Reviewer's report

Title: Bridging the Care Continuum: Patient Information Needs for Specialist Referrals

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Reviewer: Christopher B Forrest

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1. General Comments
I was excited to see an article on information transfer that occurs during the specialty referral process. This is a critically important topic and is of interest to all delivery systems. Because of my enthusiasm for the topic, I have made a large number of comments that for the most part point out gaps in the presentation of the methods. It is hard to interpret this study without a more complete description of survey methodology, scale development and their application, measurement, a specific test of the study’s hypothesis, and a richer discussion. I would suggest thinking about the take home message of this work and driving towards that. The trust-information transfer hypothesis seems problematic to me, because a patient who trusts her physician may give him the benefit of the doubt if she cannot accurately recall the details being queried, rather than information transfer leading to an incremental gain in patients’ trust. Please also strengthen the rationale for the study and your review of the literature.

2. Major Compulsory Revisions
2.1. Methods, 1st paragraph: We need more information on the sampling frame and sampling methodology.

2.2. Please indicate that the study addresses specialty referrals for patients with chronic conditions. Many are not for chronic health problems. Also, could a chronically ill patient have been referred for an acute concern?

2.3. What is meant by “validating themes” with a focus group? What type of focus group methodology was used, and how was validity assessed?

2.4. How did the interview assess whether and when a specialty referral occurred? How much could recall bias affect your results? I suggest that you add the specific wording of these items and whether patients were excluded if a referral occurred before a specified interval (say 4 months). Lastly, how did you key the respondents in to responding about a single specialist? Was last specialist seen used?

2.5. Because this paper relies so heavily on the newly created instrument, I would suggest adding more psychometric information to this paper (perhaps an appendix?). I cannot interpret the data without knowing more about the
instrument. For example, what specific criteria were used to reduce the items? Why was a 3-factor solution superior to a single factor solution? You present a single alpha, but describe 3 scales. This is unclear.

2.6. If this was a random sample of the nation, why were over two-thirds reporting a family income below $40K? This is not nationally representative. It will be important in the discussion to address why this random sample differed so much from the US population.

2.7. Please help the reader understand how you formed the item pool. Did you perform a literature review, examine existing instruments, and conduct content validity assessments?

2.8. Tables 3a & 3b confuse me. I'm not really sure what the cells are measurements of. Seems like a labeling issue.

2.9. How was trust measured?

2.10. The choice of a regression model was surprising to me. The hypothesis stated in the introduction focused on the relationship between trust and information transfer, yet the regression presented in the results was for a continuity of care outcome. I think you should delete this and consider a model that tests your hypothesis, controlling for confounders.

2.11. I am unclear why you did not use scales rather than the items on information transfer. If you have developed scales and assessed their properties, it seems to me that the results could be presented much more lucidly by using them as opposed to the multiplicity of items. It is hard to tell a store with so many independent variables. Furthermore, if we believe that there is a latent trait regarding information transfer, we should always use the scale, because an item is an incomplete and therefore biased representation.

2.12. In the conclusions you state that PCPs do not realize the importance of information transfer. I strongly disagree. Do you have any evidence for this statement? It is far more likely that PCPs work within a delivery system that prevents them from effectively transferring patient data to their colleagues.

2.13. The references are not adequate. There is a solid literature on information transfer that the authors should review and reference.

2.14. More discussion on the study’s limitations is merited.

3. Minor Essential Revisions

3.1. I think adding a sentence or two to the abstract on how the patients were selected, the sampling frame, and how the survey was administered is an important clarifying addition to the summary of the study. Would also be helpful to indicate how recently the patients had “experienced a referral.”

3.2. Your opening sentence is a bit awkward. Do you mean that transitions occur as a result of changes in health status? I’m not sure I fully agree with this. I’d
suggest a stronger opening, something that can grab the attention of the reader.

3.3. In the final paragraph of the introduction, you state “we hypothesized that there would be a relationship between the quality of the preparatory information that patients received about a first visit to a specialist and their trust in both the referring and specialist physicians.” Perhaps you could consider rephrasing this sentence to indicate the directionality of the hypothesis and what is meant by “quality of information.” Does the latter refer to amount or specific types?

3.4. P5 – “quality of referral process” – I do not think your instrument examined the totality of the referral process. Perhaps you could use a more specific label for the overall concept. Also, I would suggest renaming the factor analysis to Exploratory Factor Analysis with Principal Axis Factoring. Lastly, the EFA was done to “extract” factors but to identify factors. Did you obtain the set of factors that emerged from the qualitative work or did the EFA yield new insights?

3.5. I was surprised to see no items in the self management scale on actual patient self management of their chronic condition.

3.6. State the type of selection used.

3.7. 1st sentence of conclusions (do you mean discussion?) may be misleading. I believe all visits to a specialist resulted from some type of referral, either self-referral or physician-referral. Perhaps your figure refers to 1st visits . . . . Please clarify.

4. Discretionary Revisions

4.1. Logistic regression as a stand-alone label connotes a binary outcome, so I think you can delete “binary” from your descriptive label.

4.2. Table 2 – 4 significant digits is unnecessary and gives a false sense of precision—1 should be enough.

4.3. You may want to link your study to the medical home “movement.”

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.