PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	A mixed-method evaluation of CARITAS - a hospital-to-community model of integrated care for dementia
AUTHORS	Ha, Ngoc Huong Lien; Chan, Ivana; Yap, Philip; Nurjono, Milawaty; Vrijhoef, Hubertus; Nicholas, Sean Olivia; Wee, Shiou-Liang

VERSION 1 – REVIEW

REVIEWER	Professor Constance Dimity Pond University of Newcastle, Australia
REVIEW RETURNED	13-May-2020

GENERAL COMMENTS	This paper describes an evaluation of the Caritas network, which attempts to integrate care of people with dementia in Singapore. The RMIC-MT tool was used for the evaluation and this added strength to the study. I have a few comments: The evaluation mentions a number of barriers without giving a full explanation of why they occurred. the include: decreased attendance at meetings and learning opportunities as time went on; lack of attendance by the primary care team and community members and the fact that the primary care team operated independently. IT system problems were also mentioned. These types of problems are very common in integration attempts across many health systems, and the team is to be congratulated on its achievements. In order to have the evaluation point to ways of improving matters worldwide, this reviewer would like to see more explanation of the reasons for the barriers. One possible explanation for example for non attendance by parts of the system is that the funding for the program was channelled through the hospital (see under the heading "Functional Integration"). This was seen as a reason for other parts of the system not "assuming accountability". However, the issue of direct funding to other parts of the system for time spent on the program is not discussed in the text, although it does appear in the interview extracts used for coding: “I: In some of the programmes, let’s say if we were to be funding a particular service provider, it should factor in the time that they are taking to go and attend case discussion. R: No, that’s never the case.” [P005] It would be interesting to see mention of this possibility in the text, as it does appear in the supporting documentation.

	I also have an issue with mention of the IT problem as a barrier to "centralised case management". The concept of centralised case management seems to be potentially inimical to "collaborative and integrated person centred care" which is described as as a goal under "organisational integration". Could the authors please comment on this apparent discrepancy? Overall however, the topic is important, the paper is well written and the evaluation well done within an accepted evaluation framework. I believe the paper should be published.

VERSION 1 – AUTHOR RESPONSE

RESPONSE TO REVIEWER 1

COMMENT 1:
The evaluation mentions a number of barriers without giving a full explanation of why they occurred. They include: decreased attendance at meetings and learning opportunities as time went on; lack of attendance by the primary care team and community members and the fact that the primary care team operated independently. IT system problems were also mentioned.

These types of problems are very common in integration attempts across many health systems, and the team is to be congratulated on its achievements. In order to have the evaluation point to ways of improving matters worldwide, this reviewer would like to see more explanation of the reasons for the barriers.

RESPONSE:
We thank the reviewer for the comment. We have provided additional explanation for the barriers encountered and reflected them in the main manuscript as follows:
• Decreased attendance at meetings and learning opportunities over time
On page 13 line 298-301 and below:
First, not all members, especially those from the community, could be present at every meeting due to commitments at their primary workplaces. Thus, case discussions would be delayed, or be held outside the MDM through less personable communication channels such as exchange of emails or messages.
And on page 14 line 323-328 and below:
However, over time, staff turnover and change in the leadership of partnering organisations with attendant shifts in priorities have negatively impacted organisational integration. Engagement with the leadership of partnering organisations to align goals and discuss strategies was also observed to decrease over the years, which impeded understanding and support towards the network's shared objectives. Members of partnering organizations remarked that without consistent strong support from their employers, they felt less empowered to extend their commitment to the CARITAS' activities beyond their defined roles, especially when faced with heavy responsibilities in their own organizations.

• Lack of participation by the primary care team,
On page 14-15 line 341-347 and below:
Another issue lay in the primary care team not participating regularly at team meetings. The primary care team worked mainly with the tertiary hospital team. As such, information concerning patients from primary care was often conveyed through the hospital team members to community partners at the MDM. This inadvertently reduced the need for face-to-face interaction between the primary care team and community partners. There were hence diminished opportunities for forging a shared identity which is instrumental to normative integration.

• Lack of integrated IT system
On page 17 line 400-402 and below:
The lack of shared documentation of previous and ongoing services for patients also risked duplication of services. Even when a shared IT platform was piloted in the course of CARITAS implementation, limitations in the system's usability and capability restricted its uptake among members of the team.

We also corrected a typo error on page 14 line 330 and below:
As a result, some members were less inclined to attend weekly meetings or only attended when they needed to discuss their cases, and there were also been instances of decreased participation in learning opportunities such as case-based learning and continuing education initiatives.

COMMENT 2:
One possible explanation for example for non-attendance by parts of the system is that the funding for the program was channelled through the hospital (see under the heading "Functional Integration"). This was seen as a reason for other parts of the system not "assuming accountability". However, the issue of direct funding to other parts of the system for time spent on the program is not discussed in the text, although it does appear in the interview extracts used for coding:
"I: In some of the programmes, let's say if we were to be funding a particular service provider, it should factor in the time that they are taking to go and attend case discussion.
R: No, that's never the case." [P005]
It would be interesting to see mention of this possibility in the text, as it does appear in the supporting documentation.

RESPONSE:
We thank the reviewer for the comment. We would like to elaborate on the context of the quote in the comment. The stakeholder interviewed meant to share that funding for the programme was provided as a form of financial support to cover primarily essential direct costs of the programme rather than a financial incentive to motivate members of the network to participate. As such, while some indirect costs such as time spent travelling to meetings or to attend to cases might not be part of the funding, this was acceptable by members of the network. Indeed, most community care partners interviewed expressed that travelling was part of their work and believed it had been sufficiently accounted for. They did not see the need to quantify such indirect costs separately in the funding for the programme. To avoid any confusion, we have removed the quote from Table 3 of the main manuscript, which can be found on page 36 and below:
• "I: In some of the programmes, let's say if we were to be funding a particular service provider, it should factor in the time that they are taking to go and attend case discussion.
R: No, that's never the case." [P005]

COMMENT 3:
I also have an issue with mention of the IT problem as a barrier to "centralised case management". The concept of centralised case management seems to be potentially inimical to "collaborative and integrated person centred care" which is described as a goal under "organisational integration". Could the authors please comment on this apparent discrepancy?

RESPONSE:

We thank the reviewer for pointing this out. We did not mean to suggest that the lack of shared IT platform was a barrier to “centralised case management”. As our data did not support that, we have removed the phrase “centralised case management” from the main manuscript to avoid confusion. This is now reflected on page 18 line 415 and below:
and centralized case management
As well as page 2 line 49 and below:
However, the lack of structured documentation and a shared information-technology platform and centralized care coordinators hindered functional integration

COMMENT 4:
Overall, however, the topic is important, the paper is well written and the evaluation well done within an accepted evaluation framework. I believe the paper should be published.

RESPONSE:
We thank the reviewer for the encouraging comment.

COMMENT 5:
Please include figure legends at the end of your main manuscript.

RESPONSE:
We have provided the figure legends in the main manuscript on page 21 line 498-503 and below. Three appendices are provided at the end of the article as supplementary materials and they are:
Figure 1: A Logic Model of CARITAS
Figure 2: Scores of RMIC’s Eight Dimensions of Integration
Appendix 1. Ethnographic Observation Template
Appendix 2: Outline of an Interview Guide with Key Stakeholders in CARITAS

We added a reference in-text on page 7 line 147 and in the Reference list on page 24 line 567-569
[25] World Health Organization & World Pyschiatric Association, "Organization of care in psychiatry of the elderly - a technical consensus statement". Aging & Mental Health, 1998, 2(3), 246-252. doi:10.1080/13607869856731

Lastly, we have made slight edits to Figure 1 and removed Appendix 3 from the Supplementary Materials document.

VERSION 2 – REVIEW

REVIEWER	Constance Dimity Pond University of Newcastle Australia
REVIEW RETURNED	25-Aug-2020

GENERAL COMMENTS	This is an interesting manuscript about an important issue: an intervention to promote integration of services for people with dementia. The paper describes an evaluation that is comprehensive and has a strong theoretical foundation. It has

	identified both strengths and areas for improvement in the implementation of the intervention. The paper has already been reviewed and responded appropriately with additions that strengthen the manuscript. I believe it should be published.