Author's response to reviews

Title: Educational outreach and collaborative care leads to improved services for Developmental Coordination Disorder

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Author's response to reviews: see over
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Dear Dr. Melissa Norton,

Reference: Educational outreach and collaborative care leads to improved services for Developmental Coordination Disorder

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We are pleased to be able to submit our revisions in line with the two reviewers’ reports for your continued consideration as an article in the BioMed Central journal in Health Services Research. We have addressed all of the major compulsory revisions, minor essential revisions, and have responded to the reviewers’ discretionary revisions. The reviewers’ original comments are repeated in colour with our response written below in black.

Reviewer: Brenda N. Wilson

Major Compulsory Revisions – NONE

Minor Essential Revisions

1. The number of children who were identified, and the fact that 76% of them received a diagnosis of DCD, is an impact which would be part of the "Impact Measurement" section. This is the first impact reported in "Results" but is not listed as a measurement.

   This addition has been made.

2. Could the figures on continued use of the materials be placed in table 3 (perhaps with a footnote about the 3 groups of physicians for this variable)? It may be easier to read than when in the text.

   We can not put the continued use of materials in Table 3 as this data was collected from physicians’ responses to a different questionnaire. We have attempted to clarify why the number of respondents varies across the different questionnaires.
Discretionary Revisions

1. The apparent usefulness of the self-selected educational outreach activities which the physicians participated in were reported in both the Results and the Conclusion, including their favourite tools and those they would use again. In addition, it was noted that the OT made 84 face-to-face visits: is this the same as "Small Group Discussion" on Figure 1? Or was this an additional component of Educational Outreach, or part of Collaborative Care, or an activity that developed spontaneously through the course of the project.

This has been clarified.

It would be interesting (but discretionary), either in the Conclusion or Results, to have a synopsis of the elements/tools of the program with notation of the ones which the authors felt were the strongest contributors to the success of the program and the development of greater knowledge and skill for the physicians.

This is difficult to respond to, as physicians had varied opinions regarding which tools were most valuable to their learning. Anectodatally, many physicians reported that the DVD depicting children with and without DCD demonstrating the screening activities was helpful. We have not included this; however, if the editor wishes this addition to be made, it can be done.

2. Similarly, were the authors aware of barriers to this program which were not necessarily measured quantitatively or qualitatively, but which they would consider if replicating this program?

To respond, this would require a statement which goes beyond the data collected systematically in the study.

3. The knowledge and skills gained by physicians were used to identify children who may have DCD, and to refer them for an OT assessment. For replication purposes, it would be useful to know:

- of the 64 children referred to OT, how many referrals were from physicians who received a face-to-face visit from the OT, compared to no visit (i.e., is this component a crucial part of the education plan?)

We have clarified that all physicians received a face-to-face visit from the OT.

- whether the time frame for 3 - 4 hours for the assessment, collaboration with the physician and consultation with the family was standard practice for community OT services in that locale, or if it generally takes more or less time (this speaks to generalizability).
We can not respond to this comment, as services in our locale vary widely depending upon the institution providing the service (e.g. hospital, community care, private services).

4. My last comment is purely personal preference, but I would prefer to have the Materials which were listed in the Appendix to be integrated in the text or Figure 1. If this is not preferred by you, it would be good to tie the names of the tools in the Appendix with the ones used in the text and the ones used in the figure, as they do not always appear to be the same.

This has been clarified in the text, figures and Appendix.

Reviewer: Deborah Dewey

Major Compulsory Revisions

Title: The title of the manuscript suggests that educational outreach and collaborative care lead to improved services for children with DCD. Although there is some suggestion in the focus group results that the educational outreach and collaborative care could lead to improved services, the main finding of the study was that educational outreach and collaborative care resulted in greater perceived knowledge about DCD among the primary care physicians that participated and greater confidence in diagnosing these children. Whether this would lead to improved services for children with DCD is open to question. Therefore, the investigators should change the title of this manuscript.

We have changed the title, in accordance with this recommendation.

Consistency in reported numbers: A second weakness relates to the lack of consistency in the reported numbers of physicians who participated in various parts of the study. For example, on page 10, the authors state that 84 participants received educational outreach only. This is not consistent with the number reported in Table 3 (n = 54). Further, on page 11 they report that 88 responding physicians reported that they would recommend the materials to their colleagues. In contrast, the data provided in Table 3 suggests that 87 physicians responded. The authors need to check the sample size numbers provided in the manuscript to ensure consistency.

We have clarified the fact that the differences between numbers reported is due to the difference between the number of physicians participating in the project and the number of physicians who took the time to complete the questionnaires. In effect, 84 doctors received educational outreach, but only 54 responded to the questionnaire reported in table 3. In addition, the number of physicians completing the questionnaires has been clarified throughout the text.
Minor Essential Revisions

Introduction: In the Introduction, the authors use the terms "manage DCD" and "effective management"; however, no operational definition is provided for these terms. How do/can physicians effectively manage DCD?

We have explained what effective management of DCD includes.

Statement at the top of page 4: The statement at the top of page 4 "they (physicians) have regular, ongoing contact with their young patients....." seems a bit "strong". In many cases, physicians have very limited and irregular contact with children and because of the limited supply of primary physicians in Canada, may children have limited or no access to a primary care physician. Any medical care that is needed is provided through emergency rooms or walk-in clinics.

We have revised this statement.

Page 5 (a): On page 5, in the section Study Design, it would be helpful if the investigators provide more detail on what the mixed method evaluation approach included.

This has been done

Page 5 (b): On page 5, the first time the term occupational therapist is used, they should include the acronym (OT).

Done

Page 7 (a): On page 7, in the first paragraph, the statement "The time for educational outreach varied, ...." should be moved to the previous section on Educational Outreach.

Done

Page 7 (b): On page 7, the authors should indicate the physician's role in the collaborative care provided to the child and the amount of time this required, in addition to the occupational therapist's role and time. The inclusion of this information will provide support to the fact that the children with DCD were provided collaborative care by an OT and physician and not just care by the OT.

The time for the physician's involvement in collaborative care has been added to the text.
Changing “skills” to “skill”: The authors should consider changing "skills" to "skill" throughout the manuscript when referring to the physician’s ability to diagnose DCD.

We have addressed this issue.

Page 8: On page 8, Results section, 147 participants should be changed to 147 physicians.

Done

Page 9: On page 9, the authors should outline the cut-offs used to identify children with DCD as the reference that they refer to is an abstract and may not be readily available to readers of this article.

We are presently documenting this information in a paper which will describe the children that the physicians identified in this research. However, a short summary type article, known as an “In Brief” article, containing pertinent information for the reader has been posted on the Canchild Centre for Childhood Disability Website – www.canchild.ca.

Page 10: On page 10, the authors state that the physicians that received educational outreach "reported much increased knowledge about DCD". This wording should be changed to "reported that they have knowledge about DCD" as the authors did not ask about increased knowledge but rather about knowledge of DCD.

Change has been made

Page 11 (a): On page 11, the authors report that 4 physicians attended the family medicine focus group and 13 attended the paediatrician focus group. On page 8, they reported that 9 family physicians and 15 paediatricians were invited to attend the focus groups. It might be more appropriate to move the information from page 8 to page 11. Further, it would be helpful to know why only 24 of the 33 physicians who participated in the collaborative care component of the project were invited to participate in the focus groups and if there were any factors that differentiated the physicians that decided to participate from those that chose not to participate.

We have explained that only those physicians who had completed the entire process of the study were invited to participate in focus groups and that those who declined attendance indicated a ‘lack of availability’ for the scheduled time of the groups.
Page 11 (b): On page 11, the first sentence of the second paragraph in the section on Focus Group Results is unclear.

The statement has been changed.

Discussion: In the Discussion, it should be noted that this study did not actually assess physicians’ increased knowledge of DCD. Rather, it assessed physician’s Perceptions in increased knowledge. Therefore, at the bottom of page 12 the authors’ should state “increase in reported knowledge and……”

Good comment. Done

Limitations Section: In the limitations section, the authors should consider some discussion of factors that could influence the differences noted between the physicians involved in only educational outreach verses those involved in collaborative care. Some possible confounders could motivation towards new learning, size or focus of practice, age of the physician, etc.

We have addressed this, through discussion of the possible self-selection factors which may have contributed to the differences between physicians involved.

Discretionary Revisions – NONE

Thank you once again for considering this submission.

We look forward to hearing from you.

Sincerely,

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Clinical Researcher and Speech-Language Pathologist
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