Author's response to reviews

Title: Implementing a stepped care approach in primary care. Results of a qualitative study.

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Author's response to reviews: see over
Concerning:

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‘Getting a grip on depression’: implementing a stepped care approach in primary care. Results of a qualitative study.

Dear Editor,

Please accept our revised manuscript, in which we have addressed the comments of the editorial team, as well as those of the three referees.

In this letter we provide you with a point-by-point response to the concerns. Overlapping comments have been bundled.

We believe that the comments of all referees and the editing team were very useful and have helped us to improve our manuscript. We want to thank the individuals who invested time and energy on our document, and hope to have provided you with an adequate revision of the text.

On behalf of the authors,

Gerdien Franx
Editor’s comments

Concerning the general comment about the character of the study, we have clarified this throughout the manuscript by adding information about the context of the study. The study concerns a process evaluation of an intervention aiming to implement stepped care for depression. The implementation intervention consisted of a depression quality collaborative. Outcomes in terms of improved professional performance, clinical improvement and costs have been studied in a controlled study (reported elsewhere). Because the (positive) outcomes have not yet been published, we can not reveal them in detail at this moment. Instead we referred to a publication based on an observational evaluation of the quality improvement data gathered within the Collaborative.

1. The title of the manuscript has been changed into: Implementing a stepped care approach in primary care: Results of a qualitative study.

2. The English grammar has been improved by an English native speaker, except for the quotations, that could be re-worded as well.

3. The conclusion of the manuscript has been adapted.
1. It is not clear whether the qualitative study relates to the implementation of the stepped care model or the QIC. It is hard to see what they constitute as the 'intervention' and what constitutes drivers of change in up-take of the intervention.

   In the background and method sections (study design), we have clarified the study: a qualitative process analysis related to an implementation intervention, which was studied in a controlled design. The qualitative study aimed to document the way in which the intervention was received and implemented and the factors associated with reception and implementation.

2. The use of NPT requires more consideration - the explanation of NPT is too brief to understand what it is and how to apply it. How does the NPT theory work - do all mechanisms need to be in place for success or can there be partial achievement and non achievement on some? Did this theory guide the analysis of offer a helpful way to interpret findings?

   In the background and method-analysis sections we have explained why we chose to use NPT. The NPT-constructs were used in the end of the analysis, as sensitizing concepts that help to interpret the findings and create a more in-depth understanding. The function of NPT has thus been to provide another layer to the findings.

3. The descriptions of cognitive participation (reaching and agreement on
interventions and becoming familiar with others skills (team meetings to discuss roles and tasks) seem too similar. Some aspects of cognitive participation could also be described within ‘coherence’ which is about shared understanding. Engenders a feeling that the data may be being shoe horned into the theory. It is also important to distinguish whether NPT mechanisms are providing insight into stepped care or the QI program.

*In the methods (analysis) section we checked our description of the different constructs. We then checked the results section and table 2 to see if we had applied the constructs appropriately. This resulted in one adaptation of the table. In the discussion section we adapted the paragraph in which we discuss the NPT-constructs, by trying to balance our comments of NPT. We think that the four constructs have made us sensitive to certain processes, but agree that some were difficult to separate and also that other factors influencing the implementation process may be lacking.*

4. Results: It is important to identify the participant type and not the team in presenting data. The importance of the extracts lies in the different viewpoints of different professional groups.

*The aim of the study was to capture the teams’ perspectives on the implementation of stepped depression care. This is the reason why we performed team interviews. Although the intervention mainly had implications for GPs, the quotations correspond to a view shared across disciplines, unless stated differently. We included this point in the methods (analysis) section.*

5. There are many instances when the mechanisms for implementation are not achieved or are problematic - and yet we are given no summary of whether all
projects were successful in implementing stepped care or to what extent. And
could it be successful for individual practitioners, and not successful for others in the
same location.

In the introduction we provided information on the positive findings of the
observational data, and argued that a comprehensive presentation of the quantitative
results of the QIC intervention study is beyond the scope of this paper and will be
provided in another paper. A comprehensive overview of the successes of all the
teams, was not the goal of the analysis.

6. The final paragraph on page 12 is vague - when we are told that some clinicians
(which type?) believe 'primary care physicians should be dealing with every single
patient', what does this mean? That they should merely coordinate the care of all
patients or actively manage them and deliver interventions (CBT or self help) too?
We have tried to clarify this statement. All views were shared across disciplines
except when stated otherwise.

7. The comparison of stepped care to other 'one dimensional treatment concepts
like in the care of diabetes.... for which evidence-based treatment standards can be
developed and applied' is also confusing given that stepped care is about being multi-
dimensional. And also implies that some clinicians hold that evidence based treatment
standards cannot be developed and applied for depression. So who holds these views?
I understand that the authors are trying to present the broad range of opinions and that
not all were successful in getting full adoption of stepped care but with strong
statements such as these we need a fuller description and discussion of what is
implied.
We agree with this comment of the referee and since a more comprehensive description of this point is beyond the scope of our publication, we left this passage out.

8. The authors identify organisational, structural and cultural barriers to implementation - where do these fit within the NPT model which appreas to only deal with individuals and how they engage or act with others. Is this a failure within the NPT model to take account of the organisational and structural determinants? In many ways these seem more of a barrier than individual behaviour as they may be less amenable to intervention in the way this project was conducted via processes of meetings and exchange.

NPT does include contextual factors, but only if they can be derived from the perceptions and social interactions of individuals. Other contextual factors are beyond the scope of NPT, which we have now mentioned as a limitation.

9. The authors should review their interpretation and application of reflexive monitoring. They have interpreted this as monitoring individual patient outcomes which in my view is a very (medical) reductionist application. Should this not have been reflexive monitoring of the process of implementing stepped care or why not reflexive monitoring of the use of stepped treatment by professionals? The qualitative data should have been used to elicit examples of reflexive monitoring to show that mechanism in action as driving change (not predefine reflexive monitoring).

We completely agree with this comment and added in the result section a better explanation of the double function of the BDI as an outcome and process indicator and illustrated the latter use with a quotation.
10. Would stepped care implementation/up-take by GPs have occurred by itself if local services had been developed for low intensity treatment as alternatives to antidepressants - or did it really require the coherence and cognitive participation to deliver these and their up-take? The failure of stepped care's wider implementation may be the lack of alternatives in many locations and little else.

*We believe that our findings underscore the findings of the controlled intervention study, and reason that the uptake of the new stepped care paradigm would not have occurred spontaneously without the QIC infrastructure. We have added comments on this in the discussion section.*

11. How realistic is it to implement this project more widely? And how successful was the project given that some could not reach coherence? I feel there should be more critical discussion overall of the success of this initiative and of the usefulness and validity of NPT rather than wholesale adoption of its concepts.

*We have changed the discussion section thoroughly and added critical notes about both the QIC intervention and the NPT constructs applied to help interpret the findings. We concluded that, although full implementation of stepped care was not reached, clinicians did set steps into this direction. Using NPT, although there seemed to be some overlap between the constructs and a lack of focus on external factors, did help to understand that creating a shared understanding and making clinicians of multidisciplinary teams in depression care, engage in implementing effective models of care, were strongly influencing the process and should be more explicitly addressed in the future.*
12. Please explain how the eight multidisciplinary primary care teams created for
the purpose of the QIC came about.

*This information has been added to the methods section.*

13. The detail about member check of the findings from the analysis should have
been included in the methods section.

*This information has been transferred to the methods section.*

14. 'Gunn' is misspelled with only one 'n' intermittently throughout the manuscript.

*This spelling has been corrected.*

15. What would be more helpful is that the professional group of the person speaking
might be included in the quotations- as this is clearly important given the findings
relating to coherence around the concept of depression in particular.

*The quotations come from the multidisciplinary teams, as we aimed to gather data on
the group’s views and experiences with implementing stepped care. We added
information in the text about the background of the persons speaking, where clear
differences of views existed. In addition we provided a table with an overview of the
members of each of the teams (table 1).*

16. The paragraph beginning 'very few GPs' on page 14 does not make sense and I suspect
that the meaning implied is actually the opposite to that which is
actually conveyed. The English needs revising.

*The entire article has been revised by a native English speaker.*
17. It is not clear to the reader why the paper is called 'Getting a grip on depression'. This phrase is not included in any of the quotes- does it relate to the title of the collaborative? If so, that should be stated, and as colloquial English it should be in quotation marks whenever used in the text- which it is not (eg on page 18).

*Unfortunately we could not find the quotation ‘getting a grip on depression’ in our data. Therefore we left the first sentence out.*

18. The authors should say more about why they could only interview the teams once.

*The study has been designed as a process evaluation within the context of an intervention implementation study. For our purpose, to capture experiences with the implementation process, one interview appeared sufficient. Although we agree that more moments of data gathering would have been more informative about the implementation process over a period of time, for pragmatic and financial reasons this was not feasible. Information about this has been added in the discussion.*

19. More information about the structural context of primary care and mental health in the Netherlands would help the reader to understand the nature and ramifications of the changes introduced in the collaborative.

*In the introduction we added a paragraph about the Dutch health care system and primary care context.*

20. The 'Breakthrough Quality Improvement' method is well known internationally but should probably be properly reference (page 4).
References have been added.

21. Further discussion of the findings in relation to the international context of quality improvement initiatives in depression—particularly in the USA, would strengthen the paper.

In the discussion section we related our findings to qualitative research into two resembling American quality initiatives in primary care: the depression QIC conducted by the IHI, and the RESPECT project.

22. Why did the collaborative choose to use utilize the BDI rather than the more widely used (internationally) PHQ-9? Some explanation or at least discussion of this point would be interesting.

This information has been added in the discussion. The BDI was a widely used instrument within the organizations of the QIC expert teams who designed the stepped care model. Although the QIC participants were positive about it, we agree with the referee and discuss that an improvement of the model might consist of the uptake of the PHQ-9, which appears to be more widely used in primary care by now.
23. Some lack of detail is evident, for example, how participating multi-disciplinary teams (MDTs) volunteered for, or were recruited to, the QIC is not made clear. 

This information has been added in the methods section.

24. Description of data analysis could also be refined; the sequence from thematic coding, ordering around stepped care principles and application of the NPT mechanisms is a little vague.

We refined this description in the methods section, also by adding an example of the thematic coding and the ordering of the data.

25. Reporting omits some of the Consolidated Criteria for Reporting Qualitative Research (COREQ) criteria, for example, information on relationship between researchers and participants, duration of interviews, distribution of participants between primary care MDTs.

We checked the COREQ criteria and added additional information in the methods section, amongst which the information suggested by the referee.

26. The authors do not make clear whether the depression QIC was a success, or not. As such we do not know whether we are examining the processes of an intervention that was effective or ineffective.

We added information about the success of the QIC, in the background section. We referred to a publication based on the uncontrolled quality improvement data, as
collected during the QIC. New information, based on the controlled study, still has to be published and so a disclosure of those details are not justified at this stage.

27. Whilst it is valid to use NPT solely in analysis to guide interpretation and conclusions the theory could have been made more integral to the study, for example, in planning, implementation, integration or coding. This may have improved the coherence of the study. The authors might wish to comment on this.

*We added information about the use of the NPT theory in the methods section. We used Gunn’s framework after the analysis of our data. Gunn’s framework was published in 2010. The NPT can be considered as an additional analysis, generating new insights.*

28. The authors could consider expanding their discussion of what this paper adds to the existing, related literature.

*Please see our response to this comment in question number 21.*