Author's response to reviews

Title: Unlocking information for coordination of care in Australia: A qualitative study of information continuity in four primary health care models

Authors:

Michelle A Banfield (Michelle.Banfield@anu.edu.au)
Karen L Gardner (Karen.Gardner@anu.edu.au)
Ian S McRae (Ian.S.McRae@anu.edu.au)
James A Gillespie (James.Gillespie@sydney.edu.au)
Robert W Wells (Robert.Wells@anu.edu.au)
Laurann E Yen (Laurann.Yen@anu.edu.au)

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Author's response to reviews: see over
Re: Response to reviewers “Unlocking information for coordination of care in Australia: A qualitative study of information continuity in four primary health care models”

Dear Prof Kersnik

Thank you for the opportunity to revise the above manuscript. We found the reviewers’ remarks very useful for improving the scope and clarity of the manuscript. We have undertaken revisions as detailed below and resubmit the paper for your consideration.

Regards
Dr Michelle Banfield

Response to reviewers

Reviewer 1

Background
1) B: Although there might not be one overall accepted definition of care coordination, it would be important to know how you define care coordination in the context of your study.

Thank you for the suggestion. The working definition adopted by McDonald et al has now been added to the background.

2) B: I would change the focus set on continuity of care to care coordination since, as you perfectly describe in the introduction, continuity of care reflects the patient’s perspective, however patient’s views are not sought in the study. You could describe two interrelated care coordination types as followed: i) informational coordination: the transfer and use of the patient clinical information and ii) managerial care coordination: the provision of care in a sequential and complementary way by the different services and care levels that participate; and cite Reid et al (2002).

After consideration of various views in the literature about continuity and coordination, we have chosen to retain our focus on continuity as an aspect of coordination. However, additional definition regarding patient and provider perspective and measurability has been included in Background paragraph 3 citing Reid et al as suggested.

3) A: If you still want to describe continuity of care then please use the references properly: use Haggerty et al. (2003) or Reid et al. (2002) for defining the continuity types and the definition of informational continuity and not Waibel et al. (2012).

References have now been corrected to cite Haggerty and Reid for definitions of continuity.

4) B: E-health and chronic disease initiatives should be better described

Paragraph 5 of the Background has been significantly revised to include information both on the Australian primary health care system and more specifically to describe the e-health and chronic disease initiatives.
Methods
5) A: Key questions do not coincide with the purpose of the research and are difficult to understand. Why do you distinguish between informational continuity (coordination) and care coordination in the second study aim, if informational coordination can be considered part of care coordination? The framework needs to be better defined.

The wording of the study purpose and aims has been revised to improve clarity and provide a better link to the key questions as detailed in point 6 below.

6) B: Key questions are very, and maybe too specific for a qualitative analysis. I suggest formulating the research questions as followed: How is clinical information between providers used? What are the distracting factors of the proper use of information? What factors stimulate the use of information? Etc.

The key questions in the original manuscript were drawn directly from the interview protocol. As per the reviewer’s suggestion, these have now been simplified to the general concept/topic area each question was designed to explore. Additional information has been included in the study design section to better define the framework against which the questions were developed (Innovative Care for Chronic Conditions).

7) B: Do you want to analyse informational coordination across care levels within one organization or across organizations? This should be defined and justified.

Information continuity was examined within organisations. As described in the study design and participants sections, the cases were chosen as examples of primary care business models in the Australian system. In order to effectively inform policy development in this context, we wanted to examine the micro, meso and macro level influences as they applied to these business models, rather than trying to generalise.

8) B: Terms such as multidisciplinary care, care planning, etc. need to be defined also. Do quality improvement programs refer to chronic disease initiatives?

As described above, these questions were drawn from the interview protocol and thus the terms were prompts for providers. With the simplification of the questions, these terms have now been removed.

9) A: What were the inclusion criteria for the selection of the study participants? And for the sites?

The participants section has been rewritten to provide inclusion criteria for both sites and study participants. As this was an exploratory study, these were deliberately broad.

10) A: If I have understood correctly, cases or sites refer to organizations/practices but also to initiatives, which makes a comparison between cases difficult. A better description is needed, maybe using a table.

A table describing the cases has now been added, including basic information on the type of participants from each organisation.

11) B: Why was a group interview (focus group?) conducted for Case 2?

The group interview was conducted for pragmatic reasons: providers and managers from the organisation had very little available time but were keen to participate in the project. Scheduling a group interview was the best solution. This has been added to the procedure section of the manuscript.

12) C: The topic guide should be annexed, if possible.

Interview protocol has been uploaded as an additional file.
13) A: What is the initial framework?

Initial framework was the interview questions and prompts. This has now been clarified in the data analysis section.

14) A: The comparison across cases (four models) is not presented in the results.

The reference to the comparison being in the results has been removed as this is in the discussion.

15) A: If the analysis is segmented by cases, most probably saturation of data has not been reached. I suggest presenting results together for all cases.

As described above, a key part of the study’s purpose was to examine how micro, meso and macro level influences affected information continuity in four different models. Data saturation was achieved within each organisation. Presenting the results together for all cases would make them difficult for the reader to follow and for a global audience to apply. As discussed below in the response to Reviewer 2, key characteristics and one or two key points about how information is used have now been included at the beginning of findings for each case. Together with the improved description of the study framework, this should make it clearer that the purpose was to explore differences and as noted in the discussion, the findings suggested the handling of information depends on “the job in hand”.

16) B: Characteristics of the sample should be better presented (in a table) including sex, age and profession.

Professions of participants for each case have been included in the table describing the cases. However, due to the risk of identification, no further characteristics have been included.

Findings
17) A: A more in-depth analysis is needed and results summarized (maybe by conducting an across-case analysis, and after having reformulated the research questions).

Key points have been added to the beginning of each case’s findings. As described in response 15 above, we do not believe that an across-case analysis fits with our study design and would reduce the usefulness of the findings section. Synthesis is instead left to the discussion section.

18) C: Instead of using “interviewee”, the profession should be mentioned if relevant.

Interviewee has been changed to participant throughout the manuscript. Professions were not included as they were not relevant to remarks and the small sample presented a high risk of identification.

19) B: Reader should be able to identify the origin of the quotation (which profession).

Quotations have been given unique identifiers to illustrate the range of contributors. The need for deidentification precludes use of profession.

20) B: Authors’ expectations should not be part of the results (“It was expected that financial incentives ...”)

These were the expectations of the participants, not the authors. This sentence has been amended to reflect this. (Case One, Influence of financial incentives)

21) B: Results of the section “other themes” – which I assume are emergent topics (by using a mixed generation of categories) – should be just mentioned when considered relevant to the research questions.

Other themes are indeed emergent topics. A very wide range of these arose during data collection, of which only a small number we felt were relevant were included. Nonetheless, description of other themes has been substantially reduced to focus primarily on views on coordination. This was only clearly expressed in Cases One and Four.
22) B: Have decision makers been interviewed as stated in the methods section?

Decision makers was used broadly in this context to mean managers and members of steering committees for example. Whilst participants did fall into this category, the term has been removed from the methods section for clarity.

Discussion

23) C: I liked the summaries of the finding in the discussion section, and would consider amplifying these summaries and using them for the presentation of the result rather for the discussion.

We have chosen to leave the summaries in the discussion section as a synthesis of the more detailed information presented in findings.

24) B: Discussion of results should be done with literature on care coordination rather than continuity of care. Numerous articles have been published on that topic (including articles using qualitative research).

Thank you for the provision of the additional references on coordination. As our aims and the structure of the discussion explore the relationship between continuity and coordination, we have chosen to include references to both in the discussion.

Limitations

25) B: Why were there just a small number of participants interviewed? If saturation of data has been reached, then the number of interviewed participants would not be a limitation.

This was a limitation of study funding. As reviewer 2 noted the small number of participants as a limitation, this has not been amended.

26) B: Using semi-structured interviews, emerging topics are usually considered for the analysis and the protocol (do you refer to the interview/topic guide?) adapted to cover emerging topics, hence this would not be a limitation, either.

Thank you for the suggestion. This section has been removed from limitations.

Conclusions

27) C: The first sentence refers to faced challenges, which does not respond to your overall research question. Nevertheless, I think it would be interesting to focus the analysis on hampering factors of informational coordination and give implications in the discussion section.

The conclusion has been rewritten so that the overall research question as well as the more specific aims are addressed.

Reviewer 2

Minor Essential Revisions

1. Please, equalize the aims of the study in the Abstract with the aims defined at the end of the section Background in the manuscript

Thank you for identifying this. The aims have now been aligned between abstract and background.

2. Background, Paragraph 1

Please, specify the position of healthcare professionals involved in the survey in health care system in Australia

We were not sure what the reviewer was referring to with this point. Paragraph 1 does not refer to a survey.
3. Please, in the section Findings clear describe the major advantages of each Cases analyzed in the manuscript which can be recommended for the improvement of the coordination in primary health services globally.

A short summary of the characteristics of the organisation as well as the most salient points about their use of information has now been added to the beginning of the findings for each case. This should enable readers globally to identify parallels in their own system.

Discretionary Revisions
1. The authors can reduce the text of the section Background about continuity of care because they cite the references.

   Thank you for the suggestion. The amount of detail in this section on continuity has been reduced and replaced with better descriptions of the Australian health system and policy initiatives.

2. Relatively small sample size, but authors defined that as a limitation of the Study

   Noted. A better description of the framework and participants is now included.