

Peer Review File

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<b>Comment</b>	<b>Response</b>	<b>Changes in the text</b>
Ln 26 please place corresponding author at the end of list and Ln 39 clarify corresponding author.	We have changed the corresponding author to the most senior author, Nancy Borkowski, who is at the end of the list.	We added a line clarifying corresponding author.
Ln 50 word count 2600—The publisher has no word limit on original articles, and 2600 words does not allow for adequate background and discussion of the study, especially for non-expert readers. A count of 4000 words is more appropriate for an original research publication. Currently, 2600 is too limited to convey an important area that deserves more effort.	We have added significant narrative under the Background section of the manuscript that provides a comprehensive but concise overview of both FQHCs as well as HCCNs	Narrative was added creating new pages 3-6
Abstract 56 through 70 More detail is needed, and the Results and Conclusions are too succinct to inform PubMed viewers from comprehending the study. Please—if anything—make the methods more succinct. Abstracts are usually 300 to 350, barring restrictions.	We have edited the abstract to be more comprehensive of the study.	Please see the manuscript for track changes.

<p>Ln 144 Please expand on why only a single FY2018 was examined. Would it have been better to combine one or two more years to provide an average? Would the database have become too unwieldy to analyze? A rationale should be given for limiting the data to one FY. The method used to select the non-participating FQHCs should be stated, as well as any criteria used to group HCCN groups.</p>	<p>This study uncovered many changes in grant and grantee reporting requirements throughout the HCCN program lifecycle. Due to changes in the HCCN reporting requirements this study was limited to evaluating the 2016-2019 grant period.</p>	<p>The single year limitation was addressed in the discussion area as follows...” Due to changes in reporting throughout the HCCN program lifecycle, this cross-sectional study was limited to the FY 2018 grant reporting period. HRSA grant requirements changed in 2010 increasing the number of required participating health centers to 10 to meet the HCCN grant funding requirements. As such, there are many operating HCCNs that did not meet this 10-member threshold or elected not to pursue federal funding and therefore were not included in this study. It was also in 2010 when HRSA invited PCAs to compete for HCCN grants.”</p>
<p>Ln 159-205 In the methods more detail is needed on the composition of samples and how they were used in the tables. It’s unclear whether table calculations were based on affiliation mean scores: meanN1, meanN2 meanN3, or the sums of the non-affiliated FQHCs, freestanding and PCAs (N1, N2, N3). Table 1 should contain sums of total patients see annually if this was used as part of the calculations. The statistics described in the methods need to describe the sample source (mean or sum).</p>	<p>Thank you for your feedback.</p>	<p>Table 1 has been updated to clearly reflect mean, sum, or % used for our calculations.</p>

<p>Ln 207-222 The chi-square scores are clearly significant in table 1. The text should note whether the chi-square and ANOVA was calculated on the N (sum) of each group or the mean since this was over one FY. The table needs to include a row showing the N for each group above the row for mean.</p>	<p>Thank you for this observation. We have added information to the text to show that the chi-square and ANOVA test results are calculated on the average for each group. We have also included a row that shows the number in each group.</p>	<p>Table 1 has been updated to clearly reflect these changes.</p>
<p>It is unclear if the urban and rural frequency data represents the N of each group or the mean. The source of frequency data needs to be identified in the results narrative and table legend. Descriptors can be identified using subscripts a, b, and c, etc. to label in the table and defined in the legend. Note, analysis of the rural data is missing the chi-square value and p value.</p>	<p>Thank you for your feedback.</p>	<p>Table 1 has been updated to clearly reflect mean, sum, or % used for our calculations.</p>
<p>In cases where frequencies are expressed, please arrange as: n (%) instead of in separate rows.</p>	<p>In the cases of categorical variables where we present the frequencies, we have it displayed as n (%)</p>	<p>Table 1 has been updated to clearly reflect these changes.</p>

<p>Move the FQHC affiliation definitions from the first row—delete the row—and identify the table and legend using a letter subscript. Please insert p values next to the chi-square value after a comma and remove the last column. If possible, enlarge the font, and remove all vertical lines which are inappropriate for publications. Ideally, two horizontal lines at the top should enclose the variable labels, and a single line at the bottom below the last line of data. Add 1.15 or 1.5 space between rows if the table will fit since publishers are now using author formatted tables. The table should be able to be interpreted alone, and as such, the legend needs to provide abbreviations that fully describe that part of the study.</p>	<p>We thank the reviewer for this comment. We have used removed the last column of the table and inserted the p-values next to the chi-square value after a comma. All vertical lines are removed and there is now a space between rows. We believe Table 1 is much improved.</p>	<p>Table 1 has been updated to clearly reflect these changes.</p>
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<p>Ln 224-260 Table 2 comparing the clinical performance between the different affiliation groups is the strongest part of the study, clearly showing that HCCN affiliations in many cases were higher performing than FQHCs with no HCCN affiliation. Based on the odds-ratios of logistic regression of 1.4 to 1.5 the lower 95% C.I. are likely to be greater than 1.0 demonstrating significant differences than the referent. With Females patients, it is less clear that odds-ratios of 1.001, 1.011 and 1.012 are significant based on the absence of 95% C.I.s. This similarly applies to the row on Poverty Below 100%..., Depression and Adult Weight Screening. Even with significant 95% C.I.s the discussion needs to evaluate the clinical significance of these results, as well as supporting literature if possible. The large N for both groups may result in significance, but are the results clinically relevant? For odds-ratios of less than one, the upper C.I. should be less than one. Currently, the argument is growing that publishing estimates of effect size--like odds-ratios with 95% C.I.—convey more to the reader than isolated p values. The importance of the results in table 2 could be improved by providing the 95% CI for the significant (in bold) comparisons that the authors' considered relevant to the clinical outcomes. For example, none of the HIT Adoption odds-ratios were labeled significant, although the ratios clearly indicate they would be significant. If HIT Adoption is not relevant, this row and others should be removed to avoid confusion with the rows of relevant</p>	<p>We thank the reviewer for the observations. We have added the 95% CIs for the significant variables. Upon further review we realized that the models in Table 2 control for: 1) HIT adoption, which likely proxies for EHR adoption, and 2) patients below 100% of the FPL, which likely has non-trivial overlap with patients who are minorities, homeless, or farmworkers. We removed those x-variables and re-ran the analyses. We believe the new models have addressed the reviewer concerns. The text in the paper has been revised to reflect the new results. We have limited all results to two decimal places with the exception of a few cases in which rounding will get rid of noticeable differences.</p>	<p>Due to the extent of changes and the rerunning of models, we felt it was best to keep the changes in track changes and not in the response letter. Please see track changes in the manuscript for all the changes.</p>
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<p>comparisons. Expressing 95% C.I.s is important, especially because of the ones with small ratios. One idea in the table is to place the 95% C.I. one line below in the same cell as the odds ratios of only the significant results. To diminish busyness and confusion, the odds-ratio should be decreased to one decimal place 1.419 to 1.4 and just below for example (1.2 to 1.6) for the 95% C.I. Another idea is to leave the numbers as is in table 2, and state the odds ratio and 95% C.I.s in the text in order to handle problems like 1.001 (95% C.I. 1.003 to 1.011) where rounding to one decimal will eliminate indicated differences. Thus, readers can understand that that large N sizes can yield significant effects at low odds-ratios. Yet the relevance of these small ratios needs to be described in the discussion regarding true differences between affiliations.</p>		
<p>All formatting changes for table 1 need to be applied in table 2</p>	<p>Formatting changes from table 1 have been applied to table 2.</p>	

<p>Ln 262-267 Table 3 provides difficulty in interpreting the coefficients and 95% C.I. for linear regression analysis of margin comparisons between the affiliations. Were the regressions calculated on the based on the affiliation mean scores meanN1, meanN2, meanN3, or the sum of all the groups in each affiliation (N1, N2, N3)? In addition, the Coef. column needs more detail. I'm guessing these results are the unstandardized slope coefficient (B) with the 95% C.I.s. Please label the coefficient column with more detail since it is still a guess about what is being presented.</p>	<p>In the prior version of the manuscript, the total margin outcome was calculated as <math>(\text{total revenue} - \text{total expenditures}) / (\text{total revenue})</math>.</p> <p>To facilitate a more intuitive interpretation, we multiplied the total margin variable by 100 (to convert it to a percent) and reran the regression. In addition, we scaled some variables so the coefficients would be more easily interpretable. We also incorporated a robust correction for standard errors. Finally, we have updated the corresponding text in the manuscript to explain that the coefficients represent percentage point changes in the total margin variable now.</p>	<p>We examined the association among the three HCCN affiliation groups and financial performance using a regression model controlling for organizational characteristics and market factors (Table 3). Relative to FQHCs with no affiliation, FQHCs with a freestanding HCCN affiliation and FQHCs with a PCA/HCCN affiliation were associated with 2.3 and 1.9 percentage points higher reported total margin, respectively (<math>p &lt; 0.05</math>).</p>
<p>The legend in table 3 needs this information on the sample source for calculation in order to stand alone and be interpretable.</p>	<p>All changes from table 1 have been applied to table 3.</p>	<p>Table 3 has been updated to clearly reflect these changes.</p>
<p>All changes in formatting described for table 1 need to be applied to table 3.</p>	<p>All changes from table 1 have been applied to table 3.</p>	<p>Table 3 has been updated to clearly reflect these changes.</p>



<p>The table should illustrate—if possible—the margin differences in dollars created by 2.3% and 1.8% in the HCCN affiliations. It may not look like a lot by % but translate to large monetary differences.</p>	<p>We thank the reviewer for this suggestion. In the prior version of the manuscript, the total margin outcome was calculated as <math>(\text{total revenue} - \text{total expenditures}) / (\text{total revenue})</math>. To facilitate a more intuitive interpretation, we multiplied the total margin variable by 100 (to convert it from a proportion to a percent) and reran the regression. In addition, we scaled some variables so the coefficients would be more easily interpretable. Finally, we have updated the corresponding text in the manuscript to explain that the coefficients represent percentage point changes in the total margin variable now.</p>	
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<p>The Results narrative is inadequate for explaining the meaning of the Table 3 and needs to be expanded and clarified to more fully describe it to the reader. Describe and explain in simple story form from beginning to end like you are teaching clinicians in institutional care with no background, for example. Ln 144-267 The overall results section is written with many complex sentences one after another with little, if any, explanation of the goals of obtaining that data. These sentences should focus on significant findings that will be interpreted in the discussion. Topic sentences can orient non-experts to the goal of that part of the study, usually followed by the results of the study. A paragraph topic statement may work, but with more complex information the reader often needs a prior orientation sentence just before the results in order to provide comprehension. The word count is available to expand this section.</p>	<p>Thank you for the suggestion. We have gone through the results section and clarified the writing, focusing on significant findings to be interpreted in the discussion. We have also added topic sentences to aid with interpretation.</p>	<p>Due to the extent of changes and the rerunning of models, we felt it was best to keep the changes in track changes and not in the response letter. Please see track changes in the manuscript for all the changes.</p>
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<p>The paragraphs in the discussion can be used along with the literature in validating, supporting or distinguishing the results of your study. The discussion needs additional work. Customarily each section of the results are briefly reiterated (whole or part of table), and then how you interpret the results. Literature is cited in this area that helps explain or support your results. If your results are unique and contributing knowledge to the area, the literature can allow you to briefly show its uniqueness. I usually say “To our knowledge nothing has been published on...” “Thus, the results reveal significant new information to guide investigators or providers, or administrators, or etc...” Data that is confirmatory is “These results are consistent with the study by Jones et al. 1985.”</p> <p>Essentially, the discussion is retelling the results in sequence but with interpretation and literature support. Your current discussion statements may fit better as the discussion is developed.</p>	<p>Thank you for your comments and feedback.</p>	<p>We have added narrative to the Discussion section further explaining our study results.</p>
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