Author's response to reviews

Title: Online Training in Two Community Health Centers to Address Tobacco Smoke Exposure of Children

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Author's response to reviews: see over
Prof Gian Luigi Marseglia  
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Dear Professor Marseglia,

The suggested changes to the manuscript Online Training in Two Community Health Centers to Address Tobacco Smoke Exposure of Children have been made. A point by point explanation of the changes is below.

Thank you for your efforts on our behalf with the manuscript. We look forward to working with your team at BioMed Central in the future.

Please do not hesitate to contact us if there are any further questions, comments, or revisions.

Sincerely,

Jonathan P. Winickoff MD, MPH
Reviewer's report
Title: Online Training in Two Community Health Centers to Address Tobacco Smoke Exposure of Children
Reviewer: Aaron Chidekel

Reviewer's report:
METHODS:

1. Comment: In paragraph 1, it is suggested that the authors provide a temporal context for some of the references, some of which are nearly a decade old.

Answer: Thank you for the suggestion. A temporal context has been provided for the articles, as can be seen on page 3.

2. Comment: Similarly, in paragraph 2, the authors refer to one of their groups’ papers from 2003, reference 9, to present data about current and state of the art approaches. The authors should clarify this temporal context as well for obvious reasons: 2003 is not current and what was state of the art a decade ago is no longer so today.

Answer: The sentence on page 3 has been changed and now reads: “In a national survey conducted in 2006, less than 40% of smoking parents reported that their child’s clinician advised them to quit smoking [9].”

3. Comment: In both the introduction and methods sections, the lines between the current intervention and the more comprehensive CEASE intervention are at times blurred and it is hard for the reviewer to discern the relationship between the current intervention and the CEASE project. For example, is the on-line training in the current work a component of the CEASE system? If it is, this should be explicitly stated or the differences between the current and prior modules better defined. The authors state that one of the goals of the study was to develop and test an innovative on-line training for clinicians but it almost sounds like they deployed a previously developed tool in a novel fashion.

Answer: Thank you for this observation. The Intervention section on pages 6-7 now contains more comprehensive information about the components of the intervention. The section now reads:

“The distance training and intervention consisted of training pediatric health care providers in pediatric tobacco control and materials to support practice change. The training included a new online training module, telephone training calls, email support, and a training manual, complete with a training DVD. The online portion of the intervention was developed for the study in conjunction with the American Academy of Pediatrics (AAP) online training division. The course, Help Every Family Quit Smoking, worth one AAP CME credit, is based on previously tested pediatric practice-based...
methods to help families quit smoking [4]. Through video clips, educational slides, and quizzes, pediatric clinicians learn about the benefits of parental smoking cessation as well as the harms of tobacco use, tobacco smoke exposure and children, and thirdhand smoke [4]. Clinicians are also coached in how to help families set smoke-free home and car rules, and help all family members who smoke quit smoking. The course takes approximately one hour to complete. For the study, the designated project leader/champions completed the online component of the training, but the training was offered for free to any other physicians or nurses who wished to complete the course. Other aspects of the training included a whole office telephone training call, a training manual, and email/telephone support, which had been previously developed as part of the CEASE intervention to meet the needs of child health care clinicians [], but were tailored to the needs of the pediatric office being trained and to the distance-based context of the intervention (pediatric offices were asked about the online training and supported with any problems they had with it and were supported by phone and email if there were any questions about the intervention). All clinicians and staff were requested to attend the telephone training call, for which lunch was provided; the call included watching components of the training DVD on the call, asking about how aspects of the intervention could be tailored for the practice, and addressing any potential barriers that the practice foresaw.

The intervention also included practice support materials, which had been developed for prior CEASE projects; the materials included a one page sheet to ask and document family smoking and smoke-free home and car rules, educational materials about smoking for families, a fax referral form to the tobacco cessation quitline, posters promoting smoking cessation, and preprinted prescription pads for nicotine replacement therapy. The materials were provided for free and were also available on the CEASE website.

The practice was considered trained in the intervention after the project champion completed the online training module, after the training telephone calls, and after the project champion had completed a 10 chart review to check that smoking status had been documented."

4. Comment: Is this study the PediaLink CEASE Study? If it is then this should be introduced and discussed further, if it is not, then why is it mentioned since it is not brought up again in the paper.

Answer: For the sake of clarity, the name PediaLink CEASE Study has been removed.

5. Comment: Is there more information about how and when in relationship to the study data collection visits that the offices completed the training? The authors simply state that a team leader was required to complete the course. Do they simply mean the online module? Was there more to it than this? Did any other members of the office teams complete the course?
Answer: Thank you for this comment. Information about the timing of the data collection has been added on page 7 with the sentence:

“The practice was considered trained in the intervention after the project champion completed the online training module, after the training telephone calls, and after the project champion had completed a 10 chart review to check that smoking status had been documented.”

Information about the training components has been added to the Intervention section on pages 6-7.

6. Comment: The dates of the study are unclear. The timeline in the text does not match with the timeline on figure 1, which does not match with the dates stated in the text. This is very confusing to this reviewer. If there was an “intervention period” that explains these discrepancies, then this should be better characterized.

Answer: We have corrected the dates in the text.

7. The authors then reintroduce the CEASE intervention, which results in further confusion for this reviewer. The authors stated aim was to assess an on-line intervention but in the methods they then describe the use of telephone training and material support for practice change. Isn’t this the CEASE intervention that the authors also state is resource intensive? What exactly was done to intervene in the practices is very unclear to this reviewer.

Answer: Thank you for the comment. This has been further clarified on page 4 with the text: “However, traditional CEASE training strategies can be resource intensive for both the training staff and the clinicians being trained, especially the coordination of in-person trainings to locations far from the trainers. The aim of this study was to develop and test innovative distance training and materials for clinicians to address the tobacco smoke exposure of children, the establishment of no-smoking rules, and parental smoking cessation.”

As well, the Intervention section on pages 6-7 includes further information on the intervention and trainings offered as part of the study and now reads:

“The distance training and intervention consisted of training pediatric health care providers in pediatric tobacco control and materials to support practice change. The training included a new online training module, telephone training calls, email support, and a training manual, complete with a training DVD. The online portion of the intervention was developed for the study in conjunction with the American Academy of Pediatrics (AAP) online training division. The course, Help Every Family Quit Smoking, worth one AAP CME credit, is based on previously tested pediatric practice-based methods to help families quit smoking [15]. Through video clips, educational slides, and quizzes, pediatric clinicians learn about the benefits of parental smoking cessation as well as the harms of tobacco use, tobacco smoke exposure and children, and thirdhand
smoke [16]. Clinicians are also coached in how to help families set smoke-free home and car rules, and help all family members who smoke quit smoking. The course takes approximately one hour to complete. For the study, the designated project leader/champions completed the online component of the training, but the training was offered for free to any other physicians or nurses who wished to complete the course. Other aspects of the training included a whole office telephone training call, a training manual, and email/telephone support, which had been previously developed as part of the CEASE intervention to meet the needs of child health care clinicians [17], but were tailored to the needs of the pediatric office being trained and to the distance-based context of the intervention (pediatric offices were asked about the online training and supported with any problems they had with it and were supported by phone and email if there were any questions about the intervention). All clinicians and staff were requested to attend the telephone training call, for which lunch was provided; the call included watching components of the training DVD on the call, asking about how aspects of the intervention could be tailored for the practice, and addressing any potential barriers that the practice foresaw."

8. Comment: Inconsistencies in the data collection methods also require clarification. “Anyone” could ask, “healthcare providers” could advise and the primary outcome of the study was rates of “clinicians” asking and advising. The main concern of the reviewer is the use of the word “anyone” without further clarification that anyone in these practices is a “clinician” or a “healthcare provider.” Furthermore, the intervention specifically targeted physicians and there is no information in the paper about whether the physicians disseminated the training to “anyone” else or to other “healthcare providers” including other physicians in the study sites.

Answer: We have clarified in the methods and results that the pediatric health care provider includes clinicians and the pediatric office staff who were both trained in the intervention.

9. Did the practices know when the study team was present? This is a potential source of bias and should be discussed.

Answer: This comment has been addressed on page 8 with the following text:
“While some in the practice knew that the research assistant was at the practice, this fact was true at both baseline and follow-up time points. In addition, many efforts were taken to reduce bias, such as having the research assistant conduct interviews in the most private location possible, away from the reception desk or other areas where clinicians could hear and be reminded of the presence of the research assistant.”

10. Are the total numbers of office visits during the weeks of data collection known? Similarly, what proportion of office visits were captured? Based on the authors’ inclusion criteria, it seems like fewer than half of the total visits to each practice
may have been captured and this may be an important point. For example 65 visits X 5 days is 330 visits per week. 470 visits collected divided by 3 weeks of data collection is only 157 visit per week. This is also a potential source of bias. The authors at least should disclose these potential limitations to the reader. The spirit of these comments is several fold: Firstly, since this is an interventional rather than a descriptive study, methodological clarity is important.

Secondly, after reading the methods section, this reviewer has no idea how to implement this intervention. If the authors want their intervention generalized into practice further clarity is indicated. Finally, the authors claim to show a significant effect of what is described as a one-hour on-line intervention and the reader is not clearly shown how this was implemented or who even completed the intervention in the practices.

Answer: We thank the reviewer for this comment regarding visits. It has been clarified on pages 7-8 with the statement:

“While both practices attested that the practice saw a minimum of 65 childcare visits per day, it was quickly learned that the practices did not consistently see this number of patients due to factors such as school holidays, summer vacations, and staff changes.”

It has also been added to the Limitations section with the text:

“As well, the patient flow rate in both practices was much lower than anticipated, due to circumstances beyond the control of the study team or practice.”

We thank the reviewer for this comment regarding the intervention. The steps of the intervention have been clarified and expanded throughout the article, adding information about the other aspects of the distance training and the training of office staff. More information has also been added to the Limitations section with the text:

“We do not have data on the sustainability of the intervention nor do we have follow-up data on parent smoking behavior in homes and cars. Through the American Academy of Pediatrics PediaLink division, the CEASE team has developed a more intensive quality improvement module; the eQIPP module, which is a long-term quality improvement training system. The eQIPP module has been developed to lead practices through systematic changes in their practice around addressing tobacco use and exposure. This module, available at www.eqipp.org is currently undergoing rigorous testing and may mitigate implementation issues experienced in this study [22].”

11. Comment: The authors should explicitly state what values are being combined in table 3 and check the accuracy of the numbers. Similarly, they should also clearly define how many questionnaires were answered at each site, at each time point.

Answer: We have checked the accuracy of the numbers and have clarified the number of questionnaires answered at each time point in the results section and added them in the timeline as well to make it clearer.
12. Comment: In the discussion the authors use the phrase “completely distance based tobacco control education intervention” and “the implementation of CEASE” resulting in further confusion for this reviewer: The stated aim was to evaluate “online training for clinicians” while the methods describes online education, telephone training and materials to support practice change. It is very unclear what the intervention was, how it was developed, how it differs from the CEASE program and who in the practices participated in the training.

Answer: In the Intervention section on pages 6-7 and throughout the discussion, we have clarified the intervention and the aims.
Reviewer's report

Reviewer: Kinga Polanska

Reviewer's report:

1. There is no clear information how many participants are interview in each Practice at each time point. The information given in the text is confusing and need to be improved. In table one the authors are indicating that Practice 1 had 470 participants and Practice 2 had 177 of them whereas in table 3 we have information that Practice 1&2 combined had 470 participants prior to intervention and 177 post-intervention. This need to be checked and corrected as in that version of manuscript it is confusing. I propose to add such (exact) information to fig. 1.

Answer: We thank the reviewer for suggesting to clarify the numbers as it helps in understanding the numbers better. We have clarified the number of people interviewed at various time points and added them to the timeline figure as well. We also checked the accuracy of the numbers.

2. If would be reasonable to add the p value into table 1:

The p values have added to the table.

3. There is no information about participation rate of the parents in each Practice at each time point of questionnaire collection. The participation rate in interview can have significant impact on the results. The is no clear information that every parent who visited pediatric center during the time of the study was intervened or some selections were made (such can also have the impact on results.

Answer: We would like to thank the reviewer for this comment. While the research assistant attempted to interview every exiting parent, some parents may have been missed. It is unknown how many were not interviewed. This has been added to the Limitations section on page 14 with the text:

“While the research assistant at the practice attempted complete capture of all parents leaving the practice, some parents may have been missed; it is unknown how many parents exiting the practice were missed.”

4. The headings in table 2 are confusing. Shouldn’t it be ”Practice 1 (Control) 6 weeks post-intervention in Practice 2”?

Answer: Thank you for the suggestion. We have made the changes accordingly.

5. The introduction part need to be rewritten i.e. “currently few pediatricians “ is not informative and the percentages should be given.
Answer: Thank you for the recommendation. This has been reworded on page 3 to read:

“In a national survey conducted in 2006, less than 40% of smoking parents reported that their child’s clinician advised them to quit smoking [9].”