Author's response to reviews

Title: Primary care clinician preferences for working with a collaborative intervention team

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Author's response to reviews: see over
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Implementation Science

Dear Dr. Mittman,

We wish to resubmit the manuscript, “Primary care clinician preferences for working with a collaborative decision support team” for consideration for publication as a short report in Implementation Science. We have found the reviewers’ comments to be very helpful and have revised the manuscript considerably to reflect their concerns. Responses to the reviewers’ comments are below.

We have not published this manuscript elsewhere, and would be happy to make any further revisions necessary.

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Thank you for your consideration.

Sincerely,

Steven K. Dobscha, MD

Responses to Specific Review Comments—Reviewer #1

Major Compulsory Revisions

1. In general, I found the description of SEACAP too detailed. Though this survey was conducted as part of this study, the report itself is limited to clinician survey responses and therefore the references to the larger study should be limited. For example, the target enrollment and study period for SEACAP does not contribute to the topic of the report and the makeup of the SEACAP team appears to be unnecessary to this report.

Response: We have condensed the description of the SEACAP study, presenting only the information most relevant to the current objectives (p. 4).
2. The overall number of patients followed by the participating sites was not informative. Rather, it would be helpful if there was a fuller description of the sites at which the providers are located. For example, are these sites located in a specific area of the country or over several different regions? How large are the clinics? Though the author does note that clinicians are from 3 urban and 2 rural sites, how many were from each setting?

Response: We have included this information in the text on page 3 and 4.

3. I did not understand why information from non-intervention providers was reported since they did not complete the preference survey. This information should be deleted as well as the comparison between intervention and control clinicians since it is does not contribute to the primary or secondary objective of the study.

Response: We agree, and have deleted findings regarding the SEACAP control clinicians. We did note in the description of the sample (no longer in the results section) that there were no important differences between intervention and usual care clinicians.

4. Though a clinician's reporting that they wanted to cosign all intervention notes were positively associated with preference for telephone or pager communication and with being contacted before intervention team assessments, I couldn't find where the number of providers who reported these classifications was noted in the manuscript. Please include.

Response: These numbers are reported in the second column of Table 1.

5. Though the authors report that the level of priority placed by clinicians on skilled chronic pain management was positively correlated with preference for in-person communication, I could not find descriptive information concerning how the 21 clinicians responded to the questions presented in Appendix A. This would have been helpful in understanding the correlations described on pages 5 and 6. Please include.

Response: We have eliminated reporting on the associations among attitudes items and preferences (see response to second reviewer below).

Discretionary Revisions
1. Since the clinicians were from rural and urban sites, it would have been interesting to this reader if there were (or were not) differences in the reported preferences between the two settings.

Response: We have included this information in the manuscript (but note that the small number of rural PCPs limits the conclusions we can draw from this data).

Responses to Specific Review Comments—Reviewer #2

Major Compulsory Revisions
1. The title and abstract suggest a specific focus on clinician preferences for collaborative team interactions. The full paper also reports results for survey items
regarding satisfaction with pain resources, including correlation scores between these items and collaboration preferences. If the pain resource data are useful in understanding preferences regarding collaboration (the paper’s focus), this should be explained more clearly. If the pain resource data are not useful in understanding preferences for interaction, it seems best to exclude them from this paper (along with subject characteristic data for subjects in the usual care condition, whose interaction preferences were not surveyed). A decision regarding inclusion of Appendix A should be based on this assessment as well. If the data from the main attitude survey are not reported or used in the analyses, this survey should not be included in the paper.

Response: We appreciate this comment and have struggled with whether to report the attitudes information in this manuscript. We have decided not to report the attitudes information, since it contributes only marginally to the paper’s main findings, and reporting more comprehensive information about the attitudes findings would be beyond the scope, and main objectives, of this manuscript.

2. The level of detail provided in the two paragraphs presenting key results and in the subsequent single paragraph discussing the findings (opening with “Several findings are noteworthy”) is somewhat disappointing. Given the focus of the analyses (on preferences), additional analysis and discussion of variations in preferences, and in associations and possible determinants of variations in preferences, would enhance the value and contribution of the paper. The stated secondary objective of the study (“to examine associations among preferences and baseline attitudes regarding pain management, job satisfaction, and satisfaction with local pain treatment resources”) should also be considered in determining how to expand the presentation of results and discussion.

Response: We have revised the second objective, removing the exploration of associations of preferences with attitudes items. While striving to keep this manuscript in the form of a short report, we have also included additional information in the results section about differences in preferences by panel size, gender and whether the practice was rural vs. urban, and have expanded our discussion of these findings.

3. Additional discussion of implications would also be useful. A key conclusion (captured in the concluding sentence of the abstract) mentions the advantages of customizing coordination protocols to PCP preferences to improve PCP satisfaction, but fails to consider any adverse consequences of customization. It’s not clear whether bending protocols to PCP preferences is preferable to modifying PCP preferences to achieve PCP willingness to abide by an established, consistent coordination and communication protocol. Is standardization needed or useful? Does customization and variation entail any disadvantages?

Response: We agree, and have included information about these ideas in the discussion.

Minor Essential Revisions

1. The first sentence of the second paragraph (regarding previous surveys – references 11-16) requires clarification. Because clinician preferences for interacting with team members
would seem to be a central focus of attitude and satisfaction surveys, the first half of the sentence might be modified to note that several surveys have documented “selected” clinician attitudes and satisfaction (because they do not document the specific attitudes you are studying --preferences for interaction). The second half of the sentence could then be revised to state that the prior surveys do not examine “clinician preferences for interacting with other collaborative team members.” Any existing survey of clinician preferences would fall into the universe of surveys regarding clinician attitudes and satisfaction mentioned in the first half of the sentence. (The phrase “this study” in this paragraph might also be replaced by a phrase referencing “the focus of this paper” or the analyses reported in this paper. The paper reports a subset of data and findings from a larger study. Labeling the content of the paper using the term “this study” is potentially confusing.)

Response: We agree and have made changes in this section as suggested.

2. Several key terms used in the manuscript would benefit from clarification. Collaborative interventions: The term “interventions” has multiple uses in the implementation science literature, referring to clinical activities (treatments, care models) and implementation programs. The term “collaborative interventions” should be defined (or perhaps replaced by terms such as collaborative care models or care delivery approaches). The term “intervention team” could be replaced by “care team” to further clarify.

AND

3. The meaning of “collaborative interventions” is also uncertain based on the sentence in the opening paragraph of the paper referring to “productive interactions between patients and primary care clinicians” – implying collaboration between PCP and patient rather than collaborative by individuals comprising a multidisciplinary care team. The next sentence also fails to describe collaboration with a care team (“Collaborative interventions involve patient and provider activation and education, monitoring of clinical outcomes over time, decision support with feedback to clinicians, and modifications in information systems.”) This sentence describes the broader chronic care model rather than the collaborative care team component of that model.

Response: We appreciate these considerations. The term “collaborative care” is broad and somewhat vague, and can refer (depending on whom one is reading) to interactions between patients and clinicians and to interactions within a group of clinicians. We have rewritten the background section to attempt to address these issues. We have used the term “support team” to refer to the decision support team that consists of the care manager and chronic disease expert.

4. Preferences: The term “preferences” is used in an ambiguous manner in certain places. The abstract states “preferences of clinicians for working with collaborative intervention teams” – implying that the paper examines whether clinicians prefer to work with (or within) a team vs. alone. Yet the analyses clearly indicate that working within a team is given: the specific focus of the survey and analyses is preferences regarding specific aspects of interacting with a team (e.g., setting, frequency, mode of interaction). This should be stated as early as possible (in the abstract and an opening paragraph of the paper).
Response: We have modified the manuscript in several places to make this clearer.

5. **Clinicians**: Does the term “clinicians” refer to all clinically-trained members of the team, or only the primary care providers (MDs, PAs/NPs)? The study examines PC provider preferences, but it’s not clear whether your statement in the abstract regarding published research refers to research on PC provider preferences only, or other clinicians’ attitudes as well. The phrase “41 of 42 participating clinicians” (and others using “clinicians”) could use the term “PCPs” or other abbreviation or term to indicate primary care providers and avoid ambiguity.

**Response**: We have used the term PCP to distinguish primary care providers from other members of the care team throughout the manuscript.

6. **Although your preferences may differ from mine, I find the Research Article structure (Background, Methods, Results, Discussion) preferable to the Short Report structure -- and I favor use of a structured abstract (Background, Methods, Results, Conclusions). If agree with my preferences, please insert the appropriate headings in your revision.**

**Response**: We agree, and have made these changes in format.