Review article

Mapping Evidence of Patients' Experiences in Integrated Care: A Scoping Review

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ABSTRACT

Objectives: Despite the established clinical and cost-effectiveness of integrated care (IC) models for patients with comorbid mental and physical illness, little is known about whether these models facilitate a better care experience from the patient's perspective. The authors conducted a scoping review of the literature to explore how IC influences patients' care experiences.
Methods: MEDLINE, EMBASE, PSYC INFO CINAHL, AMED, the Cochrane Library, and grey literature were searched to identify relevant articles. Eligible studies were systematically reviewed and analyzed, using thematic analysis approach, to identify patterns, trends, and variation in patient experience within IC settings.
Results: Search results yielded 5250 unique resources of which 21 primary studies met our eligibility criteria for analysis. Findings from this scoping review revealed variation in patients' experiences in IC settings. IC models enhanced patients' experience by creating theraputic spaces: improving patient access to care, developing collaborative relationships, and personalizing patient care to address individual needs.
Conclusion: Productive interactions with care team were key to improve patient engagement and experience of centeredness in IC settings. Successful implementation of IC demanded purposeful alignment of IC structural components and care processes to create therapeutic spaces that address patient care needs and preferences.

1. Introduction

Patient experience is a key indicator of the quality of care [1–4]. While extensive research has demonstrated the link between patient experience and health outcomes, a growing challenging to deliver patient-centered care is the rising complexity of managing chronic health conditions associated with increased health complications, higher rates of mortality, and rising hospitalization costs [2,5]. This growing complexity in population healthcare needs calls for sustainable models of care that can improve both patient experience and outcomes.

Kilbourne and colleagues identified integrated care (IC) as a health care innovation that can mitigate these quality gaps in patients with comorbid physical and mental health conditions [6]. IC comprises a range of care models that varies in structure primarily based on the degree of mental and physical health services integration, ranging from coordinated, co-located (collaborative care), to fully-integrated care models (behavioural health integration) as outlined by the Center for Integrated Health Solutions (CIHS) integration framework [7–9]. In the past decade, robust research, including seminal work by Wagner and Katon, has established the evidence for the effectiveness of collaborative and fully-integrated care models to deliver high-quality care that aligns with the Quadruple Aim; through improved quality of care experience, reduced costs, and improved clinician satisfaction [10]. Moreover, the American Psychiatric Association (APA) and Academy of Psychosomatic Medicine (APM) joint report, in 2016, collated the evidence on IC effectiveness and provided a framework of the core principles of collaborative care, as a widely disseminated model of IC, that promote patient-centered care:1) team-driven; 2) population-focused; 3) measurement-guided; and 4) evidence-based care [11].

Nevertheless, research in IC is yet to explain the process by which
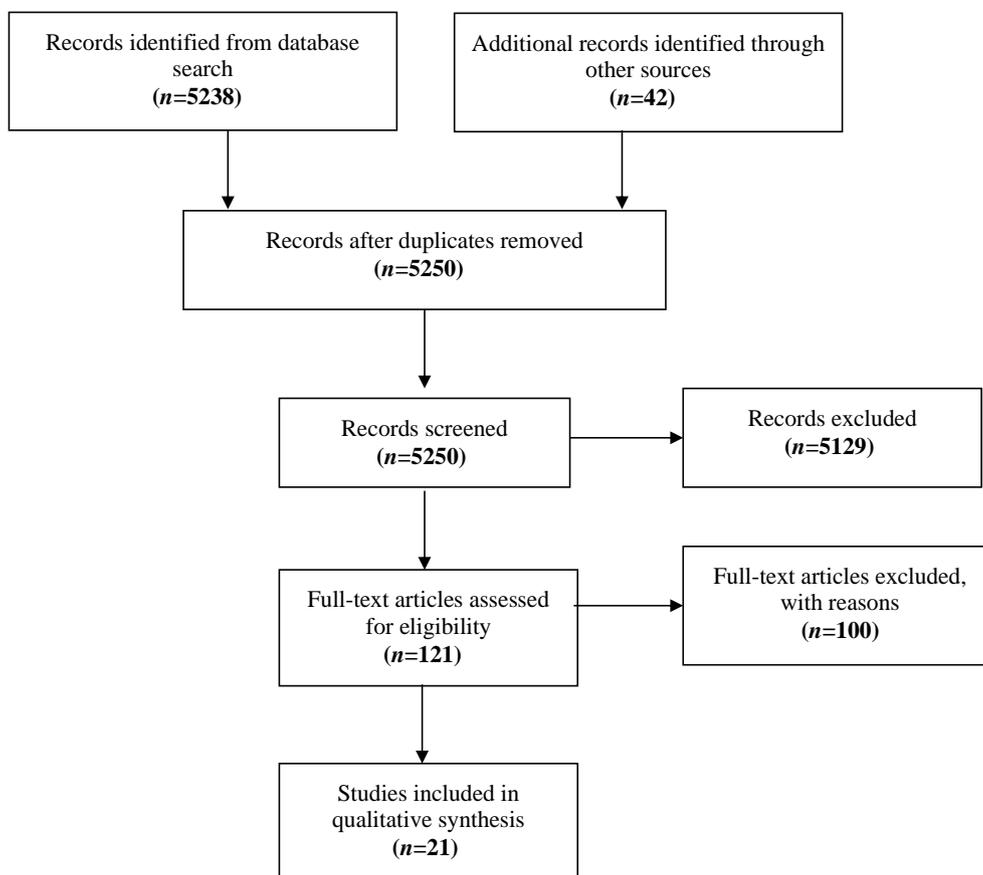

Fig. 1. PRISMA flow diagram outlining scoping review search results.

care setting integration shapes patients' experiences of care. Patient experience is a complex multidimensional construct that has been linked to multiple care domains including individuals' emotional and physical lived experience, patient-care provider interactions, healthcare organization culture, degree of patient involvement, continuity of care, and patient-centeredness [3,4,12–15]. However, patient experience has been erroneously equated to patient satisfaction, which does not capture the above complexity of this construct. As a result, a lack of clarity remains in how these concepts are examined in the literature [16,17].

In IC, patient experience has been predominantly evaluated using the Patient Assessment of Chronic Illness Care (PACIC) developed by Glasgow and colleagues, a patient self-reported measure that assesses the degree to which care is congruent with the chronic care model (CCM) [18,19]. Despite its widespread, cumulative evidence from the literature remains inconclusive and non-generalizable [5,20,21]. A recent systematic review by Arditi et al. identified a wide heterogeneity ($I^2 = 99\%$) in PACIC scores across studies and that could not be explained by differences in healthcare delivery or patient characteristics [22]. Further results from a confirmatory factor analysis by Gugiu et al. questioned the psychometric validity of a PACIC to provide reliable interpretation across similar populations, supporting Arditi's et al. conclusion [20,21]. In addition to the heterogeneity in patient self-reported studies, a systematic review Sunderji et al., evaluating implementation of quality care measures in IC, highlighted the paucity of quality measures focusing on client/patient-centeredness [23]. Together, the inconclusive evidence from the literature highlights a gap in our understanding of patient care experience in IC and how it is assessed .

Therefore, the objective of this scoping review was to systematically map the literature to surface existing knowledge gaps and identify important aspects of patients care experiences in IC focusing primarily on collaborative care and integrated behavioural health in primary care as evolving evidence-based care models [11,24,25]. In this scoping review, the primary research question aimed to examine the breadth of existing evidence on patients' experience with chronic illness receiving care in IC settings; the secondary research question focused on identifying the dimensions of patient experience that were affected by IC setting structural components and care context. Findings from this scoping review will be valuable to inform future implementation efforts and quality improvement initiatives.

2. Methods

We used the Arskey and O'Malley scoping review framework, enhanced by Levac et al., and the Joanna Briggs Institute (JBI) scoping review guidelines, to enhance the reproducibility and reliability of our study findings [26–28]. The previously published protocol for this scoping review was drafted using the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines, prior to the development of the PRISMA extension for Scoping Reviews (PRISMA-ScR) [30–32].

2.1. Stage 1: identify the research question

The primary and secondary research questions are stated above and used the Beryl's Institute definition of patient experience based on this definition's broad conceptualization of patient experience [14]. The Beryl Institute defines patient experience as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions, across the continuum of care" and it is the most comprehensive definition to-date [14,33].

2.2. Stage 2: identifying relevant studies

We used an iterative process to identify relevant studies involving several discussions with the research team and two librarians [GN, KF] at our institution. We followed the Joanna Briggs Institute (JBI) recommended scoping review guidelines in developing our search strategy protocol [28]. We drafted a search strategy using the peer review of electronic search strategies (PRESS) 2015 evidence-based checklist guidelines, and drafting the finalized search protocol [33]. The following biliographics databases were searched from 1988 to Aug 2018: MEDLINE, EMBASE, Psyc INFO, CINAHL, AMED and the Cochrane Library. We also included relevant grey literature from Google Scholar, Web of Science, and key research journals in the field (see Appendix 1) and further search strategy details have been previously published [32]. For study selection see the PRISMA diagram in (Fig. 1).

2.3. Stage 3: study selection

Peer-reviewed journal papers eligible for inclusion met the following criteria: published between the period of 1988-Aug 2018, written in English language, examined patient experience in IC settings. In this review, we conceptualized integrated care as a continuum of care that comprise a range of care models based on differences in clinical setting structure and care team-coordination level. Therefore, IC studies eligible for inclusion in this scoping review had to meet the following inclusion criteria: 1) meet SAMHSA (CIHS) integration framework description in regard to IC clinical setting structure/level of coordination (Appendix 2) align explicitly with the chronic care model and collaborative care core principles defined in the APA-APM Dissemination of Integrated Care 2016 Report: 1) team-driven 2) measurement-guided 3) evidence-based 4) population-focused [11]. An example of how these criteria were used to determine studies eligibility is described in Appendix 3.

We excluded studies examining patient experience using single self-reported measures (i.e. PACIC) due to inconclusive evidence and non-standardized application to evaluate patient experience in IC [14]. Two independent reviewers (AY and RC) determined studies eligibility, and in cases of uncertainty, a third reviewer (SS) with expertise in the topics of integrated care, medical psychiatry was consulted.

Stage 4: Data Charting.

Two independent reviewers (AY and RC) completed data extraction of eligible studies including study characteristics, model components, study aim, methodology, outcome, and population.

2.4. Stage 5: collating, summarizing, and analyses

We undertook three stages of data synthesis and analyses. First, two authors (AY & ZC) independently reviewed all 21 studies. We then synthesized findings and developed themes linking key concepts related to patient experience of care in integrated care settings. We used a thematic analysis approach to critically analyze the articles and generate open codes. In this stage, all studies that met study inclusion criteria (1) or (2) from above were first considered in aggregate. Then, the small number of studies that explicitly met principles defined in the APA-APM model (inclusion criteria 2) were analyzed separately to determine whether and how inclusion criteria (ex. level of integration and degree of comorbidity) differing from those of the broader SAMHSA (CIHS) integration framework contributed to patients' experiences in IC settings. Iterative discussions and consultation with experts on our research team helped us proceed to a higher level of thematic analysis, generating broad categories and higher-level themes. Third, our research team met to discuss the higher-level themes with respect to the broader concepts and knowledge of IC models that allowed us to generate a framework on the meaningful aspects of integrated care models that improved patient care experience and outcomes.

2.5. Stage 6: consultation phase

The consultation phase is a major contribution in scoping reviews, particularly when there is a breadth of information, inconsistencies or vagueness in the literature. In this scoping review, the purpose of the consultation phase was to validate the literature findings and inform our developing framework of how IC structure influence patients experience from a patient perspective [32]. Given the existing gaps in the IC literature, patient [CL] involvement in data analysis was valuable in eliciting salient aspects in IC structural elements that were transformative to patient experience of care from a patient's lens. Notably, besides refining our coding and framework, iterative discussions of the literature analysis with [CL] surfaced a critical difference in how patients perceived care integration. For example, from the patient's perspective, care-team collaborative care or IC practice meant focusing on the patient's need and fostering positive interactions with the care team members regardless of population type or setting. Therefore, this additional patient consultation was instrumental in including patients' perception of "integrated care" in our iterative analysis and interpretation of the literature.

3. Results

Of 5250 unique resources, 21 primary studies were eligible for full-text analysis (Fig. 1). Overall, included patient experiences studies covered a range of populations, locations, and time periods. The key findings and characteristics of the analyzed studies are summarized in Table 1. Two studies addressed self-management of co-morbid physical health conditions in collaborative care settings [34,35]. Three collaborative care studies examined patient experience receiving mental health support in primary care [36–38]. Two studies evaluated patient experience receiving integrated care for complex care needs including mental, physical, and social health needs. Five studies examined the care experiences of marginalized patient populations receiving care in safety-net clinics, other collaborative care studies evaluated patients experience receiving care for co-morbid mental and physical illnesses in integrated behavioural health in primary care, two studies explored IC patient experience in the geriatric, and two studies reported veterans care experience receiving (HIV) treatment through tele-collaborative care in primary care.

3.1. Thematic analysis

Our analyses revealed significant variations in patients' experiences across IC settings. In exploring this variability, our analyses suggest that the way in which IC elements are designed and implemented shape the way patients experience care in IC settings by personalizing care to address individual needs, developing collaborative care relationship, and facilitating access to care (Fig. 2).

3.2. Cross-cutting theme: the way that therapeutic spaces are designed can influence the way that patients experience their care

The cross-cutting theme in this scoping review highlighted the importance of aligning the structural components within IC models with their intended function to design effective "therapeutic" spaces. Therapeutic spaces were characterized as IC clinical environments and processes promoting privacy, confidentiality, cultural sensitivity and, adopting a non-judgmental care philosophy [38–44]. Therapeutic spaces in IC were a vehicle to cultivating a productive patient-care team relationship and addressing population-specific care needs. In this scoping review, studies attributed differences in patient experience to varying abilities of IC models to create therapeutic spaces that align with population care needs. Specifically, the structural components of IC (i.e. clinical setting environment, physical spaces, all processes and components of care delivery, including care team organization and care

Table 1
Summary of Studies Included in Scoping Review.

Classification of Studies	Author & Year	Country	Patient Population	Clinical Setting	Study Design	Study Aim(s)
Self-managing chronic illness in primary collaborative care	(Noël et al., 2004) [34]	US	Multimorbid conditions (n = 60)	Mental health/behavioural management in physical health setting	Qualitative: Focus-group	Explore the collaborative care needs and preferences in primary care patients with multiple chronic illnesses
	(Bauer et al., 2018) [35]	US	Patient with co-morbid depression or anxiety (n = 38)	Mental health/behavioural management in physical health setting	Mixed-methods	Assess the feasibility and acceptability of a mobile health platform supporting Collaborative Care
Mental health interventions in primary collaborative care	(Mukherjee et al., 2006) [36]	US	Anxiety & panic disorder (n = 21)	Mental health/behavioural management in physical health setting	Qualitative: Semi-structured interviews	Examine the feelings of disadvantaged patients about and their experiences of treatment for anxiety disorders in primary care settings.
	(Simpson et al., 2008) [37]	UK	Depression (n = 13)	Mental health/behavioural management in physical health setting	Qualitative: Semi-structured interviews	Explore the experiences of UK patients who received collaborative care as a treatment for depression in our pilot randomised trial, and in particular their views on its acceptability
	(Nadeau et al., 2017) [38]	Canada	Migrant families (Youth (5) & families (n = 1)) with a psychiatric diagnosis & receiving collaborative care mental health services for at least 6 months.	Mental health/behavioural management in physical health setting	Qualitative study: exploratory multi-case study	Understand quality of care including factors improving access to care and collaborative YMH services use, efficacy and satisfaction, for this vulnerable population
IC for severe mental, physical co-morbidities, and social health needs	(Small et al., 2017) [55]	UK	Patients with severe mental illness (SMI), physical comorbidities, and psychosocial care needs (n = 13)	Physical health care in mental health setting.	Focus groups & semi-structured interviews	Explore service user, carer and professional experiences of and preferences for service user and carer involvement in physical health discussions within mental health care planning; and develop a conceptual framework of effective user-led involvement in this aspect of service provision
	(Sheff et al., 2017) [56]	US	Medicaid (high need patient population based on medical conditions and psychosocial profiles) (n = 13)	Physical health care in physical health setting	Qualitative study: focus groups	Assess the unique needs of a Medicaid population to identify gaps in support, patient-perceived barriers to care, and patient-identified opportunities for health improvement
IC for Marginalized patient populations with chronic illness	(Brener et al., 2013) [43]	New Zealand	Hepatitis C virus (HCV) (n = 24)	Mental health/behavioural management in physical health setting	Qualitative evaluation – Mix Method study	Assess the role of the clinic in improving health outcomes, knowledge, lifestyle practices and psychosocial functioning of the target population
	(Treloar et al.,2014) [42]	AU	Substance Abuse & HCV (n = 57)	Mental health/behavioural management in physical health setting	Qualitative: Semi-structured interviews	Explore barriers and facilitators to HCV assessment and treatment in the OST setting among clients
	(Wrenn et al., 2017) [39]	US	African American, adults with co-occurring mental & physical illness (n = 33)	Mental health/behavioural management in physical health setting	Mixed Methods: focus groups (n = 9) & semi-structured interviews	Explore cultural factors influencing integrated health care models to help address depression and selected co-occurring chronic health conditions in underserved African-American population
	(Stanhope & Henwood, 2014) [46]	US	Chronic homelessness & severe mental illness (SMI) (n = 15)	Physical and mental health care	Qualitative: Semi-structured interviews	Understand consumer perspectives on the major barriers and facilitators to addressing their health needs.
	(Mead, Andres, & Regenstein, 2014) [48]	US	Disadvantaged patient population with heart disease (n = 387)	Mental health/behavioural management in physical health setting	Qualitative: Focus-group	Gain a unique perspective of a high needs patient population that often experiences difficulty accessing high quality care
IC for patients with co-morbid mental and physical illness	(Knowles et al., 2015) [40]	UK	Diabetes, coronary heart disease & co-morbid depression (n = 29)	Mental health/behavioural management in physical health setting	Qualitative: semi-structured interview	Determine how the collaborative care model was implemented by usual care providers in a UK setting. Determine how patients and providers understood and experienced the integration of mental and physical health care.
	(Webster. Ekers & Chew-Graham, 2016) [49]	UK	Depression & ong-term physical conditions (LTC) (n = 14)	Mental health/behavioural management in physical health setting	Qualitative study: Grounded Theory approach	Assess acceptability of a Brief Behavioural Activation intervention within a collaborative care framework; and identify barriers and

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Table 1 (*continued*)

Classification of Studies	Author &Year	Country	Patient Population	Clinical Setting	Study Design	Study Aim(s)
	(Rao et al., 2016) [41]	India	Co-morbid diabetes & depression (n = 37)	Mental health/behavioural management in physical health setting	Qualitative study: Focus groups & semi-structured interviews	facilitators to engaging with the intervention from the patient and clinician perspective. Develop and test an integrated care model for patients with co-morbid depression and diabetes in India, focusing on understanding perspectives to inform culturally-sensitive adaptations of the intervention.
	(Balasubramanian et al., 2017) [45]	US	Co-morbid depression (n = 25)	Mental health/behavioural management in physical health setting	Mixed-Methods	Evaluate effect of integrated care, adapted to local contexts, on depression severity and patients' experience of care
	(Davis et al., 2018) [25]	US	Co-occurring mental, physical illness & social needs (n = 24)	Mental health/behavioural management in physical health setting	Qualitative study: In-depth interviews	Understand patients' perceptions of the care they received in ACT clinics to assess strategies and needs for integrating physical and behavioural health services based on real-world primary care practices and CMHCs [implementation efforts]
IC treatment for older adults	(Spoorenberg et al., 2015) [57]	The Netherlands	Geriatric population with complex needs (n = 23)		Qualitative: semi-structured interview	Evaluate the opinions and experiences of community-living older adults receiving integrated care and support.
	(Saini et al., 2016) [58]	UK	Physical and mental health co-morbidities and early stage dementia in an integrated care nursing homes (n = 23)	Mental health/behavioural management in physical health care setting for elder residents	Qualitative study: Ethnographic study	Examine practices relating to end-of-life discussions with family members of people with advanced dementia residing in nursing homes; and explore strategies for improving practice.
IC treatment for veterans with physical and/or mental illness in primary care	(Batka et al., 2016) [47]	US	Veterans with Post-traumatic stress disorder (PTSD) (n = 76)	Mental health/behavioural management in physical health setting	Qualitative: semi-structured interview	Examine stakeholder experiences receiving integrated care treatment for PTSD and depression within primary care clinics in the U.S for veterans participating in the Stepped Treatment Enhanced PTSD Services Using Primary Care study
	(Ohl et al., 2013) [44]	US	Veterans with HIV infection (n = 32)	Mental health/behavioural management in physical health setting	Qualitative: Mixed-method	Determine the feasibility of telehealth collaborative care (TCC) program; and identify factors influencing implementation in rural settings.

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Fig. 2. Framework summarizing main themes from the literature on patient experience in integrated care (IC).

philosophy) influenced whether patients perceived integrated care settings to be "patient-centered".

Importantly, while service level integration (i.e. the physical proximity of services) enhanced patients' experience of IC in some studies, clinical setting integration alone was not sufficient to establishing "therapeutic" spaces [40]. Most studies, focused on integrating physical and mental health services in primary care settings, showed that care service integration fostered a positive patient care experience. However, few studies eluded to some patient populations questioning the purpose of integrating both physical and mental health care in the same space when not targeted to patient care needs [25,38,40,45]. The reported variation in patient perspective may have resulted from the important distinction between 'physical' integration of care services under one roof and the patient experience of 'therapeutic' integration. Overall, the deliberate and successful creation of therapeutic spaces in IC settings was critical in addressing stigma and improving access to care, engaging patients in their care and establishing relationships with the care team that promoted open dialogue to address sensitive issues (e.g. use of drugs, end-of-life discussions, side effects of antipsychotic medication, sexual dysfunction).

"This was an especially sensitive issue with regard to collaboration and communication between health services and schools. While some youths (two) and parents (two, same dyad as youth) did not mention concerns about confidentiality issues and could view the possibility of accessing [youth mental health]YMH services in school as convenient—even if most of them (four youth, four parents) preferred to be seen at the [community local services centres] (CLSC) or at home—others worried that sensitive information could be leaked in the school environment and have a negative impact on the youth's or family's life (two youth, three parent, twice from same dyad)." [38]

Furthermore, IC models created opportunities for sharing care experiences and enabling patients' peer-support. In this study, patients perceived the IC setting as a designated space that was conducive to dynamic interactions among patients with similar care and illness experiences. Patients valued these group-interactions as they felt empowered to share their care experiences and expose their concerns:

"It's easier to talk to someone that's going through what you're going through than it is to talk to someone who's never been through it. Like, a lot of doctors, you know, they never been homeless, and they really can't comprehend what you're saying or what you're going through." [46].

3.3. Personalizing care to address individual needs

Providing care that addressed patients' unique health needs, including specific physical and mental health needs, promoted active patient engagement and relationship building in IC settings. For instance, an optimal mutual collaboration between the patient and the care provider seemed to occur when the patient's individual care needs and preferences were accounted for during the development of the treatment plan.

Furthermore, patients' desire for personalized care was evident in recent mobile-health (m-health) feasibility studies examining patients' perspective of m-health tools to support self-managing and monitoring of their health. In these studies, the notable variability in patients engagement with m-health applications was attributed to differences in how patients perceived the utility of these platforms to support their self-management [35,41]. For instance, patients' experiences ranged from seeing the utility of these tools to promote self-awareness of health status and enhance access to care, to a lack of understanding how to use these tools. A novel finding in one study was patient concerns related to data sharing and confidentiality of information particularly for data capturing emotional and mental well-being [35].

This variability in patient perceptions regarding m-health interventions in IC settings is illustrated in the following example. Bauer et al. assessed the feasibility and acceptability of an m-health platform to support patients with comorbid depression and diabetes [35]. Some patients described a lack of understanding of the utility of these m-health tools to support their care and improve health outcomes:

"So I don't know what all the goals of the app are. But if it were a goal for the app to provide immediate help in terms of some crisis, then you probably want to make that a little bit more clear." [35]

In contrast, other patients experience highlighted the utility of m-health platform to monitor and support patients with comorbid depression manage their feelings:

"If there was something that I personally had a hard time saying about my feelings or the week or whatever, she already had an idea because I had already put in some input for that." [35]

These studies illustrated the need for personalizing care in IC models, including care delivered through m-health platforms, in order to align with patients' preferences and goals, such as eventual self-management.

3.4. Developing collaborative care relationships

Most studies described the importance and positive changes in patient-care team interactions facilitated mainly through effective patient-care team communication. These changes underscored the value of IC models in improving patient care experiences, primarily through improved patient-care provider relationship in primary care settings. Furthermore, care continuity in IC models was supported by improvements in care coordination efforts and building a cohesive relationship with the care team members. The establishment of patient-care team alliance enabled addressing key barriers to care accessibility and promoting patient engagement in their care. For instance, establishing cohesive relationships with the case managers enabled patients to access care promptly and to better understand patients' unique needs and preferences. Batka et al. described how a collaborative care PTSD intervention promoted productive interactions with veterans who perceived the care facilitator to be invested in their care by listening, discussing their treatment plans and objectives, and supporting treatment adherence:

"[S/he] listens to how I feel and helps me cope with it better. [S/he's] not telling me how they [the military] see it or trying to make me change my opinion. I can tell [her/him] exactly what's on my mind and how I feel…" [47].

3.5. Facilitating access to care

One of the primary ways by which the structure of IC models influenced patient experience was by improving access to specialists care by addressing stigma and inequalities experienced by patients. Provider advocacy within IC settings addressed patient, provider and system factors that collectively shaped patients' experience of care. For instance, marginalized patient populations often struggled to disclose their human immunodeficiency virus (HIV) status in their day-to-day networks for fear of negative repercussions [42–44]. As a result, studies identified the importance of patient-care team interactions and a non-judgemental culture in IC settings as critical components to reshaping patient experience. In these settings, staff protected patients' privacy, respected their preferences for disclosure, and worked collaboratively with patients to address inequalities in accessing care.

"Patients' perceptions of what integration meant revolved around the sense that the collaborative approach granted them access to mental health care that had hitherto been out of reach either because physical health problems had taken centre stage in routine primary care consultations or because seeking mental health treatment was stigmatized". [40]

In addition, telehealth collaborative care (TCC) provided an opportunity to use technology to overcome accessibility barriers impeding care service delivery. For example, the TTC model was identified as an established means to improving veterans access to mental health, and speciality care in primary care.

"Patients indicated a number of ways access improved with TCC: time spent traveling and away from work decreased; travel was less stressful and costly; and the wait time before visits at community-based outpatient clinics was typically shorter than at the specialty clinic." [44]

Patient-level factors that influenced patients' willingness to accessing care or treatment included patient education. Patients' perceptions of the health system and structures in place given their past experiences were identified as potential barriers to accessing care. For example, patients with co-existing mental and social needs reported a lack of knowledge about their illness and a limited ability to discuss their treatment plan with their care providers as internal barriers that impeded their ability to access services. It is worth noting that support groups in IC settings helped address these barriers by bolstering patient knowledge and engagement level in their own care.

"But, this program really teaches that you can do it yourself, just need the knowledge; and they showed me, yea, you're right, I can do it. Don't be afraid to talk to your doctor. I used to be shy about talking to my doctor. Let them do the talking. I figured they know it all. No, not necessarily, I have an agenda." [46]

IC models also addressed cultural factors that contributed to patient stigma and difficulties accessing care [38,39,41]. These factors include addressing misunderstandings, preconceived notions about physical/mental illnesses, and providing culturally adapted psychoeducation tailored for patients and their families. This psycho-education and support was found to enhance patient self-efficacy and to further develop patients' coping strategies to better manage distress related to stigma.

3.6. Analyses across models of integration

Based on our analyses, the framework described above was uniformly applicable across the continuum of care and across the range of care models. The framework remained relevant across the care continuum irrespective of differences in the degree of physical and mental health care integration or the level of care team-coordination. While we observed variations of experiences across all studies, the degree of co-morbidity and classifications/level of physical and mental health service integration were not specific themes that emerged as influencing patients' experience or perception of their care in IC. Moreover, the

above framework resonated with studies that reflected the collaborative care model, as defined by the APA-APM report. Rather, patients in these studies felt cared for when factors unique to their conditions and patient level factors were addressed (personalization); when care was more accessible (e.g. via proximity of services and cost reduction); when continuity of relationships was a core component of care; and when trust was increased between patients and providers [25].

4. Discussion

This scoping review identified pivotal knowledge gaps in our understanding of patients' experience of care in IC. We identified 21 primary studies that examined the effects of implementing IC on patient experiences in primary care settings from patients' perspectives. Overall, studies in this review clearly highlighted that implementation of IC in primary care settings has the capacity to influence patients' experience of care and purposefully create "therapeutic spaces" by personalizing care to address individual needs, developing collaborative care relationship, and facilitating access to care.

This review underscored the influence of environmental facilitators and barriers (including physical and organizational factors) on IC care processes and resulting impact on patients' perceived care experience. For example, we found that studies that considered population specific barriers to accessing care such as stigma, illness acuity, cultural, and ethnicity factors were able to amend their care processes to address patients care needs and promote longitudinal relationship-building in IC settings [38,39,41–44,48]. Conversely, studies with variable implementation efforts and unclear consideration of contextual factors reported mixed outcomes related to patient care experiences [40,47,49]. Thus, recognizing the contextual environmental factors influencing IC care processes and the underlying mechanism influencing patients' experiences are necessary for promoting patient-centered care .

Another important theme related to variation in care experiences was the individual difference in patients' care needs within a given population. For instance, collaborative care studies in this review that examined patients m-health acceptability and engagement reported a range of experiences and challenges related to using these m-health tools to engage patients in self-management and monitoring [35,41,50]. Some of the reported challenges expressed by patients' related to concerns about m-health data sharing and privacy, specifically for data capturing emotional and mental well-being [35]. This finding is particularly important as healthcare systems evolve to leverage telehealth technology to extend care accessibility to having infrastructure that accommodates individual variations in patients perception and knowledge engaging with these platforms to support health self-management.

Existing ways to evaluate the patients' perspective of their care experiences fall-short from capturing the complexity and realm of patients' experience. Findings from this scoping review offer a new perspective to understanding patient experience in IC. In addition to the presents a framework to potentially explain how IC approaches may influence patients' care experiences to support chronic illness self-management and improve long-term health outcomes in primary care settings [51–54]. Moreover, this review surfaced the effect of IC structural components on patients' experience, which is an area that is not captured in current patient-reported measures, such as PACIC [20]. Future research should strive to generate new knowledge explaining how these patient-related factors are being accounted for when implementing and evaluating patient experience in IC.

Our scoping review findings should be interpreted in the context of the following limitations. We used broad inclusion criteria, specifically the CIHS classification framework, which could have introduced some variability in our findings. However, we also analyzed themes in studies meeting the more specific APA-APM integrated care principles. Moreover, studies that did not include a description of an IC model may

not have been captured in our review despite potentially having IC components. While we employed a rigorous systematic thematic analysis approach to data analyses that was informed from a patient perspective, our findings subsume the high-level themes in this literature. As studies capture a range of patient experience measures, future studies may be able to provide a more quantitative synthesis of study results.

In summary, the following scoping review highlighted additional dimensions of patient experience in IC settings. Given the limited focus on patient experience measures specific to IC in the literature, this review highlights a strong need to expand existing evaluative processes of patient experience in IC to include patients' perspective on additional care integration domains, such as structural components. Moreover, this review highlights how patients' understanding of care integration may differ from that of a health system, and should be considered in future evaluation measures of IC.

Data sharing statement

Unpublished study data, such as the search protocol for the other databases, are available upon request to the corresponding author.

Acknowledgements

Author's contributions

AY led the design, conceptualization, execution of the review, and drafted the manuscript. AY developed the search strategy and conducted the search consulting with an expert librarian (KF) in medical sciences database search at our institution. (AY and RC) worked on data collection. AY and ZC collaborated on the thematic analysis of the collected data, drafting, and finalization of the manuscript. DW, MM, and SS guided the conceptualization of the work, the thematic analysis, and served as content experts in the consultation stage. They validated the review findings and contributed to the finalization of this manuscript. SS copy-edited and guided the intellectual narrative of this review. SS is the corresponding author of this work. All authors reviewed and authorized publishing of this manuscript.

Declaration of competing interest

The authors declare that they have no competing interests.

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Disclaimer

The views expressed in this study reflect the authors' own perspective.

Patient consent

This study does not require patient consent.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.genhosppsych.2019.08.004.

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