Author's response to reviews

Title: Do existing mechanisms contribute to improvements in care coordination across levels of care in health services networks? Opinions of the health personnel in Colombia and Brazil

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Author's response to reviews: see over
Dear Dominik Ose

We are sending a new version of the manuscript “Do existing mechanisms contribute to improvements in care coordination across levels of care in health services networks? Opinions of health personnel in Colombia and Brazil”, which contains the changes suggested by the editor and referees:

As recommended by the editor, the paper has been copyedited by a native-English speaking professional translator with scientific writing expertise to improve the style of written English.

We have listed all referees’ comments and the corresponding changes in the manuscript are indicated here and highlighted in yellow in the text; we also give a rationale for each change, point by point.

With regard to the observations and recommendations of Ilana Graetz

1. It is not clear why the two countries, Columbia and Brazil, were selected for this study. They have different healthcare systems and organizational structures. Were there reasons why these two countries made for an interesting analyses and comparison?

There were various reasons for the selection of Colombia and Brazil: first, the relevance of the topic for both countries – poor coordination is considered to be one of the main obstacles to attaining effective healthcare outcomes, in Colombia and Brazil, similarly to many Latin American countries -, in addition to the policy challenge that it entails; second, the lack of evaluations of interventions to improve care coordination, in spite of the fact that macro-level policies in Colombia and Brazil in recent years have promoted
the introduction of integrated healthcare networks (IHN) at the meso-level and care coordination mechanisms at the micro-level; and finally, as the referee indicates below, we expected to find that the use of care coordination would be influenced by the contextual differences between them, such as the type of healthcare networks introduced (enrolment-based healthcare networks in Colombia, and regional-based network in Brazil), and differences between the care coordination mechanisms promoted by policies – (wider variety and more focused on clinical management in Brazil). The results of our study point to several characteristics of the organization of the health systems that influence the implementation of care coordination mechanisms, as outlined in the discussion: in Colombia, the fragmentation of healthcare delivery into multiple providers that compete for contracts with insurers and the predominance of short-term contracts, and in Brazil, the small size of the municipalities emerged as hindering factors to the implementation of coordination mechanisms in the networks.

We have clarified and emphasized these points in the background section of the article.

2. Were there specific factors or characteristics of the two healthcare systems that drove hypothesis about what the authors expected to find in terms of use care coordination. For example, did they believe that a single payer system like Brazil would have higher use of care coordination mechanisms relative to Columbia?

Due to the fact that studies which analyse the experience of the health personnel in the use of care coordination mechanisms developed in healthcare networks are practically inexistent, the study adopted a qualitative exploratory design in order to discover the limitations and benefits of the use of coordination mechanisms and influencing factors from the perspective of the health personnel involved. For this reason, we did not establish a hypothesis on the determinants of the use of care coordination mechanisms; these emerged from the data instead. Moreover, the results of the study suggest that the differences between countries in the use of care coordination might be attributed to the characteristics of the health systems to an extent, but also that there are also other relevant factors related to the organization of the services – such as the working conditions or organizational models (co-location, etc.) – and professional training.
3. In the methods, the authors state that the specific regions included were selected for being densely populated with a large proportion of low SES patients. Why was this important/relevant for this study?

The study areas are those of the Equity-LA project (http://www.equity-la.eu/), the broader project in which this study is framed (Vázquez et al. 2012). The aim of Equity-LA is to analyze the impact of different Integrated Health Care Networks on access to healthcare, care coordination and quality of care in the General System of Social Security in Health (SGSSS) of Colombia and the Unified Health System (SUS) of Brazil. Densely populated urban areas with a high proportion of the population belonging to the low or medium-low socioeconomic strata were selected mainly because most people in both countries live in this type of area.

We have added this information in the methods section.

4. How were the networks contacted to participate in the study? Who was contacted in each network? What proportion refused?

In Colombia, all the insurers operating in the study areas were contacted and invited to participate by means of a letter addressed to the manager. A series of meetings took place with those that responded to the invitation to present the research project and encourage them to participate. Finally, most of them rejected to participate in the study (22 out of 27).

We have now added this information in the methods section and also discussed it as a limitation of the study.

5. Once the network agreed to participate, how were individual informants selected? Was it a random sample? Did any refuse? What proportion refused?

We conducted theoretical or criterion sampling (Patton 1990); that is, study cases (networks) and informants (health personnel) were selected according to predetermined criteria (described in the text) which were considered relevant to the use of mechanisms for care coordination between care levels.

For the actual selection of informants, an institutional contact provided a list of possible candidates according to the above criteria and the researchers selected the informants from the list. In one of the contributory scheme networks of Colombia, the
administrative personnel and managers of the insurer contacted refused to participate (Table 2).

We have provided more details on the sampling criteria and refusals to participate in the methods section, and discussed them as limitations of the study.

6. **Who conducted the interviews? Was it the same in both countries?**

In each study country, there was a research team made up of senior researchers with different backgrounds and in-depth knowledge of qualitative methods, the research topic and the context, as well as junior researchers that were intensively trained to develop the knowledge and skills required and then closely monitored. Both senior and junior researchers participated in the collection of data, including the principal investigators (AM; MRF), who also supervised their work together with the project coordinators (IV/MLV), co-authors of the article.

We have included this information in the methods section.

7. **Describe the difference between an administrative professional and a manager.**

Administrative professionals are those working in support services related to the coordination of patient access across care levels (reception, user service desk, patient referral centres, etc.) and managers are chief directors, heads of department or middle managers.

We have explained with more details the sample criterion in the methods section.

8. **The writing throughout could be more concise with shorter sentences and clearer language. For example, the definition of care coordination on page 4 is confusing. Unclear what the authors mean by ‘objective administering the conflicts’**.

A native English-speaking professional translator with scientific expertise has copyedited the paper to improve the style of the language. Following the reviewer’s suggestion, we have revised the translation of the care coordination concept used in the paper.

9. **In table 2, define ‘I level’, ‘II level’, and ‘III level’**
We have defined the level of care complexity in table 2.

With regard to the observations and recommendations of Cherona Hajewski

1. Method of study is utilizing a semi-structured interview process with a sample of professionals of different care levels and a thematic content analysis of the segmented cases, informant groups and themes. This approach is appropriate to the type of study however; it is not described anywhere in the article the background and experience of the interviewers, how the interviewers were selected and how they were prepared to conduct the interviews. To include this detail in the article is recommended.

In each study country, there was a research team made up of senior researchers with different backgrounds and an in-depth knowledge of qualitative methods, the research topic and the context, as well as junior researchers that were intensively trained to develop the knowledge and skills required and then closely monitored. Both senior and junior researchers participated in the collection of data, including the principal investigators (AM; MRF), who also supervised their work together with the project coordinators (IV/MLV), co-authors of the article.

We have included this information in the methods section.

2. The data from the interviews is presented in a summary table; it is presented in quotes identifying the interview category. The sample by category is small and therefore, the emphasis on this manuscript supporting the opinions of the authors needs to be emphasized. The interviews only identified the limitations of the current delivery system and did not identify potential improvements and/or solutions. This could be more clearly stated.

The objective of the study was to analyze the health personnel’s use of mechanisms for coordination between care levels. The informants mainly highlighted difficulties in the use of existing care coordination mechanisms; the only informants who also mentioned their positive contributions to care coordination were from ambulatory care centres of the contributory networks. The lessons for the use of coordination mechanisms are drawn both from the limitations and the contributions identified, and these are set out in the discussion section of the article.
We have altered the introduction of the discussion in order to acknowledge the contribution of these care coordination mechanisms, and revised the introduction of the section, "Lessons for the use of coordination mechanisms from the experiences of Colombia and Brazil", to clarify that the lessons are drawn from the analysis of barriers and facilitators identified, and not directly from the opinions of the informants.

With regard to the quotations presented in the summary table, as the reviewer indicates, only a few examples of the analytical categories were included due to space limitations. We have selected quotations that we consider better exemplify both difficulties in the use of care coordination mechanisms and positive contributions to care coordination. However, a full transcript of the interviews could be made available on request.

3. Discussion and conclusion of manuscript is comprehensive and complete though the suggestion "that coordination mechanisms are poorly implemented in the majority of the networks" is not clearly demonstrated and I would recommend this statement is revised.

Following the recommendation of the reviewer, we have revised this statement.

4. Limitations of the study are not stated; this would benefit the manuscript.

Following the recommendation of the reviewer, we have included this information in the manuscript.

Having carried out the modifications in accordance with the reviewers’ comments, we would like to once again express our interest in publishing this revised manuscript in your journal.

Kind regards,

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References
