



Erratum To: Virtual house calls for Parkinson disease (Connect.Parkinson): study protocol for a randomized, controlled trial

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After the publication of this article [1], it was discovered that eleven of the trials listed in the original article's Table 1 [1], had been erroneously identified as taking place in the home [2–12]. These studies actually evaluated physician videoconferencing visits with patients located in clinics. To ensure accuracy, we repeated the literature search in September of 2015, using the same search terms reported in the article and filtered for a publication date prior to July 1, 2014 (the original work was performed in June 2014.) We searched PubMed using the terms 'telemedicine AND home AND randomized' (378 results), 'randomized AND video AND home' (259 results), 'videoconferencing AND randomized' (178 results), and 'virtual AND visits AND home' (33 results), and reviewed the 141 studies identified in the review by Dr. Wootton mentioned in the article [13]. Of the 848 search results and 141 studies identified by Dr. Wootton, a total of six randomized controlled trials involving physician video calls directly to a patient in the home were identified (four from the original review [14–17] and two additional studies [18, 19] identified through the new search). The eleven misidentified articles have been removed from the Corrected Table 1, and included for clarity as Erratum Table 2. The final paper listed in Erratum Table 2, Bishop JE et al. [3], has also been corrected here: our article reported 19 subjects, but the abstract indicates that 17 completed the study. We sincerely apologize for the oversight and any inconvenience these errors might have caused.

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Corrected Table 1 Randomized, controlled trials involving video based virtual house calls from physicians (N = 6)

| Study | Year | Sample size | Study population | Intervention(s) | Duration | Primary outcomes | Results |
|--------------------------------------|------|-------------|--|--|----------|--|--|
| Dorsey ER et al. [14] | 2013 | 20 | Individuals with Parkinson disease | Randomized to (1) in-person care or (2) care via telemedicine | 7 months | <ul style="list-style-type: none"> Feasibility Quality of life | <ul style="list-style-type: none"> Virtual house calls were feasible As effective as in-person care |
| McCrossan B et al. [15] | 2012 | 83 | Infants with congenital heart defects | Randomized to (1) videoconferencing support, (2) telephone support, or (3) control | 10 weeks | <ul style="list-style-type: none"> Acceptability Healthcare resource utilization | <ul style="list-style-type: none"> Clinicians were more confident in treating patients in video visits vs. telephone Parents were satisfied with video visits Healthcare resource utilization was lower in video-conferencing group |
| Leon A et al. [17] ^a | 2011 | 83 | Individuals with HIV | Randomized to (1) usual care or (2) Virtual Hospital care for one year, then crossed over after one year | 2 years | <ul style="list-style-type: none"> Clinical Healthcare resource utilization Quality of life Satisfaction | <ul style="list-style-type: none"> Satisfaction with Virtual Hospital was high Clinical outcomes were similar for both groups |
| Morgan GJ et al. [16] | 2008 | 30 | Parents of children with severe congenital heart disease | Randomized to (1) telephone or (2) videoconferencing follow-up | 6 weeks | <ul style="list-style-type: none"> Parents' anxiety Clinical Clinician and patient satisfaction | <ul style="list-style-type: none"> Videoconferencing decreased anxiety levels compared to telephone and allowed better clinical information |
| Dalolio L et al. [19] | 2008 | 137 | Individuals with spinal cord injury | Randomized to (1) home (or nursing home or hospital) telemedicine (physician and nurse) and telerehabilitation (therapist) or (2) standard post-discharge care | 6 months | <ul style="list-style-type: none"> Clinical Satisfaction | <ul style="list-style-type: none"> Telemedicine patients at one out of four sites had statistically significantly better functional improvement Satisfaction with interactions with nursing and medical staff and information and treatment received were higher in the telemedicine group |
| Whitlock WL et al. [18] ^a | 2000 | 28 | Individuals with Type II diabetes | Randomized to (1) home videoconferencing (monthly physician calls and weekly nurse calls) or (2) standard in-person care | 3 months | <ul style="list-style-type: none"> Clinical Quality of life Satisfaction | <ul style="list-style-type: none"> Some clinical outcomes improved significantly more in the telemedicine group Quality of life was unchanged Physicians and case managers reported high subjective utility of telemedicine Technology problems were an obstacle |

^aStudy evaluates an intervention that includes virtual house calls, but also includes other telemonitoring and/or electronic communication methodologies

Erratum Table 2 Randomized, controlled trials involving video based physician visits with patients in clinical environments (N = 11)

| Study | Year | Sample size | Study population | Intervention(s) | Duration | Primary outcomes | Results |
|--------------------------|------|-------------|---|---|-----------|---|--|
| Fortney JC et al. [8] | 2013 | 364 | Individuals with depression | Randomized to practice-based or telemedicine-base collaborative care | 18 months | • Clinical | • Telemedicine-based collaborative care yielded better outcomes for depressed patients |
| Moreno FA et al. [9] | 2012 | 167 | Hispanic adults with depression | Randomized to telemedicine care from a psychiatrist or usual care from a primary care physician | 6 months | • Clinical • Quality of life | • All participants improved on clinical measures • Time to improvement was shorter in telemedicine group |
| Ferrer-Roca O et al. [7] | 2010 | 800 | Primary care patients referred for specialized care | Randomized to face-to-face hospital referral or telemedicine from specialist | 6 months | • Quality of life | • Telemedicine care was comparable to face-to-face care • Diagnosis and examination to start treatment were faster in the telemedicine group |
| Stahl JE, Dixon RF [12] | 2010 | 175 | Patients in a general primary care practice | Interviewed face-to-face and via videoconferencing, order randomized | 2 visits | • Satisfaction • Willingness to pay | • Patients and providers were highly satisfied with videoconferencing but preferred face-to-face • Technical quality of video calls had significant impact on satisfaction |
| Dorsey ER et al. [6] | 2010 | 14 | Individuals with Parkinson disease | Randomized to usual care or care via telemedicine | 6 months | • Feasibility | • Virtual house calls were feasible • Virtual house calls improved disease-specific measures significantly compared to usual care. |
| Dixon RF, Stahl JE [5] | 2009 | 175 | Patients in a general primary care practice | Randomized to one virtual visit and one face-to-face, or two face-to-face consultations | 2 visits | • Diagnostic agreement • Satisfaction | • Physicians and patients highly satisfied with virtual visits • Diagnostic agreement between virtual and in-person evaluation was similar to comparison of two in-person evaluations |
| Ahmed SN et al. [2] | 2008 | 41 | Epilepsy patients | Randomized to telemedicine follow up or conventional | 1 visit | • Cost effectiveness • Cost to patients and caregivers • Satisfaction | • 90 % of patients in both groups satisfied with quality of services • Cost of telemedicine production was similar to patient savings |
| O'Reilly R et al. [10] | 2007 | 495 | Patients referred for psychiatric consult | Randomized to face to face or telepsychiatry | 4 months | • Clinical • Cost effectiveness • Satisfaction | • Similar outcomes were seen in both arms • Telepsychiatry was at least 10 % less expensive than in-person care • Both groups expressed similar satisfaction |

Erratum Table 2 Randomized, controlled trials involving video based physician visits with patients in clinical environments (N = 11) (*Continued*)

| | | | | | | | |
|----------------------------|------|-----|--------------------------|---|----------|---|--|
| De Las Cuevas C et al. [4] | 2006 | 140 | Psychiatric outpatients | Randomized to face-to-face or telepsychiatry | 24 weeks | <ul style="list-style-type: none"> • Clinical | <ul style="list-style-type: none"> • Telepsychiatry had equivalent efficacy to face-to-face care |
| Ruskin PE et al. [11] | 2004 | 119 | Veterans with depression | Randomized to telepsychiatry or in-person psychiatrist visits | 6 months | <ul style="list-style-type: none"> • Clinical • Cost effectiveness • Healthcare resource utilization • Satisfaction | <ul style="list-style-type: none"> • Both groups were equivalent in clinical outcomes, cost, patient adherence, and patient satisfaction. |
| Bishop JE et al. [3] | 2002 | 17 | Psychiatric patients | Randomized to videoconference or face-to-face | 4 months | <ul style="list-style-type: none"> • Satisfaction | <ul style="list-style-type: none"> • Similar satisfaction observed in both groups |

Published online: 05 January 2016

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