Author's response to reviews

Title: How Personal and Standardized Coordination Impact Implementation of Integrated Care

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Author's response to reviews: see over
Thank for your thoughtful comments on our manuscript. We appreciate the opportunity to improve the presentation of our work. We have considered each of your comments and respond to them below for each major section of the manuscript. In particular, we have deepened the analyses with regard to the implications of the study for implementing integrated care.

**Title/Abstract**

**R4.1. In Abstract: It is not clear to me, why do we need this research? In Background of Abstract**

“The purpose of this study was to identify how the implementation of integrated mental health and primary care affected and was affected by coordination processes. Standardized coordination consists of impersonal codified processes. Personal coordination consists of interpersonal communication processes.” The above sentences are not clear. In Results of Abstract is simple. This isn’t clear from the manuscript that the relation of Personal and Standardized Coordination with the Integrated Care. In Background: these should be more clearly stated and concise.

We have revised the abstract to clarify the purpose of the research and results

**R4.2. Are the methods appropriate and well described?**

In methods of Abstract: something should be described, such as the time of interviewed, et al. In Participants, something about 16 PC/MHI clinics across eight VA medical centers should be simple described.

We have made the changes in the abstract as suggested.

**R4.5. Do the title and abstract accurately convey what has been found?**

The title conveys what has been done but not what has been found.

We have revised the title to focus more on the main research question.

**Conceptual Framework**

**R5.1. Saying : «Both standardized and personal coordination are needed» it's not a strong innovation. Mintzberg say that since decades. So, authors must going further.**

We believe that we have made the innovation clearer in this draft. We have clarified our research questions in the introduction (lines 68-72). Our innovation is to identify the organizational factors that may impact standardized and personal coordination, and make recommendations about how leaders and policy makers may be able to facilitate the implementation of integrated care.
**R1.1. Integrated care: How is integration defined? What is the operational definition of integrated care in the context of VAMCs? Do you mean structural/financial integration, clinical integration, or/and informatics integration?**

We clarified in the introduction that we are studying and measuring clinical integration (lines 58-60). We also clarified in the methods that the VA mandated a transition from consultation to collaborative models of mental health care in the primary care setting. However, details of how to operationalize this collaboration was left to the discretion of local leaders (lines 120-125).

**R1.2. Service line management: Is this part of the service line management initiative in VAMCs?**

These VAMCs do have a service line management structure. We agree that this is an important detail and have added this to the Setting section (lines 116-118).

**Methods**

**R5.2. I'm OK with the inductive strategy for analysis, but authors may clarify the conceptual framework, more "operationalized" for the analysis work.**

We have revised the Data Analysis section to more clearly indicate what concepts we looked for from the conceptual framework, and which concepts emerged from analysis. Essentially, we expected to find instances of standardized and personal coordination in the interviews (defined on lines 181-183). All other concepts were inductively identified from the data. The definitions of these emergent concepts are provided in Table 2, and discussed in the results section in detail.

**R2.3 line 180 - I was not clear what theoretical coordination framework was being referred to - perhaps it was the personal/standardized categorization, but if so this seems a rather limited framework upon which to base the analysis.**

We have clarified that we did focus on standardized and personal coordination in our final analysis (lines 184-186). This framework is derived from the Charns et al (1999) paper that was in turn based on organization theory. However, this was a second stage of analysis that was conducted after the initial inductive coding, in which we identified organizational factors as emergent concepts (lines 165-171). We conducted the analyses in this way (i.e., first inductive, then deductive) in order to broaden and elaborate the framework for the health care context in the current study.

**R1.3. Perceived vs. actual coordination: How is coordination assessed or measured? Are joint projects between the units considered as coordination or collaboration?**

Coordination was assessed using the perceptions and recollections of leaders and clinical staff who were interviewed about integrated care. We recognized that perceptions can vary among informants. For this reason, we purposefully selected informants from different roles (e.g., primary care and mental health) in order to collect diverse perspectives of the coordination concept. We did compare participants’ responses within sites. There were differences in how primary care and mental health perceived practices, but we focused this paper on the similarities among these reports rather than the differences.
Regarding the differences between coordination and collaboration, this paper does not focus on collaborative behaviors. The purpose of the intervention was to switch from a consultation to collaborative model of care. Collaboration is therefore reported in these interviews, but we are focusing on how the standardized or personal coordination processes are being implemented, and what factors were reported to impact that implementation. Both standardized and personal coordination were used to promote collaborative care.

R1.5. The relationship between personal and standardized coordination procedures or guidelines: What is the duration of the observation for the intervention?

The duration of the interviews was 45 minutes. We only interviewed participants one time. However, participants were asked to discuss how the coordination practices changed over time. Thus, examples were recollections of changes that had occurred over the past year in which the intervention was implemented.

Results
R5.3. I suggest to the author to develop the 270 section (How can personal coordination improve standardized coordination procedures?), in the way to explain how both types of coordination can me articulate with more efficiency. In the same way, adjustment strategies may be developed.

Thank you for this suggestion. We recognize that the implications of this section were not fully clear. We now present this section as key findings related to how integration can be implemented (now the 272 section).

R2.1 While the paper illustrates where personal integration overcame barriers to do with gatekeeping and so on, and while it did provide some insight into what enabled personal integration to work (physical proximity), it did not provide insight into what stops personal integration from happening. Three maximum variation case studies drawn from within the sample of interviews might be able do this, where the reader is given the context and a detailed thick description that illustrates where personal integration was possible and worked, compared to contexts where personal integration did not seem possible or if possible, still failed.

Thank you for this methodological suggestion. We recognize that we needed to explain the implications of our analyses more clearly. We have refocused our third research question from “How can personal coordination improve standardized coordination procedures?” to “How can the implementation of integrated care be facilitated?” We reformatted the examples of integrated care implementation (lines 273-328) to better highlight the practical implications for the paper. We also took your advice and now start the section by contrasting three cases that vary in personal coordination (one high, two low) to highlight key differences (lines 273-281).

R2.2. If the authors could go to the qualitative convention of thick description and so “thicken” up the findings, analysis and discussion then it would be a very good
contribution.
We completely agree. However, our IRB adopted a conservative approach to our re-analysis of data that was not originally collected for research - the IRB specified that we were not to use quotes. This severely restricts our ability to present the data using conventional qualitative style. However, you should be able to see how we strove to be specific in our paraphrased examples in order to be as “thick” as possible within our constraints.

R2.4. lines 243-258 - the examples given looked more like definitional and service criteria issues than leadership priorities which is the section heading

We see how the leadership priorities section was not clear. We now clearly specify how these are examples of differences in leadership priorities (in addition to definitional and service criteria issues). This section is now lines 241-260.

R1.4. Factors influencing the perception: The pro- and con aspects of the two types of organizational coordination may be influenced by different factors. What are these factors?

Our analyses mostly highlighted factors that positively influenced coordination (physical proximity, interaction history, computer mediated coordination, formal meetings, training, and unscheduled time). Leadership priorities were reported as negative factors, but certainly could also be positive (if they were shared).

R4.4. Does the manuscript adhere to the relevant standards for reporting and data deposition? I feel that the report of results should be more concise.

We have made an effort to cut down the results to be more concise.

Discussion

R1.6. Replication: Is the assumption replicable in other VAMCs?

We believe that the reviewer is asking about the transferability of our results to other VAMCs (and other healthcare systems). This is an important point – particularly given that we are now emphasizing the findings as practical guidance. Transferability refers to whether the findings can be used by others to achieve the same result. So, a relevant transferability question is – would a healthcare system leader be better equipped to implement integrated care after reading this article.

Because observed similar relationships among organizational factors and coordination across multiple VAMCs in different situations, we believe that we have captured enough variation to facilitate transfer of the research findings to other settings. Certainly, the cross-sectional nature of the data collection and the conservative IRB restriction against quotations limits the “thickness” of the data described, and so it is possible that important details were accidently omitted. However, we conducted an iterative process of comparisons across sites, and have
highlighted the factors that were repeated in different settings. Thus, we have reasonable confidence in the transferability of findings. We note this on lines 334-337 and 362-364.

R4.3. Are the discussion and conclusions well balanced and adequately supported by the data?
I have an impression that the data could be more thoroughly/deeply discussed. What I miss is a discussion on the consequences of the findings for the existing theories/practice. In the present version of the manuscript the previous findings are simply summed up without relating the new findings to the existing ones.

We see now that these implications were not clear. Our change in focus from a conceptual paper about standardized and personal coordination to a paper about the practical implications of the two concepts should clarify your concern (lines 30-32, 72). We compare different instances of using personal coordination to overcome barriers to integrated care (lines 273-328). In the discussion, we highlight this as a key finding (lines 332-334), and discuss how this finding advances the literature (lines 338-344).