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Integrating Nursing and Social Work in the Management of Patients with Chronic Diseases: A Narrative Review

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ABSTRACT: Chronic diseases are a major public health concern and require continuous medical care, lifestyle changes, and long-term support. Patients living with chronic conditions often face physical, psychological, social, and financial difficulties that affect their ability to manage their health. Although medical treatment is essential, it may not be sufficient to address all these challenges.

Nurses and social workers play important and complementary roles in the management of chronic diseases. Nurses provide clinical assessment, patient education, symptom monitoring, medication adherence support, and preventive care. Social workers focus on psychosocial assessment, emotional support, family counseling, healthcare accessibility, and coordination of community resources.

Collaboration between these professionals can support disease self-management, improve continuity of care, and reduce barriers to treatment. This narrative review examines the individual and shared roles of nurses and social workers in managing chronic diseases, with particular attention to diabetes, cardiovascular diseases, chronic respiratory diseases, and chronic kidney disease. It also discusses the benefits of interdisciplinary collaboration, common challenges, and practical strategies for improving patient-centered care.

1. INTRODUCTION

Chronic diseases are among the leading causes of disability and death worldwide. Conditions such as diabetes, cardiovascular diseases, chronic respiratory diseases, and chronic kidney disease require long-term treatment and regular follow-up. These conditions also place a considerable burden on patients, families, and healthcare systems 1.

Managing a chronic disease involves more than receiving medical treatment. Patients are often expected to take medications regularly, follow dietary recommendations, attend medical appointments, and make changes to their daily routines. For some patients, maintaining these responsibilities can be difficult, especially when they experience financial problems, limited family support, or psychological distress.

Traditional healthcare approaches have often focused on treating physical symptoms. However, effective chronic disease management requires a broader understanding of patients' medical and social needs. The Chronic Care Model emphasizes the importance of coordinated healthcare services, patient participation, and continuous professional support 2,3.

Nurses and social workers are important members of the healthcare team. Their responsibilities differ, but their work frequently overlaps. Nurses help patients manage the clinical aspects of their conditions, while social workers address personal and social circumstances that may interfere with treatment.

By working together, these professionals can develop more realistic care plans and provide support that reflects the individual needs of each patient.

2. AIM OF THE REVIEW

This narrative review aims to:

- Describe the role of nurses in chronic disease management.
- Examine the responsibilities of social workers in supporting patients with chronic conditions.
- Discuss the shared roles of nurses and social workers.
- Explore the potential benefits of interdisciplinary collaboration.
- Identify barriers to effective teamwork.
- Present practical recommendations for improving integrated chronic disease care.

3. REVIEW METHODOLOGY

This article is structured as a narrative review of selected literature related to chronic disease management, nursing practice, medical social work, patient education, psychosocial support, and interdisciplinary healthcare.

The discussion draws on published scientific articles, systematic reviews, clinical recommendations, and international healthcare frameworks.

The literature is organized into major themes, including professional responsibilities, patient needs, disease-specific interventions, continuity of care, and interdisciplinary collaboration.

Unlike a systematic review, this narrative review does not aim to provide an exhaustive assessment of all available studies or a quantitative analysis of their findings.

4. UNDERSTANDING THE NEEDS OF PATIENTS WITH CHRONIC DISEASES

Patients living with chronic diseases often experience challenges that extend beyond their medical conditions. Their ability to manage their health may be influenced by income, education, housing, employment, family relationships, and access to healthcare services.

These factors are commonly described as social determinants of health. Research has demonstrated that social and economic circumstances contribute to differences in health outcomes and healthcare accessibility 4,5.

For example, a patient with diabetes may receive appropriate dietary advice but may not have enough money to purchase healthy food. A patient with chronic kidney disease may understand the importance of attending dialysis sessions but may struggle to find reliable transportation.

Limited health literacy can also affect a patient's ability to understand medical instructions, use medications correctly, and recognize warning signs 6.

Social isolation represents another important concern. Patients who lack supportive relationships may experience difficulties coping with chronic illness and maintaining healthy behaviors 7.

These situations highlight the importance of assessing patients as individuals rather than focusing only on their medical diagnoses.

5. THE ROLE OF NURSES IN CHRONIC DISEASE MANAGEMENT

Nurses are directly involved in the daily care of patients with chronic diseases. Their regular contact with patients allows them to identify health problems, provide education, and support long-term treatment plans.

5.1 Clinical assessment and monitoring

One of the main responsibilities of nurses is to assess patients' physical conditions and monitor changes in their health.

This includes monitoring vital signs, evaluating symptoms, assessing pain, reviewing treatment responses, and identifying early signs of complications.

For patients with chronic diseases, regular monitoring is particularly important because deterioration may develop gradually. Early recognition of changes can support timely medical intervention and help prevent serious complications.

5.2 Patient education

Patient education is an essential part of nursing practice. Nurses help patients understand their medical conditions and explain the importance of following treatment recommendations.

Education may include:

- Correct medication administration.
- Healthy eating and physical activity.
- Monitoring symptoms at home.
- Recognizing warning signs.
- Attending regular medical appointments.
- Preventing disease-related complications.

Self-management education can improve patients' knowledge, confidence, and ability to participate in their healthcare 8,9.

Nurses should provide information using simple language and practical examples. They should also consider patients' cultural backgrounds and educational levels.

5.3 Supporting medication adherence

Patients with chronic diseases often take several medications for long periods. Complicated treatment schedules, medication side effects, forgetfulness, and financial difficulties may affect adherence.

Nurses can identify these problems during routine assessments. They can help patients develop medication routines and communicate concerns to physicians and pharmacists.

When financial or social difficulties interfere with treatment, nurses can refer patients to social workers for further assessment and assistance.

5.4 Prevention and early detection of complications

Nurses contribute to the prevention of chronic disease complications through regular monitoring, preventive education, and early intervention.

For example, nurses caring for patients with diabetes can assess foot health and provide education about preventing diabetic foot ulcers.

Similarly, nurses working with patients with heart failure can monitor changes in body weight, breathing difficulties, and fluid retention.

These activities support early recognition of health problems and appropriate referral to other healthcare professionals.

5.5 Psychological and emotional support

Living with a chronic disease can be emotionally demanding. Patients may experience fear, frustration, anxiety, or uncertainty about their future.

Nurses provide emotional support by listening to patients, answering their questions, and encouraging them to participate in their care.

They can also recognize signs of psychological distress and refer patients to social workers or mental health professionals when additional support is required.

5.6 Care coordination and follow-up

Nurses contribute to continuity of care by coordinating follow-up appointments, communicating with healthcare professionals, and monitoring patients after discharge.

Nurse-led services can support continuity of care for patients moving between hospital and primary healthcare settings 10.

Regular follow-up also provides opportunities to identify new problems and adjust care plans in cooperation with the healthcare team.

5.7 Patient advocacy

Nurses act as patient advocates by helping patients express their concerns, understand available treatment options, and participate in healthcare decisions.

They also support patients' dignity, privacy, independence, and right to receive appropriate healthcare.

6. THE ROLE OF SOCIAL WORKERS IN CHRONIC DISEASE MANAGEMENT

Medical social workers address the social, emotional, and environmental factors that influence patients' health.

Their contribution is particularly important when patients experience difficulties that cannot be resolved through medical treatment alone.

6.1 Psychosocial assessment

Social workers assess patients' personal and social circumstances to identify factors that may affect their health.

This assessment may include family relationships, financial resources, employment, housing conditions, emotional well-being, transportation, and available social support.

The information obtained through psychosocial assessment helps healthcare teams develop care plans that are appropriate for each patient's circumstances.

6.2 Financial and socioeconomic support

Patients with chronic diseases may experience financial difficulties because of treatment costs, transportation expenses, or reduced ability to work.

Social workers help patients identify available financial assistance programs, charitable organizations, insurance resources, and government support services.

Addressing these barriers can improve patients' ability to access healthcare and continue their treatment.

Evidence suggests that social work interventions may contribute to improved health outcomes and reduced healthcare costs, although results vary across healthcare settings 11,12.

6.3 Psychological and emotional counseling

A chronic disease diagnosis can affect patients' emotional well-being and sense of independence.

Social workers provide psychosocial counseling to help patients cope with changes in their health, employment, relationships, and daily activities.

They may also identify patients who require specialized psychological or psychiatric care.

6.4 Family assessment and counseling

Family members often play an important role in supporting patients with chronic diseases.

However, caregiving responsibilities can create emotional stress, financial pressure, and difficulties within families.

Social workers help families understand patients' needs, improve communication, and identify appropriate caregiving arrangements.

They also provide guidance to caregivers experiencing stress or difficulties managing their responsibilities.

6.5 Coordination of community resources

Social workers connect patients with services available outside healthcare facilities.

These services may include home healthcare, rehabilitation programs, transportation assistance, community support groups, financial assistance, and social welfare programs.

Access to appropriate community resources can help patients maintain independence and continue managing their conditions outside the hospital.

6.6 Discharge planning

Social workers contribute to safe hospital discharge by assessing patients' living conditions, family support, transportation arrangements, and access to follow-up services.

Individualized discharge planning may reduce hospital readmissions and improve the transition from hospital to home 13.

Social workers collaborate with nurses and other healthcare professionals to identify potential difficulties before patients leave the hospital.

6.7 Patient rights and social advocacy

Social workers advocate for patients who experience difficulties accessing healthcare services or social support.

They help patients understand their rights, available services, and eligibility for assistance programs.

Their advocacy is particularly important for older adults, individuals with disabilities, low-income patients, and people with limited family support.

6.8 Promoting social integration

Chronic diseases may limit patients' ability to participate in work, family activities, and social events.

Social workers encourage patients to maintain meaningful relationships and participate in community activities whenever possible.

Supporting social integration can help reduce isolation and improve emotional well-being.

7. SHARED ROLES OF NURSES AND SOCIAL WORKERS

Although nurses and social workers have different professional responsibilities, they share several important roles in chronic disease management.

Interprofessional collaboration can improve communication and coordination between healthcare professionals, although its effectiveness depends on how collaborative services are organized 14,15.

Area	Nursing role	Social work role
Patient assessment	Clinical and physical assessment	Psychosocial and environmental assessment
Patient education	Disease and treatment education	Education about social services and available support
Emotional support	Therapeutic communication	Psychosocial counseling
Medication adherence	Monitoring and education	Addressing financial and social barriers
Family support	Caregiving and clinical education	Family assessment and counseling
Discharge planning	Clinical readiness and instructions	Home environment and resource coordination
Follow-up care	Symptom monitoring	Social support and service accessibility
Patient advocacy	Clinical needs and patient rights	Social rights and equitable access
Quality of life	Physical health and independence	Social and emotional well-being

7.1 Developing individualized care plans

Nurses and social workers can contribute to individualized care plans that address both medical and social needs.

For example, a nurse may identify that a patient has difficulty controlling blood glucose levels. A social worker may discover that the patient has limited access to healthy food.

By sharing this information, both professionals can help develop a care plan that is realistic and appropriate.

Personalized care planning may improve patients' ability to manage chronic conditions and participate in treatment decisions 16.

7.2 Supporting patients with multiple chronic conditions

Patients with multiple chronic diseases often have complex treatment requirements and may experience difficulties coordinating healthcare appointments.

Nurses can monitor clinical conditions and treatment responses, while social workers can help organize support services and address barriers to care.

Integrated interventions for patients with multimorbidity should consider their individual priorities and treatment burden 17.

7.3 Supporting patients with mental health concerns

Depression and anxiety can affect patients' motivation and ability to manage chronic diseases.

Nurses can identify changes in patients' behavior and emotional well-being, while social workers can provide psychosocial support and coordinate appropriate referrals.

Collaborative care has demonstrated benefits for selected patients living with depression and chronic medical conditions 18.

8. NURSING AND SOCIAL WORK ROLES IN SPECIFIC CHRONIC DISEASES

8.1 Diabetes mellitus

Diabetes requires continuous self-management, medication adherence, healthy eating, physical activity, and regular monitoring.

Role of nurses:

- Monitoring blood glucose levels.
- Teaching insulin administration.
- Providing diabetic foot care education.
- Recognizing hypoglycemia and hyperglycemia.
- Supporting medication adherence.
- Encouraging healthy lifestyle changes.

Role of social workers:

- Identifying financial barriers to treatment.
- Addressing food insecurity.
- Supporting patients experiencing diabetes-related distress.
- Helping patients access community resources.
- Encouraging family participation in diabetes management.

Diabetes self-management education and support are important components of effective diabetes care 19,20.

8.2 Cardiovascular diseases

Patients with cardiovascular diseases often require long-term treatment and lifestyle modifications.

Role of nurses:

- Monitoring blood pressure and heart rate.
- Assessing symptoms of disease progression.
- Providing medication education.
- Encouraging appropriate physical activity.
- Educating patients about cardiovascular risk factors.

Role of social workers:

- Addressing transportation and financial barriers.
- Supporting patients with employment difficulties.
- Helping patients access rehabilitation services.
- Providing psychosocial support.
- Reducing social isolation.

Patient self-care and the identification of treatment barriers are important aspects of cardiovascular disease management 21,22.

8.3 Chronic respiratory diseases

Chronic respiratory conditions, including asthma and chronic obstructive pulmonary disease, can significantly affect daily activities and independence.

Role of nurses:

- Monitoring respiratory symptoms.
- Assessing oxygen saturation.
- Teaching correct inhaler techniques.
- Providing smoking cessation education.
- Supporting respiratory self-management.

Role of social workers:

- Assessing home and social conditions.
- Coordinating home healthcare services.
- Providing emotional support.
- Helping patients access rehabilitation programs.
- Supporting patients with reduced mobility or employment difficulties.

Structured self-management interventions can help patients develop practical skills for managing chronic respiratory diseases 23.

8.4 Chronic kidney disease

Chronic kidney disease requires long-term monitoring and may eventually require dialysis or transplantation.

Role of nurses:

- Monitoring patients during treatment.
- Providing dialysis-related education.
- Assessing fluid balance.
- Reinforcing dietary and medication recommendations.
- Recognizing treatment-related complications.

Role of social workers:

- Arranging transportation support.
- Addressing employment and financial concerns.
- Supporting patients adjusting to dialysis.
- Providing family counseling.
- Coordinating community and rehabilitation services.

The long-term burden of chronic kidney disease highlights the need for comprehensive healthcare and psychosocial support 24.

9. BENEFITS OF NURSING AND SOCIAL WORK COLLABORATION

9.1 Improved patient-centered care

Collaboration allows healthcare professionals to understand patients' medical conditions and personal circumstances.

Patients are more likely to receive appropriate support when care plans reflect their needs, preferences, and available resources.

9.2 Improved disease self-management

Patients may become more confident in managing their health when they receive both clinical education and practical social support.

Nurses provide the knowledge and skills required for disease management, while social workers help patients overcome barriers that interfere with these activities.

9.3 Reduced avoidable hospital readmissions

Patients with chronic diseases may return to hospital because of worsening symptoms, poor medication adherence, or inadequate support after discharge.

Transitional care interventions and coordinated follow-up can help reduce some avoidable hospital readmissions 25–27.

9.4 Improved continuity of care

Collaboration supports communication between hospitals, primary healthcare centers, home healthcare services, and community organizations.

This is particularly important for patients who require long-term treatment from several healthcare professionals.

9.5 Improved quality of life

Addressing physical, emotional, and social needs can help patients maintain independence and participate in meaningful daily activities.

Although the effects of integrated care vary between patients, a comprehensive approach may provide better support than focusing exclusively on clinical symptoms.

9.6 Improved healthcare efficiency

Coordinated healthcare services may reduce unnecessary duplication of assessments and improve the use of available resources.

Organizational approaches that support chronic illness care can help healthcare teams provide more consistent and coordinated services 28.

10. CHALLENGES TO EFFECTIVE COLLABORATION

Despite its potential benefits, collaboration between nurses and social workers faces several challenges.

10.1 Heavy workloads

Nurses and social workers may have large numbers of patients and limited time for interdisciplinary discussions.

10.2 Unclear professional responsibilities

In some healthcare settings, professional roles are not clearly defined. This may result in duplication of work or important patient needs being overlooked.

10.3 Communication difficulties

Limited communication between healthcare professionals can delay referrals and affect continuity of care.

10.4 Limited community resources

Social workers may identify patient needs but find that appropriate financial, transportation, or community services are unavailable.

10.5 Cultural and language barriers

Differences in language, cultural beliefs, and health-related expectations may influence communication and patient participation.

10.6 Limited interdisciplinary training

Healthcare professionals may receive insufficient training in teamwork and may not fully understand the responsibilities of other disciplines.

Addressing these challenges requires organizational support, clear policies, adequate staffing, and regular professional communication.

11. THE ROLE OF DIGITAL HEALTH TECHNOLOGIES

Digital health technologies can support collaboration between nurses and social workers.

Electronic health records allow authorized healthcare professionals to document assessments, communicate concerns, and review shared care plans.

Telehealth services can also help patients who have difficulties attending healthcare facilities.

Nurses may use telehealth to monitor symptoms, provide education, and reinforce treatment instructions. Social workers may use digital communication to conduct follow-up assessments, provide counseling, and coordinate support services.

Research suggests that telemedicine can improve selected healthcare outcomes, although its effectiveness varies according to the condition and type of intervention 29.

Healthcare organizations should also consider patient privacy, digital literacy, accessibility, and the availability of internet services when implementing digital health interventions 30.

12. RECOMMENDATIONS FOR HEALTHCARE ORGANIZATIONS

Healthcare organizations can improve collaboration between nurses and social workers by implementing the following practices:

Recommendation	Expected benefit
Establish clear professional responsibilities	Reduce confusion and duplication
Conduct interdisciplinary meetings	Improve communication
Develop shared care plans	Support coordinated patient care
Introduce routine psychosocial screening	Identify social barriers early
Establish clear referral pathways	Improve access to social work services
Provide joint professional training	Strengthen teamwork
Involve patients and families	Improve participation in care
Strengthen community partnerships	Increase access to support services

Recommendation	Expected benefit
Use shared electronic documentation	Improve continuity of care
Monitor patient outcomes	Evaluate service effectiveness

Healthcare organizations should also consider developing measurable indicators to assess interdisciplinary chronic disease management.

These indicators may include hospital readmission rates, patient satisfaction, medication adherence, completed social work referrals, follow-up attendance, and patient-reported quality of life.

13. DISCUSSION

Chronic disease management is a continuous process that requires cooperation between patients, families, and healthcare professionals.

The literature discussed in this review highlights the importance of addressing both medical and social factors when caring for patients with long-term health conditions.

Nurses have an important role in clinical monitoring, patient education, prevention of complications, and treatment adherence. Their regular contact with patients allows them to recognize problems and provide timely support.

Social workers contribute by addressing financial difficulties, family concerns, emotional distress, and barriers to healthcare accessibility. Their involvement can help healthcare teams understand why some patients experience difficulties following treatment recommendations.

For example, a patient who repeatedly misses follow-up appointments may be considered non-adherent. However, further assessment may reveal transportation difficulties, caregiving responsibilities, or financial problems. In such cases, education alone may not resolve the problem.

Collaboration between nurses and social workers allows these barriers to be identified and addressed more effectively.

Nevertheless, interdisciplinary collaboration should not be viewed as a guaranteed solution to every chronic disease management problem. Its effectiveness depends on professional communication, available resources, organizational support, and the individual needs of patients.

Future healthcare models should encourage early psychosocial assessment alongside clinical assessment. This approach may help healthcare teams identify vulnerable patients before their medical or social circumstances become more complicated.

14. LIMITATIONS

This review has several limitations. As a narrative review, it does not include a systematic literature search, formal quality assessment, or quantitative analysis of research findings.

Some of the available evidence examines broader interdisciplinary healthcare interventions rather than collaboration specifically between nurses and social workers.

Differences in healthcare systems, professional responsibilities, and community resources may also limit the applicability of findings across different countries and healthcare settings.

Future studies should directly evaluate nursing and social work collaboration using measurable clinical, psychosocial, and economic outcomes.

15. CONCLUSION

Chronic diseases affect many aspects of patients' lives, including their physical health, emotional well-being, financial circumstances, and social relationships.

Nurses and social workers play complementary roles in addressing these challenges. Nurses provide clinical assessment, patient education, symptom monitoring, and treatment support. Social workers address psychosocial needs, family concerns, financial difficulties, and barriers to healthcare accessibility.

Effective collaboration between these professionals can support patient-centered care, improve disease self-management, strengthen continuity of care, and potentially reduce avoidable hospital admissions.

Healthcare organizations should encourage interdisciplinary teamwork through clear professional responsibilities, shared care plans, regular communication, and appropriate access to community resources.

A comprehensive approach that considers both medical and social needs is essential for supporting patients living with chronic diseases and improving their long-term quality of life.

REFERENCES

[1] World Health Organization. Noncommunicable diseases. Geneva: World Health Organization. Available from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

[2] Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. Milbank Q. 1996;74(4):511–544.

[3] Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. JAMA. 2002;288(14):1775–1779. doi:10.1001/jama.288.14.1775.

[4] Marmot M. Social determinants of health inequalities. Lancet. 2005;365(9464):1099–1104. doi:10.1016/S0140-6736(05)71146-6.

[5] Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. 2014;129(Suppl 2):19–31. doi:10.1177/00333549141291S206.

[6] Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: an updated systematic review. Ann Intern Med. 2011;155(2):97–107. doi:10.7326/0003-4819-155-2-201107190-00005.

[7] Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. PLoS Med. 2010;7(7):e1000316. doi:10.1371/journal.pmed.1000316.

[8] Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient self-management of chronic disease in primary care. JAMA. 2002;288(19):2469–2475. doi:10.1001/jama.288.19.2469.

[9] Lorig KR, Holman H. Self-management education: history, definition, outcomes, and mechanisms. Ann Behav Med. 2003;26(1):1–7. doi:10.1207/S15324796ABM2601_01.

[10] Davis KM, Eckert MC, Hutchinson A, et al. Effectiveness of nurse-led services for people with chronic disease in achieving an outcome of continuity of care at the primary-secondary healthcare interface: a quantitative systematic review. Int J Nurs Stud. 2021;121:103986.

[11] Steketee G, Ross AM, Wachman MK. Health outcomes and costs of social work services: a systematic review. Am J Public Health. 2017;107(Suppl 3):S256–S266. doi:10.2105/AJPH.2017.304004.

[12] McGregor J, Mercer SW, Harris FM. Health benefits of primary care social work for adults with complex health and social needs: a systematic review. Health Soc Care Community. 2018;26(1):1–13.

[13] Gonçalves-Bradley DC, Lannin NA, Clemson L, Cameron ID, Shepperd S. Discharge planning from hospital. Cochrane Database Syst Rev. 2022;2:CD000313. doi:10.1002/14651858.CD000313.pub6.

[14] World Health Organization. Framework for action on interprofessional education and collaborative practice. Geneva: World Health Organization; 2010.

[15] Reeves S, Pelone F, Harrison R, Goldman J, Zwarenstein M. Interprofessional collaboration to improve professional practice and healthcare outcomes. Cochrane Database Syst Rev. 2017;6:CD000072. doi:10.1002/14651858.CD000072.pub3.

[16] Coulter A, Entwistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database Syst Rev. 2015;(3):CD010523. doi:10.1002/14651858.CD010523.pub2.

[17] Smith SM, Wallace E, O'Dowd T, Fortin M. Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. Cochrane Database Syst Rev. 2021;1:CD006560. doi:10.1002/14651858.CD006560.pub4.

[18] Katon WJ, Lin EHB, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. N Engl J Med. 2010;363(27):2611–2620. doi:10.1056/NEJMoa1003955.

[19] Powers MA, Bardsley JK, Cypress M, et al. Diabetes self-management education and support in adults with type 2 diabetes: a consensus report. Diabetes Care. 2020;43(7):1636–1649. doi:10.2337/dci20-0023.

[20] Beck J, Greenwood DA, Blanton L, et al. 2017 national standards for diabetes self-management education and support. Diabetes Care. 2017;40(10):1409–1419. doi:10.2337/dci17-0025.

[21] Riegel B, Moser DK, Buck HG, et al. Self-care for the prevention and management of cardiovascular disease and stroke: a scientific statement for healthcare professionals from the American Heart Association. J Am Heart Assoc. 2017;6(9):e006997. doi:10.1161/JAHA.117.006997.

[22] Khatib R, Schwalm JD, Yusuf S, et al. Patient and healthcare provider barriers to hypertension awareness, treatment and follow up: a systematic review and meta-analysis of qualitative and quantitative studies. PLoS One. 2014;9(1):e84238. doi:10.1371/journal.pone.0084238.

[23] Effing TW, Vercoulen JH, Bourbeau J, et al. Definition of a COPD self-management intervention: International Expert Group consensus. Eur Respir J. 2016;48(1):46–54. doi:10.1183/13993003.00025-2016.

[24] Jha V, Garcia-Garcia G, Iseki K, et al. Chronic kidney disease: global dimension and perspectives. Lancet. 2013;382(9888):260–272. doi:10.1016/S0140-6736(13)60687-X.

[25] Joo JY, Liu MF. Effectiveness of transitional care interventions for chronic illnesses: a systematic review of reviews. Appl Nurs Res. 2021;61:151485.

[26] Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The importance of transitional care in achieving health reform. Health Aff (Millwood). 2011;30(4):746–754. doi:10.1377/hlthaff.2011.0041.

[27] Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006;166(17):1822–1828. doi:10.1001/archinte.166.17.1822.

[28] Wagner EH, Glasgow RE, Davis C, et al. Quality improvement in chronic illness care: a collaborative approach. Jt Comm J Qual Improv. 2001;27(2):63–80.

[29] Flodgren G, Rachas A, Farmer AJ, Inzitari M, Shepperd S. Interactive telemedicine: effects on professional practice and health care outcomes. Cochrane Database Syst Rev. 2015;(9):CD002098. doi:10.1002/14651858.CD002098.pub2.

[30] World Health Organization. WHO guideline: recommendations on digital interventions for health system strengthening. Geneva: World Health Organization; 2019.