Author's response to reviews

Title: Chronic disease management: a qualitative study investigating the barriers, facilitators and incentives perceived by Swiss healthcare stakeholders

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Author's response to reviews: see over
Dear Editor,

We thank you for the opportunity to submit a revised manuscript (MS: 3711838466739606) to BMC Health Services Research. We have carefully examined the comments made by you and the three reviewers and addressed these point-by-point. Comments were addressed fully with responses and changes in the manuscript, as detailed in the accompanying text. While reading the whole manuscript again, we made additional changes where appropriate. All the modifications are tracked within the text.

We believe that the changes we have made based on the reviewers' comments have greatly improved the quality of our manuscript.

We thank you again for your suggestions and consideration of this resubmission.

Sincerely yours,

Stéphanie Lauvergeon, PhD Candidate

NB: Our official address has just changed; it has been modified on the website of the journal.
Editor’s Comments

1. «Please adhere to RATS guidelines for reporting qualitative studies. PRISMA? Systematic Reviews http://www.prisma-statement.org/ »

   While preparing the manuscript, we referred to RATS guidelines indeed. For the current revision, we have looked again at these guidelines and have complemented the text, particularly in the Methods section. We have also answered the reviewers’ comments taking into account RATS guidelines.

   Since our research is not a systematic review, we could not use PRISMA.

2. « Please make the following formatting changes during revision of your manuscript. Ensuring that the manuscript meets the journal’s manuscript structure will help to speed the production process if your manuscript is accepted for publication». 

   We have now used the template provided in the BMC’s authors’ checklist.

3. « After reading through your manuscript, we feel that the quality of written English needs to be improved before the manuscript can be considered further. We advise you to seek the assistance of a fluent English speaking colleague, or to have a professional editing service correct your language. Please ensure that particular attention is paid to the abstract. »

   This article was copy edited by a native English speaker professional translator. This is specified in the acknowledgement section. It was also additionally checked by two other fluent English speaking colleagues, who read again and modified the abstract for the current revision.

Reviewer #1

4. “The study was performed in two modes of focus groups and individual interviews. The demographic information about the focus groups are clearly mentioned but detailed information about the individuals is not clearly specified. Also, the numbers should be corrected as it was mentioned that 33 interviews were done: 35 in French, 8 in German.”

   We did not detail demographic information of the individuals we interviewed because we did not select them according to their “personal” characteristics. In fact, we selected them according to their knowledge on the studied topic (purposive sampling). To be clearer, we have changed the text as follows:

   “Each group received a letter detailing the aims of the study and made us contact with a key informant member interested to participate in our study.”

   We apologize for the mistake in numbers. We have corrected the text as follows:

   “Thirty-three individual interviews were conducted: 25 in French, 8 in German.”
5. “Focus groups are performed with diabetic patients. No evidence was provided that the people living with diabetes are representative of all people suffering from chronic diseases.”

We agree with this comment. Initially, we have chosen to perform three focus groups with chronic diseases patients: one with diabetic patients; one with patients suffering from heart failure and one with COPD patients. For the FG with diabetic patients, it was easy to recruit participants since there is a Diabetes Association which agreed to help us. Conversely, there are no associations of patients with heart failure or COPD in Switzerland. We have nevertheless tried to recruit heart failure and COPD patients by contacting the regional association of cardiologists and pneumologists. This was unfortunately unsuccessful. The few physicians who accepted to help recruiting patients failed to recruit a sufficient number of patients. Eventually, we gave up organizing the planned focus groups with heart failure and COPD patients.

We have added the following information in the text:

“Initially, we planned to organize FGs with patients suffering from diabetes, heart failure and chronic obstructive pulmonary disease (COPD). However, because the absence of patients’ associations targeting the latter two diseases and the lack of success of cardiologists and pneumologists in recruiting these patients, we eventually renounced to organise these two focus groups.”

6. “The process of selecting patients from those who agreed to participate needs to be elaborated more clearly. The criteria are provided but the demographics of the selected participants should be presented too. This will help the readers to judge the generalizability of this study to their own setting ».

We agree that demographic information could be interesting. However, we have decided not to describe it since we had tried to get a large variety of stakeholders who were chosen as key informants by the contacted organizations or associations. It is thus not relevant to describe the age or gender of participants. For the focus-groups, we only proceeded to participants selection (as described in the Method/study population/focus groups section on page 6) if more than 12 possible participants were listed.

7. “It could be more methodologically accurate, if the two interviewers coded the transcripts independently and then compare their results to prevent individual bias rather than one person checking the work of the other researcher.”

Considering the vast amount and the large data variety, only one researcher (SL) analyzed the data to obtain consistency in the analysis process. The thematic analysis conducted was made inductively, thus requiring a thorough and detailed data exploration. The researcher (SL) and the last author (IPB) exchanged regularly on this process and the last author checked all the analyses to ensure consistency.

8. “In the results section, the main focus of the article is on the common themes among various interviewees. Although the difference of opinions are specified, but in most cases the rationale behind those differences are not presented. For example, this investigation is presented for incentives at patient level, where the reason for different opinions among physicians and health insurers with the rest of participants are discussed. The same approach should be extended to other parts to improve the article. Root Cause Analysis (RCA) is a good method to address this issue.”
The objectives of our study were to explore opinions of various healthcare stakeholders on the development of CDM programs in Switzerland in order to understand barriers, facilitators and incentives to their implementation. We did not intend to investigate more in details the rationale behind the differences discovered. The analysis consisted in reducing and categorizing the discussion content using thematic analysis. We have only interpreted the data in the discussion section.

The part of the text to which the reviewer is referring (incentives at the level of patients) corresponds to an explanation provided by participants themselves (what was said by participants is reported). In fact, we did not give any reason to the difference in opinions. To avoid misunderstanding, we clarified the text as follows:

“By contrast, physicians and health insurers expressed their scepticism about the effectiveness of such incentives because, according to them, they could lead to patients’ participation to CDM for economic reasons, or to a “two-speed healthcare”, with some patients preferring to pay more for having free choice of care”

9. “Also, two changes are recommended to improve the article itself:
   - The selection of keywords can be improved by matching the terms to MeSH keywords, e.g. Qualitative methods are worded as Qualitative Research.
   - In the references some of the articles titles are presented in languages other than English. As this journal is published in English, translating these titles to English can improve the usability of the journal for all readers”

We have made the suggested changes.

Reviewer # 2

No specific comment made by reviewer n° 2

Reviewer # 3

10. “The manuscript is generally well written and easy to follow. Some copy edits would be helpful prior to publication. For instance, capitalization is often inconsistent (see the list on page 5 as an example) and some language constructions are awkward or incorrect (e.g. “made us” on page 6, “mean” should be “means” at the bottom of page 10, “participating to CDM program” on page 15).”

As suggested, we have changed capitalization and other awkward or incorrect language constructions.

11. “The timing of the interviews and focus groups (year, month) is not clear in the manuscript.”

We have added the following information within the text:
“Two researchers, specialized in qualitative research methods, conducted the individual interviews and the FGs between October 2009 and June 2010.”

We have also specified the duration of the interviews and FGs.

12. “The discussion section mentions that participants in interviews and focus groups were provided with information about chronic disease management. It would be helpful if this context could be briefly described in the methods for clarity about the context in which participants were commenting on facilitators, enablers, and barriers.”

Participants did not comment on facilitators or barriers explicitly mentioned. In fact, they had to think of possible barriers and facilitators that could exist and impact, within our healthcare system, CDM development. We have clarified this in the Method section:

“Before exploring the participants’ opinions on CDM, we first asked participants if they had previously heard about it. If they did not know CDM, we briefly defined it. Indeed, we explained that it was a means to eliminate care fragmentation, that it included patients’ self-management and professionals’ teamwork, and that CDM programs were based on formal evidence of effectiveness and were adapted to patients’ needs. The latter point was illustrated with a figure of Kaiser’s triangle. For the FGs, we also added a clinical vignette presenting the story of a fictive patient benefiting from CDM.”