Author’s response to reviews

Title: Effectiveness of a tailored implementation strategy to improve adherence to a guideline on mental health problems in occupational health care

Authors:
Margot Joosen (m.c.w.joosen@tilburguniversity.edu)
Karlijn van Beurden (karlijnvanbeurden@yahoo.co.uk)
David Rebergen (David.Rebergen@Sharedambition.com)
Monique Loo (mloo@telfort.nl)
Berend Terluin (b.terluin@vumc.nl)
Jaap van Weeghel (j.vanweeghel@tilburguniversity.edu)
Jac Van der Klink (j.j.l.vdrklink@tilburguniversity.edu)
Evelien Brouwers (e.p.m.brouwers@tilburguniversity.edu)

Version: 1 Date: 12 Dec 2018

Author’s response to reviews:

BMC Health Services Research

Dear editor,

Thank you for considering our manuscript ‘Effectiveness of a tailored implementation strategy to improve adherence to a guideline on mental health problems in occupational health care: a cluster randomized controlled trial’ as having the potential to be published in BMC Health Services Research.

We are grateful to the editor and the reviewers for their time and efforts in assessing our manuscript and we appreciate their valuable comments. We have addressed the comments in the revised manuscript and by integrating them we think it has improved. As requested, we have
included point-to-point responses to the editor’s and reviewers’ concerns and have made references to the changes made in the manuscript.

We hope you will find our revised manuscript acceptable for publication and look forward to hearing from you.

Yours sincerely,

On behalf of all authors,

Margot Joosen

Reviewer reports:

Tracy Robinson (Reviewer 1):

1) Overall this is a well written manuscript with robust methods however, some clarification is needed. This article reports on one phase (an audit) of a wider RCT but, at times, it reads as though the focus is on the actual RCT. Clearer delineation of these study phases would be helpful (although I do acknowledge some overlap).

Response: thank you for your feedback and comments. Indeed the current paper reports on analysis of an audit of medical records to determine the effectiveness of an implementation strategy for occupational physicians, which was indeed one phase of a larger RCT study. We understand that it is not always clear what the focus is of this paper and how it relates to the larger project. To clarify this we have modified the text at several places: the title (we removed cluster randomised trial in the title to avoid confusing) (p.1, line 2), in the abstract (p.2, line 11), in the Introduction (p5, lines 10-p6, line 9 and p7, lines 4-5) and Discussion (p 18, line 26 and p 19, line 27) and used the phrase ‘larger project’ throughout the manuscript for the overall project of which the study described in the current paper is part of.
2) The study addresses an important implementation issue re guideline adherence. I think your background section could include more info about the reported challenges associated with translating new evidence into practice via guidelines. You list some of the barriers (e.g., environmental barriers) but several are worthy of elaboration. Also, the literature on implementation identifies limitations of relying on education to change practice behaviour, i.e., knowledge change does not equate to behaviour change and some discussion of this would be important since it is the heart of your intervention.

Response: Indeed, the challenges of translating new evidence knowledge into practice and behaviour change highly relates to this study. We have provided an explanation of the barriers found by Cabana (p 4, lines 12-16) and have elaborated on the barriers perceived by the OPs in our study (p 5, lines 15-23). In addition, we enriched the introduction with what is known in the literature about (in)effective implementation strategies (p 4, lines 17-21).

3) Similarly on page 8 where you describe your implementation strategy you note that a PDCA cycle approach was used but this is also worthy of some elaboration - particularly re how solutions were applied and evaluated. I think the good information in Table 1 could be condensed a little and while you refer your reader to other literature for more explanation of training, I think this is also worthy of a little more explanation.

Response: We agree with the reviewer that the PDCA cycle needs some elaboration. We have added an explanation of the approach we used to the method section (p 9, lines 16-22) and also added a table which provides an overview of the structure of the training and how the PDCA approach was used (p 10, line 16). In addition we added an example of how OPs were engaged in implementing a specific guideline recommendation using the PDCA approach as an additional file to the paper (see also p. 10, lines 7-9).

4) Some minor grammatical issues on page 9 (Line 15) and lines 4-5 need rewording as they imply the OPs had a diagnosed metal health problem (this easily addressed).

Response: We have solved the grammatical issues by rewording the sentences (p 11, line 9) and (p 11, lines 26-27).
5) Another question I have relates to the guidelines themselves - having been revised over 10 years ago begs the question of whether they need any updating - is this worth a mention in your discussion?

Response: Yes you are absolutely right about this. At present the Dutch MHP guideline is being revised by the Netherlands Society of Occupational Medicine and expected in 2019. We have mentioned this now in the discussion (page 20, line 18-22).

6) I think the first sentence of your discussion does overstate your findings somewhat (or else they need more explanation).

Response: We have changed the first sentence of the discussion into: ‘In this study we found that OPs who received a tailored guideline training showed significantly greater adherence rates to the guideline for mental health problems in occupational health care compared to OPs who were exposed to traditional guideline dissemination’. (p 17, lines 5-8)

7) While I agree that intention to treat may help address some challenges with RCTs - this approach is vulnerable to Type II error and raises questions about the heterogeneity of sample - this would be good to reflect on in your limitations?

Response: We are aware that using Intention to treat analysis has some disadvantages. Because this is a pragmatic trial in which we want to test the effectiveness of a guideline training in a real life setting, we have chosen intention to treat as the primary analysis. Indeed, this approach has limitations, such as being more susceptible to type II error. We have now reflected on its limitations in de discussion (p 21, lines 14-21).

8) Overall, the question of how effective is education for guideline dissemination is also worth elaboration. I applaud your engagement with 'experts' during your study - this is also worth describing in more detail. Were they all OPs? What about workers themselves? Might they have any role in updating guidelines? What kind of stakeholder engagement processes might be helpful in the future?
Response: The implementation strategy was a participant-focused programme in which peer learning groups of OPs were formed to discuss the problems the OPs face in their daily practice and find solutions together to overcome these problems. Because of this participant-focused structure, all OPs in the intervention group were actively involved. For future research and for the development of implementation strategies it would be recommended to also involve other stakeholders such as management of the OHS, employers, health care professionals and workers. For the development of guidelines for OPs it is recommended to involve different stakeholders, including representatives of workers/patients, employers and different health care professionals, and this is current practice. We have now elaborated on the role of the OPs in several parts of the manuscript (p9, lines 10-11, p10, lines 7-8, p 19, lines 17-18 and lines 23-25) and included in the discussion the recommendation to involve different stakeholders when improving the implementation strategy (p 20, lines 12-17).

9) Also, in your discussion section, Page 16 -Lines 7-10 read like results - the same is true for page 176 - Lines 4-9 - both these sections report findings more clearly than in your results section?

Response: In the discussion, we have linked the current results to the reported outcomes from the larger project. The findings reported on page 16 are from another study within the larger project that specifically looked at the relationship between guidelines use and patient outcomes (see the reference included). The results on page 17 refer to the qualitative analysis of barriers OPs perceived to use the guideline. To address this properly, we have rephrased both sections to make clear that these results are reported in other papers (p 18, lines 26-29, p 19, lines 27-30).

10) Overall this is an important study that has the potential to significantly add to our understanding of how to ensure updated guidelines are implemented in practice and the kinds of strategies that may work - I recommend publishing but also think there would be much benefit in strengthening your background and discussion re education as an implementation strategy. I also think a little more delineation of this second phase of your study (its essentially an audit) would be helpful. Of course you need to identify that it is part of a wider RCT but then please focus on the audit phase itself.

Response: Thank you for your comprehensive feedback and helpful comments. We have incorporated your suggestions to strengthening the background and discussion regarding
different types of implementation strategies and focus on the audit of medical records as mentioned in our responses above.

Bryan Rodgers (Reviewer 2): This paper describes results from analysis of an RCT assessing the implementation of a strategy intended to improve adherence to mental health care guidelines by occupational physicians (OPs) in the Netherlands. The trial included 66 OPs from six regional offices of the occupational health service in South Netherlands. Randomization was at the OP level with approximately equal numbers of intervention and control OPs at each site. The intervention arm OPs received eight two-hour training sessions designed to identify and address barriers to implementation of the mental health guidelines developed by the Netherlands Society of Occupational Physicians. The control arm OPs received no training or 'placebo' intervention. The outcome measures for the present paper were a set of performance indicators (PIs) to assess the care provided by OPs to individual workers. The analyses reported in the present paper used data from 114 workers who had taken sick leave and agreed to participate (56 intervention and 58 control). They received care from 34 of the study OPs (16 intervention and 18 control). The medical records of the workers were evaluated for all consultations with their OP over the period of sick leave up to one year. Twelve PIs falling into five "key" domains were rated independently by two assessors. Statistical analyses followed the RCT design of the study to contrast each indicator between the intervention and control arms, with consideration given to the clustering of OPs. The main findings were that the intervention OPs showed significantly greater adherence to the guidelines on six of the twelve PIs. Significant differences were also found for four of the five domains of PIs: Process diagnosis, Problem orientation, Interventions/treatment and Relapse prevention, but not for Continuity of care. Overall, however, adherence to the guidelines was low in both groups with adequate adherence falling as low as 2% on one of the PIs and below 10% on half of the twelve PIs. The authors conclude that although the implementation improved adherence, the "adherence to the guideline recommendations is still far from optimal and needs to improve to guarantee high quality of occupational mental health care".

1) The strengths of the present study include the RCT design, the thoroughness of the implementation strategy (i.e. training), the outcome measures (PIs) developed and utilised which intentionally map on to the guidelines, and the attention in data analysis to possible clustering effects of OPs (which turned out not to be an issue). Weaknesses include the achieved sample size, evidenced by wide confidence intervals, and the possibility of contamination from physicians in the intervention arm to their control colleagues (as acknowledged in the Discussion). It is a trade-off between the latter and the risk of having different types of workers under different area offices and the authors have likely made the better call on that decision.
Another acknowledged weakness is that OPs' records may not reflect accurately their findings and activities. A further possible weakness (I could not discern from all the references to "clustering" whether this has been taken into account or not) is that the OPs are the real unit of analysis in the present study, not the workers. There are data from 114 workers but only 34 OPs. Did the statistical analyses take account of the nesting of workers within OPs? This is a much greater threat to the design that the clustering of OPs in their office settings. (My apologies if I have misunderstood this and that the former is the type of clustering already taken into account. If so, please clarify this in the description of the statistical analyses.)

Response: Thank you for your comprehensive overview of the current study and its strengths and weaknesses. Indeed one of the weakness is that we have data of only 34 OPs; 16 in the intervention group and 18 in the control group, which does affect the study’s power. We have chosen the workers as unit of analysis because this provides information about how OPs act in different cases (e.g. symptom severity, complexity of problems, type of work and work organisation). In the statistical analyses the clustering of workers within OPs has been taken into account. This is indeed not clearly described and we have now clarified this in the method section (p 13, line 30 and p 21, line 21 and lines 26-27)

2) There are some difficulties with the scope of the present manuscript and the way it is presented. Some of these are serious issues and affect the core of the interpretation of the findings and the suggestions made for the future of implementation of guidelines and for research on this. I note from the declarations of interests that two of the authors were involved in the development of the present guidelines but the level of their involvement is not stated (other than not receiving payment from their subsequent use).

Response: Thank you, yes the role of the two authors in the guideline development needs to be transparent. The guideline was developed in 2000 and revised in 2007 by the Netherlands Society of Occupational Medicine. JvK was the chair of the guideline committee in 2007 and ML was involved as one of the members of the guideline committee. We have now included this extra information to the conflicts of interest section (p 23, lines 15-17)

3) The main problem I encountered with the present manuscript centres on the separation of the current paper from previously reported findings from the same study. (I note that the authors express this as "alongside a cluster RCT" but there is only one study with one registered protocol.) This gives an artificial feel to the paper (the elephant in the room is not
unacknowledged in any way). Further, after reading some of the previous publications and the study protocol, I found it very hard to understand the interpretation of results in the manuscript. First, the trial did not achieve expected outcomes in terms of workers' wellbeing (primarily return to work). The publication detailing this is in the references of the present paper (#39) but is not referred to anywhere in the text and the main results are not discernible from the manuscript. Of course, the aims of the present paper are not in regard to the workers' outcomes but it is very strange that this does not get a mention given the content of the Introduction and Discussion sections. A second publication published in 2017 (#42) is more problematic. The same group of authors reported that, irrespective of the intervention, adherence to the guidelines by OPs is not associated with workers' outcomes. This being the case, what possible value is there in adherence or, indeed, strategies to encourage adherence? The manuscript is written from the perspective that adherence to guidelines is necessarily a good thing, e.g. see first paragraph of the Introduction, and the final sentence of the Abstract states "adherence to the guideline recommendations is still far from optimal and needs to improve to guarantee high quality of occupational mental health care.") This presumption of guideline adherence clearly does not apply to the current circumstances. It is possible that the vague final sentence of the Conclusions section of the present paper is alluding to this point, but, if so, it will be lost on the large majority of readers if they are not provided the information to draw their own conclusions.

Response: First, we acknowledge that the focus of this current study and its relation to the larger project was not clearly formulated in the manuscript. The current paper reports on analysis of an audit of medical records to determine the effectiveness of an implementation strategy for occupational physicians, which was done in the context of a larger RCT study. As part of this larger project also studies on patient outcomes, a feasibility study of the implementation strategy and a qualitative study have been conducted and reported elsewhere. To clarify this we now used the term ‘larger project’ throughout the manuscript for the overall project of which the study described in the current paper is part of. We have also added information about the different studies within the larger project in the Introduction (p5, lines 10-p6, line 9 and p7, lines 4-5) and Discussion (p 18, line 26 and p 19, line 27).

Second, the studies within the larger project that focused on patient outcomes showed that the implementation strategy did not lead to better patient outcomes (i.e. reduced sickness absence). It is uncertain whether the absence of this effect is a result of theory failure (is the guideline not effective) or process failure (is there still an implementation problem). Therefore, the current study which focuses on the adherence of the guideline by OPs is very relevant and shows that overall OPs still do not adhere adequately to the guideline, but that the studied implementation strategy does improve adherence. Subsequently, because overall adequate guideline adherence was not achieved by the OPs, the effect of adequate guideline adherence on patient outcomes
could not be evaluated. The analyses on the association between overall low adherence and reduced sickness absence, showed no significant association. But we did find a significant associations between a specific recommendations (i.e. regular contact between OP and the worker) and reduced sickness absence. Overall, we argue that it is of value to find strategies to improve adherence to guidelines and at the same time invest in developing/updating guidelines that include high quality evidence and that match the needs and daily practice of the target group. We have now elaborated on these conclusions in the discussion (p 18, line 28, p 19, lines 3-8).

Also, we have reframed the final sentence of the abstract (p 2, lines 1-2) and adapted the conclusion by adding specific stakeholders that are recommended to be involved to improve the implementation strategy (p 22, lines 11-12). We have also elaborated on the involvement of other stakeholders in the discussion section (p 20, lines 12-17).

4) Are the authors in fact concluding that the NVAB guidelines have little value? This IS highly relevant to the particular aims of the present paper because it is understandable that OPs would not adhere to guidelines if they themselves perceive them to be irrelevant to workers' outcomes. Even if this is not actually the view of OPs (the authors would know better than I) it is still a necessary issue to acknowledge and discuss, as it is one plausible explanation for the study's findings (across all of the papers).

Response: See also response 3, we cannot conclude that thus particular NVAB guideline is of little value because overall adherence is still low and therefore the relationship between good guideline use and patient outcomes cannot be evaluated. A lack of outcome expectancy was indeed one the barriers that OPs addressed in the training sessions but was not indicated as one of the major constraint for not using the guideline. In the feasibility study which is part of the larger project we have found that OPs perceived less knowledge-related and attitude-related barriers (lack of outcome expectancy is part of the latter) after the guideline training, but that external barriers, such as lack of time and conflicting policy, remained prevalent and seem to be the major barriers for using the guideline after the implementation strategy. This is now being discussed in the discussion section (p 19, lines 6-8 and p 20, line 1)

5) Something else that is necessary for readers outside of, or unfamiliar with, the OP system in the Netherlands is a little more explanation of OPs' role in relation to other health care providers. To what extent do they provide mental health treatment themselves or facilitate access to mental health care from other professionals for the workers affected? I could not get a good feel for this
and trying to read between the lines was as confusing as helpful. I note for example, that the PIs relating to continuity of care (5.2) include "Consultations with the worker take place every 3 weeks during the first three months of sickness absence. Thereafter consultations take place every 6 weeks." For workers who have a mental health problem serious enough to prevent them from going to work, this seems highly inadequate if it is the only source of support. Can I assume that they must actually be receiving other treatment (from GPs or specialists)?

Response: The role of the OP in the Netherlands in case of sickness absence of a worker is three-fold; 1) certification of the sickness absence, 2) provide return to work support to the sick-listed worker and, 3) advising the employer regarding return to work activities and work adaptations if necessary. The return to work support to the worker is predominantly case/process management focusing on the interference of work and health. In case of mild problems the OP can provide care management as well. The OP can also refer the worker to specialized care professionals and programs. Usually, other health care professionals are involved in the treatment of the health condition, such as the general physician and a psychologist. It is recommended by the guideline that the OPs communicates with the different care providers involved and try to align the treatments. We have now explained this in more detail in the method section (setting) (p 8, lines 6-13).

6) Why are there no guidelines/PIs on how frequently these workers receive evidenced based good quality mental health care?

Response: This would be very interesting but this is not one of the recommendations of the MHP guideline and therefore outside the scope of this study. Besides that, this kind of information is not available from the medical records we used in this study because the medical records used by OPs are not linked/shared with the medical records other health care providers use to document patients information.

7) Playing devil's advocate, PI 3.2 seems the only PI out of 12 that I might anticipate to have some benefit for workers' wellbeing/recovery. No amount of monitoring and recording will improve outcomes in the absence of effective treatments and/or self-help strategies (neither of which appear to be monitored).
Response: Since the focus of the current study was to assess the degree in which OPs adhere to the guideline recommendations, outcomes on workers’ level were not included. To measure guideline adherence, PIs were developed that reflect the guideline recommendations, including all phases of the guideline: diagnosis, problem assessment, intervention and continuity of care. In this guideline, monitoring is part of the diagnosis process (to subsequently make reasoned decisions about interventions needed) and therefore included as PI. Although workers’ outcome was not the focus of the current study we do agree with the reviewer that not all PIs influence workers’ outcome in an equal way. The same can be said about guideline adherence; not all PIs might have the same influence on guideline adherence by an OP as some PIs might have been conditional for others. For example, if an OPs does not have regular contact with the employer (PI5.3), he/she will presumably also have less information about the perspective of the employer regarding the recovery of the worker (PI1.3). This is one of the limitations of the study and we have now added this limitation to the discussion section (p 21, line 9-12).

As well as the main points above there are a few minor issues that the authors could take on board if they revise the paper.

8) 1) There are a few places where English language does not quite work. In the abstract "little is known" in place of "few is known". Generally, though, the paper is extremely well written.

Response: We have replaced ‘few is known’ with ‘little is known’ (p 2, line 4)

9) 2) The terminology of "key PIs" is a little confusing as this suggests that some of the 12 PIs are more important than others. Here the PIs are grouped into five domains (or areas) and it would be better to use a term indicating a higher-level grouping rather than "key".

Response: We agree with the reviewer that the terminology ‘key PIs’ is subject to multiple interpretations. We have now used ‘grouped PIs’ as an alternative throughout the manuscript (p.13, line 4).
10) 3) Participant workers' inclusion criteria are provided on page 9. I saw from the registered protocol on line that three exclusion criteria were applied to the present study but could not see these in the present manuscript. Were they implemented? If so, they should be included in the paper. Further, how are these exclusion criteria justified, as censoring on the main outcome variable would work against the demonstration of differences between the intervention and control arms of the trial:

2. Sick leave duration of less than 4 weeks, 3. Sick leave duration of more than 8 weeks.

Response: The 3 exclusion criteria in the registered protocol were: 1. Acute crisis or suicidality, 2. Sick leave duration of less than 4 weeks, 3. Sick leave duration of more than 8 weeks. During the design of the larger project we have encountered some practical problems with exclusion criteria 2 and 3. The eligible workers were selected from the registration data of the OHS. Only after the first meeting with the OP, data on diagnoses and sickness duration were available. By the time the OP had registered these data, some workers were on sick leave for over 8 weeks. To not jeopardise the whole project because of low inclusion rates, the project team decided to include workers with CMD as primary reason for sick leave as diagnosed by an OP, who are on sick leave when selected from the registration system after their first meeting with the OP. This has been reported in the Design paper of the larger project [1]. In addition, the first criterion, acute crisis or suicidality, was implemented as planned. In response to the feedback we have adapted the inclusion criteria to match the formulation in the Design paper and have added the (first) exclusion criterion to the manuscript (p 11, lines 11-15).

11) 4) On page 11, the section covering statistical analysis says "The intention-to-treat principle was used in the analyses." I am puzzled as to how this would be operationalized for the analyses reported in the present paper. No workers' outcomes are analyzed so their data are irrelevant here. As to the OPs' the OPs who did not see any participating workers could not provide data from records, so only those who did see participating workers (n=34) could be included in the analyses. They can only be assigned to the intervention and control arms of the trial in accordance to their original allocation in the design (as there is no other categorization to use), so what does "intention to treat" signify?

Response: Also on the OP level, original allocation can be altered. Ideally, an OP guides a worker throughout the entire sickness and recovery process. However, in practice the worker might switch from OP, because of holiday leave or illness of the OP, or because the OP changes
location. Because we used the intention-to-treat principle, in all cases the worker’s medical record was analysed in the way the worker was randomized at the beginning of the trial, regardless of whether the worker completed their guidance with the same OP. We have now added this extra information to the discussion section (p 21, lines 14-21)

12) 5) Some figures in Table 5 are clearly incorrect, particularly risk differences and their confidence intervals. I think this is due to the inconsistent use of minus signs for those differences where the % is higher for the control arm. There are also some instances where a the decimal place has been omitted. In the bottom right-hand cell, I do not understand how the CI can be [0,0].

Response: Thank you for pointing out these inaccuracies. We have now added the missing decimals, corrected the [0,0] CI and have added the minus sign to the risk differences where the % is higher for the control groups (p 16, line 14: table 6)

13) 6) The consideration of possible "barriers" in the Discussion is not always clear to make the distinction between barriers to guideline adherence and the constraints (particularly external constraints) which nullify the potential benefits of guideline adherence. These are two conceptually different things and would show up in different ways in the design of the current study. There is a further lack of specificity in the Discussion where the word "might" is often used in contexts where the present study has not only collected data but already published findings in previous journal articles. It seems odd to speculate about things already reported on.

Response: We have used the framework of Cabana to structure the discussion about barriers for guideline use during the training sessions with OPs. In addition, this framework was used in the qualitative study to analyse and categorise the barriers mentioned by the OPs. In this framework three types of barriers are defined: knowledge-related barriers, attitude-related barriers and external barriers. We have now referred to this framework in the discussion section to clearly make a distinction between the types of barriers (p 19, lines 27-30). Also, we have now referred to the previous reported findings of the larger study and used stronger expressions when referring to the published findings (p 18, lines 13-16, p18, lines 26-28).
14) Overall, I can see value in reporting (especially from an RCT) how a systematic intervention does or does not change the behaviour of professionals and why it can work and why it might not work as well as expected. However, it is very confusing to find these results presented in isolation from the context of the full study and, in some instances, with implications and conclusions that conflict with earlier publications from the team.

Response: Thank you for your detailed and comprehensive feedback. We have addressed your comments and in particular paid attentions to the presentation of the current study as part of a larger project and placed the results into context by linking them to the results from the larger project.

Bonnie Kaiser (Reviewer 3): This is a well described evaluation of a peer group implementation strategy aiming to improve adherence to mental health guidelines in the context of occupational healthcare. There are a couple big-picture comments that could have fairly strong implications for interpreting the study. My other comments are minor.

1) The point made in the discussion that these findings might only reflect medical record-keeping and not actual behavior is an important one. Do you have any data (e.g., recordings of the peer group sessions) that might speak to this? For example, I don't know if physicians might have mentioned that they routinely do some of the things that are indicated by medical records as rarely happening - or maybe they mention that when they do ask about these things, the patient always says it's not happening, so they don't write it down. Just wondering if there's anything you could use to give a sense in one direction or the other, or are we just left wondering whether these data have any meaning in relation to the reality of clinical care?

Response: Thank you for your feedback and comments. Indeed, the performance indicators reflect the behaviour of the OP to the extent to which the OP documents his/her findings, decisions and actions in the medical records. Nevertheless, previous research has shown this to be a better measure of actual behaviour compared to self-reported adherence [2]. Another advantage is that an audit of medical records does hardly interfere with normal routine behaviour of the OP, as would (video) observations would have done. OPs also mentioned that in some cases their reimbursement depends on how well they used the guideline. For example, depending on the contracts, the OHS receives reimbursement for each contact between the OP and the employer. This is mentioned in the discussion section (p.18, line 6-11).
2) It could be helpful to have a bit more context regarding OHSs' relation to employers to gauge how practical it would be to expect OPs to engage directly with employers. I don't have a sense of how close that connection is or if it's more like it's just on paper. This affects interpretation of PIs involving getting employers' perspective and even things like speed of first consultation (my first thought is why does this have anything to do with the OP when it's more about the employer/employee taking the initiative to make an appointment, but that might be a na""
discussion, and monitoring the progress of the groups. But the trainer also made sure that all the different parts of the content of the guideline and all guideline recommendations were discussed by the groups, thereby ensuring that not only the structure but also the same content was discussed in all peer groups. One of the biggest advantages of this format is that the specific topics that matters most to OPs and the barriers that they face in their daily practice were discussed and solutions were found for their specific contexts. Another benefit is that it is known that peer-learning activates preknowledge and can impart sustainable knowledge and performance change. We have now included more information about the format of the implementation strategy and the role of the trainer (p 9, lines 10-13, page 10, lines 7-14 and line 16: table 2).

4) Similarly, were there any measures of 'quality' in regards to the intervention (this could include things like the quality and richness of discussion for each peer group). I would assume these would impact outcomes. This would be somewhat analogous to the 'fidelity' measure of assessing attendance at peer group sessions.

Response: In a previous published feasibility study [3] we have reported on the compliance of the training and the experiences by the OPs. All participating OPs attended all 8 training sessions. The protocol was carried out as planned: iterative Plan-Do-Check-Act cycles were conducted across all topics of the guideline in all six groups. Also, 90% of the participating OPs perceived that the ‘small groups’ and ‘8 sessions spread over 1 year’ strongly contributed to higher guideline adherence. In addition, in the previous published qualitative study [4] an analyses of the peer group training is reported. The variety and width of the barriers and the suggested solutions shows the richness of the discussions in the groups. We have now added this information to the method section (implementation strategy) (p 10, lines 10-14)

5) Descriptions of what the RCT consisted of were confusing. Sometimes it seems that the RCT consists solely of the training in this specific guideline using this implementation strategy (compared to a control group). At other times, this study is described as occurring alongside the RCT, which makes me wonder what the focus of the actual RCT was. It it just that the primary outcome of interest was related to workers' outcomes, or was there more to the RCT than described here?

Response: We understand that the context in which this study was conducted is not clearly described. This current paper reports on analysis of an audit of medical records to determine the
effectiveness of an implementation strategy for occupational physicians, which was done in the context of a larger RCT study (i.e. the larger project). In this project an implementation strategy (i.e. peer group training) is developed, implemented and tested to improve guideline adherence among OPs and thereby improving occupational health care for workers with mental health problems. The larger project consists of different phases and focuses on OPs outcomes and workers’ outcomes of which the results are reported in different papers. To clarify this we have modified the text at several places: in the Introduction (p5, lines 10-p6, line 9 and p7, lines 4-5) and Discussion (p 18, line 26 and p 19, line 27) and used the phrase ‘larger project’ throughout the manuscript for the overall project of which this current study is part of.

6) I’m also confused about where the clustering occurred, since it seems that OPs were randomized at the level of the individual rather than the practice/OHS.

Response: The randomisation took place at the level of the individual OP level but was pre-stratified on work location. Six sites of a large OHS participated in the study, all participating OPs works at one of these sites. At each site 1 peer group/intervention group was formed and 1 control group. To establish equal groups at each location we randomisation the OPs of each location to the intervention or control condition. To clarify, we have now adjusted the information about the randomization in the method section (p 11, lines 27-29).

References


