Author’s response to reviews

Title: Providers' preferences for pediatric oral health information in the electronic health record: a cross-sectional survey

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Editor's Comments

1. Please move all the tables to the end of the main text (after the references).

Response: This change has been made

2. In the 'Ethics approval and consent to participate' section of the declarations please provide a statement detailing the consent to participate sought from the healthcare providers.

Response: This change has been made.

3. Please refer to each author by their initials in the 'Authors' contributions' section.

Response: This change has been made.

4. Please complete and upload the STROBE checklist for observational/cross sectional studies (https://strobe-statement.org/index.php?id=available-checklists) and upload it as an additional file on re-submission.

Response: This change has been made.
Reviewer 1 Comments:

1. Can you make it clear in the manuscript what you learned from employing 3 regression models that you could not have learned without such elaborate approaches?

Response: Thank you for raising this issue. The three models were run as sensitivity analyses. To prevent confusion for the reader, we have deleted the log-linear and log-log models from the regression output and indicated in the Methods - Data Analysis section (page 8) that these models were run as sensitivity analyses. We also deleted references to the three models in the results section.

2. I believe your finding that primary care providers find "traditional elements of primary care information (e.g., tracking immunizations)" more important than oral health information not very surprising. I am sure similar findings would emerge in every specialty no matter what. It would have been interesting to compare the level of importance of two "unrelated" (everything is related in health, so in quotation marks here) areas in the eyes of primary care providers. Obviously, you cannot change that anymore…just food for thoughts.

Response: This is a great point and we certainly will keep it in mind for future work in this area. We have added a statement about this issue in the Discussion section (page 12).

3. "For a modest EHR development cost, " - After being involved for 20+ years in software development, I can judge that there are no "modest" development costs no matter how small the development. Please provide an exact number or remove the unsupported qualifier.

Response: Thank you for pointing this out. We have removed the modifier.

4. "This study has a few limitations" is superfluous under a headline "Limitations" - one would hope you would not add a section like that if there were no limitations. Suggest to remove.

Response: Thank you. We have removed this sentence to eliminate redundancy.

Reviewer 2 Comments:

1. First, the hypothesized positive association between provider's information preferences and oral health screenings and referral rates (page 6, lines 27-33) may be an indicator of the need for documentation/reporting of these actions for reimbursement and/or local quality measures. In the limitations section, the authors seemed to suggest this potential (page 16,
lines 14-24), but seemed to side-step the issue somewhat. It would be helpful to be more clear that the study could not identify whether the practices had protocols for oral health screenings, services, or referrals, and if documenting these activities was part of usual care. It has been my experience working with providers that documentation is driven by the need for reimbursement, quality measure attainment, or liability prevention. The underlying driver of higher documentation rates may be the presence of practice protocols.

Response: This is a great point. We have added language to the Discussion (page 11) and Limitations (page 13) sections about the possible implications of not having data on the practices’ protocols for oral health services.

2. Second, related to the first issue above, would it be fair to say that the study results could be viewed as testing for a preference among practitioners to document services versus not documenting services?

Response: This is an important question to consider. However, some of the information elements are not simply documentation requirements as they provide the primary care physician with information that could be useful during the encounter, e.g., links to educational materials, reminders about guidelines for oral health services, and classification of oral health status based on risk factors. Nevertheless, as you suggest, documentation is an important consideration, which we expanded upon in the manuscript (as described in the response to the previous comment).

3. Third, the categories of percentages of well-child visits increase in an inconsistent way (1%, 10%, 15%, 25%, 50%), yet the authors selected a logarithmic function to discuss the results. Because we have no access to the actual responses within each range, it is unclear to me if the categories were engineered to produce a functional form of the data that corresponded to a log model.

Response: Thank you for raising this point. We dropped the log-linear and log-log model in response to comments from Reviewer #1, which also addressed this concern.

4. Fourth, the OLS model for oral health screenings used a reference group (Table 3, line 41) that appears to have only 4 observations (Table 1, line 44), and may have less if one of these four were dropped from the model (n=194 vs. 211 surveyed).

Response: Similar to the previous comment, we dropped the log-linear and log-log model due to comments from Reviewer #1, which eliminates this issue. Note: Logging the variable causes
observations with a value of 0 to be dropped (since the log of 0 is undefined). For this survey question regarding oral health screenings, if a respondent answered 0%, their answer would be 0 and therefore omitted in the log-log model (when the independent variables are logged as well as the dependent variables).

5. Fifth, the OLS model variables account for only 18% of the variance in practitioner responses (R2 = .1842 in Table 3). This is not particularly robust and should be addressed in the limitations.

Response: We added more detail to the Limitations section (page 13) to explain how the model may have omitted variables that could explain the low R2.

6. Lastly, in Table 1, the proportion of pediatric patients under 4 years of age would be better stated as a percentage. The text (page 9, line 7) states the proportion as a percentage, and most of the data in the table are presented as percentages. It is a minor issue, so this is a suggestion.

Response: Thank you for pointing this out. We have changed the proportion to a percentage in Table 1 and revised the SD.