Author's response to reviews

Title:A process-based framework to guide NP integration into primary healthcare teams.

Authors:

Damien Contandriopoulos (Damien.contandriopoulos@umontreal.ca)
Astrid Brousselle (Astrid.Brousselle@usherbrooke.ca)
Carl-Ardy Dubois (carl.ardy.dubois@umontreal.ca)
Mélanie Perroux (perrouxmelanie@gmail.com)
Marie-Dominique Beaulieu (marie-dominique.beaulieu@umontreal.ca)
Isabelle Brault (isabelle.brault@umontreal.ca)
Kelley Kilpatrick (kelley.kilpatrick@umontreal.ca)
Esther Sansgter-Gormley (egorm@uvic.ca)
Danielle D'Amour (danielle.damour@umontreal.ca)

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Author's response to reviews: see over
November 12, 2014

Dr. May Nawal Lutfiyya
Associate Editor
BMC Health Services Research

Dear Professor Lutfiyya:

We first want to thank the reviewers for their insightful comments, which were extremely helpful to us in improving the paper.

We have done our best to address all the comments provided. Numerous minor modifications were made to the text but we also provide below a discussion of how we responded to the most important reviewers’ comments.

Dr. Thistlethwaite is correct in suggesting the research project at the core of the present article led to more than one paper. However each article has a specific focus and was written as a fully autonomous contribution. The present paper's nickname in the research team is “the summative paper” as this paper aims to summarize and integrate the core conclusions that the research project produced.

Regarding the specific criticism that "this particular paper makes a large jump from your description of the methodology and methods to the recommendations" we agree that the article does not provide an in-depth presentation of the data. The data supporting the recommendations provided here constitute a large and diverse corpus composed of, on the one hand, 58 published documents (ranging from 3 to 278 pages each) and, on the other hand, the transcripts of 34 interviews (ranging from 45 minutes to nearly two hours). Given the size and nature of this corpus we don't believe it to be practical to aim for an in-depth presentation of the data itself. The paper provides a detailed description and justification of the approach (the combination of logic analysis and implementation analysis), data collection methods, and analytic processes that led to the recommendations. We edited the paper to strengthen the description of each of those aspects. As suggested by Dr. McGrath, we also included a figure
that provides a visual representation of the methods and of the integration of the various data sources.

On a related subject, Dr. Thistlethwaite was surprised not to find direct quotes from our interviews. We could easily have identified, translated, and quoted from the interviews. However, we remain unconvinced that this would increase the article’s validity or provide a reliable way for the readers to get in touch with primary data. The reviewer states "The reader has to take on trust your findings without quotes." We would argue that providing quotes may be an exercise in cherry picking. How could the reader be sure we are not selectively quoting outlying opinions? We believe quotes can be very useful to illustrate the way in which informants phrase or conceive an issue, but that quoting is not a tool that can provide the reader with more confidence that the authors are reliably interpreting the data. Given the aim of keeping the article reasonably short, and given the number of informants and of topics raised in the paper, we believe that illustrating all topics with one or more quotes would significantly decrease the paper’s readability. Conversely, in our view, selectively providing quotes only when we have a sharp one at hand would skew the paper by providing more emphasis on some topics just because we happen to have nice quotes to go with them.

Regarding the suggestion to include a table providing information on respondents, we agree that such information could be interesting for the readers. However, we fear it would be quite easy for Quebec readers to guess the identity of our cases with the information now included in Table 1. This is not a problem as long as we do not disclose the identity of the informants themselves. But if we state that in each case we interviewed the NP, physician partners, and Chief Nursing officer (which is the case), then we believe we would be disclosing enough information for readers to identify our informants and we fear being in contravention of our commitments to the participants and the Research Ethics Committees.

Still on the methodology, Dr. Thistlethwaite raised specific questions on the convergence between the analytical methods used to synthesize the evidence from the literature review and the realist review approach. The methods used in the article are, in our view, very much inspired and convergent with the various works of Ray, Pawson and Greenhalgh. Our starting point was the logic model of the Ministry of Health and Social Services’ (MHSS) NP deployment plan. This was the "theory" subjected to a realist review. The evidence was then structured to test and refine this theory and ultimately to gain an understanding of the factors and mediating variables that influence the effectiveness of NP integration, seen as a complex organizational-level intervention. We agree that the article could have been clearer and could provide more details.
on those aspects. We have edited it accordingly. In the same way, Dr. Thistlethwaite raised several specific questions about exclusion criteria and validity scores, and about the case studies. We have edited the paper to clarify all the issues raised.

Dr. McGrath also raised a question about the nature of the logic model that was produced. As it is now stated more clearly in the article, we used both available documentation and consultation with experts from the MHSS to build a logic model (the final version of the logic model is attached to this letter). This model was then an integral part of the abstraction sheet used to conduct the literature review (the abstraction sheet is also attached here). By analyzing the published evidence, we were able to identify inductively five themes that went beyond the idiosyncrasies of Quebec's situation and, in our opinion, contributed to an understanding of the factors and mediating variables that influence the effectiveness of NP integration. In drafting the current version of the article we felt that including the logic model in the paper contributed little, especially for an international audience. In the end that model was a tool that structured our research process but not a relevant outcome for the focus of the paper. The new Figure 1 in the paper clarifies this process and provides this information in a visual way.

Dr. Thistlethwaite raised the issue of the external validity of the paper for the global readership of the journal. Specifically, he suggested that the paper needed to better describe the NPs’ work settings, their scope of practice and training, to better define primary care, etc. This comment also echoes comments from Dr. McGrath. We agree that the paper could have been clearer and more detailed on those aspects. We have added a new context section that provides a summary description of Quebec's insurance and care delivery system, of NP training, scope of practice and certification process, on the nature of the "deployment" and on care delivery structures where NPs work. We believe this information will allow readers to contextualize the external validity that our findings can have in their respective settings.

However, we disagree with Dr. McGrath’s statement that “The title [...] for the article needs to be firmly oriented to Canada, and particularly Quebec”. The aim of the article was, from the outset, to provide a reasonably generic framework to guide NP integration into primary healthcare teams. Obviously, context will matter to a huge extent in any actual process of integrating an NP into a new team. A framework to guide such a process will thus need to find a balance between local and external validity. Too much contextualization to local idiosyncrasies will increase local validity but will hamper external validity and meaningfulness in other contexts. Conversely, trying to aim for a perfectly generic and universal framework would produce a result whose level of abstraction would limit usability. We believe our paper, especially in its revised version, strikes a
reasonable balance and provides insights that might interest an international readership. Our own review of the literature suggests that many of the conclusions and insights provided here could be of interest in other jurisdictions.

Finally, both reviewers raised several specific questions about statements made in the papers. We edited the text accordingly and either modified the problematic statements or provided a clearer or stronger justification.

We hope the paper in its current version will be considered acceptable for publication.

Sincerely,

Damien Contandriopoulos
Communications efficaces
Soutien aux milieux pour l’intégration
Définition claire des rôles / responsabilités

Incitatifs financiers
Répartition géographique planifiée

Main d’œuvre
Bonne intégration IPS à l’équipe clinique
Pratique performante des équipes cliniques intégrant des IPS

Améliorer la performance du réseau
Améliorer les soins de 1ère ligne

Accessibilité

Contrat MD/IPS
Loi 90

MSSS
Agences
DSI
GMF/CSLS/UMF
CSSS
OIIQ
CMQ

Modèle logique théorique
Modèle logique opérationnel

Plan de déploiement
Représentation graphique du modèle logique de déploiement de 500 IPS au Québec tel que construit à partir des documents officiels du MSSS, des Agences et des ordres professionnels

Représentation graphique du modèle logique de déploiement de 500 IPS au Québec tel que construit à partir des documents officiels du MSSS, des Agences et des ordres professionnels

Produit dans le cadre du projet IRSC/MSSS « Soutenir le déploiement des infirmières praticiennes de première ligne au Québec » déc. 2011. Contact damien.contandriopoulos@umontreal.ca
Grille d'analyse des données / projet ipspl.info

**Pays**: Indiquer le pays d'origine des données, Pour les articles canadiens, mettre la province, pour les articles comparatifs, mettre international

**Résumé**: Écrire un résumé de quelques lignes qui présente le contenu de l'article et sa contribution principale

**Source des données**: Indiquer le type d'étude (données primaires, données secondaires, éditorial) (qualitatif, quantitatif) etc.

**Valeur scientifique**: Mettre une note de 1 à 3 sur la valeur scientifique. 1= Excellente, 2= Bonne, 3= Faible. Des études avec un cadre conceptuel explicites et cohérent, une collecte de données appropriée, une analyse des données cohérente sont 1. Des études qui présentent des données mais avec quelques faiblesses (collecte peu explicite, analyse non fondée sur un modèle etc.) sont 2. Le reste est 3. Les analyses de données secondaires et en particulier les revues de la littérature sont 1 si elles sont systématiques et cohérentes, 2 si elles sont analytiques non systématiques et 3 si c'est du saupoudrage de références ad-hoc.

**Snowball**: Si pertinent, identifier les références qui semblent pertinentes et qui ne sont pas dans notre liste.

**Ranking**: Code de I à III pour la pertinence: I = contribution majeure à la compréhension des phénomènes étudiés (intégration et pratique clinique performante), II = contribution significative; et III = contribution anecdotique ou nulle

**Lien modèle logique**: Dans le cas des articles avec un ranking de I ou II, Identifier un ou des liens avec le modèle logique ci-dessous en utilisant les lettres en rouge

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Représentation graphique du modèle logique de déploiement de 500 IPSPL au Québec tel que construit à partir des documents officiels du MSSS, des Agences et des ordres professionnels

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Modèle logique opérationnel Modèle logique théorique