Author's response to reviews

Title: Part II, Provider Perspectives: Should patients be activated to request evidence-based medicine? - a qualitative study of the VA Project to Implement Diuretics (VAPID)

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Author's response to reviews: see over
September 4, 2009

Brian Mittman, Editor-in-Chief
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Dear Dr. Mittman:

We greatly appreciate the opportunity to revise and resubmit our manuscripts, 1) “Part I, Patient Perspectives: Activating patients to engage their providers in the use of evidence-based medicine: a qualitative evaluation of the VA Project to Implement Diuretics (VAPID),” (MS#: 1344534079247213) and 2) “Part II, Provider Perspectives: Should patients be activated to request evidence-based medicine?: a qualitative study of the VA Project to Implement Diuretics (VAPID)” (MS#:1362923924720769) to Implementation Science for consideration for publication. We appreciate the time and effort you and the reviewers have put into our manuscript and believe that it has improved because of it.

Please find attached our responses to the reviewers’ comments. We have revised each paper to complement each other with the thought that the patient paper would be listed first.

We feel the revisions have greatly strengthened the papers. We believe the revised manuscripts contributes to the broader literature on the implementation of patient-activation interventions, particularly as they allow for a comparison of two stakeholder groups—patients and providers. Although we recognize its limitations, we feel that the iterations have made this a manuscript that meets the high standards of your journal.

Thank you for considering this resubmission.

Sincerely,

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I. Major Compulsory Revisions

1) The objective of the authors was to understand the effectiveness, barriers to, and acceptability of the intervention, as well as the suitability/acceptability of patient-activation for more widespread guideline implementation. These study questions were not well framed because the introduction did little to set-up the study question. The first paragraph contains some extraneous background and relied on mostly old references. While the problem of uncontrolled hypertension remains, it is a much more targeted and nuanced problem nowadays in VA. The article by Eve Kerr in Ann Intern Med (May 2008) and the accompanying editorial by Phillips and Twomboy provide a much more current framework.

Response: We appreciate the reviewer’s comments concerning the introduction, and the section has undergone significant edits. The revised first paragraph focuses more clearly on the problem of hypertension, and the framework for the problem has been updated. The paper by Kerr and editorial by Phillips and Twomboy are helpful in this context, and contributed further to the revised discussion concerning the effectiveness of the intervention. The remainder of the introduction has been revised to more clearly connect the problem of uncontrolled hypertension to both interventions targeting the problem and the specific study questions we address. These changes are explained further in subsequent responses.

2) The third paragraph of the introduction does describe potential uses of qualitative methods following a clinical trial. However, this description is not specific to the VAPID study. Why do the interventionalists believe they need a qualitative description of the trial’s success? What aspects of the primary study results are poorly understood or need additional clarification?

The need for a qualitative evaluation in this specific study has now been addressed explicitly following the fifth paragraph of the introduction. We hope that the questions posed in the revised text better frame the evaluation and its value in this context.

(Starting on page 6, para 1) “While trial data show increased discussion and prescribing rates, the limitations of these measures and a paucity of similar research leaves unanswered questions concerning the process, acceptability and wider suitability of the intervention among providers:

(1) What factors or elements of the intervention process facilitated or prevented changes in prescribing behavior? Which of these were unique to this intervention, or might be modifiable? Replication and future adaptation require an understanding of these factors and their context and consistency within the intervention, and failure to detect differences between implementation as planned and as practiced reduces the utility of outcome data. [28]

(2) How acceptable was the intervention to providers as stakeholders whose cooperation would be necessary for broader implementation? Evidence suggests implementation strategies may not be widely accepted or adopted by providers who feel their decision latitude is unnecessarily diminished [24,29-31]. What were provider attitudes towards this intervention that attempted to alter their decision-making by targeting the patient or “consumer” directly, and how would they feel if it were implemented more broadly or applied to other aspects of care?
These questions were addressed through semi-structured interviews of participating primary care providers, complemented by patient perspectives reported in a companion article. We report here results on (1) how the intervention created or facilitated changes in the prescribing behavior of participating providers; (2) what barriers may have prevented changes in prescribing behavior; and (3) how acceptable providers found the intervention strategy and its various components. From these and complementary patient results, we also hope to inform a broader understanding of the suitability of patient-activation strategies to implement guidelines on a larger scale, for other therapies, and in alternate settings.”

3) The methods lack significant clarity.

a) How were the questions in the interview guide developed and refined? Did it evolve with subsequent interviews? If so, how? How do the individual questions map to the study aims?

Response: We added text in the methods section to better clarify how the interview guide was developed. In addition, the study aims are listed in the methods section and map onto the interview questions provided in the appendix.

(page 8, para 2) “A semi-structured interview guide was used, with open-ended and probing questions designed to elicit information relevant to effectiveness, acceptability, and wider applicability of the intervention, the main research questions for the qualitative provider sub-study (See Appendix). The interview guide was revised as new content was incorporated from previous interviews; however, the revisions of the interview guide primarily focused on clarification of questions and adding additional probes.”

b) What was the sampling strategy for recruitment?

Response: We appreciate the reviewer’s question because we did not realize we had not fully described the sampling procedures. We randomly sampled providers from each site who had seen at least 4 patients who brought in letters to insure we talked with providers who had experience with the intervention. We have now clarified this in the methods.

(page 8, para 1) “Telephone interviews were conducted with 21 providers who participated in the intervention at the Iowa City and Minneapolis Veterans Affairs Medical Centers (VAMCs) and four community-based outpatient clinics (CBOCs). The providers were purposefully sampled by site. To increase the likelihood they experienced the intervention, the sample also was limited to the 55 (30 from IA and 25 from MN) providers who had seen at least four intervention patients. From this sample, providers were randomly selected and emailed a formal request letter, followed by a reminder phone call after two weeks, if necessary. The recruitment process continued until data redundancy was reached and approximately equal numbers were recruited from each site (n=10 IA; n=11 MN). Forty-one providers in total were emailed.”

c) It is difficult to follow the difference between the process of developing a coding system and the process of applying the coding system. Was a standardized qualitative method use for these processes?

Response: The coding process was based on the anthropological training of two of the authors (CB, HSR)—best described by Agar (1996) in The Professional Stranger. In addition, the initial
coding process most closely follows the description of the editing approach in Crabtree and Miller (1999). We have made changes/additions to the methods section to clarify the details of this process on page 9, paragraph 1.

d) How many interviews comprised “the first set”? What was the degree of agreement (Kappa score or %agreement) of the initial coding? What was the process of reaching consensus? More detail is needed regarding the differences in coding for the remaining transcripts. Doesn’t seem appropriate that only one coder was involved. There is mention of “a sample of these transcripts” being coded by two others…how many? What was the agreement with the primary coder? How were differences adjudicated?

Response: We clarified that there were six transcripts in the initial set used to develop the codebook and that 3 transcripts were then coded to test the codebook. We did not formally measure agreement through quantitative reliability analysis, but in reviewing the consensus process it was clear that there was strong agreement between coders. However, since we did not measure agreement, we now only discuss the how we resolved disagreements. The consensus process is described more fully in the paper. In the anthropological tradition it is common for one coder to complete the coding of transcripts.

(page 9, para 1) “Initial analysis of the first six transcripts was conducted by three study team members (CBD, HSR, MBW) who developed a coding template based upon the research objectives, interview guide, and interview content. The coding template was used to conduct a thematic content analysis for all interviews, with content codes assigned to categorize passages. The next three interviews were then independently coded for content themes to test the codebook. In cases where coders disagreed, differences were discussed until consensus was reached. Consensus involved the discussion of disagreements among interviewers, including where the coding of passages should stop and start, passages a coder did not mark, or the removal of a code from a particular passage. The consensus process served to increase the validity and reliability of the codebook by refining the content boundaries of the codes and making coding more consistent. The final consensus was then entered into NVivo 8, a software package for qualitative data management and analysis [38]. The remainder of the 21 total transcripts were content coded by the first author (CBD).”

e) How did the code key and coding system evolve? And how was re-coding performed? How was thematic saturation determined in this context?

Response: Interestingly (and uncharacteristically), the codebook evolved very little from its original development. Considerable efforts were made during the development of the codebook to try to make it comprehensive, and thematic saturation (or data redundancy by theme) was found to be highly consistent. Only two to three codes were added over the course of the thematic coding. The main coder did return to previous transcripts when a new code emerged, but this was an infrequent occurrence. In addition, the content of most of the thematic categories was consistent so it was determined no additional interviews were necessary. 21 interviews were conducted to balance the number of providers by site, but saturation was reached for almost all of the codes after 12-15 interviews had been completed.

4) Need more descriptive information of the study sample (i.e., a table 1), including any information about non-responders.
Response: A Table 1 with available information about responders and non-responders has been added to the manuscript and referenced in the methods section.

(page 8, para 1) “Forty-one providers in total were emailed. Of those, thirteen providers did not respond to emails or phone calls, four declined, and three were unable to schedule time during the study period (Table 1).”

5) The discussion is well-balanced and supported by the data. However, I felt that it did not do an adequate job of explaining the findings, rather it was more just a restatement of the results. For qualitative papers, the discussion sections need to put the results into some larger context. What was striking to me is that the intervention seemed to do little more than act as an availability heuristic. There was not much complexity to it at all. The findings that the incentive and telephone prompt did little is not surprising if one takes into account the simplicity of the providers’ comments. The providers’ concerns about the incentives is a distraction to the main point of the paper. Furthermore, it seems to me that the intervention was not a patient-activation intervention but rather a "patient-requests" intervention, again an availability heuristic generator. Rich Kravitz has written eloquently about the power of patient requests (Kravitz et al. HSR 2002 and Kravitz Med Care 2002) and that work could provide further context for this study’s findings.

Response: The discussion has been significantly revised to contextualize the results more thoroughly. The results describing the process of the intervention have been related more clearly to hypertension and clinical inertia.

(page 26, para 2) “Uncontrolled hypertension may have been particularly well suited to this patient-activation intervention and the ways providers described the intervention as facilitating change. Few providers indicated that the intervention provided them with any new information about thiazides, supporting previous evidence that the gap between evidence and practice in the case of hypertension management is more a matter of clinical inertia rather than provider knowledge [4,5,10,11]. These studies suggest that two primary contributors to clinical inertia—or failure to initiate or intensify therapy when indicated—may be clinical uncertainty and competing demands. It is possible that this intervention helped to overcome clinical uncertainty by providing a sort of confirmation that treatment would be appropriate, particularly for those cases in which providers described the intervention acting as a ‘reminder’ or highlighting ‘oversights.’ The targeted, personalized information contained in the letter, the presentation of the letter in clinical appointments, and the source of the letter could all have played a role in reinforcing for providers the certainty of the indication for treatment with thiazides. Further, providers’ description of the intervention as ‘aligning’ patient and provider ‘priorities’ suggests the intervention reduced competing demands within the consultation, focusing the discussion on an asymptomatic condition that may otherwise be superseded by more acute or symptomatic concerns.”

Response: The results on the process and value/acceptability of the intervention are further contextualized by discussion of patient requests and concordance.

(page 28, para 2) “This sort of informed patient participation has been increasingly advocated [51-57], and improved patient-provider concordance—or decision-making based on shared information and negotiation—may improve medication adherence and satisfaction for many patients [49,58]. Though providers emphasized the value of the discussions the intervention
generated, the degree to which the prescribing decisions were shared in this case is not fully apparent from the interview data. The results do suggest that the satisfaction of providers with the discussions generated in this intervention is related at least in part to the selection of appropriately indicated patients and the focus provided by the intervention letter. Such targeted patient-activation may prove more widely useful in both generating informed discussion and targeting it to improve patient-provider concordance.”

Response: We especially appreciate the reference to the literature on patient requests, and it provided a useful context for better understanding the results. Interestingly, as we point out in the discussion, only one provider responded that a patient actually requested to be prescribed a thiazide.

(Starting page 27, para 1) “At the same time, some potential concerns about the process and acceptability of this intervention surround the patient-initiated approach to initiating changes in provider behavior. Patient-initiated demand for services often take the form of specific requests, and such requests have been found to have a significant effect on providers’ clinical decisions [41-43]. However, requests can consume limited consultation time and be perceived as demanding by physicians, while failure to fulfill a request, even when the requested service is not indicated, can threaten patient satisfaction and trust [41-43]. Of particular concern have been requests for potentially inappropriate prescribing or other improper or unnecessary care generated by the advertising techniques adopted for patient-activation [33,44-51].

Interestingly, however, only one provider interviewed responded that a patient had specifically requested to be prescribed a thiazide, and the vast majority instead described patients as initiating the discussion with a question about thiazides or presenting the intervention letter simply as a task they were to complete. Perhaps correspondingly, provider responses suggest there was little if any pressure to prescribe or sense of dissatisfaction or mistrust from patients if the provider decided a thiazide was not appropriate. A study of patient perspectives of the intervention found patients described their interactions with their providers in similar ways [34]. Given the efficacy of the intervention, it seems the letter and prompt for discussion preserved some of the positive influence that can be generated by a patient request without the pressure that could be viewed as negative. This suggests that, while the intervention was intended to create a specific demand for evidence-based therapy, there may be value in designing interventions that focus more on generating specific discussions rather than patient demand.”

Response: We appreciate that the discussion on financial incentives is somewhat distinct from the focus of this paper, and the role of incentives is actually being addressed in a separate manuscript, which is under consideration at the Journal of General Internal Medicine. However, we have retained a brief discussion of incentives (page 30, para 3), as it was the most common ‘negative’ expressed by providers, and thus we feel it is important to acknowledge this concern in the results we are reporting in order to provide a balance account of provider reactions to the intervention.

6) An important limitation that is left out is social acceptability bias. The recruitment strategy, the inability to blind participants, and the questions in the interview guide cannot avoid this limitation. It probably curbed the interviewer’s ability to ask more probing question about why the patient requests were so powerful despite the fact that providers claimed to know about the appropriate guidelines and evidence-based actions.
Response: This is an excellent point, and this limitation has been added to the discussion.

(page 31, para 1) “Finally, a social desirability bias may have influenced the interviewers’ behavior and hindered them from explicitly asking providers why they were not prescribing thiazides (even though they stated that they understood the guidelines). Such an influence could have interfered with gaining a better understanding of why the discussion with patients prompted such an even greater increase in prescribing.”

II. Minor Essential Revisions

7) The second paragraph of the introduction could do a better job of a) defining “patient-activation” and b) describing the elements of patient activation that comprised the VAPID intervention, and c) relating those elements to the general conceptual model of patient-activation. This would better set-up the aims, results, and discussion on this topic.

Response: The fourth paragraph of the revised introduction now more clearly describes “patient activation” as the adoption of social marketing and direct-to-consumer advertising techniques to motivate patients to undertake a specific, suggested action. An example has also been added for clarification. We then describe how patient-activation was adopted in the context of the intervention. A more complete definition and description of “patient activation” appear in a companion paper that describes the patient perspectives from the intervention trial. This companion article will precede the provider article. Also, additional details about the “activation” process are outlined in the methods section of this paper.

(page 5, para 2) “Patient activation” uses the techniques of social marketing and direct-to-consumer (DTC) advertising to motivate patients to undertake a suggested action [21]. For example, printed materials may be designed to educate patients with a chronic disease in a manner specifically focused on motivating exercise or self-management [22,23]. As a guideline implementation strategy, the techniques of patient activation have been attempted only on a limited basis, and while not rigorously evaluated, have thus far shown mixed success [22,24-26]. Our study follows what was, to our knowledge, the first randomized-controlled trial of a patient-activation intervention to improve adherence to clinical practice guidelines. In this trial patients were provided with tailored information about their blood pressure, including risks and appropriate therapy, framed as motivation to pursue a suggested action: discussing the information with their providers. The intervention was successful in prompting both high patient-provider discussion rates and a significant increase in guideline-concordant prescribing [27].”

8) In the results section, the quotes on “influence on prescribing behavior beyond the intervention” do not appear very novel. There are many prior qualitative and quantitative studies on this topic. The same is true about the “sources that inform prescribing behavior” section.

Response: While other studies show that the influence of interventions can disseminate beyond the target group of participants, we nonetheless believed it was important in this case to include these data, as it does show that, in this specific patient-activation intervention, there was for many providers a conscious carry-over from the discussions with intervention patients that affected their care of other patients not targeted for intervention.
We also appreciate that results on the ‘sources that inform prescribing behavior’ aren’t necessarily novel, but we believed that these data are important, as they show that for these specific providers that we interviewed (as with others considered in studies focused specifically on this topic), sources are disparate. The scope of the study was certainly not to catalog or rank every source, and we don’t believe these data offer novel insights into sources that typically inform prescribing behavior, but it does allow the point that while the providers we interviewed draw upon disparate sources, patients are a common ‘source’ through whom information can be directed. We believed it would be better to include the data that suggests such disparate sources for the providers we interviewed, rather than generalizing from previous studies. That said, we also understand that these results may appear tangential to the focus of the manuscript, and we would be willing to remove them if the editor prefers.

9). The findings about aligning priorities would benefit from a discussion of the literature on “concordance.” Reference #50 by Pollack is an example but the discussion really doesn’t pick up on this broader literature.

Response: We agree with the reviewer, and discussion of concordance has been incorporated to contextualize these findings, as described in response to comment #5 (revision on page 28, para 3). We refrained here from anything too extensive as the literature on concordance is focused on several ideas that the results from the companion patient paper speak to more clearly.

10). An addition, the recent work by Kevin Volpp (NEJM 2009) on the power of patient-directed financial incentives would be helpful in putting into context the results on incentives in the current paper.

Response: While we retained some discussion on incentives, the results from the provider interviews that pertain to the use of incentives are limited, with just a few providers mentioning their use as a possible negative. Thus, we believe that broader discussion of the impact of financial incentives is beyond the scope of this paper. As discussed after comment #5, however, the broader results on the efficacy of financial incentives will be addressed elsewhere, and we believe the work by Volpp will be helpful in that context.

III. Discretionary Revisions

11) Descriptive differences between physicians versus PA/NP would be interesting to know.

Response: Major themes were consistent between physicians, PAs, and NPs. However, we agree that if more interviews were conducted with each, it would have been interesting to compare and look for more subtle differences that could have emerged.

12) The overall description of the results is good. One minor point is that sometimes it was difficult to separate quotes from themes or authors’ comments; therefore it would be helpful to indent, use italics, or other methods to distinguish the quotes.

Response: We appreciate this comment, and have attempted to highlight this distinction within the bounds of the formatting rules of IS.
Reviewer 2: Derjung Tarn

This is a well-written article that provides interesting information on provider attitudes toward a patient activation strategy in which hypertensive patients received incentives and letters to discuss the use of thiazide diuretics with their providers. The study demonstrates that the intervention strategy was an effective reminder to consider prescribing a thiazide, and was acceptable to the providers interviewed at the end of the study. Data on patient views about initiating discussions with their providers would have greatly enhanced the study.

Response: We agree, and have therefore included data on patient views in a companion article also submitted to IS.

- Major Compulsory Revisions

1) The authors present some interesting findings, but may consider tempering some of their conclusions. The major limitation of the study is the fact that only half of the providers with patients in the study were interviewed. The authors acknowledge this limitation in the Discussion section, and state that these providers may have had more negative views of the study. In light of this, it seems that the conclusion that the intervention was “highly acceptable” to providers may be overstated.

Response: This is a very fair point, and the conclusions have been tempered in response to the reviewer’s comments.

(page 32, para 1) “Patient-activation was not only effective at implementing thiazide diuretics, but provider interviews suggested it was also acceptable in the context of this intervention, and could be similarly acceptable if utilized for broader implementation efforts. The effects on prescribing behavior were facilitated in some ways unique to patient-activation, and providers did report valuing the changes in patient care prompted by the intervention, but they focused much more on the value of patient-activation itself and the interest and discussions it generated. This emphasis suggests that the benefit of the intervention was not limited to its effects on prescribing behavior, but rather included facilitating a more mutually informed and focused clinical encounter.”

2) Similarly, the authors conclude that the patient-activation intervention “strengthens the provider-patient interaction,” but there is no evidence of this in the manuscript. Data on positive physician feelings about their relationship with the patient were not presented, though some of the providers interviewed expressed some concern that the intervention might undermine provider trust. While the provider-patient interaction could have been strengthened by the interaction, it also is difficult to draw this conclusion without knowing the patient’s viewpoint. If the authors want to discuss the relationship between patient requests and satisfaction with the visit, they might consider citing some of Kravitz RL et al’s work on request fulfillment.
Response: We appreciate this comment, and it points out a poor choice of wording on our part. As the reviewer stated, our data do not suggest ‘positive feelings;’ rather, they suggest that providers felt that the intervention was an appropriate means of informing patients and prompting/guiding the discussions that were initiated. We have revised our conclusions to more clearly relate this.

(page 32, para 2) “Patient-activation shows potential as an implementation strategy that may not only reinforce existing evidence or guidelines, but may also initiate and guide patient-provider discussions with the potential of ‘aligning’ the priorities of patients and providers. Patient-activation should be tested as in implementation strategy in other areas of evidence-based medicine.”

Response: The viewpoints of the patients will be reported in a companion article, but even with those, it is difficult to draw the conclusion that the patient-provider interaction is ‘stronger.’

Finally, we appreciate the reference to the work on patient requests, and our discussion has incorporated this literature to provide a better context for our results.

(Starting page 27, para 1) “At the same time, some potential concerns about the process and acceptability of this intervention surround the patient-initiated approach to initiating changes in provider behavior. Patient-initiated demand for services often take the form of specific requests, and such requests have been found to have a significant effect on providers’ clinical decisions [41-43]. However, requests can consume limited consultation time and be perceived as demanding by physicians, while failure to fulfill a request, even when the requested service is not indicated, can threaten patient satisfaction and trust [41-43]. Of particular concern have been requests for potentially inappropriate prescribing or other improper or unnecessary care generated by the advertising techniques adopted for patient-activation [40,44-51].

Interestingly, however, only one provider interviewed responded that a patient had specifically requested to be prescribed a thiazide, and the vast majority instead described patients as initiating the discussion with a question about thiazides or presenting the intervention letter simply as a task they were to complete. Perhaps correspondingly, provider responses suggest there was little if any pressure to prescribe or sense of dissatisfaction or mistrust from patients if the provider decided a thiazide was not appropriate. A study of patient perspectives of the intervention found patients described their interactions with their providers in similar ways [34]. Given the efficacy of the intervention, it seems the letter and prompt for discussion preserved some of the positive influence that can be generated by a patient request without the pressure that could be viewed as negative. This suggests that, while the intervention was intended to create a specific demand for evidence-based therapy, there may be value in designing interventions that focus more on generating specific discussions rather than patient demand.”

3) In the Data Analysis section, the authors state that “Initial analysis of the reviewed transcripts was conducted by three study team members.” Did the three study team members review all of the transcripts or just a subset of them? If just a subset, how were those transcripts chosen and how many were there? The authors also state that the “first set of completed interviews was also independently coded for content themes.” This is somewhat unclear. Did the authors pick out a set of interviews to code, and if so, how many did each author review independently?
Response: We clarified that the initial analysis was conducted by three study team members on transcripts from the first six interviews. The next three interviews were then each independently coded by each of the three study team members in order to test the codebook. The remainder of the interviews were coded by the first author. As noted in the response to the first reviewer, the coding process was based on the anthropological training of two of the authors (CB, HSR). As described by Agar (1996) in The Professional Stranger, it is customary in this tradition for coding to be conducted by one coder.

(page 9, para 2) “Initial analysis of the first six transcripts was conducted by three study team members (CBD, HSR, MBW) who developed a coding template based upon the research objectives, interview guide, and interview content [35]. The coding template was used to conduct a thematic content analysis for all interviews, with content codes assigned to categorize passages [36,37]. The next three interviews were then independently coded for content themes to test the codebook. In cases where coders disagreed, differences were discussed until consensus was reached. Consensus involved the discussion of disagreements among interviewers, including where the coding of passages should stop and start, passages a coder did not mark, or the removal of a code from a particular passage. The consensus process served to increase the validity and reliability of the codebook by refining the content boundaries of the codes and making coding more consistent. The final consensus was then entered into NVivo 8, a software package for qualitative data management and analysis [38]. The remainder of the 21 total transcripts were content coded by the first author (CBD).”

- Minor Essential Revisions

1) In the Data Analysis section, the authors might consider explaining the process of “matrix coding” in more detail.

Response: The description of this process has been revised and clarified by providing an example of how the coding was used.

(page 9, para 1) “Two coders (CB, MW) conducted matrix coding of passages categorized by thematic content to identify specific provider responses and the distribution of provider opinions [39]. For example, passages from each provider that were coded “opinion of intervention” were independently classified by each coder into the discreet categories of positive, negative, neutral, or unknown; disagreements were adjudicated by a third coder (HSR) who acted as a tiebreaker.”

- Discretionary Revisions

1) Is there information on the specialties of providers who chose not to participate in the study? This probably is beyond the scope of the study, but it would be interesting to see if the rates of discussion / prescriptions varied among those interviewed and those who were not.

Response: We have included a table with characteristics of responders and nonresponders, but unfortunately we did not collect information regarding specialties of providers although all clinicians practiced in a primary care setting.

2) Did the providers receive an incentive to participate in the interviews?
Response: The providers did not receive any incentive to participate in the interviews.

3) Did the authors reach saturation in their coding process?

Response: Consistent themes emerged quickly in the coding process, and thematic saturation was reached quickly, within 12-15 interviews.