Reviewer’s report

Title: The Improved Delivery of Cardiovascular Care (IDOCC) through Outreach Facilitation: study protocol and implementation details

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Reviewer: Zsolt Nagykaldi

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Reviewer Comments:

“The Improved Delivery of Cardiovascular Care (IDOCC) through Outreach Facilitation: study protocol and implementation details”

(Implementation Science - Version 2)

This is a large-scale, cluster-randomized, stepped-wedge clinical trial to evaluate the impact of practice facilitation on the delivery of cardiovascular care in primary care practices located in nine divisions of the Champlain Local Health Integration Network (LHIN) in eastern Ontario, Canada.

Strengths of the publication:

1) Although there is a growing literature on practice facilitation, the study has the potential to bridge a significant gap pertaining to the impact of practice facilitation on the delivery of cardiovascular care and also other types of care which have not yet been investigated via rigorous and generalizable experimental trials (large RCTs).

2) The stepped-wedge design is innovative in primary care research. The authors outline a systematic (step-wise) methodology and a thoughtful approach that could be cost and time-saving. In particular, the multi-method study could elucidate some of the reasons for potential differences in outcomes between groups (qualitative arm), in addition to the effect of the intervention (quantitative arm). The authors also seem to take care to triangulate findings from these domains.

3) The topic and research approach have significant relevance to primary care practice and it is likely that outcomes and lessons from this study can be transferred to other settings.

4) The paper is well written and presents ideas in a clear, logical, and concise manner. The research methodology and analyses are sound and appropriate for measuring the proposed outcomes (practice level quality of care composite scores, change of proportion of patients at target level and the narrative of the practice transformation process) that are immersed into the widely accepted chronic care model and system change via outreach facilitation approach. Patient clustering has been addressed in the design and analyses.
Weaknesses of the publication:

1) The study has several minor, but considerable limitations, in addition to the ones discussed by authors, that have not been fully acknowledged. Several important elements of practice facilitation need to be addressed. These include:

a) the importance and methods of relationship building between facilitators and participating practices;

b) steps taken to build functional practice teams before attempting to redesign practice systems that may not necessarily have a functioning practice team;

c) clarifying academic detailing as not only “audit and feedback”, but a step that includes an introductory visit by a respected community leader peer-clinician (often academic), who puts the project into the perspective of current clinical evidence and establishes trust and acceptance between clinicians and facilitators.

2) The manuscript is not clear about the methods of implementing clinical practice guidelines in practices, a critical area in translational and implementation studies. Are these guidelines available only on paper or as electronic documents via the web? Was there any attempt to provide computerized point-of-care clinical decision support? What do facilitators do to help practices put these often complex and contradicting guidelines into daily practice, making them usable and valuable for point-of-care shared decision-making? Similarly, how was the implementation of recall / reminder systems and patient registries facilitated? What happened in practices with existing electronic medical records?

3) Although the stepped-wedge design is an intriguing possibility in primary care, it is more ideally suited for relatively short interventions, where the impact can be determined in a timely manner. Most primary care practice improvement projects take a considerable time when less usual types of confounding factors, such as change in health care policy, economic climate, clinical practice, etc., can also modify the environment in which the sequential interventions are delivered. This could be, perhaps, considered in the paper.

4) Minor suggestions: please use the word “preventive” instead of “preventative”. Please describe if there is an estimate for the frequency of various services that are delivered, but NOT documented in patient charts (although could be obtained from alternative sources) and how lack of documentation may potentially impact the study. Was there some financial compensation / incentive for practices? If not, did this have an impact on participation? Although the level of analysis is the patient, there is a fine, but firm distinction between practice-level process outcomes that the study is aiming at and patient-level (i.e. personalized) health outcomes which could be underscored somewhat more when authors talk about “patient-centeredness” in the context of the study.

Level of interest: An article of outstanding merit and interest in its field

Quality of written English: Acceptable
Statistical review: Yes, and I have assessed the statistics in my report.

Declaration of competing interests:

I have no conflicts of interest.