Author's response to reviews

Title: Reduction of missed appointments at an urban primary care clinic: a randomised controlled study

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Author's response to reviews:

Dear Editor,

Re: Reduction of missed appointments at an urban primary care clinic: a randomised controlled study

We thank you for reviewing the manuscript named “Reduction of missed appointments at an urban primary care clinic: a randomised controlled study” and for offering us the opportunity to re-submit a revised version of the paper in the light of the reviewers’ suggestions.

You will find below our responses to all points raised by the two reviewers and the changes made in the text.

1st reviewer’s report:

1. One issue that I don't think is clear concerns the proportion of participants who actually have a mobile or fixed phone. It seems unlikely to me that so few people (6%) had both types of phone. I expect that in fact many had chosen to provide only the mobile number to the clinic. If I am correct, the text needs to state this more clearly. For instance, instead of stating that "55.7% (n=586) of patients reported having a mobile phone" it should state that "55.7% (n=586) of patients had a mobile phone number recorded at the clinic." Similarly, in the Abstract, the statement that "Only 61.7% patients reported having a cell phone" needs adjusting.

We agree with the remark and made the following changes:

- Abstract – result section: “Only 61.7% patients had a mobile phone recorded at the clinic”.
- Abstract – conclusion section: we suppressed the sentence “whom mobile
phone penetration was only 61.7%.

- Result section, p10: “In the intervention group, 55.7% (n=586) of patients had a mobile phone recorded at the clinic, 25.6% (n=269) a fixed phone, 6% (n=63) both a fixed and a mobile phone and finally 12% (n=127) no phone.”

- Discussion section, p14: “The success of such an intervention depends on the mobile phone and phone penetration and recording in a given population [27, 28]. In our population, only 51% of the patients had their mobile phone recorded at the clinic and 6% both a mobile and a fixed phone. It is not possible to estimate on such basis penetration rates of mobile phones among our patient population since patients may prefer to give only one phone number. However, while penetration rates of mobile phone range from 20% to 99% over the world (calculated as the % of total telephone subscribers), in Switzerland, mobile phone subscribers represented 64.6% of total telephone subscribers in 2008 [28].”

2. I felt that the economic evaluation was very limited, and only just worth including. The economic implications are of course important and need discussing. However, the analysis given is very much dependent on the health care setting. If a missed appointment costs the clinic in Switzerland 80 Euros then this is clearly a figure that can be used to balance the costs of administering the intervention. However, in everyday practice the work would be done by an administrative staff member, not a research assistant, and the benefits would include reductions in otherwise wasted physician time, etc... So in a different setting the economic implications may be very different and this needs acknowledging in an international journal.

We agree and modified the text in the following way. In the discussion section, we shifted the paragraph on the economic evaluation under limitations and modified the text in the following way:

Discussion section – limitation section, p. 16: “Finally, the economic evaluation, which, proved to be economically efficient, similarly to other randomised studies testing text messaging and/or mobile phone reminders only, [2, 11, 16, 35] was limited and did not take into account the precise number of missed appointments which led to subsequent rebooking. Economic implications may differ according to the health care system: wasted physician time may be more relevant in countries based on a capitation payment system, while financial losses may raise more concerns in health care systems based on a fee-for-service model.

3. Fisher is incorrectly spelt Fischer beneath Table 2.
We replaced Fischer by Fisher beneath Table 2.

4. Page 9: "Difference level of 0.05 or less was considered statistically significant." I think this should be "P values of 0.05 or less were considered statistically significant."
We modified the text in the desired way:
- Method section, p. 9 – statistical analysis: “P values of 0.05 or less were
considered statistically significant”.

5. In the Abstract, when describing the sequential intervention I think "1. phone call reminder" should be "1. phone call (fixed or mobile) reminder". Also in the Abstract, "SMS" should be "Short Message Service (SMS)" for readers who do not know this abbreviation. It is given later in the text but needs to also be given in the Abstract.

We changed the text in the following way:
- “1. phone call (fixed or mobile) reminder; 2. if no phone response: a Short Message Service (SMS) reminder; 3. if no available mobile phone number: a postal reminder.

2nd reviewer’s report:

1. Is the sub-group analysis powered sufficiently to draw the conclusions the authors have drawn?

Power analysis is used a priori to estimate if a sample size is big enough to avoid a Type II error, which would lead to consider that there is no observed difference between groups in the sample, whereas this difference is actually true in the population study. Post hoc power analysis cannot be used to add something to the interpretation of the results. Since the observed power is completely determined by the observed p value, it would yield to a completely different sample size than the one calculated before the study using a priori assumptions.

References:
- Zumbo, B.D. and Hubley, A.M. (1998). A note on misconceptions concerning prospective and retrospective power. The Statistician. 47-2. 385-388. A PDF copy of this paper may be obtained by e-mail from bruno.zumbo@ubc.ca.

Therefore, we can only make hypotheses about the lack of effectiveness of the intervention in the HIV and dietician groups, the small number of patients being one possible reason. This is developed in the discussion in the following way:

“However, subgroup analysis shows that the intervention’s effectiveness was only statistically significant in the primary care and the tobacco cessation consultations. While reasons of the lack of efficacy of the intervention in the HIV and dietician consultations are not clear, one explanation could be attributable to low numbers of patients enrolled in the HIV (n=303) and in the dietician consultation (n=127). Other characteristics such as patient profiles or patterns in profiles may also have impacted on such differences.”

2. What is ‘allophone’?

Allophone is a term used to designate people not speaking the language of the community they live in. It has been used in a few papers published in
international journals. Since its use may be “Swiss”, we replaced the term “allophone” by “non French speaking”.

- Result section – sociodemographic and medical profil of non attenders, p11: “There were no increased odds of missed appointments for variables such as undocumented migrants, non French speaking patients, new patients, or post ED visits.”

We join to this letter a new version of the revised manuscript and hope that the corrected manuscript will suit you.

Yours sincerely,

Dr. N. Junod Perron