Author’s response to reviews

Title: Addressing safety risks in integrated care programs for older people living at home: a scoping review

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Author’s response to reviews:

Dear editor,

With this letter, we inform you that we have revised the manuscript titled "Addressing safety risks in integrated care programs for older people living at home: a scoping review." We would like to thank both reviewers for their consideration of our manuscript. We were pleased with the compliments of the first reviewer and grateful for the valuable observations of the second reviewer. We believe that most issues stemmed from unclarities about how we framed the research, and we are confident that the revisions have significantly improved our manuscript. Please find below a point-by-point response to the reviewers’ comments. We hope to have addressed the comments of the reviewers satisfactorily and look forward to receiving your final decision.

Yours sincerely,

The authors

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Response to the reviewers’ comments

Reviewer 1
1. Thank you for this submission that details a scoping review undertaken to explore the evidence for integrated care programmes where at least one intervention component addressed safety risks. Data were extracted on the programmes characteristics, safety risks addressed, and the activities and interventions used to address them. Overall I think that the article makes a significant contribution to the literature. It is well designed with a strong rationale for the research. The search strategy is described well and is in line with PRISMA guidelines.
Authors’ response: We thank the reviewer for his compliments.

2. Line 71 - I don't think it is relevant to mention Canada here.
Authors’ response: Following the feedback from reviewer 2, we revised our introduction, and the section to which this refers has been removed.

3. Lines 62-67- more information is needed about integrated care programmes - maybe from line 107 – 115
Authors’ response: We added additional information to give more background to the ‘why’ of integrated care and what it entails. See Lines 65-74.

4. Lines 273-274 - rewrite as it is unclear what you mean
Authors’ response: We meant to convey that “Given the multidimensional nature of risks, the prevention of these risks might benefit from an integrated, interdisciplinary approach”. However, after reconsideration, we felt that this sentence did not add to the argument of the paragraph. Therefore, we decided to remove it.

Reviewer 2
5. I have read the manuscript several times, as I believe that the topic of your paper fits the scope of the journal, and because your conclusion that safety is not addressed enough or not at all in integrated care programs is an important societal and organizational conclusion. I also appreciate the work that has been done as I know how much effort is needed to undertake a scoping review. However, I am sorry to say that after careful and thorough consideration I decided to reject the paper. When evaluating papers for potential publication in BMC Geriatrics (which is a high standard paper), I look if a paper is able to add to knowledge in some substantive way, and makes a significant contribution to the literature. With regard to your paper I have serious concerns about your theorization, contribution and methodology.

Authors’ response: We would like to thank the reviewer for her thorough and careful consideration of our manuscript. We appreciate the interest in our research and the observation that we draw an important organisational and societal conclusion. The concerns about the theorisation, contribution, and methodology will be addressed below. We do hope this will alter the reviewer's view of the manuscript.

6. One of my concerns is about your theoretical or conceptual framing of your study. Firstly, you state and discuss that integrated care has the goal (and in the abstract you formulate it as the ultimate goal) to support elderly to live safely at home. I believe this statement is very strong, and is not argumented well enough. As you discovered (e.g. pp. 7, lines 169-170), safety or improvements in safety is never explicitly mentioned as a goal. As this finding is in contrast with your statement about the position of safety in integrated care programs, it should have been framed more in depth, within existing literature, why safety is an issue and how integrated care is related to safety according to the current body of knowledge on the relationship between integrated care and safety. For instance lines 66-68: "integrated care programs have the potential to tackle many of the risks that may undermine older people's ability to live safely at home". But, what is then exactly the problem with safety for elderly living at home. Why are they unsafe, how are they unsafe and why do they encounter safety risks, and why could integrated care potentially avoid risks or solve risks and make it safer? To state
that safety is an aim, these questions should be answered at the forefront of the paper in the introduction.

Authors’ response: We thank the reviewer for these observations. We reviewed our introduction section and we agree that the framing of our study could be improved on several points:

- The statement that “supporting older people to live safely at home” is the ultimate goal of integrated care is, indeed, not correct. Instead, what we meant to convey was the following: an increasing number of older people are living at home, often with complex and chronic health and social care needs. In this context, the organisation of integrated primary and community care is considered an essential step towards supporting older people to live independently at home for as long as possible. For older people to successfully age in place, it is also important to maintain their safety.
- As acknowledged in the literature (1-7), older people could encounter many problems and limitations that pose risks to their ability to live safely at home. For this review, we followed the principles of a framework for health-related safety, developed by Lau and colleagues (1), that suggests that such risks could relate to older people’s health and functioning, their lifestyle and behaviour, their social or physical environments, and the health and social care they receive. These risks could lead to a multitude of problems that challenge people’s ability to live safely at home, and could ultimately result in emergency department visits, (re)hospitalisation, institutionalisation, and mortality. After reviewing our introduction, we acknowledge that this line of reasoning was not explicitly described, and we have therefore reviewed our introduction to make this more clear.
- Following the first two points, we argue that efforts to address these risks and prevent problems are important. Given its proactive, interdisciplinary, and comprehensive character, integrated care may provide opportunities to do this. At the same time, we know from the literature that such preventative integrated care programs are not always effective and that the ‘prevention’ aspect is not always well reflected in programs. Therefore, we think it is valuable to learn more about precisely in what way integrated care programs address safety, i.e., which types of risks are considered and what kinds of activities/interventions are used to tackle them? This knowledge could help identify gaps and provide directions towards what might additionally be needed to support older people to live safely at home.

We revised our abstract and introduction to clarify this line of reasoning. Please see Lines 27-33 and 57-107.

7. Secondly, your theorization of safety, safety-risk and harm is not clearly described. Safety is operationalized as minimizing the risk of harm associated with individual functioning and behavior, social and physical environments, and health and social care management. This very broad definition lacks a more concise and concrete conceptualization on what constitutes a risk and what harm is within the context of safety. It might well be that minimizing risk of harm is not related to safety, but to functional decline for instance. On several occasion you discuss this issue by stating that interventions have not been implemented to reduce risk, but to avoid decline or other more health related and social outcomes. The same pertains to concepts like harm or risk or living safely at home. When is a risk a safety risk, when is harm related to safety and what it means to live safely at home. With regard to the latter, I believe a distinction should also be made between objective and subjective safety. An elder can be completely safe, but not feel safe.

Authors’ response: Our definition of safety is based on an existing framework by Lau and colleagues (2007) (1). Following the principles of this model, and other literature on problems and risks among older people living at home (2-7), we purposely conceptualised safety in a broad way to be able to look at safety in relation to multiple domains of people’s lives. This broad concept means that harm (in this context: problems that could undermine people’s ability to live independently at home) could result from a wide range of risks, including e.g., functional decline or a lacking informal care network. We
clarified our conceptualisation of safety in the revised version of the introduction (See lines 76-90), and in the description of our inclusion criteria (see Lines 148-151).

Given this conceptualisation of safety, the aim of our review was to examine the extent to which integrated care programs address these risks. An in-depth examination of how different risks may attribute to different types of harm was outside the scope of this review.

With regard to the last remark, we agree that there is a difference between objective and subjective safety. Indeed, someone can be objectively safe, but not feel safe, or the other way around: feel safe, but not objectively be safe. It is a limitation that our definition of safety does not include subjective safety. We covered this observation in the discussion of our methodological considerations. See Lines 349-355.

8. I am also unsure how to locate your contribution within the context of safety. Your paper spent a lot of effort on describing interventions and categorizing them as safety interventions, without explicating what the direct connection is between the content of the intervention, the risk that is addressed, and how the intervention avoids a risk and hence leads to safety. As the interventions were not intended to improve safety I get the impression that your study is disconnected with the perspective of the authors of the selected studies on the intent of their program (avoid health problems, enforce self-management, reduce etc.). Your line of investigation seems to be disconnected from the perspective and line of investigation of the selected studies. At the same time, I found a disconnection between your research motivation and specific methodology. In essence, I question to what extent your assessment of the selected studies is appropriate for addressing your research aim and questions. My methodological concern in this regard is that you defined yourselves if an intervention was related to safety. As you mention many times (e.g. lines 193-195), you as reviewers defined and interpreted risks as safety-risks or intervention components as safety interventions or outcomes as safety outcomes, whilst the authors themselves did not. Given what I stated above about conceptual unclearness, it seems that the results are more your own subjective interpretation of something that is not there.

Authors’ response: We thank the reviewer for these observations and would like to take this opportunity to provide some clarifications. Regarding the observation that our study is disconnected from the perspective of the authors of the selected studies, we acknowledge that this is indeed the case. However, we do not necessarily perceive this disconnection as a negative characteristic of this study. As we describe in the revised version of the introduction (see Lines 101 – 107), our review aimed to provide insight into how integrated care programs currently address the safety of older people living at home. To this end, we identified a range of integrated care programs for older people living at home in the published literature. We wanted to examine in what way these programs that may have had different methods and aims addressed safety risks as defined in our conceptualisation based on the framework of Lau et al. We do not agree that this is a subjective interpretation of something that is not there; instead, we are looking at existing information through a different lens. We further clarify this in the abstract (Lines 42-43), in Lines 174-181, and also mention it in the discussion of our methodological considerations (see Lines 345-349).

Regarding the reviewer’s first remark, that we did not clarify ‘what the direct connection is between content, risk and how the intervention avoids that risk’: Our review aimed to identify the types of risks that were being addressed, and the scope of activities that were used to tackle these risks. We identified this based on the descriptions and reasoning provided in the included studies. An examination of intervention mechanisms of all these identified activities was beyond the scope of this review. We clarify this in Lines 177-183.

9. In the end your conclusions seem too strong, given the theoretical, conceptual and methodological issues. e.g. lines 264-267 where you conclude that programs do address safety. In fact
they did not. You continue your discussion (lines 316-323) by stating that the results emphasize the importance of a multidisciplinary way of addressing safety. Besides not really giving arguments for these statements, your paper does not provide the evidence for a multidisciplinary nor multidimensional approach.

Authors’ response: Given the foregoing observations from the reviewer, we understand the remark about our conclusions. We hope, however, that with our responses to the different comments of the reviewer we have been able to clarify these issues. In light of this, we (still) conclude that the reviewed integrated care programs address safety. It may not have been an aspect of the programs’ initial aims, but examining these programs using our conceptual framework has shown that programs do address many risks for problems that could undermine people’s safety at home. We revised Lines 297-298 to give some more context to this conclusion.

In response to the reviewer’s second remark, we would like to point out that we did not intend to state that our results emphasize the importance of a multidisciplinary way of addressing safety. We agree that our review does not provide the evidence for this statement. However, given the multidimensional nature of problems and risks, and after reviewing the interventions, and reflecting on the results of the scoping review, we do suggest (Line 361 and onwards) that explicitly addressing safety in a multidimensional and multidisciplinary could potentially have some advantages.

To avoid any confusion, we revised some sentences in the first paragraph of the implications (Line 361-364). Furthermore, we think that the first sentence of par. 2 of the discussion might also have been confusing. As it did not particularly add to the argument of that paragraph, we decided to remove the sentence.

10. I must admit that within this context I do not agree with your reflection on studies that assess effects. I believe that if we want to understand how safety is addressed within in integrated care, intervention studies with safety as an outcome measure can be very useful. I agree that interventionistic designs in this field of research are complex and have their limitations, but I do not agree that they are ill-designed to handle the complexity of integrated care programs (line 348). Too many good intervention studies have been done with traditional methods with valid methodologies and results. I also believe that this reflection is in contrast with your methodology as one of your inclusion criteria is "the study addressed the evaluation of an integrated care program, meaning that we included studies that published program protocols, as well as process and outcome of evaluations of programs (lines 116-118). Why was this a criterion, given your reflection. You were not searching for outcomes of programs, but the content of a program. Given your aim, which is not about effectiveness, using designs like these as in inclusion criteria, can exclude a lot of more qualitative or conceptual or descriptive papers of programs that would have given good answers to your questions. Something you state in your reflection (lines 348-353)

Authors’ response: We agree that the statement to which the reviewer refers may have been too strong. We revised Lines 391-395 to nuance our reflection.

In response to the reviewer’s remark regarding our inclusion criteria, we would like to state that we did not necessarily exclude qualitative or descriptive papers. We chose ‘program evaluation’ as an inclusion criterion because this would help us to identify real, existing (i.e., already implemented or to be implemented) programs. However, since we were searching for content rather than outcomes, we purposefully also included program protocols and descriptions, as well as process evaluations. We added this reflection to our methodological considerations (see Lines 334-336).

References
1. Lau DT, Scandrett KG, Jarzебowski M, Holman K, Emanuel L. Health-Related Safety: A


