Author’s response to reviews

Title: Identifying and Addressing Gaps in the Implementation of a Community Care Team for Care of Patients with Multiple Chronic Conditions

Authors:

Kasey Boehmer (boehmer.kasey@mayo.edu)
Diane Holland (holland.diane@mayo.edu)
Catherine Vanderboom (vanderboom.catherine@mayo.edu)

Version: 1 Date: 23 May 2019

Author’s response to reviews:

Per the editorial guidance, we have provided a point-by-point response to the reviews received from BMC Family Medicine and uploaded a clean manuscript file.

Maria Papadakaki (Reviewer 1): Thank you very much for inviting me to review this manuscript, which reports on initial findings of a community chronic care model pilot test. I hope that my comments will be found useful during the revision process.

Response: Thank you for these helpful suggestions. It appears that the biggest source of confusion throughout the paper was the lack of a clear aim for this paper, and we have now addressed that and related issues with our revisions, addressed point-by-point below.

Background

1. The authors need to provide a review of existing community care models as well as evidence on their strengths and limitations, and afterwards identify the added value of the community chronic care model that they are testing in their own study.

Response: We have now added a paragraph to describe the program that served as a first of its kind and model for the CCT, and noted the challenges of creating such a program.

“Programs that leverage partnerships between healthcare systems and existing community programs address these deficiencies observed in the current structure of chronic care delivery. An early exemplar of such program is Vermont’s “Blueprint for Health,” an initiative that began as a pilot in the state in 2003, which included a community care team at the heart of its healthcare delivery reform. During the Blueprint for Health pilot, the program reduced patient hospitalizations, emergency department visits, and overall costs, and has since been adopted by the majority of primary care practices in Vermont. While inspiring that such state-wide transformation could occur in Vermont, it has been documented that there are significant
challenges to connecting community and healthcare resources. In depth studies of these connectivity challenges have pointed to individuals in each system believing they are essentially living in two separate worlds, and it is not necessarily either parties job to connect or refer to the other.11”

2. The aim of this study is not clear. Is it an attempt to adapt a model in a different setting? Is it an attempt to explore the feasibility as well as implementation barriers of the model? Is it an attempt to test the model's effectiveness to improve certain patients' outcomes? or is it just to develop a toolkit? Adding clear objectives, research questions and a hypothesis, would be helpful.

Response: We have now revised the last paragraph of page 6 and the final sentence in our abstract background to clearly state our aim.

“Based on the positive pilot findings and solid stakeholder endorsement of the CCT’s assistance to patients, there was strong interest in moving the CCT from a research-funded pilot program to a sustainable resource available to the local community and primary care practices. However, given known challenges enacting such connectivity as the standard,11 and locally acknowledged general lack of awareness about the CCT amongst primary care physicians, care coordinators, and social workers in the two healthcare systems’ primary care clinics, additional implementation support was required. Therefore, the aim of this study was to develop an implementation toolkit to sustain referral to the CCT in the future.”

3. In the background section, the authors refer to "an exemplar program" as well as to the results of pilot implementation work already conducted. Please add some references to support all these statements.

Response: We have now added the paragraph, described above, to point out that Vermont’s program was in fact the exemplar, with appropriate citations, and revised the following paragraph (paragraph 1, page 5) to begin instead with “Modeled after Vermont’s Blueprint for Health, the Community Care Team (CCT) was developed and implemented in a county in an upper Midwestern state.12,13”

Methods

4. In the methods section, besides simply listing the tasks undertaken, I would like to see a conceptual basis guiding implementation as well as a methodological framework. It seems scientifically weak as it is currently presented.

Response: In our original version, we did cite the methodological framework used, the AIDED Model for Implementation and Scale. We have included a figure of the model, now Figure 1, to bring further attention to this model.
5. The methods section is focused on the presentation of the different phases of the model. However, the authors need also to present in a structured way, the setting, the participants' recruitment in CCT team, inclusion/exclusion criteria for patients' enrollment, etc.

Response: The description of the CCT and patients eligible are described in the introduction on page 5 paragraph 2, and pilot results are described elsewhere (reference 12).

"Modeled after Vermont’s Blueprint for Health, the Community Care Team (CCT) was developed and implemented in a county in an upper Midwestern state. The county is served by two healthcare delivery systems, both that have substantial primary care practices. The CCT was developed using three proven approaches to meet the needs of patients with chronic illness: 1) care coordination by either a nurse or social worker, 2) partnerships with existing community services, and the use of the Wraparound process. Patients appropriate for the CCT program are adults with chronic health conditions who are overwhelmed, usually by both their burden of illness and treatment, and identified as unable to participate or ‘stuck’ in their self-care for unknown reasons. A care coordinator, social worker, public health nurse, or other primary care clinician can identify eligible patients. After enrollment, a member of the CCT meets patients in their home for a comprehensive assessment of their health and living environment, and then the CCT holds an initial group meeting with the patient and their support persons at their primary healthcare clinic. During this meeting, the CCT focuses on patient strengths to leverage them to improve self-care and on identifying patient and family priority concerns. Based on the strengths and concerns assessed, the CCT creates with the patient and their support person(s) a shared action plan to address their priority concerns. The action plan includes concrete tasks, delegates each task to a member of the CCT, the patient, or their caregiver, sets up a timeline for completion and follow-up, and indicates the expected results. Additional deliverables of the CCT meeting include a Crisis Prevention Plan based on patient-identified changes signaling a difficult day and the need to obtain assistance before the situation spirals out of control, and a Circle of Support, which includes community and informal resources available to assist the patient with self-management activities. A copy of each group meeting proceedings and the Action Plan is made available to all team members, patients and caregivers at the end of each group session. The work of implementing the Action Plan takes place over the subsequent 12-week period. The CCT meets again with the patient and their caregiver(s) following the 12 weeks to re-evaluate progress toward goals, address new problem areas, and finish any outstanding tasks."

The purpose of this paper, however, was to engage with key stakeholders involved in delivering and referring to the CCT in order to build an implementation toolkit to sustain its existence beyond the research funding. We did not have IRB approval to collect patient health information as part of this portion of the study. Types of staff engaged are accurately described my profession at the end of page 7.

“To do a comprehensive assessment we conducted 13 chart reviews of previous CCT patients, conducted an observation of a referral, an observation of a CCT home visit post-referral, and conducted 11 interviews with current and potential referral sources to the CCT including three physicians, two CCT staff, four nurse care coordinators, and two social workers.”
6. The authors further need to identify the framework of analysis. How are they planning to evaluate their work? This should be consistent with the study objectives.

Response: We are sorry this was unclear, but it has now been corrected through revision of the introduction, as described above. The purpose of this portion of the study was to develop a toolkit to sustain referrals to the program after the research funding ended. It is unclear whether there will be future evaluation of the toolkit now that it is in practice.

Results

7. It was extremely difficult to follow the results without clear study objectives and methodology. The authors present a series of activities undertaken and a variety of outcomes but these are not linked to clear study objectives and a structured methodological framework.

Response: The results are organized in alignment with the methodological framework (AIDED) in the order of each of the AIDED steps. We hope that the clarification of the aim of this work, and the inclusion of the AIDED diagram to follow the steps (Figure 1) provide further clarity to our readers.

8. There are several terms used without prior explanation/definition. Who were the "referrers", "the stakeholders", etc. Such explanations should be provided earlier in the "methods" section.

Response: We have now clarified referrers and stakeholders in paragraph 2, page 7, and in paragraph 1, page 8 respectively.

“The purpose of the Assess phase was to understand what the CCT had accomplished for patients referred to and graduated from the program, as well as to understand the information needs of potential referrers (clinicians, care coordinators, and social workers) to the CCT program.”

“We used the information gathered during the Assess phase to inform the Innovate phase. During the Innovate phase, we worked with stakeholders (referrers to and delivers of the CCT program) to iteratively design an implementation toolkit to support sustainable referrals to and feedback communication from the CCT.”

Discussion

9. The discussion reports on the "success" of the study in developing a toolkit. What were the criteria for a successful toolkit? How does this outcome meet the study objectives?

Response: The “success” referred to is the translational success of using of an implementation and scale-up model (AIDED), not previously used in this type of setting, to create the toolkit. We hope clearly identifying and pointing out the AIDED model used clarifies this.
10. Most importantly, the results section does not clearly show this success.

Response: This is addressed in the point above, regarding the success of using a new model in this type of setting to develop an implementation toolkit.

11. I also miss the consistency between the study objectives and the findings in the discussion. At the background section the authors aimed to address the challenge of "....general lack of awareness about the CCT amongst primary care physicians, care coordinators and social workers...". How did they address this challenge?

Response: We have clarified this issue by revising our aim, as described above, and describe how stakeholders were engaged in our methods section.