Author's response to reviews

Title: No more 'business as usual' with audit and feedback interventions: Towards an agenda for a reinvigorated intervention

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Author's response to reviews: see over
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RE: MS: 6747128591084496

Dear IS Editors,

Thank you for the opportunity to respond to the reviewers’ comments regarding our manuscript, “No more 'business as usual' with audit and feedback interventions: Towards an agenda for a reinvigorated intervention”

We are thrilled to note that the reviews were positive and that publication of this manuscript was encouraged.

We wish to thank Referee #1 for her very helpful and thoughtful comments. We have made a number of small changes that we believe improve the manuscript.

Itemized responses to the suggestions follow below.

We eagerly look forward to your response.

Sincerely,

Noah Ivers,

On behalf of Anne Sales, Heather Colquhoun, Susan Michie, Robbie Foy, Jill Francis, and Jeremy Grimshaw

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1) The article is written in a system perspective, which is good. This includes the interdependency between different organizational levels and that design of the A&F must be adapted to the level at which the feedback is directed. It is also highly interesting that co-interventions are suggested as a prioritised research subject. This gives the opportunity to investigate co-effects and synergies of using multiple implementation strategies. But it also brings to mind the issue of cost-effectiveness of strategies as multiple interventions, compared to single intervention, do not always yield so much better effect that it gives real value for money.

   Thanks – On Page 9, we have added a comment regarding exploring synergy between co-interventions, and on Page 10, we added a comment regarding the importance of considering the cost of different co-interventions.

2) The findings are described as a “theory-informed intervention design”, which is fine. However, there is very little about the underlying mechanisms of change, i.e. the text describes what works but not HOW and WHY it works. It would, e.g. be interesting to know why senior colleagues are better conveyors of feedback messages than unknown investigators. The Theory of Planned Behavior (TPB) would suggest it is because the social pressure is stronger within the professional community. The RURU taxonomy of
implementation strategies claims that the underlying mechanism of A&F is reinforcement.

*Thanks – On Page 6, we have more clearly explicated the reference to social influence connecting the construct from TPB to the findings regarding the impact of senior colleagues, as per the suggestion.*

3) Page 3, 1st paragraph: “…can provide objective data regarding discrepancies between current practice and target performance.” I would like to ad: “… as well as comparisons of the performance in relation to other caregivers.

*This has been changed.*

4) Page 4 and Table 2: The three types of characteristics mentioned to influence effectiveness of A&F, contextual and recipient characteristics and A&F intervention characteristics, could also include characteristics of the implementation object, i.e. the targeted behaviour. These characteristics are important and could differ a lot, between e.g. restricted use of antibiotics, giving advice on smoke-stop or making use of a new type of medical equipment. Rogers’ Diffusion of innovations theory could be useful here. Adding this would also be more consistent with the statement on page 5 “the ‘ideal’ design for A&F interventions depends on the recipient, their context, and the targeted behaviour”. The effect of A&Fs directed to individuals may differ substantially for easy-to-use clinical interventions compared to the use of complex interventions such as programs for treatment of compulsory behaviours or sophisticated medical equipment, which require higher level decisions and specific training. This is also mentioned on page 10 but is not made clear in table 2. It would also be of interest to see this further developed in the context of recipients’ perception of control over their choices.

*Thanks for catching this. The role of targeted behaviour has been made more clear in Table 2. We have also edited Page 4 and Page 11 to highlight the issue, as suggested, and also added a comment on the complexity of the targeted behaviour on page 7.*

5) Page 6: Here Rogers' Opinion leaders is mentioned briefly and I think this could be developed further with other actors in this theory, e.g. the use of Change agents and Change aides (who complement the change agent, by having more intensive contact with clients. They may have less competence credibility but are overall more trusted). (Rogers, 5th ed. 2003)

*We took this suggestion as discretionary. Where we mention opinion leaders, we do so merely to point out a potentially relevant hypothesis to test as a co-intervention. It seems to us somewhat beyond the scope of this manuscript to delve deeply into various aspects of Rogers’ theory as it might relate to co-interventions for A&F. We would hope that those pursuing this option would use the reference and consider a multi-arm trial (as suggested elsewhere in the manuscript) to test the cost-effectiveness of different strategies to support professional behaviour change.*
6) Page 6: The subject of "motivation to change" could also be developed further, e.g. with type of motivation: inner/outer – performance or competence oriented (Grol & Grimshaw, 2003) and by relating it to theories of “readiness to change”

We acknowledge the vast body of literature related to organizational and personal readiness to change, but again feel it is beyond the scope of this manuscript to delve deeply into the issue, as it is not A&F-specific. We also acknowledge that certain non-modifiable recipient characteristics may predict the response to particular interventions. We have added a comment on Page 6 regarding the potential role of tailoring messages within A&F according to recipient characteristics.

7) Page 7: An interesting notion: “... when A&F successfully directs attention toward specific tasks, it may influence prioritization of these goals”. This is something that ought to be discussed more in connection with financial incentives. You probably get a sort of crowding-out effect that means more of the rewarded behaviour and less of other care components, equally valuable. Did you find anything in the literature about this effect?

While we would tentatively agree with your interpretation, we are unaware of specific literature regarding this effect. There is always the possibility that any implementation intervention could have unintended consequences if, for instance, health professionals pay less attention to issues of importance for patients.

8) Page 12, second point: "... how costly are they to implement and is there potential for sustainability and spread?" It is not clear to me if you talk about the A&F intervention or the clinical intervention/behaviour change that is being implemented. I guess it is the A&F intervention?

We have edited this to clarify that the focus of this point is indeed the A&F intervention.