Reviewer's report

Title: Facilitating Factors for Achieving Clinical Integration: A comparative study of Kaiser Permanente, Northern California and the Danish Healthcare System

Version: 1 Date: 10 July 2009

Reviewer: Nick Goodwin

Reviewer's report:

1. Is the question posed by the authors well defined?
The purpose of the research presented in the paper is clear - (a) to quantify 'clinical integration'; (b) to make a comparison as to whether there is 'more' clinical integration in the integrated service delivery model of Kaiser Permanente compared to the Danish health care system based on three perceived issues by primary care professionals - timeliness of information transfer, agreement on roles and responsibilities, and established co-ordination mechanisms; and (c) to examine if any specific organisational factors were associated with more clinical integration.

2. Are the methods appropriate and well described?
Yes, these are comprehensively described

3. Are the data sound?
Yes, I would say so

4. Does the manuscript adhere to the relevant standards for reporting and data deposition?
Yes

5. Are the discussion and conclusions well balanced and adequately supported by the data?
To an extent - see below A-D comments

6. Are limitations of the work clearly stated?
Yes, but not all - see below A-D comments

A. There is one issue for me in that the authors utilise theoretical frameworks without testing them - for example, Gillies et al's (1993) conclusion (p.9) that clinical integration is the most important aspect of integrated care is taken as a given; and later (p.19) there is passing reference to the Alter and Hage framework on co-ordination, but only as justification for a tool based on the use of stakeholder perceptions. I think both approaches are OK to use in the analysis, but should be recognised as possible limitations since, as the authors state, the
importance of this focus to what are complex associations are theoretically-derived rather than empirical observed. Since the work does not set out to query either theory, but to utilise it as a way to focus the analysis, then some recognition needs to be given of the limitations in doing so.

B. There is also an important issue in that the paper primarily examines the perceptions of primary care professionals rather than a wider range of care professionals. What we know about KP compared to Denmark and UK health systems is that the system has been set up to be much more 'vertically integrated' (i.e. between primary and hospital setting) as a means to incentivise care out of hospitals. The UK and Denmark lack the same level of vertical integration - so to some extent the article is really uncovering the fact that clinicians in KP 'recognise' the fact that they are working in a vertically integrated system since the key factors of information flow, roles and responsibilities and care co-ordination are essential components to achieving that. This is not, to the same degree, a systemic quality or goal in Denmark or the UK. This might lead to an argument about the problems faced in Denmark and the UK in improving integrated care. For example, in the management of a patient with cancer or a long-term condition - both in terms of care quality and cost-effectiveness. The apparent findings from PROCARE (p4) - and indeed from Starfield and the Commonwealth Fund studies - that Denmark and UK are 'more developed' in coordination of care strategies (assumptions based mainly on organisational indicators) hide deficiencies in clinical integration that this study uncovers quite clearly. I think this is an important argument that the authors might be willing to consider, and is somewhat different to the conclusion raised at the top of page 18. It might also lead to the conclusion that a similar study could be undertaken with primary and hospital-based clinicians.

C. p.15 - interesting that effect of practice-size on clinical integration did not differ greatly. Other studies on integrated delivery systems - for example by Shortell - suggest you need large physician groups to integrate care cost-effectively. Similarlt, many other studies show HiT to be a significant variable in enabling integrated care.

D. As you suggest (bottom p.18), the paper has limitations - for example, on other factors such as culture, incentives, governance, payments, management etc ... - it may be there are a wide number of factors to

7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?
Yes, there is very good use of the material on which their analysis is founded and this is valuable to the paper overall.

8. Do the title and abstract accurately convey what has been found?
Not really - I am not sure the paper really examines 'facilitating' factors for achieving clinical integration at all, rather it examines the association between integrated delivery systems and core aspects of clinical integration. The abstract
is fine. What the article shows for me is that 'vertically-integrated' systems (where primary and secondary care is connected) lead to better 'clinical integration' in a way that 'horizontally-integrated' systems (primary/community care only) do not.

9. Is the writing acceptable?
Yes, on the whole it is quite well written and the technical language is understandable - at some point I would have liked some clarity as to the rationale for the use of some of the methods, as well as a more 'lay' explanation of their utility. e.g. p.10 - what is Cronbach's coefficient and how does it help?

- Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

1. On page 9, I would have liked more information as to why the three core aspects of clinical integration were chosen (is there any prior understanding that these are good markers of clinical integration?) and what they mean - e.g. what does 'established coordination mechanism' mean? To me it might infer adherence to a care protocols or care plan based on a clinical pathways; it might be regular peer-review of performance and activity related to benchmarked standards; it might be a managerial system for co-ordinating patients through the system - it is a very non-specific term. So, I would like the authors to expand their definitions of these terms, and also to make reference later as to how these terms were presented to the clinicians in their survey

2. Address the issues I have raised in point 6, above - A, to be considered in the limitations; and B. to be considered in the discussion.

- Major Compulsory Revisions (which the author must respond to before a decision on publication can be reached)

None - I support publication