lack of evidence-based outcome measures in the supportive care/palliative care space".		
26. Morrin et al, 2013. Alberta healthy living program - a model for successful integration of chronic disease management services	Prevention Follow-up (multi-morbidity)	Given the prevalence of multimorbidity and the commonality in approaches, fragmented single disease management must be replaced with integrated care of the whole person. A community-based chronic disease management program, supports adults with, or at risk for, chronic disease to improve their health and well being. Participants gain confidence and skills in how to manage their chronic disease(s) by learning to understand their health condition, make healthy eating choices, exercise safely and cope emotionally. This approach is associated with reduced acute care utilization and improved clinical indicators, and achieves efficiencies through an integrated, disease-spanning patient-centred approach.	The program includes 3 service pillars: disease-specific and general health patient education, disease-spanning. Integrated community based chronic disease management (person centredness central) based on the expanded CCM; patient empowerment and self management support; addressing broader determinants of health; interprofessional teams; integration of services in partnership with the health system and community; application across chronic conditions. Targeted prevention and CC management for diverse and vulnerable populations: partnerships between chronic disease management, primary care and community; adaptability of standards of care according to local specificities. Challenges include human resources recruitment and retainment in rural areas, unintegrated information systems, funding. Community-based chronic disease management program is effective to improve self-management of chronic disease(s).	Effectiveness Efficiency Equitability Person centredness	Self-management Service delivery design Community partnership Engagement Integration

			PwCC learn to understand their health condition, make healthy eating choices, exercise safely and cope emotionally. Integration leads to efficiency.		
27. Nuno et al, 2012. Integrated care for chronic conditions: The contribution of the ICCCF Framework	All	Literature were reviewed to identify initiatives designed and implemented following the ICCCF Framework, including any evidence on the effectiveness, cost-effectiveness and feasibility of the ICCCF. The ICCCF Framework has inspired a wide range of types of intervention and has been applied in a number of countries with diverse healthcare systems and socioeconomic contexts. The available evidence supports the effectiveness of this framework's components, although no study explicitly assessing its comprehensive implementation at a health system level has been found.	Support a paradigm shift: increasingly encourage the adoption of a different model to enable effective care for chronic conditions Manage the political environment: formulation of policies and planning of services occur in a political context, all stakeholders-politicians, managers, clinical leaders, patients, families and community members should be considered and involved in the change process Build integrated care: The expected outcomes of integrating services are higher quality of care and better health, as well as less waste of resources, improved efficiency, and a more satisfying experience for both patients and professionals. Align policies for health: Collaboration across multiple sectors is of fundamental importance when designing, developing, and implementing policies and strategies which affect health. Use healthcare personnel more effectively: framework, health professionals must have the necessary skills and competences. They need to enhance interpersonal and communication	Effectiveness Efficiency Person-centred care	Leadership & governance (systems and facility levels) Multisectoral involvement Resource utilization HRH satisfaction / motivation Delivery service design (community & facility-based services) Decision support Integrated care Collaborative care

			<p>skills, and incorporate new technologies into their work routines and relationships with patients</p> <p>Centre care on the patient and family: it is particularly important that the values, objectives and knowledge of patients themselves are considered in the decision-making processes about their own healthcare. Support patients in their communities: The care of patients with chronic conditions cannot be limited to their contacts with health services; patients need support at home, at work, and in the community, where they spend most of their time, living with their condition. Emphasise prevention: implementation of certain strategies at population and individual level to reduce the incidence and worsening of certain chronic diseases.</p> <p>The available evidence supports the effectiveness of the components of this framework, although no studies explicitly evaluating its full implementation at the health system level were found.</p>		
28. Lebina et al, 2020. A mixed methods approach to exploring the moderating factors of implementation fidelity of the integrated chronic	Follow-up (general, ?co-morbidities)	Chronic care models like the Integrated Chronic Disease Management (ICDM) model strive to improve the efficiency and quality of care for patients with chronic diseases. However, there is a dearth of studies assessing the moderating factors of fidelity	<p>The following components were identified:</p> <p>Facility re-organization - management of patient flow to improve operational efficiency, reducing waiting time and patient satisfaction with the health services.</p>	Efficiency Accessibility	Healthcare organization Decision support Governance Self-management Patient satisfaction

disease management model in South Africa		during the implementation of the ICDM model. This study assessed moderating factors of implementation fidelity of the ICDM model. The moderating factors of implementation fidelity of the ICDM model were the existence of facilitation strategies (training and clinical mentorship); intervention complexity (healthcare worker, time and space integration); and participant responsiveness (observing operational efficiencies, compliance of patients and staff attitudes). One feature of the ICDM model that seemingly compromised fidelity was the inclusion of tuberculosis patients in the same stream (waiting areas, consultation rooms) as other patients with noncommunicable diseases and those with HIV/AIDS with no clear infection control guidelines. Participants also suggested that poor adherence to any one component of the ICDM model affected the implementation of the other components. Contextual factors that affected fidelity included supply chain management, infrastructure, adequate staff, and balanced patient caseloads.	Clinical supportive management - promotes quality care for patients with chronic diseases and support for the healthcare workers with appropriate training, guidelines and clinical mentoring. Assisted self-management - patients are assisted with self-management of their chronic diseases and provide adherence monitoring, screening for complications and point-of-care testing in the community. Strengthening support systems - aligned with the ideal clinic initiative of enhancing supply chain management and collaborations with other stakeholders, such as school health team		Multisectoral involvement Resources management Collaboration
29. Ameh et al, 2017A. Relationships	Follow-up	The objectives of this study were to: i) assess patients' and	Used Donabedian's seven elements of quality of medical care: Efficacy,	Efficiency Accessibility	Leadership

<p>between structure, process and outcome to assess quality of integrated chronic disease management in a rural South African setting: applying a structural equation model</p>	<p>(general, ?comorbidities)</p>	<p>operational managers' satisfaction with the dimensions of ICDM services; and ii) evaluate the quality of care in the ICDM model using Avedis Donabedian's theory of relationships between structure (resources), process (clinical activities) and outcome (desired result of healthcare) constructs as a measure of quality of care. The patient satisfaction questionnaire (PSQ-18), with measures reflecting structure/process/outcome (SPO) constructs, was adapted and administered to 435 chronic disease patients and the operational managers of seven primary healthcare facilities in north-east South Africa. The mediation pathway showed that the relationships between structure, process and outcome represented quality systems in the ICDM model. Structure correlated with process (0.40) and outcome (0.75). Given structure, process correlated with outcome (0.88). Of the 17 dimensions of care in the ICDM model, three structure (equipment, critical drugs, accessibility), three process (professionalism, friendliness and attendance to patients) and three outcome (competence, confidence and coherence)</p>	<p>Effectiveness, Efficiency, Equity, Optimality, Acceptability and Legitimacy. Although Efficacy is hard to measure, it refers to care provided under optimal conditions and is the basis against which measurements should be made. Effectiveness describes the outcome of interventions; Efficiency refers to cost reductions without compromising effects; Equity refers to the fairness in the distribution of healthcare in populations; Optimality is about balancing the costs and benefits of healthcare; Acceptability encompasses accessibility of healthcare and interpersonal patient-provider interaction; and Legitimacy refers to the social acceptability of the healthcare institution regarding the manner in which healthcare is delivered. The choice of which of these elements, as well as their relative prioritisation, should be guided by the contexts in which quality of care is being assessed. Eight dimensions for successful HIV program were identified: medicines, equipment, hospital referral, defaulter tracing, prepacking of medicines, clinic appointments, patient waiting time, and coherence of integrated chronic disease care</p>	<p>Continuity</p>	<p>Delivery system design Care integration Resources management</p>
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		dimensions reflected their intended constructs.			
30. Ameh et al, 2017B. Quality of integrated chronic disease care in rural South Africa: user and provider perspectives	Follow-up (general, ?co-morbidities)	A case study of seven PHC facilities in northeast South Africa where the the ICDM model was implemented was done. Focus group discussions were used to obtain data from 56 purposively selected patients 18 years. In-depth interviews were conducted with operational managers of each facility and the sub-district health manager. Donabedian's structure, process and outcome theory for service quality evaluation underpinned the conceptual framework in this study. The manager and patient narratives showed the inadequacies in structure (malfunctioning blood pressure machines and staff shortage); process (irregular prepacking of drugs); and outcome (long waiting times). There was discordance between managers and patients regarding reasons for long patient waiting time which managers attributed to staff shortage and missed appointments, while patients ascribed it to late arrival of managers to the clinics. Patients reported anti-hypertension drug stock-outs (structure); sub-optimal defaulter-	Made us of Donabedian's structure-process-outcome framework to assess quality of care, where there are relationships between SPO constructs based on the idea that good structure should promote good process and good process should in turn promote good outcome (unidirectional pathway). Processes identified were related to professionalism, referral, time with nurses, defaulter, friendliness, examination, prepacking, communication, appointment and attendance. Structure characteristics identified were related to accessibility, critical medicine and equipment availability. Outcome characteristics identified were related to confidence, waiting time, competence and coherence	Efficiency Accessibility	Leadership Delivery system design Resources management

		tracing (process); rigid clinic appointment system (process). Emerging themes showed that patients reported HIV stigmatisation in the community due to defaulter-tracing activities of home-based carers, while managers reported treatment of chronic diseases by traditional healers and reduced facility-related HIV stigma because HIV and NCD patients attended the same clinic.			
31. Ulbrich et al, 2017. Care models for people with chronic diseases - integrative review	Follow-up (general)	This is a literature review which identified care models and the impact of using these in the care of people with chronic diseases. Three categories emerged from the analysis: health care costs, model-based care experience, and patient autonomy. The articles addressed self-management, case management and care model for people with chronic diseases. The major impacts on the use of the models were: a better relationship between the patient and the health professional, an increase in the autonomy of the person with chronic illness, and a reduction in personal and health care expenditure.	Case management involves shared decisions, support the patient to manage his condition and promoting care based on scientific literature, improved communication between health professionals and patients in order to make them partners in decisions taken on their care and in the pursue of better health conditions, planning of care can be used as a tool which can serve as a guide to record goals and facilitate case management Self-management: teaching skills for problem solving, incite changes in behavior, to teach patient to recognize signs and symptoms of exacerbation of the disease and act before these; example: health provider distributes information and guides self management to identify problems, modify habits and lifestyle where necessary SM - Carelink -	Efficiency Person-centredness	Delivery system design Self-management Care linkages (coordination)

			assist elderly in self management of chronic conditions with home visits, nursing interventions, health education and continuous monitoring. Three categories emerged from the analysis: health care costs, model-based care experience and patient autonomy. The articles focused on self-management, case management and the model of care for people with chronic diseases. The main impacts on the use of the models were: a better relationship between the patient and the health professional, an increase in the autonomy of the person with chronic disease and a reduction in personal and health care expenses. Nurses need to be actively involved in applying these models of care to people with this type of disease.		
32. Grover & Joshi, 2015. An Overview of Chronic Disease Models: A Systematic Literature Review	Prevention & Follow-up	This literature review examined various existing chronic disease models, their elements and their role in the management of diabetes, chronic obstructive pulmonary disease (COPD), and cardiovascular diseases (CVD). A total of 23 articles were reviewed and where 5 chronic disease models were identified: Chronic Care Model (CCM), Improving Chronic Illness Care (ICIC), Innovative Care for Chronic Conditions (ICCC), Stanford Model	Health system: The entity desiring to implement CCM is composed of staff, leaders, operations, values, and goals of the organization and may vary from small family practice to a multisite integrated health system. Clinical information system: needs to have readily accessible disease specific database of individual patients and this database should alert the provider to needed tests and provide tracking. The system should facilitate and promote	Effectiveness, including cultural effectiveness Efficiency Person (and family) centredness Continuity	Leadership & governance (system and facility levels) Multisectoral involvement Resource management Healthcare organization Delivery system design Decision support

		<p>(SM) and Community based Transition Model (CBTM). CCM was the most studied model. Elements studied included delivery system design and self-management support (87%), clinical information system and decision support (57%) and health system organization (52%). Elements including centering care on the patient and family (13%), patient safety (4%), community policies (4%), built integrated health care (4%) and remote patient monitoring (4%) have not been well studied. Other elements including supporting paradigm shift, managing political environment, aligning sectoral policies for health, using healthcare personnel more effectively, supporting patients in their communities, emphasizing prevention, identifying patient specific concerns related to the transition process, and health literacy between visits and treatments have also not been well studied in the existing literature.</p>	<p>exchange of information between providers and patients. Decision support: Defined as evidence based guidelines consistent with scientific evidence and patient preference. These guidelines should be embedded into daily practice and should be shared with patients to encourage participation. Delivery system design: Involves how care delivery services are organized, staffed, and delivered. This element is typically where care innovations are implemented and represents an important opportunity to improve the quality of care and health outcomes of patients. Self Management support: Emphasizes patient's role in managing health. Established self-management techniques such as mutual goal setting and action planning have focused on various methods of teaching such as group classes, skill development, and various lifestyle behaviors. Community including organizations: Involves linking and using community resources that support healthcare effort by clinicians. The use of church-based support groups, local community health programs, clinic based support groups and internet are acceptable community interventions.</p>		<p>Clinical information systems Self-management Collaborative care Integrated care Community linkages Cultural competency & sensitivity</p>
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			<p>Patient safety: A system seeking to improve chronic illness care must be motivated and prepared for change throughout the organization.</p> <p>Cultural competency: self-management. Health literacy and cultural sensitivity are two important features and providers are increasingly being called upon to respond effectively to the diverse cultural and linguistic needs of patients</p> <p>Care coordination: An information system can identify groups of patients needing additional care as well as facilitate performance monitoring and quality improvement efforts.</p> <p>Community policies: Mobilize community resources to meet needs of patients by advocating for policies to improve patient care.</p> <p>Case management: Provide clinical case management services for complex patients and care that patients understand and that fits with their cultural background.</p> <p>Support a paradigm shift: Provide clinical case management services for complex patients and care that patients understand and that fits with their cultural background.</p> <p>Manage political environment: Policy-making and service planning inevitably occur in a political context. Political decision-makers, health care</p>		
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			<p>leaders, patients, families, and community members, as well as organizations that represent them, need to be considered. Build integrated healthcare: Care for chronic conditions needs integration to ensure shared information across settings and providers, and across time. Integration also includes coordinating financing across different arms of health care including prevention efforts and incorporating community resources that can leverage overall health care services. Align sectoral policies for health: The policies of all sectors need to be analyzed and aligned to maximize health outcomes. Health care can be and should be aligned with labor practices Use healthcare personnel more effectively: Health care providers, public health personnel and those who support health care organizations need new, team care models and evidence-based skills for managing chronic conditions. Advanced communication abilities, behavior change techniques, patient education, and counseling skills are necessary in helping patients with chronic problems Center care on patient and family: Management of chronic conditions requires lifestyle and daily behavior change. Focusing on the patient in this way constitutes</p>		
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			<p>an important shift in current clinical practice. Support patients in their communities: Patients and families need services and support from their communities. Communities can also fill crucial gap in health services that are not provided by organized health care. Emphasize prevention: Most chronic conditions are preventable. Strategies for reducing onset and complications include early detection, increasing</p>		
<p>33. Disler et al, 2012. Interventions to support a palliative care approach in patients with chronic obstructive pulmonary disease: An integrative review</p>	<p>Palliative / End of life</p>	<p>A palliative approach is appropriate for individuals with end-stage COPD, yet currently few interventions embrace this holistic, multidisciplinary and inclusive perspective. An integrative review was done to describe interventions to support a palliative care approach in patients with end-stage COPD. A range of palliative interventions are used to address the needs of individuals with end-stage COPD. Although evidence exists for discrete elements of palliative management in this patient group, there is limited evidence for health service coordination and models that integrate the multiple domains of palliative care with active management. A comprehensive and collaborative approach is required to address</p>	<p>Symptom control for individuals with end-stage disease can likely be improved using a palliative approach. Advance care planning should be commenced early to ensure care is commensurate with individuals' needs. Training is required to support providers in commencing advance care planning discussions. A comprehensive and collaborative approach is required to address the complex needs of chronic conditions. The following should be considered: Psychosocial care, relationship with healthcare professionals, Advance care planning, Access to care</p>	<p>Effectiveness Accessibility Person-centredness</p>	<p>Delivery system design Decision support Collaborative care Comprehensive care Holistic, psychosocial care</p>

		the complex and varied needs of individuals with end-stage COPD and their families.			
34. Kari et al, 2021. Effectiveness and cost-effectiveness of a people-centred care model for community-living older people versus usual care – A randomized controlled trial	Follow-up (elderly)	This research evaluated effectiveness, QoL and physical performance, and cost-utility of a people-centred care model (PCCM). The intervention comprised an at-home patient interview, health review, pharmacist-led clinical medication review, an interprofessional team meeting, and nurse-led care coordination and health support. Healthcare resource use were collected and transformed into costs. A healthcare payer perspective was adopted. Incremental cost-effectiveness ratio (ICER) was calculated, and one-way sensitivity analysis was performed. The ICER was – 73 638€/QALY, hence, the developed PCCM dominated usual care, since it was more effective and less costly.	This paper is on integrated care through interprofessional team meeting; an at-home patient interview by a named nurse and a pharmacist; completing health (the named nurse) and clinical medication (a pharmacist) reviews; and agreeing on the care and medication plan based on the patient’s care targets and needs at an interprofessional team meeting (ITM) (the named nurse, a pharmacist and a GP).	Effectiveness Efficiency Person-centredness	Delivery system design Coordination Integrated care
35. Kamajian et al, 2010 . Utilizing medical homes to manage chronic conditions.	Follow-up (elderly)	Primary Care Medical Home (PCMH) models provide physicians with excellent opportunities to co-create competent portals to health care that are positive and beneficial for both patients and physicians. PCMH adoption leads to cost savings, better health	Core features: enhances access: encourages better communication between patient and providers; payment reform practices to reduce waste and insufficiency while enhancing patient centered care; personal physicians- one personal physician oversees the care provided by all others involved in the process	Effectiveness Efficiency Safety Person-centredness	Healthcare organization Delivery system design Collaborative care Continuous quality improvement

		outcomes, and higher levels of patient satisfaction. Primary care physicians working within a PCMH framework was consistently associated with better outcomes: reductions in preventable hospital admissions for patients with chronic diseases, reduced mortality rates, reduced utilization rates, increased patient compliance rates, and reduced medical expenses.	to encourage collaboration and teamwork; Physician directed medical practice- leads a team who collectively take responsibility of the ongoing care of patients ; quality and safety: continual improvement and accountability ; whole person orientation - dealing with mind and body outcomes: cost savings, better health outcomes, and higher levels of patient satisfaction.		Holistic (mind-body) Patient satisfaction
36. Brownson et al, 2007. A quality improvement tool to assess self-management support in primary care	Follow up (general)	A tool is introduced as a quality improvement instrument for healthcare providers to assess their current capacity to support and implement consistent patient-centered self-management congruent with the Chronic Care Model, the Expanded Chronic Care Model, and the model of Resources and Supports for Self Management. In an implementation of the tool, the noted growing demand for patient- and family-centered approaches to care was addressed by teaching provider organizations how to implement robust models of collaborative self-management support through an approach known as a “learning network.”	Focuses on self-management support based on conceptual model "Resources and Support for Self Management" (Person Centered Care dimension) (determinants people/staff/systems to support health services) Takes two primary sections (Patient Support and Organizational Support) rather than the 6 areas of the Chronic Care Model.	Effectiveness Person-centredness	Healthcare organization Decision support Self-management Collaborative care
37. Harvey et al, 2015. Improving the identification and management	Diagnosis & Follow up	Undiagnosed chronic kidney disease (CKD) contributes to a high cost and care burden in secondary care. Uptake of	Proper management of financial resources towards quality improvement enabled increased identification and improved	Effectiveness Efficiency	Leadership & governance (Resources /

<p>of chronic kidney disease in primary care: lessons from a staged improvement collaborative</p>		<p>evidence-based guidelines in primary care is inconsistent, resulting in variation in the detection and management of CKD. A two-phase collaborative was implemented; key elements of the intervention included learning events, improvement targets, Plan-Do-Study-Act cycles, benchmarking of audit data, facilitator support and staff time reimbursement. An improvement collaborative with tailored facilitation support appears to promote the uptake of evidence-based guidance on the identification and management of CKD in primary care.</p>	<p>management of patients with CKD in primary care through support to promote uptake of evidence-based guidelines.</p>		<p>financial management) Incentives Decision support Continuous quality improvement</p>
<p>38. Hayashino et al, 2015. A cluster randomized trial on the effect of a multifaceted intervention improved the technical quality of diabetes care by primary care physicians: The Japan Diabetes Outcome Intervention Trial-2 (J-DOIT2)</p>	<p>Follow up</p>	<p>The effect of multifaceted interventions using the Achievable Benchmark of Care (ABC) method for improving the technical quality of diabetes care in primary care settings was evaluated. Physicians in the intervention group received a monthly report of their care quality, with the top 10% quality of diabetes care scores for all physicians being the achievable benchmark. Multifaceted intervention, measuring quality-of-care indicators and providing feedback regarding the quality of diabetes care to physicians with ABC, was effective for improving the technical quality of care in</p>	<p>Feedback sheets for adherence were implemented included reminders for regular visits. Healthcare provided included lifestyle modification interventions aimed to encourage behavioural changes in terms of diet and exercise - these multifaceted interventions improve the technical quality of diabetes care. Mechanisms increasing adherence to (self)care can increase (technical) effectiveness</p>	<p>Effectiveness Efficiency</p>	<p>Decision support Self-management Continuous quality improvement</p>

		patients with Type 2 diabetes in primary care settings.			
39. Hirschoorn et al, 2009. Reported care quality in federal Ryan White HIV/AIDS Program supported networks of HIV/AIDS care	Follow up (regular)	To facilitate quality management and improvement activities, the quality, accessibility, and coordination of services of care networks from the perspective of case management and medical providers, administrators and consumers were measured. Quality management and support activities of the entire network, as well as reported quality of services at individual care sites were measured. The care networks were rated highly on access, quality, and coordination between case management and primary care providers. However, there were frequently differences in ratings of quality and barriers by type of respondent (consumer representatives, grantees, and providers). There were also substantial variations across care networks in network characteristics, perceived effectiveness, performance measurement, and quality improvement activities. The results indicate that the Program has been successful in some areas of developing networks of care, but additional support is needed to strengthen the comprehensiveness and	This paper is about developing networks: strengthening the comprehensiveness and coordination of care; using information systems to track service utilization. The network was effective in linking patients into care; with the care delivered across a network of services and programs in a geographic area such as a city or county. Integration of care across networks improves care coordination and comprehensiveness of care; these and effective linking can improve care continuity	Accessibility Continuity	Clinical information systems Care coordination Comprehensive care Leadership & Governance (Quality management system) Continuous quality improvement

		coordination of care. Additional work also is needed to better define and measure the essential characteristics of coordinated and integrated networks of care and assess whether those characteristics are related to access and quality of care and services.			
40. Joseph et al, 2015.Going beyond the vertical: leveraging a national HIV quality improvement programme to address other health priorities in Haiti	Follow up (regular)	Expertise and framework of a national HIV quality improvement programme was successfully leveraged to spread capacity and improve quality across a network of clinics in HIV and other targeted areas of healthcare delivery in rural Haiti. Facility quality improvement capacity increased with spread from HIV to other areas of inpatient and outpatient care, including tuberculosis (TB), maternal health and inpatient services in all 12 supported healthcare facilities. A significant increase in the quality of HIV care was also seen in most areas, including CD4 monitoring, TB screening, HIV treatment (all $P < 0.01$) and nutritional assessment and prevention of mother-to-child transmission (both $P < .05$), with an increase in average facility performance from 39 to 72% ($P < .01$).Using a diagonal approach to leverage a national vertical programme for wider benefit	Involved (1) capacity building and peer to peer learning ; (2) use of a standardized performance measurement approach to routinely and reliably assess the quality of care ; (3) Improving vital signs monitoring by sensitization and training on the importance of vital signs monitoring system; (3) Reducing the length of time to ensure appropriate chart - bed and chart identification; (4) Improving ART coverage by tracking patients for follow-up and by counseling, and ensuring drug availability and (5) Improving nutritional assessment among HIV- training and sensitization of staff on importance of nutritional assessment. Staff training and sensitization can improve efficiency and engagement of PwHA	Effectiveness Efficiency Accessibility Continuity	Service delivery design Decision support Resources management Quality improvement Engagement

		<p>resulted in accelerated change in professional culture and increased capacity to spread quality improvement activities across facilities and areas of health-care delivery. This led to improvement within and beyond HIV care and contributed to the goal of quality of care for all.</p>			
<p>41. Pullen et al, 2021. CONQUEST Quality Standards: For the Collaboration on Quality Improvement Initiative for Achieving Excellence in Standards of COPD Care</p>	<p>Diagnosis & Follow up</p>	<p>Key opportunities to optimize treatment for COPD are often not realized due to unrecognized disease and delayed implementation of appropriate interventions for both diagnosed and undiagnosed individuals. A collaborative, interventional COPD registry was created, with the following quality standards 1) identification of COPD target population, 2) assessment of disease and quantification of future risk, 3) non-pharmacological and pharmacological intervention, and 4) appropriate follow-up.</p>	<p>Identification: use of targeted approach on "at risk" patients can help to find undiagnosed patients Assessment of disease and risk identification: symptom assessment using specific tools, identifying other co-morbidities, risk assessment, using risk prediction tools, Pharmacological and non-pharmacological interventions: along with required therapies, patient motivation and engagement, adequate and prompt pharmacological therapy, regular assessment and follow up Appropriate follow up: Medication, devices and symptom review: should be recorded and reviewed with appropriate biomarkers, smoking and nutritional assessment using BMI and guidelines and rehabilitation. The quality and availability of health personnel to detect COPD cases early, treat them and follow them up are documented. For example, doctors are more than seven times more likely to detect</p>	<p>Effectiveness Accessibility Person-centredness</p>	<p>Delivery system design Decision support Collaborative care Engagement HRH management (appropriate skill mix)</p>

			undiagnosed COPD. Thus the issue of access to quality health services arises.		
42. Wellwood et al, 2011. Developing a Tool to Assess Quality of Stroke Care Across European Populations. The EROS Quality Assessment Tool.	Complications	There are significant differences in the provision of care and outcome after stroke across countries. A systematic review and grading of evidence for stroke care across the clinical pathway was done and a quality tool was developed and field-tested. In field testing, the proportion of positive responses to evidence-based items ranged from 43% to 79% across populations. Proportions of different types of evidence being implemented were similar: high quality 62%, limited quality 72%, and expert opinion 54% across the populations. More than half (4 of 7) of the centers provided stroke unit care and thrombolysis, but availability and access to inpatient rehabilitation varied significantly, with poor access to community follow-up for rehabilitation and medical management.	Development and testing of a quality tool for evaluating stroke care across the clinical pathway. Utilized an algorithm that accounted for the level of evidence, measurement properties, and consensus of opinion obtained using the Delphi techniques, The study concluded that the tool may be used as a framework to compare services and promote increased implementation of evidence-based care. The 11 domains studied were: specialist stroke services, management protocols, multidisciplinary team, caregivers and family, acute specific medical diagnosis, acute medical and surgical interventions, early disability assessment and management, rehabilitation interventions, transfer back to the community, long-term management, and supplementary questions	Effectiveness Accessibility Continuity	Healthcare organization Delivery system design (multidisciplinary teams; community-based and facility-based) Care coordination Decision support
43. Hawthorne et al, 2012. Diabetes Care Provision in UK Primary Care Practices	Follow up (regular)	Primary care practices have organisational structures in place and are, as judged by routine quality indicators, delivering high quality care. There remain evidence-practice gaps in the care provided and in the self confidence that patients have for key aspects of self management.	Collaborative, person-centered care; targetting specific behaviour to improve outcomes.	Effectiveness Person-centredness	Self-management Collaborative care

<p>44. Fletcher et al, 2012. The integrated team approach to the care of the patient with cardiovascular disease</p>	<p>Follow up (general)</p>	<p>Cardiovascular disease (CVD) is a costly, worldwide problem with significant annual morbidity and mortality. Guideline-based primary and secondary prevention is effective in preventing and controlling CVD. During the acute phase of care, various teams are activated as appropriate to specific needs of the patient in the medical (invasive and noninvasive) and surgical specialties. The outpatient phase varies with diagnosis and condition of the patient and team members are involved as needed. An integrated team effort is essential to the best care for each patient regarding individual management and will assure that evidence-based guidelines, in both treatment and secondary prevention, are implemented.</p>	<p>Emphasis on integrated team in PHC, to increase effectiveness and cost-effectiveness, reduced use of health care services and lower health care costs in patients with common chronic health conditions, including heart failure, asthma, and diabetes). Link with patients “personal team” of family and friends - with whom the health care team must effectively relate transition from hospital to home. Lead stays with HC professionals to ensure maximum effectiveness</p>	<p>Effectiveness Efficiency Continuity</p>	<p>Decision support Care integration Collaborative care</p>
<p>45. Mitchell et al, 2019 . Development and implementation of a team-based, primary care delivery model: challenges and opportunities</p>	<p>Follow-up (general)</p>	<p>A health service was configured to accommodate a team-based care model that included complete colocation of clinical staff to foster collaboration, designation of a physician team manager to support a physician to advanced practice practitioner ratio of 1:2, expanded roles for registered nurses, and integration of clinical pharmacists, behavioral health specialists, and community specialists; this model was</p>	<p>Adopting the team-based care model designed by Mayo Clinic showed a mean positive response for the Safety Attitudes Questionnaire. Focus on HRH and skill mix. The "team based care" can be compared to a multidisciplinary team (MD, nurses, behavioural specialists, community liaisons, etc.) to improve the quality of primary care (not chronic care specific, albeit able to attend well to chronic conditions thanks to how the</p>	<p>Effectiveness Efficiency (person-centredness)</p>	<p>Delivery service design (multidisciplinary) HRH management (appropriate skill mix) Integrated care Community linkage</p>

		designed to accommodate the growth of nonvisit care. The implementation of this team-based care model and the key metrics that were tracked to assess performance related to the quadruple aim of improving population health, improving patient experience, reducing cost, and supporting care team's work life are described.	multidisciplinary team is established). They also have close relationships through "an integrated community specialist model, in which specialists serve in a consulting role within the primary care practice".		
46. Van Houtven et al, 2019. A Path To High-Quality Team-Based Care For People With Serious Illness	Follow-up (general)	Although most care for people with serious illness is delivered by multiple providers and agencies, there is no gold standard for how to assemble, train, unify, and sustain strong teams. Using lessons from complexity science, a way of studying complex systems, improving team connections; the quality, quantity, and timeliness of information flow; and the purposeful seeking of diverse perspectives to interpret information and make decisions as a means of driving effective self-organization of teams and leading to high-quality outcomes are proposed. An adaptable intervention that helped improve connections, information flow, and cognitive diversity and resulted in effective self-organization in the Department of Veterans Affairs health care system are highlighted.	Importance of teambased approaches inspired by complexity thinking, hence focusing on integrated care. Teams are however conceptualized crossing organizational boundaries of health and social care, including family caregivers, focussing on collaborative instead of directive leadership. This "cognitive diversity" in perspectives within the team is considered a key successfactor. This approach goes beyond continuity of care and focuses on establishing network connections between all the carers involved, best under the coordination of a designated team member that works as a "connection hub" (case manager) which equally involves the importance of outreach (= going to the patient, getting out of the health service) and a shared assessment (information) system (including on social determinants).	Effectiveness Person and family centredness Continuity	Healthcare organization Delivery system design Decision support (Clinical) information systems Integrated care Collaboration

		Challenges to building teams across systems and sectors are described.	Not only attention for patient but also family centredness.		
47. Washington et al, 2011. Tailoring VA primary care to women veterans: association with patient-rated quality and satisfaction	Follow-up (women)	<p>Primary care delivery models tailored to women's needs and preferences are associated with higher quality and satisfaction and adoption of these models were recommended by the Veterans Administration (VA). Women veterans' ratings of their VA health care quality, gender-related satisfaction, gender appropriateness, and VA provider skills in treating women were assessed at VA sites nationwide.</p> <p>The sites which adopted the primary care models tailored to women were rated higher on most dimensions of care. Facilitating establishment of these optimal care models at other sites is one strategy for improving women veterans' experiences with VA care.</p>	<p>This study analyzed the difference on quality and patient satisfaction based on the facilities' adoption of the women's primary care model. Gender-related satisfaction was measured with the PCSSW. A 7-item scale was used for the gender appropriateness scale. A single item measure of perception was used for the VA provider's skill component. The quality of care was measured with the Consumer Assessment of Health Plans Survey global rating of health care. It mainly draws on the importance of diversity sensitive approaches (in this case based on gender) which is however central to all health service delivery (including chronic care).</p>	(Effectiveness) Equitability Person-centredness	<p>Service delivery design</p> <p>Decision support</p> <p>Patient satisfaction</p>
48. Campbell et al, 2012. A framework for discussion on how to improve prevention, management, and control of hypertension in Canada	Prevention, diagnosis, follow-up (elderly)	<p>An environmental scan of past and current activities was done and, proposals were made for key indicators, and targets to be achieved by 2020, and what changes are likely to be required (in Canada) to achieve the proposed targets. Broad changes in government policy, research,</p>	<p>The following recommendations are useful: Build healthy public policy Reorient/redesign the health services delivery system and use an integrated interdisciplinary primary healthcare team approach along the continuum of health promotion,</p>	Effectiveness Efficiency Person centredness	<p>Leadership and governance (systems and facility levels)</p> <p>Delivery system design</p> <p>Decision support</p>

		<p>and health services delivery are required for these changes to occur.</p>	<p>disease prevention, early detection, treatment, and control Build partnerships to create supportive environments and evolve the healthcare system, and to better integrate disease management with population health promotion, engaging all levels of government, health organizations, and healthcare professionals, nongovernment organizations, academics, relevant institutions, and corporations / businesses. Strengthen community action by broadly implementing community-based programs operating in places where people live and work that have been shown to substantively prevent, detect, and control hypertension and otherwise integrate best practices for blood pressure management into existing effective community health programs. Develop personal skills for better self-management and ensure that all people have the resources, knowledge, and ability they need to optimally prevent, detect, and control hypertension, and recognizing that this recommendation is highly dependent on implementing and maintaining supportive environments. Improve decision support.</p>		<p>Clinical information systems Self-management Community resources Stakeholder involvement Integrated care Quality improvement</p>
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			<p>Promote a culture of evaluation and continuous quality cycles in the collection of key indicators of prevention, detection, treatment, and control, and evaluate the uptake of findings—that the knowledge about the processes and outcomes of interventions is making a difference. Optimize information systems. Use rapidly evolving information technology and systems to their ultimate potential to transfer knowledge on how to improve hypertension prevention, detection, treatment and control.</p>		
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