Author’s response to reviews

Title: Validity and Reliability of the Spanish version of the Organizational Readiness for Knowledge Translation questionnaire (OR4KT)

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Author’s response to reviews:

Dr. Bryan Jeffrey Weiner
Associate Editor
Implementation Science

Re: IMPS-D-17-00253R1, Validity and Reliability of the Spanish version of the Organizational Readiness for Knowledge Translation questionnaire (OR4KT)

October 6, 2017

Dear Dr. Weiner,

Thank you for your interest in our paper and for giving us the opportunity to resubmit a revised version based on your comments and the thorough suggestions from peer reviewers.

We have pleasure in submitting our revised manuscript as requested, as well as our response to these comments and suggestions. For your convenience, we reproduce the reviewers’ comments verbatim, before detailing our response to each of the points made.
REVIEWER REPORTS:

Reviewer #1: The authors have considered my comments thoughtfully and completely, and have addressed them to my satisfaction. I think the representation of the factor analysis as a CFA strengthens the conceptual rigor and appreciate the statement of intent to research poorly functioning items in the future when more data is available.

I have only one major question related to the ROC. The authors state that 7 out of the 20 practices had OR4KT scores set at 0, yet Table 5 has 14 values, so I am not sure if there is an error there.

I am also unsure about the authors' decision to select 50% as the cutoff for the known groups validity analysis. Known groups validity is intended to determine whether two groups that should have logically different levels of a construct reflect this difference in the measured scores, but I am having a hard time understanding why there should be a hypothesized difference between practices where 50% of the physicians agree to participate in PVS III and those that do not. That seems arbitrary to me and and a low bar. Despite the note of caution in the discussion section, I remain skeptical about the utility of the ROC analysis and about the proposition that a score of 64.48 means anything meaningful in practice. There are two practices (Bolueta and Ellorio) that have engagement higher than 60%. Conceptually, it seems more conceptually justifiable to propose the score of a practice that has engagement of 60% or more as the cut off and presenting the ROC curve. If the cutoff score results in a number of practices with a lower engagement % but a higher OR4KT score, this would be an important area to point our for future research. But without justification for why 50% was selected, this analysis seems more like an exercise to propose a cutoff score than having any bearing on what it means in practice. I would encourage the authors to consider this further.

Reviewer #2: Having carefully reviewed the authors' responses to the reviewers and editor's revisions, I consider that the manuscript is now suitable for publication.

ASSOCIATE EDITOR NOTES:

Please attend to the two minor issues raised by the Reviewer below. In addition to checking (and possibly correcting) for errors in Table 5 and text, please address the issue about the 50% cutoff for distinguishing "engaged" and "not engaged." Can you strengthen the case for using this cut-off based on prior research? If it's more an experiential/intuitive cut-off, that's worth acknowledging. Perhaps a good place to address this issue would be in the limitations section where you discuss the ROC analysis. This paragraph could use a little more elaboration anyway.
Perhaps you could also address there (a) what ROC results would have been ideal for known-groups validity or (b) what needs to happen next for known-groups validity.

Firstly, we have verified and corrected the error in Table 5 (the first row was left over) and the text associated with it (page 17 line 10 and page 27).

Secondly, we consider that those centers in which the majority of the professionals commit to participate and sign collaboration consent are clearly different from those in which those professionals are in minority. Absolute majority is the most popular method to make group decisions and reach group consensus, which are the fundamental procedure under the process of collaborative modeling of PVS programs. We do admit that this is the first evaluation of the validity of OR4KT, which should be considered as the first exercise to explore the identification of a cut-off score, and this has been highlighted in the limitation section (page 17, lines 5 to 9).

“(2) we consider that those centers in which the majority of the professionals commit to participate and sign collaboration consent are clearly different from those in which those professionals are in minority. Absolute majority is the most popular method to make group decisions and reach group consensus, which are the fundamental procedure under the process of collaborative modeling of PVS programs, but it’s a an experiential cut-off”

In addition, in the future research section (page 17, lines 24 to 26) it has been added that it would be convenient to carry out more analysis of known groups once we know that health centers of participants in PVS-III have reached the standards to consider that they have modified their preventive practice.

“Finally, it would be convenient to carry out more analysis of known groups once we know that health centers of participants in PVS-III have reached the standards to consider that they have modified their preventive practice.”

We hope that this version will be considered suitable for the journal.

Please do not hesitate to contact us if there are any further doubts.

Yours sincerely,

Gonzalo Grandes, MD, MS