Author's response to reviews

Title: Factors affecting the use of patient survey data for quality improvement in the Veterans Health Administration

Authors:

Elizabeth A Davies (Elizabeth.Davies@kcl.ac.uk)
Mark M Meterko (Mark.Meterko@va.gov)
Martin P Charns (Martin.Charns@va.gov)
Marjorie E Nealon-Seibert (Marjorie.Nealon-Seibert@va.gov)
Paul D Cleary (Paul.Cleary@yale.edu)

Version: 4 Date: 23 September 2011

Author's response to reviews:

Dear Flory Mae Calumpita,

Re: MS 2143849721515850 Factors affecting the use of patient survey data for quality improvement in the Veterans Health Administration

Thank you for very much indeed for the decision to accept this paper with minor essential changes. We have set out the changes we have made in response to the reviewer comments below and marked these within the manuscript in red:

Major compulsory revisions

1. Background (last paragraph): as suggested the authors link their hypotheses to the 3 study goals. I, however, do not understand the relationship between ‘the types of support to be determined’ and the hypotheses that ‘improvement strategies are multi-stage and iterative’ (goal 2).

Response: We have re-worded these two sentences to make the link clearer: “To determine what types of supportive improvement strategies are necessary for implementing and sustaining patient-centered care. We hypothesized that these would be multi-stage and iterative, having effects over several years.”

2. Discussion: Although the authors acknowledge the limitations of their study to a larger extent, I still miss some comments in this regard:

a. Last sentence, 1st paragraph: this sentence is misleading. The results show that the authors felt the differences were big enough to distinguish between high and low performing facilities, only the difference appeared to be the other way around. More reflection is needed.

Response: This paragraph has been revised and added to:
“We made intensive efforts to understand the specific kinds of policies and activities that facilitate and/or inhibit patient-centered care, but the data did not allow us to achieve this third goal of the study. Although we identified many factors that we thought were likely to be related to how well the facility provided such care, in the final analysis we made the wrong judgment about these differences in terms of distinguishing whether their performance was high or low. With the benefit of hindsight and un-blinded knowledge of actual performance, clues about lower emotional support in the second facility can be seen in interviews describing continued attempts to improve this element of patient experience. On reflection, there were insufficient data from individuals with experience spanning the full study period; information from more such individuals could have made the decision more accurate.”

b. Limitations: I would (again) mention that the data did not allow to answer goal 3 of the study.

Response: This point has been mentioned again.

3. Discussion, comparison other findings: this paragraph repeats the results of some previous studies. This information is already provided in the background and I miss the direct comparison. It should not be left to the readers to make this comparison for themselves. It is only mentioned that patient involvement was also not prominent in the present study.

Response: The two studies have been described in more detail and direct comparisons have been draw out more fully and added to the discussion as requested. After reflection the point about the lack of patient involvement in all studies has been moved to the section describing implications for future research.

Minor essential revisions
1. For me it is still not clear how the 6 facilities were selected. It is now clear why it was difficult to select improving facilities, but why not also 2 stable low performers for instance? The selection procedure seems quit random.

Response: Our selection process was not random but was influenced by observed patterns in the data, the need to select sites with definite trends in their scores over all nine periods and to have useful comparison sites with stable scores. As a team we chose the two facilities that had improved the most, having moved from the “low” to “high” performance group, and one stable low performer as a comparison site. We then identified two stable high performers and one stable medium performer as a comparison site. We reasoned that these sets of comparisons would likely provide us with useful insights on factors relevant to how facilities improved or sustained high performance by comparison to sites with consistently lower scores. These points have been added to the methods.
2. Discussion, implications future research: the authors provide several recommendations to improve the response rate among staff members. I miss suggestions to convince the directors of facilities to participate in the first place.

Response: We now suggest that higher profile multi-site studies of the implementation of defined initiatives offering training and support (similar to our previous research in Minnesota) might also encourage directors to agree to their facilities being included.

Dr Elizabeth Davies