Reviewer’s report

Title: Under the same roof: co-location of practitioners within primary care is associated with the comprehensiveness of care for patients with chronic conditions.

Version: 1
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Reviewer: Grant Russell

Reviewer’s report:

Thank you for the opportunity to review this article, Under The Same Roof: Co-Location Of Practitioners Within Primary Care Is Associated With The Comprehensiveness Of Care For Patients With Chronic Conditions.

I have a series of recommendations on the article which I shall arrange under the requested subheadings. The article is succinct, clear and relevant to the issues that clinicians and policy makers are struggling with in the delivery of quality primary care. Statistics seem appropriate for a non statistician, and the findings well overviewed in the discussion. I think that the limitations section was particularly well written notwithstanding the reservations I have detailed below.

I have several comments that require attention:

1) Although the core question is well articulated, I do have some concerns that the definition of comprehensiveness used (line 122 - greater range of services, specialized programs, and specific clinics tailored to their conditions) is different from broader constructs of primary care comprehensiveness. Canadian experts defined comprehensiveness as "the provision, either directly or indirectly, of a full range of services to meet patients’ health care needs. This includes health promotion, prevention, diagnosis and treatment of common conditions, referral to other clinicians, management of chronic conditions, rehabilitation, palliative care and, in some models, social services)." (1).

2) The methods are well described however there are 2 important issues that potentially have an impact on the interpretation of the data.
   • Sampling methods were not particularly systematic, and it was hard to see how the practices responding compared to size, model and location of practices within each nation.
   • Questionnaires were sent to practices, but it seems (as suggested on line 169) that roster size was not established for the practice. We have an idea for the number of different professions at each site, but not the number of individual FTE GPs. There are some family health teams in Ontario with many dozens of providers at a number of satellite sites within the same organization. It was unclear whether such practices could be skewing the findings. Lack of data from Ontario on model is also concerning given the likely influence of model on a number of quality domains.
3) as mentioned, the limitations well articulated, however several limitations are not mentioned. These represent my main concerns with the article:

• At least two recent articles evaluated comprehensiveness in Ontario primary care (2, 3) Neither were cited, but both demonstrate the importance of group (rather than panel) size on comprehensiveness, and measure rurality, and a number of other explanatory variables.

• The outcome variables were well described (Provision of Disease management programs, Special sessions/clinics, level of nurse service provision and equipment use), but not necessarily representative of a consensus definition of comprehensiveness.

• With the limited perspective of comprehensiveness, there is a danger of over interpretation of the data. The reader (or at least this one!) is not convinced that the measure of comprehensive is sensitive enough or that critical explanatory variables have been assessed. For example, that it may be a core characteristic of the work of several professional groups (in particular dieticians and diabetes educators) to hold and run special clinics or disease management services as part of their normal work. Using a binary variable (service present/not present) a positive score would come from an occasional course delivered to a handful of patients. It is difficult to assume more without more detail, especially with the lack of data on practice size and location.

a) Major Compulsory Revisions
The authors need to
• Either measure, or acknowledge the lack of data on rurality and practice size (as measured by physician FTE) in adjusting for the outcome measures.
• Acknowledge broader definitions of comprehensiveness.
• Relate the finding to other investigations of comprehensiveness, particularly in Canada and NZ.
• Acknowledge the potential of confounding by multisite group practices – by definition these aren’t collocated, but would not be determined by the question: “Which of the following disciplines are working in your practice/centre?”

Minor Essential Revisions
Nil

Discretionary Revisions?
A table (online) of the frequency of the different provider groups would be helpful.
The authors may like to consider whether, in the title, they should delete the definite article before “comprehensiveness”:

2. Devlin RA, etal Practice size, financial sharing and quality of care. BMC Health


**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** Yes, but I do not feel adequately qualified to assess the statistics.

**Declaration of competing interests:**

No conflict of interest, although I am involved in a new study using the same data set.